Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 26 March 2025, 13:30 - 16:30

Agenda

13:30 - 13:30 ***Meeting agenda***
0 min

00. Agenda for Part 1 ICB Board 26.03.25.pdf (5 pages)

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

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

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

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

03. DRAFT NW ICB Board Part 1 Minutes 29012025 v2.pdf (14 pages)

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

04. ICB Board Committee Register March 2025.pdf (5 pages)

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

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

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

13:30 - 13:30 **7. Chair and Chief Executive's Report**
0 min

07.Chair and Chief Executive's Board report - Final.pdf (6 pages)

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

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13:30 - 13:30 **8. Lived experience item - the Voice of Youth**
0 min

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

09. P&C Committee Report to Board.pdf (4 pages)

13:30 - 13:30
0 min

10. Report from the Quality and Safety Committee

10. Quality and Safety Committee Report to Board.pdf (8 pages)

13:30 - 13:30
0 min

11. ICB Board Health Inequalities Maturity Assessment

11. ICB Board_Health Inequalities EDI reporting_Mar25 final.pdf (6 pages)
11.1 NWICB EDS2025 - Final version.pdf (85 pages)
11.2 Gender Pay Gap Report 31.03.24 FINAL.pdf (10 pages)
11.3 WRES report as at 31.03.24 FINAL.pdf (8 pages)
11.4 WDES report as at 31.03.24.pdf (11 pages)
11.5 NWICB Health Inequalities Improvement Plan - Final draft.pdf (36 pages)

13:30 - 13:30
0 min

Comfort Break 10 Minutes

13:30 - 13:30
0 min

Commissioning, Delivery and Performance

13:30 - 13:30
0 min

12. Financial Report for Month 10

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

13:30 - 13:30
0 min

13. Phase One report NHS England – to follow

13. ICS I&I Phase 1 Deloitte's Report January 2025.pdf (2 pages)
13.1 NW I&I Support - Summary Report FINAL.pdf (30 pages)

13:30 - 13:30
0 min

14. Report from the Finance Committee

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

13:30 - 13:30
0 min

15. Integrated Performance Report (IPR)

15. 2025.03.26 Performance narrative.pdf (8 pages)
15. 2025.03.26 Performance Report.pdf (51 pages)

13:30 - 13:30
0 min

16. Performance Management Framework approval

16. Performance Management Framework.pdf (2 pages)
16.1 FINAL NWICB Integrated Performance Management Framework.pdf (21 pages)

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13:30 - 13:30
0 min

17. The Joint Forward Plan Refresh 2025/26 – 2029/30

17. ICB Board report 26 March 2025.pdf (5 pages)
17.1 ICB_Part_1.pdf (133 pages)

17.2 ICB Part_2 - AC edits - March 2025 v3.pdf (48 pages)

13:30 - 13:30
0 min

18. Report from the Commissioning and Performance Committee

18. CP Committee Report to Board.pdf (8 pages)

13:30 - 13:30
0 min

19. Report from Primary Care Commissioning Committee

19. PCCC Report to Board.pdf (8 pages)

13:30 - 13:30
0 min

System Oversight

13:30 - 13:30
0 min

20. Governance Handbook updates

20. Board paper Gov Handbook changes March 2025.pdf (4 pages)

13:30 - 13:30
0 min

21. Board Assurance Framework

21. Risk Management Report-Board-Pt1-BAF-Mar 25.pdf (3 pages)
21.1 Appendix 1-Board Assurance Framework-Board Pt1 Mar 25.pdf (66 pages)

13:30 - 13:30
0 min

22. Report from the Audit and Risk Committee

22. ARC 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

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

13:30 - 13:30
0 min

24. Questions from the Public

13:30 - 13:30
0 min

25. Any other business

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NHS
Norfolk and Waveney
Integrated Care Board

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

Wednesday, 26 March 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 21 March 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.

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Chair: Hein van den Wildenberg (Vice Chair)

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

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Item	Time	Agenda Item	Lead
		Strategy and Partnerships	
10.		**Report from the Quality and Safety Committee**	Cathy Armor
11.		**ICB Board Health Inequalities Maturity Assessment** To present the ICB Organisational Health Inequalities Improvement Plan 2025-2027 and reports for discussion and agreement.	Mark Burgis
		Comfort Break 10 Minutes	
		Commissioning, Delivery and Performance	
12.		**Financial Report for Month 10** To receive a summary of the financial position as at month 10.	Steven Course
13.		**Phase One report NHS England**	Steven Course
14.		**Report from the Finance Committee**	Hein Van Den Wildenberg
15.		**Integrated Performance Report (IPR)** To provide assurance to the ICB Board and highlight significant elements of the system performance reporting.	Andrew Palmer on behalf of Matt Dooley
16.		**Performance Management Framework approval** To share the draft of the Integrated Performance Management Framework and seek ratification for the framework.	Andrew Palmer on behalf of Matt Dooley
17.		**The Joint Forward Plan Refresh 2025/26 – 2029/30**	Andrew Palmer
18.		**Report from the Commissioning and Performance Committee**	Hein Van Den Wildenberg
19.		**Report from Primary Care Commissioning Committee**	Ian Wake/Hein Van Den Wildenberg
		System Oversight	
20.	3.50	**Governance Handbook updates**	Karen Barker

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

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NHS
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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.

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Protocol for submitting questions to the ICB Board

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

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

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

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

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

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

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

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

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

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NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Wednesday, 29 January 2025

PART 1 – Meeting in public

Board members present:

- Hein Van Den Wildenberg (HvdW), Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB (Chair)
- 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
- Stuart Keeble (SK), Local Authority Partner Member
- Ian Wake (IW), Local Authority Partner Member
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Dr Faisil Sethi (FSe), Partner Member – NHS Trusts (Community & Mental Health)
- Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director of Performance, Transformation and Strategy, and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney ICB
- Matt Dooley (MD), Executive Director of Commissioning and Performance, NHS Norfolk and Waveney ICB
- Stuart Lines (SL), Director of Public Health, Norfolk County Council (part attendance)
- Andy Yacoub (AY), Chief Executive, Healthwatch Suffolk (part attendance)

Attending to support the meeting:

- Belle Ward (BW), Executive Assistant, NHS Norfolk and Waveney ICB (Minutes)
- Sara Tough (ST), Executive Director of Children's Services, Norfolk County Council

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting. Apologies were received from the following Board members: • Rt Hon. Dame Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB • Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services	

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	The Chair welcomed Dr Faisil Sethi (FSe), Chief Medical Officer and Deputy CEO of Norfolk and Suffolk NHS Foundation Trust (NSFT) to the Board. The Chair extended his thanks to CD for her contribution to the Board and more broadly in her role at NSFT. The Chair noted that Cllr Bill Borrett had resigned from the Board and on behalf of all Board members, extended his thanks for his contributions. He noted that the Integrated Care Partnership (ICP) would nominate a new member to the ICB Board.	
2.	**Questions**	
	The Chair noted that two questions had been received from the public that did not relate to agenda items. He confirmed that both would be answered in writing and that the answers would be published on the ICB website.	
3.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 27 November 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 ICB'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 were seven items on the action log, all of which were proposed to be closed. **Agreed:** The ICB Board agreed all actions to be closed.	
7.	**Chair and Chief Executive's Report**	
	TB introduced the item by highlighting key points from the report. She formally congratulated The Right Honourable Dame Patricia Hewitt on her recent damehood, noting this was richly deserved. The report was noted.	
	Learning from People, Staff, and Communities	
8.	**Learning from People, Staff and Communities**	
	PD'O introduced the item and thanked Healthwatch Norfolk for their work in producing the video about dentistry. PD'O noted the challenges around dentistry and that this was an area which the ICB received the highest number of complaints regarding access and availability.	

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MB provided context, explaining the ICB took on responsibility of dental provision in April 2023 from NHS England. The ICB had then produced both short and long-term dental plans, and was investing £7m in 2024/25 in dental services. As a result of the investment in an urgent treatment service, two thousand additional urgent appointments had been created.

Questions and comments from Board members:

- FS commented that given how difficult it was to recruit and retain dental professionals, and referenced the lack of a dental school in the East of England. She noted work was underway with stakeholders to address this.
- FS noted a successful GP fellowship scheme which could be rolled out to dentistry to encourage newly qualified dentists to live and work in Norfolk and Waveney.
- AD asked how up to date the information 111 holds was, given the people in the video were contacting dental practices and unsuccessful in securing an appointment.
- MB explained that information was kept as up to date as possible and if they were made aware that practices were not offering services, the ICB team would respond and investigate. MB added that fundamentally, the challenge was due to capacity.
- DH asked how many treatments would be needed in a year to make an impact. He explained he would like to understand the enormity of the task given the lack of dentists and suggested sight of a trajectory or milestone would be helpful, so the Board could measure success.
- MB agreed to check with the ICB team.
- FSe commented that it was complicated and suspected the number of appointments needed would be far larger when taking into account the number of people who had attempted to get an appointment and failed.
- SC asked if there was an assessment of the national insurance increase and its impact.
- MB confirmed that since taking on responsibility, there had been a positive shift in working relationships between the ICB and dentists themselves.

The Chair extended his thanks to Healthwatch Norfolk for their support with the video and to PD'O and MB for their input.

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	Action: MB to investigate how many dental treatments would be needed for significant improvement and to provide a trajectory or milestone in order to measure success. The ICB Board noted the report.	**MB**
9.	**Report from Patients and Communities Committee**	
	AD reported that the Committee wanted to highlight to the Board the issues with accessing mental health services. AD highlighted areas of concern relating to challenges with referrals to specialist mental health services and how carers of people with serious mental health issues, often felt undervalued and unsupported. Long waiting lists for ADHD and ASD diagnosis were highlighted as another concern. AD noted that work was underway but there remained room for improvement. **Agreed:** The ICB Board noted the report.	
	Strategy and Partnerships	
10.	**Joint Children's update - the Children's Landscape and Opportunities in Norfolk**	
	PD'O and ST introduced the item, highlighting key items from the presentation. They explained that a joint view was needed to raise the visibility of children, to note the common challenges and the fantastic work being undertaken for a consistent and collective strategy for children. Questions and comments from Board members: • TB commended the huge amount of work that had gone on behind the presentation, adding it was great to see the combined team working well together. • TB asked about prevention, and if we were to do nothing other than what was already being done, what would happen to demand. She suggested that younger people needed to be considered as part of the prevention agenda and the integrated neighbourhood teams. • ST explained that this could not be solved by one agency, and it must be done through prevention at a local level. She added that if nothing was done differently, demand would increase, noting that the pandemic had impacted on the situation, but that the issue had existed before that too. • ST noted the prevalence and increase in demand, as well as changes in our understanding of children with social, emotional, mental health needs and children with ASD and ADHD.	

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- AD noted she was encouraged by the ambitions. AD asked ST from all the work needed, what were the top two or three challenges that we could address.

- ST responded that this would be a three-to-five-year plan however there will be areas which could be enacted very quickly in the short term. The top two things to make us more effective and improve outcomes for children were a high quality, inclusive mainstream education and high-quality care for children at risk of significant harm who could not live in their family network.

- CA referred to a discussion last year about the removal of SEND funding for schools and the impact of this on teaching assistants, resulting in teachers not being equipped to support children on a one-to-one basis. She asked if this went ahead.

- ST confirmed funding was not removed from schools, but there was an in-year adjustment to ways that money was being allocated to schools, and this had meant individual schools had needed to make some difficult decisions. She further explained the need for specialist provision was outstripping current budgets, and that colleagues were constantly looking at how to collectively use funding to make it go further.

- PD'O noted that funding was going to remain a challenge in any portfolio, but what had already been observed in mental health was teams coming together to work differently to better support children.

- PD'O added that the principles for integration should be applied to all areas across the ICS for the future, as it results in a better outcome for the service user, allows our workforces to work together and have one badge.

- SK noted that one of the ICB's in the north west had permission to link up children's data with health data, adding there were some exciting opportunities to evaluate. SK asked a question about the school zones piece and what opportunities had been found so far.

- ST explained the phasing of the school zones was described as zoning, inclusion, and partnerships, noting schools had been incredibly supportive and engaged. The shared ambition was to be able to share information with each other, to be more collaborative and to have a shared understanding of the community that we serve. She added that this would also allow us to hold each other to account.

- PD'O noted that the ICB collaborated very closely with colleagues in neighbouring ICBs.

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	Action: TB to explore with ST how to include young people's perspective in integrated neighbourhood teams as part of the prevention agenda. **Action: Paper to come to Board to focus on strategic alignment and collaborative approach.** **Agreed:** The ICB Board noted the report.	**TB** **PD'O**
11.	**Report from the Quality and Safety Committee**	
	AD introduced the item, highlighting key points from the report. This focused on mental health waiting lists, referral management and palliative care challenges, including inequalities. AD reminded colleagues to include children and young people in the palliative care provision. AD escalated to the Board mental health waiting lists and referral management with the view of seeking a system response to support colleagues at NSFT. Questions and comments from Board members: • FSe commented that he fully endorsed the need to work as system to address challenges in terms of the interface with primary care and mental health. He thanked those who had facilitated such conversations over the past couple of months and noted he was fully involved in this work. **Agreed:** The ICB Board noted the report.	
12.	**Health Inequalities and EDI update and proposed approach for reporting**	
	MB introduced the item, highlighting the key points for health inequalities and equality, diversity and inclusion reporting requirements (EDI) and approach. Questions and comments from Board members: • DH asked if there was any retrospective EDI data for the ICB following the reorganisation, given that we had set an ambition to improve or at least maintain this. He noted we were going to need to make further difficult decisions, so awareness of EDI for our own staff was hugely important. • MB confirmed that as organisation, the ICB had increased capacity and supporting a new a Health Inequalities team. The team was driving this work forward and the framework for action, which had good system support.	

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	• SK welcomed this being brought together. He noted that in the NHSE statement, the report was broken down by both deprivation and by ethnicity and some measures specifically focused on cardiovascular disease, which would have been identified as one of the opportunities going forward. He suggested setting targets to shift the baseline information rather than monitoring, to give ourselves a challenge around those metrics. • FS added that this was the exact challenge the Population Health and Health Inequalities Board had been tasked with and explained this was one reason why much work had been undertaken to develop the dashboard. • CA noted aspects of this, in particular EDI and the gender pay gap, to be very much part of the Remuneration, People and Culture Committee's focus. A plea was made to ensure this was picked up at the committee so they could undertake deep dives. • PD'O reflected that the ICB could be leading on an overarching and consistent EDI plan across both the ICB and ICS, rather than there being multiple plans held. **Action: MB to bring a report about ICB EDI metrics post restructure.** **Agreed:** The ICB Board noted the report and agreed the recommendations.	**MB**
	Commissioning, Delivery and Performance	
13.	**Financial Report for Month 8**	
	SC introduced the item by highlighting key points from the report. SC reported the month 8 position delivered the ICB a year-to-date surplus of £258,000 which was in line with plan. In terms of achieving the ICB year end £387,000 surplus position, SC noted there remained £8.1m of risk. SC explained that whilst the ICB was delivering on plan for a surplus position, the NHS part of the ICS had an underlying deficit of £120.3 million. SC noted there were two main items on the strategic risk register to flag, the underlying deficit position and delivery against the efficiency and transformation programme. **Agreed:** The ICB Board noted the report.	
14.	**Report from the Finance Committee**	

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	The Chair introduced the item, noting there was overlap with the Month 8 Report. The Chair explained there would be a formal review with regional colleagues looking at the forecast outturn with the month 10 results. He noted there was reasonable assurance that the ICB would meet its financial plan for this year, but that next year's financial envelope would be very challenging. The Chair reported that he had omitted to mention under the Chair's report that as a Committee, an update was received on the joint review held by the ICB and Norfolk County Council on the Better Care Fund, Better Joint Social Care and Health Assurance Board. **Agreed:** The ICB Board noted the report.	
15.	**Integrated Performance Report (IPR)**	
	The Chair commended the team on the Integrated Performance Report (IPR). MD introduced the item by highlighting key points from the report, including the development behind the IPR, progress made defining the metrics at each tier and the governance structure. MD explained there had been considerable progress and anticipated reporting through the new format to come to the Board in May. Questions and comments from Board members: • CA extended her thanks to MD for the report but made a plea for the use of acronyms to be reduced. • FS noted the serious impact on operational delivery because of winter pressures and increased delivery demand and provided assurance to the Board on two points of information. FS explained she had joined the Quality team on an unscheduled visit to the tempory escalation spaces to ensure the patients being cared for in those areas were visible, safe and cared for. FS confirmed she received good assurance during the visit. Secondly, good assurance had been received from that morning's Infection and Prevention Control Meeting, noting rigor shown by providers who have responded to the increase in flu and RSV. She added that there had been a huge amount of work and pressure on staff, yet they had come together and done everything possible to reduce the impact on patient care. • The Chair extended his thanks to FS for her assurances.	

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	• PD'O commented that the collective experience and knowledge had created a space where patients were receiving safe care, despite extremely difficult circumstances. • PD'O added the IPR had matured quickly and noted MD comments about other committees being included in it. PD'O flagged that there was a quality strategy with agreed metrics across the system, and that those metrics would sit within the IPR so there would be one set of data. **Agreed:** The ICB Board noted the report.	
16.	**Report from the Commissioning and Performance Committee**	
	The Chair introduced the item by highlighting key points from the report, including approval of the transfer of the patient choice policy from the Quality and Safety Committee to the Commissioning and Performance Committee. The chair noted that all meetings had so far been held in private. In principle, it had been agreed to start conducting public meetings from May onwards. **Agreed:** The ICB Board noted the report.	
17.	**Specialised Commissioning (CEO delegation)**	
	AP introduced the item by highlighting key points from the report, noting the key difference this time was the timing, hence the recommendation to Board to agree the Chief Executive Office could sign the revised delegation and collaboration agreements on behalf of the ICB once finalised. Questions and comments from Board members: • DH asked if the same concerns he had previously about budget handover at the same time as commissioning responsibility applied this time. DH noted the financial pressure the system was under and increased pressure for the coming year. • AP explained the risk profile was different due to the nature of the services, the number, and the data. The services previously transferred had detailed coding and activity information so we could verify the value of services against the funding. AP elaborated that this was not possible this year because of the nature of the block contract, so a detailed piece of work was underway. • AP added that the concept of risk share was being explored so this could be managed across the six ICBs. • AP confirmed the services were well understood and known but were not as visible through the data.	

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	• AD commented that just under 70 services transferring was a lot and should have substantial money attached. She questioned that whilst the consortium has an oversight, how does the ICB closely monitor performance and quality. • AP explained services were already in a way in the trusts that we have relationships with. So, although they were commissioned differently, they would still happen. Hence there was a holistic quality conversation that we would have and through the contract route, includes everything that happens, noting that we wouldn't necessarily deal with the contractual implications. • AP noted there were benefits of bringing this back into the ICB in being able to join up pathways. • PD'O asked that in view of more services coming down into the BLMK hosted service, had there been any conversation about extending the quality arrangement. She added that she would welcome clarity around the escalation process with provider collaborative colleagues. • AP explained that pathways within the same site were easier to understand, but for pathways where patients might go outside of local providers, this was where a lead provider approach would be taken. AP confirmed that the collaborative were alert to this and would monitor, noting the point about escalation. • AP added the combination of reports, papers and collaboration agreement was the right framework to work within and that previously escalations had been dealt with at the Joint Commissioning Committee. An audit would be undertaken in March or April and would provide an independent view as to whether there was anything to be further improved. **Agreed:** The ICB Board noted the report and approved the recommendation that the Chief Executive Officer signs the revised delegation and collaboration agreements on behalf of the ICB Board once finalised.	
18.	**Primary Care Commissioning Committee**	
	The Chair introduced this item, highlighting key points including the approval of the proposal to close Toftwood Medical Centre. The Chair noted this decision was not taken lightly. Patients registered at Toftwood would be transitioned to two neighboring practices as well as having the option to register at another practice if they were within its catchment. **Agreed:** The ICB Board noted the report.	

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	System oversight	
19.	**NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR)**	
	SC introduced the item by highlighting key points from the report, explaining NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. NHSE requires commissioners and providers of NHS-funded care to complete an EPRR annual assurance process. Questions and comments from Board members: • FS highlighted the importance of this work, noting the team had been tested having experienced extreme urgent emergency pressures, extreme weather alerts and exceptional events such as the vessel Ruby in Great Yarmouth. FS commended the EPRR team for their hard work and dedication. • FS noted she, TB, and members of the EPRR team were involved in all day exercises, including a recent mass evacuation exercise. • The Chair noted it was good to see the Queen Elizabeth Hospital improving too last year, but noted several other providers had deteriorated slightly and asked if the team had identified any themes driving the change. • SC explained the were several reasons and that the appropriate actions plans had been put in place to rectify this. SC noted that once we had a better rhythm and had the new standards, we could better ensure things like policy reviews happen in a timely way, so we hit the assessment in good order. • AD referred to cyber security and the latest announcement about banning public organisations from paying ransom demands. She asked if we had more work to do to improve cyber security across the system or were we secure from those demands, and from data breaches. • SC responded that it is a constant battle, but through the Audit Committee, we had recognised this was a particular area to focus on. He explained that Ian Riley, Executive Director of Data and Digital, would be attending the next Audit Committee deep dive to talk about this for both the ICB and the system. He added that whilst all is being done that can be, it is not an area in which we could afford any complacency. **Agreed:** The ICB Board noted and approved the contents of the paper.	
20.	**Board Assurance Framework**	
	KB introduced the item, noting one change had been made to Board Assurance Framework (BAF) 4.	

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	Questions and comments from Board members: • The Chair asked what had driven the change given it is an important risk (adult mental health). The change was from 16 to 12 and passed a critical threshold. • MD explained that there had been a complete review of the framework as the previous version was primarily focused on community transformation, which was an SDF funded programme. The funding for this work had now ceased and the scope of this work would be incorporated into the broader improvement initiatives across NSFT and the wider system. This now reflected our shift towards a pathway-based approach. • MD further explained that this approach emphasized cross organisation collaboration, clinical standardisation across geographies and a more integrated partnership model. • DH commented that it should be noted that not only the size of the BAF and headings had changed in the last few months, but that committees now had responsibility for each risk. • DH added that as a Board, we should take assurance that committees would be undertaking deep dives over the course of the next 12 months, feeding into the Audit Committee who would have oversight. What the Board had received did not include all the background and ongoing work to monitor and manage risks to a suitable outcome. **Agreed:** The ICB Board noted the contents of the paper and approved the change to BAF 4.	
21.	**Report from the Audit and Risk Committee**	
	DH highlighted cyber and digital had been a reoccurring theme at Audit Committee. A deep dive was scheduled to check if the balance between finance and digital investment was right in the environment we were operating in. Additionally, DH noted a post-restructure report from HR highlighted that people were working at capacity and this was impacting on staff. A clear communication plan and action plan was needed to address this over the course of the next twelve months. **Agreed:** The ICB Board noted the report.	

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	Remaining Committees Reports and Questions from the public	
22.	**Report from the Remuneration, People and Culture Committee Part 1**	
	CA provided a verbal update, highlighting the need for the ICB to address restorative culture issues. From a system perspective, the Committee focused on workforce, training needed to fulfil future requirements and the difficulty in manging long-term asks and the short-term financial challenge. CA explained that the Committee looked at retention and in particular exit interviews, which were found not to be commonplace. For the system, areas of focus were the ICS Collective Culture Programme which had been rolled out across three of the trusts and also the leadership offering. Questions and comments from Board members: • PD'O commented that there was acknowledgement that it was tough for everyone, whatever their role. Feedback from the ICB team was that it was really important to feel heard and listened to. • PD'O referred to the NSFT 'Listening in to Action' model which she added had been very highly evaluated by staff because they felt their voice was being listened to. She suggested we should be conscious of initiatives in the system and how we could benefit from learning and evaluation. • PD'O noted she was the ICB's Freedom to Speak Up lead. • FSe commented the 'Listening in to Action' had been highly effective over the last six months, driving improvement and trust. He noted that this was not a one off and that there would be another wave of sessions. **Action: FSe to bring a report to Board on 'Listening in to Action'.** **Agreed:** The verbal update was noted.	**FSe**
23.	**Questions from the Public**	
	There were no questions from the public.	
24.	**Any other business**	
	No other business was raised.	
25.	**ICP update and report**	
	The ICB Board noted the report.	

Date, time, and venue of next meeting:

1.30pm – 4.30pm Wednesday 26 March 2025
Meeting to be held virtually via Microsoft teams

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

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

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

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Catherine 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		Chair of Council, Norwich University of the Arts	2024		
		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. No direct interest although conflicts of interest noted if necessary		Present	Although risks are minimal this will always be declared as with Trust Board declaration of interests
		James Paget University Hospitals NHS FT	X	X	X	Direct	Director of Acute Trust – commissioning decisions could impact my employer.		Present	Decisions impacting the allocation of resources etc to providers would require me to declare an interest not vote on the decision
		Great Yarmouth & Waveney		X		Direct	Place Chair – Gt Yarmouth & Waveney Place Board. No direct interest although conflicts of interest noted if necessary.		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.
		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.

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NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		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.
		Norfolk & Waveney MIND	X			indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	To date	Not involved in any discussions and decisions that might benefit N&W Mind
		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		X		Direct	Chief Medical Officer and Deputy Chief Executive Officer, Norfolk and Suffolk NHS FT	Sept 2024	Present	
		Faculty of Health and Social Sciences, Bournemouth University, Poole			X	Direct	Visiting Professor, Faculty of Health and Social Sciences, Bournemouth University, Poole	Sep-21	Present	
		Arts & Mental Health Charity, Hospital Rooms, London			X	Direct	Trustee & Board Member, Arts & Mental Health Charity, Hospital Rooms, London	Feb-19	Present	
		Lensfield Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
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	Beccles Medical 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
		James Paget University Hospital		X			My wife works at the JPUH, in a non-decision making role		Present	Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the decision will be taken in the best interests of the system with the necessary due-diligence taking place prior to final decision being made.
Emma 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.

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NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
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	Executive Director of Adult Social Services	Norfolk County Council		X		Direct	Executive Director of Adult Social Services, Norfolk County Council	14/10/2025	Present	
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
Fran Whymark	Board Member, Chair of; Norfolk Health and Wellbeing Board and Integrated Care Partnership	Norfolk County Councillor and Cabinet Member for Public Health and Wellbeing.			X	Direct	Chair of; Norfolk Health and Wellbeing Board and Integrated Care Partnership	05/03/2025	Present	
		Broadland District Councillor			X	Indirect	Leader of Conservative Group	13/05/2023	Present	

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

Declared interests of the Board

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Rackheath Community Councillor			X	Indirect	Community Councillor	May-15	Present	
		Fairhaven Woodland and Water Garden			X	Indirect	Member	20/03/2021	Present	
		National Trust			X	Indirect	Member	28/07/2018	Present	
		Ramblers Association			X	Indirect	Member	31/05/2022	Present	
		Hoveton & Wroxham Men's Shed			X	Indirect	Treasurer	Nov-20	Present	
		Educational Foundation of Alderman John Norman			X	Indirect	Trustee	Jun-07	Present	
		Leeds Educational Charity Bawdeswell and Foxley			X	Indirect	Chairman and Trustee	Jun-15	Present	
		Thorpewood Medical Group,			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

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NORFOLK & WAVENEY ICB Action Log Part 1 - Wednesday 26 March 2025							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
39	29-jan-25	How many dental treatments would be needed for significant improvement and to provide a trajectory or milestone in order to measure success	MB to investigate how many dental treatments would be needed for significant improvement and to provide a trajectory or milestone in order to measure success	MB	26-mar-25	MB to provide a verbal update on this action at the meeting	Open
40	29-jan-25	Including young people's perspective in integrated neighborhood teams as part of the prevention agenda.	TB to explore with ST how to include young people's perspective in integrated neighborhood teams as part of the prevention agenda.	TB	26-mar-25	TB met with ST on 05 March 2025 to explore and agree ways to action amd move this agenda forward. Propose closure of action.	Propose closure of action.
41	29-jan-25	Focus on strategic alignment and collaborative approach of Including young people's perspective in integrated neighborhood teams as part of the prevention agenda. .	Paper to come to Board to focus on strategic alignment and collaborative approach.	TDO	26-mar-25	Paper placed on forward planner . Date TBC	Open
42	29-jan-25	MB to bring a report with retrospective and progress made to date on ICB EDI metrics post restructure.	MB to bring a report with retrospective and progress made to date on ICB EDI metrics post restructure.	MB	26-mar-25	EDI report including WRES data included on meeting agenda	Propose closure of action.

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Agenda item: 07

Norfolk and Waveney
Integrated Care Board

Subject:	**Chair and Chief Executive's report**
Presented by:	**Hein van den Wildenberg, Acting Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Hein van den Wildenberg, Acting Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**26 March 2025**

Purpose of paper:

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

Executive Summary:

The report covers the following:

A. Rt Hon Dame Patricia Hewitt DBE steps down as Chair of NHS Norfolk and Waveney
B. Changes to NHS funding and NHS England
C. Planning for 2025/26
D. New Community Diagnostic Centre and Willow Therapy Unit welcome first patients
E. Expansion of urgent dental care
F. Region's mental health trust exits special measures
G. Hospitals' group model takes another step forward
H. Meetings and visits

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Report

A. Rt Hon Dame Patricia Hewitt DBE steps down as Chair of NHS Norfolk and Waveney

As Board members will know, Rt Hon Dame Patricia Hewitt DBE has stepped down from her role as Chair of NHS Norfolk and Waveney Integrated Care Board. We want to put on record our gratitude and appreciation for everything she has done as Chair of the ICB and more broadly over the past eight years. Patricia's wealth of experience, including as a former Health Secretary, has been invaluable over that time.

Patricia has always thought about people's health and wellbeing in the broadest terms, not just focusing on what the NHS can do to treat someone's health condition, but also on what we can collectively do keep people healthy and well, and prevent them from getting ill in the first place. This ethos and mindset will stick with us.

It was absolutely right that her lifetime of service and her contribution to improving people's health, wellbeing and care was recognised in the New Years Honours List, when Patricia was awarded a damehood. We wish her all the best for the future.

B. Changes to NHS funding and NHS England

A series of significant changes to the NHS were announced last week. These included the abolition of NHS England and plans to subsume their duties within the Department for Health and Social Care, a 50% reduction in staff numbers for the ICB, and that providers will need to make cost reductions too.

At this stage we are unclear about the specific ask and the full implications, but reductions of this level will clearly impact on the capacity of ICBs. We expect to be told more details about the changes in the coming days and weeks, and as we find out more, we will share further details with the Board and other stakeholders.

As you would expect, our immediate priority has been to support staff who have just gone through an organisational review and restructure that has reduced our running costs by 30% over the last two years.

C. Planning for 2025/26

Since the Board's last meeting, the NHS planning and operational guidance has been published, along with our financial allocation for 2025/26. We are putting the final touches on our plans for the year ahead, but it is clear that it will be a particularly challenging year.

Our financial performance was good last year, we set and delivered a balanced budget for 2023/24. However, the financial position of the NHS as a whole and public services has become more challenging since then. We are expecting to make even greater efficiencies this year than we did last year, but it will not be enough to break-even, as this table shows:

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2023/24	2024/25	2025/26
• Delivered £116m of efficiencies • Delivered a break-even budget	• Forecasting to deliver c£149m of efficiencies • Forecasting a c£36m system deficit	• Need to deliver efficiencies and savings of c£280m to break-even

We are continuing to take action to reduce the deficit we are forecasting for this financial year, down from the c£54m we were forecasting at month ten. We now expect the deficit this year to be c£36M, with the ICB and all providers breaking even, except the Queen Elizabeth Hospital NHS Foundation Trust.

There are a range of factors that are affecting our finances, from short-term factors like the recent period of higher inflation, to longer-term trends, such as our ageing population and the increase in people with multiple long-term conditions.

We will do everything we can to make efficiencies to protect services. However, given the scale of the challenge, we must make savings, and this will mean making changes to some services. Ultimately, we have to operate in the budget allocated to us.

On 3 March, the ICB launched a public consultation on potential changes to some services. These relate to the GP Out of Hours Service, GP practices across Norfolk and Waveney, the Walk-in Centre in Norwich and the Vulnerable Adults Service. It is vital that we hear from local people about what they think of the different options we are considering. We would encourage people to find out more and share their views. There is more information on our website: www.improvinglivesnw.org.uk/service-changes.

We know that other public services and the voluntary, community and social enterprise sector are facing similar challenges with their finances too. We will continue to work with partner organisations to join-up services, improve care and make services more sustainable.

There are also things that we can all do which will help maintain and improve our personal health, as well as support services. For example, getting vaccinations if you're eligible, attending your appointments or letting services know as soon as possible if you can't, and using the NHS App if you can. There are also lots of brilliant healthy living tips and resources on https://www.norfolk.gov.uk/readytochange, which are well worth a look at.

D. New Community Diagnostic Centre and Willow Therapy Unit welcome first patients

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In really positive news, two new facilities have opened over the past few weeks – the Community Diagnostic Centre at the Norfolk and Norwich University Hospital, and the Willow Therapy Unit.

The diagnostic centre is our third such facility and together they have significantly increased our imaging and diagnostic capacity, thanks to an £85.9m investment. The centre will offer Ultrasound, X-ray, CT and MR scanning and will be open between 8am-8pm seven days a week. It is anticipated that the team will see 430 patients a day once at full capacity.

The Willow Therapy Unit, offering patients enhanced support to recover and regain independence after a stay in hospital, has welcomed its first patients. The Norfolk Community Health and Care NHS Trust (NCH&C) facility in Norwich will provide a supportive and comfortable environment for 48 patients.

The £19 million development involved patients, carers, and staff in its planning. It includes an assessment kitchen and a self-service café-style area, helping patients build confidence in carrying out everyday tasks such as preparing drinks and snacks.

The unit has been designed to facilitate the seamless transition of patients from acute hospitals back into the community. Therapists and nursing staff at the Willow Therapy Unit will work closely together, playing an active part in supporting patients to achieve their functional goals.

For more information about the Willow Therapy Unit,
visit: www.norfolkcommunityhealthandcare.nhs.uk/willow-therapy-unit

E. Expansion of urgent dental care

Over the last few months we've seen a significant increase in the number of people receiving dental care from our Urgent Treatment Service. 2,500 people are now being treated every month and the number continues to increase. 25 dental practices are now involved across Norfolk and Waveney, with the ICB investing £1.6m in the service this year. Patients who are in pain can contact NHS 111 who will triage their need for an urgent appointment and refer to a local practice if appropriate.

We are looking to invest more in the Urgent Treatment Service next year in order to to deliver 21,520 additional urgent dental appointments (which is our share of the national target of 700,000 appointments). Discussions are underway with local providers to agree plans.

We know that local dental services continue to be very challenged and that sustainable, long-term change will take time. However, we want to recognise the good work being done by ICB colleagues and that there is progress being made.

F. Region's mental health trust exits special measures

Since the Board last met, Norfolk and Suffolk NHS Foundation Trust has exited special measures following a review by NHS England. The trust moving out of intensive support after three years is testament to the commitment and collaboration of everyone involved. There is still much more to do to continue improving patient services, but it's important to acknowledge all the effort put in by staff, service users,

Dave Rieley
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their families and wider partners, and the spirit of collaboration through which this was achieved.

G. Hospitals' group model takes another step forward

Our three acute hospital trusts have now published the full case for establishing a group model. The case for change shows that closer working between our three hospital trusts will help us to achieve the things that matter most to patients, such as tackling waiting lists and ensuring people can be treated quickly in an emergency. The change will also improve efficiency and deliver better value for money, which is vital at a time when there is real pressure on NHS finances. Importantly, it will deliver these improvements while also recognising the different needs of the communities the hospitals each serve.

More information and the case for change can be found on our website: https://improvinglivesnw.org.uk/hospitals-group-model-takes-another-step-forward/

H. 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 has been strong focus on financial and operational planning for the year ahead, so I have been involved in a number of regional and local meetings about this, along with other executive colleagues.
- Following the recent national announcements about changes to the NHS, I have met with regional and national colleagues, as well as briefed ICB staff. I have also briefed our MPs on this topic, and discussed dentistry and our finances with them as well.
- I have continued to meet with colleagues across the region regarding palliative and end of life care. On a related note, I also attended a joint event with the Department of Health and Social Care and the Parliamentary and Health Service Ombudsman's on Advance Care Planning. At the meeting we discussed the recommendations from the PHSO's report End of Life Care: Improving 'Do Not Attempt CPR'.
- I have attended the Norfolk and Waveney Acute Hospitals Collaborative Committees in Common meetings. It has been good to hear about and discuss the case for change for moving towards a group model, and importantly to hear about the practical actions the hospitals are already taking, such as the investment in the Electronic Patient Record.
- I had an introductory meeting with Gareth Everton, the new Executive Director of Adult Social Care at Suffolk County Council. It was good to hear about his experiences from other parts of the country and what we could learn locally.
- On a similar note, I met with colleagues in Essex and visiting the Corringham Integrated Medical and Wellbeing Centre Visit to hear about how they have

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developed integrated community health and care hubs. It was really exciting to learn about what they have done and to see it in action.

- I toured the new Willow Therapy Unit just before it opened; it looks great and more importantly it will play a key role in improving people's recovery following a hospital stay.

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Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Patients and Communities Committee Report**
Presented by:	**Cathy Armor, Deputy Chair – Patients and Communities Committee**
Prepared by:	**Mark Burgis, Executive Director of Patients and Communities**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 March 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 29/1/25)	This paper provides an update from the meeting held on 27 January 2025.
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: Waiting times: - Patient Experience

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	- Complaints, Feedback and Concerns – Acute Hospital Waits - Long Waits Data - Waiting Well Project – Place Example • Place Board Report: Norwich • Population Health and Inequalities Board Update • Ageing Well Programme Board Update including Frailty Attuned Acute Care Workstream 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 November. 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 in November. The committee thought an additional control was required around health inequalities and the impact of the systems financial position. No operational risks had met the threshold to be escalated to the committee however the committee agreed it would be helpful to have sight of some of the operational risks and the challenges the team experience in relation to these and these will be discussed at a future meeting.
Key items for Board to take note of:	The committee agreed the following items should be escalated to the Board: **Waiting Times** • The number of patients waiting 78 weeks or more had reduced considerably over the past year. Those waiting more than 65 weeks had been reducing but the rate of dissent had slowed because of industrial action. • Many people on waiting lists are struggling in pain and are often linking with their GP practice and primary care which creates additional activity. As well as impacting on primary care,

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	patients waiting longer for elective interventions will also end up coming through as urgent patients and the demand for urgent front door care increases too. • The elective care reform plan published has made a commitment to return to an 18-week referral to treatment target by the end of Parliament. • Communication to patients while they wating is very poor. Healthwatch Norfolk recommended the committee consider proposing that an audit of how complaints across Trusts is undertaken • Many vulnerable people who won't make a complaint directly into the system but might make a complaint to the VCSE provider supporting them. Are we linking in with providers in the voluntary sector to collate what information they may about long waits. • It will be helpful to see which specialities have the longest waiting times and how that links to the complaints received, and how it links to workforce recruitment in those specialities - we must make better use of the data available and how it influences our actions. • Waiting Well Project – a successful local initiative in North Norfolk which ran from March 2022 to October 2023 and supported patients waiting for hip or knee replacements. • **The ICB took an action to gather data from the acute hospitals and primary care to help improve understanding of complaints and patients' experiences.** **Norwich Place:** • 39% of the Norwich population live in Core20 neighbourhoods and the most deprived areas of the country, meaning 55,500 residents are at greatest risk of the poorest outcomes. There is also a 10.4-year gap in life expectancy across the city. One of the top priorities for Norwich Place is reducing and tackling health inequalities. • In terms of national benchmarking, Norwich has a high prevalence of alcohol related illness and self-harm. Lower levels of healthy eating, relatively high levels of hospital activity around stroke and heart attacks. There are significant levels of mental health

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	• People and communities in Norwich see community as the biggest asset and well-being is cited as being the biggest problem. • Healthwatch Norfolk felt there is a lack of focus and investment in prevention. **VCSE Risks:** • The VCSE Assembly is developing a risk register which will identify some of the risks which sit within the voluntary sector but will also be highlighted as system risks as they will impact on the population of Norfolk and Waveney. It was noted that some of the risks were linked to several VCSE contracts ending at the end of March.
Items requiring formal approval of Board:	There are no items requiring approval from Board.
Confirmation that the meeting was quorate:	The meeting on 27 January 2025 was quorate, as defined in the Governance Handbook

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Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Quality and Safety Committee Report**
Presented by:	**Cathy Armor, Quality and Safety Committee Deputy Chair**
Prepared by:	**Evelyn Kelly, Quality Governance & Delivery Manager**
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 2025**

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 29 January 2025 to 26 March 2025.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett (Deputy Chair Cathy Armor)
Meetings since the previous update:	06 February 2025,14:00 – 17:00 06 March 2025,14:00 – 17:00 (chaired by Deputy Chair)

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.

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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:	**06 February 2025** • UEC Quality and Ambulance Response Times • Deep Dive: Access to Weight Management Services • LD&A Quality Committee Assurance Report • SEND Quality Committee Assurance Report • Children's Neurodevelopmental Pathways **06 March 2025** • IPR Quality Dashboard KPI Discussion • All-Age Safeguarding Assurance Report • NHS Continuing Healthcare Assurance Report • JPUH Referral and Waiting List Surveillance • CYP Quality Committee Assurance Report • NSFT Waiting Times **Committee Approvals for this period:** • ICB Research and Evaluation Policy • ICS System Quality Group Terms of Reference • ICB Integrated Performance Management Framework
BAF and any Board Operational risks relevant / aligned to this Committee:	**Risk 011: Continuing Healthcare** Risk reflects 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. **Risk proposed to reduce from 20 to 16 and agreed at March Committee Meeting.** **Risk 012: EEAST Response Time and Patient Harms** Risk reflects the pressures in our urgent and emergency care system, with delays in handover of patients into hospital impacting on ambulance response times to calls in the community. **This is a dynamic risk that increased to a score of 25 in February and reduced back to 20 in March, reflecting response time trends.** **Risk 034: Surge Capacity to Support Acute Trusts** Risk remains at 16, reflecting the seasonal pressures currently being experienced within the system and reflects the increased use of surge beds, which creates risk in

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	relation to quality and experience of care. This is also a potential area of moral injury to staff. **Risk 035: 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. **Risk 038: 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. **Risk 039: 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. **Risk 040: 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. **Risk 041: Euroking E3 Maternity Information** Risk reflects concerns related to the potential for unintended errors in pregnancy records, both within current pregnancy and those previous, which raises a patient safety risk. **Risk reduced to 12, reflecting the work being undertaken in response to the National Patient Safety Alert and proposed to de-escalate from Committee to team oversight at the February Committee Meeting.** **Risk 042: 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. **Risk 043: 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,

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	identified, and offered risk reducing measures to protect against potentially preventable cancers. **Committee approved the risk to move over to Commissioning & Performance Committee for oversight at the March meeting.** **Risk 044: 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. Additional risk around the national NI increase and small business resilience is also flagged. ICB and local authority market engagement will continue to support and monitor impact. **Risk 045: 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. **Committee approved the risk to move over to Commissioning & Performance Committee for oversight at the February meeting.** **Risk 046: 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. **Committee approved the risk to move over to Commissioning & Performance Committee for oversight at the February meeting.** **Risk 047: 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 risks around impact on patient safety, quality of care and public health protection. **Risk 048: 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.

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	Risk 050: Histopathology Delays and Cancer Pathways Risk remains at 12, reflecting the impact of histopathology delays on the timely diagnosis and management of patients on suspected Cancer pathways. **Committee approved the risk to move over to Commissioning & Performance Committee for oversight at the March meeting.** **Risk 051: Acute Oncology Medical Staffing** Risk remains at 12, reflecting the impact of medical staffing shortages on Oncology Teams and Cancer pathways. **Committee approved the risk to move over to Commissioning & Performance Committee for oversight at the March meeting.** **Risk 058: Public Trust and Reputational Damage** Risk reflects the impact of poor patient experience and patient harms in respect of delayed ambulance conveyance. **This is a dynamic risk that recently reopened to reflect live system pressures. Committee agreed to reopen the risk at a score of 15 at the February meeting.** **Risk 059: Deconditioning and Infection** Risk reflects the impact of prolonged hospital length of stay for patients who are medically fit to be discharged but who are waiting for community care packages to support them. Longer admissions increase the risk of hospital-acquired infections and deconditioning. **This is a dynamic risk that recently reopened to reflect live system pressures. Committee agreed to reopen the risk at a score of 16 at the February meeting.** **Risk 060: Specialist Palliative and End of Life Care** Risk remains at 12, reflecting the variation in accessibility and quality of specialist palliative and end of life care (PEOLC) across the Norfolk and Waveney footprint, resulting in variation in patient experience and outcomes and associated health inequalities. **Risk 061: CYP MH Responsible Clinicians** Risk remains at 16. 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.
Key items for Board to take note of:	**CYP Neurodevelopmental Service** It is now thought that 15% of the global population are neurodivergent. In the UK, 1% of people are thought to be on the autism spectrum and about 4% are thought to have

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	attention deficit hyperactivity disorder (ADHD). Dyslexia, dyspraxia, and dyscalculia (difficulty in understanding numbers) sit at about 10%, 6% and 6% respectively. They are regarded as neurodevelopmental conditions and many overlap. With increasing understanding of neurodiversity and the numbers of individuals seeking assessment and understanding of their neurodiverse needs, systems are experiencing challenges with capacity in existing commissioned pathways. The report detailed the system approach in Norfolk and Waveney to transforming the support available to local children, young people and families. The system is working on an integrated model and providing universal training to better understand and support neurodivergent individuals and additional guidance for parents and primary care is being developed to ensure they choose quality-assured provision when accessing services through 'right to choose'. **Special Educational Needs and Disabilities (SEND)** Committee were briefed on the development and improvement plans for education, health, and care provision for CYP with SEND and their families across Norfolk and Suffolk. It included recommendations from the recent inspection reports published by Ofsted and the CQC, drawing the system's attention to the priority area around the transition of children to adulthood. Committee noted on the significant increase in demand for education, health, and care plans, driven by the belief that these plans are the only way to access appropriate education provision. Long wait times for mental health provision are a major challenge, impacting the ability to provide timely support to children and young people with SEND. Transition from children to adult services can be problematic, requiring coordination across multiple services to ensure a smooth move. A thematic review showed that the same difficulties with transition are being experienced nationally. Committee were asked to note the progress and ensure we are working as a system, recognising everyone's individual roles and responsibilities within this space. Committee reflected on the recent Integrated Care Partnership workshop, where inclusion hubs and the importance of working together collectively to support children with SEND was discussed. **Access to Weight Management Services** Committee received a deep dive focusing on the challenges and actions taken to address the lack of access to Tier 3 Weight Management Services in Norfolk and Waveney, highlighting that poor access to services prevents people from getting NICE recommended support to improve their quality of life and reduce the risk of comorbidities

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	associated with weight. This has a wider impact on people in terms of self-care and prevention and the need to provide support before needs escalate to higher tiers of complex, invasive treatment. Committee reflected on the pressing need for General Practice to understand the rules of Right to Choose as they relate to access to these services outside of the county. A need for education around tirzepatide (Mounjaro) was also noted, following new NICE recommendations published in December 2024. Committee discussed the importance of ensuring that non-digital access to Weight Management Services is available and functioning properly for those who cannot use digital platforms. Committee noted that the ICB Clinical Threshold Policy for Weight Management Services is being reviewed by the Clinical Policy Development Group this month to ensure it aligns with NICE guidance and addresses the needs of the highest priority patients. Weight Management Services risk oversight has moved over to Commissioning and Performance Committee going forward. **Quality Metrics and the Integrated Performance Report** Committee noted the work undertaken in alignment with the wider ICB refresh and refocus of the Integrated Performance Report (IPR), to provide clarity on the scrutiny, oversight and assurance of key KPI across Programme, Committee and Board levels, with maximum of 15 metrics for all groups. A proposed set of metrics were shared with Committee for review and agreement. Members made a request for additional metrics on mental health to be added to the proposal for quality oversight, including Annual Physical Health Checks and the Dementia diagnosis rate. Members also suggested some metrics linked to the national dataset around roll-out of Martha's Rule. Committee was asked to agree three metrics that the ICB Board should be regularly reviewing. Members did not feel that three metrics would be sufficient for Board overview and requested additional flexibility. Committee discussed the need for further conversations to ensure the quality metrics sitting within the IPR are appropriate and comprehensive. **ED Mental Health Enhanced Observations** The JPUH Chief Nurse noted that communication had been received that NSFT would be ceasing enhanced observation support for patients under section waiting in the Emergency Department for a mental health bed. A request was made by Committee for assurance to be provided around the impact on quality and safety and risk mitigation measures. The ICB Executive Director of Nursing took an

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	additional action to liaise and discuss with the NSFT Chief Nurse. **NHS Continuing Healthcare (CHC)** Committee received an update on performance and quality of local NHS CHC provision highlighting the NHSE assurance process, the progress made in recruitment, and the performance targets achieved over the last six months. Committee noted the steps taken to improve governance, including the daily package approval panel and the consistency of package approvals. Committee heard the impact of additional training and clarification of fast track CHC criteria and the positive impact on reducing inappropriate requests, enabling clinicians to focus on the quality of packages. The Committee's VCFSE Member identified an opportunity to link the VCFSE Assembly into work being done in collaboration with NCC and SCC to support quality improvement and resilience. **Committee Approvals** **ICB Research and Evaluation Policy** Committee approved the policy which described the framework underpinning the definition, conduct, governance (including registration), ethics and dissemination of research and evaluation taking place within the ICB. **ICS System Quality Group Terms of Reference** Committee approved the annual update of the ICS SQG Terms of Reference which is aligned to the National Quality Board guidance. **ICB Integrated Performance Management Framework** Committee approved the framework covering ICB reporting and management review and arrangements for scrutiny and assurance and oversight and management. Final ratification will be taken through Board in March 2025. Committee members noted that oversight and approval of the ICB Patient Choice Policy has moved to the Patients and Communities Committee.
Items requiring formal approval of Board:	• ICB Integrated Performance Management Framework
Confirmation that the meeting was quorate:	The February and March 2025 meetings were quorate, as defined in the Governance Handbook.

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Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Health Inequalities and EDI reporting**
Presented by:	**Mark Burgis, Executive Director Patient & Communities**
Prepared by:	**Shelley Ames, Head of Health Inequalities & VCSE** **Amrita Kulkarni, Senior Programme Manager – Health Inequalities & VCSE** **Dawn Turner, HR & OD Business Partner**
Submitted to:	**NHS Norfolk & Waveney Integrated Care Board Meeting**
Date:	**26 March 2025**

Purpose of paper:

To present the following reports to ICB Board for information:

- Equality Delivery System – EDS2
- Gender Pay Gap report
- Workforce Race Equality Standard Report (WRES)
- Workforce Disability Equality Standard Report (WDES)

To present the ICB Organisational Health Inequalities Improvement Plan 2025-2027 for discussion and agreement.

Executive Summary:

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

This paper provides a summary of the findings of a number of key reports that there is a requirement to publish by 31 March 2025. All reports demonstrate good progress in achieving our health inequalities and EDI obligations but identify further areas for improvement.

The ICB Organisational Health Inequalities & EDI Improvement Plan provides a clear plan to address areas of improvement identified through the development of our reporting requirements, alongside all-staff engagement to measure confidence and capability to address health inequalities and where we can drive improvements in our processes and the way that we work to address structural inequalities.

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The report makes the following four recommendations:

- Note and agree the prepared reports for publication
- Agree and endorse the ICB Organisational Health Inequalities Improvement Plan, noting actions for Board members and leadership.
- Agree oversight for future reporting to be provided by Patient & Communities Committee.
- Consider non-exec Director oversight/nominated sponsorship for the implementation of the programme, particularly given national policy shifts and proposed organisational change.

Report

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.

The approach to these reporting requirements was outlined at January's Board meeting and the included reports are now ready for publication.

Equality Delivery System (EDS2)

The Equality Delivery System 2 (EDS2) is a self-assessment framework developed by NHS England to help NHS organisations evaluate and improve their performance in supporting individuals with characteristics protected under the Equality Act 2010.

This report presents evidence of successes and challenges in Norfolk and Waveney Integrated Care Board (ICB) across the three key domains of EDS2:

1. Commissioned or Provided Services
2. Workforce Health and Well-being
3. Inclusive Leadership

To align with other NHS organisations in the system, three services - Maternity, Diabetes, and Audiology were selected for assessment for Domain 1. The evaluation was based on four key outcomes:

- 1A: Service users have the required levels of access to the service.
- 1B: Individual service users' health needs are met.
- 1C: Service users experience the service safely and without harm.
- 1D: Service users report positive experiences.

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The collected evidence confirms that all three services are achieving activity for each outcome, resulting in a total organisational score of 8 for Domain 1.

WRES and WDES

The WRES / WDES is an annual report alongside the EDS2 and EDI Annual report and publish by 31 March 25 on the Improving Lives Website.

Key findings include:

5.2% of workforce came from a BME.
The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for BME staff (20%) than white (15%)
14% of BME staff experienced discrimination from other staff than white staff (5%).
8% of workforce are disabled
47% of disabled staff believed there were equal opportunities for career progression or promotion,
The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for disabled staff (15%) than non disabled staff (9%)
14% of disabled staff compared to non-disabled staff (9%) say they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
86% of disabled staff say the ICB has made reasonable adjustments to enable them to carry out their work.

An WRES/WDES action plan for 2025/6 has been completed which focus on 4 themes:

1. Representation, Recruitment and Retention
2. Learning and Development
3. People Policy and Procedures
4. Staff Experience

Gender Pay Gap

We are required to publish Gender Pay Gap calculations no later than 30 March each year and this will report alongside the EDS2 and Health Inequalities and Equality, Diversity and Improvement Plan to the ICB Board March 2025 meeting.

Key findings from the report note through the ICB re structure the female headcount has decreased by 1%, whilst the male headcount has increased by 1%. Over half of male ICB colleagues have an assignment of band 8 and above (including non-banded roles), the gap between those in a band 9 and non-banded roles has decreased by 3.54% since 2023, meaning more females have been successful in gaining those roles. Although the average hourly rate gap has increased by 2.47% since 2023 for male employees, the gap has decreased in relation to the average median hourly rate by 11.54%. Our 2023 staff opinion survey, with a response rate of 67% with 489 responses, noted 61.9% of staff were satisfied or, very satisfied with levels of pay. This was a positive difference of 5.76% on the previous year. However, our data has shown that female employees are more likely to be in lower paid roles and therefore it is important that we remove any barriers to career progression in order this upward trend continues.

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NHSE Statement on Information

Given the scale of the requirement for NHSE and the need to consolidate a wide range of data sets, as well as liaise across the organisation to prepare the report, this is being

prepared to be published in the summer alongside our annual report. Future updates will be brought to the attention of the Board.

ICB Organisational Health Inequalities & EDI Improvement Plan

The ICB improvement plan has been prepared in response to the ICS 'Health Inequalities Commitments' and outlines the key actions required of our organisation to tackle structural health inequalities, embed an approach to inequity in all that we do, and improve outcomes for our residents, particularly those most vulnerable.

The plan was developed in utilising feedback from the ICB Board HI Maturity Assessment undertaken by ICB Board members, alongside a programme of all-staff engagement, including a session at the all-staff away day, all staff briefings and Joint Senior Leaders workshops. It aligns to legislative expectations and best practice advocated via the NHSE Health Inequalities Improvement Programme and the Institute of Health Equity 'Marmot' approach which advocates for 'transformational processes' to support a reduction in health inequalities.

The improvement plan focuses on 4 domains and recommends a cross organisational, 'distributed leadership' approach:

- Workforce and organisational development
- Processes and resources
- Data, intelligence and voice
- Leadership and governance

It is recognised that this plan will need to 'flex' to respond to future organisational changes, with a potential for changes in leadership and operational implementation. Given the continued requirement to reduce inequalities within planning guidance, the future focus on shifting from treatment to prevention, and the financial case for reducing inequalities to reduce system pressures in the long term, it is recommended that this action plan be embedded as planned and that the organisation identifies SROs and a NED lead to support continued implementation that is responsive to change.

Recommendation to the Board:

- Note and agree the prepared reports for publication.
- Agree and endorse the ICB Organisational Health Inequalities Improvement Plan, noting actions for Board members and leadership.
- Agree oversight for future reporting to be provided by Patient & Communities Committee.
- Consider non-exec Director oversight/nominated sponsorship for the implementation of the programme, particularly given national policy shifts and proposed organisational change.

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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

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	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

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Classification: Official

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NHS England

NHS Equality Delivery System 2022
EDS Reporting Template

Version 1, 15 August 2022

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Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

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NHS Equality Delivery System (EDS)

Name of Organisation		**Norfolk and Waveney Integrated Care Board (N&W ICB)**	**Organisation Board Sponsor/Lead**
			Mark Burgis, Executive Director of Patients & Communities
Name of Integrated Care System		Norfolk and Waveney	

EDS Lead	Shelley Ames, Head of Health Inequalities and VCSE Partnering Tracy Williams, Clinical Lead for Health Inequalities and Inclusion Health Fran Weston, Head of People Dawn Turner, HR and OD Business Partner		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	Dec 2024 and Jan 2025		**Individual organisation**	N&W ICB
			Partnership* (two or more organisations)	Specsavers Scrivens Norfolk Deaf Association Audiological Science
			Integrated Care System-wide*	-

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Date completed	Feb 2025	**Month and year published**	Mar 2025
Date authorised	Feb 2025	**Revision date**	Feb 2026

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Completed actions from previous year	
Action/activity	**Related equality objectives**
ICB Health Inequalities Board maturity assessment undertaken, and an improvement plan has been put in place. Non-Exec Director identified from ICB Board to attend Board HI training provided by NHS Providers. Contributions of all Joint Senior Leaders to the development of ICB Health Inequalities Improvement Plan.	Board members (Band 9 and VSM) and line managers consistently demonstrate their understanding of and commitment to equality and health inequalities by participating in mandatory training, embedding inclusive practices within their decision-making processes, and regularly monitoring and reporting progress against organisational equality and health inequalities objectives.
New documentation and organisational policy launched for Equality Health Impact assessments and a combined EHIA and QIA process introduced in autumn 2024. Oversight for the process is through Quality and Safety Committee with quarterly reporting to the Patient and Communities Committee.	To embed equality and health inequalities considerations into commissioning decisions and governance processes by ensuring that all Board and Committee papers (including minutes) consistently identify related impacts and risks, outline mitigation and management strategies, and demonstrate alignment with organisational equality and health inequalities objectives.
The outcome of the organisation change programme was finalised in July 2024 and the ICB was pleased to host an all-staff event on 12 November 2024 with the focus firmly on reset, rebuild and looking forward. At the event there was a focus on the values that shape the ICB's culture and the role of all ICB employees in upholding these. With this in mind an	To foster good relations To promote equal opportunity To eliminate unlawful discrimination

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ICB Cultural Assessment was launched in December 2024, in addition to the NHS National Staff Survey. The ICB Cultural Assessment and NHS National Staff Survey will also feed into the launch of the ICB's Management Programme to support NHS England's national priority to create a clear view on the expectations of line managers in relation to people management. The Management Programme will have three themes 'managing self', 'Managing Teams' and 'Managing in the ICB'. The programme will be underpinned by the ICB's organisation values of respectful, inclusive and innovative. The Programme hopes to launch in the early Spring 2025.	
Our staff groups, networks and champions continue to provide an excellent foundation to implement, educate and communicate many initiatives. The EDI Staff Group launched a survey designed to seek feedback on the work of the EDI Staff Network Group and this has enabled areas of focus for 2025. Our EDI Staff Group will also be sponsoring and promoting health initiatives to support those staff with long term conditions and provide education to support our managers.	To foster good relations To promote equal opportunity To eliminate unlawful discrimination
Focus remains on our EDI and Health Inequalities Improvement Plans and HR/EDI are working in greater collaboration to align our EDI and Health Inequalities workstreams. There will be a dedicated EDI module in the Management Programme to increase and further promote a greater awareness and understanding of EDI.	To foster good relations To promote equal opportunity To eliminate unlawful discrimination
We have revised our Freedom to Speak up policy in line with the national policy issued from NHS England and the National Guardians office. A	To foster good relations To promote equal opportunity

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module for line managers that mirrors the document "Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services" is being developed. It provides comprehensive guidance for fostering a culture where speaking up is encouraged and valued. It emphasizes the importance of leadership in setting the tone for an open and inclusive environment. The module will cover the valuing speaking up, role-modelling positive behaviours, ensuring workers know how to speak up safely, and using feedback for continuous improvement. We intend to increase our Freedom to Speak Up Guardians and Champions to support this and will be recruiting for these roles in February 2025. The guide provides helpful guidance outlining the roles and responsibilities of Freedom to Speak Up guardians	To eliminate unlawful discrimination
Our regular staff briefings continue to provide an excellent communication method to reach our staff to provide education and continue to demonstrate the ICB's values of, at all times being respectful, inclusive and embracing new ways of working by being innovative and continually improving. The values are embedded in everything we do, including our policies our job descriptions, our recruitment process and interview documentation to name but a few.	To foster good relations To promote equal opportunity To eliminate unlawful discrimination

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EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

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Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**1. Maternity** Collaboration with partner organisations to develop a range of translatable resources for service users including a multilingual padlet and webinars. Scoping underway to map current translation tools and services, perinatal pathway mapping and researching community experience/ requirements to inform prioritisation of work to support non-English speaking families/ communities. Collaboration with ICS partners on the Healthy Child Programme to bring access to healthy start vouchers online. A heat mapping exercise was conducted to help define key priorities within the five-year equity and equality plan for maternity and neonatal services in Norfolk and Waveney. This exercise analysed data on deprivation, ethnicity, the birthing population, and lifestyle	**2 Achieving**	Local Maternity and Neonatal System

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		behaviours to identify health inequalities across the region. Community Hubs in place at James Paget University Hospital (JPUH) and Queen Elizabeth Hospital (QEH). Midwifery-led continuity of carer is established in the areas with the highest deprivation (QEH and JPUH), with plans to expand to NNUH. This initiative aligns with the maternity clinical focus of the Core20PLUS framework, ensuring consistent care for women from Black, Asian, and minority ethnic backgrounds, as well as those from the most deprived communities. Project manager in place to take forward implementation of Norfolk and Norwich University Hospital (NNUH) community hub. Family Hubs implemented across Norfolk and LMNS working in partnership. Core20 groups identified and work underway to collaborate with VCSE sector. For example, the implementation of a maternity social prescribing pilot supporting service users from our most deprived (Core20) localities from early pregnancy. The project, working in collaboration with Family		

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		Hubs in Norfolk and PCNs and Citizens Advice in Waveney, aims to raise awareness of the free services and support available to families during pregnancy and after their baby is born. The project was prompted by a deep dive into pre-term births, stillbirths and neonatal deaths which showed that, while clinical care was good, the poorest outcomes were centred in the areas of highest need. Social prescribing was previously only available to people via GP referral, meaning there was a gap in provision for families throughout pregnancy. Social prescribing aims to complement medical care with holistic support within the community to meet families' practical, social and emotional needs affecting their health and wellbeing. In its initial few months of implementation, uptake of service users requesting onward support has surpassed initial estimates with a referral rate of over 20%, confirming that there is a need for this service. **2. Diabetes** **Core Diabetes Primary Care and Prevention:** All 105 GP practices within Norfolk & Waveney Integrated Care System (NW ICS)		Chris Bean Clinical Transformation Programme

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		provide routine diabetes care, including annual reviews and interventions aligned with NICE care processes. These reviews improve patients' quality of life, functioning, and life expectancy. Most diabetes care is delivered in primary care settings, with specialist services available for complex cases. **Type 2 Diabetes and the Young (T2DaY):** Focused on early-onset Type 2 Diabetes (EOT2D) for individuals under 40 years of age. Reviews address classification, glycaemic optimisation, contraception, cardiovascular risk, and psychological/social needs. All NWICS GP practices are signed up to provide these reviews. **Enhanced Primary Care (Pilot Programs):** Multidisciplinary care enhances diabetes management for complex cases between primary and secondary care. Three pilot sites are currently active in the core20 areas- West Norwich, Swaffham, Downham and Great Yarmouth, offering		

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		services like injectable therapy initiation and upskilling for primary care staff. **Structured Patient Education:** Available for Type 1 and Type 2 diabetes across six providers in different localities covering the core20 deprived areas. Digital education programs are also offered (Healthy Living for Type 2 and My Type 1 Diabetes). **Specialist Community Services:** Provided for complex Type 2 Diabetes cases via multidisciplinary teams across three providers. Historical commissioning differences lead to variations, e.g. Central Norfolk uses facilitator staff rather than specialist nurses. Existing referral pathway (for over 18s) from primary care to Active NoW for exercise referral and access to wider community provision to support on-going management of long-term conditions such as diabetes. **Specialist Community Diabetic Footcare:** Aims to prevent complications like neuropathy, gangrene, and amputations.		

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		Services vary by locality, with some areas lacking outreach for housebound or care home patients. Case for change in development to address the inequity of care as a part of the new model of care for diabetes. **Specialist Hospital Diabetes Services:** Address advanced care needs, e.g., insulin pump therapies and management of complex conditions. Significant variations in services include lack of inpatient footcare at JPUH and no perioperative diabetes pathway at QEH and NNUH. **Diabetes Prevention and Remission:** Programs like NDPP (NHS Diabetes Prevention Programme) and T2DR (Type 2 Diabetes and the Young) support lifestyle changes to prevent or manage Type 2 Diabetes. NDPP has a Population Health Management Protect NoW project recruiting patients from GP practices with a high prevalence of Non-Diabetic Hyperglycaemia (NDH), the practices are often located in the core20 areas and have historically had low referral rates from primary care. Delivered through Xyla and Oviva, with demographic data monitoring service uptake.		

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		Children & Young People (CYP): Referrals to the three acute pathways are received via traditional NHS routes, such as GP, ED admissions and from other Consultants. All 3 acute Trusts have a specialist paediatric diabetes team to support CYP, up to their 19th birthday. These multidisciplinary teams typically include consultants, specialist diabetes nurses, dietitians, and psychologists who work collaboratively to offer comprehensive care. All 3 Acute Trusts have a well-defined transition pathway, with regular transition clinics to host MDT discussions. Community-based support is also available through organisations like Diabetes Norfolk, a registered charity focused on improving care for individuals with diabetes in the region. They fund projects aimed at enhancing diabetes services and provide resources for patients and families. The ICB is committed to addressing health inequalities for CYP in the most deprived quintiles and ethnic minority groups who often face barriers to accessing optimal diabetes care. This aligns with the Core20PLUS framework for children and young people covering the clinical focus area of diabetes.		Beccy Godfrey CYP Commissioning and Transformation

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		We plan to develop strategies to ensure that services and interventions are tailored to meet the specific needs of these groups. This includes considering and addressing potential barriers that CYP from deprived and underserved backgrounds may face in accessing diabetes technology. **3. Audiology** A community Age-Related Hearing Loss (ARHL) service has been commissioned for patients registered with a GP in the central Norfolk area. Patients in the east and west of the county can access ARHL services from their local acute hospitals. Community services are delivered by multiple providers including: • Norfolk Deaf Association (Trading as Hear for Norfolk) • Scrivens • Specsavers • Audiological Science • The Outside Clinic The pathway is commissioned in line with NICE Guidance for patients aged 50 and over with suspected hearing loss and it provides the ability for patients to self-refer, ensuring easy levels of access.		Bertone Santos Socorro Community Commissioning

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		Children and Young People Audiology Paediatric Audiology (PA) and Newborn hearing Screening is commissioned through the three acute trusts. Referrals are made to PA through primary care, community and public health screening programmes. Services undertake testing and provide onward referral for CYP with specialist needs to local ENT services (grommets, surgical procedures, bone anchored hearing aids etc) and tertiary services as appropriate (cochlear implants) Providers supply and monitor hearing and communication aids and liase with Teachers of the Deaf.		Rebecca Hulme, Children young people and maternity
	1B: Individual patients (service users) health needs are met	**1. Maternity** In support of more personalised care, the Local Maternity and Neonatal System (LMNS) launched a new Personalised Care and Support Plan (PCSP) across the system in 2024. Every woman and birthing person will receive a PCSP at their first midwife appointment to support them to explore, understand and record their individual choices for pregnancy, birth and the first few	**2 Achieving**	Local Maternity and Neonatal System

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		weeks of parenthood, ensuring informed decision-making around perinatal care. Paper and fully accessible and translatable digital copies as well as an Easy Read version have been produced to support inclusivity and equity. This resource was developed in collaboration with our Maternity and Neonatal Voices Partnership leads to ensure service user voice was at the heart of this project. The PCSP is also available on Just One Norfolk to allow for translation and spoken word. Collaboration with Norfolk Libraries to offer digital gifting scheme to support equality of access. Phase one of the LMNS dashboard is in place. Local heat mapping and health needs assessment has been completed in collaboration with Public Health. Asset mapping exercise has been completed as part of the needs assessment. Design and successful roll out of a perinatal pelvic health service across Norfolk & Waveney. Design and successful roll out of a smoking		

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		cessation service within maternity services. Alcohol in pregnancy page launched on JON website (translatable) providing accurate information to service users. Inclusion health Local Learning Events developed to support clinical colleagues' knowledge, awareness and confidence to improve service user care, outcomes and experience. Sessions to-date have focussed on inclusion health groups such as asylum seekers and refugees, LGBTQ+, neurodiversity, bereavement and social prescribing. The series has been very well attended and has strengthened our links with VCSE organisations within the community, leading to increased collaborative working to support inclusion health groups. Attendees fed back that they felt better informed and more confident in their ability to tailor support to members of inclusion health groups. Local learning events are evolving into a trial of podcasts to allow most staff to access these as and when needed. Published NHS Workforce Race Equality Standard data (at Norfolk & Waveney level to protect anonymity). LMNS invited to join ICS health inequalities		

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		oversight group (HIOG), the group brings together system partners to co-ordinate and take system- wide action to reduce health and care inequalities across Norfolk and Waveney. A pre-term births deep dive has been completed and Pre-Term Births midwife and project manager has been successfully recruited to, the post will ensure learning is taken forward from the deep dive conducted. IBCLC (International Board Certified Lactation Consultant) places secured for 25 members of staff working in infant feeding roles. Roll out of GP breastfeeding friendly scheme aligned with Start for Life infant feeding friendly initiative to improve support for sustained breastfeeding, if patients choose to do so. The SmartStart maternity tobacco dependency service has been implemented in all three Trusts. So far this year, as the service embeds, the SATOD (Smoking Status at Time of Delivery) rate has reduced from 11.2% to 8.8%. We predict this downward trend will continue as SmartStart supports more pregnant smokers to set quit		

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		dates and become smokefree when they give birth. LMNS breastfeeding strategy has been co-produced, with input from Maternity and Neonatal Voices Partnerships and colleagues from acute and community infant feeding leads and public health. Development of collaborative network of VCSE and health and social care in support of vulnerable communities is underway. Implementation of maternity social prescribing pilot in Norfolk in collaboration with Family Hubs to support Core20PLUS communities in pregnancy. Lead Transformation midwife has commenced a 3 year fully funded PhD in health inequalities in underserved communities which will enable system learning and inform service delivery planning. **2. Diabetes** **Type 1 Diabetes and Disordered Eating (T1DE):** Type 1 Diabetes-Related Disordered Eating (T1DE), sometimes called Diabulimia, is a condition where people with Type 1 diabetes deliberately restrict their insulin to lose		Chris Bean, Clinical Transformation Programme

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		weight. This can lead to serious short- and long-term health complications and increases the risk of death by three times. To address this, NHS England provided funding for a pilot service in Norfolk and Waveney, which launched in November 2023. The service, run by Norfolk and Norwich University Hospital (NNUH), is available to all patients across Norfolk and Waveney ICS and has secured funding until March 2026. This specialist service brings together local clinical experts to improve care for adults with T1DE, ensuring they receive joined-up, coordinated support. The team includes: • A T1DE psychologist • Psychiatrists from Norfolk and Suffolk Foundation Trust (NSFT), specializing in eating disorders • Diabetes specialist nurses • Dietitians • Consultant clinicians from NNUH Together, they provide personalized, comprehensive care designed to improve confidence and diabetes management for adults with T1DE. This integrated approach has been proven to lead to better health outcomes.		

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		Transitioning Young Adults (TYA): Improves continuity of care for individuals aged 19–25 transitioning to adult diabetes services. Tackles health inequities among young people in deprived communities who have poorer outcomes and less access to diabetes technology. **Type 2 Diabetes and the Young (T2DaY) Project:** Addresses the needs of individuals with early-onset Type 2 Diabetes, including their psychological and social support needs. **NHS Diabetes Prevention Programme (NDPP) and Type 2 Diabetes Path to Remission (T2DR)** initiatives provide support for non-diabetic hyperglycaemia (NDH) and Type 2 remission, focusing on reducing health inequalities. A case for change is in development to ensure that service redesign aligns with quality impact assessments (QIA) and equality and health inequality assessments (EHIA).		

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		Early Onset Type 2 Diabetes (EOT2D) & the Protect NoW Project occurs before age 40 and is more common in ethnic minorities and socioeconomically deprived areas. In Norfolk and Waveney, around 2,000 people have EOT2D. It tends to be more aggressive, with higher rates of obesity, depression, diabetes-related distress, and early complications. Most patients are managed solely in GP practices. To improve care, NHS England funded additional GP reviews (T2DaY reviews), with funding secured until March 2026. All 105 GP practices in Norfolk and Waveney are offering these reviews, but low patient engagement has been a challenge. To address this, the Protect NoW team will run patient engagement webinars, directly inviting individuals to informative sessions with clinicians and encouraging them to attend their GP reviews. The T2DaY review includes: • Diabetes classification • Contraception & pregnancy planning • Glucose, cardiovascular risk, and weight management		

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		• Psychological wellbeing & social needs **Diabetes Prevention & the Protect NoW Project** Type 2 diabetes is largely preventable through lifestyle changes. In Norfolk and Waveney, around 105,000 people have Non-Diabetic Hyperglycaemia (NDH) (pre-diabetes), putting them at high risk. The NHS Diabetes Prevention Programme (NDPP) provides support to help patients with NDH or a history of Gestational Diabetes (GDM) make healthy lifestyle changes. While all 105 GP practices can refer patients, many in high-need areas (higher deprivation/NDH prevalence) are not actively doing so. To improve uptake, the Protect NoW team will contact eligible patients directly, offering them the opportunity to join the programme. **New Diabetes Care Model for Norfolk & Waveney** A new diabetes care model has been developed to address inequities in services and health outcomes across Norfolk & Waveney. Historically, fragmented commissioning and rising demand, especially		

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		for Type 2 diabetes, have worsened disparities in care. The new model aims to: • Detect complications early and intervene to prevent progression • Provide specialist support to improve quality of life and life expectancy Full implementation depends on ICB approval, with a five-year rollout planned if approved. **Diabetes Technologies Implementation in Norfolk & Waveney** In December 2023, NICE published Technology Appraisal (TA943) for Hybrid Closed Loop (HCL) systems in Type 1 diabetes management, followed by NHSE's 5-year implementation strategy in January 2024. Both emphasise prioritising those with the greatest need, including: • Children & young people • Pregnant individuals or those planning pregnancy • Adults using insulin pumps who want to transition to HCL		

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		Norfolk & Waveney ICB, in collaboration with ICS Acute Trusts, established a Diabetes Technologies Working Group to oversee implementation. This includes ICS-wide implementation plans for priority groups and ongoing monitoring to address gaps, particularly in deprived and BAME communities, where diabetes-related health outcomes are poorer. **Children & Young People (CYP)** Norfolk and Waveney are actively working to enhance the proportion CYP with type 2 diabetes who receive NICE care processes. Key initiatives include: <u>Implementation of Continuous Glucose Monitoring (CGM):</u> In line with the CYP Core20plus framework (Diabetes- clinical area of focus) the Norfolk and Waveney Integrated Care Board (ICB) has developed an implementation plan to provide CGM systems to all CYP with 1 diabetes. While this plan primarily targets type 1 diabetes, the infrastructure and experience gained may benefit those with type 2 diabetes in the future.		Beccy Godfrey CYP Commissioning and Transformation

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		Adherence to NICE Guidelines: Healthcare providers across N&W follow NICE guidelines for diagnosing and managing type 1 and type 2 diabetes in CYP. These guidelines recommend regular monitoring of blood glucose levels, HbA1c measurements, blood pressure checks, and assessments of growth and puberty to ensure comprehensive care. Educational Programs: The Norfolk and Waveney Integrated Care System offers educational programs, such as "Diabetes NoW – Learning," to support individuals in managing their diabetes. These programs aim to empower patients and their families with knowledge and skills to effectively manage the condition. Norfolk & Waveney ICB plan to collaborate with system partners to develop approaches that support access to regular, holistic diabetes reviews for CYP with type 2 diabetes, particularly in underserved areas. **3. Audiology** As stated in NHS England's publication, 'What works: Hearing Loss and Healthy Ageing', hearing is essential for healthy ageing, enabling us to communicate with		Bertone Santos Socorro, Community Commissioning

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		friends and family, participate in society and retain our independence, health and wellbeing, quality of life, and remain in employment if we wish. Yet the major cause of hearing loss is age-related and as the ageing population grows, the impact of hearing loss for the individual and society grows. The Community Age Related Hearing Loss (ARHL) service has been commissioned for members of our population who may benefit from accessing this service, using hearing aids to improve hearing following a hearing loss diagnosis, including: • Reduced cognitive decline; studies have shown that hearing aids can slow cognitive decline in older adults, particularly those at high risk of dementia. • Decreased Risk of Dementia; treating hearing loss with hearing aids may help lower the risk of developing dementia. • Reduced Social Isolation; hearing aids improve communication abilities, making it easier for individuals to engage in conversations and social activities. This can significantly reduce feelings of isolation and loneliness.		

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		• Improved Mental Health; by enhancing the ability to hear and communicate, hearing aids can also improve overall mental health, reducing symptoms of depression and anxiety that are often associated with hearing loss. • Improved quality of life; treating hearing loss allows people to participate more fully in social and recreational activities and improve communication with loved ones. Commissioning a community-based service for ARHL has also increased accessibility, allowing people to access care closer to home. By having a self-referral pathway, this further improves access to services as people do not need a GP appointment to seek advice, help and support. **Children and Young people** Without timely and effective intervention, hearing loss has a detrimental impact on a child's development, including their language and communication, educational achievement, emotional well-being, and employment options. Approximately 50% of cases of deafness by the age of 10 are present at birth and		Rebecca Hulme, Children young people and maternity

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		detected by the newborn hearing screening programme (NHSP). Whilst the implementation of a NHSP has been a great success with around 27 babies a week being identified with a permanent childhood hearing impairment (PCHI) in England, the NHSP is not designed to detect mild hearing loss in infants, and a significant number of permanent hearing losses in children are of later onset than birth . Fluctuating temporary hearing losses caused by middle ear effusions are common in children and can lead to delays in speech development, behavioural problems and educational achievement. Paediatric audiology services play an essential role in the identification of all children with hearing loss, and timely and effective management of that deafness. Individual audiology services and the teams that support children should aspire and strive to deliver the best possible care to children / young people and families. In Norfolk and Waveney, services are commissioned to assess, measure, treat and refer mild, moderate and sever hearing loss.		
	1C: When patients (service users) use the service, they are free from harm	**1. Maternity** Development of data dashboard in progress which overlays clinical outcomes with health, social and ethnicity data. This has enabled a	**2 Achieving**	Local Maternity and Neonatal System

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		recent deep dive into still births of Black and Asian women and further work underway to improve barriers to access to care. Maternal Medicines Centre launched at NNUH, as part of the Eastern Region's maternal medicine service. All GPs receiving Trust notifications of patients diagnosed with or history of gestational diabetes as part of diabetes prevention programme. NICE CG110 antenatal care for pregnant and birthing people with complex social factors implemented via Peri natal Mental Health project. Specialist Lotus team set up to support implementation of maternal mental health (MMH) service with a focus to improving access for women from ethnic minorities and areas of deprivation. Personalised Care Support Plan implementation across all Trusts, supporting informed patient choice, decision-making and more personalised care. Maternity Neonatal Voices Partnerships supported to co-produce plans to reflect		

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		engagement with ethnic minority and other health inclusion/ Core20 groups. Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. National data shows a link between these complications and deprivation. The SmartStart maternity tobacco dependency service has been implemented in all three Trusts. So far this year, as the service embeds, the SATOD rate has reduced from 11.2%to 8.8%. We predict this downward trend will continue as SmartStart supports more pregnant smokers to set quit dates and become smokefree when they give birth. **2. Diabetes** Diabetes care and support are routinely monitored to guide future commissioning. Key monitoring mechanisms include: • Governance – CVDR Programme Board, Diabetes Expert Reference Group, Diabetes Technologies Working Group • Pathway Transformation – Development of the new diabetes care model		Chris Bean, Clinical Transformation Programme

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		• Audits – National Diabetes Audit, Footcare Audit, and Inpatient Safety Audit • Secondary Prevention – Service data from T2DR, NDPP, and Structured Education • Service Performance – Oversight by the Commissioning & Performance Team • Collaboration – Acute Hospital Collaboratives & Specialty Clinical Network for Diabetes • External Reviews – Insights from Getting It Right First Time (GIRFT) recommendations These measures ensure continuous improvement and equitable diabetes care across Norfolk & Waveney. **Children & Young People (CYP)** Healthcare providers adhere to comprehensive safeguarding policies and procedures to ensure the safety and well-being of CYP. The Norfolk and Waveney ICB collaborates with the Norfolk Safeguarding Children Partnership to promote effective cooperation. They provide resources, develop template policies, and offer guidance to health		Beccy Godfrey CYP Commissioning and Transformation

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		partners to meet their safeguarding obligations. For CYP with complex diabetes, the NSCP has specific protocols to manage concerns. These protocols emphasise early identification of risks and a coordinated multi-agency response to ensure timely assessment and intervention. National audits, including the National Paediatric Diabetes Audit (NPDA) track service quality and identify areas for improvement. Norfolk & Waveney ICB plans to consider the impact of social determinants of health, such as housing and food insecurity, on diabetes management in disadvantaged families. **3. Audiology** Our commissioning approach ensures that contracts with community providers include safeguarding measures to ensure providers have appropriate policies and safeguarding leads in place. In addition, providers report directly to the ICB with quality metrics on any incidents, patient experience feedback and complaints.		Bertone Santos Socorro, Community Commissioning

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		We act promptly on these metrics to ensure we address potential patient harm, learn from past experiences and sharing best practice. Any serious incidents are escalated to the ICB Quality and Safety Committee. Children and Young People Services are encouraged to audit outcomes and to participate in IQIPS accreditation. One provider has achieved accreditation, and the other two providers are exploring the potential to undertake this within the group model. The system is participating in the Paediatric Hearing Service Improvement Programme supported by the Regional Team in order to with the aim of conduct a nationally coordinated review of all paediatric audiology services within the NHS in England and aims to identify and recall babies and children at risk, mitigate harm caused by misdiagnosis or delayed diagnosis, and support services in delivering quality improvement interventions Visits to each of the providers are planned in Q4 2024-2025		
	1D: Patients (service users) report positive experiences of the service	**1. Maternity** Bespoke staff training is delivered to support cultural competence, including sessions on Eastern European service users and migrant	**2 Achieving**	Local Maternity and Neonatal System

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		workers/ asylum seekers. An ongoing programme of inclusion health local learning events has been developed as a result. Vision, values and aims aligned to ICS health inequalities framework for action to reduce health and care inequalities across Norfolk and Waveney. Health needs analysis complete and work is underway to enhance health inequalities data. Service user voice is embedded in our work via our Maternity and Neonatal Voices Partnerships within each of our three Trusts. Recent examples of service user involvement include initiatives to support bereaved families, families with neonatal babies and improving the antenatal care provision across the system. Ethnicity data is included on Datix and incident reports. Appointment of clinical fellow to Maternity Fellowship to support equity and equality work. WRES data analysed and presented in the Equity and Equality health needs		

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		assessment. Scoping is underway and findings will influence plans to reduce inequalities. **2. Diabetes** The Transitioning Young Adults (TYA) and Type 1 Diabetes and Disordered Eating (T1DE) pilots are collating patient experience data and information. This is being nationally evaluated and will inform future commissioning. The NHS Diabetes Prevention Programme (NDPP) and the Type 2 Diabetes Path to Remission (T2DR) programme, whilst nationally commissioned, have oversight at a local level, NWICB receive regular reports and case studies from providers and continue to monitor delivery of high-quality care. The ICB has a mechanism in place to gather direct feedback and experiences from underserved communities to inform service design and future thinking for diabetes. **Children & Young People** Paediatric diabetes services gather patient feedback through various mechanisms to assess and improve the quality of care		Beccy Godfrey CYP Commissioning and Transformation

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		provided to CYP, such as: patient surveys to gather insights into their experiences with the paediatric diabetes services. Patient Participation Groups (PPGs) are also facilitated so that CYP and their families can engage with healthcare providers to discuss services and provide feedback. The National Diabetes Paediatric Audit (NPDA) also includes patient survey results through its Parent and Patient Reported Experience Measures (PREM) report. **3. Audiology** Our commissioning approach requires our providers to undertake surveys on patient experience and outcomes, as well as ensuring a complaints policy is in place. Providers submit regular reports providing the ICB assurance, which include a Patients' Satisfaction Report, including separate questionnaire outcomes for hearing assessments and fitting, and another for aftercare. These reports highlight the quality of service, patient satisfaction and areas for improvement. Providers also submit analysis of Friends and Family Tests (FFT) received from patients following their experience of receiving this service.		Bertone Santos Socorro, Community Commissioning

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		Patient feedback is resoundingly positive, with people responding with “strong agreement” or “agreement” to all questions. Supporting narrative from patients was also very positive, explaining how they felt at ease and reassured by the audiologists. In terms of areas for improvement, many comments have been received to state that no changes are necessary with only one stating they needed further specialist support which was being facilitated by the provider. Whilst our providers have not received many suggestions on how the service may be improved, based their own observations and ambition to ensure that they continue to offer a high quality, professional and accessible service, actions going forward are as follows: Maintain High Standards: Continue to uphold the high standards of service quality, professionalism, and patient care that have been praised by patients. Enhance Patient Education: Continue to focus on patient education regarding hearing aids and hearing loss, as this has been highly appreciated by patients.		

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		Enhance the Booking Process: Implementing an online booking system to make it easier for patients to schedule, reschedule, or cancel appointments. Monitor and Respond to Feedback: Continue to regularly collect and analyse patient feedback to identify areas for continuous improvement and ensure that patient needs and concerns are addressed promptly. Actively work towards increasing accessibility for people to access ARHL services in rural areas within the next 6 months.		
Domain 1: Commissioned or provided services overall rating			**8**	

Domain 1: Commissioned or provided services

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Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

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Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	The ICB provides a variety of resources for our employees to manage long term health conditions, including one to one support, our 'your health and wellbeing' intranet page. With access to the Digital Weight Management Programme, the Employee Assistance Programme and further resources to support Domestic Violence and Abuse, Macmillan Support, Menopause resources, Veteran Mental Services, TRiM and Office Health. The ICB has 7 dedicated Health and Wellbeing Champions focusing on Mental Health, Men's Health, Financial Health, Women's Health and Physical Health and Social Health. Staff have been actively signposted to the staff vaccinations for autumn and winter 2024. The ICB (along with the Norfolk and Waveney ICS) is working towards being accredited as a Menopause Friendly Employer. ICB Menopause Awareness Week in October 2024, co-ordinated by NHSFT was attended by 1000 staff across the ICB and ICS. There will continue to be quarterly online menopause support groups for ICB staff. The ICB utilises Health and Wellbeing Passports as part of health and wellbeing conversations together with a Wellness	2 Achieving	HR / OD

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		Assessment and Action Plan. Further training and education to raise awareness with People Managers will be available in the supporting attendance, health and wellbeing and flexible working module of the Management Programme which will be rolled out in 2025. The ICB will continue focus and commit to the Norfolk and Waveney ICS Health and Wellbeing Plan to providing healthy work environments, with relevant and timely wellbeing support to enable our workforce to be well at work, feel valued, have a sense of belonging which includes promoting and maintaining good physical and psychological wellbeing and supporting those who need additional help. We will also be appointing a number of - additional Welfare Officers to provide support to those staff involved in investigation and disciplinary procedures. The ICB's Teams channels continue to provide and signpost staff to health and wellbeing information with dedicated channels on Equality, Diversity and Inclusion, Finance Matters, Menopause, HR, Learning and Development, Mindfulness, Staff Rewards, Discounts and Benefits. Together with signposting to the #We care Together website.		

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		We also have a Learning Hub and a Career Resource Portal which provides resources and leadership and management support. We support staff with information on apprenticeships, Schwartz rounds and a talent collaborative network and resource hub. Our Staff Involvement Group meets monthly and was established to ensure the ICB had the opportunity to engage and listen to the views of staff and help to inform both organisational decision making and organisational planning. We are refreshing our terms of reference following the restructure to both identify the aims and objectives of the group but also to ensure there is representation from across the whole of the organisation The ICB also has weekly Staff Briefings where staff are regularly signposted to health and wellbeing initiatives. EDI Staff Group is promoting a calendar of health and religious events with updated resources and links on national awareness days. This calendar is available on the EDI Intranet site and is regularly promoted on the ICB's EDI intranet channel. The ICB has launched the opportunity for staff to buy a further 1 week of leave each year		

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		which we hope will enhance employee satisfaction and well-being. The ICB will also launch Wagestream in 2025, via an online portal they can access. It provides flexibility giving staff the opportunity to choose when to get paid using a percentage of the money they have already earned (hours worked). This benefit will reduce financial stress between pay checks hopefully leading to improved mental health with reduced financial pressure leading to a more focused and engaged workforce. The Staff Opinion Survey (2023) noted that 60% of staff who answered the survey (67% response rate) said “My organisation takes positive action on health and well-being” (this was down by 5% on 2022).		

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	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The ICB is committed to reviewing its anti-racism initiatives (strategy) as part of its EDI Strategy and Plans, EDI Policy and Dignity at Work Policy. Business in the Community Race at Work Charter. This will link to the NHS Anti-Racism Strategy. The ICB's Health Inequalities and EDI improvement Plan together with are WRES & WDES action plan will highlight areas of concern that we will continue to address throughout 2025/2026. This review will also support and underpin the ICB values of at all times being respectful, inclusive and embracing new ways of working by being innovative and continually improving. Together with the NHS People Promise and the ICB's Eight Ambitions of the Joint Forward Plan. The ICB is also taking steps to build a stronger and more supportive culture. We are launching a series of workshops in February 2025 to explore how we can build a restorative and just culture where everyone feels valued. Strengthen teamwork with tools for resilience and mindset practice and create a workplace focused on collaboration, learning and growth. The ICB's Management Programme includes an EDI module which will focus on antiracism,	1 Developing	HR / OD

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		abuse, harassment and bullying, to raise awareness and education. This will be rolled out throughout 2025. The ICB has committed to taking and enforcing a zero tolerance approach to unwanted, inappropriate and / or harmful sexual behaviours within the workplace and will sign up to the Sexual Safety Charter in 2025. The ICB has created a system wide micro aggression portal to allow all staff the opportunity to informally and anonymously log incidences of bullying and harassment. Whilst we are pleased to report only a few incidences four,have been reported, although this is a relatively low number, one is too many. This tool is also on the ICB staff intranet and will be a tool for colleagues in the ICB to continue to log incidences. The ICB also works closely with the Freedom to Speak Up Guardian to collaboratively address issues and improve experience. We will be further supporting our Guardians in 2025 and will be hoping to increase the number of Guardians and Champions available and we hope will represent the diversity of the staff.		

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		The ICB will also be promoting the NIDAS stalking and harassment Campaign 2025 via our Staff Briefing and via our teams channel. The aims of this campaign are: • To raise awareness of what stalking is and harassment is, and the differences between the two • To encourage victims to recognise behaviours linked to stalking and harassment • To encourage those who are experiencing stalking and harassment to seek support. The Staff Opinion Survey 2023 detailed headline results which were published in March 2024. The response rate was 67% with 489 responses and benchmarked against 41 other ICBs. The ICB is above our comparator average for all 7 People Promise themes and staff engagement and morale. Areas showing most improvement include flexible working opportunities and bullying/harassment at work by patients/service users. A significant improvement in managers encouraging staff, involving them in decisions, supporting with wellbeing, and valuing work. Unfortunately, areas showing a decline since our 2022 survey		

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		(in line with a national deterioration in these areas) include teams not working together to achieve objectives, feeling unwell as a result of work-related stress and staff reporting feeling worn out. Key responses noted (national comparator) 91% (91%) gave a response of no, when asked if they had personally experienced harassment, bullying or abuse at work from patients / services users, their relatives or other members of the public in the last 12 months. 93% (90%) gave a response of no, when asked how many times have you personally experienced harassment, bulling or abuse at work from managers in the last 12 months. 86% (88%) gave a response of no, when asked how many times have you personally experienced harassment, bulling or abuse at work other colleagues in the last 12 months. 43% (43%) confirmed they did report the last time they experience harassment, bullying or abuse at work. We are pleased to note: 59% ((55)% are confident the ICB would address their concerns. 71% (67%) thinks the ICB respects individual differences (e.g. cultures, working styles, background, ideas)		

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		76% (74%) of people in the ICB are understanding and kind to one another. 77% (77%) reported the people I work with are polite and treat each other with respect.		

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	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	As noted in section 2A staff have access to the Employee Assistance Programme (via VIVUP) providing qualified counsellors and support specialist 24/7 and 365 days a year to discuss any emotional, personal and work-related issues. In addition we have trained workplace Mental Health First Aiders and Champions. We continue to signpost all staff through the regular staff briefings to any support available, our intranet provides details of support and guidance, and our Teams Channels promote and remind staff of support available, should they need this. We are able to refer staff to Occupational Health (via NNUH OPAS portal) who offer additional support. We have a recognition agreement in place with our Trade Unions and sign post staff to Trade Unions Representatives who are independent of an employee's team. Staff may also log micro-aggressions anonymously and safely and also speak to the Freedom to Speak Up Guardian and Champion.	2 Achieving	HR / OD

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	2D: Staff recommend the organisation as a place to work and receive treatment	The 2023 Staff Opinion Survey noted 49% said they would recommend my organisation as a place to work, . although this percentage has significantly fallen from 67% in 2022. Whilst unfortunately we have seen a downwards trend, we are still above the national comparator of 45%. It is important to note we have just completed a lengthy and large-scale change programme, and we acknowledge this has been an extremely unsettling and worrying time for staff. The ICB hopes to have a second annual 'All Staff Event' to build team cohesion and collaboration and boost morale and engagement, facilitate communication and enhance our organisation culture and encourage innovation. We previously highlighted staff successes and achievement which was warmly received and therefore we will repeat this The ICB is reviewing and updating their Recruitment and Selection Policy with a further focus on neurodiversity. The ICB is also encouraging all recruiting managers to attend further training on Recruitment and Selection as part of the Management Foundation Programme.	2 Achieving	HR / OD

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		We will continue to focus on improving the monitoring and quality of exit interviews and how this feedback and can improve working conditions and this will help to inform future ICB EDI plans. The ICB is focused on improving staff retention and has the following areas of focus: • Recruitment and Onboarding • Talent Management and Staff Development • Health & Wellbeing • Employee Experience • Flexible Working Regular one to one review meetings and appraisals continue to provide staff with the opportunity to receive support, both personally and professionally. There continues to be regular opportunities for People Managers to attend Performance Appraisal Training. The ICB support Apprenticeships to develop talent within the organisation and support organisational growth. The ICB has a dedicated Apprenticeship panel which meets quarterly to review applications to ensure fairness, equity and inclusion.		

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		We continue to recognise the importance of our staff groups particularly the Staff Involvement Group to ensure we listen to their views which in turn help the ICB to improve our working environments. Also our EDI staff group to ensure we support and empower all staff to achieve their potential through creating positive change. The EDI Staff Group have recently issued a survey asking for feedback. From this the EDI Staff Group have refreshed their terms of reference and have identified 3 areas for the EDI Staff Group to focus on raising awareness of Hidden Disabilities, Neurodiversity and Age. We continue to be supportive of those staff with protected characteristics and we need to ensure that we allow protected time for our staff to engage with ICB Staff Networks and Groups The ICB is supporting an Inclusive Talent Culture using Scope for Growth and using the 'Growth Arc – depth, breadth and stretch' to support employees to reflect and discuss opportunities for personal development. The ICB will sign up to the Disability Confident Scheme and will continue to support the NHS		

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		Two Ticks (disability status at the shortlisting stage (NHSE).		
Domain 2: Workforce health and well-being overall rating			7	

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Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

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Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	As part of the EDI improvement plan the higher impact objective 1 -measurable objectives on EDI for Chairs, Chief Executives and Board members. Smart objectives have been developed and appraisals have been carried between January to March 2024. These objectives and plans also reference the NHS Leadership and competency framework. All Board Members and those with line management responsibilities are required to undertake EDI Mandatory Training every 3 years to the NHS standard. All Executive Directors have access to Executive Coaching with an External Coach. All Board Member and Executive Directors are attending an EDI Board Development session hosted by Roger Kline (external advisor to the NHS Improvement working group on EDI on the new national HR strategy and who has authored several reports on race equality) in April 2025. We are currently reviewing the SRO for EDI and we hope to confirm a Board Member	1 Developing	HR / OD

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		responsible for EDI and supporting our EDI Staff Network Group in early 2025. The two ICB Non Executive Directors are also attending the Health Inequalities Programme in 2025. The Executive Nursing Director is our Senior Reporting Officer and Principal Freedom to Speak Up Guardian. Our Executive Medical Director is the ICB's Caldicott Guardian. Our Executive Director of Finance is the SRO for Risk and Compliance		

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	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	All public Board papers are on the website. The EDI Board champion role is being reviewed as part of the organisational change. Although the development of the EDI improvement plan now sits with the HR and Organisational Development teams, and they will work closely with the EDI staff group and EDI leads across the ICS. There is a section on EIA at the end of every Board paper that presenters ensure is completed. Work on addressing Health Inequalities has been delegated to the Patients and Communities Committee. The Equality agenda is overseen by the People and Culture Committee as part of the broader People agenda. The ICB's Equality Impact Assessment process has been reviewed and there is now a combined QIA and EHIA process and panel. The panel are currently prioritising existing and new projects on a weekly basis. Part of this is to test the process and forms being	1 Developing	HR / OD / Health Inequalities

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		completed. The panel is also taking the opportunity to test the process and identify any training needs that might be highlighted to enable further training and education of staff to support understanding of the Quality Impact Assessment and Equality Health Impact Assessment processes. The ICS Health Inequalities Strategic Framework for Action was published in May 2024 following a 9 month collaborative engagement process across the ICS. Following the ICS restructure, the ICB Health Inequalities & VCSE Partnering team was established in July 2024. Part of the team's remit is supporting System Leadership in the implementation of the Health Inequalities Strategic Framework for Action; this includes governance structures, and work programmes. As part of the Strategic Framework for Action, a series of *Health Inequalities Commitments* were launched at the 2024 ICS Conference. These Commitments included an ask of the system to complete a *Self-Assessment* to support system baselining of health inequalities activity. The		

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		intention is to utilise the outputs of these assessments to develop an *ICS Improvement Plan* and accompanying resources. As well as a system Improvement Plan, organisations completing the Self-Assessment are also encouraged to develop their own Improvement Plan which will feed into the wider system plan. The ICB, being fully signed up to the commitments, is committed to completing the self-assessment and developing and implementing their own Health Inequalities Improvement Plan (approval March 2025 with ongoing implementation from then). The Health Inequalities & VCSE Partnering Team has been engaging with the wider ICB to support the completion of their self-assessment, including leading a Health Inequalities session at the All Staff Away Day, as well as subsequent Joint Senior Leaders workshops. The feedback from these sessions have been collected and are feeding into the self-assessment submission, as well as the Improvement Plan. The key area of focus for the Improvement Plan will include: *processes*		

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		and resources, workforce and OD, Leadership and Governance and Data, intelligence and voice. The delivery of the plan will be overseen by senior leaders, forming part of an MDT. One of the Health Inequalities Commitments asks organisations to allocate a Health Inequalities Lead as well as develop a network of Advocates. The ICB Health Inequalities & VCSE Partnering Team are currently engaging with ICB staff to co-design the ICB Advocate network; this will include co-designing roles and responsibilities, training and support offers as well as creating spaces for ICB staff to share best practice and develop their common understanding of health inequalities. This will feed into the wider Health Inequalities advocate programme across the ICS. To support the wider health inequalities agenda and the development and implementation of the Advocates network and Improvement Plan, the ICB Health Inequalities & VCSE Partnering Team are hosting fortnightly drop in sessions on		

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		Tuesdays to create an opportunity for engagement. ICB Colleagues can drop in to discuss: • Connecting with the VCSE sector • Advice and guidance around Core20 populations • Community Voices insights and guidance • Providing feedback on training and support needs • Accessing our Clinical Lead for Health Inequalities and Inclusion Health This is also an opportunity to do some engagement around the HI advocate network. Aligned to the development of the Advocates Networks, the Health Inequalities & VCSE Partnering Team team are co-ordinating local activity in relation to the national NHS England Core20Plus Ambassador Programme. Norfolk and Waveney currently have approx. 40 people in cohort 3 across the ICS who are engaging with the national programme, 11 of which are ICB members of staff. Each member of the cohort is delivering a project		

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		in the inequality space. Projects cover all aspects of our day to day work, from data quality to service quality improvement and increasing awareness of service provision. Some more patient facing projects include: increasing digital access for patients living in rural communities, identifying and recording reasonable adjustments for all patients on General Practice Learning Disability and Significant Mental Illness registers, increasing engagement and co-production with children and young people facing inequalities, and increasing access to healthcare services for the deaf community. The projects are currently in development and work is also going on in the background to align as many of the projects as possible. This programme cohort will also be feeding into the HI advocate programme and network with the ambition of bringing together all champion and advocates roles supporting Health Inequalities to share best practice and opportunities, as well as supporting the implementation of the Health Inequalities Strategic Framework for Action.		

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	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	The ICB applies the current Fit and Proper Person Regulations to all Board Members and all Executive Directors. A documented full Fit and Proper Test is completed annually and where there are new appointments or when an individual changes role. There is a governance system in place to manage performance and operational delivery against the ICB's Joint Forward Plan and Clinical Strategy which focuses on delivering high quality patient services and being a well led and good employer. There are dashboard reports in place to measure key metrics relating to Population Health Management and patient outcomes are presented to Board regularly. Appraisal processes are in place and appraisal refresher training sessions will continue to be offered to all managers. All Directors and People Managers have access to Electronic staff Record (ESR) performance dashboards to review and monitor progress against performance	2 Achieving	HR / OD

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		(appraisals, attendance and mandatory training). Leadership and management support programmes will be delivered throughout 2025 for all People Managers.		
Domain 3: Inclusive leadership overall rating			4	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): ***tbc -*** ***Peter Passingham (Unison Rep)***	**Independent Evaluator(s)/Peer Reviewer(s):** ***tbc*** ***Evelyn Kelly, Chair of Equality, Diversity & Inclusion Group (ICB) reviewed & commented on dd/mm/2025 and submitted for further discussion and review at the EDI staff Group meeting on 26 February 2025.***

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EDS Organisation Rating (overall rating): 19
Organisation name(s): Norfolk and Waveney ICB
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

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EDS Action Plan	
EDS Lead	**Year(s) active**
Shelley Ames, Head of Health Inequalities & VCSE Partnering	2025-2026
EDS Sponsor	**Authorisation date**
Mark Burgis, Executive Director of Patients and Communities	

Domain	Outcome	Objective	Action	Completion date

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Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Diabetes- Addressing gaps in service provision and expanding to underserved populations.	Due to historical commissioning arrangements, there are differences in care provided across the ICS e.g., footcare (community and in-patient), diabetes technologies and services for transitioning young adults and those with disordered eating. - Implement new model of diabetes care across the ICS - Implement diabetes technologies in line with NHS England strategy (aligns with the CYP clinical area of core20) - Utilise learning from evaluation of pilot initiatives to inform future commissioning	Progress report- Mar 2026

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	1B: Individual patients (service users) health needs are met	Maternity- Enhance personalised care and inclusivity for women accessing maternity services	Implement and monitor the rollout of the new Personalised Care and Support Plan (PCSP), ensuring accessibility through paper, digital, and Easy Read versions, and expanding awareness via Just One Norfolk. This aligns to the core20 plus 5 maternity domain (clinical area).	Feb 2026
		Strengthen support for vulnerable communities	Expand maternity social prescribing in collaboration with Family Hubs and develop a collaborative VCSE and health network to improve care for underserved and inclusion health and plus groups.	Feb 2026
		Collaborate with system partners to develop approaches that support access to regular, holistic diabetes reviews for CYP with type 2 diabetes, particularly in underserved areas.	Propose multidisciplinary team (MDT) clinics, where diabetes specialists, dietitians, mental health professionals, and social care workers provide coordinated care to all. Explore the option of mobile clinics in community centres, schools, and faith-based settings to reach underserved areas. Encourage services to be co-designed with input from CYP and	March 2026

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			their families to make care more accessible and engaging. Explore the option of telehealth consultations and remote monitoring tools for blood glucose management. Signpost CYP to apps and online support groups tailored for young people with type 2 diabetes so access can be made remotely.	
	1C: When patients (service users) use the service, they are free from harm	Audiology- Improve Patient education Consider the impact of social determinants of health, such as housing and food insecurity, on diabetes management in disadvantaged families.	Improve patient understanding of hearing aids and hearing loss through educational sessions and updated resources Explore the option of training care coordinators within primary care networks (PCNs) to identify and support families facing housing, financial, or food insecurity. Train clinicians to have sensitive conversations about housing, food access, and financial difficulties. Evaluate current questionnaires / tools used to assess social risks to ensure they are simple and effective.	Feb 2026 March 2026

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	1D: Patients (service users) report positive experiences of the service	Maternity- Use WRES data and health needs assessment findings to drive targeted plans reducing maternity inequalities. Audiology- Ensure high quality of care	Utilise WRES data analysis and Equity & Equality Health Needs Assessment findings to inform targeted plans for reducing inequalities. Ensure continued delivery of high quality professional and accessible care through patient satisfaction surveys, regular reviews and actions taken as a result of the patient feedback.	Feb 2026 Feb 2026

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Domain	Outcome	Objective		Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Effective communication of health and wellbeing offers to staff Eliminate unlawful discrimination	Our staff groups, networks and champions continue to provide an excellent foundation to implement, educate and communicate many initiatives. Our EDI Staff Group will also be sponsoring and promoting health initiatives to support those staff with long term conditions and provide education to support our managers via national calendar. Accreditation as a Menopause Friendly Employer. Launch of Wagestream	Ongoing Ongoing	2025 2025

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	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To Foster good relations	To review the ICB's antiracism strategy as part of its EDI Strategy and Plans, EDI Policy and Dignity at Work Policy. The ICB's Health Inequalities and EDI improvement Plan together with are WRES & WDES action plan will highlight areas of concern that we will continue to address. To launch a series of workshops in February 2025 to explore how we can build a restorative and just culture where everyone feels valued. Strengthen teamwork with tools for resilience and mindset practice and create a workplace focused on collaboration, learning and growth. To present the ICB's Management Programme, EDI module focusing on antiracism, abuse,		2025 2025/2026 2025 2025/2026

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			harassment and bullying to raise awareness and education. To sign up to the Sexual Safety Charter.		2025
			To recruit further FTSU Guardians and Champions.	Ongoing	2025
			To continue to promote Freedom to Speak Up and Micro-aggression Porrtal to support those employees who would like to speak up.	Ongoing	2025
			To continue to review the results of the staff opinion survey 2023 and compare against the 2024 results and implement focus groups to continuously improve the ICB's working environment.		

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	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Eliminate unlawful discrimination Promote equal opportunity	Continue to support the Employee Assistance Programme Continue to support and promote Freedom to Speak up To ensure that the ICB continues to listen and engage with staff through Staff Network Groups, Staff Briefings to continuously improve and learn. Continue to strive towards providing psychologically safe environments	Ongoing Ongoing	2025 2025

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	2D: Staff recommend the organisation as a place to work and receive treatment	Achieve and promote best practice in equality, diversity and inclusion .	To host a second annual 'All Staff Event' to build team cohesion and collaboration. Reviewing and update Recruitment and Selection Policy with a further focus on neurodiversity. Encouraging all recruiting managers to attend further training on Recruitment and Selection as part of the Management Foundation Programme. We will continue to focus on improving the monitoring and quality of exit interviews and how this feedback and can improve working conditions and this will help to inform future ICB EDI plans. To provide Appraisal Training for People Managers.	Ongoing 2025 2025 Ongoing 2025 Ongoing Ongoing	

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			To continue to support Apprenticeships to develop talent. To continue to support Staff Network Groups. To support the EDI Staff Group to focus on raising awareness of Hidden Disabilities, Neurodiversity and Age. We continue to be supportive of those staff with protected characteristics and we need to ensure that we allow protected time for our staff to engage with ICB Staff Networks and Groups We continue to support an Inclusive Talent Culture using Scope for Growth and using the 'Growth Arc – depth, breadth and stretch' to support employees to reflect and discuss opportunities for personal development.	2025	

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			The ICB will sign up to the Disability Confident Scheme and will continue to support the NHS Two Ticks (disability status at the shortlisting stage (NHSE).		

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Domain	Outcome	Objective		Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Identify and continue to address inequality as an employer	All Executive Board Members EMT to support the implementation the Health Inequalities & EDI improvement action plan and EDI High Impact Objectives and actions. Continuing to improve the working environment for all staff – giving them a sense of belonging, value opportunities to feel psychologically safe and to thrive Appoint an SRO for EDI.	Ongoing Ongoing	2025
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Identify and continue to address inequality as an employer	All Public Board Papers are the website A review of the EIA process to ensure process is effectively followed for all future projects and programmes of work.	Ongoing	2025

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	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Identify and continue to address inequality as an employer	A documented full Fit and Proper Test is completed annually and where there are new appointments or when an individual changes role. There is a governance system in place to manage performance and operational delivery against the ICB's Joint Forward Plan and Clinical Strategy which focuses on delivering high quality patient services and being a well led and good employer. There are dashboard reporting in place to measure key metrics relating to Population Health Management and patient outcomes are presented to Board regularly.	Ongoing Ongoing Ongoing Ongoing Ongoing	2025

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			Mentoring and coaching support is available and in place for Board members. All Directors and People Managers have access to performance dashboards to review and monitor progress against performance (appraisals, attendance and mandatory training). Leadership and management support programmes will be delivered for all People Managers.		

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Patient Equality Team
NHS England and NHS Improvement
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Daniel Hamil
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Norfolk and Waveney
Integrated Care Board

Gender Pay Gap Report

March 2024



The NHS People Promise

Davey, Heidi
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Summary

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

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



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The ICS has three overarching goals:

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

NWICB organisational values were co-created through a collaborative process with our staff and represent how we wanted to live our values through everything we do. Connected to; each other, the work we do, a common purpose, our partners across the system and always to our patients/public. At all times being respectful, inclusive and embracing new ways of working by being innovative and continually improving.



This is also aligned with the NHS People Promise to work together to improve the experience of working in the NHS for everyone. As an ICB we are committed to delivering this promise. The support we offer all of our staff in the ICB from our People Services is linked to each of the seven People Promise domains.



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NWICB employed 684 employees as of 31 March 2024 and is committed to being an equal opportunities employer and equality and diversity is embedded into everything it does.

Gender Pay Gap Analysis

Requirements

In accordance with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, employers with 250 or more employees are required to publish Gender Pay Gap calculations no later than 30 March each year.

The gender pay gap is not the same as equal pay, it's the difference between the average pay of all men compared to the average pay of all women. In an organisation which adheres to structured pay grades and equal pay the Gender Pay Gap will highlight variances between genders if there's a proportional difference in the distribution of the workforce across the grades.

The legislation requires an employer to publish six calculations:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
6. Proportion of males and females when divided into four groups ordered from lowest to highest pay.

The information must be published on both the employer's website and on a designated government website. An employer should then use that information to help understand any underlying causes for their gender pay gap and take suitable steps to minimise it.

As stated above gender pay reporting is different to equal pay; equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. The gender pay gap shows the difference in the average pay between all men and women in a workforce based on hourly pay. It takes account of mean and median averages, as well as 'bonus' payments. Clinical Excellence Awards, payable to medical Consultants, are classed as bonus payments for gender pay reporting purposes, however this is not applicable to the ICB.

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Within the NHS, excluding Very Senior Managers (VSM), pay scales are set nationally and terms and conditions prescribe pay arrangements on appointment. Jobs for all staff on Agenda for Change (all staff excluding medical and VSM) are subject to NHS

Job Evaluation to determine appropriate pay bandings. This therefore has a positive and significant impact on preventing gender related pay discrepancies.

Technical Information - Employee's to Include

For **ordinary pay**, only 'Full Pay Relevant Employees' are to be included. A 'Full Pay Relevant Employee' is any employee who is employed on the snapshot date of 31st March 2024 and who is paid their usual full basic pay during the relevant pay period. If employees are being paid less than their usual basic pay rate, or nil, during the relevant pay period as a result of being on leave, then they are not a 'full pay relevant employee'. It does not matter whether any leave is taken during the relevant pay period – what matters is whether the pay is reduced during that relevant pay period due to the leave.
If an employee is paid less than their usual basic pay or piecework rate during the relevant pay period for reasons other than leave (for example because they have been on strike), they still count as a full-pay relevant employee.

For bonus pay all employees should be included

Table 1: Gender breakdown (snapshot as at 31 March 2024)

Gender	Headcount	Percentage
Female	520	76%
Male	164	24%
Total	684	100%

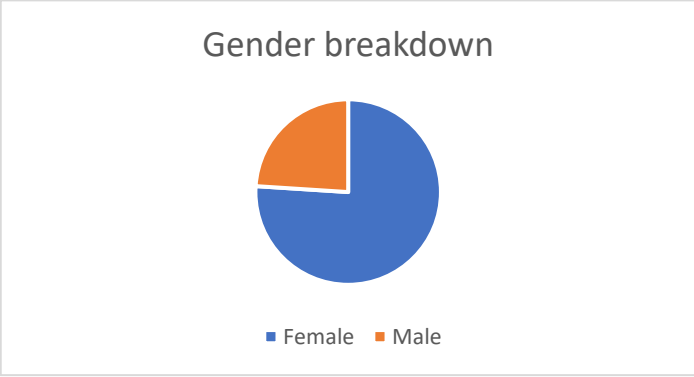

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Table 2: Illustrates the % of males and females in each band

% Assignments per band	Gender	
Band	Female	Male
Band 2 - 4	19.47%	5.42%
Band 5	12.02%	8.43%
Band 6	16.79%	10.24%
Band 7	15.84%	17.47%
Band 8	29.01%	44.58%
Band 9 & Non Banded	6.87%	13.86%

Table 2 highlights that over half of male ICB colleagues have an assignment of band 8 and above (including non-banded roles)

Table 3: Average Rates of Pay – by gender (snapshot date 31 March 2024)

Average & Median Hourly Rates		
Gender	Average of Median Hourly Rate	Average of Hourly Rate
Female	22.369	27.262
Male	26.057	41.697
Difference	3.687	14.434
Pay Gap%	14.15%	34.62%

Table 3 details the mean and median hourly pay rates per employee on the snapshot date. Males were paid on average £14.43 more than females. This indicates that the average pay for males is higher than females and highlights the middle value is also higher than the females.

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Table 4: Gender breakdown of employees in each quartile

Number of Employees by Gender & Quartile					
	Gender				
	Female		Male		
Quartile (Q1 - low, Q4 = High)	Count	%	Count	%	
1	135.00	87.66%	19.00	12.34%	
2	147.00	83.52%	29.00	16.48%	
3	123.00	71.10%	50.00	28.90%	
4	115.00	63.54%	66.00	36.46%	
Total	**520.00**		**164.00**		**684.00**

Table 4 shows the distribution of the workforce broken into quartiles with all employees ranked according to the hourly earnings and split into 4 quartiles.

Table 5 and Table 6 illustrates the same data in graph format.

Quartile	Female %	Male %	Grand Total
1	26.0%	11.6%	22.5%
2	28.3%	17.7%	25.7%
3	23.7%	30.5%	25.3%
4	22.1%	40.2%	26.5%
Grand Total	**100.0%**	**100.0%**	**100.0%**

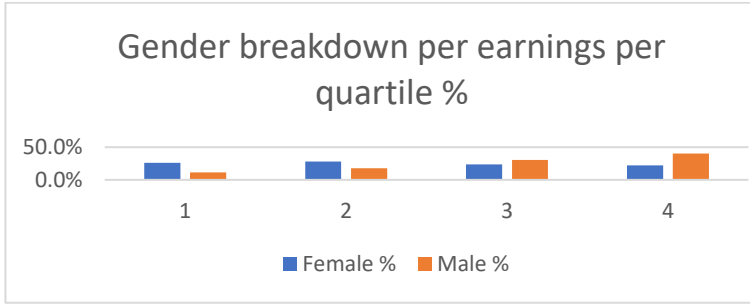

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Table 5 illustrates representation of quartile across each gender as a percentage.

Ordinary pay

All NHS staff are aligned to Agenda for Change they all receive equal pay for undertaking equal roles. There can be a slight variation within each banding depending on the pay step progression.

Bonus pay analysis

The NWCB doesn't make specific payments in regards of bonuses.

Understanding the ICB's Pay Gap

Male staff earn on average an hourly rate of £14.43 more than their female colleagues. This is also reflected in the median hourly rate of pay illustrating that male colleagues earn £3.69 more.

Whilst the ICB employs more female staff the percentage of males holding more senior roles from band 7, 8 and 9 is greater than their female colleagues. This is in spite of males being significantly less represented across the entire workforce.

Comparison from 2024 report

Through the ICB re structure the female headcount has decreased by 1%, whilst the male headcount has increased by 1%. Over half of male ICB colleagues have an assignment of band 8 and above (including non-banded roles), the gap between those in a band 9 and non-banded roles has decreased by 3.54% since 2023, meaning more females have been successful in gaining those roles.

Although the average hourly rate gap has increased by 2.47% since 2023 for male employees, the gap has decreased in relation to the average median hourly rate by 11.54%.

Action plan to close the Gender Pay Gap

NWICB has a high proportion of female employees. It is therefore important the organisation should be in a position to remove internal barriers to pay parity and provide more noticeable support to our female employees who may be more likely to take on additional caring responsibilities at home.

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Our 2023 staff opinion survey, with a response rate of 67% with 489 responses, noted 61.9% of staff were satisfied or, very satisfied with levels of pay. This was a positive difference of 5.76% on the previous year. However, our data has shown that female

employees are more likely to be in lower paid roles and therefore it is important that we remove any barriers to career progression in order this upward trend continues.

Whilst our staff opinion survey (2023) noted 80.7% of those who answered the survey felt there were opportunities for flexible working patterns, (which is an increase of 4.3% on the previous year and an overall increase of 10.4% over the last two years), demonstrating a clear indication this is moving in a positive direction. It is important to ensure there is increased understanding of flexible working options and we seek other opportunities to help to remove barriers in order to promote and support conversations about working patterns and job roles. The legislation introduced on 6*th* April 2024, provides gives any employee with the right to make a statutory flexible working request from the first day of their employment, this is promoted within the organisation and assists with wellbeing conversations.

49.3% of staff said they would recommend the ICB as a great place of work, which is a significant decrease of 18.66% compared to last year. In order to address this, we will seek further feedback from our leavers at exit interviews to understand how we might make further improvements, this included gaining valuable feedback from our EDI staff engagement group. As a result we have amended our exit interview process. With this in mind, we have recently introduced a Microsoft Survey Form consisting of 13 questions and 3 of which focus on equality, diversity and inclusion:

1. Have you personally experienced violence or aggression at work from patients, service users, their relatives, members of the public or colleagues?
2. Have you personally experienced discrimination at work from patients, service users, their relatives, members of the public or colleagues?
3. Have you personally experienced harassment, bullying or abuse at work from patients, service users, their relatives, members of the public, colleagues or Manager? Addition: If you answered yes to any of the above - Did this contribute to your decision to leave the organisation?

NWICB is rolling out a Management Foundation Programme following the 2023 NHS England launch of a framework outlining the expectations of NHS line managers in relation to people management. ***"How to manage teams, How to manage people"***
We know from our own experience, and from what staff have told us through staff surveys, focus groups and feedback, that the role of the line manager is vital to how we feel at work, and to delivering our services. Managers give direction, help clarify individual and team objectives, and are instrumental in ensuring colleagues feel valued, supported, and cared for at work. One of the modules will cover supporting attendance including flexible working and wellbeing support.

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NWICB respects individual experiences (e.g. culture, working styles, background, Ideas) and 86% of said the NWICB had made reasonable adjustments to enable them to carry out their work.

We will continue to seek feedback from our EDI staff network group to further understand our workforce and how we might make further improvements.

70.9% of staff completing the staff opinion survey said they had an appraisal in the last 12 months this is down 2.61% from the national comparator. It is important that we must continue to support career development and identify and manage the talent in our organisation The Management Foundation Programme will provide core leadership training together with training on Appraisal Skills. There are also internal apprenticeships with the NHS Leadership Academy such as the Chartered Manager Degree with Mary Seacole or Senior Leader with Rosalind Franklin & CIM. We will continue to seek further promotion of leadership programmes for Women.

NWICB continues to support an Inclusive Talent Culture using Scope for Growth framework and using the 'Growth Arc – depth, breadth and stretch' to support employees to reflect and discuss opportunities for personal development.

NWICB regularly reviews People Policies to ensure they remain fair, relevant and supportive of staff needs and boosts morale and job satisfaction. These People Policies support the promotion of a positive and inclusive work environment and values diversity and wellbeing, helping to attract and retain staff. The NWICB have recently revised the Recruitment and Selection Policy to include an extensive question bank with a dedicated section on equalities, diversity and inclusion. We will continue to work on de-biasing recruitment to ensure that our recruitment processes our robust and fit for purpose whether this be recruiting internally or externally to the organisation. There is also further training on Recruitment and Selection, Onboarding and Probation available on the Management Foundation Programme.

NWICB will continue to focus and deliver on our Equality, Diversity and Inclusion Improvement Plans using the data gained from our Workforce Race/ Disability Equality Standards, Public Sector Equality Duty and Equality Delivery System 2 reports.

NWICB will review the 2024 staff opinion survey results once available, in comparison with this gender pay gap report and consider the impact of these results.

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The NWICB remains committed to our NHS People Promise to work together to improve the experience of working in the NHS for everyone.

Workforce Race Equality Standard (WRES)

The WRES report is a snapshot as of 31 March 2024 of where the ICB is on addressing inequalities. The ICB wants to ensure we retain the talent and continues to attract people from a variety of diverse backgrounds to join our workforce. In addition to the WRES data we have completed the Equality Diversity Standard report 2 and EDI Improvement Plan together with the 6 high impact actions aim to ensure our staff work in an environment where they are supporting to live the ICB's values and can provide the best care to our patients.

The data highlighted has been compared against our staff survey and here are some of the key findings:

- 5.2% of workforce came from a BME background
- 16% of BME staff at very senior manager level
- 0.42% of white and 0.47% of BME applicants were likely to be appointed from shortlisting
- 36% of staff from a minority background believed there were equal opportunities for career progression or promotion,
- The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for BME staff (20%) than white (15%)
- 14% of BME staff experienced discrimination from other staff than white staff (5%)
- There are no BME staff on the ICB board membership

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Workforce Race Equality Standards Indicators

We are....
Inclusive
Respectful
Innovative



Workforce indicators - for each of these four workforce indicators, compare the data for white and BME staff

1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:
   - Non-Clinical staff
   - Clinical staff - of which
     - Non-Medical staff
     - Medical and Dental staff

   Note: Definitions are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2. Relative likelihood of staff being appointed from shortlisting across all posts
   Note: This refers to both external and internal posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
   Note: This indicator will be based on data from a two year rolling average of the current year and the previous year. For consistency, organisations should use the same methodology as the have always used
4. Relative likelihood of staff accessing non-mandatory training and CPD

National NHS Staff Survey indicators (or equivalent) - for each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. Percentage believing that trust provides equal opportunities for career progression or promotion
8. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Board representation indicator For this indicator, compare the difference for white and BME staff

9. Percentage difference between the organisations' Board membership and its overall workforce disaggregated:
   By voting membership of the Board
   By executive membership of the Board
   Note: This is an amended version of the previous definition of Indicators

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Workforce Race Equality Standards - statistics

WRES Indicator		Year				Trend
		2021	2022	2023	2024	
1 Percentage of BME staff	Overall			Data to follow	5.2%	
	VSM (8c-VSM)			Data to follow	16%	
2 Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants				Data to follow	0.4%	
3 Relative likelihood of BME staff entering the formal disciplinary process compared to white staff				Data to follow	0%	
4 Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff				Data to follow	1%	
5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	9%	8%	6%	Not available	
	White	9%	7%	7%	Not available	
6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	17%	20%	20%	Not available	
	White	13%	15%	15%	Not available	
7 Percentage of staff believing that their trust provides equal opportunities for career progression or promotion **	BME	36%	38%	36%	Not available	
	White	65%	59%	53%	Not available	
8. Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months	BME	12%	13%	14%	Not available	
	White	4%	4%	5%	Not available	
9 BME board membership				Data to follow	0%	

Data source ESR report. 0.7% of staff chose not to state their race
Please refer to slide 9 in the EDI Annual Report to see the BME representation for the ICB workforce.
Indicators 5 to 8 were taken from data from the Staff Opinion Survey Benchmark Report 2023

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Theme 1 Representation, Recruitment and Retention

Theme 1 Indicators 1, 2 & 9 Representation, Recruitment and Retention			
Actions		**When**	**People Promise**
1.1	To review the recruitment and selection policy	2025	
1.2	To offer recruitment and selection training for all recruiting managers (to include unconscious bias)	2025	
1.3	To review the exit interview process and questions to provide further analysis to support improvements in retention. To continue to be a member of the Retention Steering Group to share best practice and improvements in retention.	2025	
1.4	Ensure recruitment panels have a diverse representation, this will be reflected in the recruitment and selection policy.	2025	
1.5	Ensure all recruitment campaigns and advertising have consistent wording reflecting the ICBs values.	2025	
1.6	Ensure all interviews are conducted in line with the recruitment and selection policy and appropriate questions from the question bank and interview rating templates are followed. This will include a mandatory EDI question.	Ongoing	
1.7	The ICB will sign up to the Disability Confident Scheme and will continue to support the NHS Two Ticks (disability status at the shortlisting stage (NHSE).	2025	

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Theme 2 Training and development

Theme 2 Indicators 2 & 4 Learning and Development			
Actions		**When**	**People Promise**
2.1	To continue to regularly monitor compliance figures to ensure all staff have completed mandatory Equality, Diversity Inclusion Training.	Ongoing	
2.2	To continue to regularly monitor compliance figures to ensure all staff have completed mandatory Speak Up, Listen Up and Follow Up for Senior Managers. To conduct an audit of staff who fall within the category of 'Senior Manager' and review.	Ongoing	
2.3	To increase awareness of the opportunities for learning and continuous professional development and apprenticeships via Staff Briefings, Teams Channels and the Intranet.	2025 / 26	
2.4	All People Managers to be offered the opportunity to attend the Management Foundation Programme	2025 / 26	
2.5	To support an Inclusive Talent Culture using Scope for Growth framework and using the 'Growth Arc – depth, breadth and stretch' to support employees to reflect and discuss opportunities for personal development.	Ongoing	
2.6	EDI staff Group will sponsor 'lunch and learn' on EDI and co-present with the ICB EDI Lead and Organisational Development Team.	2025 / 26	

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Theme 3 Formal Procedures

Theme 3 Indicator 3 People Policy and Procedures			
Actions		**When**	**People Promise**
3.1	As part of the Management Foundation Programme to encourage all line managers to attend, to enable discussions on disciplinary procedures, awareness of unconscious bias when considering informal and formal disciplinary procedures.	2025/26	
3.2	To ensure all disciplinary panels have neutral and diverse panels. This will be reflected in the Disciplinary Policy.	Ongoing	
3.3	Ensure staff are aware role of the Freedom to Speak Up Guardian and Champion and how to contact them	Ongoing	
3.4	To launch a series of workshops in February 2025 to explore how we can build a restorative and just culture where everyone feels valued. Strengthen teamwork with tools for resilience and mindset practice and create a workplace focused on collaboration, learning and growth.	2025 /26	
3.5	To include a regular update as part of ICB Partnership Meetings with our recognised Trade Unions.	Ongoing	

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Theme 4 Staff Experience

Theme 4 Indicators 5, 6, 7 & 8 Staff Experience			
Actions		**When**	**People Promise**
4.1	The ICB to participate and actively promote the NHS Staff Opinion Survey on Staff Briefings and Teams channels.	Ongoing	
4.2	To encourage all staff to complete their equality, ethnicity and disability data on ESR so we might further understand the composition of our workforce and can identify areas for improvement. To closely monitor progress on this, to hopefully achieve an upward trend.	Ongoing	
4.3	Ensure that all Equality, Diversity and Inclusion reports and shared with the EDI Staff Group to seek their engagement and feedback.	Ongoing	
4.4	To increase the Freedom to Speak Up Guardian (2) and Champions to support the ICB and Primary Care	2025	
4.5	Ensure the ICB continue to support the ICS Health and Wellbeing Leads group to consider Health and Wellbeing initiatives (Wellbeing Conversations and Passports, Restorative and Just Culture)	2025/26	
4.6	Accreditation to be a Menopause Friendly Employer	2025	

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Theme 4 Staff Experience

4.7	To sign up to the Sexual Safety Charter.	2025	
4.8	To continue to support and make staff aware of the ICB's micro-aggression portal to ensure staff may have a voice and seek support.	Ongoing	
4.9	Continue to support the Employee Assistance Programme and ensuring the ICB continues to listen and engage with staff through Staff Network Groups, Staff Briefings to continuously improve and learn.	Ongoing	
4.10	To host a second annual 'All Staff Event' to build team cohesion and collaboration.	2025	
4.11	All Executive Board Members EMT to support the implementation the Health Inequalities & EDI improvement action plan and EDI High Impact Objectives and actions. Continuing to improve the working environment for all staff – giving them a sense of belonging, value opportunities to feel psychologically safe and to thrive	Ongoing	
4.12	Appoint an SRO for Equalities, Diversity and Inclusion	2025	

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Workforce Disability Equality Standard (WDES)

The WDES report is a snapshot as at 31 March 2024. Valuing our disabled staff is essential as it fosters an inclusive culture that respects and supports diversity, leading to increased staff morale, productivity and loyalty. It also drives innovation by bringing unique perspectives and problem-solving approaches and embraces a much broader talent pool.

In addition to the WDES data we have completed the Equality Diversity Standard report and EDI Improvement Plan together with the 6 high impact actions aim to ensure our staff work in an environment where they are supporting to live the ICB's values and can provide the best care to our patients.

Key findings:

- 8% of workforce are disabled
- 0.5% of disabled applicants were likely to be appointed from shortlisting
- 47% of disabled staff believed there were equal opportunities for career progression or promotion,
- The percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for disabled staff (15%) than non disabled staff (9%)
- 14% of disabled staff compared to non-disabled staff (9%) say they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- 38% of disabled staff compared to non-disabled staff (48%) say they are satisfied with the extent to which their organisation values their work.
- 86% of disabled staff say the ICB has made reasonable adjustments to enable them to carry out their work.
- There are no Disabled staff on the ICB board membership

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Workforce Disability Equality Standard (WDES) Metrics

There are ten WDES metrics.

- Three metrics focus on workforce data;
- Five are based on questions from the NHS Staff Survey;
- One metric focuses on disability representation on boards;
- One metric (metric 9b) focuses on the voices of Disabled staff.

Three WDES metrics (2, 5 and 10) are the equivalent of indicators set out in the Workforce Race Equality Standard (WRES), whilst WDES metric 1 is similar to the WRES indicator on workforce representation.

WDES metric 4 is closely related to the two WRES metrics (5 and 6) on bullying and harassment.

WDES metric 9a draws from the NHS staff engagement score, which is an amalgamation of several questions in the NHS Staff Survey.

WDES metric 9b asks for evidence of action to facilitate the voices of Disabled staff to be heard. (Depending on the response, evidence of actions or plans to address the gap should be added to the organisation's Annual report).

It should be noted that within the WDES metrics the term 'Disabled compared to non-disabled', analyses the differences in experience between those staff who have responded 'Yes' and 'No' to monitoring questions about whether they have a disability. The label "Unknown" is used to refer to the other options recorded on ESR, namely "Prefer not to answer", "Not declared" and "Unspecified".

Workforce Disability Equality Standard (WDES) Metrics

Workforce Indicators for each of these three workforce indicators compare the data for disabled and non disabled staff.
Metric 1 Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and clinical staff in clusters 1 to 4.

- Cluster 1 AfC Bands under 1, 1, 2, 3 and 4
- Cluster 2 AfC Bands 5, 6 and 7
- Cluster 3 AfC Bands 8a and 8b
- Cluster 4 AfC Bands 8c, 8d, 9 and VSM
- Cluster 5 Medical and Dental staff, consultants
- Cluster 6 Medical and Dental staff, non-consultant career grades
- Cluster 7 Medical and Dental staff, trainee grades

Metric 2 Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
Metric 3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.

National NHS Staff Survey metrics for each of the five staff survey indicators, compare the outcomes of the responses for disabled and non disabled staff
Metric 4 Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patient/service users , their relatives or other members of the public, managers, other colleagues:
Metric 5 Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
Metric 6 Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
Metric 8 Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.
Metric 9a The staff engagement score for Disabled staff, compared to non-disabled staff.

Disabled staff Engagement
Metric 9b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes or No)?

Board representation indicator for this indicator, compare the difference for disabled and non disabled staff.
Metric 10 Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated by voting and non-voting membership of the board and by executive and non-exec membership of the board.

Davenfield
24/03/2025 12:20:17

Workforce Disability Equality Standard (WDES) Results

WDES Metrics		Year				Trend
		2021	2022	2023	2024	
1. Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	Disabled			Data to follow	8%	
	Non disabled			Data to follow	87%	
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.				Data to follow	0.5%	
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.					0%	
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months:	Disabled	7%	7%	6%	Not available	
	Non disabled	12%	10%	10%	Not available	
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months	Disabled	12	15	13	Not available	
	Non disabled	7	7	7	Not available	
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Disabled	15	15	15	Not available	
	Non disabled	8	8	9	Not available	
4 Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled	46	40	48	Not available	
	Non disabled	46	42	43	Not available	
5. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled	56	50	47	Not available	
	Non disabled	63	57	52	Not available	
	Disabled	15	15	14	Not available	

Davey, Heidi
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Workforce Disability Equality Standard (WDES) Results

6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non disabled	11	10	9	Not available	↓
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	51	45	38	Not available	↓
	Non disabled	58	52	48	Not available	↓
8. Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.	Disabled		89	86	Not available	↓
	Non disabled		80	80	Not available	↔
9a. The staff engagement score for Disabled staff, compared to non-disabled staff.	Disabled	6	6	6	Not available	↔
	Non disabled	7	6	6	Not available	↓
9b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes or No)?					Yes	
10 Percentage difference between the organisation's board voting membership and its organisation's overall workforce					tbc	

Staff with a disability is noted to have a Long Term Condition or illness.
Staff non disability is noted not to have a Long Term Condition or illness
Data source ESR report. 4.5% of staff chose not to state their disability
See full data set report dated 31.03.24
Please refer to slide 7 in the EDI Annual Report to see the disability representation for the ICB workforce.
Indicators 5 to 9a were taken from data from the Staff Opinion Survey Benchmark Report 2023
The Staff Opinion Survey for 2024 were not available at the time this report was published.

Davey,Heidi
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WDES metrics grouped into themes linking to WRES

	Recruitment, retention and representation	Training and Development	Formal Procedures	Staff Experience & engagement
1. Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.				
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.				
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.				
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months:				
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months				
4. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months they or a colleague reported it				
5. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.				
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.				
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.				
8. Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.				
9a. The staff engagement score for Disabled staff, compared to non-disabled staff.				
9b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes or No)?				
10 Percentage difference between the organisation's board voting membership and its organisation's overall workforce				

Davey, Heidi
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Workforce Disability Equality Standard Action Plan

Theme 1 Indicators 1, 2 & 9 Representation, Recruitment and Retention			
Actions		**When**	**People Promise**
1.1	To review the recruitment and selection policy	2025	
1.2	To offer recruitment and selection training for all recruiting managers (to include unconscious bias)	2025	
1.3	To review the exit interview process and questions to provide further analysis to support improvements in retention. To continue to be a member of the Retention Steering Group to share best practice and improvements in retention.	2025	
1.4	Ensure recruitment panels have a diverse representation, this will be reflected in the recruitment and selection policy.	2025	
1.5	Ensure all recruitment campaigns and advertising have consistent wording reflecting the ICBs values.	2025	
1.6	Ensure all interviews are conducted in line with the recruitment and selection policy and appropriate questions from the question bank and interview rating templates are followed. This will include a mandatory EDI question.	Ongoing	
1.7	The ICB will sign up to the Disability Confident Scheme and will continue to support the NHS Two Ticks (disability status at the shortlisting stage (NHSE).	2025	

Davey,Heidi
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Workforce Disability Equality Standard Action Plan

Theme 2 Indicators 2 & 4 Learning and Development			
Actions		**When**	**People Promise**
2.1	To continue to regularly monitor compliance figures to ensure all staff have completed mandatory Equality, Diversity Inclusion Training.	Ongoing	
2.2	To continue to regularly monitor compliance figures to ensure all staff have completed mandatory Speak Up, Listen Up and Follow Up for Senior Managers. To conduct an audit of staff who fall within the category of 'Senior Manager' and review.	Ongoing	
2.3	To increase awareness of the opportunities for learning and continuous professional development and apprenticeships via Staff Briefings, Teams Channels and the Intranet.	2025 / 26	
2.4	All People Managers to be offered the opportunity to attend the Management Foundation Programme	2025 / 26	
2.5	To support an Inclusive Talent Culture using Scope for Growth framework and using the 'Growth Arc – depth, breadth and stretch' to support employees to reflect and discuss opportunities for personal development.	Ongoing	
2.6	EDI staff Group will sponsor 'lunch and learn' on EDI and co-present with the ICB EDI Lead and Organisational Development Team.	2025 / 26	

Davey, Heidi
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Workforce Disability Equality Standard Action Plan

Theme 3 Indicator 3 People Policy and Procedures			
Actions		**When**	**People Promise**
3.1	As part of the Management Foundation Programme to encourage all line managers to attend, to enable discussions on disciplinary procedures, awareness of unconscious bias when considering informal and formal disciplinary procedures.	2025/26	
3.2	To ensure all disciplinary panels have neutral and diverse panels. This will be reflected in the Disciplinary Policy.	Ongoing	
3.3	Ensure staff are aware role of the Freedom to Speak Up Guardian and Champion and how to contact them	Ongoing	
3.4	To launch a series of workshops in February 2025 to explore how we can build a restorative and just culture where everyone feels valued. Strengthen teamwork with tools for resilience and mindset practice and create a workplace focused on collaboration, learning and growth.	2025 /26	
3.5	To include a regular update as part of ICB Partnership Meetings with our recognised Trade Unions.	Ongoing	

Davey, Heidi
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Workforce Disability Equality Standard Action Plan

Theme 4 Indicators 5, 6, 7 & 8 Staff Experience			
Actions		**When**	**People Promise**
4.1	The ICB to participate and actively promote the NHS Staff Opinion Survey on Staff Briefings and Teams channels.	Ongoing	
4.2	To encourage all staff to complete their equality, ethnicity and disability data on ESR so we might further understand the composition of our workforce and can identify areas for improvement. To closely monitor progress on this, to hopefully achieve an upward trend.	Ongoing	
4.3	Ensure that all Equality, Diversity and Inclusion reports and shared with the EDI Staff Group to seek their engagement and feedback.	Ongoing	
4.4	To increase the Freedom to Speak Up Guardian (2) and Champions to support the ICB and Primary Care	2025	
4.5	Ensure the ICB continue to support the ICS Health and Wellbeing Leads group to consider Health and Wellbeing initiatives (Wellbeing Conversations and Passports, Restorative and Just Culture)	2025/26	
4.6	Accreditation to be a Menopause Friendly Employer	2025	

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Workforce Disability Equality Standard Action Plan

4.8	To continue to support and make staff aware of the ICB's micro-aggression portal to ensure staff may have a voice and seek support.	Ongoing	
4.9	Continue to support the Employee Assistance Programme and ensuring the ICB continues to listen and engage with staff through Staff Network Groups, Staff Briefings to continuously improve and learn.	Ongoing	
4.10	To host a second annual 'All Staff Event' to build team cohesion and collaboration.	2025	
4.11	All Executive Board Members EMT to support the implementation the Health Inequalities & EDI improvement action plan and EDI High Impact Objectives and actions. Continuing to improve the working environment for all staff – giving them a sense of belonging, value opportunities to feel psychologically safe and to thrive.	Ongoing	
4.12	Appoint an SRO for Equalities, Diversity and Inclusion	2025	
4.13	Review ICB Policies; EDI Policy and Dignity at Work policy to ensure align with anti racism and anti bullying and harassment.	2025 / 26	
4.14	To continue to promote the NIDAS Stalking and harassment Campaign 2025. To raise awareness, encourage victims to recognise behaviours linked to stalking and harassment and encourage those who are experiencing stalking and harassment to seek support.	2025	
4.15	To sign up to the Race in the Workplace Charter to make a public commitment to improving equality of opportunity in the workplace	2025 / 26	
4.16	EDI Staff Group will sponsor education events on Long Term Conditions to raise awareness	2025 / 26	

Davey,Heidi
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Improving lives **together**
Norfolk and Waveney Integrated Care System

Organisational Health Inequalities & Equality Diversity & Inclusion Improvement Plan

Norfolk & Waveney Integrated Care Board

2025-2027

Davey, Heidi
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Davey, Heidi
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Introduction

In May 2024, the Norfolk and Waveney Integrated Care System (ICS) published a Health Inequalities Strategic Framework for Action. Overseen by the Integrated Care Partnership, this 10 year framework sets out a vision, principles and a clear ask of ICS partners to take action in their own organisations to address inequalities made through a Health Inequalities Commitment. The Health Inequalities Strategic Framework for Action can be found here.

The NHS has a significant role to play in the tackling health inequalities:

1. Influencing and supporting multi-agency action to address social and wider determinants of health
2. The NHS is a significant economic actor in its own right
3. Tackling inequalities in healthcare provision - *ensuring equitable access, excellent experience and optimal outcomes*

In response to government ambitions to develop a 10 year plan for the NHS, the King's Fund (2024) has made recommendations for how the NHS can tackle health inequalities, which have been considered in the development of this improvement plan. These include:

- Re-orientating to focus on prevention.
- Changing our relationships with people and communities, from 'power over' to 'power with'.
- Tackling racism and discrimination and cultivating a culture of compassion.
- Enabling staff to identify and act on health inequalities.
- Empowering place-based partnerships to take more decisions about how NHS money is spent.
- Actively supporting Voluntary, Community and Social Enterprise (VCSE) organisations through changes in financial planning and commissioning.



Davey Smith 24/03/2025 12:36:17

This plan predominantly focuses on how we can tackle structural inequalities within our own organisation, by improving staff confidence and our *ways of working*, to ensure we embed tackling inequalities in all that we do.

King's fund research shows that NHS staff are sometimes not aware of how health inequalities affect their work and can impact on individuals or how to identify and act on them.

Mainstreaming work to tackle health inequalities by making it everybody's business rather than limiting it to a small group of specialists is a key part of accelerating progress. All staff have a role to play in tackling health inequalities through the 'three A's'

- Awareness
- Action
- Advocacy

The NHS cannot tackle health inequalities meaningfully without prioritising work to tackle racism and discrimination in all its forms - for our staff and for the communities we serve. There is a significant emphasis on equality, diversity and inclusion in this plan.

Not only should we be engaging communities and different groups that experience discrimination to ensure services are accessible and delivered in a way that's appropriate for all, we also need to ensure that we support our internal workforce in order to reflect the values of our organisation and ensure that we tackle inequalities in **all** that we do.

We recognise the need to develop a culture of compassion in which leaders hold crucial conversations about equality, diversity and inclusion, where they hear and reflect deeply on what staff are telling them and then take the necessary action to help address inequalities and discrimination in the workplace.

Daisy Wyatt
24/03/2025 12:20:17



Our NHS Obligations and Legal Duties

The below table provides a summary of the key **national** reporting/legislative requirements of the ICB in relation to health inequalities.

Requirement	Summary
NHSE Statement on Information on Health Inequalities	Alongside our Annual Report due to be published in June annually, the ICB must: • Demonstrate an understanding of healthcare needs, including qualitative insights. • Demonstrate an understanding of health access, experience and outcomes. • Publish information on health inequalities focusing on elective recovery, urgent and emergency care (UEC), respiratory, mental health, cancer, cardiovascular disease (CVD), diabetes, smoking, oral health, learning disability and autism (LD&A) and maternity. • Demonstrate use of data (including qualitative) to plan and transform healthcare.
Equality Delivery System (EDS2)	We are expected to publish a report by the end of February every year that covers the following: • Commissioned or provided services - demonstration of access and that patients needs are met. • Workforce health and wellbeing - that staff are supported to manage long term conditions, have access to support and advice and that staff recommend the organisation as a place to work. • Inclusive leadership - that leadership within the ICB routinely demonstrate their understanding of, and commitment to, equality and health inequalities and that consideration for inequalities is embedded into reporting, risk, performance and monitoring systems and processes.

Davey, Heidi
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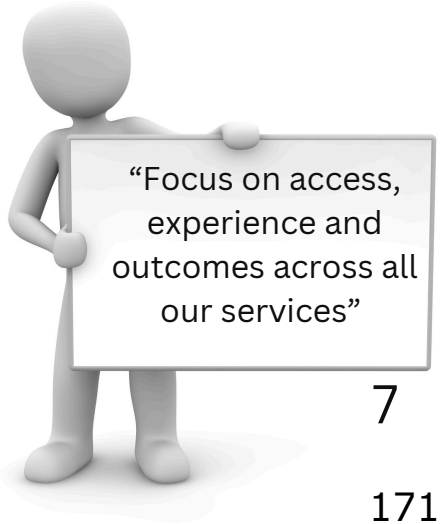
Requirement	Summary
Public Sector Equality Duty	We are expected to publish accessible information that shows how we are complying with this duty. This must include data about the protected characteristics of the workforce and others affected by our work, such as those that use our services. We must include evidence that we use qualitative insights. The ICB must publish at least on equality objective every 4 years that is specific and measurable. In accordance with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, we are expected to publish Gender Pay Gap calculations together with an action plan to close any gender pay gaps identified in the workplace experience, and submit and upload the required data return to the gov.uk portal, no later than 30 March each year.
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	We are expected to publish two reports on our workforce data – one on race and the second on disability. We must also produce and publish action plans to close any race and disability equality gaps identified in the workplace experience. These reports align with the EDS2 report and Health Inequalities and Equality, Diversity and Improvement Plan and we expect to publish these reports by the end of February every year.
National Quality Board Shared Commitment to Quality	The NQB Shared Commitment set out a single vision of quality, based on the need to provide high-quality, personalised care for all. Refreshed in 2021 it provides an updated definition of quality for those working in health and care systems and partnerships and aligns with the two quality frameworks for Public Health and Adult Social Care, the NHS Patient Safety Strategy and the People Plan. The current Shared Commitment definition of quality includes that care is equitable; that everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

Davey, Heidi
24/03/2026 12:20:17

Requirement	Summary
Equality and Health Inequalities Impact Assessment	The ICS is committed to its duty to reduce inequalities in access and outcomes and ensuring that a consistent approach is taken to inform commissioning decisions, business cases, financial recovery plans and any other business plans. This includes a robust evaluation for their potential impact on groups with a protected characteristics and Core20plus communities who have poorer health outcomes, and whether and to what extent our equality duties and duties in relation to health inequalities are affected and facilitate legal compliance.

Davey Heidi
24/03/2025 12:20:17



The below table provides a summary of the key **local** reporting/legislative requirements of the ICB that have specific reference to health inequalities. Further information on strategies that include objectives to reduce inequalities can be found in appendix 1.

Strategy	Summary
Norfolk and Waveney Joint Forward Plan	The Joint Forward Plan sets out out our ambition to develop (complete) and deliver 2 strategic pieces of work: A Norfolk and Waveney Health Inequalities Strategic Framework and a Population Health Management Strategy. Initial PHM priorities have been identified that align with the Core20plus5 framework, which include; smoking and smoking in pregnancy, serious mental illness health check uptake, cardiovascular disease, diabetes and respiratory, early cancer diagnosis and improving outcomes for children and young people.
Norfolk and Waveney Integrated Care Strategy	The Integrated Care Strategy is a high level framework aimed at improving health and care outcomes and guides the work of the Integrated Care Partnership. It has four key priorities; driving integration, prioritising prevention, addressing inequalities and enabling resilient communities. Its priority actions relating to inequalities include using evidence to address needs, collaborative system working, consulting and engaging with seldom heard communities, ensuring accessibility of services, and building trust with those engaging in our communities.
Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action	Our local Health Inequality Strategic Framework for Action responds to the Joint Froward Plan ambition, and takes the priority actions described in the Integrated Care Strategy a step further, identifying the key populations and key steps we can take to take action together to reduce inequalities. The vision and principles are further described on page 7.

Dave Hall 24/03/2025 17:29

Vision and Principles

Vision

We have aligned our vision with that which is published in the Norfolk and Waveney Integrated Care System Health Inequalities Strategic Framework for Action.

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

Principles

Our organisational Health Inequalities Improvement Plan is underpinned by the principles of the ICS Health Inequalities Strategic Framework for Action, as outlined below:

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

Davey, Heidi
24/03/2025 12:20:17



Healthcare Inequalities Objectives 2025-2027	How will this be measured?
Work with partners to improve health outcomes for Core20Plus communities and those with protected characteristics.	Produce plans that set out: • specific health issues to tackle • target population groups • interventions that will be delivered • performance metrics related to delivery of interventions and qualitative and quantitative benefits we can monitor
Work with partners to improve access, experience and trust in healthcare within our Core20plus communities and those with protected characteristics.	Develop a methodology to: • Assess current approaches and performance in relation to accessibility, experience and trust • Promote and incorporate best practice approaches in relation to accessibility, experience and trust and improving health literacy • Promote consistent approach to use of qualitative feedback to establish benchmark performance and identify progress towards objective at regular points (e.g. six monthly, TBC)

Davey, Heidi
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Organisational Health Inequalities Objectives 2025-2027	How will this be measured?
Improve ICB workforce understanding, confidence and capability in addressing health inequalities.	Measure effectiveness of provision of support, guidance and training to staff: • Promote self-assessment to enable bench-marking • Undertake qualitative sampling exercises to monitor progress against benchmark • Promote self-assessment at regular intervals to monitor progress against benchmarking

Work with partners to improve collection and accuracy of data relating to Core20plus communities and those with protected characteristics	• Identify current data quality deficits
	• Produce a plan to:
	  ◦ identify priority areas to focus on improvement
	  ◦ set out interventions, including responsibility for delivery, with assigned lead from the ICB to support
	  ◦ Track performance through periodic data quality reports, that use sampling to identify rate of improvement against objectives

Improve our organisational processes and ways of working to support delivery of improved equity	• Develop co-produced programme of support that is consistent with good practice in relation to health equity, including continued development of Equality and Health Inequality Impact Assessments • Promote take up of the programme within the ICB • Monitor take up of the programme within the ICB • Obtain qualitative feedback regarding the efficacy of the programme amongst ICB staff

Davey, Heidi
24/03/2025 12:21:17

Equality Diversity and Inclusion (EDI) Organisational Objectives 2025-2027	How will this be measured?
To create an environment where staff feel valued, respected and included.	Staff survey.
To improve staff awareness and of EDI and personal accountability in how they behave and support EDI initiatives and the ICB's values.	Staff Survey Specific evaluations/staff feedback Staff EDI Channel activity
To provide equality of opportunity in our employment practices to ensure we are a fair and inclusive employer.	Staff Survey
To provide EDI learning and development opportunities for staff.	Staff Survey E-Learning compliance Attendance and feedback from Management fundamentals programme Staff EDI Channel activity
To empower and support staff networks and employee led groups to implement, educate and communicate EDI initiatives.	Feedback EDI Staff Group EDI Calendar of events
To continue to engage and listen to staff to further strengthen our engagement processes.	Staff Survey

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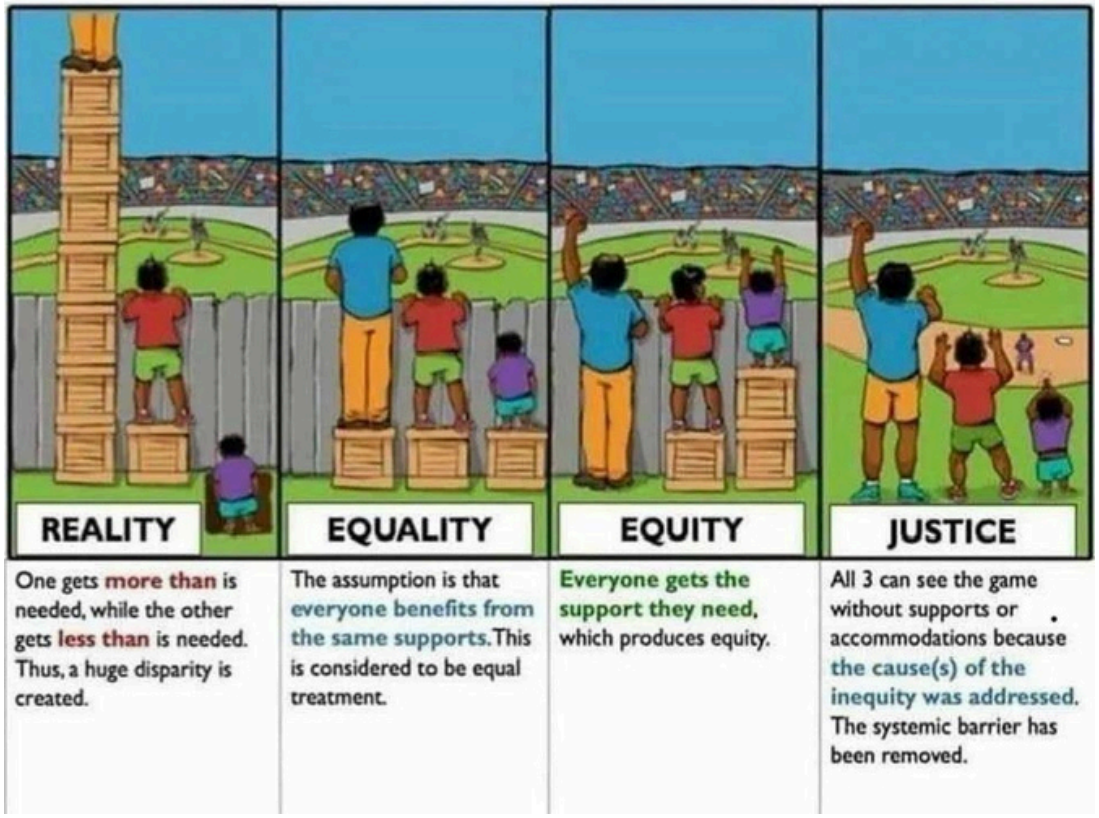
24/03/2025 12:20:13

Self-Assessment

Board members and staff from across the ICB have participated in a series of self-assessments and 'temperature checks' to inform the development of this report. This has helped us to understand our starting 'baseline' position, areas of strength and where we have areas for improvement.

Engagement has included:

- Board participation in Board Health Inequalities Maturity Assessment developed by NHS Providers
- All staff away day event
- 'Joint Senior Leaders' workshops
- Meetings with teams and individual staff
- Engagement via EDI Group



Board Health Inequalities Maturity Assessment

ICB Board members were asked to assess themselves against a maturity matrix developed by NHS Providers. This assessment scored maturity against four domains and provides a 'rating' for our current levels, as well as recommendations for improvement that have been reflected in this action plan:

- Building public health capacity and capability (maturing)
- Data, insight, evidence and evaluation (maturing)
- Strategic leadership and accountability (thriving)
- Systems partnerships (maturing)

Davey, Hel
24/03/2025 11:20

A copy of the full feedback report can be seen in Appendix 3.

All staff away day and joint senior leader feedback

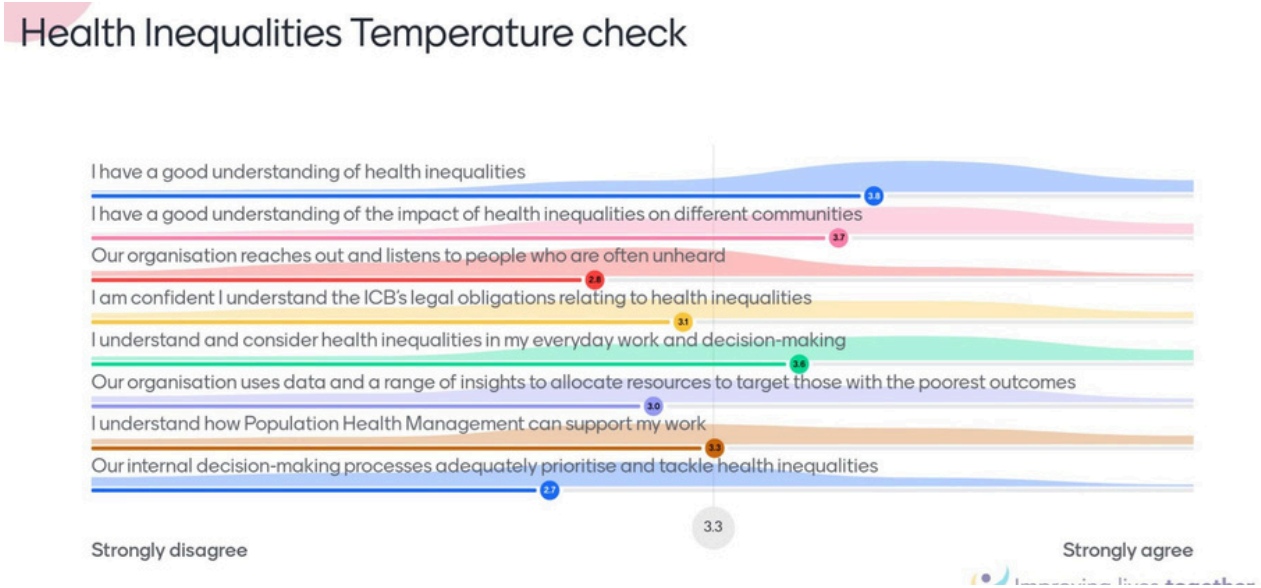
The all staff away day provided an opportunity to speak to all ICB staff and undertake a temperature check of current confidence levels in addressing health inequalities.

The event demonstrated a reasonable level of understanding of health inequalities, but that we need to think about how our processes, policies and ways of working reflect our ongoing commitment.

When asked about the ‘what good looks like’ it was clear that understanding levels were mixed in relation to equality and equity, and that despite high levels of confidence, a focus on workforce and organisational development and culture remains important.

Staff were asked to identify the tools that would help them to improve their ability to address health inequalities in their every day work. The following five themes were highlighted:

- Training
- Data access and analysis
- Funding
- Collaboration (internally and externally)
- Support with public engagement





Action Plan Summary

We have agreed four areas of focus for our improvement plan:

- Workforce and organisational development
- Processes and resources
- Data, intelligence and voice
- Leadership and governance

It is proposed that a senior SRO (Director/AD level) is identified for each area of focus to oversee progress and enable reporting to EMT, ICB Board etc.

It is also proposed that an ICB Board member be identified to provide oversight to each of the and areas of focus.

It is proposed that an operational lead is identified for each theme/action. These operational leads will come together in a working group to lead implementation and monitor progress of this action plan.



Dave/Heidi
24/03/2025 12:20:17

Domain 1: Workforce and Organisational Development

SRO: TBC

Theme	Actions	Who	By when
Training	Develop suite of training to support staff confidence and understanding, to include; • Equity vs Equality • EHIA training, learning resources and feedback from EHIA panel • Confident conversations/Cultural Confidence • Inclusion Health and Intersectionality • Trauma informed practice • Active Bystander • Bitesize learning sessions – impact of inequalities on our Core20 'Hear Me, See Me' series plus groups (in partnership with VCSE sector) • Health inequalities 'clinics' and drop in sessions • Population Health Management training sessions • NED health inequalities training (NHS Providers) • Accessible Information Standard • Behavioural insights • Digital inclusion • A clear understanding of what Equality, Diversity and Inclusion is and why it is so important • Understand the policies and processes which support EDI in our ICB • Understanding unconscious bias when making decisions that affect people • Challenging unacceptable behaviour • How to be an advocate for EDI practices and enhancing difference • 'What Works' Health inequalities evidence	HR/OD Workforce Quality HI & VCSE Digital PHM Research & Innovation	Mar 2027 16

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Theme	Actions	Who	By when
EDI	Identify Executive SRO to support ICB EDI group. Further development of EDI group in response to survey, including development of staff groups and alignment with wider system. Further development of ICS EDI approach and relaunch of Network.	EDI group HR	Mar 2026
Employer Supported Volunteering	Relaunch and promote ESV policy across organisation Work with VCSE Assembly, Empowering Communities Partnership and Vision for Volunteering to develop 'menu' of opportunities for staff to volunteer	HI & VCSE HR	Oct 2025



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Theme	Actions	Who	By when
HR	• Accreditation as a Menopause Friendly Employer (HR) 2025 • Launch of Wagestream (HR) 2025 • To review the antiracism strategy as part of the EDI Strategy and Plans (HR) 2025 / 2026 • To sign up to the Sexual Safety Charter (HR) 2025 • Encourage all recruiting managers to attend further training on Recruitment and Selection (HR) 2025 • To continue to focus on improving the monitoring and quality of exit interviews and how this feedback and can improve working conditions and this will help to inform future ICB EDI plans (HR) 2025 • To support the EDI Staff Group to focus on raising awareness of Hidden Disabilities, Neurodiversity and Age (HR) 2025 / 2026 • The ICB will sign up to the Disability Confident Scheme and will continue to support the NHS Two Ticks (disability status at the shortlisting stage (NHSE) (HR) 2025 / 2026 • Embed inequalities/EDI training into induction processes • Embed consideration for inequalities and PHM into appraisal processes • Embed EDI staff group members into HR Policy Review Group	HR Corporate Gov HI & VCSE team	Mar 2026

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Domain 2: Processes and Resources

SRO: TBC

Theme	Actions	Who	By when
Commissioning	Reflect consideration for HI (and VCSE partnering) into sustainable commissioning processes Development of commissioning principles and strategy for VCSE commissioning	HI & VCSE team Commissioning & Performance Commissioning teams PMO	Mar 2026
EHIA	Conduct a review/evaluation of year 1 of QIA and EHIA process that's been implemented, including an understanding of impact on decisions made that might have an impact for underserved communities. This is including staffs confidence and competency in completing them QIAs/EHIAs Develop approach to assess aggregated risk, including interdependencies with other stakeholders across the ICS.	Research & evaluation Quality HI & VCSE PMO Corporate Gov	Nov 2025

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Theme	Actions	Who	By when
Social value	Development of Social Value Framework embedded into commissioning, contracting and procurement processes.	Procurement Commissioning and performance Commissioning teams Procurement HI & VCSE	Mar 2026
Financial allocation	Review of spend and impact of spend on inequalities Develop a framework for equitable investment in response to ICP endorsed recommendations.	Finance HI & VCSE Commissioning teams	Dec 2025

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Theme	Actions	Who	By when
Contracts	Identify and embed KPI's and standardised wording in contracts relating to health inequalities. Monitor performance of contracts against HI KPIs.	Commissioning & Performance Contracts and procurement Commissioning teams HI & VCSE	Oct 2025
Communications and engagement	Review of complaints and patient experience feedback processes and development of accessibility plan, including collection of data on current sources of feedback.	Corporate Gov Communications HI & VCSE	

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Domain 3: Data, intelligence and voice

SRO: TBC

Theme	Actions	Who	By when
Data	Further development of Health Inequalities Dashboard and NHSE Statement reporting to support decision making Implementation of Data Quality Project to improve ethnicity and Core20plus data quality	BI HI & VCSE	Ongoing
Engagement and Insights	Refresh of People and Communities Strategy in line with ICS guidance (see Appendix 2) Development of Community Voices toolkit to support roll out and integration into decision making Embed a requirement for qualitative insights in planning of services (sustainable commissioning approach)	Comms HI & VCSE Research & Innovation	March 2026
Evidence base	Incorporate health inequalities considerations into evidence and evaluation templates/processes. Development of ICS Resource Hub to share good practice and evidence base resources.	Research & Innovation PHM HI & VCSE	October 2025

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Theme	Actions	Who	By when
Impact	Develop annual impact report to respond to NHSE Statement and EDS2 requirements, as well as demonstrate impact of ICS HI Framework. Include data reporting on health inequalities outcomes in Internal Performance Reports for all Boards.	All	Feb 2026 Feb 2027
Innovation	Development of co-production framework for innovation, with emphasis on reducing inequalities. Explore opportunities for innovation to support Core20plus5 ambitions.	Research & innovation team HI & VCSE team	Oct 2025

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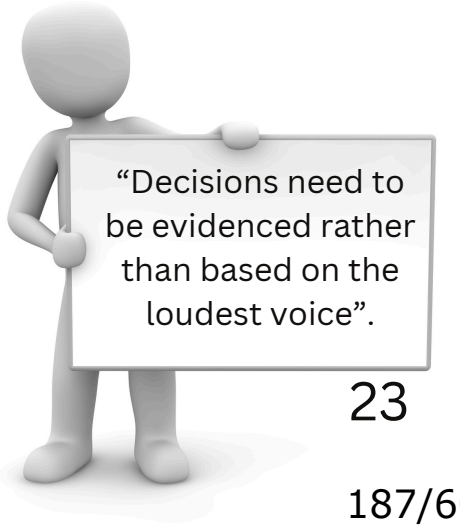

Domain 4: Leadership and governance

SRO:

Theme	Actions	Who	By when
Oversight	Annual TOR review of governance structures. Development of an ICB Improvement Plan Oversight Group (cross-organisational) to drive and monitor implementation Continued development of key work programmes and working groups: Core20plus5, NHS Anchors, Inclusion Health, Improving Access & VCSE Strategy Annual impact report to ICB Board	HI & VCSE	Oct 2025 Apr 2025 Jan 2026/ Jan 2027
Leadership	Continued investment in and development of Health Inequalities & VCSE team & integrated post/team with NCC Public Health. Continuation of Executive Level Senior Responsible Officer for Healthcare Inequalities. Continuation of clinical leadership via Health Inequalities & Inclusion Health Steward Identification of non-executive Lead for Healthcare Inequalities	Patient & Communities	Ongoing

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Theme	Actions	Who	By when
Place	Review of Place opportunities/supporting development of place teams to address HI and utilise PHM, including developing integrated working between HI & VCSE and place teams.	HI & VCSE Place teams	Oct 2025
Reporting & risk	Include equity and health inequalities related impacts and risks in all board and committee papers, alongside actions for how they will be mitigated and managed. Full review of Health Inequalities risks in light of ICS governance structures. Inclusion of HI considerations in all risk analysis.	Corporate governance	Oct 2025
ICB Advocates	Development of ICB Health Inequalities Advocates & ICS Advocate Network to share learning and best practice. Establish an organisational lead point of contact for each 'plus group' to support system partnership working.	HI & VCSE	March 2026

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Theme	Actions	Who	By when
NHS Anchors	Undertake the UCL 'How Strong Is Your Anchor' self-assessment to further identify areas of strength and improvement for employment, procurement, land and buildings, sustainability and partnership and leadership. Further develop ICS NHS Anchor Leadership Group to consolidate baseline findings and develop system improvement plan.	HI & VCSE HR Procurement Estates Place	Mar 2026

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Actions for Leadership

The NHS Health Inequalities Board Maturity Assessment made a number of recommendations for leadership.
The key recommendations relating to leadership are:

1. Chief Executive:

   - Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these.
   - Ensure that board members, senior leaders (Band 9 and Very Senior Managers), and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality, diversity and inclusion and health inequalities.
   - Include equality and health inequalities related impacts and risks in board and committee papers (including minutes), alongside actions for how they will be mitigated and managed.

2. Executive Lead for Health Inequalities:

   - Ensure integrated working with HR and equality, diversity, and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality.
   - Work collaboratively with senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives, and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems.
   - Work collaboratively with executive board members leading on the organisation's anchor institutions work, to ensure alignment with the health inequalities agenda.
   - Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community, and social enterprise (VCSE) sector organisations.

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3. Non-Executive Directors

   - All NEDs should seek opportunities for personal development on health inequalities.

Appendix 1: Wider system strategies

Strategy	Summary
Norfolk and Waveney Quality Strategy	The ICS Quality Strategy outlines our quality priorities and makes a commitment to the people of Norfolk and Waveney, to deliver quality of care, based on what matters most to the people using our services and the insight and expertise of our compassionate, skilful, and innovative workforce. One of the core objectives of the strategy is to use insights around health inequalities and population health to achieve fair outcomes.
Norfolk and Waveney Clinical Strategy	The Clinical Strategy commits to the development of plans and strategies to deliver the Core20plus5 improvement frameworks, whilst ensuring a larger proportion of resources go to communities and patient groups that experience the greatest inequalities. There is a commitment to ensuring services are offered fairly and equitably and that reasonable adjustments are made when required.
Norfolk and Waveney Research and Innovation Strategy	This strategy commits to ensuring research and innovation is accessible to communities, as well as ensuring research and innovation are incorporated into the design and planning of services. This will be crucial when planning services and programmes that address health inequalities.

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Appendix 2: People and Communities Approach

The overarching vision for working with people and communities in Norfolk and Waveney is that all ICS partners will consistently collaborate to share insight and learning. This will maximise resources and ensure that the voice of local people, especially from inclusion groups, is shared as widely as possible.

We will work towards the following 10 principles from national ICS guidance when working with people and communities at neighbourhood, place and system level. These will be tested with local people as this approach develops and adapted to reflect local aspirations and our 5-Year Joint Forward Plan as needed.

With the changing internal and external landscape it will be important to further develop and refine this plan in 2025/26.



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Appendix 3: ICB Board HI Maturity Assessment Report

Use the following link to regenerate the tool with your answers:https://health-inequality-tool.net/reload/EUVFYZJQy

Scoring

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	5	63%	Maturing
2 - Data, insight, evidence and evaluation	9	64%	Maturing
3 - Strategic leadership & accountability	16	89%	Thriving
4 - System partnerships	7	70%	Maturing

Recommended Objectives

1 - Building public health capacity & capability	Maturing
2.3	NEDs: All NEDs to seek opportunities for personal development on health inequalities
3.3	Chief executive: Ensure staff at all levels of the organisation are aware of the vision and strategy for tackling health inequalities and understand their roles in delivering these
3.8	Chief executive: Ensure that board members, senior leaders (Band 9 and Very Senior Managers) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
4.10	Executive lead for health inequalities: Ensure there are systems

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	areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups)
10.5	Clinical, quality and research: Work with research partners and in partnership with other NHS organisations to ensure participation in relevant research related to health inequalities, to develop an evidence-base on the effectiveness of provider led interventions to tackle inequalities
10.9	Clinical, quality and research: Consider active case finding approaches to reduce health inequalities, such as hypertension case finding and early cancer diagnosis
10.11	Clinical, quality and research: Engage with groups that may not be traditionally involved in research or quality improvement, such as those from deprived areas, underrepresented ethnic minority groups, those with protected characteristics and/or inclusion health groups

3 - Strategic leadership & accountability **Thriving**

4.2	Executive lead for health inequalities: Ensure integrated working with HR and equality, diversity and inclusion (EDI) executive leads to achieve strategic alignment for workforce EDI and tackling inequality
6.2	Strategy: Embed an equity lens across all organisational priorities, strategic documents and annual planning processes
7.2	Finance: Work with commissioners and external organisations to identify funding opportunities for health inequalities initiatives

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4 - System partnerships **Maturing**

4.8	Executive lead for health inequalities: Work collaboratively with

	in place to support frontline work on health inequalities, such as consolidating learning and sharing of best practice across the organisation and establishing learning networks or communities of interest for health inequalities
5.6	People: Develop opportunities and systems to encourage and enable staff to develop public health expertise across a range of roles
5.7	People: Consider training and development opportunities on inclusion health and trauma informed practice, with priority for staff interested in becoming inclusion health specialists. Training should be refreshed, as relevant
10.6	Clinical, quality and research: Build in-house capacity and capability for health inequalities research work

2 - Data, insight, evidence and evaluation **Maturing**

3.10	Chief executive: Include equality and health inequalities related impacts and risks in board and committee papers (including minutes), alongside actions for how they will be mitigated and managed
8.2	Operations/delivery: Ensure a trust wide focus on inclusive recovery and operational improvement through an equity lens
8.3	Operations/delivery: Establish a culture of data reporting among staff on health inequalities outcomes, and on the impact of health inequality initiatives. Consider staff training to enable staff to feel confident in asking questions around ethnicity
9.6	Data, digital and information: Consider how digital technology, such as electronic patient record systems, could be used to support health inequalities decision making
9.9	Data, digital and information: Collect qualitative data through engagement with population groups to incorporate patient's views into health inequalities work (such as those from deprived

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	senior leaders and health inequality leads in the ICS, other provider organisations/provider collaboratives and primary care networks (PCNs) to share learning and ensure scalability of health inequalities strategic work across systems
4.11	Executive lead for health inequalities: Work collaboratively with executive board members leading on the organisation's anchor institutions work, to ensure alignment with the health inequalities agenda
4.12	Executive lead for health inequalities: Work with system partners to ensure the trust has pathways to engage with communities and local voluntary, community and social enterprise (VCSE) sector organisations
8.6	Operations/delivery: Enable services to embed co-production principles to inform work on health inequalities. Co-production could include with staff, public and patient reference groups, engagement events, or similar mechanisms

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1 - Building public health capacity & capability

1	Has your board received training and/or development on health inequalities?	Partial
2	Does your trust deliver regular training to all staff groups on health inequalities?	Partial
3	Has your trust delivered any quality improvement work or change programmes related to health inequalities?	Partial
4	Does your trust employ public health specialist staff and is the wider workforce encouraged to develop public health expertise?	Yes

2 - Data, insight, evidence and evaluation

1	Is your trust's data on patient ethnicity accurate and comprehensive?	Partial
2	Does your trust board routinely receive performance data broken down by ethnicity and deprivation?	Partial
3	Does your trust use existing population health data (e.g. population demographics and index of multiple deprivation) in your analysis of trust-level data?	Yes
4	Has your trust taken part in any research related to health inequalities?	Partial
5	Has your trust carried out engagement with communities to inform work on health inequalities?	Yes
6	Has your trust reviewed any care pathways to consider the extent to which they enable equitable access, experience, and outcomes?	Partial

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7	Has your trust reviewed the accessibility of your services in relation to the digital and health literacy rates of your local population?	Partial

3 - Strategic leadership & accountability

1	Does your trust have commitments to reducing health inequalities within its strategy documents?	Yes
2	Does your trust have a named board-level Executive Lead for health inequalities?	Yes
3	Does your board have health inequalities objectives set in your annual review process?	Yes
4	Is your Executive lead for health inequalities providing strategic leadership and embedding an equity lens into cross-organisational work?	Partial
5	Is there a clear governance structure for the trust's health inequalities work within your trust, including a group or committee that provides oversight?	Yes
6	Does your trust/board use a health inequalities impact assessment tool in your business case process?	Yes
7	In allocating trust resources, are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits?	Yes
8	Does your trust have a programme of work aimed at reducing health inequalities experienced by staff members?	Partial
9	Does your trust use and implement NHS England's 'Core20PLUS5' framework to guide the organisation's approach to reducing health inequalities?	Yes

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4 - System partnerships

1	Is your trust represented on appropriate Integrated Care System group(s) to contribute to population health decision making in your region?	Yes
2	Is your trust contributing to anchor institution working?	Yes
3	Does your trust have programmes in place to improve access to employment to underrepresented groups in your organisation?	No
4	Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities?	Partial
5	Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives?	Yes

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Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

January 2025

(Month 10 2024/25)

ICB Board – Part One: 26 March 2025

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1. Executive Highlights

- The following report is based on the financial plan submitted to NHSE on 12 June 2024, which included a planned £387k surplus position.
- This report represents the **M10 January 2025** 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 £0.322m 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 recovery plan identified by finance during the I&I process, whereby the assumed unidentified efficiency delivery (£8.1m) is removed from the forecast and replaced by non-recurrent measures, was enacted in month 9. The non-recurrent measures identified were the increased delivery of the Elective Recovery Fund (ERF) and the headroom within the Delegated Acute Specialised Commissioning budget. Whilst this will reduce the financial risk in-year, it will not improve the underlying deficit or the financial plan for 2025/26.
  - £(0.7)m of slippage on identified efficiency delivery within the Prescribing and Better Care Fund portfolios, and
  - £4.0m 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 M10 the £51.3m net planning risks were reassessed to £5.3m, which are excluded from the forecast. **Total net risks, including new risks in addition to planning risks, total £2.7m**. This is a reduction of £2.3m from last month, which is primarily due to additional slippage identified and improved prescribing figures.
- The M10 **underlying deficit is £122.4m**, a deterioration against the planned deficit of £101.8m. This arises from the full year effect of Recurrent CHC packages and the removal of the Non-Recurrent in-year savings being used to deliver the 2024/25 Financial Position. This figure is consistent with M09.

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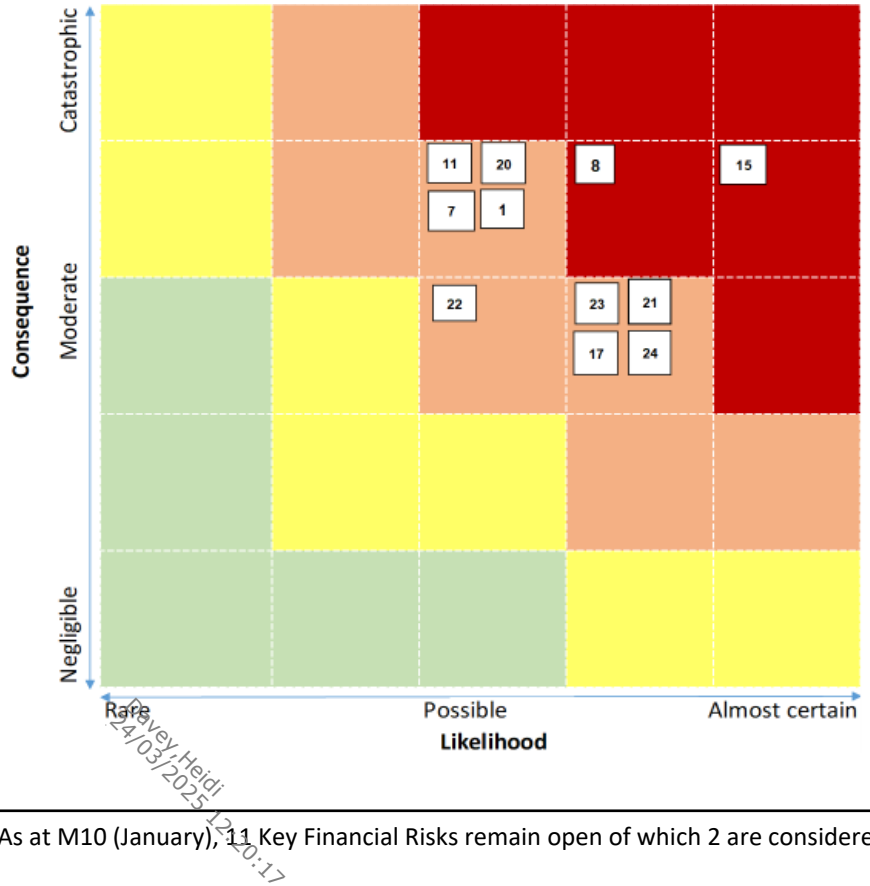
2. ICB Strategic Financial Risk Register

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



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Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Nov-24	Dec-24	Jan-25
Achievement of Plan	1	Achieve the 2023/24 financial plan **(BAF 11)**	12	12	12	12
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	17	Inflationary pressures	9	12	12	12
	20	Impact of new prescribing guidance	8	12	12	12
	21	Impact of Direct Commissioning transfer	9	12	12	12
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	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	12	12	12
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	16

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

As at M10 (January), 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 M09 (December), there have been no changes to either the impact and likelihood as well as the risk classifications.

3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st January 2025.

Non-Current assets
The non-current assets balance includes the right of use assets for the lease of the premises at King's Lynn and Norfolk County Council, 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 £16.4m balance is made up of aged debtors of £0.9m (including Norfolk County Council £0.4m & NHS England £0.3m), net of a provision against this balance of £0.3m, prepayments & accrued income of £13.6m and dental under delivery of £2.2m. 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 £25m since March 2024, driven principally by ICB and system invoice accrual timing. The £161m balance is made up of trade creditors of £3m, Prescription Pricing Authority & dental accruals of £26m, payroll costs including GP pensions of £3m, deferred income of £3m, prior year accruals of £11m and ICB and system invoice accruals of £115m. 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 £10.2m. All invoices raised outside of the contractual conditions against which the ICB made a full and final settlement on remain on-hold.

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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 31/12/24	Position as at 31/01/25
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,005	1,005	1,005
Accumulated Depreciation	(332)	(476)	(492)
Total non-current assets	673	529	513
Current assets			
Trade and Other Receivables	23,673	12,935	16,396
Cash and Cash Equivalents	376	3,997	2,159
Total current assets	24,049	16,932	18,555
Current liabilities			
Trade and Other Payables	(174,924)	(159,592)	(160,822)
Lease Liabilities	(218)	(193)	(193)
Provisions for liabilities and charges (including non-current)	(12,786)	(1,803)	(1,749)
Total current liabilities	(187,928)	(161,588)	(162,764)
Long Term liabilities			
Non-Current Payables	(820)	(422)	(422)
Non-Current Lease Liabilities	(472)	(327)	(318)
Total non-current liabilities	(1,292)	(749)	(740)
Net assets employed	(164,498)	(144,876)	(144,436)
FINANCED BY TAXPAYERS EQUITY			
General fund	(164,498)	(144,876)	(144,436)
Total taxpayers equity	(164,498)	(144,876)	(144,436)

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 10 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(1.0)	(8.8)	(7.8)	(1.1)	(8.9)	(7.8)
NNUH	(1.9)	(13.0)	(11.1)	0.0	(8.4)	(8.4)
QEH	(3.6)	(28.5)	(25.0)	(0.8)	(38.5)	(37.7)
NSFT	0.1	(0.7)	(0.8)	0.0	0.0	0.0
NCH&C	0.9	1.0	0.2	1.5	1.5	0.0
Provider Subtotal	**(5.5)**	**(50.1)**	(44.6)	**(0.4)**	**(54.3)**	(53.9)
ICB	0.3	0.3	0.0	0.4	0.4	0.0
N&W System Total	**(5.1)**	**(49.7)**	(44.6)	**0.0**	**(53.9)**	(53.9)

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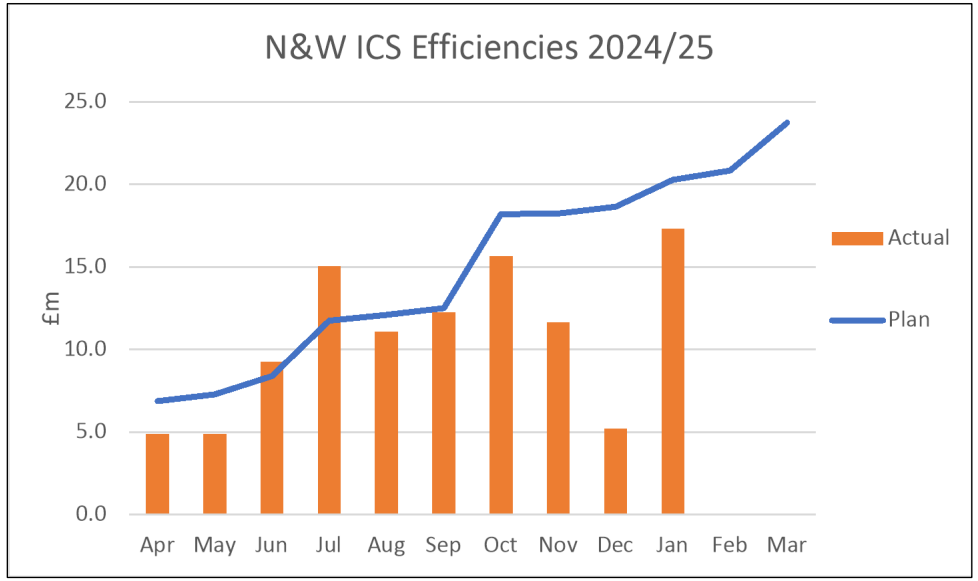
- The position M10 YTD is a £49.7m deficit, which is £44.6m adverse against plan.

- The forecast outturn for the system is a £53.9m deficit, including the non-recurrent deficit funding of £21.0m allocated in M6. The majority of risks in month 9 are now reflected in the M10 FOT position, however there is a net risk of £4.4m against this reported position.

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 10 YTD			Forecast Outturn			Forecast Outturn	
Organisation	Plan	Actual	Variance fav/(adv)	Plan	Actual	Variance fav/(adv)	Recurrent	Non-recurrent
JPUH	17.5	16.1	(1.3)	22.4	20.8	(1.6)	8.7	12.1
NNUH	37.8	28.4	(9.4)	50.1	50.1	0.0	21.7	28.4
QEH	21.1	6.0	(15.0)	29.5	8.2	(21.3)	7.3	0.9
NSFT	14.4	13.0	(1.4)	17.4	17.4	0.0	8.2	9.2
NCH&C	6.2	6.2	(0.0)	8.4	8.4	0.0	3.1	5.3
Provider Subtotal	**97.0**	**69.8**	(27.2)	**127.8**	**104.9**	(22.9)	**49.1**	**55.8**
ICB*	37.4	37.6	0.2	51.2	43.8	(7.4)	23.6	20.2
N&W System Total	**134.3**	**107.3**	(27.0)	**178.9**	**148.7**	(30.2)	**72.6**	**76.0**
ICB Budget Rephasing*	0.4	0.0	(0.4)	0.0	0.0	0.0	0.0	0.0
Reported ICB position	**37.8**	**37.6**	**(0.2)**	**51.2**	**43.8**	**(7.4)**	**23.6**	**20.2**
Revised system position	**134.8**	**107.3**	**(27.4)**	**178.9**	**148.7**	**(30.2)**	**72.6**	**76.0**



**ICB Internal reporting differs to the IFR submitted position due to a YTD efficiency plan rephasing of £0.4m. Therefore, the ICB are reporting a YTD adverse position of £0.2m against plan whereas the position against the submitted plan is a £0.2m overperformance.*

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

Year-to-date:

- The efficiency position M10 YTD against plan is an adverse variance to plan of £27.0m. When including the ICB internal plan rephasing it is £27.4m adverse.
- Recurrent efficiency delivery is £56.0m against the plan of £85.2m, £29.3m under and NR delivery is £51.4m against the plan of £49.1m, £2.3m over, generating the net under delivery of efficiencies against plan of £27.0m.
- JPUH, NNUH, QEH and NSFT have various CIP schemes that are not meeting plan due to slippage.
- NCHC is on plan and the ICB is £0.2m favourable to plan.

Full year forecast:

- Full year efficiency programme forecast is £148.7m, £30.2m adverse to plan. This variance is due to QEH forecasting £21.3m lower than planned, the ICB £7.4m lower than planned mainly due to under delivery of Non-NHS procurement and JPUH forecasting £1.6m lower than planned.

Presented 24/10/2024 12:20:15

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 10											
	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	8.9	(0.2)	0.2	0.3	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	14.0	4.4	3.6	(0.0)	(3.6)	13.2	14.0	0.8	
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**	**6.8**	**(14.5)**	**71.3**	**60.9**	**(10.4)**	
RAAC												
JPUH	7.2	1.7	8.9	8.9	(0.0)				8.9	8.9	(0.0)	
QEH	25.0	10.0	35.0	35.0	0.0				35.0	35.0	0.0	
Subtotal Including RAAC	**82.1**	**11.7**	**93.9**	**98.0**	**4.1**	**21.3**	**6.8**	**(14.5)**	**115.2**	**104.8**	**(10.4)**	
Adjustments												
Reduced IFRS 16 Allocation						(10.8)	0.0	10.8	(10.8)	0.0	10.8	
N&W System Total	**82.1**	**11.7**	**93.9**	**98.0**	**4.1**	**10.6**	**6.8**	**(3.8)**	**104.4**	**104.8**	**0.4**	

Central Programmes £m	Forecast Outturn @ Mth 10											
	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			135.8	106.5	(29.3)	0.0	0.0	0.0	135.8	106.5	(29.3)	
N&W Total Capital Programme			**229.7**	**204.5**		**10.6**	**6.8**		**240.2**	**211.3**		

Davey Hall 24/03/2025 12:08:17

- M10 combined system CDEL performance FOT is a minor overspend of £0.4m. SCB will discuss mitigation in its next meeting.
- IFRS16 schemes are £14.5m lower than plan, this underspend is offset by the £10.8m reduced IFRS16 allocation.
- In addition to system CDEL, RAAC & IFRS 16 funds, there is £135.8m of central programme funding, making the total capital resource for N&W ICS £240.2m.
- Central programmes are forecasting an underspend primarily due the NANOC2 programme delays. With the expectation of funding and completion in 2025/26

Specific organisational FOT variances, as previous reported:

- NSFT CDEL overspend due to delayed receipt of c. £4m VAT reclaim on the Rivers Project, expected to be received 2025/26.
- NNUH IFRS 16 underspend due to lower than expected IFRS 16 costs in various procurements e.g. renal contract renewal.
- NSFT IFRS 16 underspend due to deferred procurements and a prior year IFRS 16 overstatement generating a benefit in 2024/25.
- NCHC IFRS 16 underspend due to deferred renewal of the Rackheath lease to 2025/26

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.

SW Sheffield 24/05/2021 12:20:17

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.

Davey Heidi
24/03/2025 12:20:17

Norfolk and Waveney
Integrated Care Board

Agenda item:13

Subject:	Investigation and Rapid Intervention Programme - Phase 1: Deloitte's Report January 2025
Presented by:	Steven Course, Executive Director of Finance
Prepared by:	Steven Course, Executive Director of Finance
Submitted to:	NHS Norfolk and Waveney Integrated Care Board Metting
Date:	26 March 2025

Purpose of paper:

To present the Phase 1 report from Deloitte regards the Investigation and Rapid Intervention Programme for the Norfolk and Waveney Integrated Care System.

Executive Summary:

In response to the Norfolk and Waveney Integrated Care Systems M06 2024/25 financial forecast the system was placed into category 4 of the national Investigation and Rapid Intervention Programme (I&I), a category which required urgent external independent review and challenge to help provide in-year mitigations to ensure delivery to the original accepted financial plans for the system.

The national I&I Programme is split into two phases, with the first phase around Investigation of the in-year financial opportunities which included 5 key areas of focus,

- System Grip and Control,
- Workforce
- Project Management Office and Governance,
- 2024/25 Financial Plans including Efficiencies, and
- Financial Opportunities.

Throughout November 2024 Deloitte who were appointed to undertake phase one of this programme for the ICS, reviewed all parties for the above focus areas.

The findings presented in the Deloitte's report on Appendix A, detail proposed interventions categorising these into high impacting on staff costs and other costs. The report also presents workforce trends, risks to the then M6 based forecasts for identified mitigations and proposes objectives for the financial plans in relation to 2025/26.

Recommendation:

The Board are required to note the findings of the report.

Dave Hegel
24/03/2025 12:20:17

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	The ICS are required to adhere to their financial plans as accepted in the 2024/25 financial planning rounds. Whilst the drivers of the then month six based forecasts overspends were understood, the I&I programme was required to help identify mitigations to support the forecasts to come back to plan.
Impact Assessment (environmental and equalities):	N/A
Reputation:	Delivery of the ICS financial plan and management of the overall system position ensures a good evidenced based reputation. Forecasts requiring approval from NHSEI where off-plan were only approved after the I&I programme and additional scrutiny and challenge.
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
Reference to relevant risk on the Board Assurance Framework	N/A

Davey, Heidi
24/03/2025 12:20:17

Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney ICS

NHS England Investigation & Intervention Programme

Phase 1 Report

Davey Heidi
24/03/2025 12:20:17

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1. Executive Summary
2. FY24/25 FOT
3. System Grip and Control
4. FY24/25 Proposed Interventions
5. Workforce
6. PMO and Governance
7. FY25/26 Planning

Davey Heidi
24/03/2025 12:20:17

1. Executive Summary

Davey, Heidi
24/03/2025 12:20:17

Executive Summary: Scope and Approach

This Investigation & Intervention (I&I) diagnostic took place over four-weeks in November 2024 and covered five providers and the ICB (hereafter referred to as 'System Partners'): Norfolk and Waveney Integrated Care Board (ICB), Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), James Paget University Hospitals NHS Foundation Trust (JPUH), The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH), Norfolk and Suffolk NHS Foundation Trust (NSFT) and Norfolk Community Health and Care NHS Trust (NCHC).

Scope

The rapid review covered five key lines of enquiry; (1) System Grip and Control, (2) Workforce, (3) PMO and Governance, (4) FY24/25 Financial Plans and CIPs, and (5) financial opportunity areas.

Approach

- Structured interviews to explore key lines of enquiry and grip and control checklist with Finance, Commissioning, Transformation PMO and HR stakeholders.
- Desktop review of plans, governance structures and relevant meeting inputs and outputs across system partners, including meeting observations where required.
- A 'lighter touch' approach was adopted for JPUH and QEH given previous work with the them.
- Confirmation and validation of key findings with senior system partner stakeholders.
- 'Deep dives' including investigation of material areas of slippage and risk.
- Assessment of strength of control across twelve key areas (pay and non-pay controls, supporting processes and financial management).

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Output

Based on our assessment and review we have proposed five interventions for 24/25. These interventions have been costed and examined for their potential impact on in-year run-rate and FOT.

Due to the timescales of this investigation phase, assumptions have been used to quantify the impact of the interventions. These assumptions have been tested with Directors of Finance, with validation feedback reflected as appropriate.

In addition, we have proposed three additional interventions which we recommend are quantified and explored in the next phase of work.

Executive Summary: Key observations

24/25 Forecast Outturn

At M6 the system was forecasting a £55.8m deficit (including mitigations and efficiencies), £55.8m adverse to the systems breakeven plan. This is driven by underperformance against plan at NNUH, QEH, JPUH. Since the fieldwork has been completed, system partners have been undertaking further work on assessing and revising their forecast outturn, where appropriate. Due to timescales, we've not been able to reference this on-going work as part of this review.

FY24/25 Financial plans and CIP

Our assessment of CIP and financial recovery plan actions was conducted on information available at the time of assessment, specifically M5 CIP trackers and M6 financial reporting data for FRP actions. The assessment has identified £9.5m of risk which, if realised, would result in a **risk adjusted forecast outturn of £65.3m**, £65.3m adverse to the systems break-even 24/25 plan.

Generally, CIPs share some common themes including; backloading into H2, a relatively high proportion of non-recurrent or tactical measures and significant values of non-identified savings.

Collaborative transformation schemes under the leadership of the Financial Recovery Board have attracted a high-level of support from system leaders however they have not been fully worked up for financial and activity impact and formally tracked.

The risk adjusted forecast outturn is a view of the system's financial position at the point in time at which assessments were made. However, plans to mitigate risks and overall deficit continue to progress which may result in improvements to the system deficit as the year progresses.

System grip and control

The I&I recognises that there has been work across the system to implement stronger workforce grip and control processes. For example, weekly vacancy control panels, implementation of triple lock processes. QEH have made progress in reducing their temporary nursing spend through stronger controls.

Davey Heidi
24/07/2025 12:20:17

However, there are key themes across system partners where the strength of grip and control was lacking, predominantly across the Medical workforce, specifically temporary pay and rostering. Most control areas have been assessed as either Standard or Enhanced demonstrating there's an opportunity for all system providers to tighten controls further.

PMO & Governance

The review has observed examples of good practice in CIP monitoring and reporting, governance structures, multidisciplinary working between finance and PMO functions.

Challenges identified have included; data consistency and coherence of reporting, capacity, multidisciplinary working, multiplicity of governance and clarity and stability in recovery governance. The system Financial Recovery Board's plans are not supported by full programme management disciplines, notably financial and activity tracking.

Workforce

Since 19/20 there has been significant WTE growth across the system. This has not been matched by increases in weighted activity, leaving a significant productivity opportunity across the system. Temporary staff spend has also increased significantly with bank costs across the system increasing by just over 80%.

Some workforce related financial recovery plans are in place, but the pace of delivery is lacking and impact on in-year run rate has yet to be fully realised.

Interventions & Next steps

Considering the findings from this exercise, five high-impact interventions have been identified for immediate action in 24/25. Interventions have been costed for part year effect with two sets of costings presented, unmitigated and mitigated opportunity value. The mitigated value is based on a more cautious set of assumptions, developed following feedback from system partners regarding safeguarding, clinical quality and safety, operational pressures and mobilisation timescales. The identified interventions are valued at a system-mitigated value of **£4.7m - £15.2m for FY24/25**.

Three additional interventions for 24/25 have been highlighted with a recommendation that these are rapidly evaluated for in-year impact.

The report outlines recommendations for next steps to implement these interventions.

Potential opportunities for 25/26 have also been identified, using best practice seen in other systems as a comparator.

Executive Summary: 24/25 proposed interventions

Costed high-impact interventions – 24/25
Recommendation for **immediate implementation of stronger levels of control across five key areas.**

Intervention	NNUH	JPUH	QEH	NSFT	NCHC	ICB
Enhanced vacancy controls	✓	✓	✓	✓	✓	✓
Medical temporary pay	✓	✓	✓	✓	n/a	n/a
Nursing temporary Pay	✓	✓	✓	✓	✓	n/a
Overtime	✓	✓	✓	✓	n/a	n/a
Non-Pay	✓	✓	✓	✓	✓	✓

Full costings can be found in slides 14 -16 of this report.

Other high-impact interventions – 24/25
Recommendation for **immediate quantification of in-year impact.**

Intervention	NNUH	JPUH	QEH	NSFT	NCHC	ICB
Balance sheet measures (Ensure all potential organisation B/S releases have been peer reviewed for consistency and transacted where agreed)	✓	✓	✓	✓	✓	✓
Business case approvals (Detailed assessment by each organisation and cease uncommitted expenditure planned for Q4)	✓	✓	✓	✓	✓	✓
ERF Optimisation (Consider feasibility for Q4 ERF ramp up at speciality level, to maximise income – leverage mutual aid and capacity where appropriate)	✓	✓	✓	n/a	✓	✓

Davey Heidi
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Executive Summary: 24/25 interventions - next steps to support implementation

Next Steps

- System partners to **rapidly mobilise arrangements** to strengthen grip and control measures following independent assessment.
- Organisation and system management information to be developed **to demonstrate impact of heightened controls** and inform continuous review and assessment of whether controls need to be further strengthened.
- **Quantify additional 24/25 interventions not yet costed**, report outputs to System FRB as part of peer challenge and consistency of approach across all system partners (i.e. treatment of accounting policies on annual leave and Working Time Directive accruals).
- **Establish revised terms of reference for System FRB to oversee 24/25 interventions** – including implementation, monitoring and impact. The System FRB should have representation from each system partner, with clear SROs for respective Recovery Actions, accountable for reporting delivery and progress to the FRB.
- Ensure FRB Recovery Schemes are informed by **detailed actions, milestones and financial impact monitoring**. These should be agreed with system partners as appropriate, reviewed and scrutinised as part of the System FRB on a fortnightly basis.

Davey, Heidi
24/03/2025 11:20:17

2. FY24/25 FOT

Davey,Heidi
24/03/2025 12:20:17

System Forecast Outturn

The system was forecasting a deficit of £55.8m at M6, £55.8m adverse to the 2024/25 breakeven plan

24/25 Plan

A £21m deficit plan was agreed for the Norfolk & Waveney system at the start of 24/25. This was subsequently reduced to break even after receipt of £21m break even funding.

YTD (M1-6) Performance

The year-to-date financial position has been challenging and underperformance against plan has resulted in a £32.6m deficit at month 6, £26.3m adverse to the break-even plan.

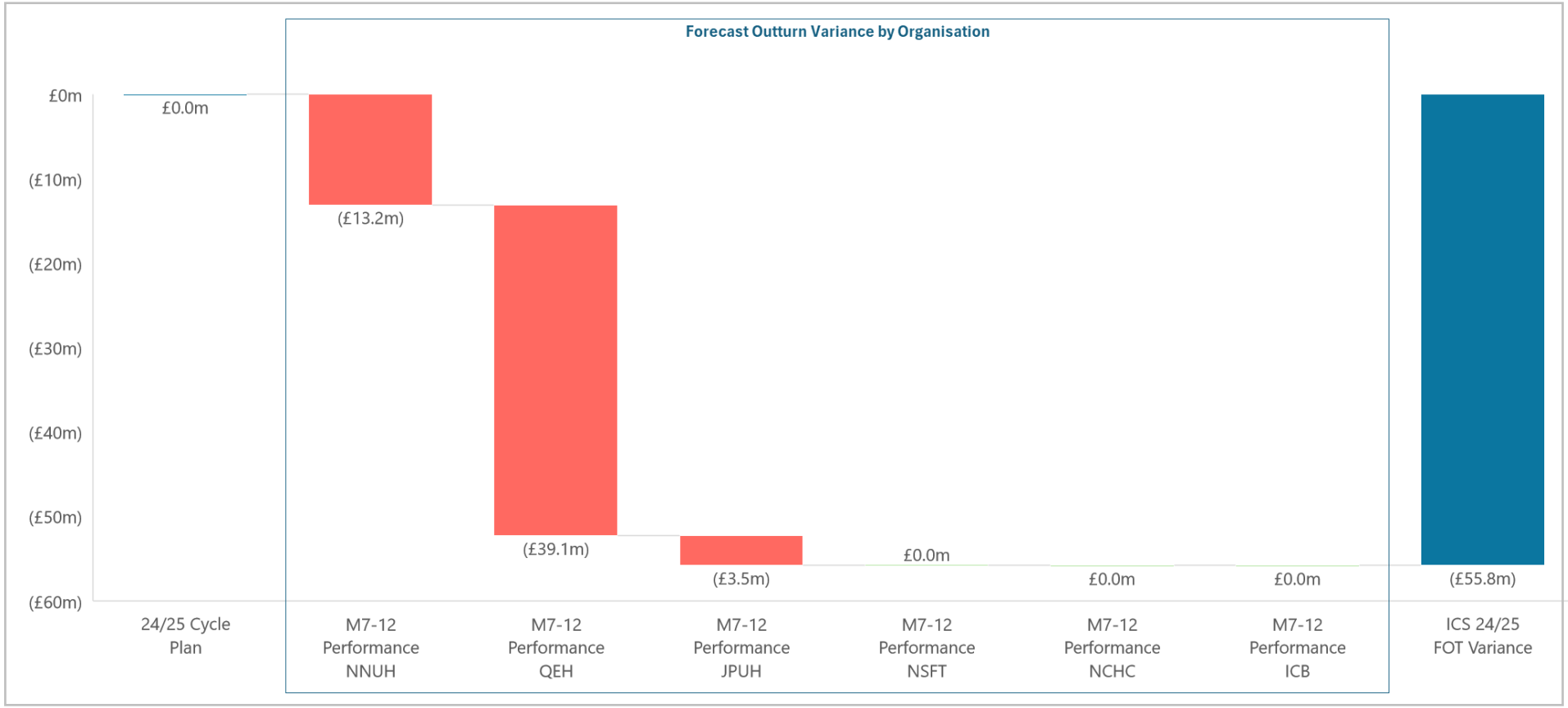
Forecast (M7-12) Performance

The system have forecast a further unmitigated £89.2m underperformance in M7-12, resulting in a £115.5m unmitigated forecast outturn.

Financial Recovery Plan

Financial recovery plans have been developed by JPUH, NNUH, NSFT and in the process of being developed at QEH. Financial recovery plans introduce an additional £59.7m of mitigations that will reduce the systems FOT deficit to £55.8m, £55.8m adverse to the 24/25 break even plan.

Norfolk & Waveney ICS Forecast Outturn Variance to Plan at Month 6



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Risks to System Forecast Outturn

Risk assessment of forecast outturn
The risk assessment utilised the most recent CIP and FRP data available, specifically M5 trackers for CIPs and M6 financial reporting data for FRPs. However, ICS organisations are continuously developing their FRP actions and advancing CIP programmes therefore **this assessment reflects the risks to FOT at the specific point in time when the assessment was conducted**.

NNUH
- The assessment has identified delivery risks totalling £1.3m to the delivery of FRP mitigations and £0.6m relating to delivery of CIP schemes.
- Since our fieldwork has been completed the Trust have improved the overall forecast outturn. This continues to be an area of focus for the Trust.

NSFT
- The assessment has identified delivery risks totalling £1.6m to the delivery of FRP mitigations, of which £1.4m relate to the FRP actions not yet agreed. The trust is currently in the process of identifying FRP actions to mitigate this risk.

ICB
- The assessment has identified delivery risks totalling £1.1m to the delivery of CIPS given their complexity of delivery. The ICB has reviewed mitigations at month 8 including confirmed ERF funding and has a high-level of confidence in its original FOT. Therefore, this delivery risk has not been included in the risk adjusted forecast.

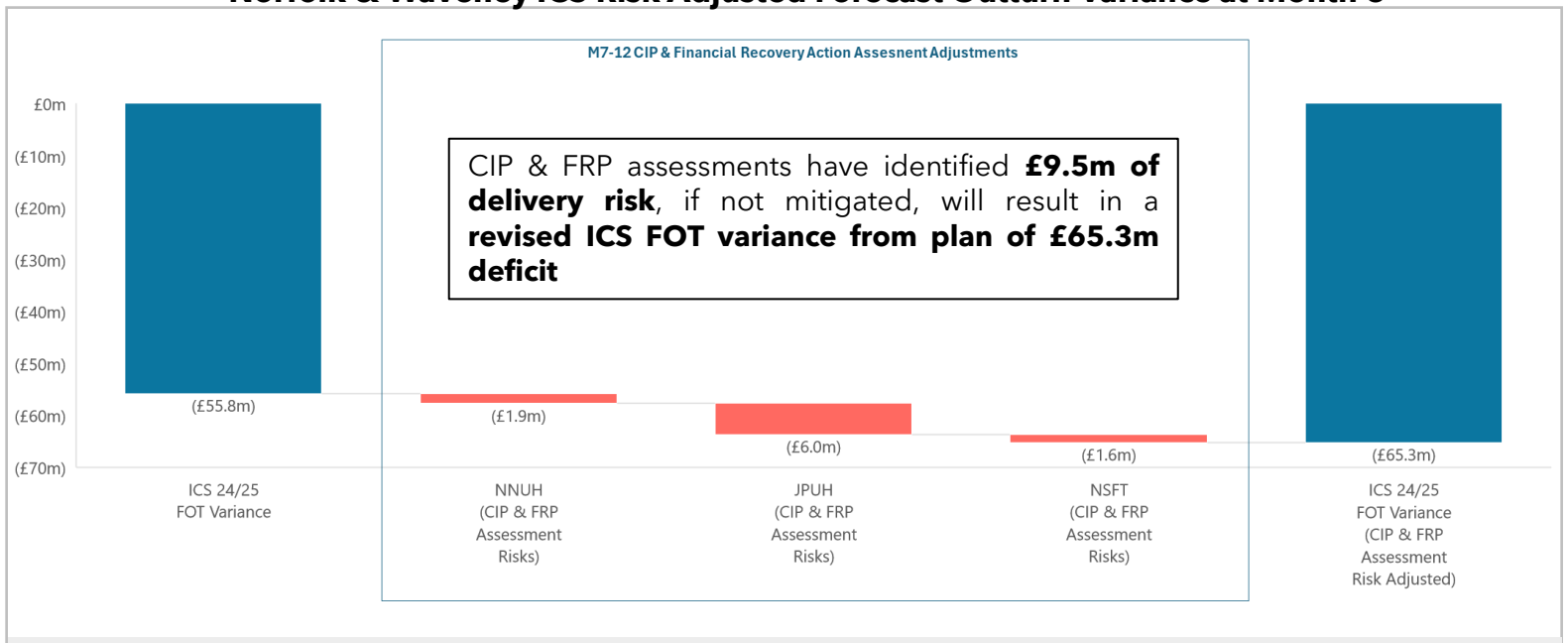
JPUH
- At the point of assessment sufficient detail was not available to apply detailed testing, however interviews with JPUH have identified a £6m CIP under-delivery risk. The trust is currently in the process of identifying additional opportunities to mitigate this risk.

QEH
- It has not been possible to assess further schemes in QEH as they are still in development.

Bravey Board 24/10/2024 Item 2.3

CIP and FRP assessments have identified £9.5m of risk to the M6 FOT resulting in a risk adjusted FOT of £65.3m.

Norfolk & Waveney ICS Risk Adjusted Forecast Outturn Variance at Month 6



Approach

To assess the risks in delivering the system's forecast outturn financial position, an assessment was conducted on all FRP actions; and high value CIP schemes where the combined planned savings exceed 60% of the total planned 24/25 CIP savings. CIPs and all mitigating actions included in FRPs was assessed using data from M5 and M6. This assessment rated the schemes against 3 criteria, across:

- Complexity of Delivery
- Ownership and Governance
- Financial Analysis and Trajectory

Each scheme was given a numerical score which was used to risk adjusted the forecasted CIP or FRP yield, as below:

Low Risk	Forecast adjusted to 90%-100%*
Medium Risk	Forecast adjusted to 60%
High Risk	Forecast adjusted to 20%

Risk adjusted yields drive the FOT adjustments set out in the waterfall diagram above.

*Non-recurrent budget / reserve releases where balances already exist and are frequently monitored by finance are assumed to be 100% deliverable.

3. System Grip and Control

Davey, Heidi
24/03/2025 12:20:17

Grip and control assessment summary

Approach to assessment

Through documentation review, stakeholder interviews and meeting observations, an assessment of the strength of controls (control level) across twelve key areas (pay and non-pay controls, supporting processes and financial management) has been made.

The assessment was based on a framework which rates control strength on a continuum from partial to strong. Standard is the basic, 'business as usual' level of control expected, through to strong which is the tightest level of control which could be applied.

Directors of Finance have had the opportunity to 'check and challenge' their assessment and supporting evidence.

Points to consider

We recommend a thorough and rigorous approach to strengthening controls across both workforce and non-pay, supported by arrangements to ensure such controls are deployed and operating effectively across each organisation.

There should be focus on KPIs to track and measure impact, and reporting flows to monitor at organisation and system level.

Non-pay controls should align with workforce control arrangements, including senior oversight, restrictions on specific categories and challenge forums prior to approval.

Davey Heidi
4/09/2025 12:20:17

Control level: Partial | Standard | Enhanced | Strong | N/A

#	Area	Norfolk and Waveney Integrated Care Board (ICB)	Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)	James Paget University Hospitals NHS Trust (JPUH)	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)	Norfolk and Suffolk NHS Foundation Trust (NSFT)	Norfolk Community Health and Care NHS Trust (NCHC)
1	Vacancy Control	Enhanced	Enhanced	Enhanced	Enhanced	Enhanced	Strong
2	Nursing Agency and Temp Spend	Enhanced	Enhanced	Enhanced	Strong	Enhanced	Enhanced
3	Nursing Rostering	N/A	Strong	Enhanced	Enhanced	Enhanced	Strong
4	Other Staff Agency and Temp Spend	Enhanced	Standard	Enhanced	Standard	Enhanced	Standard
5	Medical Locums and Temp Spend	N/A	Partial	Standard	Standard	Enhanced	N/A
6	Medical additional shifts	N/A	Partial	Enhanced	Enhanced	Standard	N/A
7	Medical Rostering	N/A	Partial	Partial	Partial	Partial	N/A
8	Non-Pay Controls	Strong	Enhanced	Standard	Standard	Standard	Enhanced
9	Reporting, Review and Governance	Strong	Enhanced	Standard	N/A	Standard	Enhanced
10	Absence Management	Strong	Standard	Standard	Standard	Enhanced	Enhanced
11	PMO	Enhanced	Standard	N/A	N/A	N/A	Standard
12	Financial Recovery Arrangements	Enhanced	Standard	Standard	Standard	Standard	Standard

4. FY24/25 Proposed Interventions

Davey, Heidi
24/03/2025 12:20:17

24/25 proposed interventions - Costed (system level)

Unmitigated System FY25 Opportunity: £7.0 – 19.7m
Mitigated System FY25 Opportunity: £4.7 – 15.2m
Unmitigated System FY26 Opportunity: £57.0 – 88.1m
Mitigated System FY26 Opportunity: £53.8 – 82.1m

The below table outlines potential saving opportunities from the implementation of five interventions during 24/25. Potential opportunity values and the value of 'savings already included in plan' were discussed with Directors of Finance. As a result of these discussions, adjustments were made to the values of 'savings already in plan'. We also introduced an additional set of opportunity values (which we have called 'mitigated' forecasts) to account for feedback we received on the practicality of implementation.

Detail of the unmitigated and mitigated assumptions can be found on slides 17 and 18.

			Unmitigated Forecasts				Mitigated Forecasts			
No.	**Intervention**	**Opportunity**	**FY25 Low (£000s)**	**FY25 High (£000s)**	**FY26 Low (£000s)**	**FY26 High (£000s)**	**FY25 Low (£000s)**	**FY25 High (£000s)**	**FY26 Low (£000s)**	**FY26 High (£000s)**
1	Vacancy controls (substantive staff only)	Non-Clinical: **System-wide recruitment freeze for all staff groups until end of the financial year**.	4,288	4,288	16,296	16,296	4,074	4,288	15,481	16,296
		Other Clinical: **System-wide recruitment freeze for all staff groups until end of the financial year**.	986	986	3,745	3,745	986	986	3,745	3,745
		Medical: **System-wide recruitment freeze for all staff groups until end of the financial year**.	2,381	2,381	9,046	9,046	2,381	2,381	9,046	9,046
2	Medical temporary pay	a. **Conversion of all medical agency spend to bank**	1,281	1,601	2,561	3,525	1,121	1,401	2,561	3,525
		b. Implementation of stronger controls for **other medical temporary spend, including WLI's**	1,762	4,406	3,201	8,812	1,762	4,406	3,201	8,812
		c. Implementation of stronger controls for **medical rostering**	881	1,762	1,762	3,525	771	1,542	1,762	3,525
3	Nursing temporary Pay	a. **Ban on nursing bank usage on fully-established wards** b. Implementation of stronger controls for all **nursing temporary pay**	7,041	14,081	14,081	28,162	6,160	12,321	14,081	28,162
4	Overtime	**Overtime ban** in non-clinical/non patient facing areas for rostered staff	756	1,512	1,512	3,025	662	1,323	1,512	3,025
5	Non-Pay	**Implementation of stronger non-clinical non-pay controls** across the system	2,393	5,983	4,787	11,967	1,197	2,992	2,393	5,983
		Total identified	21,769	37,000	56,992	**88,102**	19,113	31,639	53,784	82,119
		Savings already in plan*	-14,824	-17,278			-14,373	-16,459		
		Additional opportunity	6,945	**19,722**	56,992	**88,102**	4,739	**15,180**	53,784	**82,119**

The table includes **high-level estimation of financial impact of respective interventions in 25/26**. These have been incorporated to **provide a scale of impact and FYE** of respective interventions on basis of the assumptions set out. These are estimated only and **should be used to inform next steps and discussion on workforce re-design and transformation** programmes, alongside quality, safety and performance priorities.

**NSFT and ICB have savings already in plan to the value of £7.4m and £0.3m, greater than the total identified savings and therefore no additional opportunity.*

Davies Heidi 24/03/2025 12:24:17

24/25 proposed interventions – Costed (system partner level) - Unmitigated forecast

Unmitigated System FY25 Opportunity: £7.0 – 19.7m
Unmitigated System FY26 Opportunity: £57.0 – 88.1m

No.	Intervention	Opportunity	Period	FY25 Low (£000s)							FY26 Low (£000s)	FY25 High (£000s)							FY26 High (£000s)
				NNUH	JPUH	QEH	NSFT	NCHC	ICB	ICS		NNUH	JPUH	QEH	NSFT	NCHC	ICB	ICS	
1	Vacancy controls (substantive staff only)	Non-Clinical: **System-wide recruitment freeze for all staff groups until end of the financial year**.	PYE 4 months	1,545	463	726	938	381	234	4,288	16,296	1,545	463	726	938	381	234	4,288	16,296
		Other Clinical: **System-wide recruitment freeze for all staff groups until end of the financial year**.		355	183	168	213	67		986	3,745	355	183	168	213	67		986	3,745
		Medical: **System-wide recruitment freeze for all staff groups until end of the financial year**.		1,156	352	610	250	13		2,381	9,046	1,156	352	610	250	13		2,381	9,046
2	Medical temporary pay	a. **Conversion of all medical agency spend to bank**	PYE 4 months	441	558		282			1,281	2,561	551	698		352			1,601	3,525
		b. Implementation of stronger controls for **other medical temporary spend, including WLI's**	PYE 4 months	706	320	630	106			1,762	3,201	1,765	801	1,576	264			4,406	8,812
		c. Implementation of stronger controls for **medical rostering**	PYE 4 months	353	160	315	53			881	1,762	706	320	630	106			1,762	3,525
3	Nursing temporary Pay	a. **Ban on nursing bank usage on fully-established wards**	PYE 4 months	2,827	746	1,520	1,587	361		7,041	14,081	5,653	1,493	3,039	3,174	722		14,081	28,162
		b. Implementation of stronger controls for all **nursing temporary pay**																	
4	Overtime	**Overtime ban** in non-clinical/non patient facing areas for rostered staff	PYE 4 months	294	128	123	211			756	1,512	588	256	246	422			1,512	3,025
5	Non-Pay	**Implementation of stronger non-clinical non-pay controls** across the system	PYE 4 months	1,327	357	303	250	157		2,393	4,787	3,317	892	758	625	392		5,983	11,967
		Total identified		9,003	3,268	4,395	3,890	978	234	21,796	56,992	15,636	5,457	7,754	6,345	1,574	234	37,000	88,102
		Savings already in plan		-6,869	-2,734	-1,000	-3,980*	-96	-234*	-14,824		-6,869	-2,734	-1,000	-6,345*	-96	-234	-17,278	
		Additional Opportunity		2,134	534	3,395	0	882	0	**6,945**	**56,992**	8,767	2,723	6,754	0	1,478	0	**19,722**	**88,102**

Daisy Heidi 24/03/2025 12:24:17

**NSFT and ICB have savings already in plan to the value of £7.4m and £0.3m, greater than the total identified savings and therefore no additional opportunity.*

***The non-pay opportunity value (excluding non-programme and commissioning contract spend) for the ICB was immaterial and has therefore been removed.*

24/25 proposed interventions – Costed (system partner level) - Mitigated forecast

Mitigated System FY25 Opportunity: £4.7m – 15.2m
Mitigated System FY26 Opportunity: £53.8 – 82.1m

No.	Intervention	Opportunity	Period	FY25 Low (£000s)							FY26 Low (£000s)	FY25 High (£000s)							FY26 High (£000s)
				NNUH	JPUH	QEH	NSFT	NCHC	ICB	ICS		NNUH	JPUH	QEH	NSFT	NCHC	ICB	ICS	
1	Vacancy controls (substantive staff only)	Non-Clinical: **System-wide recruitment freeze for all staff groups until end of the financial year**.	PYE 4 months	1,468	440	690	892	362	223	4,074	15,481	1,545	463	726	938	381	234	4,288	16,296
		Other Clinical: **System-wide recruitment freeze for all staff groups until end of the financial year**.		355	183	168	213	67		986	3,745	355	183	168	213	67		986	3,745
		Medical: **System-wide recruitment freeze for all staff groups until end of the financial year**.		1,156	352	610	250	13		2,381	9,046	1,156	352	610	250	13		2,381	9,046
2	Medical temporary pay	a. **Conversion of all medical agency spend to bank**	PYE 3.5 months	386	488		247			1,121	2,561	482	610		308			1,401	3,525
		b. Implementation of stronger controls for **other medical temporary spend, including WLI's**	PYE 4 months	706	320	630	106			1,762	3,201	1,765	801	1,576	264			4,406	8,812
		c. Implementation of stronger controls for **medical rostering**	PYE 3.5 months	309	140	276	46			771	1,762	618	280	552	93			1,542	3,525
3	Nursing temporary Pay	a. **Ban on nursing bank usage on fully-established wards**	PYE 3.5 months	2,473	653	1,330	1,389	316		6,160	14,081	4,946	1,306	2,659	2,778	632		12,321	28,162
		b. Implementation of stronger controls for all **nursing temporary pay**																	
4	Overtime	**Overtime ban** in non-clinical/non patient facing areas for rostered staff	PYE 3.5 months	257	112	108	184			662	1,512	515	224	216	369			1,323	3,025
5	Non-Pay	**Implementation of stronger non-clinical non-pay controls** across the system	PYE 4 months	663	178	152	125	78	**	1,197	2,393	1,658	446	379	313	196	**	2,992	5,983
		Total identified		7,773	2,867	3,962	3,452	836	223	19,113	53,784	13,040	4,665	6,885	5,526	1,288	234	31,639	82,119
		Savings already in plan		-6,869	-2,734	-1,000	-3,452*	-96	-223	-14,373		-6,869	-2,734	-1,000	-5,526*	-96	-234	-16,459	
		Additional opportunity		904	133	2,962	0	740	0	**4,739**	**53,784**	6,171	1,931	5,885	0	1,192	0	**15,180**	**82,119**

**NSFT and ICB have savings already in plan to the value of £7.4m and £0.3m, greater than the total identified savings and therefore no additional opportunity.*

***The non-pay opportunity value for the ICB was immaterial and has therefore been removed.*

Daveyfield 24/07/2025 12:12:17

24/25 proposed interventions - Assumptions (1 of 2)

Assumptions used for calculating the opportunity cost for each intervention is provided below. The mitigated assumptions reflect feedback from system partners.

No.	Intervention	Opportunity	Unmitigated Assumptions		Mitigated Assumptions	
			Low	High	Low	High
1	**Vacancy controls (substantive staff only)**	Non-Medical: **System-wide recruitment freeze for all staff groups until end of the financial year** Medical: **System-wide recruitment freeze for all staff groups until end of the financial year**	• N/A	• Trust and staff group specific turnover rates (Model Hospital FY24) were used to calculate leavers, phased over 4 months • Average cost per substantive WTE was calculated using M5 FY25 PFRs and PWRs • **100% of non-clinical posts are not replaced and 50% of clinical posts are not replaced**	• **95% of non-clinical posts are not replaced and 50% of clinical posts are not replaced**	• **100% of non-clinical posts are not replaced and 50% of clinical posts are not replaced**
2	**Medical temporary pay**	a. **Conversion of all medical agency spend to bank**	• Average bank and agency costs were calculated using M5 FY25 PFRs and PWRs • **80% of agency is converted to bank** • Saving is applied over a 4-month period	• **100% of agency is converted to bank**	• **Two-week implementation period where no savings made**	• **Two-week implementation period where no savings made**
		b. Implementation of stronger controls for **other medical temporary spend, including WLI's**	• Average bank costs were calculated using M5 FY25 PFRs and PWRs • Agency converted to bank in 2a. was included in calculating bank usage over a 4-month period • **10% reduction** in bank usage	• **25% reduction** in bank usage	• As before	• As before
		c. Implementation of stronger controls for **medical rostering**	• As in 2b • **5% additional reduction** in temporary staffing usage	• **10% additional reduction** in temporary staffing usage	• **Two-week implementation period where no savings made**	• **Two-week implementation period where no savings made**

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24/25 proposed interventions - Assumptions (2 of 2)

No.	Intervention	Opportunity	Unmitigated Methodologies		Mitigated Methodologies	
			Low	High	Low	
3	**Nursing temporary Pay**	a. **Ban on nursing bank usage on fully-established wards** b. Implementation of stronger controls for all **nursing temporary pay**	• As in 2a (for Nursing Agency and Bank) • **50% reduction in bank and agency usage**	• **100% reduction in bank and agency usage**	• **Two-week implementation period where no savings made**	• **Two-week implementation period where no savings made**
4	**Overtime**	**Overtime ban** in non-clinical/non patient facing areas for rostered staff	• Non-clinical and non-patient facing overtime makes up 1% of substantive non-clinical, support to clinical, and registered STT pay • **50% reduction** in overtime	• **100% reduction** in overtime	• **Two-week implementation period where no savings made**	• **Two-week implementation period where no savings made**
5	**Non-Pay**	**Implementation of stronger non-clinical non-pay controls** across the system	• Discretionary spend makes up **5% of total non-pay** • **20% reduction** in discretionary spend	• **50% reduction** in discretionary spend	• Discretionary spend makes up **2.5% of total non-pay**	• Discretionary spend makes up **2.5% of total non-pay**

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* % of non-pay bill that is discretionary spend is an assumption for illustrative purposes. Recognising that system partners who pay for PFI and CNST costs this % will be higher.

Other 24/25 interventions for consideration

In addition to the five interventions already outlined it is recommended that the following areas are rapidly evaluated for possible impact in 24/25, with quantification in Phase 2.

1 **Balance Sheet measures:** There are some significant accruals within the system, and these should be rapidly appraised for feasibility to improve the position.

2 **Business Case approvals:** Temporary stop on recently approved business cases where spend has not yet been incurred or contracts signed with formal executive level oversight and risk assessment and reporting to financial recovery governance structures.

3 **An urgent appraisal** of whether ERF income, net of costs of additional sessions and over time, is being maximized by the system: Are there opportunities for further mutual aid, reevaluation of independent sector contract content and quantum by specialty, judged against the system's position on long waiters? Norfolk and Waveney currently have 1,118 patients waiting over 65 weeks against a target of 500 with ERF performance at 117.5% against a target of 103.1%.

Dave Reidi 24/03/2025 12:20:17

5. Workforce

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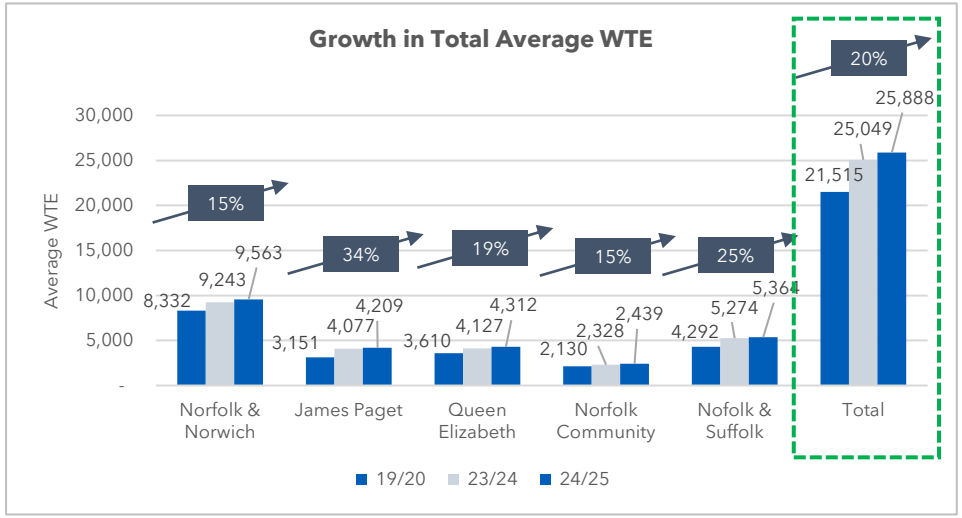
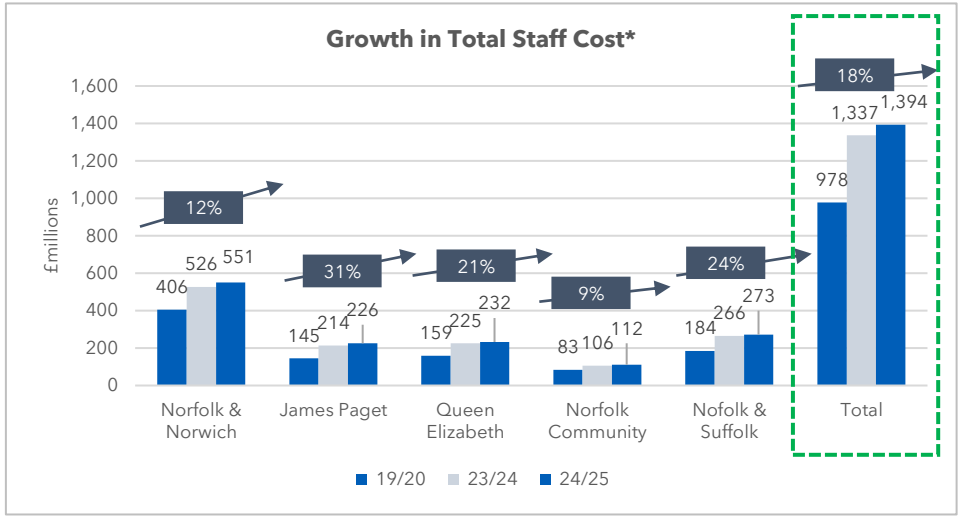
System Workforce Growth (WTE and spend)

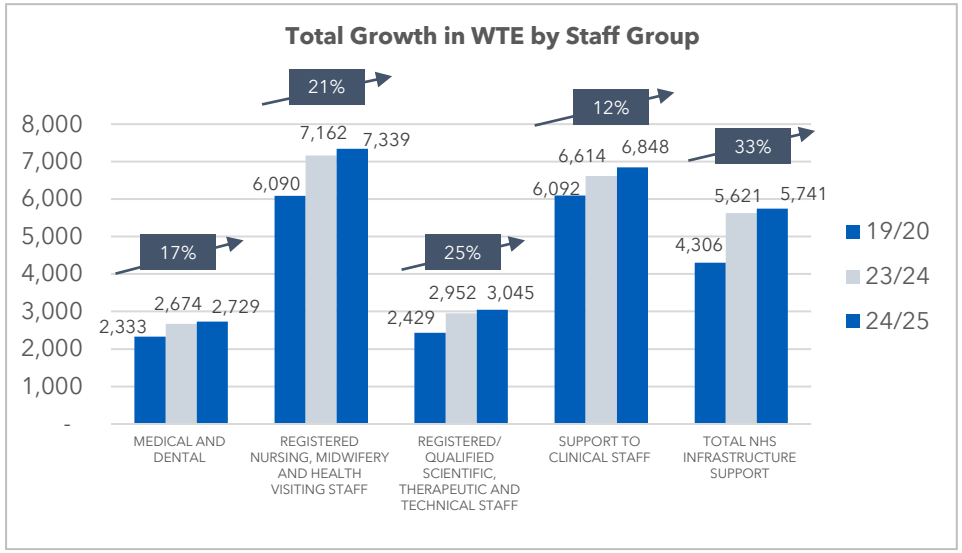
System WTE growth and spend (FY19/20 – M5 FY24/25)

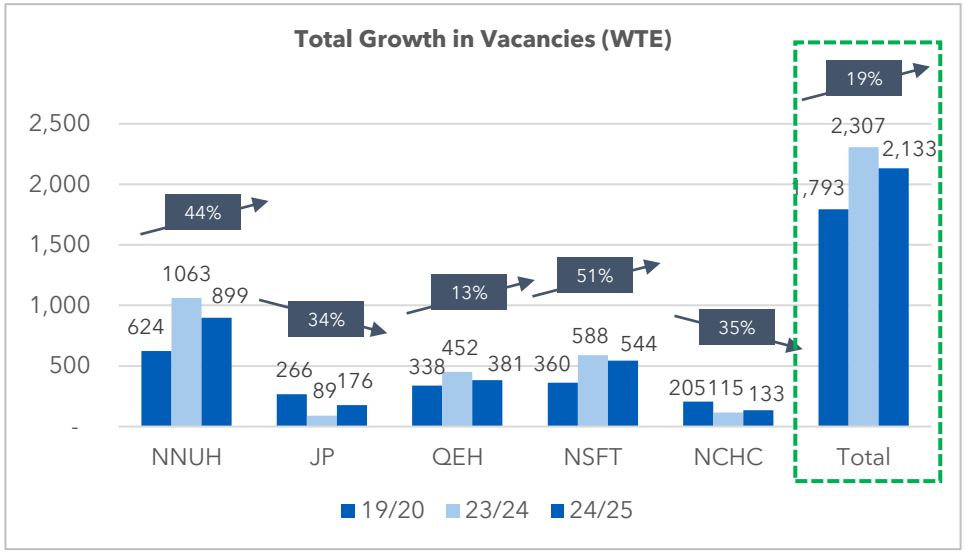
- Since FY20, there has been **20% WTE growth across the system**, with JPUH and NSFT growing the most at 34% and 25% respectively. Growth at NSFT is partly informed by the current Recovery Support Programme.
- Since FY20, the **growth in total staff costs is 18%** (excluding national NHS pay uplifts). JPUH has seen the greatest growth, at 31%, with NSFT and QEH just after at 24% and 21%, respectively.
- The staff group with the greatest growth in WTE across the system is **NHS Infrastructure Support** which has grown by 33%.
- Since FY20, **vacancies across the system have increased by 19%.** The system partners with the greatest growth in vacancies are NSFT (51%) and NNUH (44%).

**growth in pay spend for substantive staff excludes national NHS pay uplifts from 19/20.*









Source – FY20, FY23, FY24 PWR and PFRs

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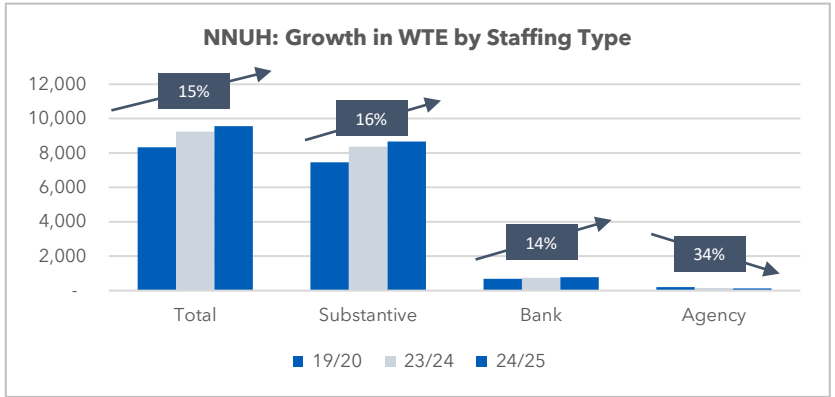
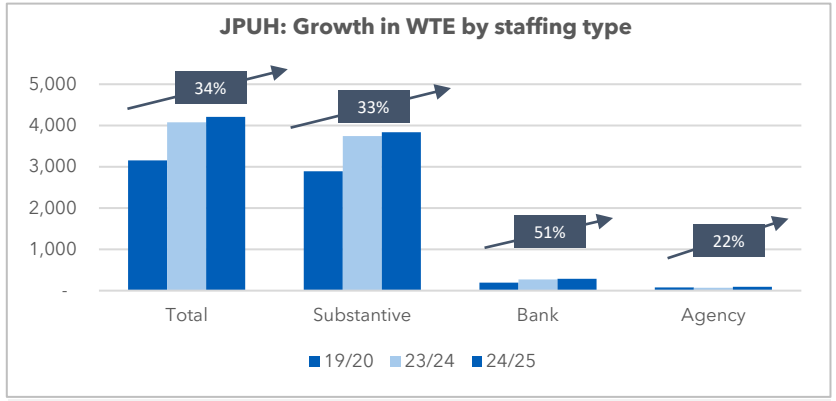
System Partner Workforce Growth (Staffing Type)

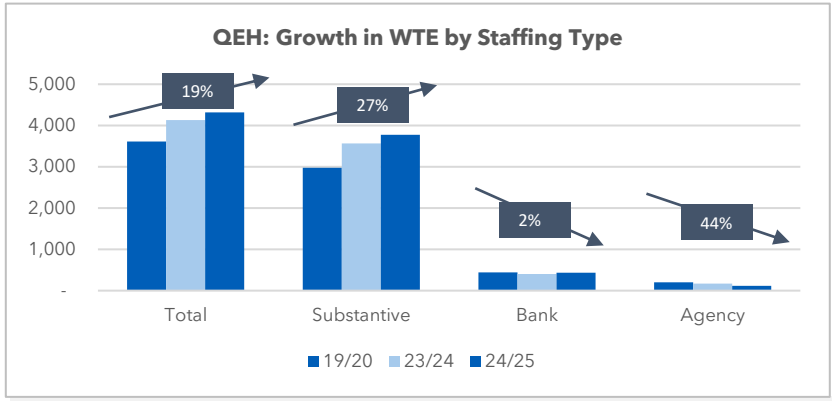
System Partner WTE growth by staffing type (FY19/20 – M5 FY24/25)



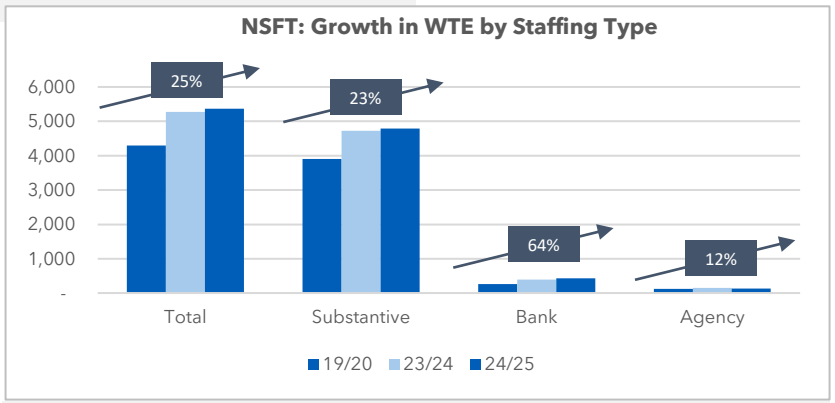
- Since FY20, there has been **WTE growth of 15%,** driven by a **16% increase in substantive staff**. Pay for substantive staff has grown by 9% *.
- **Bank WTE grew by 14%** while **Bank spend increased by 46%. Agency WTE decreased by 34%** while **Agency spend increased by 2%**.



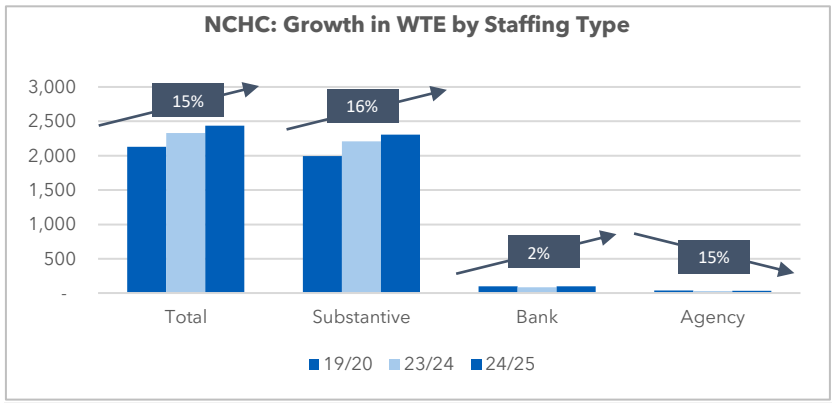
- Since FY20, there has been **WTE growth of 34%,** driven by a **33% increase in substantive staff**. Pay for substantive staff has grown by 28%*.
- **Bank and Agency WTE increased by 51% and 22%** respectively. **Bank spend increased by 134%** and **Agency by 35%.**



- Since FY20, there has been **WTE growth of 19%,** driven by a **27% increase in substantive staff**. Pay for substantive staff has grown by 17%*.
- **Bank WTE decreased by 2%** while **Bank spend grew by 141%. Agency WTE decreased by 44% and spend decreased by 22%.**



- Since FY20, there has been **WTE growth of 25%,** driven by a **23% increase in substantive staff**. Pay for substantive staff has grown by 21%*.
- **Bank WTE increased by 64%** while **Bank spend grew by 111%. Agency WTE increased by 12%** and spend stayed the same.



- Since FY20, there has been **WTE growth of 15%,** driven by a **16% increase in substantive staff**. Pay for substantive staff has grown by 8%*.
- **Bank WTE increased by 2%** while **Bank spend grew by 23%**. **Agency WTE decreased by 14%** and **spend decreased by 34%.**

**growth in pay spend for substantive staff excludes national NHS pay uplifts from 19/20.*

Source – FY20, FY23, FY24 PWR and PFRs

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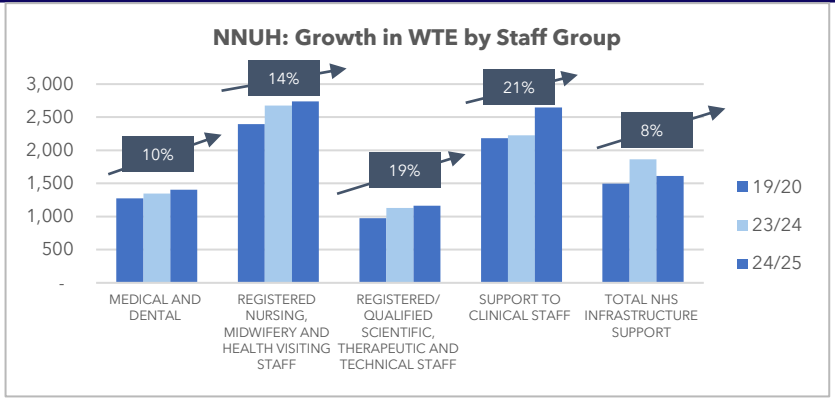
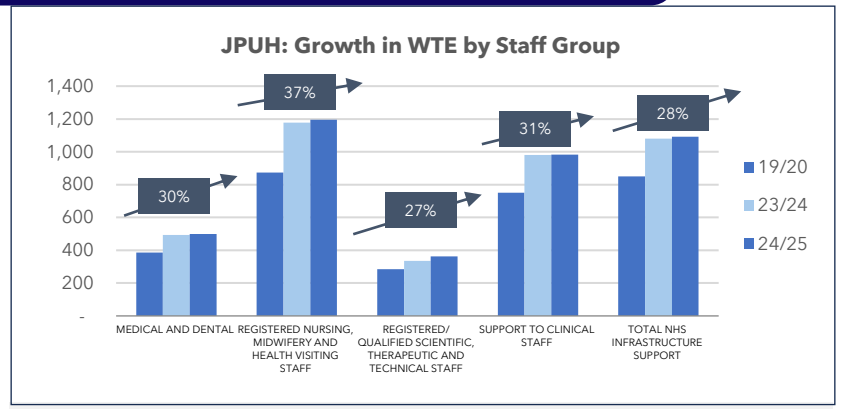
System Partner Workforce Growth (Staff group)

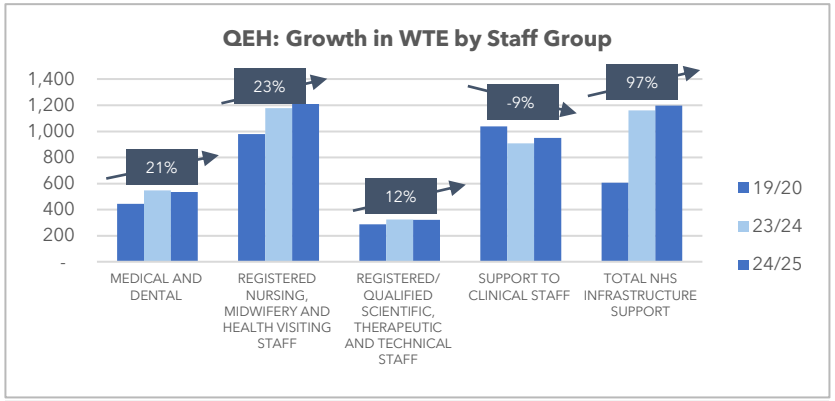
System partners WTE growth by staff group (FY19/20 – M5 FY24/25)



- The greatest growth in WTE from FY20 to YTD FY25 was in **Support to Clinical Staff**, which grew by 21%, followed by **Registered / Qualified Scientific, Therapeutic and Technical Staff**, which grew by 19%.

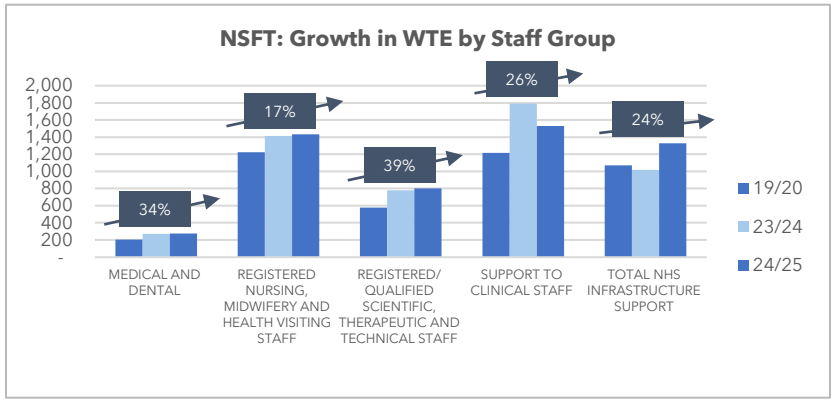


- The greatest growth in WTE from FY20 to YTD FY25 was in **Registered Nursing, Midwifery and Health Visiting Staff**, which grew by 37%..
- Support to Clinical Staff WTE decreased by 2%.

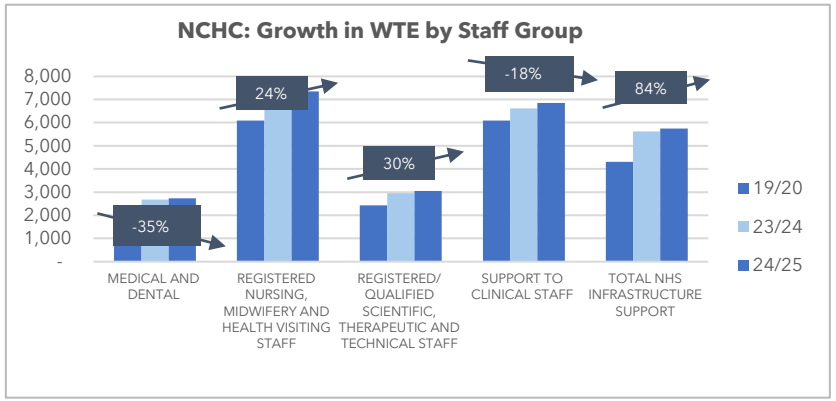


- The greatest growth in WTE from FY20 to YTD FY25 was in **NHS Infrastructure Support Staff**, which grew by 97%, followed by **Registered Nursing, Midwifery and Health Visiting Staff**, which grew by 23%.
- Support to Clinical Staff WTE decreased by 9%

We understand there have been changes to job coding that have impacted WTE growth for 'NHS Infrastructure Support Staff' and 'Support to Clinical Staff' staff groups.



- The greatest growth in WTE from FY20 to YTD FY25 was in **Registered / Qualified Scientific, Therapeutic and Technical Staff**, which grew by 39%, followed by **Medical & Dental Staff**, which grew by 34%.



- The greatest growth in WTE from FY20 to YTD FY25 was in **NHS Infrastructure Support Staff**, which grew by 84%, followed by **Registered / Qualified Scientific, Therapeutic and Technical Staff**, which grew by 30%.
- Medical and Dental staff WTE decreased by 35% and Support to Clinical Staff WTE decreased by 18%.

Source – FY20, FY23, FY24 PWR and PFRs

Steve Helm 24/03/2025 12:20:17

System Partner Temporary Staff Usage & Spend

System partner temporary staffing usage and spend (FY19/20 – M5 FY24/25)

Bank Growth

Since FY20, **the usage of Bank staff has grown by 21%** across the system. The greatest growth in usage has been at NSFT (64%) and JPUH (51%). **Bank costs have grown at a greater rate (81%),** with the greatest growth in bank costs seen at QEH (141%) and JP (134%).

Agency Growth

Since FY20, **Agency usage has decreased by 20%** across the system. The greatest growth in usage has been at JP (22%) and NSFT (12%). In comparison, **agency costs have remained the same across the System**, albeit there has been growth in agency costs at JPUH (35%) and NCHC (34%). Despite decreases in agency usage seen across the System, the only Trust to achieve a reduction in agency cost is QEH.

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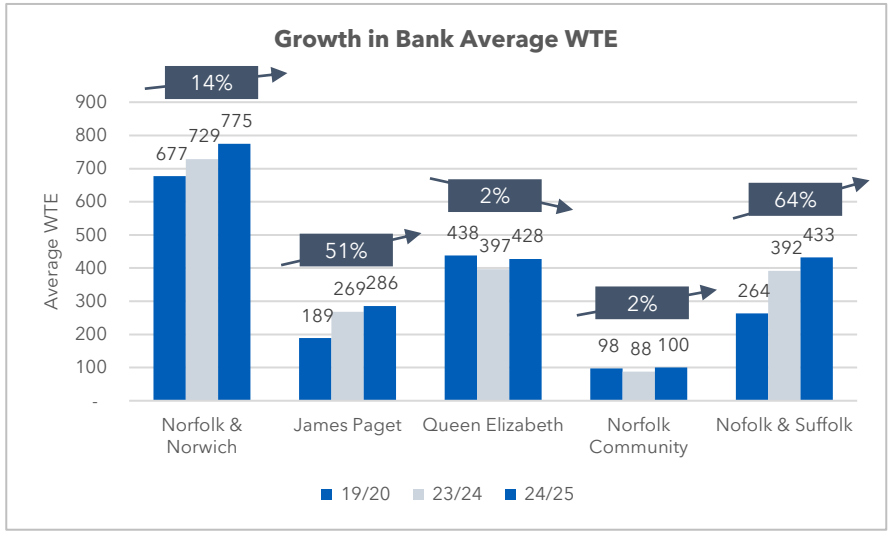
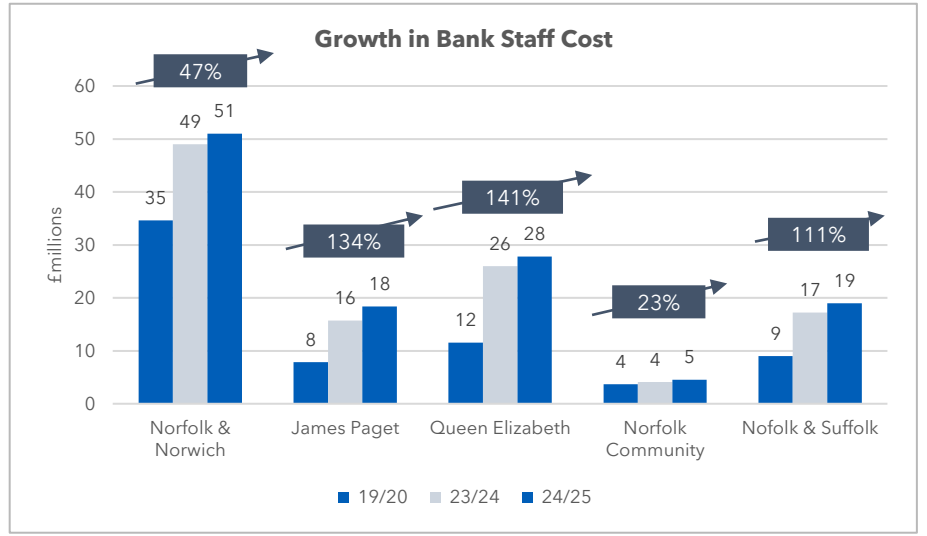
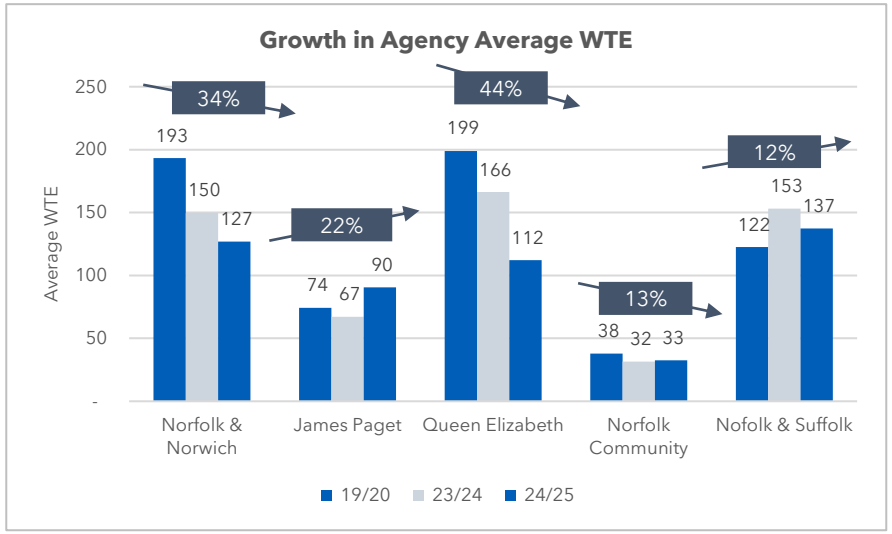
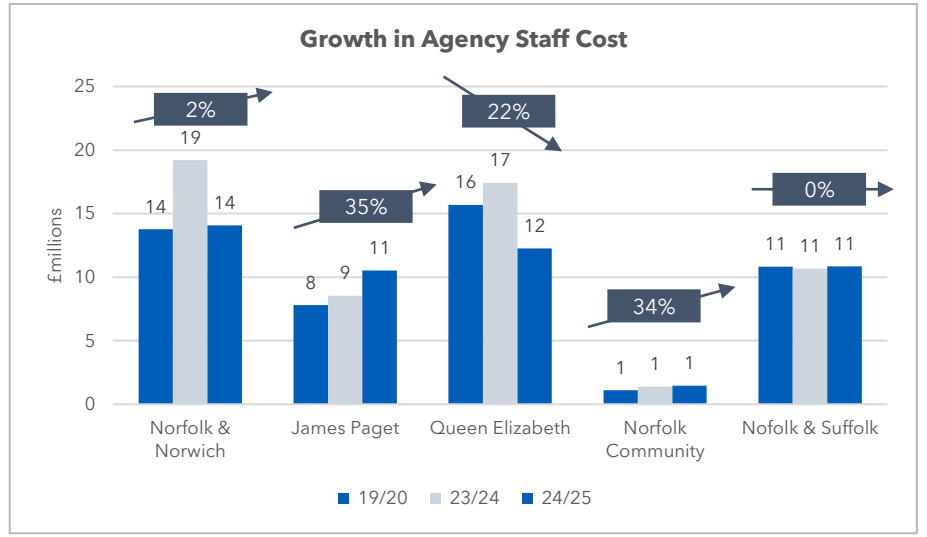








Source – FY20, FY23, FY24 PWR and PFRs

System WTE Growth compared to CWAG - Acute

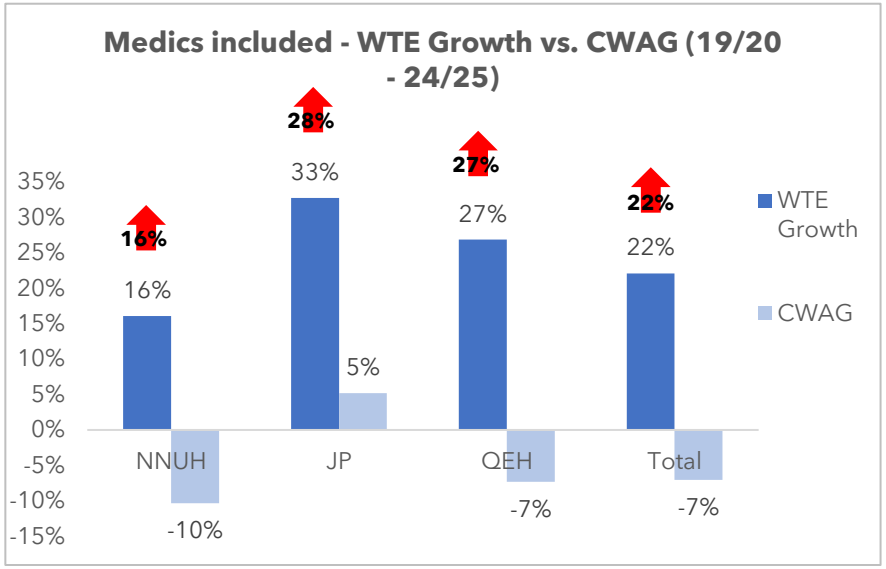
High level analysis was carried out comparing the growth in WTE at NNUH, JPUH, and QEH to their Cost Weighted Activity Growth (CWAG) between FY20 and FY25. CWAG data was not available for NSFT or NCHC, so these system partners are excluded here.

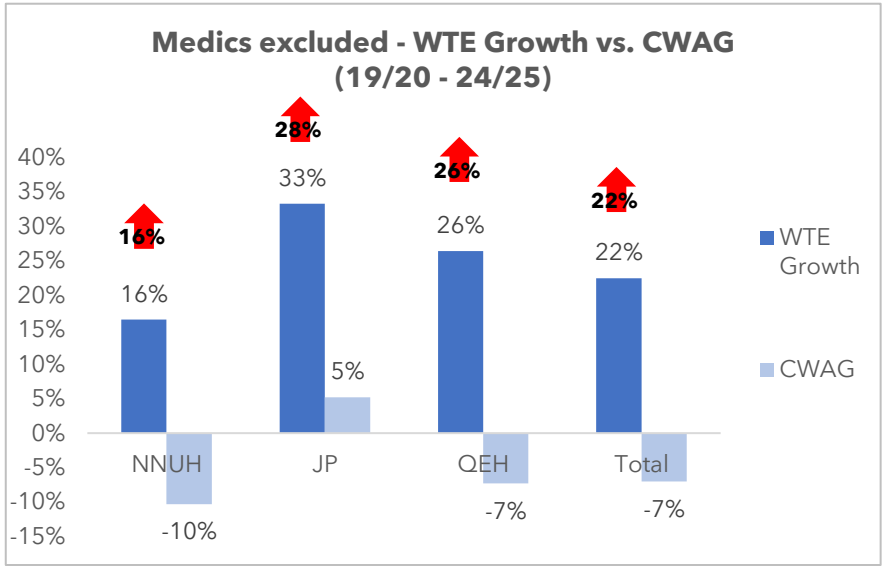
From FY20 to date **WTE growth has been substantially greater than CWAG** across the system.

Reducing WTE in line with weighted activity could reduce pay spend by £39 – 79m (including Medics).

Since FY20, there has been absolute growth in WTE of 25% across all system partners. The greatest growth was seen in NHS Infrastructure Staff, which increased by 41%.

There is a **medium-term consideration for system partners to assess how it leverages the workforce growth in context of future clinical services review.**





Metric	NNUH	JP	QEH	Total
Reduce Growth above Activity by 25%	£16,762k	£10,170k	£9,980k	£39,306k
Reduce Growth above Activity by 50%	£33,524k	£20,340k	£19,960k	£78,612k

Metric	NNUH	JP	QEH	Total
Reduce Growth above Activity by 25%	£11,308k	£7,537k	£7,078k	£27,442k
Reduce Growth above Activity by 50%	£22,615k	£15,073k	£14,155k	£54,884k

Source – PFRs and PWRs 19/20 and 24/25. NHSE CWAG report 24/25

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6. PMO and Governance

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PMO and Governance

Overview

The system Financial Recovery Board (FRB) plans are not supported by full programme management disciplines, notably financial and activity tracking. Challenges identified have included data consistency and coherence of reporting, capacity, lack of alignment across functions, limited clarity of responsibilities and reporting lines and turnover in recovery leadership. The review has observed examples of good practice in CIP monitoring and reporting, governance structures and multidisciplinary working between finance and PMO functions.

Capacity and Scope

- All system partners have PMO personnel in place, although not all have capacity commensurate with their responsibilities and the severity of the financial challenge and some partners have a lack of clarity on WTE dedicated to CIP PMO.
- Currently recruiting to vacancies with some system partners relying on external interim support or ad hoc support from other teams within their respective organisations.
- The system FRB is supported by an administrative PMO arrangement.

Financial Recovery Governance

- Most system partners have documented governance structures dedicated to financial recovery; it is noted that several forums do not have terms of reference or are conducted informally with irregular meeting cadences and limited action tracking. Some system partners have multiple forums, leading to risk of duplication of effort and lack of clarity of responsibilities.
- There has been some instability in recovery governance with forums being newly introduced or revised in-year e.g. the system FRB has had several resets.
- The majority of system partners have struggled to generate new CIP ideas of significant recurring materiality and that were ready to go in H1 2024/25.
- There was significant variation in the quality of CIP reporting in place.

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Application of Programme Management Disciplines

- CIP trackers, PIDs and CQIA processes are in place and whilst most are completed to a high-level, there are some gaps including QIA processes not being documented, schemes progressing through gateways without completed workbooks and incomplete information within scheme workbooks and CIP trackers.

7. FY25/26 Planning

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25/26 Principles for Priorities and Planning

The system should commence its planning for FY 25/26 with **four key objectives:**

- A system productivity improvement programme to reduce recurrent run rate by aligning a right-sized workforce with service redesign in all key programmes of care and with right-sizing of demand.
- Supporting productivity improvement with a single version of the truth regards activity and financial tracking and reporting to the system Financial Recovery Board to enable transparent tracking of progress.
- Development of a contracting and funding model to align with the agreed productivity trajectories.
- A step up in clinical ownership and drive of redesign and demand management measures across the system – across elective and non elective care

Delivery of these objectives will require an agreement on the balance of responsibilities, acknowledging the delivery autonomy of system partners.

A system-level Financial Recovery Board with dedicated resources is necessary to apply full progamme management discipline and rigour.

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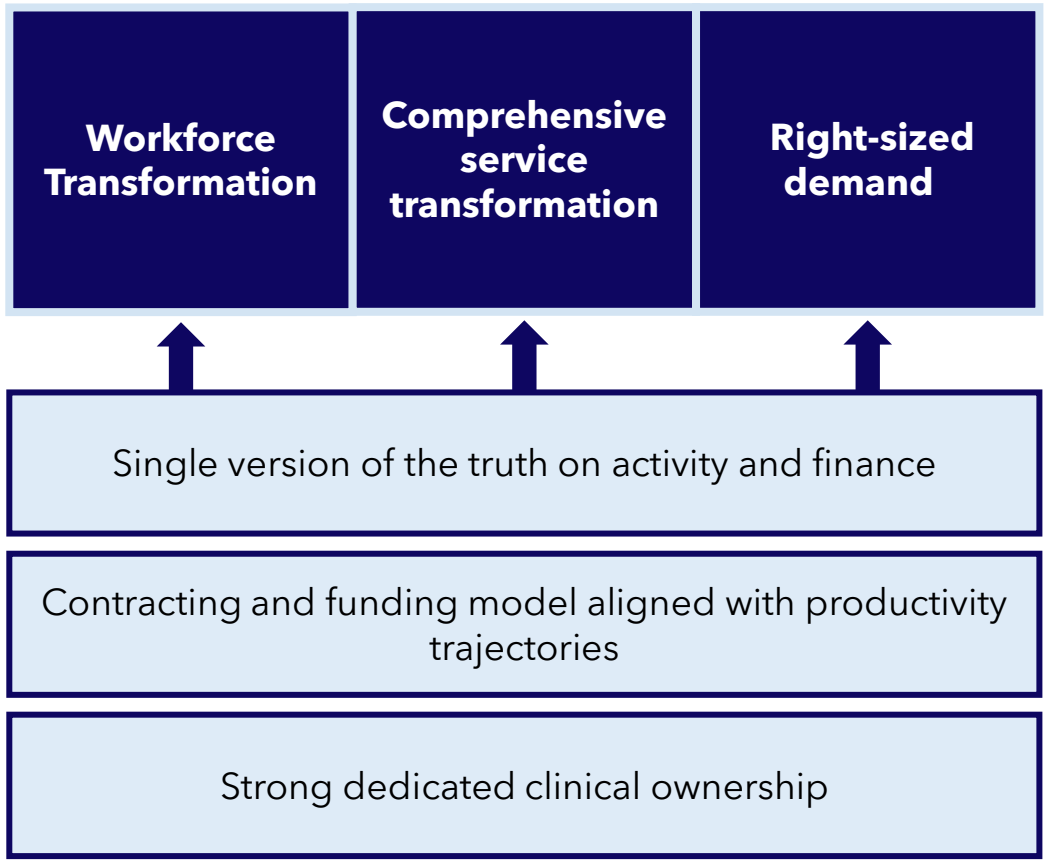

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Davey Hall
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Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Director of Commissioning Finance**
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 2025**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 25th of February 2025.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 29.01.2025 Subsequent Meetings: 04.02.2025 , 25.02.2025
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 10** results, i.e. per January 2025.* Much information regarding Month 10 is already captured in the Month 10 Finance Report of the Executive Director of Finance, immediately preceding this agenda item. Focusing therefore on the main aspects of Month 10 reporting:

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	- At **Month 10 (January 2025)** the NHS entities in the N&W ICS show a Year to Date deficit of £(49.7)m vs a Planned deficit of £(5.1)m, i.e. a shortfall of £(44.6)m. - At **Month 10 (January 2025)** the NHS entities in the N&W ICS show a Forecast Outturn (FOT) for the financial year of £(53.9)m vs a break-even Plan, with all three Acute hospitals contributing to this deficit. - The CDEL (**Capital** Delegated Expenditure Limit) capital spend FOT for the year of ca. £105m is expected to match the Plan. - The change in FOT is not a surprise. This report has consistently flagged limited assurance in achieving our plans since September 2024 despite many remedial actions and support for additional mitigations provided through the Investigation and Rapid Intervention Process with Deloitte. We have seen a continued trend in shortfalls arising from efficiency savings not secured particularly in the second half of the year, and significant operational pressures arising from reduced activity and associated Elective Recovery Income (ERF), and pay costs often at premium rates. - In recognition of this the ICB and system leaders have introduced early in the financial year several *grip & control* measures, including a triple lock mechanism for most of pay and non-pay spend. The Financial Recovery Board was formed to drive across the N&W system in-year savings and identify medium financial savings. As this did not yield the results sought, the Norfolk & Waveney system was put in NHS England's I&I (Investigation & Rapid Intervention) Programme, in category 4 in October 2024 based on the month 6 financial position. The Committee has received verbal updates on the so-called Investigation phase (Phase 1), carried out by Deloitte. - Whilst the increased scrutiny has not enabled achieving a break-even plan for the system, it has resulted in more *grip & contro*l, stronger ownership for the financial challenge and trade-offs across the system and within individual providers and ICB. This then forms the back-drop for the preparation of the 2025/26 financial plan. - The **2025/26 financial plan** is prepared in line with an activity plan and a workforce plan, that need to be

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consistent.

The Finance Committee considered the draft financial return, with a final return due on March 27th (the day after the Board meeting).

- The Committee was presented with the draft numbers, showing a ca. £(80)m deficit, assuming a delivery of ca. £200m in efficiencies, i.e. a total £280m required to be made. Further work is happening to reduce this £80m gap, but it will in all likelihood require certain services to be reconfigured, curtailed or not renewed as part of Sustainable Commissioning Programmes.

- Other topics covered during the two meetings in February are:
  - Elective Recovery Fund
  - Contracting & Procurement update
  - GP prescribing and Medicines Management update, see through a financial lens

Items for escalation to Board:

1. Forecast Outturn per Month 10 shows a £(53.9)m deficit at system level.

2. The draft financial plan for 2025/26 shows a £280m savings ask

	NHS entities in N&W ICS, including ICB	**N&W ICB**
Month 8 Year to Date	Actual: Deficit of £(49.7)m vs Plan of £(5.1)m, i.e. a shortfall of £(44.6)m.	Actual: Surplus of £ 0.3m vs Plan of £ 0.3m
Forecast OutTurn (FOT) of year per Month 10	FOT £(53.9)m deficit vs Plan of £ 0.0m	Actual: Surplus of £ 0.4m vs Plan of £ 0.4m
Underlying Deficit *(* September MTFP – will be updated with final planning template)*	£(279)m underlying deficit*	£(122)m Forecast underlying deficit

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	Efficiency delivery | £179m Plan £149m Forecast | £51m Plan £44m Forecast
Items requiring approval:	None
Confirmation that the meeting was quorate:	Confirmed that meetings were quorate.

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

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Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**ICB Performance Report**
Presented by:	**Andrew Palmer Executive Director of Strategy and Deputy Chief Executive Officer**
Prepared by:	**ICB Commissioning and Performance team with contributions from teams working in subject areas.**
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 2025**

Purpose of Paper:

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

Executive Summary:

Committee are asked to note:

- Performance against the diagnostic standard observed a common cause decline (worsening position).
- While the number of people waiting 65 or more weeks for elective care has not yet met the national standard, there is a continued trend of special cause improvement.
- Cancer has observed improvements with the 28-day Faster Diagnosis Standards (FDS) showing special cause improvement.
- Inappropriate Out of Area Placements (adult mental health) achieved target of zero.
- Dementia Diagnosis remains in special cause improvement though a further dip against plan was observed in January.
- The numbers of people with Learning Disability or Autism in inpatient admission remains high against plan.
- Urgent and Emergency Care performance remains below standards, noting data flow issues with 4-hour A&E reporting and a common cause improvement in Cat. 2 Ambulance response times.
- Financial position against plan remains a significant risk.
- Reporting against the implementation of Women's health hub and Patient Safety Incident Response Framework (PSIRF) have been removed as both have been implemented.

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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 recent trust tiering meetings and Cancer Alliance Highlight reporting:

Queen Elizabeth Hospital: December 2024 FDS performance was 71.4% below their planned trajectory of 76.6%. December 62-day performance 60.5% below their trajectory of 62.5%. The trust has seen delays in radiology testing, longer waits in endoscopy and WLI reduction causing an impact. There was a deterioration in the colorectal triage effectiveness due to sickness. There have also been high levels of sickness in skin and gynae and no urology consultant cover over Christmas into the new year. This cover should be provided by NNUH as part of the SLA and a meeting is organised to discuss. Fortnightly recovery meetings are taking place with failing areas. Individual site action plans in place to support recovery and pathway redesigns planned for gynae, prostate and urology. Funding agreed for WLI and outsourcing support in diagnostics. It is anticipated that 62-day performance will reduce in January with the unvalidated forecast being 56%. There is improved forecast performance through February and into March. The keys issues for the 62-day performance are delays in diagnostic testing and reporting, dermatology capacity, increased referrals and consultant sickness impacting on admin. Histopathology turnaround times continue to be a concern and the planned move of the service to NNUH will complete in June. There are also delays in lung for chemotherapy with support due from NNUH and CUH.

Norfolk & Norwich University Hospital: December 2024 FDS performance was 69% below their planned trajectory of 75%. All but breast, head and neck, lung, paediatric, testicular and upper GI were below the overall FDS standard of 77%. January 2025 performance is expected to be behind trajectory however interventions in lower GI for additional endoscopy weekend lists and gynae additional clinics and OPH lists will support increased performance. Improvement work in lower GI and gynae is also continuing by remodelling the nurse led triage for STT pathways and improved oversight of pathway milestones and escalation points. December 62-day performance 57.9% against a trajectory of 70%. All but breast and skin were below the 62-day standard. Blackstart generator failure impacted due to rescheduling of OPAs, MDT discussions and investigations. Impact also felt on theatre lists, radiotherapy and radiology booking and reporting. Head and Neck laser surgery delays due to equipment breakdown and an increased number of late tertiary referrals.

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James Paget University Hospital: December 2024 FDS performance was 77.9% ahead of their planned trajectory of 75%. December 62-day performance 77.9% ahead of their trajectory of 75%. The 62-day backlog remains above the revised

trajectory with 102 patients at the end of December 2024. Delays seen over Christmas with patients reluctant to attend and workforce on annual leave. There is continuation of weekly meetings with divisional Ops Directors to run through 62-day backlogs and FDS. Patients have also wanted to delay diagnostic procedures with patients being contacted to advise the importance of having these tests. Colorectal patients are going straight to test, and this should improve 28-day FDS and stop the patients tipping into 62-day backlog. FDS concerns remain in gynae and colorectal. JPUH wanted to implement Telederm but the timeline slipped due to digital sign off. Potentially this shall commence in February 2025. There are PET delays due to the PMSA and a drug required for prostrate pathway patients. The alliance medical team are investigating this.

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

Elective care

The system continues to face challenges in delivering the 65-week wait target, with complexities in long-wait patient cases further compounding recovery efforts. Staffing shortages, including consultant absences, continue to impact service delivery. A critical incident at JPUH on 22nd February resulted in the cancellation of 17 long-wait patients due to bed shortages. Additionally, inpatient nursing shortfalls (25-30 nurses) remain a key pressure, despite the implementation of additional hours to mitigate impact. Weekend theatre activity and increased insourcing efforts are being used to support recovery across the system.

Diagnostics

New purpose-built Community Diagnostic Centres (CDCs) are now operational in Great Yarmouth (two CDCs) and QEH in King's Lynn, with the NNUH CDC opening in February 2025. Ensuring a sustainable workforce to fully utilise these facilities will be crucial to maximising diagnostic capacity and improving system efficiency. Workforce shortages continue to be a major challenge, particularly in gastroenterology, cardiology, and sonography. Limited consultant availability, alongside staff reluctance to take on additional sessions, continues to constrain service capacity and delay recovery efforts. Workforce challenges are having particular impact in MRI, CT, Non-Obstetric Ultra-Sound, Cardiac CT and Endoscopy.

To support the transformation of diagnostic services, a Diagnostics Working Group (DWG) will act as a system-wide forum for coordinating developments, improving efficiency, and reducing waiting times. The DWG will focus on aligning diagnostic capacity with elective recovery targets, supporting workforce planning, and overseeing demand and capacity modelling. The group will also explore funding opportunities, including NHS England and regional investments, to optimise these centres.

Davey Heidi
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Despite these challenges, improvements in scheduling, booking processes, and DNA management are beginning to have a positive impact. Some trusts have

reported reductions in long-wait RTT and diagnostic breaches, but demand continues to outpace available capacity in several areas.

3. Maternity, Neonatal and Women's Health

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?	N	Which Committee has risk oversight?	N/A

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.

Women's Health Hub is now fully implemented, therefore reporting has been removed.

4. Mental Health

Is there a recovery trajectory?	Y	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: Target achieved for December 2024 but work continues to ensure consistent compliance.

Dementia diagnosis: Work continues at Norfolk and Suffolk Foundation Trust to improve Dementia Assessment and Treatment Service, but clinical capacity has impacted rates in the current quarter. Demand for Assessments has also increased significantly.

Key ongoing activities include assessment session optimisation, embedding a new Standard Operating Procedure (SOP) and empowering service managers (post NSFT restructure) to deliver change.

Additionally, a Regional NHSE Team Event in Norwich (10/3) has also promoted further collaboration and ambition to enhance integration of ICS-wide diagnosis and support services across health, social care, local authorities, and VCSE. Next steps will be picked up at ICBs Ageing Well Dementia Programme meeting.

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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 January 2025, year-on-year delivery at 55.2% 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.

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. There are five discharges planned for March 2025 and a further discharge planned in April 2025 dependent on a Tribunal hearing outcome. Properties continue to be progressed via NHS England capital bid monies through Registered Social Landlords and a tender process for identifying providers on Norfolk County Council framework is due to begin April 2025. 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. The Health Inequalities team are working with Data and Analytics team to respond to nationally required publications and incorporate these views of system equity levels into routine review.

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.

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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

GP appointments: Norfolk & Waveney data shows an increase in the number of appointments within 2 weeks, with 81.9% seen within 2 weeks during January 2025. The number of face-to-face appointments being offered in Norfolk & Waveney continues to be higher than the national average and patient satisfaction is high. Recent work has been undertaken to review the total number of GP appointments in an effort to understand the 19% increase in total GP appointments being offered over the past 5 years. It should be noted that:

- The mode of delivery of appointment has changed in its make up in the last 5 years with 'Telephone' seeing the biggest % increase and online appointments doubling; we are still at a very high % for face to face.
- The clinician type has changed dramatically with the number of GP appointments hardly changing in 5 years, with most of the additional 1.2m appointments being delivered by other staff (most likely ARRS staff).

Dental: The national performance target for dental access is to restore activity to pre-covid levels. Activity achievement for 2024/2025 is forecast to be higher at year end than previous year based on delivery mid March 2025 which is higher than full year effect for 2023/2024. With a shift towards flexible commissioning and use of sessional payments for new pathways including access improvement, the national UDA target to restore to 2019 levels will be a challenge to meet. Using "number of new patients" as a measure of success is preferred outcome measure by the ICB. New patient data is available monthly from the BSA Data Services team for the ICB to monitor trends and activity. Workforce challenges remain a key risk factor.

Community Services: Work remains ongoing to test and refine the new data dashboard for community services. Once assured of the data completeness and quality, this dashboard will aid in identifying areas of challenge and opportunity. Overall, the services are meeting waiting time requirements, but there are a few areas such as wheelchairs or Children and Young People neurodevelopmental which have long waiting times. For these services, joint commissioner and provider working groups are taking place to plan recovery.

8. Urgent and Emergency Care

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

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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. Ambulance C2 response times are better than this time last yeast but above the 30min target.

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 into 25/26 with work continuing to improve and expand the service.

All three acute sites are looking to deliver improved ambulance handover, within 45mins by the end of February 2025, noting QEH and NNUH commenced December 2024. A range of actions are in place to support the delivery ranging from internal flow and process elements to system support in areas such as discharge.

There has been sustained pressure during January elongating handover times and creating variation, additional actions are in place in order to support resetting the position of occupancy and flow across our acute partner sites. 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. Additional actions are in place related to creating acute hospital flow, that compliments the ongoing transformation programmes but at an operational level. Priorities for next years UEC alliances consolidates further focus on key areas of patient flow across the 3 domains of community, hospital and discharge.

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.

Dave Hall
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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 remain largely stable. Increases in NHS leavers during the fiscal year have been driven by organisational restructurings - most recently at NSFT- and are otherwise in line with national trends. Sickness absence has followed national trends and seasonal expectations and have tracked on average 0.1 percentage point above the national figure.

Recommendation to the Board / Committee:

To consider the current performance areas when considering: • Planning trajectories for 2025/26 planning submission • Risk review • Commissioning decisions

Governance

Committee Approval	Commissioning and Performance Committee Agenda Item, March 2025.

Davey, Heidi
24/03/2025 12:20:17

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Project Management across Norfolk and Waveney

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IPR: National Planning Metrics

NHS Norfolk and Waveney ICB Board, 26th March 2025

Davey Heidi
24/03/2025 12:20:17

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Contents

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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.

Waveney Adi
24/03/2025 12:20:

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. This will be brought into the new IPR as appropriate.
- 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. A dashboard has been developed and requires testing for data accuracy and quality of capture.
- Women's Health Hub and PSIRF have been fully implemented and therefore reporting against these areas has been removed as the position remains static.

Davey Heidi
24/03/2025 13:00:17

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

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Metrics that are underachieving against plan / local trajectory

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Delivery area	Metric – national planning objective metrics (24/25) that show cause for some concern	Target (local trajectory target as appropriate)	Actual (to latest reporting period, as per linked slide)	Linked slide
Cancer	62-day standard to 70% by March 2025	68.1%	65.2% (Dec '24)	Slide 8
	28-day Faster Diagnosis Standard to 77% by March 2025	75.4%	71.2% (Dec '24)	Slide 9
	Increase the percentage of cancers diagnosed at stage 1 and 2 to 75% by 2028	75%	56.2 % (12m to Sept '24)	Slide 10
Diagnostics and Elective	Diagnostic tests within 6 weeks at 95% by March 2025	95%	70% (Dec '24)	Slide 12
	Eliminate waits of over 65 weeks for elective care by September 2024	0	536 (Dec '24)	Slide 13
Mental Health	Achieve the Dementia Diagnosis Rate by March 2025	63.8%	62.% (Jan '25)	Slide 25
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	31	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	Increase	Slide 42
UEC	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025 – note data issues	80%	71.7% (Jan '25)	Slide 44
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	18 min (30 min interim)	41.6 min (Jan '25)	Slide 45
Use of Resources	Reduce agency spend to a maximum of 3.2% of the total pay bill across 24/25	£41.2m	£42.7m (Forecast year)	Slide 50
	Deliver a balanced financial position for 24/25	£0	£59.3m (Jan '25)	Slide 51

Davey Heidi
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National Planning Metrics – overview (1/2)

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Area	Objective	Date	ICB/ICS	Has Plan	Reporting Value	On Plan	On Target	Capability	Variation
Quality and Patient Safety	Implement the Patient Safety Incident Response Framework (PSIRF)		ICB						
Urgent and Emergency Care	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	January 2025	ICB	✓	71.7%	✗	✗	F	
Urgent and Emergency Care	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	January 2025	ICB	✗	41.6		✗	F	
Primary and Community Services	Improve community services waiting times, with a focus on reducing long waits	November 2024	ICB	✓	479	✗			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	January 2025	ICB	✓	81.9%	✓			
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)	December 2024	ICB	✓	536	✗	✗	F	L
Elective Care	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	September 2024	ICB	✓	118.9%	✓	✓		
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	January 2025	ICB	✗	46.4%		✓	?	H
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	December 2024	ICB	✓	65.2%	✗	✗	F	
Cancer	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	December 2024	ICB	✓	71.2%	✗	✗	?	H
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%	December 2024	ICB	✓	70.0%	✗	✗	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						
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	✓	✓		

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24/03/2025 12:20:17

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National Planning Metrics – overview (2/2)

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Area	Objective	Date	ICB/ICS	Has Plan	Reporting Value	On Plan	On Target	Capability	Variation
Mental Health	Increase the number of people accessing perinatal mental health (to 66,000)	December 2024	ICB	✓	1,100	✓	✓	?	H
Mental Health	Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)	December 2024	ICB	✓	15,325	✓	✓	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	December 2024	ICB	✓	68.9%	✓	✓	?	
Mental Health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	December 2024	ICB	✓	49.6%	✓	✓	?	
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	January 2025	ICB	✓	62.0%	✗	✗	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	January 2025	ICB	✗	57.1%		✗		
People with a learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population		ICB						
Prevention and health inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people		ICB						
Prevention and health inequalities	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025		ICB						
Prevention and health inequalities	Increase the percentage of patients aged 25-84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025		ICB						
Prevention and health inequalities	Increase vaccination uptake for children and young people year on year towards WHO recommended levels		ICB						
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention interventions		ICB						
Workforce	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors		ICB						
Workforce	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan		ICB						
Use of Resources	Deliver a balanced net system financial position for 2024/25	November 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	November 2024	ICS	✓	3.4%	✗	✗		

Davey Heidi
24/03/2025 12:20:17

Cancer – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Related Board Assurance Framework risk? (provide reference)
Improve performance against the headline 62-day standard to 70% by March 2025	68.1%	65.2%	Monthly	Dec '24	10/03/25	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	75.4%	71.2%	Monthly	Dec '24	10/03/25		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%	56.2%	Rolling 12 monthly	Sept '24	10/03/25		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 24/03/2025 12:20:17

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

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

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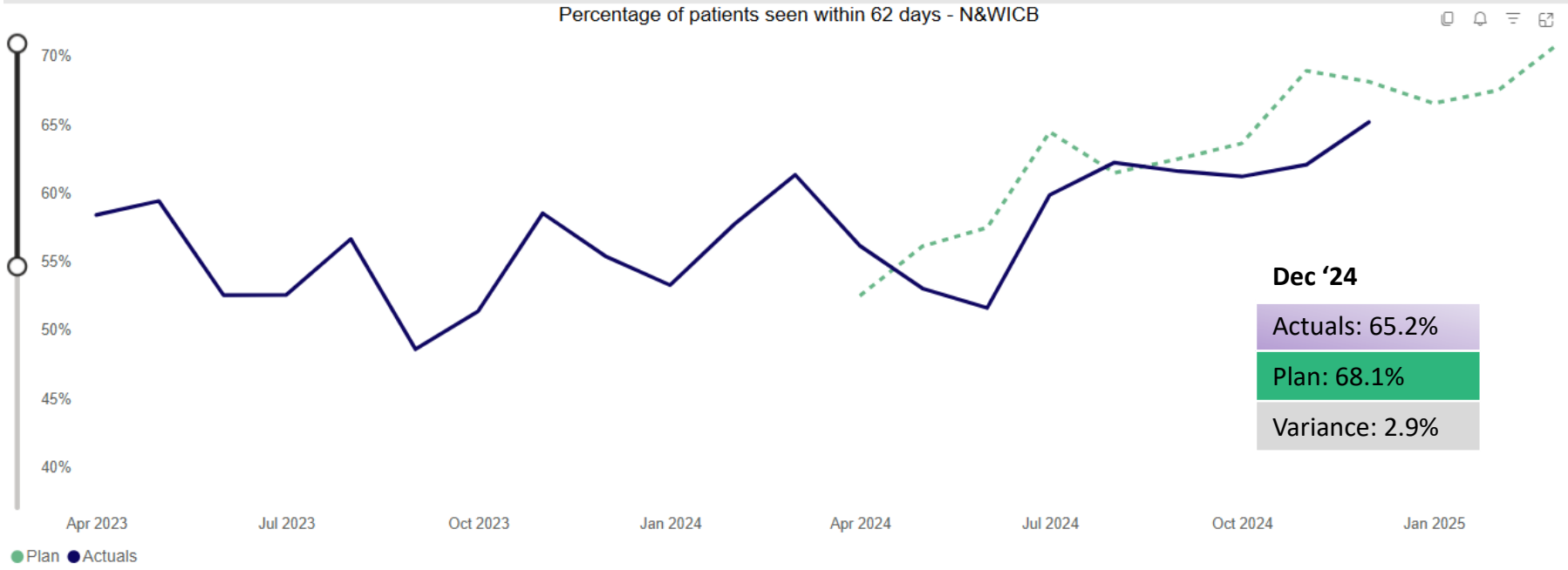
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Dec 24	65.2%	68.1%	14	59.1%	61.6%	114	70.8%	

Description of the metric

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

Description of performance

62-day performance at 65.2% against the trajectory of 68.1% for December 2024, performance is improving. However, all but the breast, haem and skin pathways remain 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 up to end of March 2025, 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.	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. Trajectories for 2025/26 being submitted as part of the operational planning process.	The continued surges in Urgent Suspected Cancer referral demand continue to provide a challenge for trusts to manage while clearing backlogs.

Daisy Heidi 24/03/2025 12:20:17

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

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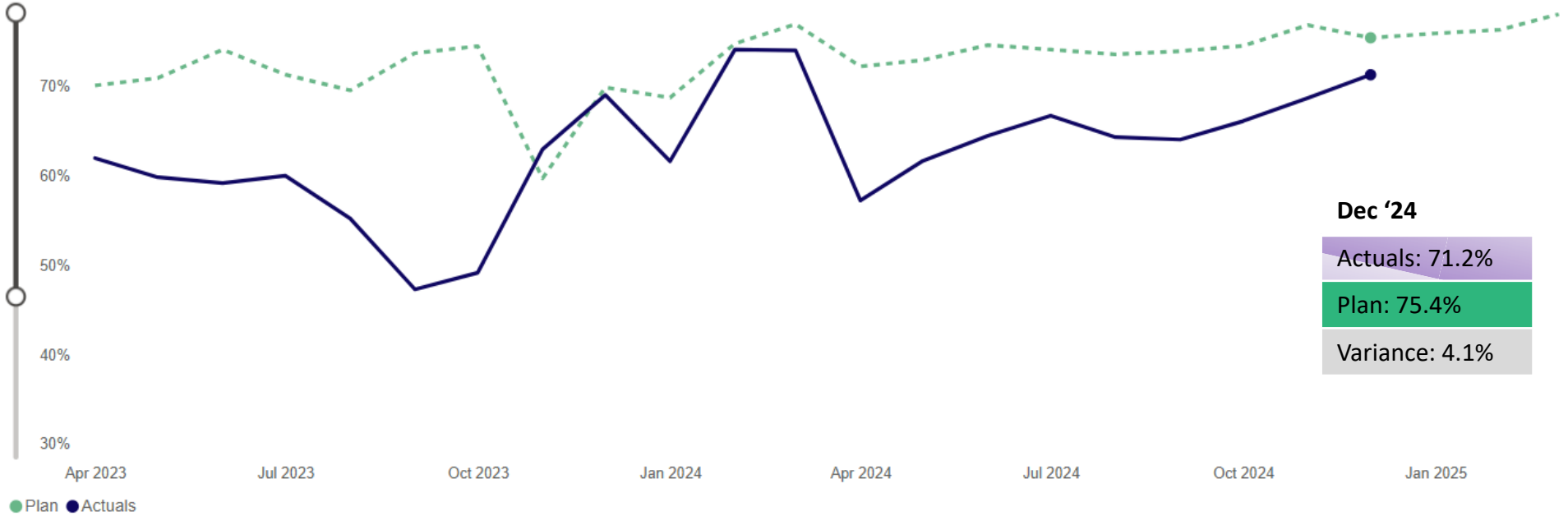
Link back to overview of underachieving metrics slide

Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following - N&WICB



Dec '24

Actuals: 71.2%

Plan: 75.4%

Variance: 4.1%

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		Dec 24	71.2%	75.4%	220	64.9%	74.2%	4,816	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 71.2% against the trajectory of 75.4% for December 2024. This is an increase from prior reporting. Breast upper GI, skin, lung, children's and head and neck are performing well. The remaining challenged pathways vary across the trusts.

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 and variable implementation of best practice timed pathways (BPTPs).	Regional and national tiering support meetings, allocation of additional NHSE 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. C the Signs pilot underway to improve quality in referrals	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. Trajectories for 2025/26 being submitted as part of the operational planning process.	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. The non-site-specific (NSS) pathway has been awarded an additional 6 months funding from April 2025 with a new business case required for future options.

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

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Link back to overview of underachieving metrics slide

Around 56% of patients are diagnosed at an early stage in N&W
Breast and **malignant melanoma** have the highest early stage proportions
The **upper GI** cancers have the lowest early stage proportions
The % of unknowns has improved from 27% in 2019 to 20% in 2023

	Trend: Oct-23 to Sep-24	Latest Rolling 12 Months	Forecast for March 2025 (+3% based on rolling 12 month data up to Oct 23)
BLMK		64.9%	67.6%
C&P		59.9%	63.9%
HWE		61.4%	63.3%
MSE		57.9%	56.5%
N&W		56.2%	60.5%
SNEE		62.7%	62.8%
East of England		60.3%	62.3%

This trajectory is managed by the East of England Cancer Alliance and last refreshed 17 February 2025.

N&W view of early diagnosis by Cancer pathway

	Latest rolling 12-months Oct-23 to Sept-24	Stage 3	Stage 4	Late Stage	Unknown %	Early %	Late %	All Staged Diagnoses
Broad Groups	Prostate	349	181	531	14%	50%	50%	1,063
	Lung	150	338	488	5%	39%	61%	977
	Colorectal	217	121	338	20%	47%	53%	676
	Oesophago-gastric	42	151	193	17%	23%	77%	388
	Breast	82	75	158	8%	84%	16%	316
	Upper GI excl OG	29	97	126	26%	20%	80%	253
	Haematological	26	89	114	44%	29%	71%	230
	Gynaecological	72	39	112	18%	59%	41%	224
	Urological excl prostate	44	32	77	54%	69%	31%	155
	Melanoma	26	7	33	9%	91%	9%	67
Detailed Groups	Oesophageal	34	120	154	12%	24%	76%	309
	Pancreatic	29	97	126	26%	20%	80%	253
	Non-Hodgkin lymphoma	20	77	96	46%	24%	76%	194
	Ovarian	45	28	73	29%	27%	73%	147
	Kidney	24	22	47	43%	58%	42%	95
	Stomach	9	31	39	34%	19%	81%	80
	Uterine	28	11	39	10%	77%	23%	78
	Bladder	20	10	30	60%	78%	22%	61
	Hodgkin lymphoma	5	8	13	29%	57%	43%	27
	Other	1	4	5	65%	0%	100%	12

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 September 2024 Norfolk and Waveney achieved 56.2% earlier diagnosis. This has decreased slightly from 56.6%. The current trajectory shows a forecast position of 60.5% for Norfolk and Waveney by March 2025.

Davey, Heidi 24/02/2025 12:29:17

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 2025. ED and Screening engagement event held January 2025. Organising to meet with all three acute trusts to discuss a review of staging completeness.	Cancer Transformation Oversight Group.	National trajectory in place. System trajectory for 25/26 target is part of planning for next year's programme with PH support.	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%	Monthly	Dec '24	11/03/24	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	0	536	Monthly	Dec '24	11/03/24		No	BAF07 – Elective Recovery
Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	103.1%	118.9%	Monthly	Nov '24 (see slide 14)	11/03/24		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%	45.7%	Monthly	Jan '24	11/03/24		No	BAF07 – Elective Recovery
Improve patients' experience of choice at point of referral	-	-	See slide 16		11/03/24		No	BAF07 – Elective Recovery
Local Metrics as indicated by exception								

Reviewed 04/03/2025 12:20:17

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

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

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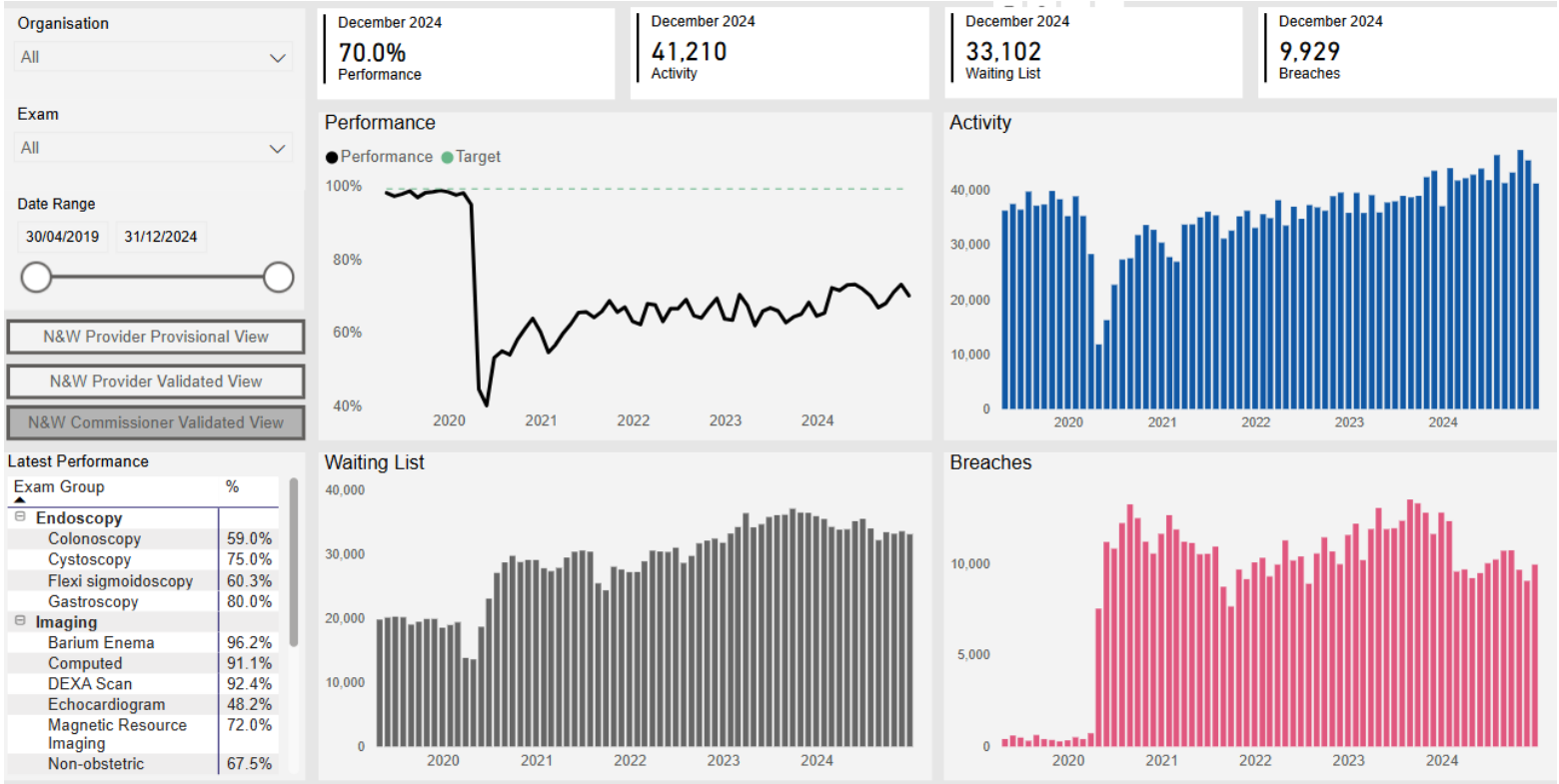
Link back to overview of underachieving metrics slide



Description of the metric

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

Description of performance

The overall performance for December 2024 (70.0%) remains below the national target, showing significant variation across providers. This represents a decline from 73.1% in the previous month.

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):
• Workforce Shortages • Demand & Capacity • Financial constraints	• Workforce: Ongoing recruitment, additional Clinical Support, locum coverage, upskilling existing staff to expand coverage. • Provider Performance and Planning Oversight Group establishing working group to cover diagnostics. • Demand & Capacity: Insourcing initiatives, mobile MRI service brought in at NNUH, Central Norfolk CDC opened end of Feb. • Strategic conversations: Ongoing system conversations are taking place to address audiology backlog challenges.	• Provider Performance and Planning Oversight Group (PPPOG). • Scheduled Care Board.	31/3/2025	• Ongoing staff shortages. • Funding constraints may limit the feasibility of increasing capacity. • Ongoing increase in demand in Audiology and Endoscopy. • Upskilling existing staff may take time to implement.

Davis, Helen
24/03/2025 12:20:17

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

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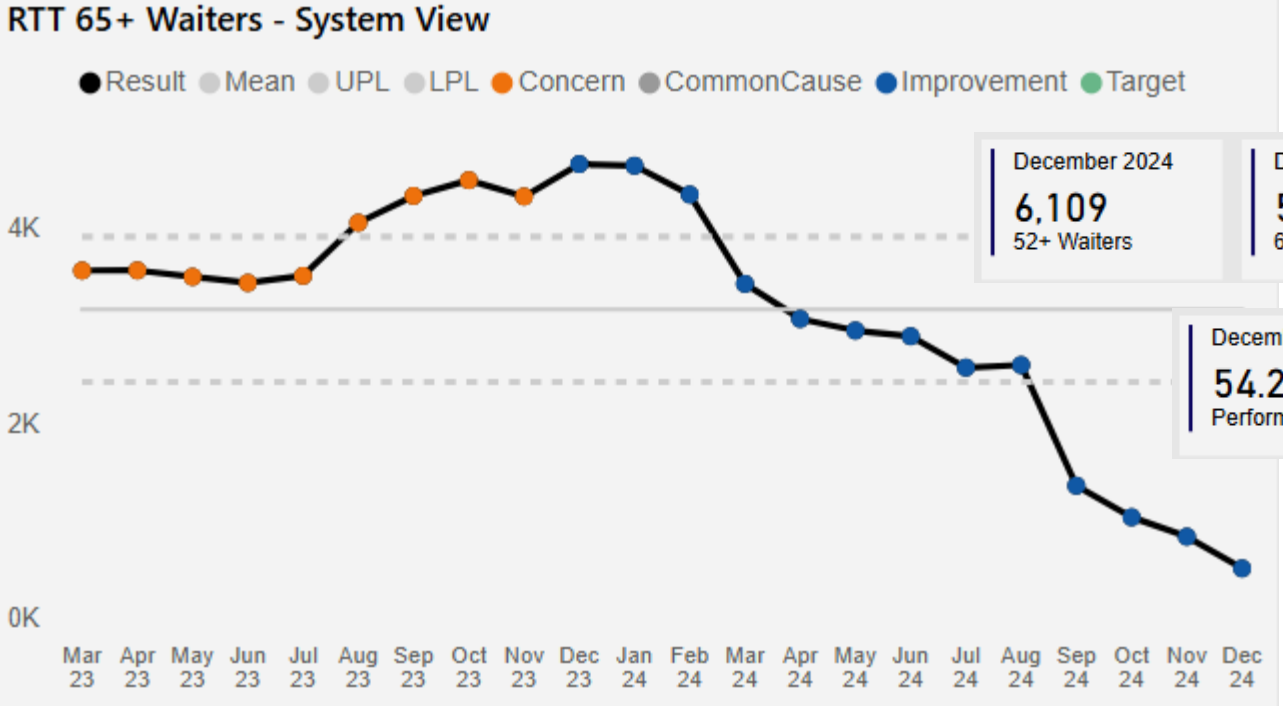

December 2024	December 2024	December 2024	December 2024
6,109	536	56	0
52+ Waiters	65+ Waiters	78+ Waiters	104+ Waiters

December 2024	December 2024	December 2024
54.2%	144,007	65,911
Performance	RTT Incomplete Pathways	RTT Breaches

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

Significant progress has been made, however, as of December 2024, the NNUH & JPUH still have waits exceeding 65 weeks.

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):
• Patient and Consultant sickness • Complexity of cases • Financial Constraints	• Wait List validation • 6-4-2 meetings re-embedded at JPUH. Cancellation of elective patients approved by COO only. • PTL oversight weekly / monthly including with Independent Sector Providers. Increasing oversight of ISP. • Provider Performance and Planning Oversight Group establishing working groups to cover productivity and demand management.	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	April 2025	• Short-term sickness • Funding constraints can limit the feasibility of increasing capacity. • Limited Specialist Availability

Daney Jeldi
07/03/2025 12:20:17

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

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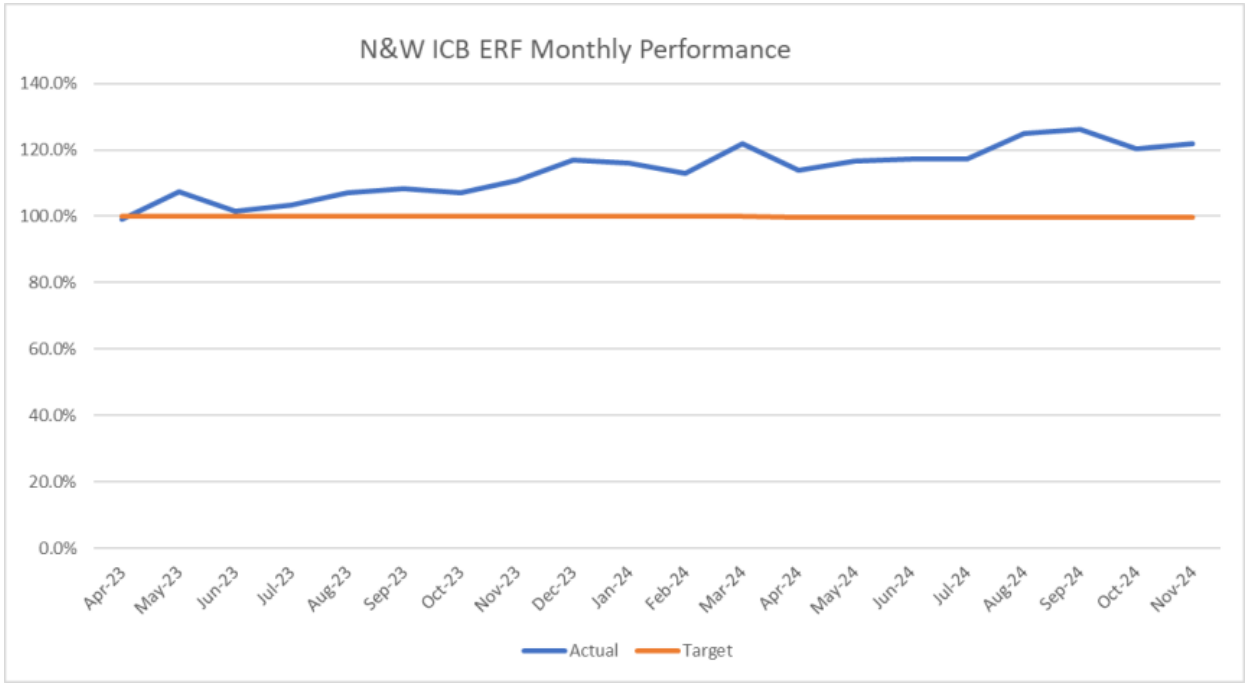

Link back to overview of underachieving metrics slide

Description of the metric

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

Description of performance

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

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Current backlog exceeds 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 • Weekend insourcing. • Use of ISP's. • 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	• ER Funding capped. • Patients being too complex safely to Independent Sector Providers • Not being unable to recruit for the Surgical Hubs and Community Diagnostic Centres. • Financial restraints

Daley, Heidi
21/03/2025 12:10:17

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

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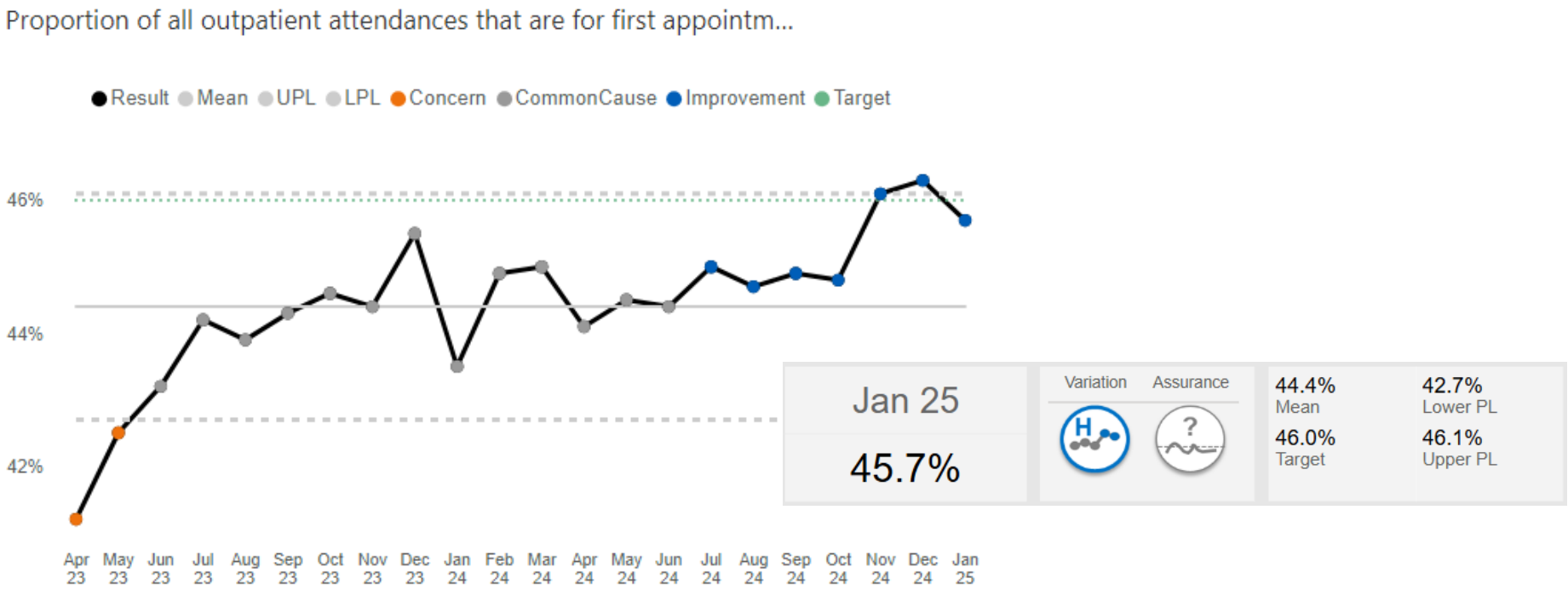
Link back to overview of underachieving metrics slide



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.
0.3% 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 all three Trusts. • 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 and demand management.	• 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.

Davey, Heidi 24/01/2025 12:20:17

PMO
Project Management across Norfolk and Waveney

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

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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.

Davey, Heidi
24/03/2025 13:30:17

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

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Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to implement the Three-year delivery plan for maternity and neonatal services	25/26	On track	Bi-annual	Sep 24	07/03/25	LMNS	No	No
Progress towards the national safety ambition	-	-	Bi-annual	-	07/03/25	LMNS	No	No
Increasing fill rates against funded establishment (less than 9% vacancies)	<9%	0.52%	Quarterly	Dec 24	07/03/25	LMNS	No	No
Local Metrics as indicated by exception								

Davey,Heidi
24/03/2025 12:20:17

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

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Project Management across Norfolk and Waveney

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

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

Link back to overview of underachieving metrics slide

Description of the metric

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

Description of performance

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

Daven Kandi 24/03/2025 15:20:07

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

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Project Management across Norfolk and Waveney

National KPI: Progress towards the national safety ambition

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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):

Daney, Heidi
14/03/2025 12:20:17

PMO
Project Management across Norfolk and Waveney

National KPI: Increasing fill rates against funded establishment

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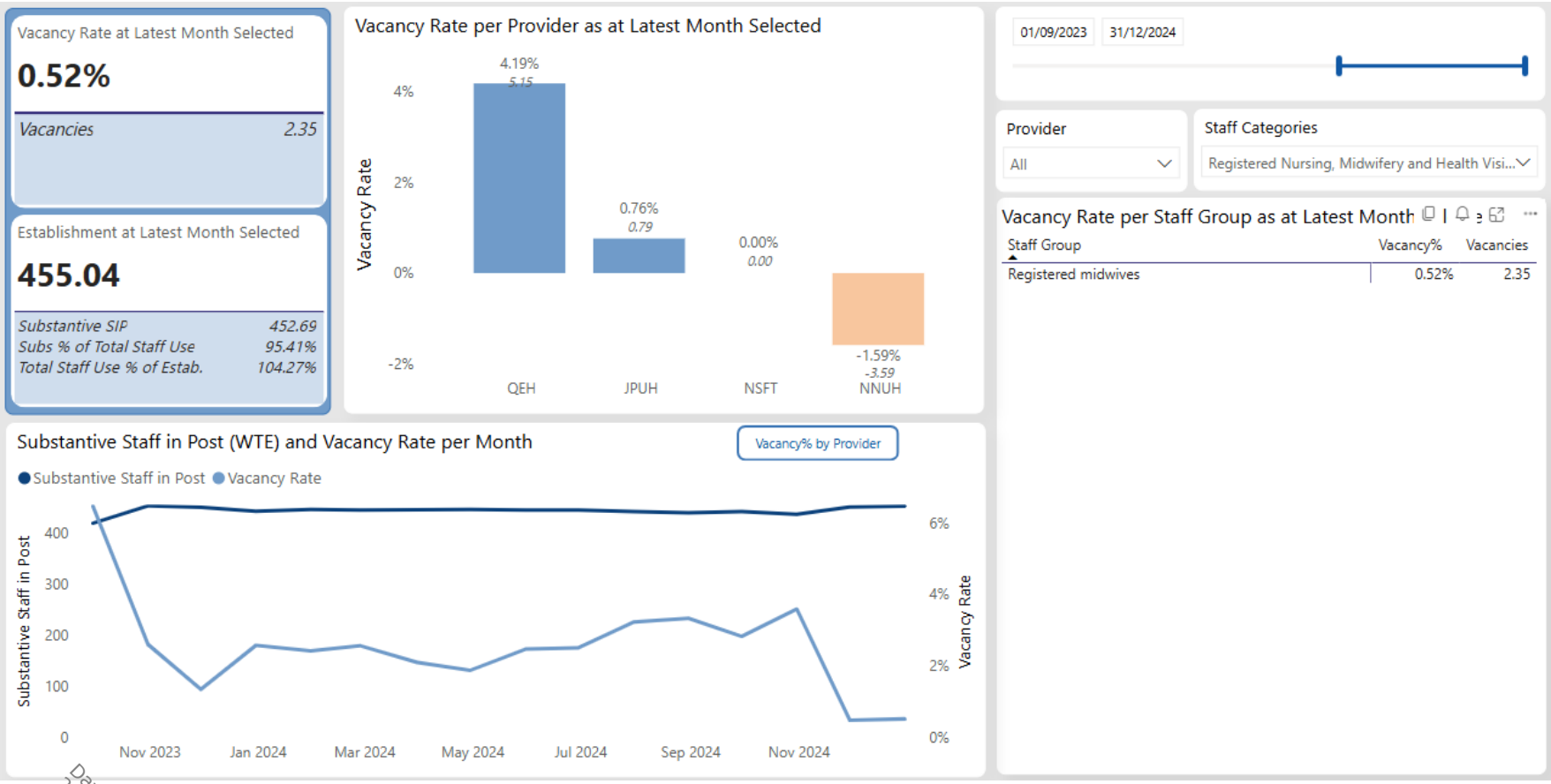

Davey Heidi
24/03/2025 12:20:17

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 18 March 2025

Vacancy rate 0.52%

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			

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	2	0	Monthly	Dec '24	11/03/25	Mental Health Integrated Delivery Group (Governance under review)	no	BAF04
Increase the number of people accessing perinatal mental health (to 66,000)	1,016	1,100	Monthly	Dec '24	11/03/25		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%	63.7%	Quarterly	Q3 24/25	11/03/25		no	BAF04
Increase the dementia diagnosis rate to 66.7% by March 2025	63.8%	62.05%	Monthly	Jan '25	10/03/25		no	BAF04
Increase the number of people accessing transformed models of adult community mental health (to 400,000)	9,735	11,090	Monthly	Dec '24	10/03/25		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) 1,041 48% 67%	1,175 49.6% 68.9%	Monthly	Dec '24 Dec '24 Dec '24	10/03/25		no	BAF04
Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)	13,242	15,325	Monthly	Dec '24	10/03/25		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.

PMO
Project Management across Norfolk and Waveney

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

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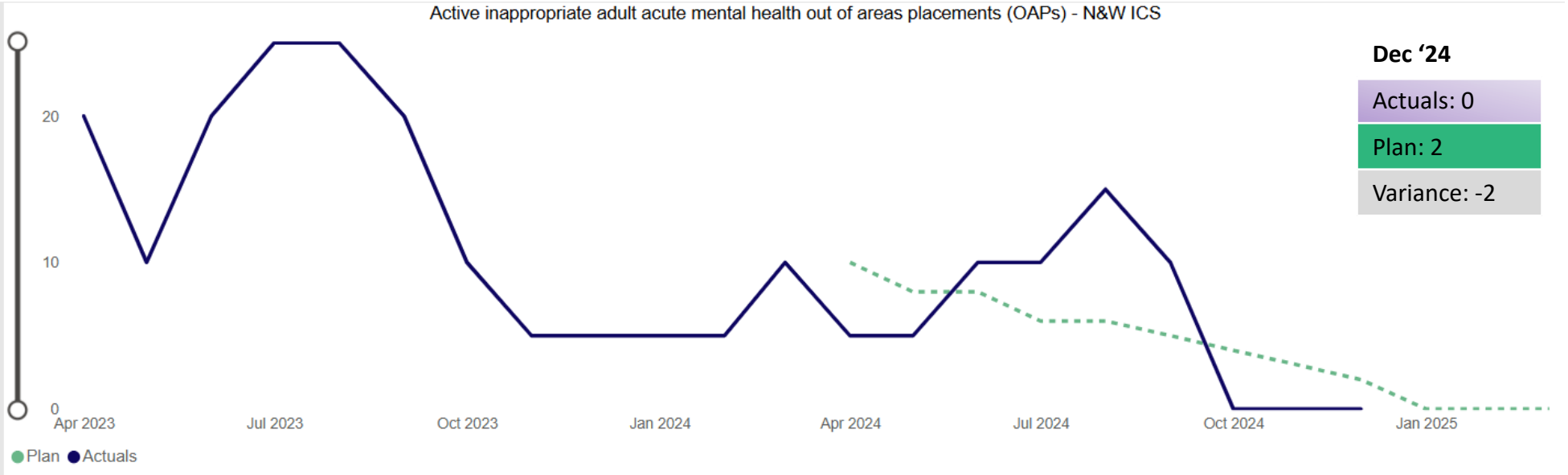
Link back to overview of underachieving metrics slide



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 was achieved but work continues to ensure compliance

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):
• 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

Davey, Heidi 24/03/2025 17:20:17

PMO
Project Management across Norfolk and Waveney

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

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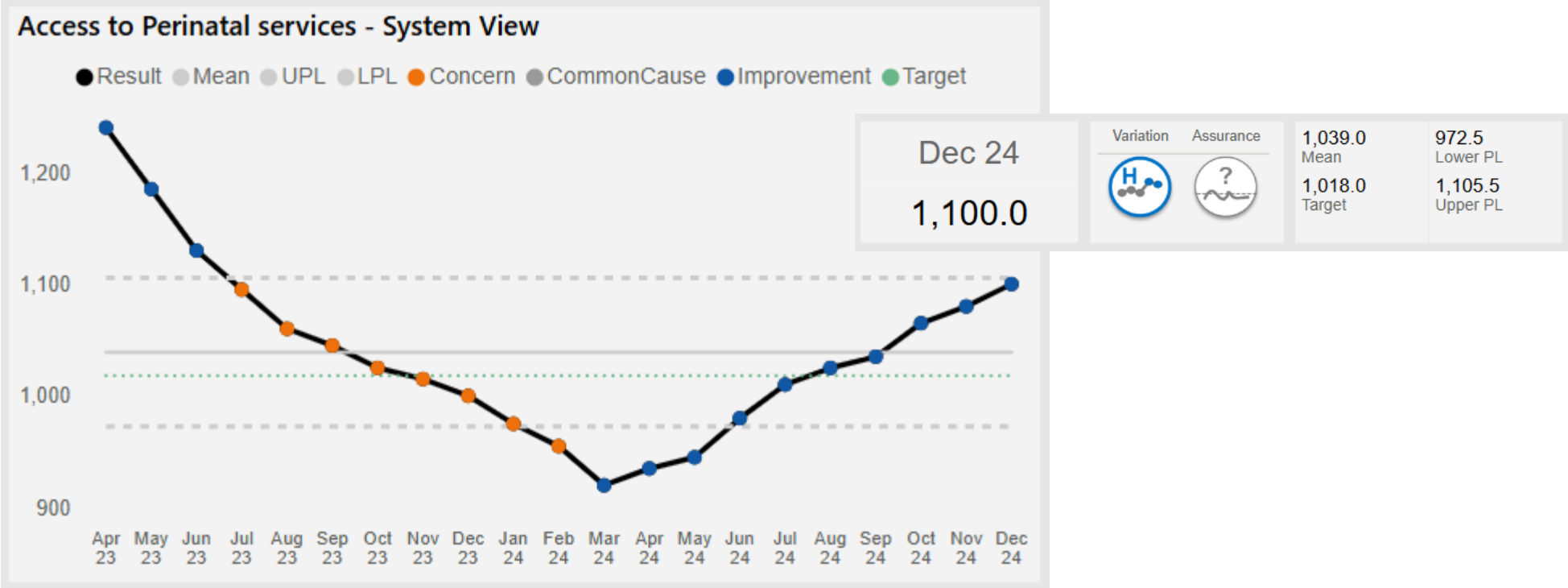
Link back to overview of underachieving metrics slide



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 above the target of 1,018

Davey, Heidi
24/07/2025 12:20:17

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

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

PMO
Project Management across Norfolk and Waveney

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

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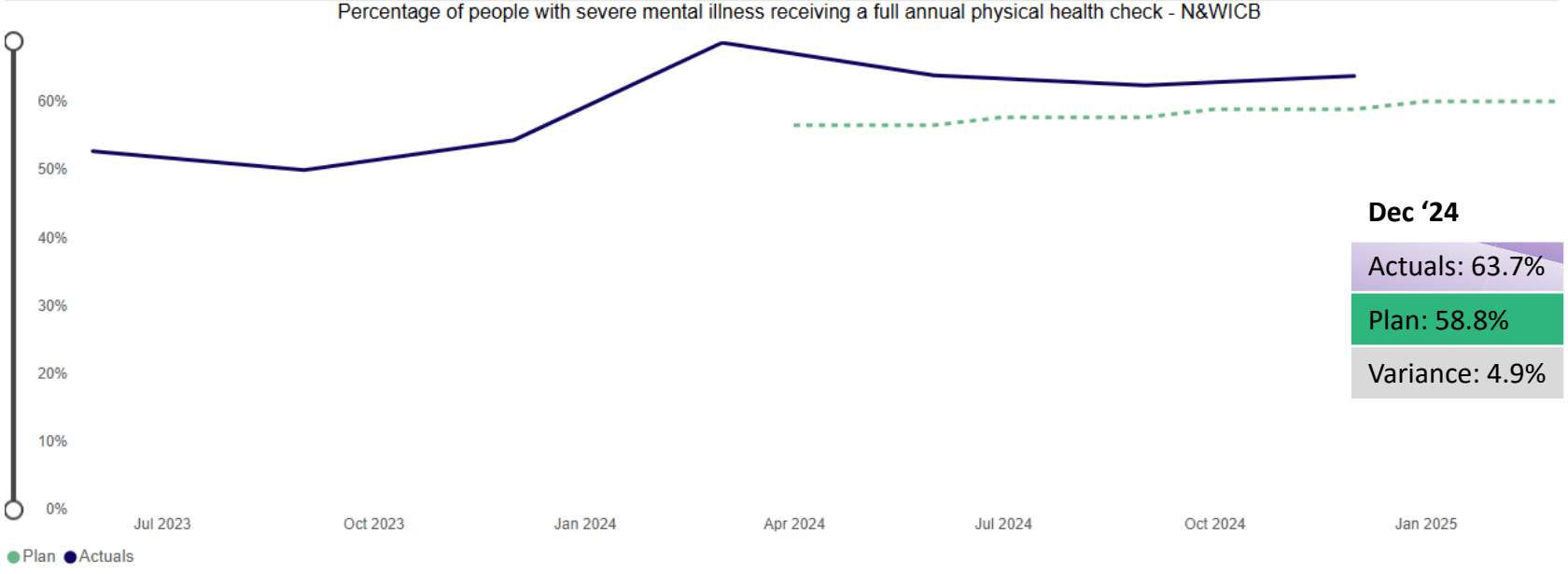
National transition of data extraction for the Physical Health check for SMI will be undertaken through GPES from Q1 24/25, replacing the PHSMI SDCS. The below shows a system position that is not shown in national reporting.

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		Dec 24	63.7%	58.8%	-	-	-	-	60.0%	

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%.
The data included in the slide includes those recorded for our patients including those reported through GP Practices and by NSFT. This differs from the nationally published data which only represents GP activity.

Description of performance

The service is meeting target as at Q3.

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

Davey.heidi 24/03/2025 12:20:17

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

PMO
Project Management across Norfolk and Waveney

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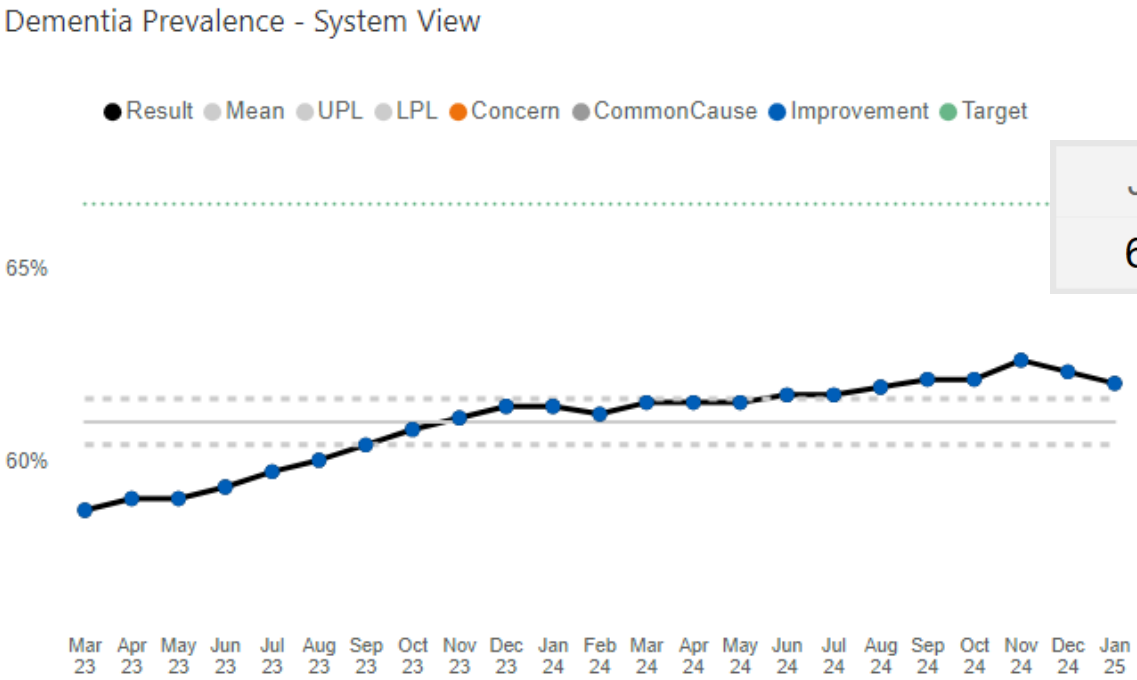
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Jan 25	Variation	Assurance		
62.0%	H	F	61.0% Mean 66.7% Target	60.4% Lower PL 61.6% Upper PL

Jan '25

- Actuals: 62.05%
- Plan: 63.8%
- Variance: 1.7%

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 remain committed to achieving 63.8% plan in 24/25. The current rate of 62.05% remains above the mean for the period shown.

This is no longer a National KPI from April 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):
Significant Place variation, which is also replicated across Dementia Assessment Treatment Services (DATS). Clinical capacity has also impacted rates in the current quarter, whilst demand for Assessments has increased.	Key ongoing activities include assessment session optimisation, embedding a new Standard Operating Procedure (SOP) and empowering service managers (post NSFT restructure) to deliver change. A Regional NHSE Team Event in Norwich (10/3) has also promoted further collaboration and ambition to enhance integration of ICS-wide diagnosis and support services across health, social care, local authorities, and VCSE.	Mental Health Integrated Delivery Group		Delays to assessment session optimisation; embedding a new SOP to address diagnosis inefficiencies; and clinical recruitment challenges, impact delivery of in year plan to boost performance in line with agreed trajectory.

Davey Heidi 14/03/2025 19:20:13

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

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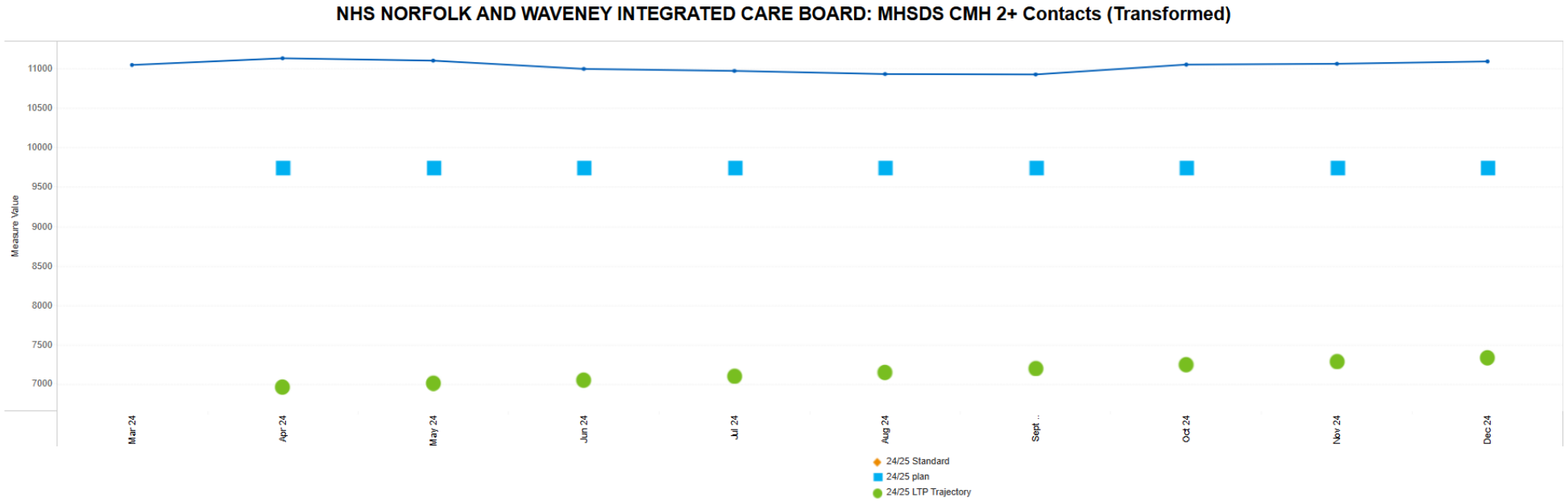
Link back to overview of underachieving metrics slide

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



Description of the metric

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

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

Description of performance

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

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

Received 24/03/2025 12:20:17

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Project Management across Norfolk and Waveney

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

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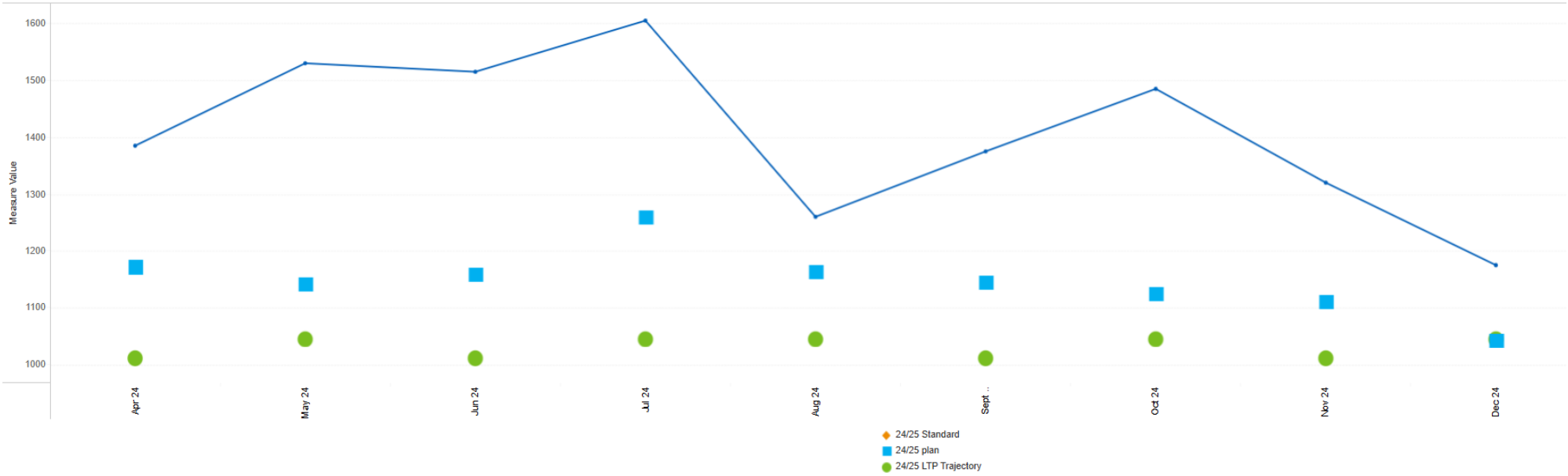
Nationally published data view used while local data feeds are re-established from the refreshed mental health data source.

Link back to overview of underachieving metrics slide

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



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

Description of performance
The service is currently meeting target

Davey Haidi 24/03/2025 13:20:17

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

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Project Management across Norfolk and Waveney

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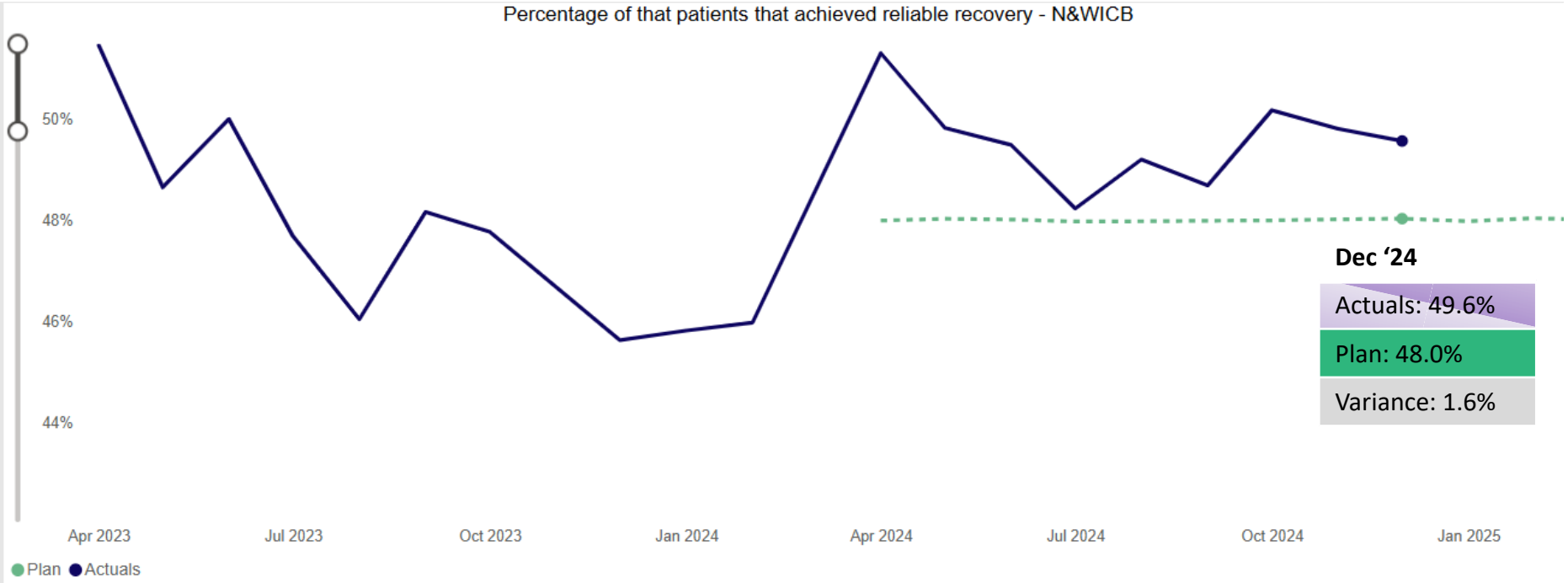
Link back to overview of underachieving metrics slide



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

Davey Haidi 24/03/2025 13:20:17

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

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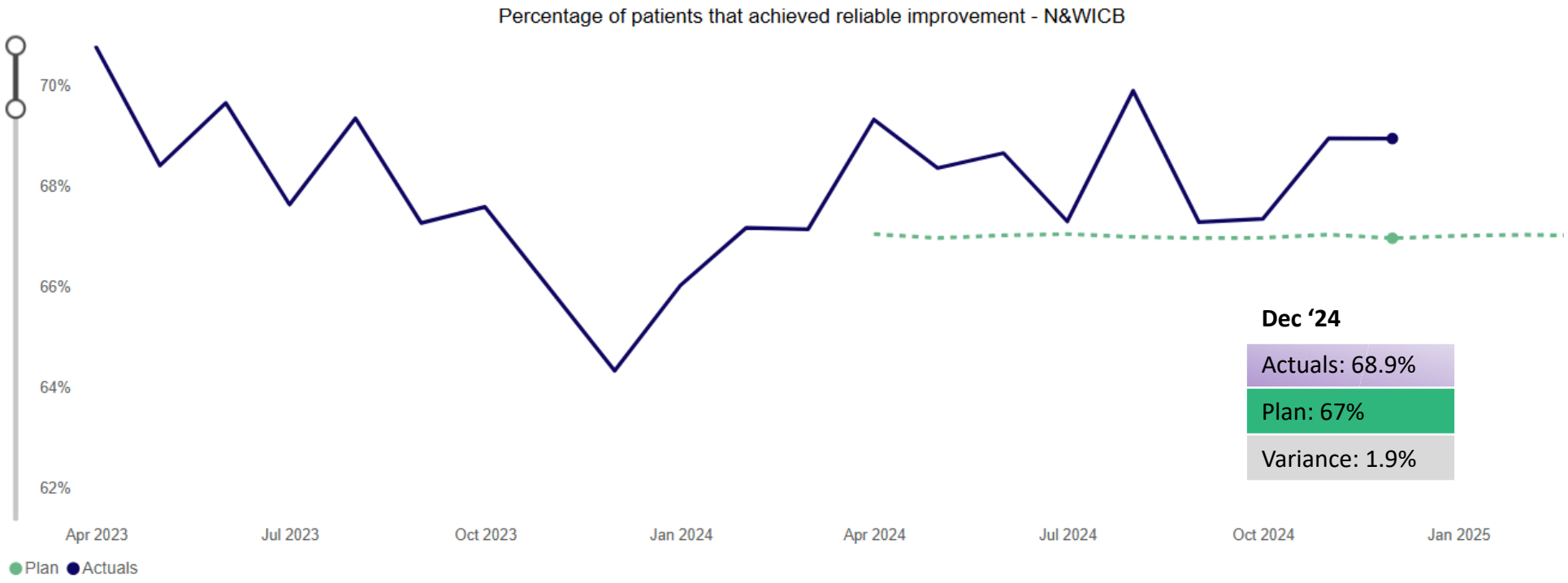
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Dec 24	68.9%	67.0%	-	68.9%	67.0%	-	67.0%	

Davey Haidi 24/03/2025 13:20:17

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

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

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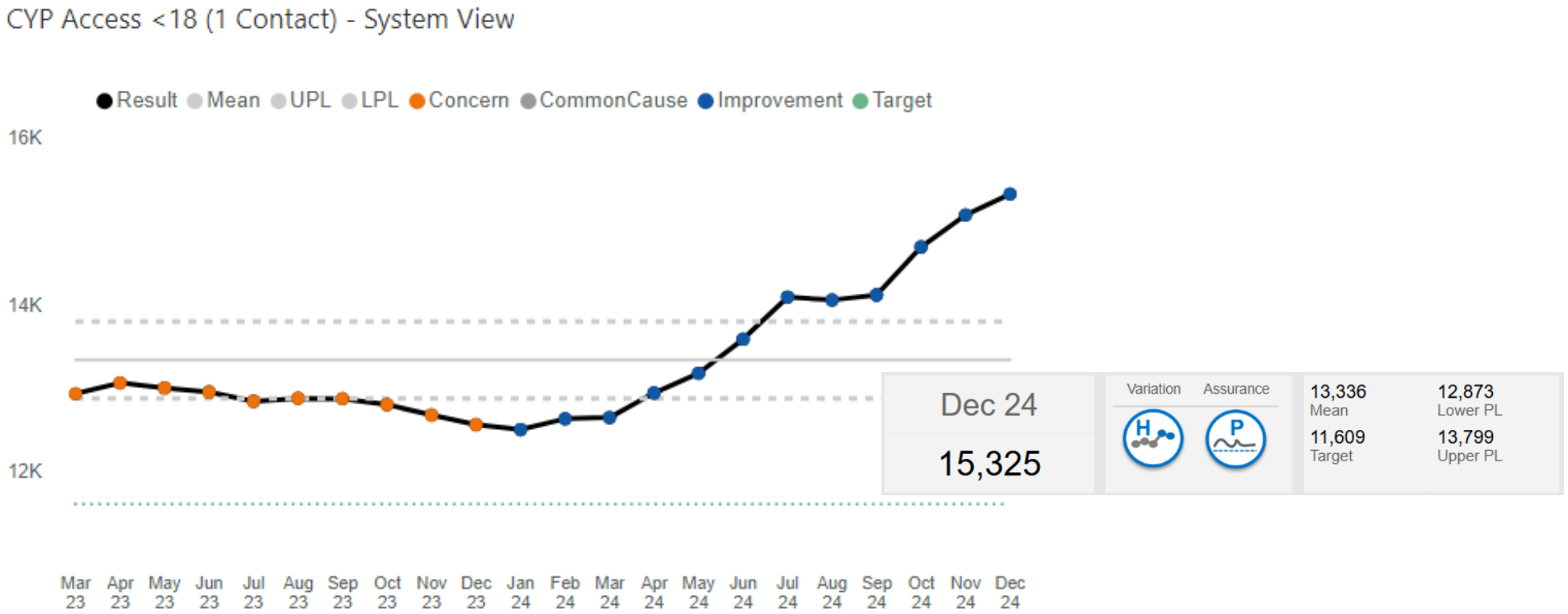
Link back to overview of underachieving metrics slide



Description of the metric

(345,000 is a national ambition)

In Norfolk and Waveney, the annual target for mental health access currently sits at 13,188 (see green dotted line to left)

Description of performance

December 2024 data shows continual over achievement of target with 15,325 CYP accessing mental health support, above a target of 13,188, during the rolling year. This is attributed to increased activity within the MHSTs and the Professional Therapeutic Pathway

Davey, Heidi
24/03/2025 12:20:17

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%	55.2%	Monthly	Jan '25	13/03/25	Learning Disabilities and Autism Programme Board	no	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	31	Monthly	February '25	12/03/25		no	

Local Metrics as indicated by exception

Davey Heidi 24/03/2025 12:20:17

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

PMO
Project Management across Norfolk and Waveney

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

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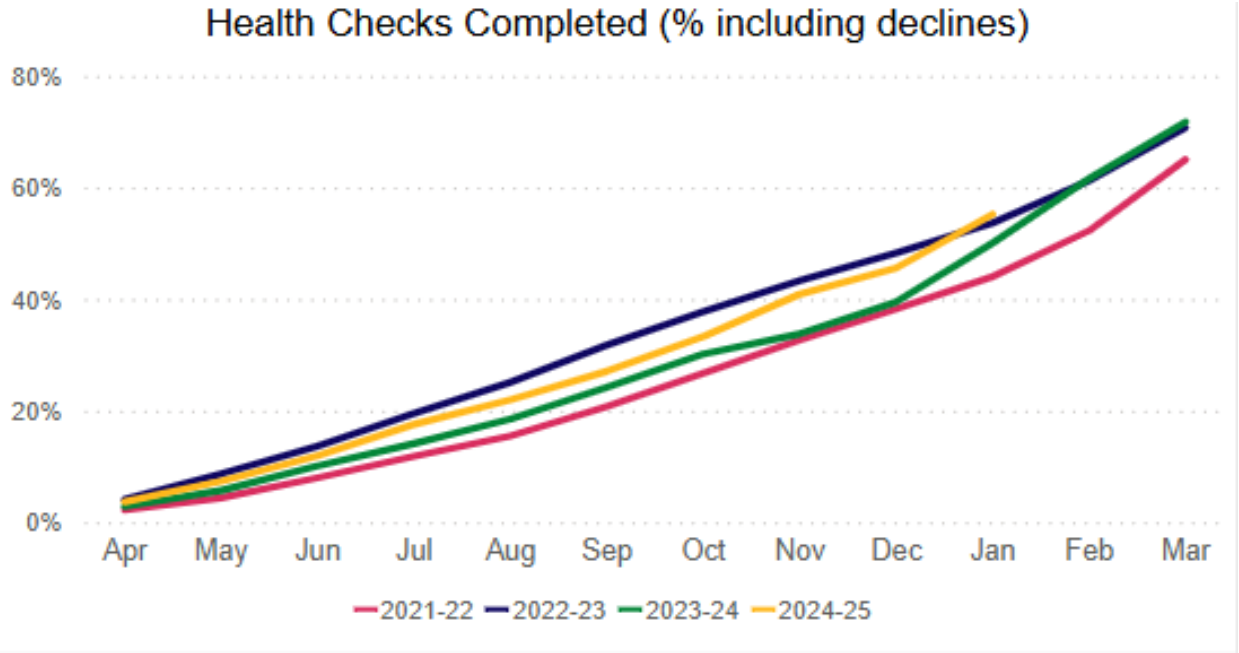
Link back to overview of underachieving metrics slide



As of the end of January 2025, 4,167 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 January 2025, delivery was 55.2% 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 January 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

Davies, Heidi
24/03/2025 12:20:17

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

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Link back to overview of underachieving metrics slide

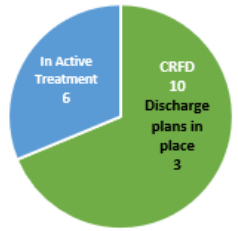
NWICB Adult Inpatients	2024									2025	
	Q1			Q2			Q3			Q4	
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Plan	12	12	12	12	12	12	12	12	12	12	12
Actual	12	13	14	14	14	14	20	17	15	16	16
Performance	0	1	2	2	2	2	8	5	3	4	4
Admissions	1	2	1	1	1	0	6	0	2	1	1
Discharges	4	1	0	1	1	0	0	3	4	0	1
Cumulative Admissions	1	3	4	5	6	6	12	12	14	15	16
Cumulative Discharges	4	5	5	6	7	7	7	10	14	14	15

NWICB Provider Collaborative Inpatients	2024									2025	
	Q1			Q2			Q3			Q4	
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Plan	11	11	11	11	11	11	11	11	11	11	11
Actual	17	17	17	16	14	14	14	14	15	15	15
Performance	6	6	6	5	3	3	3	3	4	4	4
Admissions	0	0	0	0	0	1	0	1	1	1	0
Discharges	0	0	0	1	2	1	0	1	0	1	0
Cumulative Admissions	0	0	6	0	0	1	1	2	3	4	4
Cumulative Discharges	0	0	0	1	3	1	4	5	5	6	6

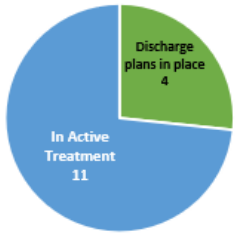
Tom Cahill, National Director of Learning Disability and Autism for NHS England has asked all regions for a push to ensure inpatient numbers are 10% less at end of year to 2023-24 totals.

This maximum figure was readjusted to 27 in January 2025 for our ICB.

ICB Current Status



Provider Collaborative Current Status



Description of the metric

Reducing the reliance on inpatient settings and enabling people with a learning disability and autistic people to live as independently as possible within their local community.

The target is 23 or below, split to:

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

Description of performance

Current position is 31, split to:

- ICB inpatient total: 16.
- 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 via funding jointly with NHS England and new care providers on the County Council framework working with Registered Social Landlords.	Norfolk County Council lead on identification of property and care providers in the community	12 to 18 months There are 5 discharges planned for March 2025.	Housing market conditions and identification of social registered landlords. Identifying care providers with required experience to support complex individuals and insurance issues for those with historic convictions for arson.

Darcy Hetts 11/03/2025 14:20:17

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	12/02/25	Population Health & Inequalities Board	no	BAF01
Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	80% by 31.3.25	67.1%	Quarterly	Sept 24	12/03/25	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	62.2%	Quarterly	Sept 24	12/03/25		no	BAF01
Increase vaccination uptake for children and young people year on year towards WHO recommended levels	95%	89% - 96%	Quarterly	Q2 25/26	12/03/25	Norfolk and Waveney Health Protection Assurance Board (Public Health)	no	
Local Metrics as indicated by exception								

Davey, Heidi
24/03/2025 20:17

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 address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people (CYP)

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Link back to overview of underachieving metrics slide

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

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

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

Description of the metric

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

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

Davey, Heidi
24/07/2025 12:20:17

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	

PMO
Project Management across Norfolk and Waveney

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

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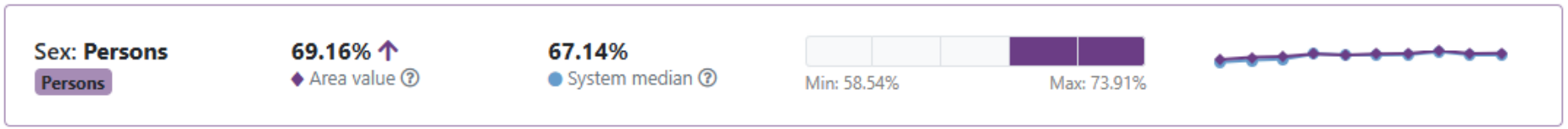
Link back to overview of underachieving metrics slide

Data for period: 12 months to Sept 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	69.16% ↑	67.14%		
Persons	◆ Area value	● System median	Min: 58.54%	Max: 73.91%



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 – Procurement commencing Mar 25.	- 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.

Davies Heidi 24/03/2025 12:20:17

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

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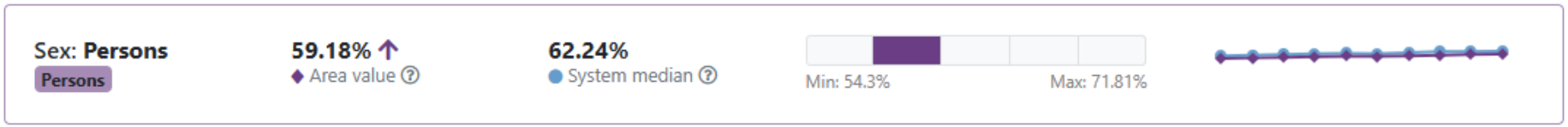
Link back to overview of underachieving metrics slide

Data for period: 12 months to Sept 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**	**59.18%** ↑	**62.24%**		
Persons	◆ Area value	● System median	Min: 54.3%	Max: 71.81%



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 Sept 2024: 59.18%.

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 – Procurement commencing Mar 25.	- 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.

Daven Heer
24/03/2025 11:20:17

PMO
Project Management across Norfolk and Waveney

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

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		23/24 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.

Dalton-Heidi 24/03/2025 12:20:12

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	81.9%	Monthly	Jan '25	12/03/25	Primary Care Commissioning Committee	No	
Improve community services waiting times, with a focus on reducing long waits	Improve	479	Monthly	Nov '24	12/03/25	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	Increase	Quarterly	Jan '25	12/03/25	Primary Care Commissioning Committee		
Local Metrics as indicated by exception								

Davey,Heidi 24/03/2025 12:20:17

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

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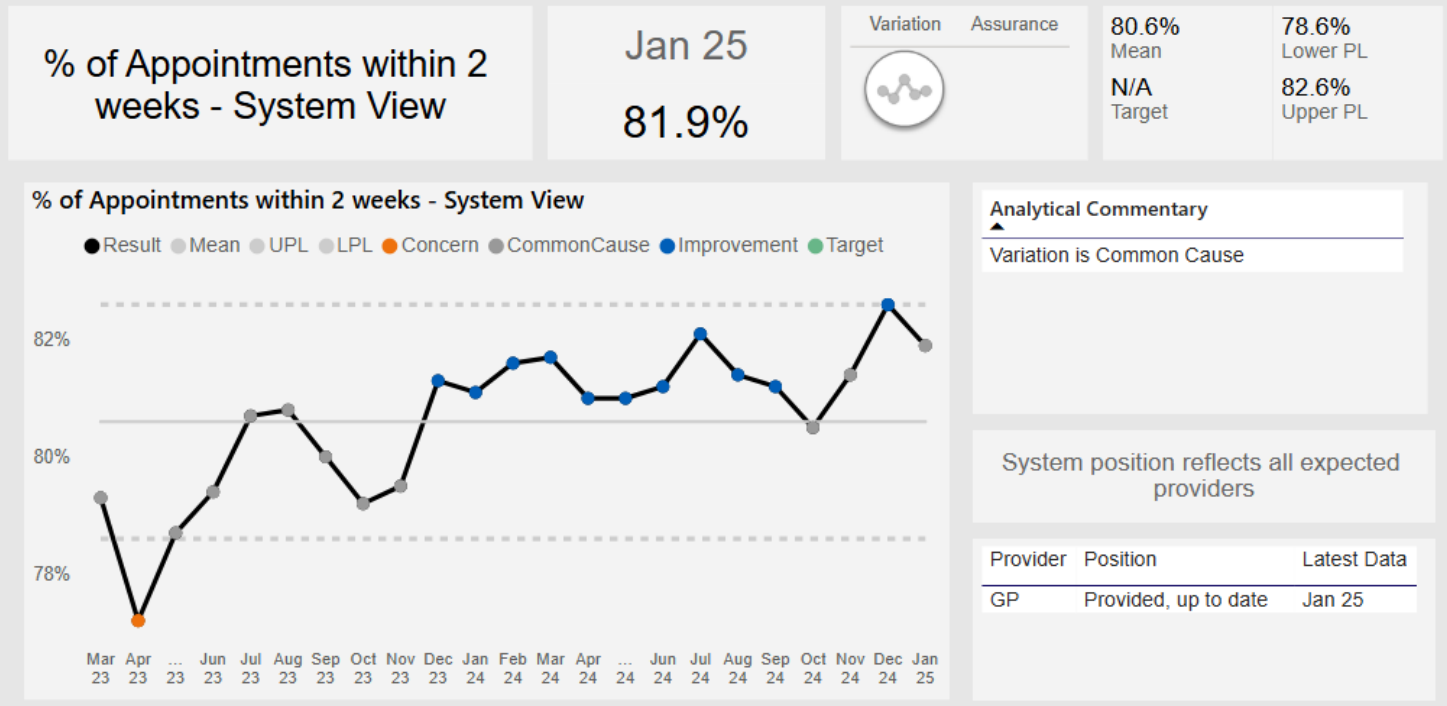
Link back to overview of underachieving metrics slide



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 January 2025, Norfolk and Waveney reported 81.9% 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)

Davey.Faidi 24/01/2025 12:20:11

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. Targeted local support programme (GPIP) being developed for 25/26 to implement Modern General Practice model	Primary Care Commissioning Committee Primary Care Commissioning Committee	End March 25 End March 25	Data consistency. Funding confirmation

PMO
Project Management across Norfolk and Waveney

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

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Link back to overview of underachieving metrics slide

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

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

Sovet Heidi
24/03/2025 12:20:17

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

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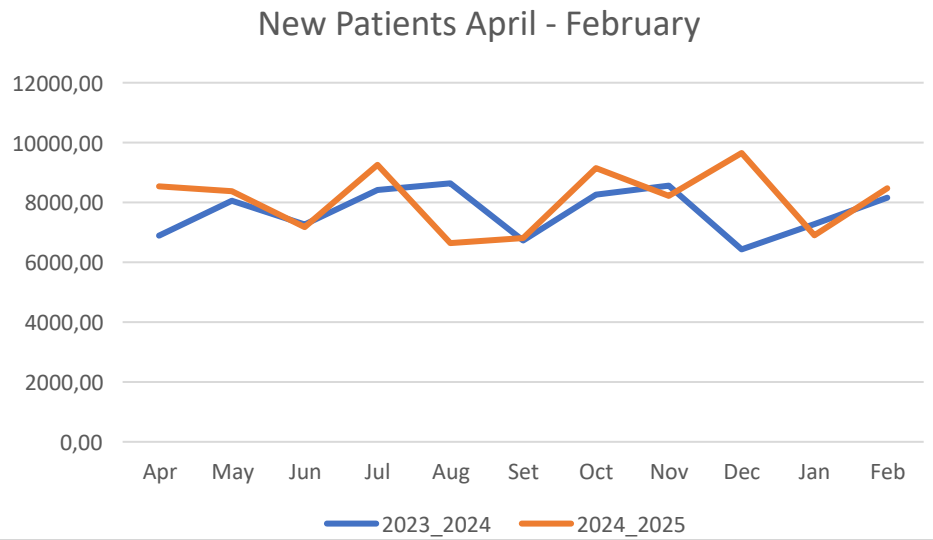
Link back to overview of underachieving metrics slide

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

- Overall activity delivered as of 12 March 2025 is 71.70% higher than full year achievement for 23/24 which was 71.59%. Forecast is that the ambition to restore activity to 2019 UDA activity levels will not be met by year end however the trend indicates an improvement in activity achieved at year end.
- New patient activity. Improvement of 4508 new patients seen compared to same period last year.

2023/2024	
April - Feb	84,676
2024/2025	
April - Feb	89,184



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 patients not seen in previous 24 months, positive trend upwards

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 Shift to flexible commissioning instead of UDA activity	Year 2 mobilisation of Long-Term Dental Plan & Workforce from April 2025/26 Access Improvement Initiative and other pathways – use of Flexible Commissioning Provider action plans and renegotiating contracts where they are failing individual targets.	Primary Care Commissioning Committee	5-year Long Term Dental Plan to Mar 2029 Workforce Strategy and Plan 2025/2026	Risks highlighted in BORR risks

Davey, Hedi
24/03/2025 12:20:17

PMO
Project Management across Norfolk and Waveney

Urgent and Emergency Care – summary

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Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	80%	71.7%	Monthly	Jan '25	12/03/25	UEC Board	No	BAF06
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	30min	41.6min	Monthly	Jan '25	12/03/25	UEC Board	No	BAF06
Local Metrics as indicated by exception								

Davey,Heidi
24/03/2025 12:20:17

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

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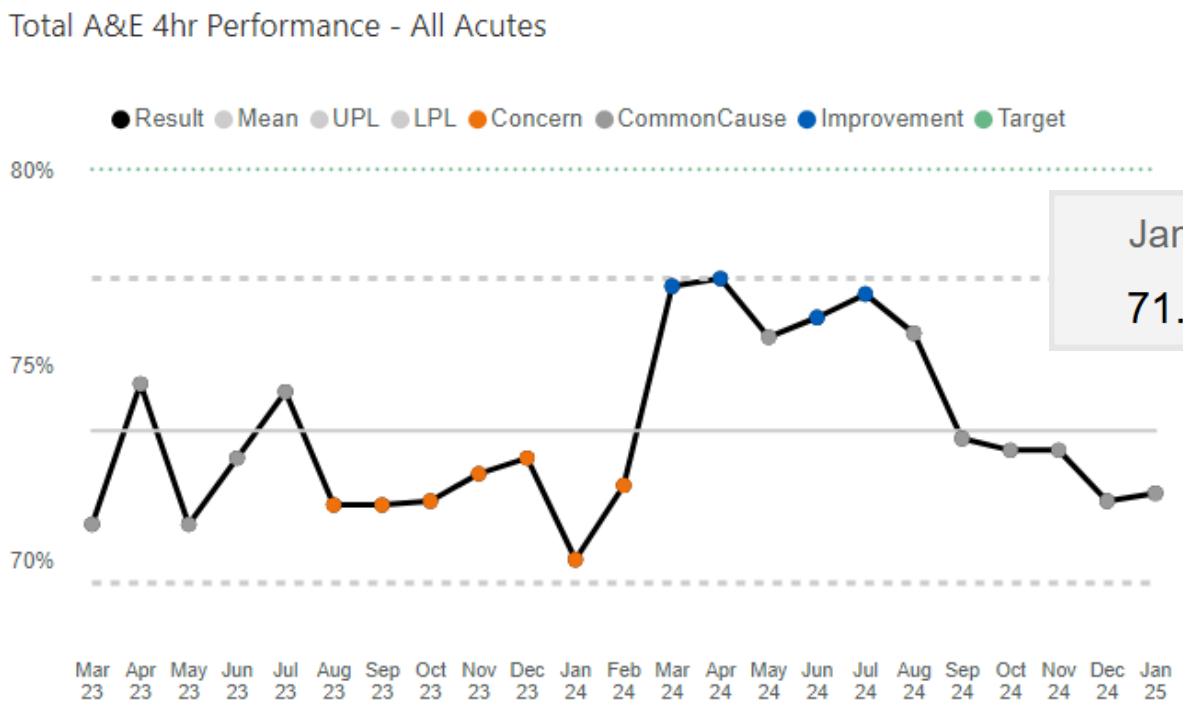
Link back to overview of underachieving metrics slide



Jan 25	Variation	Assurance		
71.7%		F	73.3% Mean 80.0% Target	69.4% Lower PL 77.2% Upper PL

A data 'pull' error has led to a data error for JPUH. Therefore, the January 2025 position will be verified in future reports.

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: 71.7%

JPUH performance: error
NNUH performance: 68.5%
QEH performance: 53.6%

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

Davey, Hadi
24/03/2025 12:20:17

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 across the ICS. 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 end of March 2025. Plans are which are currently being remodelled for 25 / 26.	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

PMO
Project Management across Norfolk and Waveney

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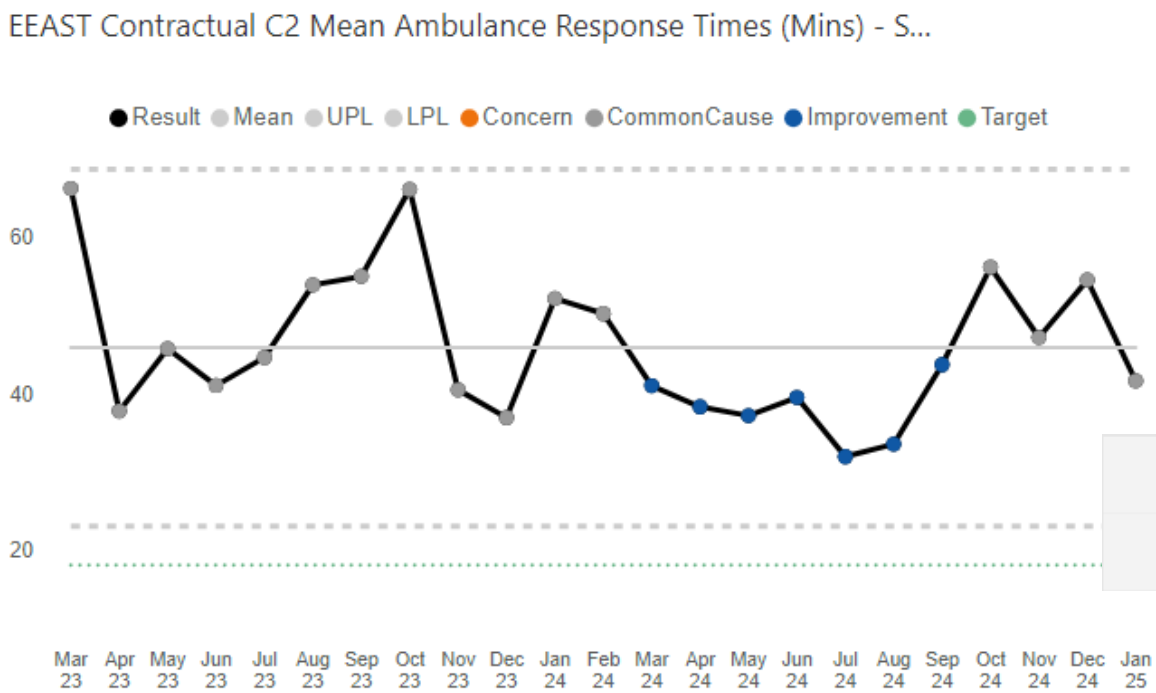
Link back to overview of underachieving metrics slide



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 41.6 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 and within community 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 end of March 2025. Plans are which are currently being remodelled for 25 / 26.	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

Cleaver, Heidi 24/03/2025 12:20:17

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Workforce, Use of Resources and Quality & Safety – summary

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Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention interventions	<0	Stable / improved	TBC	Dec '24	12/03/25	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 – this cannot be completed until LTWP reviewed.	-	TBC	N/A	12/03/25	People Board	no	
Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	£41.4m	£42.7m (forecast FY)	Monthly	M10 (Jan '25)	12/03/25	People Board	no	
Deliver a balanced net system financial position for 2024/25	£0	+£59.3m	Monthly	Jan '25	12/03/25	Finance Committee	no	
Implement the Patient Safety Incident Response Framework (PSIRF)	Implement	In place	Reporting ended as this is in place			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.

Trust Board

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

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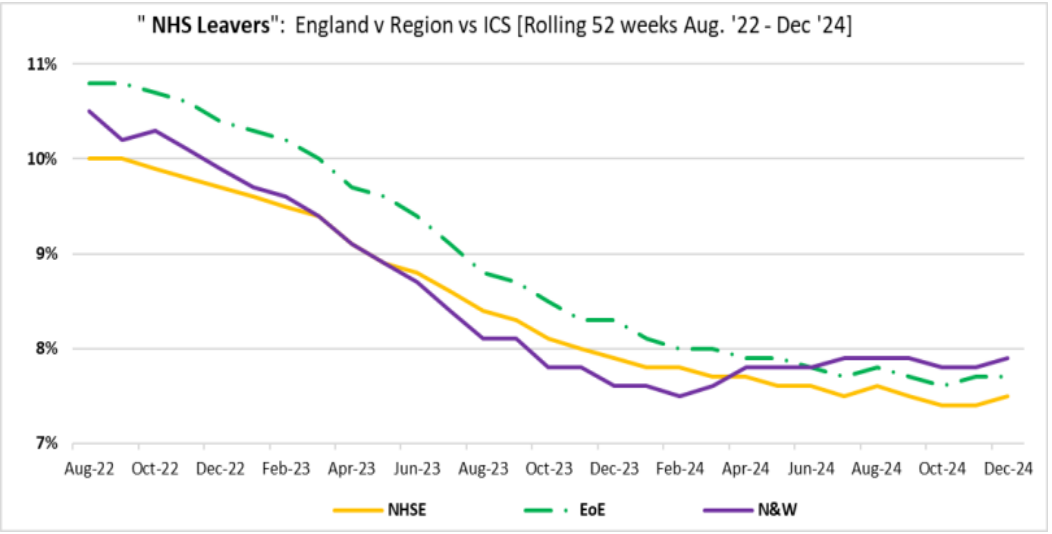
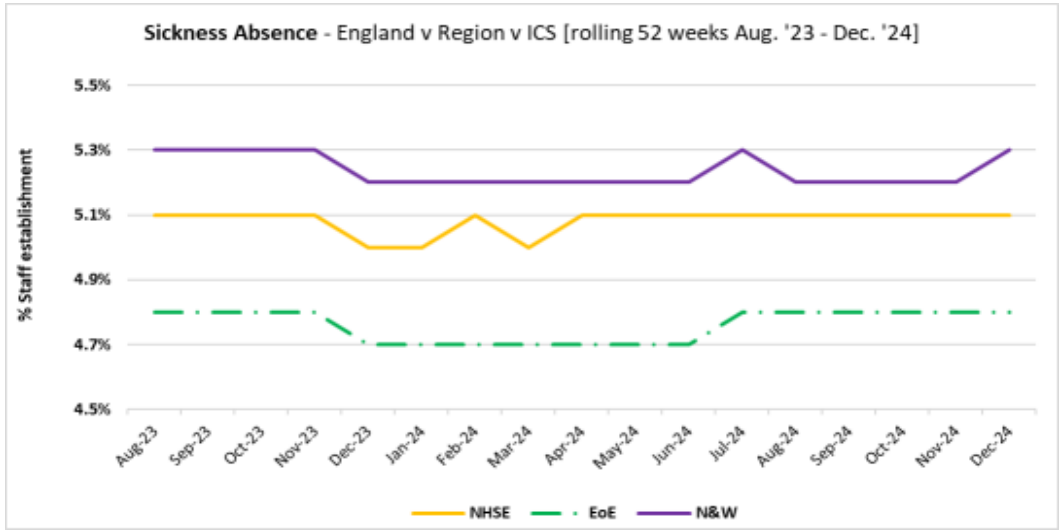
Link back to overview of underachieving metrics slide





NHS leavers across the ICS improved 0.1% in Q3, in line with the national trend. Fiscal ytd ICS NHS leavers at 7.8% are in line with EoE but +0.3% above the national benchmark. At a trust level JPUH + ECCH improved 0.3% in Q3, with all other trusts except the ICB (+0.7%) static in Q3.
At a staff group level, there was a significant reduction (0.5%) amongst HCSWs, while admin & clerical (+0.2%) continued to increase faster than national/regional benchmarks.

Across the ICS annual sickness rates increased 0.1% to 5.3%, with absence levels for the month above last December in both the Acute (+0.5%) and Community (0.9%) sectors. Annual ICS sickness absence is now 0.5% above the EoE average, where absence levels were in line with last December.
The Community increase was driven by NCHC, with sickness absence at ECCH in the month 0.4% below November and in line with last December.

Description of the metric

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

Attendance refers to staff showing up for work.

Description of performance

Leavers rates improved 0.1% in Q3, returning to Q1 levels.
Sickness rates remained flat in Q3 vs Q2.

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. - "unregistered staff" have greater employment flexibility & sensitivity to the broader socioeconomic climate. -A larger than normal proportion of leavers are "involuntary" due to restructuring programmes.	The ICS Retention Plan is currently being updated. Compassionate & inclusive culture plans, notably focussed on a restorative & justice culture + various EDI initiatives.	People Board Trust Boards	June '25 On-going	- increased "involuntary" NHS leavers due to restructuring across the ICS. - sickness absence increased +0.2% in the Community providers in Q3.

Dalby/Hegel
24/03/2025 18:20:17

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

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Link back to overview of underachieving metrics slide

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

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

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

Description of performance
Nil available at this time.

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

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

Cavan, Heidi 24/03/2025 12:20:17

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

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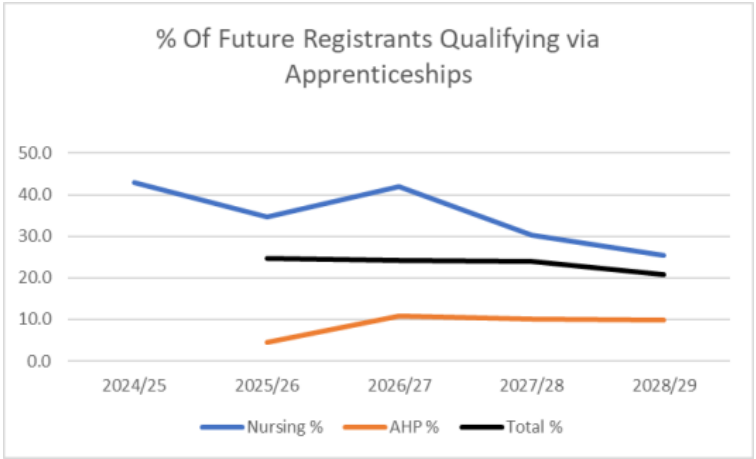
Link back to overview of underachieving metrics slide

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.



March 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

Ability to extract apprenticeship numbers across N&W. Once digital placement system functioning, we aim to have oversight of placements.

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, currently through ICB IT team. Work underway to increase supervisors and models to support learners and supervisors. Investigations underway of the Collaborative Learning in Practice model. System wide apprenticeship lead in post hosted at JPUH to support expansion and increased awareness across Norfolk & Waveney.	People Board	Q2 25/26	Due to financial pressures constraints by organisations to increase apprenticeship numbers. Nationally we are aware there will be a refresh of the LTWP in Spring/Summer 2025.

Davey, Helen
24/03/2025 12:20:17

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

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Link back to overview of underachieving metrics slide

Agency 2024/25						
£m		M10 YTD			Forecast Outturn		
Organisation		Plan	Actual	Variance	Plan	Actual	Variance
JPUH		4.9	7.5	(2.6)	5.7	9.0	(3.2)
NNUH		12.0	9.7	2.3	14.1	14.2	(0.1)
QEH		9.9	8.1	1.8	11.3	9.0	2.3
NSFT		7.3	7.8	(0.4)	8.4	8.9	(0.5)
NCH&C		1.5	1.3	0.2	1.8	1.6	0.2
N&W System Total		**35.6**	**34.4**	1.2	**41.4**	**42.7**	(1.3)

The system agency expenditure M10 Year To Date (YTD) excluding Capitalised Staff Costs (CSC) was £34.4m, which is £1.2m favourable variance against plan.

There is a £1.3m forecast overspend within agency (exc. CSC), this is an improvement since M9 mainly due to the QEH position which was £15.1m in M9 and is £9m in M10.

The forecast agency spend of £42.7m is £1.5m 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: £41.4m
Current FOT is: £42.7m

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

Davey Heidi
24/03/2025 12:20:16

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

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The position M10 Year To Date (YTD) is a £49.7m deficit, which is £44.6m adverse against plan. This is a deterioration of £0.3m from M9 when the position was £44.3m off plan.

The forecast outturn (FOT) for the system is a £53.9m deficit against a breakeven plan. This is a deterioration of £53.9m from M9 but was expected and reported that this change would be reported in M10.

The YTD QEH variance of £25.0m is mainly due to slippage within Cost Improvement Programme (CIP) delivery, bank spend and below plan activity levels. JPUH variance of £7.8m is mainly due to under delivery of CIP and the impact of industrial action. NNUH variance of £11.1m is mainly due to overspends on pay and under delivery of CIP.

Revenue surplus/(deficit) £m	Month 10 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(1.0)	(8.8)	(7.8)	(1.1)	(8.9)	(7.8)
NNUH	(1.9)	(13.0)	(11.1)	0.0	(8.4)	(8.4)
QEH	(3.6)	(28.5)	(25.0)	(0.8)	(38.5)	(37.7)
NSFT	0.1	(0.7)	(0.8)	0.0	0.0	0.0
NCH&C	0.9	1.0	0.2	1.5	1.5	0.0
Provider Subtotal	**(5.5)**	**(50.1)**	(44.6)	**(0.4)**	**(54.3)**	(53.9)
ICB	0.3	0.3	0.0	0.4	0.4	0.0
N&W System Total	**(5.1)**	**(49.7)**	(44.6)	**0.0**	**(53.9)**	(53.9)

Link back to overview of underachieving metrics slide

Description of the metric

Deliver a balanced financial position.

Description of performance

The position M10 YTD is a £49.7m deficit, which is £44.6m adverse against plan.

The forecast outturn (FOT) for the system is a £53.9m deficit against a breakeven plan.

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 10 the system is forecasting A £53.9m deficit at year end. Finance Committee will oversee progress.

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NHS
Norfolk and Waveney
Clinical Commissioning Group

Agenda item: 16

Subject:	**Integrated Performance Management Framework**
Presented by:	**Andrew Palmer Executive Director of Strategy and Deputy Chief Executive Officer**
Prepared by:	**Diane Smith, Head of Collaborative Commissioning and Performance**
Submitted to:	**Norfolk and Waveney Integrated Care Board**
Date:	**26 March 2025**

Purpose of paper:

To outline the purpose of the drafting of the Integrated Performance Management Framework for NHS Norfolk and Waveney Integrated Care Board and to seek ratification from the Board of the framework.

Executive Summary:

The Integrated Care Board (ICB) does not currently have a Performance Management Framework (PMF).

The need for a PMF was highlighted through the 2023/24 Advisory Review of Integrated Performance Management by the tiaa, who identified its requirement in order to cover "*reporting and management review and arrangements for scrutiny and assurance and oversight and management*."
This PMF has been drafted to resolve further points in the tiaa recommendations and to support the implementation of a revised version of the Integrated Performance Report for the ICB. The PMF applies to reporting to all Committees and Programme Boards as well as the ICB Board.

The PMF has been reviewed, commented on and agreed by:

- Commissioning and Performance Committee, 23rd January 2025
- Primary Care Commissioning Committee, virtually for a 2-week period to 7th February 2025
- Quality and Safety Committee, 6th February 2025

There will be a scheduled review at 6 months, to incorporate any changes as a result of 2025/26 NHSE planning and to receive feedback from key stakeholders.

Recommendation to Board:

To support and ratify the framework for formal implementation by Norfolk and Waveney ICB from March 2025.

Davey, Hayley
24/03/2025 14:20:17

Key Risks	
Clinical and Quality:	The PMF supports reporting on quality and safety metrics, and all metrics support clinical activity.
Finance and Performance:	The PMF provides structure and consistency to the management and oversight of performance
Impact Assessment (environmental and equalities):	Robust performance management and oversight feeds into impact assessments.
Reputation:	Resulting from a tiaa audit, not addressing these recommendations may lead to reputational negative impact.
Legal:	Nil noted
Information Governance:	Nil noted
Resource Required:	
Reference document(s):	• The NHS Oversight Framework • The National Health Service Act (2006) • The NHS Constitution (2023) • The Insightful ICB Board (NHSE, 2024) • Norfolk and Waveney ICB Governance Handbook • Norfolk and Waveney ICB Constitution
NHS Constitution:	Metrics covered by the PMF include constitutional metrics.
Conflicts of Interest:	Nil noted
Reference to relevant risk on the Board Assurance Framework	

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	• Commissioning and Performance Committee, 23rd January 2025 • Primary Care Commissioning Committee, virtually for a 2-week period to 7th February 2025 • Quality and Safety Committee, 6th February 2025

Davey Heidi
24/03/2025 12:20:17

Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney ICB Integrated Performance Management Framework

Document Control Sheet

This document can only be considered valid when viewed via the ICB's website or intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document:	**Norfolk and Waveney ICB Integrated Performance Management Framework**
Version:	**1**
Date of this version:	**February 2025**
Produced by:	Commissioning and Performance
What is it for?	Staff of Norfolk and Waveney ICB and NHS Norfolk and Waveney
Evidence base:	NHS Constitution. NHS Oversight Framework.
Who is it aimed at and which settings?	The policy is for use by staff of NHS Norfolk and Waveney.
Impact Assessment:	Not Applicable
Other relevant approved documents	Not Applicable
References:	Included in document footnotes.
Monitoring and Evaluation	This is a standard policy that will be reviewed and updated in line with any national and relevant local changes.
Training and competences	N/A
Consultation	N/A
Reviewed by:	Commissioning and Performance Committee – 23/01/2025 Primary Care Commissioning Committee – virtual, February 2025 Quality and Safety Committee - 06/02/2025
Approved by:	The Board, Norfolk and Waveney Integrated Care Board
Date approved:	26/03/2025
Signed:	Board chair:
Dissemination:	NWICB Intranet
Date disseminated:	TBC
Review Date:	August 2025
Contact for Review:	Commissioning and Performance

FINAL

Daver, Heidi
24/03/2025 12:30:17

Version Control

Revision History	Summary of changes	Author(s)	Version No

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Davey, Heidi
24/03/2025 12:20:17

1. Introduction

This document is intended for use by staff working for the Norfolk and Waveney Integrated Care Board (NWICB/ICB) and by colleagues with roles which contribute to assuring that the Norfolk and Waveney Integrated Care System (NWICS/ICS) is meeting its overall performance objectives. The performance objectives incorporate all sectors of the system i.e. acute and planned care, mental health, urgent and emergency care, primary care, quality and safety.

1.1. Background

The Norfolk and Waveney Integrated Care Board (ICB) has statutory duties which are reflected in the ICB's Governance Handbook[1] and the ICB's Constitution[1]. To contribute to the effective and efficient delivery of these duties, NWICB needs assurance that it has processes in place for managing performance that are robust, clear, adhered to and underpinned by an Integrated Performance Management Framework.

1.2. Distribution control

The current version of the Integrated Performance Management Framework can be found on the NWICB intranet pages. Printed or downloaded copies of this document should be considered out of date.

1.3. Endorsement

The Integrated Performance Management Framework is endorsed through the Commissioning and Performance Committee and the ICB Board ('*the Board*').

1.4. Associated documents

National documents and guidance associated with this framework include

- The NHS Oversight Framework
- The National Health Service Act (2006)
- The NHS Constitution (2023)
- The Insightful ICB Board (NHSE, 2024)

The ICB documents associated with this framework include

- Norfolk and Waveney ICB Governance Handbook*
- Norfolk and Waveney ICB Constitution*

1.5. Consultation

The following were consulted during development of this document

- Committees of the Norfolk and Waveney Integrated Care Board and their members.

Davey, Heidi
24/03/2025 12:20:37

[1] Corporate Affairs (sharepoint.com)

* These should be found on the ICB intranet.

- Programme Boards with performance metrics on the Integrated Performance Report (IPR).
- ICB Business Intelligence team.

2. Integrated Performance Management Framework

2.1. Rationale

The NHS Oversight and Assessment Framework[2] states that NHS England (NHSE) *"has a legal duty to annually assess the performance of each ICB[3]"*. This includes services delegated from NHS England.

NHSE's annual performance assessment considers how well each ICB has discharged its functions and includes, though is not limited to, how effectively the ICB has discharged the following specific duties under the National Health Service Act 2006 [3], as shown in a) – h).

a) the duty as to improving the quality of services.
b) the duty as to reducing inequality of access and outcome.
c) the duty to obtain appropriate advice.
d) the duty to facilitate, promote and use research.
e) the duty to have regard to the effect of decisions (the 'triple aim')
f) the duty to make arrangements to involve patients, carers and the public in commissioning plans and decisions that affect them.
g) the ICB's financial duties.
h) the duty to have regard to certain wider local needs assessments and strategies.

NHSE's annual capability assessment considers six functional areas, shown in i) – n) below.

i) Strategy and Planning.
j) Arranging Provision of Care
k) Governance and People.
l) Securing learning and transformation.
m) Assuring performance, quality and delivery.
n) NHS Leadership and partnership working.

These functional areas are considered alongside the criteria that each ICB needs to meet to assure NHS England, that the four purposes of Integrated Care Systems are being delivered, and that they are effectively discharging their statutory duties and powers.

Items noted in 2.1 a) – n) enable the ICB to assure performance of the healthcare system in order to meet the responsibilities of the ICB.

Davey, Heidi
24/03/2025 12:20:22

[2] NHS England » NHS Oversight Framework
[3] Section 14Z59 of the National Health Service Act 2006 as amended by the Health and Care Act 2022

NHS England provide a guide[4] to support ICB Boards to enable the most insightful and effective use of data, and this has supported the development of this document.

2.2. Purpose

Performance management may be defined as collective actions that improve performance against objectives. In this case, the objectives are of NWICS, which are assured through the NWICB.

This Performance Management Framework is intended to provide assurance to:

- NWICB's Board,
- Commissioning and Performance Committee,
- the Norfolk and Waveney population and its communities,
- NWICB and NWICS staff,
- NWICS partner organisations, and
- NHS England

that NWICB's performance is being appropriately and accountably managed and scrutinised. In doing so, NWICB will also deliver against the mission and goals of the NWICS[5] as well as the statutory duties and obligations of its constituent members.

The Framework enables the oversight and assurance of Key Performance Indicators (KPIs) - which can include, but are not limited to, those outlined in section 5 – measuring system performance (e.g. reliance on multiple providers or related to interdependencies across the system), and measures of quality, experience and outcomes.

This Framework also enables stakeholders to note and take action where there are changes to KPI's used to measure performance or their definitions, and to recognise and celebrate positive changes to performance that can contribute to improving the health and wellbeing outcomes for the citizens of Norfolk and Waveney.

The term 'KPI' is used throughout this document to refer to all relevant performance metrics.

The Framework acts as:

- a tool - providing a structured, supportive and collaborative approach to defining, managing and delivering against KPIs.
- a reference document – detailing how accountability is assigned and how performance is measured and managed.
- a model - against which the ICB can review how well it is meeting its regulatory obligations in the delivery of its KPIs and how effectively the ICB is managing its accountabilities.

Davey, Heidi
24/03/2025 12:20:17

[4] NHS England » The insightful ICB board
[5] https://improvinglivesnw.org.uk/about-us/developing-our-integrated-care-system/integrated-care-strategy/

The framework requires

- clear and agreed performance objectives and commitments.
- Measurable relevant KPIs.
- agreed roles and responsibilities.
- defined review cycles, for the systematic review of delivery against performance targets.
- escalation pathways to resolve performance where it is not meeting target or not meeting the agreed plan/trajectory – which may require involving relevant stakeholders from provider organisations, the ICB and/or the ICS.

2.3. Objective

The Framework provides performance assurance, oversight and scrutiny to support the delivery of the ICB's duties. It provides a structure for the ICB to deliver to its roles and responsibilities, as set out in Sections 2.1 and 3, by ensuring there is a clear and consistent approach to

a) agreeing performance standards that assess success against objectives.
b) defining KPI's to measure the performance standards and ensuring validated data sources to measure these.
c) providing trajectories and plans to deliver against the agreed performance standards.
d) assess attainment of and/or progress towards the agreed performance standards.
e) reporting exceptions in performance and associated risk(s) to attaining the performance standards.
f) analysing and addressing the source of performance issues when targets, plans, standards and/or trajectories are not being met.
g) delivering corrective actions including clear timelines, ownership and reporting.
h) focusing resources on areas where there are performance issues, escalations and/or risks.

3. Culture

Measuring and managing performance can provide the evidence base for change and provide information on the impact of the changes made. This drives continuous improvement, as shown in the *Model for Improvement* (figure 1). Without measures, there is no way of gauging the impact of change – as set out in the Quality, Service Improvement and Redesign (QSIR) approach.

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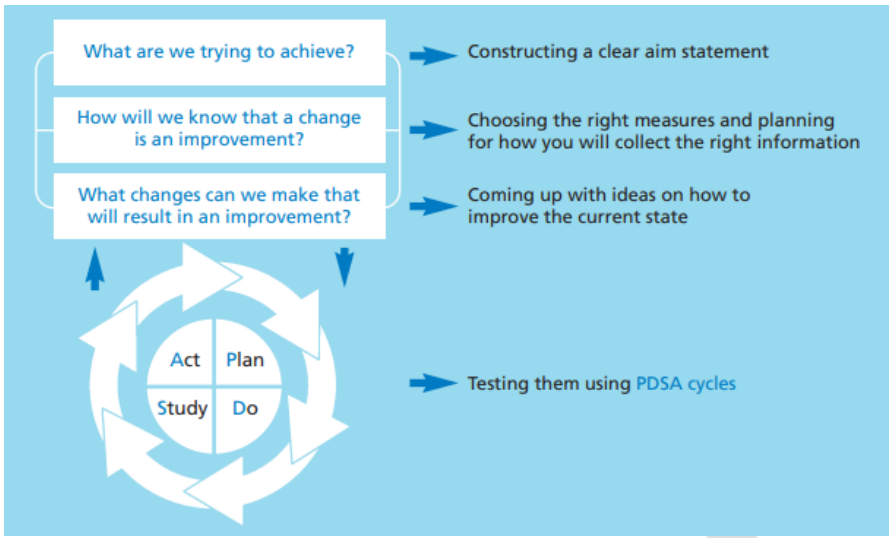

Figure 1

Additionally, performance management should be seen in the lens of a system that focuses on improved access, experience and outcomes for its population – something that requires continuous improvement.

Therefore, we need to generate and sustain a culture that uses performance as a measure of success and improvement against the goals and ambitions of the ICS. This is likely to require work in areas such as: training and upskilling; incorporation of performance measures (KPI) review across all levels of assurance; open data sharing.

4. Roles and responsibilities

The Framework takes a stepped approach to performance management by ensuring that KPIs are appropriately dispersed throughout the ICB and the wider ICS. This hierarchy supports the delivery of KPI management at every level across the system, enabling those involved to understand what is expected of them and the part they are required to play in supporting performance management for the system.

4.1. NHS England

NHS England (NHSE) has the highest level of accountability for performance management as it is responsible for the oversight of Integrated Care Boards.

NHSE's national oversight model is built around four national objectives that reflect the contribution of the ICBs and its providers to the fundamental purposes of an ICS, which are to

a) improve population health and health care.
b) tackle inequalities in outcomes, experience and access.
c) enhance productivity and value for money.
d) support social and economic development[5].

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4.2. Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board (NWICB) plans and commissions healthcare services for the local population. It is accountable for the performance and finances of the NHS across Norfolk and Waveney – a total budget of £2.6 billion a year. Also known as NHS Norfolk and Waveney, the organisation works with local people, health and care professionals, and partner organisations to improve the health and wellbeing of the people and communities living in Norfolk and Waveney[6].

ICBs bring the NHS together locally to deliver shared priorities, with an emphasis on collaboration and shared responsibility for the health of the local population. This requires governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance. These arrangements are proportionate and facilitate transparent decision-making and help to foster the culture and behaviours that enable system working[7].

The ICB's Board ('the Board') oversees a delegated committee structure, it holds those committees and their constituent system partners to collective account. It also links with the Integrated Care Partnership[8] to enable strategic leadership for the ICS. The scheme of delegation is found in the ICB Governance Handbook.

4.3. ICB Executive

Every KPI is overseen by an Executive Director within NWICB. The Executive Directors are the Senior Responsible Officers (SROs) for KPI delivery.

4.4. ICB Committees

The ICB has formal Committees which have delegated authority, from the ICB Board, for matters within the functional remit of the Committee. They ensure that each relevant Committee, its participants and any member Directors are held to account collectively for the delivery of its work programme. Committees have the oversight and management of performance functions delegated from the ICB Board, including the functions of holding the system to account, providing challenge, directing 'deep dives' and supporting improvement.

It should be noted that performance includes performance against quality and safety aspects of service delivery.

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[6] https://nhs.sharepoint.com/sites/26A_TheIntranet/SitePages/ICB-Board-and-Committees.aspx
[7] https://www.england.nhs.uk/long-read/guidance-on-integrated-care-board-constitutions-and-governance/
[8] Norfolk and Waveney Integrated Care Partnership (ICP) (improvinglivesnw.org.uk)

4.5. Programme boards and delivery/working groups

Programme boards operate via the delegation of the relevant Executive Director, who sits on the Board. Each Board covers the remit of the ICB Committees in more detail and divided into manageable remits. They can make decisions via the delegated authority of an Executive Director.

Delivery/working groups within the wider system feed into the boards/programme boards and those delivery/working groups do not have decision making authority in any way but are action based to complete tasks.

The N&W ICB Governance Handbook[9] should be consulted for current delegations from the ICB Board to Committees and Programme Boards in respect to performance.

5. Assurance

Assurance of performance and the associated KPIs is obtained through a graduated model, as illustrated below in figure 2.

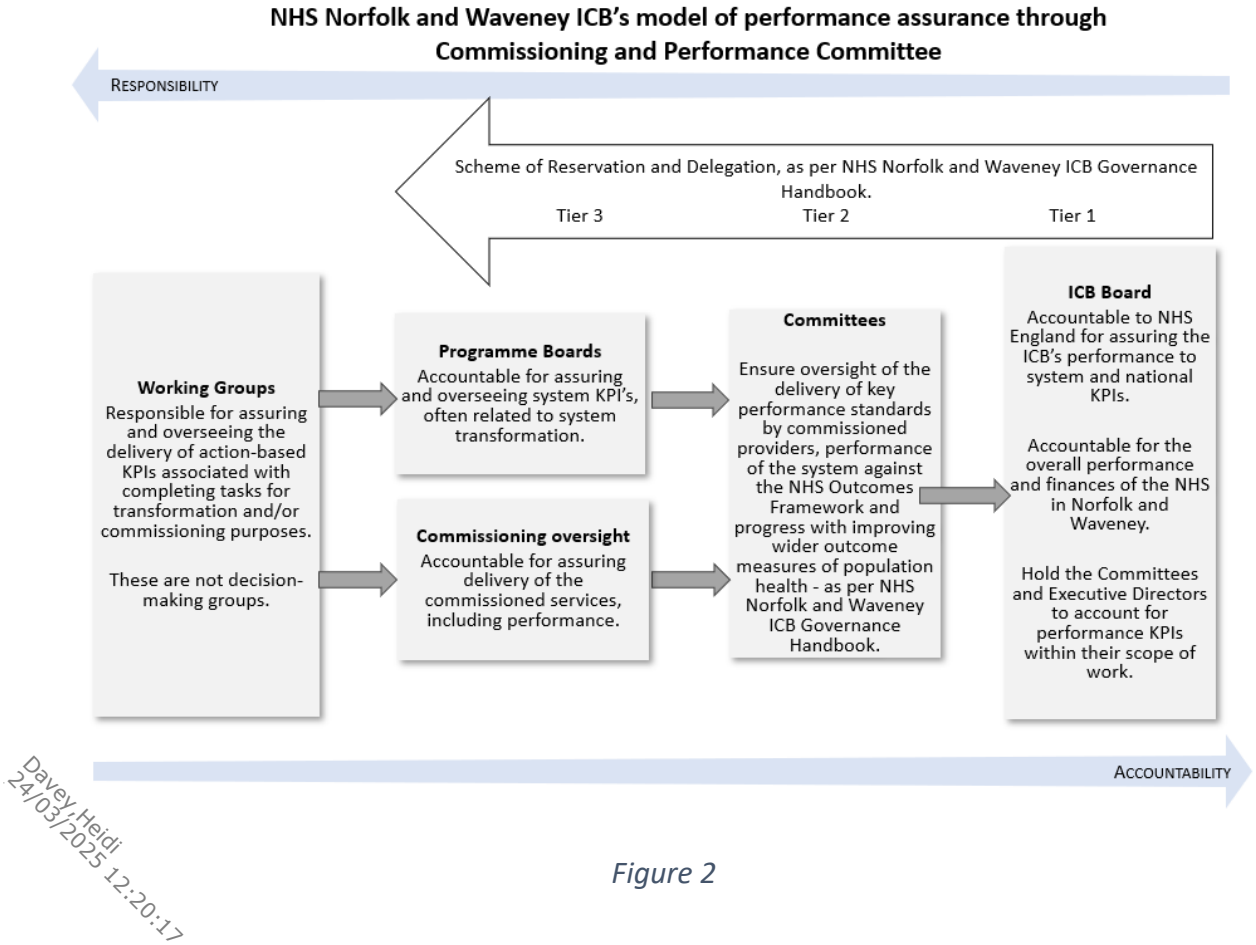

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Figure 2

[9] Corporate Affairs

6. Key performance indicators

There are many measures and indicators that are used to assess performance against the objectives and requirements of the ICB. Of those multiple measures and indicators, those which are 'key' to the overview of performance of the health system in Norfolk and Waveney should be taken to be Key Performance Indicators (KPI's). KPI's should be focused on ICB objectives and the needs and improved outcomes for the population.

6.1. Key Performance Indicators for the system

Key Performance Indicators (KPI) for the ICS – *System KPI's* - are drawn from a variety of sources, but crucially reflect and measure success of the health and care system in delivering against:

a) NHS delivery metrics, also referred to as the annual operational plan objectives.
b) National and local strategies.
c) Population needs.
d) Duties and functions Set out in section 2.1.

The key measures of performance for the system are those that **measure outcomes** - things that reflect impact on patients and demonstrate the result. These could be mortality, length of stay, improved experience or reduced emergency admissions.

Alongside these measures, both QSIR and (NHSE) Making Data Count[10] describe other measures that support these KPI's:

i. **Process measures**: these reflect the way systems and processes work to deliver the desired outcome. For example, if staff wash their hands or the length of time a patient waits for senior clinical review.
ii. **Structure measures**: these reflect the attributes of the service/provider such as staff to patient ratios and operating times of the service. These are otherwise known as input measures. These are appropriately monitored at operational levels.
iii. **Balancing measures**: these reflect unintended and/or wider consequences of the change that can be positive or negative. It is about recognising these and attempting to measure them and/or reduce their impact if necessary. An example of a balancing measure would be monitoring emergency re-admission rates following initiatives to reduce length of stay.

The system KPIs for Norfolk & Waveney can be found within the online Integrated Performance Report[11] (IPR), along with the most recent delivery information.

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[10] NHS England » Making data count
[11] Planning Objectives - Power BI

The system KPIs are typically reviewed annually, although some are required to be reviewed more frequently, such as where they relate to newly introduced national requirements.

6.2. Key Performance Indicators for Commissioned Services

KPI's for commissioned services are at provider level and are designed to describe the intended outcomes delivered by commissioned services and can be related to system KPIs. Provider KPI's will be reported through contractual mechanisms and assurance provided through contractual management arrangements. These KPI's will be appropriate, proportionate, harmonised wherever indicated and regularly reviewed to ensure they reflect system intentions and national guidance.

Where provider data contributes to a system KPI, a provider split may be shown in the system KPI to provide insights and identify learning opportunity to address issues and/or risk.

6.3. Key Performance Indicators for Transformation – *Transformation KPI*

Transformation will impact on performance in the ICS. Impact of transformation should be monitored through existing KPI's wherever possible. Before implementing a transformation project / programme the KPI's that measure impact should be determined and baselined.

Where existing KPI's will not capture the transformation impact the transformation lead will work collaboratively with appropriate others to determine measures of impact which may include KPI's. Where transformation activity requires a change to or newly commissioned services, the transformation lead will ensure all appropriate documentation is supplied to the commissioning team (where these teams are separated) for contractual changes to be made, such as completed/altered and agreed service specifications and monitoring.

6.4. Agreement of performance KPIs

All KPIs will have agreed definitions, reporting processes and clear accountabilities for assuring their performance. They should be either aligned to national guidance, technical definitions and local strategy or set out and managed within the appropriate provider contracts.

All KPIs for the system must be proposed and supported by the relevant Committee, Programme Board, or Working Group that is accountable for oversight of and assuring its performance. System KPI's will include components of contracted activity and therefore, appropriate KPI's should be included within contract schedules. Each report for tier1-3 meetings, as set out in the N&W ICB Governance Handbook, will have a maximum of 15 KPI's, unless by express exception and agreement. Should a new KPI be proposed for incorporation into the IPR as part of this structure, a review should ensure the total number stays at a maximum of 15.

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7. Reporting and review against key performance indicators

7.1. Establishing a validated and regular data flow

The lead role with responsibility for a KPI, such as the Lead Commissioner and/or a Transformation Lead, is responsible for engaging with the ICB's BI team in a timely way to jointly agree how the data is supplied to evidence performance against the KPI in the Integrated Performance Report and other key performance reports.

Early engagement with Business Intelligence (BI) will enable the agreement of appropriate methods for reporting on performance, including validated data sources/flow.

Following the agreement of the KPI, BI leads need to be provided with:

- Definition of standard for the KPI e.g. numerator and denominator
- Reporting route
- For unvalidated data (operational) – This will be via the Data Hub's processes KPI data will flow in agreed formats from each submitting provider. Every effort should be made to ensure the data flows are automated.
- For validated data (The preference) – This will also be via Data Hub with data coming for nationally published datasets via various sources.
- To enable further analysis of the information and add additional insight the datasets could contain information at a patient level and performance calculations agreed by provider to calculate KPIs on their behalf.

The N&W BI team will advise on timeframes and appropriateness of accessible data to provide any proposed KPI's.

7.2. Statistical Process Control

Wherever possible, Statistical Process Control (SPC) charts are utilised in the IPR and key performance reports to evidence a robust performance dataset. The SPC chart helps to distinguish between performance variance which is statistically significant – special cause variation – or not statistically significant – common cause variation. These distinctions set out in SPC charts help identify changes in performance that require a reaction or not[13].

7.3. Regular review

All KPI's should be meaningful and relevant. This includes being actively used to assess progress against objectives and plans.

7.3.1. System KPI review

KPI's that represent system performance will be reviewed by the performance team and through the Commissioing and Performance Committee and the ICB Board.

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[13] NHS England '*Making data count'* should be referenced to support use of SPC.

7.3.2. Commissioned services KPI review

The named commissioner/commissioning team for each contract will have responsibility for reviewing performance associated with and KPI's included within that contract, as part of a team that should include clinical lead, quality lead and business intelligence and analytics. These will be reviewed formally through contractual meetings.

7.3.3. Transformation KPI review

The transformation lead/team will have responsibility for reviewing performance associated with transformation activity and should consider potential impact on other areas of performance as change is made. These will be reviewed formally at Programme Boards, where transformation should be managed.

7.4. Data Quality

Data accuracy will be assured by ensuring validated data sources are used to draw data for the KPI's.

The Insight & Analytics team to develop and implement an automated data quality (DQ) process to ensure that data ingested into the data hub meets predefined criteria such as format and data volume tolerances. Information not meeting these criteria will be rejected and responsible commissioner alerted for action. All such actions will be automated and no 'sign off' will take place. DQ checks will only confirm that the data aligns to the specification and will not confirm completeness. Overall responsibility for data quality will reside with the responsible commissioner who will manage / address issues through the appropriate channels.

Responsible commissioner to ensure a process is put in place to document all data checks necessary including escalation to provider organisation is issues arise.

Where data accuracy/quality concerns relate directly to a provider issue, these should be raised through contractual oversight mechanisms.

Where data accuracy/quality concerns relate to a system issue, these should be raised through the appropriate Programme Board and escalated as necessary.

8. Corrective action and recovery

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Corrective action should be taken where a performance target is not meeting the agreed objective, plan or trajectory; or where there is an identified cause for concern – this can include performance remaining within process controls. SPC is a valuable tool for assessing performance and the need for corrective action, whilst also considering the wider context and interdependencies.

8.1. Identifying the need for corrective action

The roles with accountability for assuring and monitoring each KPI has the delegated authority to determine from the IPR, or relevant performance management pack, when there is a need for corrective action to address performance issues.

SPC should be used to help identify where action should be taken – see appendix B.

8.2. Corrective action

Corrective actions to address performance issues must be recorded with a clear rationale, plan and timeline. Each corrective action is assigned to the most appropriate senior role, as the action lead, with the authority to address the issue.

The action lead reports progress against the action to the role with accountability for assuring and monitoring the KPIs, including when the corrective actions have been completed or if issues have arisen that prevent the corrective action from being delivered or require escalation.

8.3. Recovery plans

A recovery plan may be indicated where a KPI is

- consistently not delivering against the agreed performance metric, its associated plan or trajectory
- where risk is high
- there are complex corrective actions
- there are significant interdependencies.

Appropriate timelines are set for recovery plans, considering the time that may be required to reflect change in the data time series. Recovery plans may have inter-dependency with contractual management and actions.

8.3.1. System recovery plans

A system recovery plan may be required where recovery involves multiple system partners or where a cause is impacting more than one system partner.

This plan can be managed within individual system partner organisations or led by one on behalf of the system. Where this occurs, the recovery plan is developed jointly and agreed by the appropriate Programme Board and/or Committee with delegated authority.

8.3.2. Provider recovery plans

Provider recovery plans may contribute to wider system recovery plans against performance or may address stand-alone issues for delivery against performance targets / objectives. These should be managed within the contractual arrangement for each provider, but the recovery plan should be considered in the overall ICB and system delivery.

Davey Lloyd 24/03/2025 12:47:17

8.4. Resourcing recovery

Suitable resource(s) should be allocated to support the corrective action required to achieve recovery. This resource may include that from the ICB, Provider(s) and/or NHS England. Dependent on the identified cause and action required, resource may include contribution from teams such as: quality / quality improvement; transformation; commissioning; operational leads; clinicians; subject matter experts; service users (please note this is not an exhaustive list).

9. Oversight and assurance

9.1. Executive oversight

For scrutiny and assurance all system KPI's reported through the IPR will have:

- Ownership by a named Executive Director owner – these will be detailed in appendix 3, to be updated as KPI's in the IPR change.
- Designation to a Committee for scrutiny and assurance.

9.2. Performance oversight structure

The groups outlined in the ICB governance structure (add link) have oversight of performance, with delegation outlined in the Governance Handbook. Each group in tier 1-3 shares a restricted number of KPI's to the group above, ensuring no group routinely has more than 15 KPI's for review.

10. Escalation

The ICB's Governance Handbook sets out the tiered delegation for assurance, including those with oversight of performance. Escalation of risks associated with performance/KPIs are managed as per the ICB Risk Handbook and the risk management system.

11. Dependencies

Fulfilling the IPMF has several interdependencies with other areas, without which the IPMF cannot operate effectively. These include, though not limited to:

- Timely publication of annual national planning guidance.
- Changes in national strategy
- Monitoring and assurance of provider performance
- Response to delivery risks

These should be considered in any changes to the IPMF and vice-versa.

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12. Review

The Executive Director of Commissioning and Performance will lead the operation of this IPMF and the ICB Commissioning and Performance Committee will be responsible for assurance on its effectiveness and to ensure timely review and update.

This framework will be reviewed at least annually and agreed through the appropriate endorsement, set out in section 1.3.

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Appendices

Appendix 1 – Roles and Responsibilities

ICB responsibilities

The ICB is responsible for arranging for the provision of healthcare services to meet the health needs of its local population, alongside other statutory duties.[14] This includes leading on the oversight of individual providers who are in turn responsible for providing safe, effective, efficient, and high-quality services.

The oversight responsibilities of the ICB includes, but are not limited to, the following[10].

a) Overseeing the commissioning and management of contracts, delegation and partnership agreements with providers.
b) Leading on the day-to-day oversight of providers to ensure effective arrangements are in place to deliver on plans, performance, outcomes, and transformation - including but not limited to
   - provider collaboratives
   - providers that function across multiple ICBs
   - independent providers
   - primary care providers.
c) Advising NHS England on the support or intervention needs of their providers within the Norfolk and Waveney NHS system, according to the principles of oversight detailed in this framework and supporting the resolution of any issues as per agreed recovery plans.
d) Managing NHS system-wide risks and delivery against performance, quality, and financial plans, and liaising with NHS England on matters relating to providers in the Norfolk and Waveney NHS system (except for those services directly commissioned by the ICB), including timely and transparent escalation of issues.
e) Working in partnership with providers, alongside other partners, to find local resolutions to risks, concerns and challenges including co-ordinating and tailoring any support or interventions required.
f) Providing assurance and input into regulator assessments of providers and NHS systems, including those led by CQC.

ICB Board

The ICB's Constitution[1] describes the Board of the ICB is a unitary Board that meets in public every other month. Details of meeting dates and times as well as papers can be found on the

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[14] NHS England » NHS Oversight Framework NHS Oversight and Assessment Framework consultation - NHS England - Citizen Space

ICB's intranet page for Corporate Affairs. The purpose of the Board is to govern effectively and, in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. The Board is responsible for

- formulating strategy for the ICB, considering the Norfolk and Waveney Integrated Care Partnership's (ICP) Integrated Care Strategy.
- holding the ICB to account for delivery of the strategy.
- being accountable for ensuring the ICB operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable.
- shaping a healthy culture for the organisation and the wider ICS partnership.

The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation.

Chief Executive

The ICB's Constitution [1] provides for the appointment of the Chief Executive by the ICB's chair. The Chief Executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources. The Chief Executive is directly accountable to the Board for meeting the ICB's objectives and to the Chief Executive of NHS England for the performance of the organisation. The Chief Executive Officer has overall responsibility for the operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.

Executive team

The Executive team of an ICB are required to:

- support the chief executive and the board to ensure that the ICB functions effectively.
- ensure national and local health priorities are considered in the integrated care strategy led by the Integrated Care Partnership (ICP), the joint forward plan led by the ICB, and any local plans and strategies developed by places and health and wellbeing boards in relation to these population groups and their needs[15].

Commissioning/operational lead within the ICB

The relevant Commissioner, contract lead or professional lead within the ICB will have oversight of the contractual position of the provider commissioned to deliver a service.

The transformation/change lead in the ICB will work with providers on time limited basis, as indicated, to agree any improvement or clinical transformation that will support in addressing performance issues and with the commissioning and contracting teams to ensure any resulting changes are reflected contractually.

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[15] NHS England » Executive lead roles within integrated care boards

Other ICB teams

The ICB works with a broad range of internal and external stakeholders ensuring incorporation of a wide variety of perspectives to assess performance comprehensively and successfully.

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Appendix 2 – Statistical Process Control

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
~	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
○				There is not enough data for an SPC chart, so variation and assurance cannot be given. Assurance cannot be given as there are no process limits.

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Appendix 3 – Executive leads for Key Performance Indicators in the Integrated Performance Report

Key Performance indicator	Performance area	Reports to (named with exception of ICB Board)			Executive SRO for the KPI
		ICB Board	Committee	Programme Board	

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Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**5-year Joint Forward Plan (JFP) refresh for 2025/26 to 2029/30**
Presented by:	**Andrew Palmer, Executive Director of Strategy and Deputy Chief Executive**
Prepared by:	**Liz Joyce, Head of System Transformation**
Submitted to:	**ICB Board**
Date:	**26 March 2025**

Purpose of paper:

This paper presents the refreshed 5-year JFP for 2025/26 to 2029/30, for approval by the ICB Board, subject to any minor drafting corrections and factual updates at the time of publication.

Executive Summary:

The JFP is a statutory requirement of the Health and Care Act 2022. This requires ICBs and their partner trusts to prepare a plan, setting out how they propose to exercise their functions in the next five years. Each partner will take the JFP through their own governance as required.

Guidance was received on 30 January about how to approach this for 2025/26. This is within the context of the operational planning priorities that were published at the same time. The Better Care Fund submission (BCF) has also been aligned with these submissions in 2025/26, which is a difference from previous years. All the 2025/26 Guidance refers to the forthcoming 10 Year Health Plan that will be published in the Spring.

Part 1 of the JFP has been reviewed and updated with partners, programme boards and local delivery groups. The eight Ambitions remain, but the 21 Objectives have been updated to reflect progress made over the past twelve months. Ambition 8 is about Productivity and Efficiency and has been refreshed and strengthened to reflect the focus on workforce and financial spending.

The 2025/26 NHSE operational planning priorities shape Year 1 of the JFP. This particularly impacts Ambitions 6 (UEC), 7 (Elective Recovery) and 8 (Productivity and Efficiency).

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The 2025/26 to 2029/30 JFP will be published on the ICS website, using the same design features as last year with infographics and case studies. It will be accompanied by a refreshed easy read version and glossary.

The JFP was presented to the Suffolk and Norfolk Joint Health and Wellbeing Boards in March 2025, and their opinions have been included in the refreshed version.

A copy of the near final draft 2025/26 – 2029/30 JFP (Part 1 and Part 2) is attached at Appendix A.

1.0 Introduction

The Joint Forward Plan (JFP) is a statutory requirement of the Health and Care Act 2022. This requires ICBs and their partner trusts to prepare a plan, setting out how they propose to exercise their functions in the next five years.

The Guidance on updating the JFP for 2025/26 was published in January 2025 and a link is provided as a reference document in the table at the end of this report.

The Guidance explains the relationship between the JFP, the Better Care Fund and NHSE operational planning which are separate processes but should align.

Norfolk and Waveney published its second JFP in June 2024 and a link is here: https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/

As a recap, our JFP is in two parts:

1) Part one is the main body of the JFP which sets out our Ambitions and Objectives i.e. the why, what and how we are going to deliver. There is considerable flexibility within the guidance as to how systems write this up; and
2) Part two which describes how we meet the Legal Duties, which is more prescribed in what we have to evidence.

The JFP incrementally builds on progress made in previous years. The current progress report can be found via this link: https://improvinglivesnw.org.uk/updates-on-the-norfolk-and-waveney-5-year-joint-forward-plan/. The next progress report is due in April 2025 and will cover the period October to March 2025.

2.0 JFP 2025/26 refresh

In line with the Guidance on updating the JFP, our revised plan reflects a continuation of the priorities agreed in the previous year.

The eight JFP Ambitions therefore remain our focus for 2025/26 and this approach has been supported by the Commissioning and Performance Committee. Each Ambition has a clear logo / branding and we have built on these in-year, using them for communications and engagement activity that relates to JFP delivery.

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Our eight ambitions for improvement



1. Population Health Management, Reducing Inequalities and Supporting Prevention



2. Primary Care Resilience and Transformation



3. Improving services for Babies, Children and Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)



4. Transforming Mental Health services



5. Transforming care in later life



6. Improving Urgent and Emergency Care



7. Elective Recovery and Improvement



8. Improving Productivity and Efficiency

The JFP is a local delivery mechanism for the Norfolk Health and Wellbeing strategy (which is also the Integrated Care Strategy for Norfolk and Waveney) and the Suffolk Health and Wellbeing strategy. These strategies have not been re-published since the first JFP was published in June 2023 and the current Ambitions remain consistent with their overarching priorities.

3.0 Summary of the content changes

Part 1 JFP:

1. The Foreword is being drafted.

2. Executive Summary updated to explain this is our third JFP, the context of the imminent 10-Year Health Plan and why this is a light touch review. The paragraph about alignment with partners plans and strategies has been updated and refers to the New Hospital Programme (NHP). The wording about affordability has been strengthened.

3. New section added that sets out what progress we have made in the first six months of 2024/25. (Noting that the October '24– March '25 report will not be available until May 2025 so is too late for a JFP publication date of 31 March 2025)

4. The evidence base has been refreshed by Public Health Intelligence colleagues at Norfolk County Council and updated with the most recent figures. The Life Course Infographic is updated and shows improvement in some of the metrics. The engagement paragraph is unchanged as no further engagement has been undertaken because of the anticipated 10-Year plan.

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5. Ambitions: Our immediate priorities have been updated to reflect the 2025/26 Operational Planning priorities and further delegation of specialised services. Within medium-term priorities the development of a framework for New

Models of Care is introduced. This is an ongoing piece of work being led through ICS EMT and is likely to be updated further prior to publication. The eight Ambitions and 21 Objectives remain, but all the Objectives have been refreshed to be current for 2025/26 and have a new fifth year added to them, if appropriate. The revisions are consistent with the 2025/26 Operational Planning requirements where relevant. Ambition 8 Objective a) has been significantly updated and references to Improving Lives Together have been removed.

6. Updated wording reflects current Place Board and Health & Wellbeing Partnership priorities and includes a reference to NHP. Provider Collaboration has been updated to reflect current priorities, the NHP and progress towards the acute group model. The group model wording will be reviewed again so it accurately reflects the position at the time of JFP publication. Providers plans and strategies are in a table format, drawing out where those plans also refer to the JFP.

7. Medicines Optimisation has been added as an enabler, which was not previously mentioned in previous versions of the JFP. The wording about the Voluntary, Community and Social Enterprise (VCSE) sector has been refreshed to reflect the current work with the Assembly.

Part 2 JFP:

There are 17 Legal Duties and 7 other areas of recommended content, and these have all been reviewed to ensure we have demonstrated ICB compliance with the duty. This is a more prescribed section, but we have cross-referenced their enabling capability to the Ambitions.

Copies of the near final draft of both Part 1 and Part 2 of the JFP are included in Appendix A. Subject to any final minor drafting corrections / updates and review of the case studies, this is proposed to be the final copy. Providers, Norfolk and Suffolk County Councils and Norfolk Healthwatch and Suffolk Healthwatch have been invited to comment on the refreshed Norfolk and Waveney 5-year JFP for 2025/26 to 2029/30.

4.0 Next steps

Subject to ICB Board approval the 2025/26 to 2029/30 JFP will be published on the ICS website by 1 April 2025, with an updated Glossary and Easy Read version.

Progress made in 2024/25 will be published on the ICS website in Spring 2024, at the ICB Commissioning and Performance Committee, the Health and Wellbeing Board / ICP meetings and within the ICB's Annual Plan.

Recommendation to the Board:

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1. That the Board of the ICB approves the refreshed 5-year JFP for 2025/26 to 2029/30, subject to any minor drafting corrections and factual updates at the time of publication.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	The requirement to achieve a balanced plan and meet the Performance standards set out in the Operational Planning Guidance – these impact Year 1 of the JFP
Impact Assessment (environmental and equalities):	Each objective within the JFP is assessed.
Reputation:	It is important that this plan is realistic, achievable and deliverable.
Legal:	This is a statutory requirement for the ICB and NHS Trusts and Foundation Trusts.
Information Governance:	N/A
Resource Required:	The JFP will be delivered within existing resources.
Reference document(s):	NHS England » Guidance on updating the joint forward plan for 2024/25
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF 07 Elective Recovery

Governance

Process/Committee approval with date(s) (as appropriate)	Commissioning and Performance Committee supported the approach to refreshing the JFP on 23/01/2025 and 20/02/2025. The Committee received the draft JFP on 20/03/2025 and supported it, noting that the wording on the Group Model and New Models of Care may need to be updated prior to publication.

Appendix A

Part 1 and Part 2 JFP

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Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Part 1: Joint Forward Plan 2025/2026-2029/2030

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Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB

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Norfolk Health & Well-Being Board opinion on the JFP

We would like to acknowledge the work that has happened to deliver this light touch refresh of the Joint Forward Plan (JFP) 2025/2026 for Norfolk and Waveney and that the JFP continues to underpin our Integrated Care System (ICS) ambitions to help the people of Norfolk and Waveney to live longer, healthier, and happier lives. We also note that the refresh continues to align to the four themes of our combined Norfolk Joint Health and Wellbeing Strategy and Norfolk and Waveney Integrated Care Strategy.

We understand that this light touch approach follows the Guidance issued for 2025/2026 and sets an expectation that ICB's and Trusts perform a limited refresh of existing plans before April 2025, given the anticipated publication of the 10-year health plan in the spring of 2025. After that, there will be a more extensive revision of JFPs aligned to wider reform of nationally co-ordinated NHS planning resources.

The Norfolk Health and Wellbeing Board continue to fully support and endorse the refreshed ambitions of the Norfolk and Waveney JFP. As part of the ICS, members of the Health and Wellbeing Board and the Integrated Care Partnership look forward to working collaboratively to fulfil the ambitions and outcomes contained within the JFP and sharing our expertise, as partners, to help achieve them.



Councillor Fran Whymark
Chair of Norfolk Health and Wellbeing Board and Norfolk and Waveney Integrated Care Partnership

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Suffolk Health & Well-Being Board opinion on the JFP

Suffolk Health and Wellbeing Board endorses the SNEE/N&W Joint Forward Plan. The Board received information of the updates to the Joint Forward Plan in March 2025 and recognises the plan takes account of the Suffolk Health and Wellbeing Strategy which was informed by the Joint Strategic Needs Assessment. The Joint Forward Plan aligns smoothly with the Health and Wellbeing Board's strategic priorities including Healthy Ageing which is outlined in their Ageing Well Strategic Framework.

The Board welcomes the alignment of priorities across the organisations, including the focus on Population Health Management and Health Inequalities among others. It's evident to see the positive steps taken to improve the key performance indicators to ensure that individuals are receiving the best quality care and services available. Furthermore, Members of the HWB were pleased to see that the plans had been produced in collaboration with a wide range of key stakeholders from across the Suffolk system.

The Board welcomes the approach within the Joint Forward Plan to provide a coherent and robust set of immediate and longer-term priorities, centred on the eight ambitions for improvement developed with system partners. The level of integration across the system is welcomed. Members also commented on the positive language in the plan with regard to ageing well and referred to the importance of inspiring public trust and confidence, noting that communication is crucial and the benefit of having simple metrics to demonstrate progress.

The Board also recognises the level of engagement that has been undertaken in producing the JFP, the degree of co-production that has been employed to bring this report and the opportunity the JFP provides for shared learning across organisations.



Councillor Steve Wiles
Chair of the Suffolk Health & Wellbeing Board and Cabinet Member for Public Health and Public Protection

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Executive Summary

Introduction

The 2025/2026 to 2029/2030 Norfolk and Waveney Joint Forward Plan is our rolling plan for the next five years setting out what we will do, and where and how we are going to improve health and care services for our local population, their families and carers. Our local communities are at the heart of our plan, and people have previously told us that they want to feel safe when they use local services, they do not want to be passed between different organisations, so they have to re-tell their story each time, and they expect services to be accessible, tailored to their needs and of good quality.

Our third JFP is a light touch refresh of the second version which was published in June 2024, within the context that the 10-Year Health Plan is expected in 2025. The plan has been refreshed to ensure it remains 'live' and addresses current needs, and is a shared plan, developed with and supported by the partners in our local system. The plan is split into two parts:

Part one draws together our public health data and learning from engagement with the people who use our services to set out the case for why we need to make changes to the way we provide services. This informed our eight ambitions for improvement and the objectives that underpin them. Within all the objectives we have been clear about what people will see improve and by when, and how partners in our ICS will work together on our commitment to making a difference to peoples' lives.

Part two provides a summary of how we will meet our legal duties, and these have been reviewed and updated. Taken together, these parts form the Norfolk and Waveney Joint Forward Plan.

We will deliver our plan through collaboration with our partners and local communities. Where services are being developed, this will involve the people that plan, provide and use our services, using a range of methods to help people participate. District, city and borough councils and the Voluntary, Community, & Social Enterprise (VCSE) sector are key partners in their local areas within Places and Health and Wellbeing Partnerships. How all parts of the system will work together to deliver this plan is equally as important as what we are going to do. There is an emerging and critical role for neighbourhood health services that deliver more care at home or closer to home.

The Life Course infographic (Figure 3) shows whether certain aspects of health in Norfolk and Waveney are getting better or are declining. This plan aims to address a number of these challenges through our ambitions and objectives. There are known challenges across Norfolk and Waveney as our population is ageing and there are inequalities that must be addressed. Where people live can also be a major factor affecting both the length and quality of peoples' lives.

Our eight ambitions for improvement

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

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Our eight ambitions are unchanged this year, but Ambition 8 has been updated to reflect a system-wide approach to productivity and financial improvement, retaining digital and workforce as key elements within that. Expected outcomes and milestones for delivering each of the 21 objectives have been refreshed.

Prevention and self-care
The eight ambitions are of equal importance, with prevention, self-care and early intervention being integral to them all. The public health data highlights where we have room to improve, and the key message is that outcomes can improve if preventative action is taken now.

This plan continues to signal a clear shift towards prevention through education and direct intervention, looking ahead and being proactive about what can be done now and enabling and supporting those people in our local population identified as most at risk. At the same time, we will ensure we tackle some of our most pressing system challenges, such as reducing waiting times for treatment, developing the availability of dental provision, our primary care workforce and ensuring people receive the right care in the right place at the right time. This is within the context of significant financial challenges.

Alignment with partners' plans and other strategies
This plan is aligned to the Norfolk and the Suffolk Joint Health and Wellbeing Strategies and key ICS strategies in areas including Population Health Management, Health Inequalities, Clinical, Research and Innovation, Quality, Digital, Workforce and Estates. Ensuring all our strategies are aligned and complement each other will better enable us to make the improvements we are committed to. The three acute hospitals have a joint acute clinical strategy, and more information can be found on this in section 6. Both the Queen Elizabeth Hospital and the James Paget Hospital are part of the New Hospital Programme which brings an opportunity to re-size and re-configure service delivery in partnership with others. On 1 April 2025 the ICBs in the East of England become the commissioners for an additional 11 specialised services, which brings an opportunity to join up pathways of care. There is more about this in section 4.

Affordability
The ambitions and objectives in the JFP are consistent with the current medium term financial planning for our system, but our financial position as a system across our NHS partners is extremely challenging and there will be some difficult choices to make. We must live within our means and so we must ensure we enhance productivity and efficiency within everything we do. By designing and transforming services to ensure the best value for money, we will be more able to provide high quality, responsive and sustainable services for our population in the future. This will not be easy, and we will need to be agile with our change programme, balancing this with the requirements for existing commitments and significant future developments such as our new Hospital build programmes and the Electronic Patient Record.





1.0 Scope of the JFP

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1.0 Scope of the Joint Foward Plan



1.1 Introducing the JFP

The JFP was a new requirement set out in the Health and Care Act 2022, for Integrated Care Boards (ICBs) and partner NHS Trusts to describe how they will arrange or provide NHS services for the local population of Norfolk & Waveney. National NHS Guidance (JFP Guidance) confirms what we must include in the plan but first and foremost this document is intended to be a practical plan that the system will deliver, and against which the local population can hold the NHS to account. The needs of our local population are at the heart of this ambitious plan, which sets out objectives to improve the quality of our services. This plan will ensure local people and our communities inform where and how services are provided.

The JFP describes how we will deliver national NHS commitments such as recovering core services after the COVID-19 pandemic and improving productivity, as well as transforming care across our eight areas of ambition. The JFP also describes how we will meet our key legal duties, and these are set out in Part 2. A number of these are also referred to within the JFP in relevant sections because they will help support our improvement and the delivery of our eight Ambitions which we set out in this plan.

This plan is predominantly about improvements in NHS services but has been developed in collaboration with partners where services are provided together.

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1.0 Scope of the Joint Foward Plan

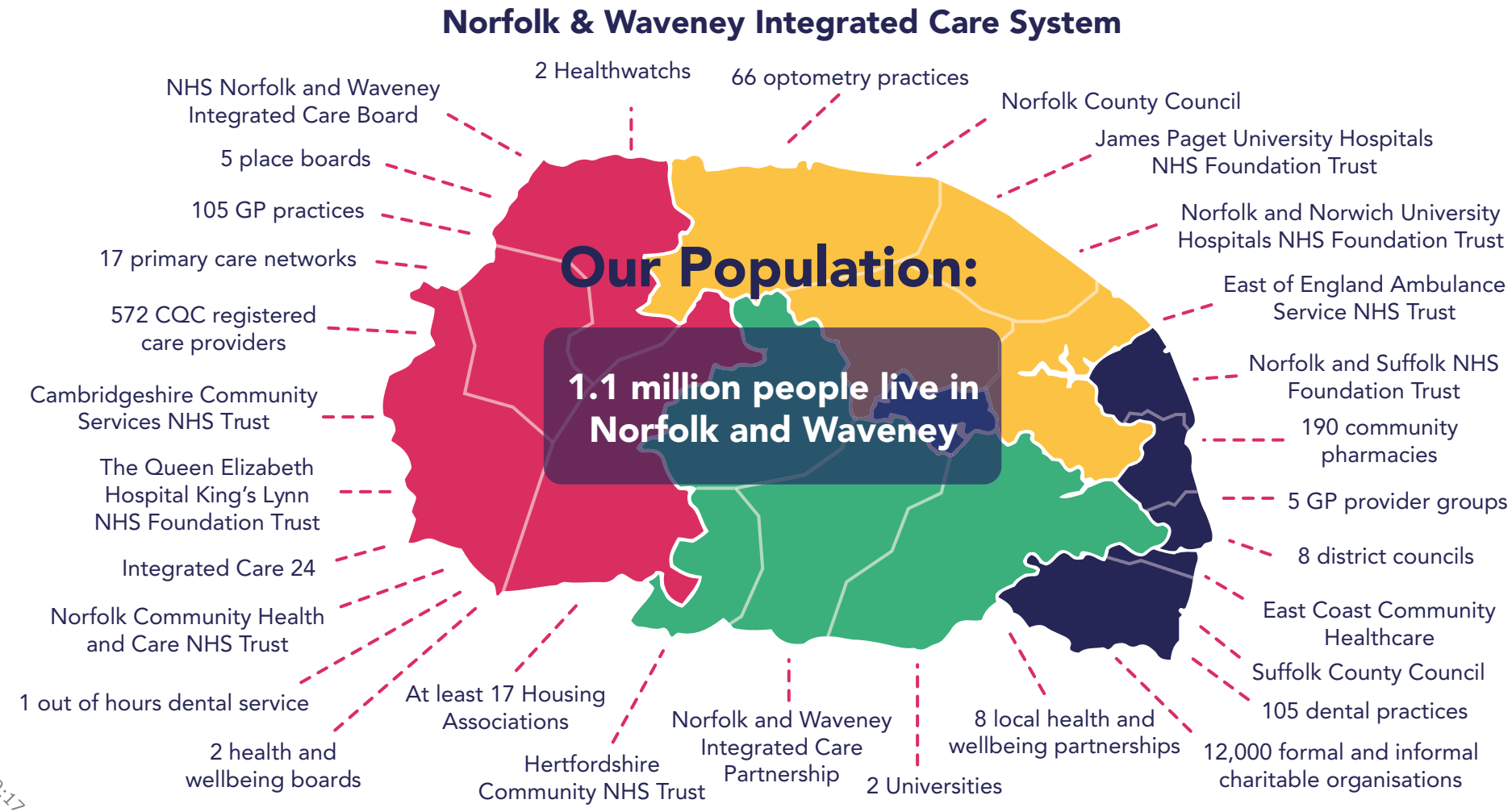

Figure 1 - Stakeholder map

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1.2 Building on progress made in 2024/2025

This is our third JFP, and we refresh it each year so we have a rolling five-year programme of improvement. The plan incrementally builds on progress made in previous years with the expectation that Objectives within the Ambitions are delivered and become business as usual and we move to the next area of focus.

The eight Ambitions and the 21 underpinning Objectives are tracked according to what has been completed, is in progress and delayed. The format of the bi-annual report follows the structure of the eight Ambitions. Progress against the plan is monitored through the Commissioning and Performance Committee and is available on the ICS website. The latest progress report can be found here.

In the October 2024 report we shared several outcomes that improve experience for patients. For example, fewer patients have fallen due to the intervention of the Unscheduled Community Care Hub, a flowchart for anti-depressant prescriptions has been introduced in primary care to ensure we are not over-prescribing, and patients are regularly reviewed and offered alternatives e.g. access to NHS Talking Therapies.

There was some excellent engagement, for example with Community Voices in the Targeted Lung Checks prevention programme which is supporting uptake, with schools in the Partnership for Inclusion of Neurodiversity (PINS) pilot and Healthwatch Norfolk have supported feedback sessions on the use of the NHS App.

There is strong leadership within the system, for example the adoption and dissemination of both the Health Inequalities (HI) Framework for Action and the Population Health Management (PHM) Strategy. Support from the Integrated Care Partnership has been excellent.

Some of the challenges were and still are around capacity, for example within primary care to deliver prevention workstreams, specifically the hypertension objective (1d). Similarly, the capacity of care home and primary care staff to be fully engaged in the Transforming Care in Later Life Ambition may impact on the ability to record frailty scores.

The elective recovery Ambition 7 and Ambition 8 Improving Productivity and Performance remain challenging to deliver, which reflects the local and national position, and work in these areas continues in 2025/2026.

1.3 Links to our transitional Integrated Care Strategy and local Joint Health and Wellbeing Strategies

It is important that our plan is consistent with local Joint Health and Wellbeing Strategies, and we have two of these which cover our ICS: one for Norfolk and one for Suffolk. Helpfully, the Norfolk Health and Wellbeing Strategy is also the Integrated Care Strategy for Norfolk and Waveney, so we have one strategy that fulfils both those functions. It was designed in this way to bring everything together, looking across both Norfolk and Suffolk and specifically focusing on themes which are not in the remit of a single part of the system but require a collaborative approach to improvement. The JFP builds on that approach, focusing on improvements that will be achieved by working together differently. Within part 2 of our JFP there is a section on implementing any local joint health and wellbeing strategy which includes a link to both the strategies.

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1.4 Link to the core purposes of an ICS

The JFP also addresses the four core (national) purposes of an ICS which are:

- 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

These core purposes have very good alignment with the Norfolk and Suffolk strategies referred to above. The JFP addresses these through the development of eight areas of ambition, enabled by working differently together and through some key strategic infrastructure which is explained in section 6.0. Our eight ambitions are set out below:

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

These eight ambitions are described in this plan with underpinning objectives, trajectories, and milestones. We want our local population to be able to see what we plan to do, by when, and what difference it will make to them in their lives.

The ambitions are at the centre of our JFP and are set out within section 4.0.

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Case Study

Providing multi-agency support to ensure people can live in warm, comfortable homes, reducing the impact on their health

Cold homes and Chronic respiratory illness is an issue for many areas across the country. In Great Yarmouth and Waveney, the local health and wellbeing partnerships are building on the approach developed in Gloucestershire, which focused on the direct correlation between cold, damp living conditions, exacerbation of respiratory illness and increased risk of hospital admission. These partnerships are made up of Local Authorities, VCSE and NHS organisations, primary care and others who are truly working together to wrap services around our people and communities.

Clinically led by Dr Sarah Flindall, East Norfolk Medical Practice, the project has been supported through ringfenced funding agreed between Great Yarmouth Borough Council and East Suffolk Council and has supported approximately 750 people this winter.

The project is reducing respiratory ill health caused by cold homes, by seeking out vulnerable people with chronic respiratory conditions who are living with fuel poverty, providing them with financial support from the national Household Support Fund.

The project is also linking individuals with other support services for their wider health and wellbeing needs, with the intention of helping people to lead longer, healthier and happier lives. This project has a big focus on prevention, helping to reduce the number of related hospital admissions and supporting people to help prevent respiratory illness from starting or indeed getting worse.



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2.0 Framework for Change

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2.0 Framework for Change

2.1 Five-point approach to developing our JFP

We have adopted a logical approach to developing our JFP, with each step drawing together all the major components of our plan into a coherent vision for improvement over the medium to long term. By doing this, we have carefully considered:



1. **Why** we are doing this – using our ICS Integrated Care Strategy and the Suffolk Health and Wellbeing Strategy we have set out the needs of our population using evidence, data and public engagement to compile an overall case for change to improve the health and outcomes for the people of Norfolk and Waveney. This is section 3.0.

2. **What** are our ambitions for improvement– these are our eight ambitions, with initial objectives identified. This is section 4.0.

3. **When** we expect to deliver – we have created a summary roadmap that illustrates when there will be activity happening on each ambition. This is in section 5.0. Within each objective there are detailed trajectories and milestones for implementation.

4. **How** we are going to work together differently to deliver this – these are the seven ways of working that we have agreed and are set out in section 6.0. This is a really important journey for us to go on as a system, these are our enablers, and we have some key areas to focus on – these are equally as vital as the ambitions and objectives themselves.

5. **Commitment** to achievable, measurable and impactful improvements – this is how we will know we are achieving our objectives in our first JFP. Our objectives are consistent with the Medium-Term Financial Plan, recognising capacity constraints and competing priorities. This is section 7.0.

Each of these five elements are set out in more detail in the sections that follow.

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Case Study

Working together to reduce re-offending, substance misuse and supporting better mental health

As a result of working together, a new clinical psychologist role has been rolled out across the Norfolk and Waveney ICS, commissioned by Norfolk County Council, employed by Norfolk and Suffolk NHS Foundation Trust, and deployed into the Project ADDER team within our VCSE-provided local drug and alcohol service (Change Grow Live).

Project ADDER aims to reduce re-offending, reduce substance misuse and promote mental health in service users with complex emotional needs, substance misuse and a history of contact with the criminal justice system. In this role, the psychologist works directly with individuals to provide intervention and indirectly with staff to increase the provision of brief psychologically informed treatments.

This reduces barriers to access as service users with high levels of complexity can be seen in a setting they are familiar with where they are used to engaging with support. The role also forms a bridge for service users to access more specialist mental health treatment within the mental health trust as needed, and a channel for specialist resources and training from within the mental health trust to be made available to project ADDER and CGL staff.





3.0 Why we are doing this – the case for change

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3.0 Why we are doing this – the case for change

In this section we talk about Population Health Management (PHM), Health Inequalities (HI) and Prevention so we have explained what we mean by these terms in the picture. They are interlinked and inform what we can do differently, and what will make the most difference to people.

Prevention - 3 levels

Prevention – 3 levels
1. Primary prevention – taking action to reduce the occurrence of disease and health problems before they arise.
2. Secondary prevention – detecting the early stages of diseases and intervening before full symptoms develop.
3. Tertiary prevention – softening the impact of an ongoing illness.

For more information – Prevention | local government Association

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

NHS England > What are Health Care Inequalities?

Population Health Management is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and wellbeing.

For more information NHS England Population Health and the Population Health Management Programme

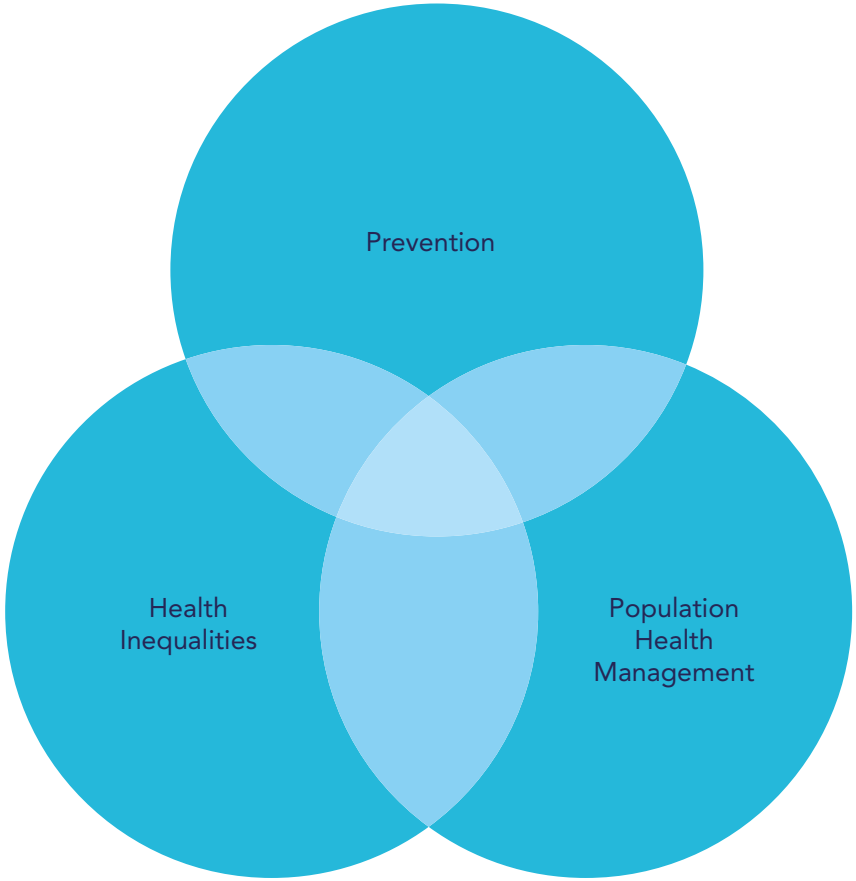

Figure 2 - PHM, Health Inequalities and Prevention

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3.1 Summary of health need for Norfolk and Waveney population

In this section we present a summary of our local population and our associated health needs using a population health management approach, which has been led by our public health team. It makes a compelling case for focusing on the ambitions we have chosen, and particularly what we can do now on prevention, to improve our health and wellbeing for the future. Let's look at some of the key facts about Norfolk and Waveney (note: numbers are rounded):

In 2023 there were **8,300** births and **12,600** deaths

In December 2024 there were **1,099,900** people registered with a General Practice in Norfolk and Waveney.

During 2023, patients attended **7,181,000** appointments with General Practice (this means that on average, each person across Norfolk and Waveney attended about 7 appointments), and **76.7%** of people have a positive experience of their GP practice

In June 2023 **83,000** children had visited a NHS dentist in the previous 12 months and **327,000** adults visited an NHS dentist in the previous two years

During 2023/2024

66,500 people in Norfolk and Waveney were in contact with Mental Health, Learning Difficulties or Autism services and **19,000** of these were under 18. This is over 6% of the total population and over 9% of the population under 18

A&E departments saw **294,000** attendances with **109,150** Norfolk and Waveney patients admitted as an emergency.

There were **1,152,000** hospital outpatient appointments and **200,460** hospital operations – of which **135,275** were operations for people on the waiting list

166,800 people in Norfolk and Waveney live in the 20% most deprived communities in England (known as the Core20 population)

In terms of physical health, in 2023/2024 the number of people diagnosed with long term health conditions (LTCs) include **191,900** with high blood pressure, **79,700** with diabetes, **40,500** with heart disease, **32,000** with atrial fibrillation or a common abnormal heart rhythm, **25,300** with Chronic Obstructive Pulmonary Disease (COPD) which is a lung condition that causes breathing difficulties and **82,600** with asthma.

In terms of mental health, **11,200** people are diagnosed with dementia, **10,700** people are diagnosed with a serious mental illness and **9,600** are diagnosed with depression anually

In 2022/2023 across Norfolk and Waveney there were **7,313** cancers diagnosed

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We know there are opportunities for longer term prevention. For example, there are estimated to be:

- more than **100,000** smokers, more than **560,000** people overweight or obese and more than **190,000** who do not exercise
- more than **87,000** people with high blood pressure that has not yet been diagnosed and managed

These facts and figures give us some of the context about the health of our population and the scale of the activity that goes on, week in week out. The longer term prevention opportunities and the number of people who have LTCs highlight where we can focus to make a difference.



3.2 The growing population – our older population

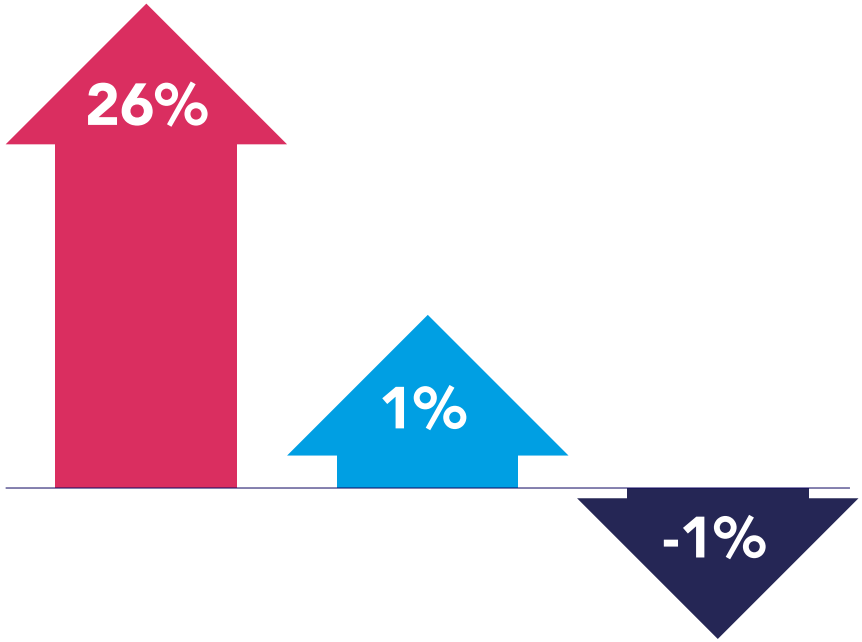
Norfolk and Waveney generally has an older population, projected to increase at a greater rate than the England average. This creates a key challenge for our health and care system and is why we have an ambition of transforming care in later life.

From 2020 to 2040 there will be an estimated:

26% increase in people aged over 65, mostly in those aged 75+

1% increase in people of working age

1% decrease in children and young people under the age of 16



The greater increase in those in later life compared to those of working age by 2040 means that there will be fewer people of working age for every person under 16 or of retirement age, which has implications for our workforce.

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Over the next five years the population is expected to grow by more than 29,000 people, and the majority will be those aged 65+. We anticipate this to continue, and by 2040 the population is likely to have increased by about 78,000 people, this is about the same as half of the current population of Norwich.

As a result of this we can expect to see an increasing demand for appointments at doctors, dentists and hospitals, emergency admissions, and an increase in the numbers of people with LTCs and increased need for care. For example, if nothing changes and current rates apply to the increasing population then over the next five years:



The demand for appointments with a GP is likely to have increased by more than a **1,000 per day**



The number of people going to A&E is likely to have increased by about **900 per month**



The number of people who have to stay in hospital having arrived as an emergency is likely to have increased by about **500 per month**

This is why it is so important that we prioritise transforming care in later life as one of our ambitions.

3.3 We can make a change

What is encouraging to note is that the risks for many LTCs can be reduced through changes in health behaviours and addressing unwarranted variation in clinical care. We have set out a clear ambition in relation to PHM, health inequalities and prevention to start the work on this.

Preventing LTCs improves outcomes for people and reduces costs. While the impacts of health behaviour change might take longer to take effect, we can see impacts over a shorter time frame by improving other aspects of the health and care system like urgent and emergency care, mental health services, and services for families and babies, children and young people and people in later life which are all ambitions in our JFP.

However, there are some poor outcomes or associated factors for people at different stages along their life course (Figure 3) and we want to tackle those. For example, a higher proportion of pregnant females smoke. When developing our ambitions and objectives we have carefully considered what this outcomes life course is telling us and focused on where we need to make improvements based on the evidence.

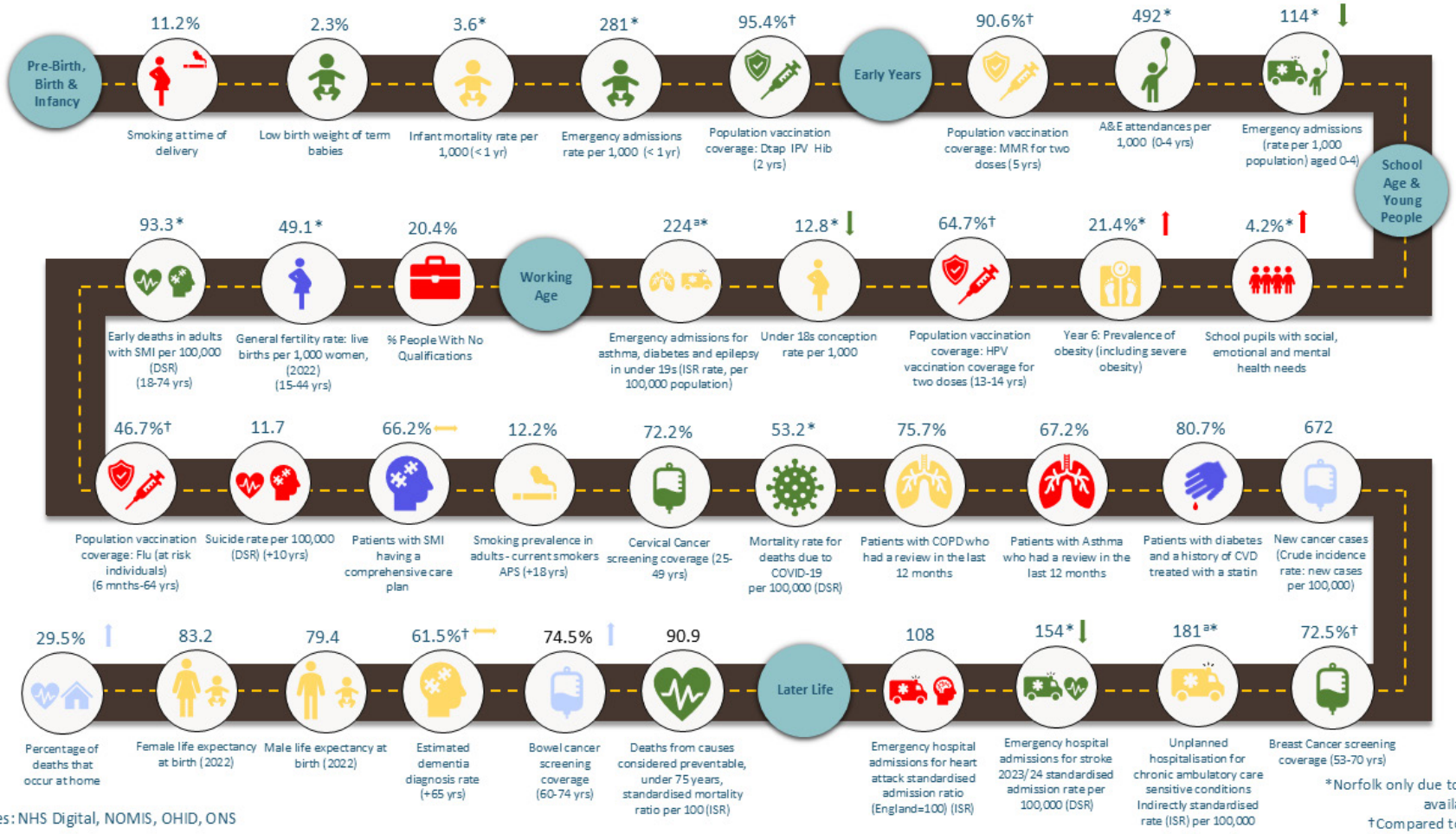
In addition to smoking, being overweight is one of the biggest causes of illness that can be prevented – it can lead to diabetes, problems with bones, joints and muscles (musculoskeletal) and heart disease (cardiovascular).

Outcomes along the life course for people in Norfolk and Waveney
Source: Insight and Analytics at Norfolk County Council

Arrows represent the trend (if available)
- Green arrows represent getting better
- Yellow arrows represent staying the same
- Red arrows represent getting worse

Icon colours show how the indicator compared to the national average (if available)

Worse **No significant difference** **Better**



Sources: NHS Digital, NOMIS, OHID, ONS

*Norfolk only due to data availability
†Compared to goal

[a] NHS OF measures are indirectly standardised to the 2012 England population structure: the ratio of actual local counts to expected (the 2012 England age rates applied to local age populations) is multiplied to the original 2012 England rate.

Figure 3 – Outcomes along the life course for people in Norfolk and Waveney

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3.4 Health Inequalities

Aside from the conditions that people die from, the amount of disability or illness that people have varies according to where you live – that is a fact. In Norfolk and Waveney many health outcomes for people are as good or better than in England overall as a comparison, and males and females generally live longer lives in Norfolk and Waveney than the England average.

However, there are stark inequalities in outcomes for people in the 20% most deprived communities (known as "Core20"), that then accumulate over the life course. These result in poorer health outcomes and ultimately a shorter life expectancy.

The State of Norfolk and Waveney report 2022 shows that the 167,000 people of Norfolk and Waveney that live in some of the 20% most deprived communities in England are more likely to:

- Have harmful health behaviours, such as smoking and being less active.
- Have multiple, limiting, long-term conditions.
- Attend A&E and be admitted to hospital for an emergency.
- Be in poor health before reaching retirement age.
- Die early.

(Core20 and CORE20PLUS5 are explained in more detail in the legal duty to reduce health inequalities in Part 2 of the JFP, and through this link: NHS England » Core20PLUS5 – an approach to reducing healthcare inequalities).

The Core20 populations in Norfolk and Waveney are shown on the map in Figure 4 and we know that the health outcomes for the populations in our most deprived communities could be improved further. This is one of our objectives in Ambition one, Population Health Management, Reducing Inequalities and Supporting Prevention.

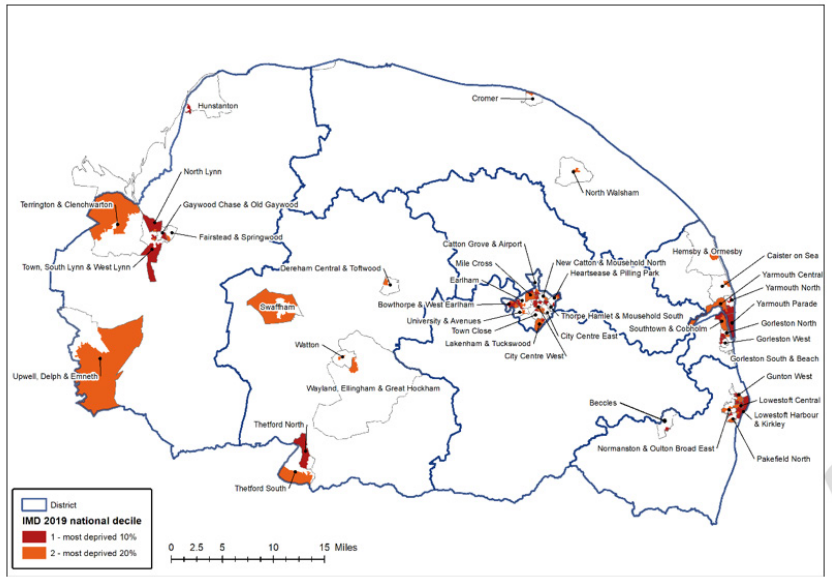

Figure 4 – "Core20" communities across Norfolk and Waveney where some or all of the residents live in the 20% most deprived areas in England according to IMD2019

Other population groups in addition to those that live in the most deprived communities are also more likely to have poor health outcomes and to die early. For example, children and young people with learning difficulties or autism and those that are looked after are more likely to experience mental health issues. According to the Norfolk Joint Strategic Needs Assessment undertaken in 2022 there is a predicted population of over 16,500 adults in Norfolk who have a learning disability, and who have an average lifespan that is over 10 years shorter than the wider population.

As people move into adulthood those with learning difficulties are 4 times more likely to die early than others with similar characteristics and those with severe mental illness are 3.7 times more likely to die early. Many of these deaths are preventable.

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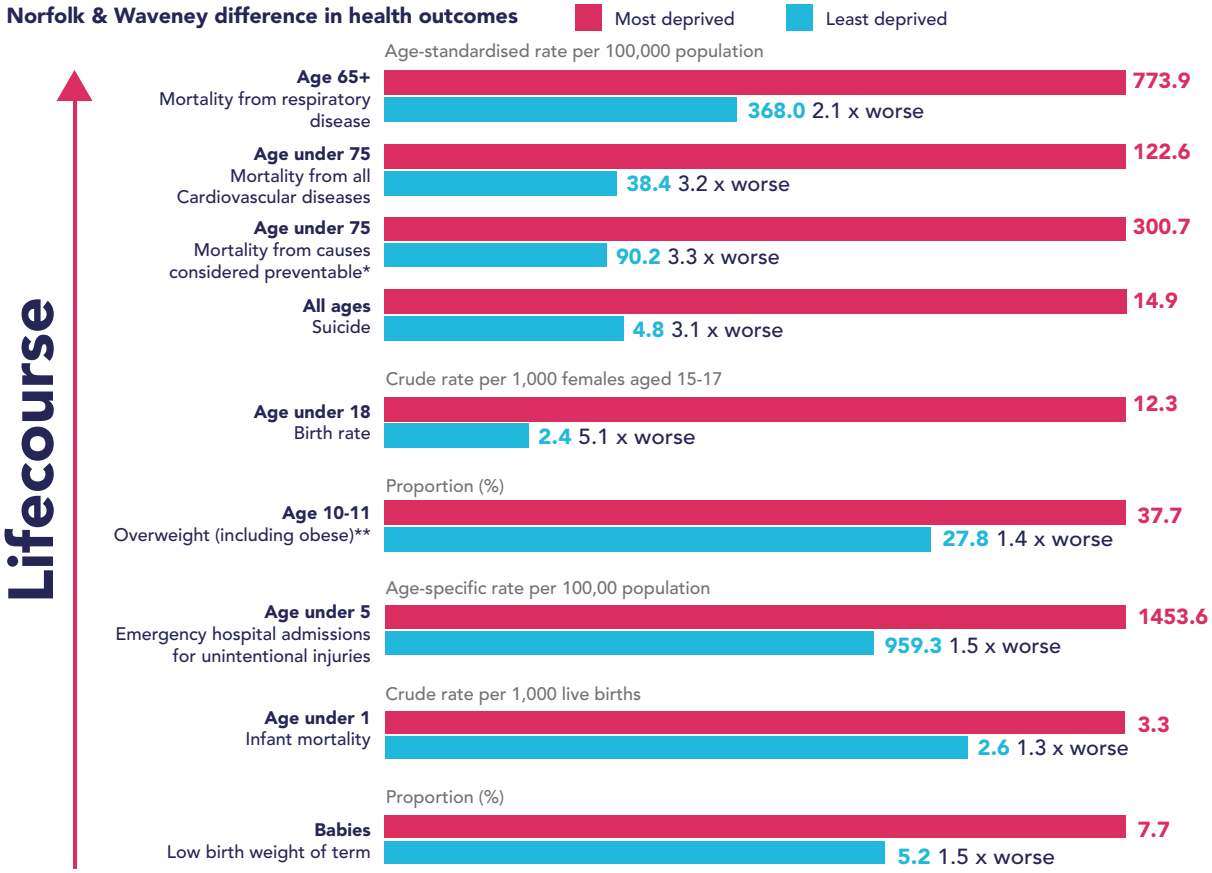
For example, Figure 5 compares the least deprived communities with the most deprived "Core20" communities:

- Babies in the most deprived areas are 50% more likely to be of low birth weight and 30% more likely to die before they are one year of age.
- Young children are 50% more likely to be admitted as an emergency.
- Year 6 children are 40% more likely to be obese.
- Teenage girls are 5 times more likely to have children.
- People are 3 times more likely to take their own life.
- People are more than 3 times more likely to die from preventable causes.



Comparison between the most and least deprived 20% (quintiles) of the population Norfolk & Waveney. *Pre-2019 definition for preventable mortality. **'Age 10-11, Overweight (including obese)' compares areas within Norfolk and excludes Waveney.

Figure 5 - Inequalities in health outcomes between the least deprived and the most deprived Core20 communities in Norfolk and Waveney

The accumulation of inequalities over the life course for those in the more deprived Core20 communities has an impact on the number of years a person is likely to live.

Across Norfolk and Waveney in 2020-2021 the gap in life expectancy between the most deprived Core20 communities and the least deprived communities was 6 years and 9 months for males and 5 years and 4 months for females.

This gap is due to more deaths in the Core20 communities from heart attacks, strokes, cancer, respiratory disease and COVID-19 (Figure 6).

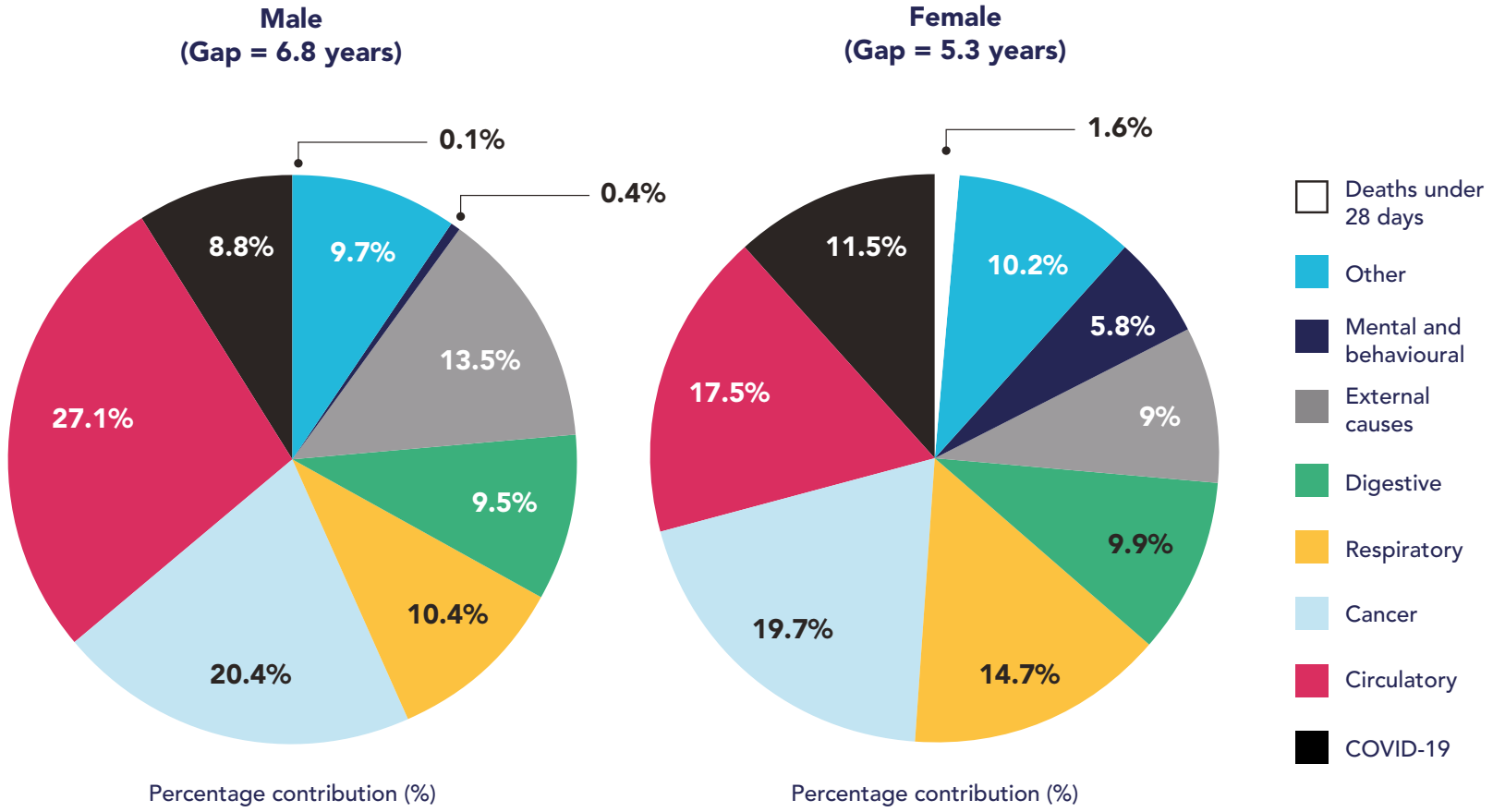


Figure 6 Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Norfolk and Waveney by cause of death, 2020 to 2021 (https://analytics.phe.gov.uk/apps/segment-tool/)

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3.5 Opportunities to improve outcomes

This is all very concerning but some of this gap in life expectancy is preventable by changing health behaviour and addressing unwarranted variation in clinical care. For example, about 20% of the life expectancy gap is due to cancer. 38% of cancers are preventable, 15% of all cancer is caused by smoking and 6% by obesity.

Across Norfolk and Waveney just over half of all cancers are diagnosed early and while overall screening uptake is good (and this helps with earlier diagnosis), people from the Core20 most deprived communities are less likely to be screened for cancer. For example, there are 46 GP practices in Norfolk and Waveney where the proportion of people screened for bowel cancer is less than the Norfolk and Waveney average. If all these practices screened at least the Norfolk and Waveney average then an additional 3,600 people would be screened for cancer. For the Core20 most deprived GP practices this is an additional 1,400 people, which is more than a third of the total.

Changing health behaviour will reduce the number of preventable cancers. Increasing the numbers of people with cancer diagnosed early, through screening and smoother progress through care pathways, means that chances of survival are better and outcomes improved.

There are also opportunities to improve outcomes for people with respiratory and circulatory conditions through changing health behaviours and reducing unwarranted variation in clinical care. For example, Norfolk and Waveney has a higher prevalence of COPD than England (2.3% vs. 1.9%) and a similar proportion of COPD patients that receive a 12-month review (75%), but there is variation across Norfolk and Waveney from practices with 47% of patients with a 12-month review to practices with over 96% of patients with a review. For circulatory conditions, the Cardiovascular Disease (CVD) prevent work shows that if we were to detect and better manage 17,000 hidden cases of high blood pressure then we would save more than 100 heart attacks and more than 150 strokes over the next three years.

Due to inequality in health behaviours, the opportunities for improving outcomes are likely to be greater in the Core20 most deprived communities. As deprivation increases the proportion of people with risky health behaviour also increases. Over the long term if we are to reduce inequality in life expectancy due to cancer, circulatory and respiratory conditions, then we will have to address health behaviours such as smoking, physical activity, obesity and diet.

Opportunities to improve outcomes are not only limited to physical health conditions as there are also opportunities to improve outcomes for those with severe mental illness. For example, of the people with severe mental illness only 66% have a comprehensive care plan compared to the England average of 72%. Across the Norfolk and Waveney GP practices this ranges from under 14% of patients to 100% of patients. By at least matching the England average across Norfolk and Waveney, more than 1,300 extra people would have a comprehensive care plan with potential risk of self-harm reduced.

By improving health behaviours and reducing unwarranted variation in services and care across Norfolk and Waveney and along the life course, it is an opportunity to improve outcomes for those from the most deprived communities AND reduce the demand on hospitals and GP practices.

This evidence makes for compelling reading and our focus on reducing health inequalities and prevention is key to improving the health and wellbeing of our local population.

The JFP includes a range of ambitions that address both some of the current issues in relation to those in later life and younger people, those experiencing poor mental health and those with existing LTCs. We also want to update our model for Urgent and Emergency Care and reduce the waiting times for planned operations as these are all affecting our population. Critically though the JFP signals an intent to get ahead of the curve, and the opportunity we have to reverse some of the most concerning trends and variations.

There are opportunities through:

- Primary prevention, intervening before health effects occur. For example, by changing health behaviours and vaccination.
- Secondary prevention, intervening to reduce the impact of disease that has already occurred. For example, regular patient reviews and by managing conditions appropriately.

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- Tertiary prevention, intervening through surgery or similar. For example, coronary artery bypass grafting, to prolong life in some people with stable congenital heart defects that have been present from birth.

Since the first version of the Joint Forward Plan was produced the Norfolk & Waveney Population Health Management Strategy has been published. This identifies smoking and smoking in pregnancy, serious mental illness, cardiovascular disease, diabetes and respiratory conditions, early cancer diagnosis and children & young people as priorities for the system, based on joined up local data and information.

An East of England level Specialised Commissioning Inequalities review has been undertaken to inform the initial areas of focus, now that these services have been delegated to ICBs. This has identified common areas with our ICB priorities namely cancer, cardiovascular disease, mental health and neonatal / paediatric services. There is more detail about specialised services in section 4.0.

The Norfolk and Waveney Health Inequalities Strategic Framework for Action has also been developed as a ten-year plan aimed at addressing health disparities by uniting partners under a common vision to improve health outcomes for all residents.

The shift from reactive to proactive care, or sickness to prevention, will be an iterative process. However early signs show that progress is being made. Bowel and breast cancer screening coverage has improved in the last two years and COPD reviews are now similar to the England average rather than significantly below. Some outcomes are also improving, for example there are now fewer hospital admissions for stroke, which shows an improving trend, making the ICS significantly better than the England average.

3.6 Public engagement on the JFP so far

In addition to the data and evidence base that we have turned into a life course, we started our public engagement to understand what matters most to the people of Norfolk and Waveney. At the time of the engagement in December 2022 to January 2023, we had started with the five ambitions listed below. We asked if local people thought they were still correct.

- Transforming Mental Health services
- Improving Urgent and Emergency Care
- Elective Recovery and Improvement
- Primary Care Resilience and Transformation
- Improving Productivity and Efficiency

We were told that some things were missing, so we added three more:

- Population Health Management, Reducing Inequalities and Supporting Prevention
- Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
- Transforming care in later life

Our online survey received 700 responses in total.

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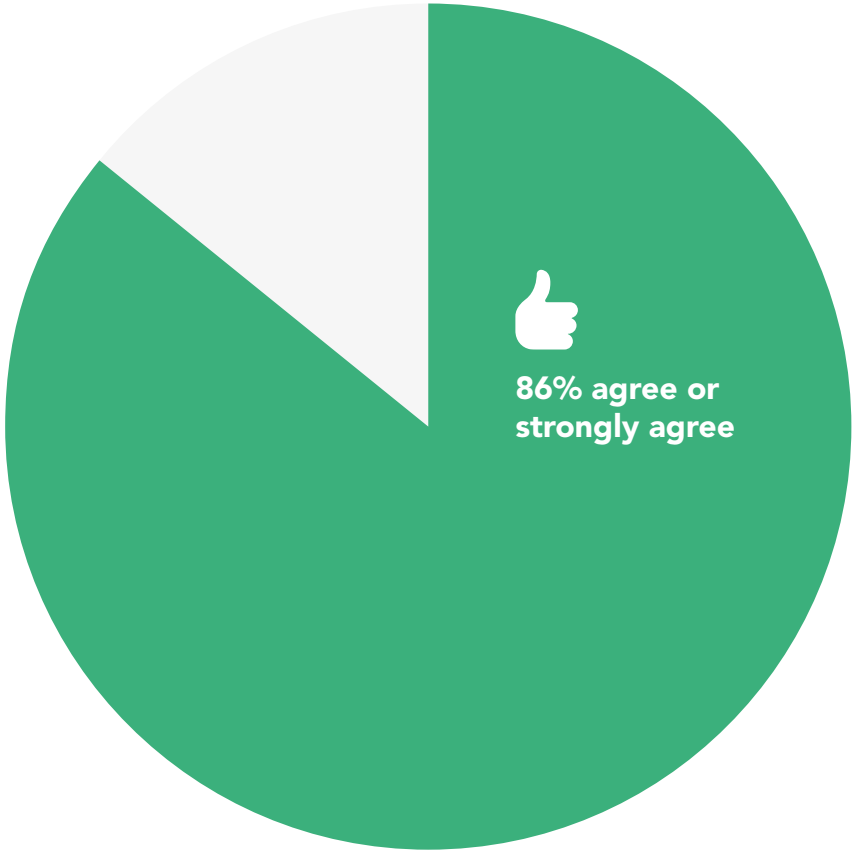
505 people out of 585 who responded (just over 86%) strongly agree or agree that we have chosen the right priorities.

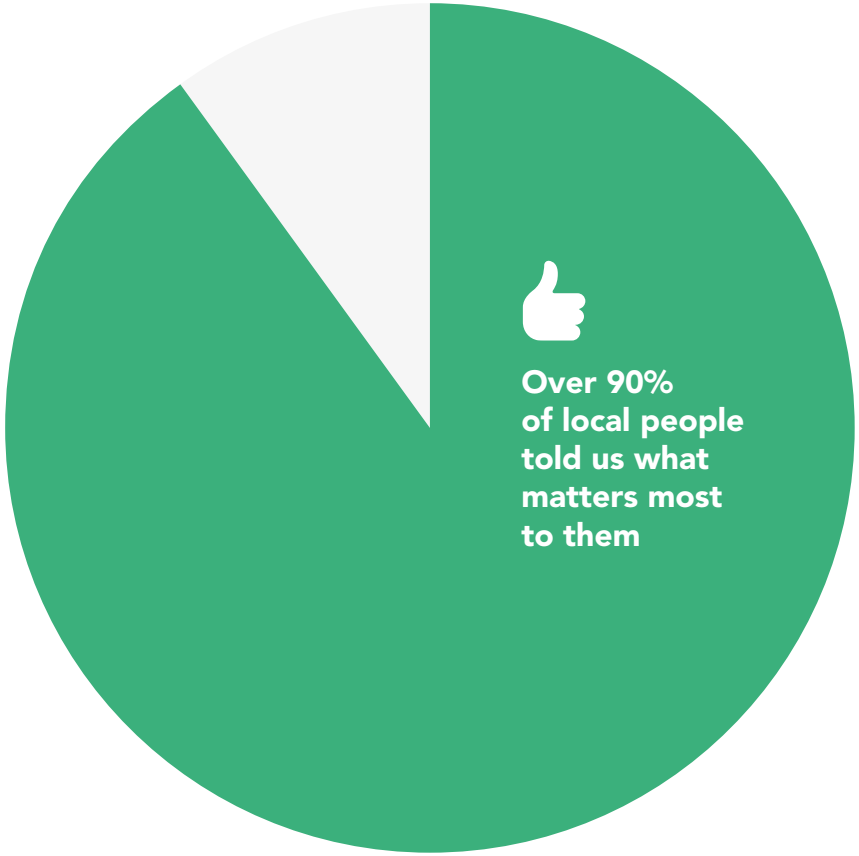


249 people also left free text comments

For example:

- The absence of social care as a priority was highlighted by some
- Perception that GP access needs improving
- More NHS dentistry needed
- Issues highlighted around older and other vulnerable people being in hospital beds due to lack of flow through the system, or disconnected services
- Concerns raised about finances – how staying within budget will impact services, and how all the priorities are to be afforded
- Emphasis on community care, including end of life and palliative, as well as primary care
- Someone who disagreed said that early help and prevention was missing
- Concerns about out of county mental health provision, and lack of early and preventative mental health provision, especially for children and young people and people with Autism
- Issues raised about recruitment and retention of staff, including social care
- Some comments that the priorities do not reflect the future aspirations of an ICS and are 'stuck in the past'
- Access to services for people with extra needs, e.g. Learning Disabilities and Autism, deaf/hearing impaired
- Improved digital connectivity between services, alongside the recognition that some people are digitally excluded

537 people out of 592 who completed surveys (just over 90%) responded to What matters most to you?



Many of the points were made again, but other issues raised include:

- Knowing an ambulance will come if I need it
- Getting help with caring responsibilities
- Palliative and end of life care, and bereavement services
- Working with VCSE and community organisations
- Simple ways of getting help – a single front door
- Joined up services, better collaboration and integration, services under one roof, continuity of care
- More help for people to help themselves
- Support for vulnerable people – homeless, CYP, families and older people
- Getting an appointment, especially with a GP – some like face to face, some online
- Shorter waiting times
- Some comments about better communications, and campaigns about using services and self help
- Health and care services aimed at men, and delivered by male staff
- Increase funding for prevention services, including physical and talking therapies, and public education and awareness raising
- The role Oral Health has to play in promoting and protecting general health and wellbeing
- Developing and supporting our workforce to help retention
- Several comments about the Walk-in Centre in Norwich and the need for a new hospital in King's Lynn

You can read the full report, including examples of the comments people made, on our dedicated webpage: Joint Forward Plan

This is not the end of the conversation. The projects that will form part of the ambitions and their underpinning objectives will need engagement, involvement and co-production with local people, those who use our services and our workforce. We will build an ongoing programme of participation that includes a range of participation methods. Working with our people and communities will be vital if we are to create services that meet the needs of the different people and groups that live in Norfolk and Waveney. Within part 2 of our JFP you can also read more about our legal duty to involve the public where there are some useful web links to further material.

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Case Study

I-statements – working with our experts by experience

Through a series of workshops and discussions with Experts by Experience, facilitated by Rethink Mental Illness and NHS Norfolk and Waveney's Mental Health programme team, a set of I-Statements, tailored to Community Transformation (CT) were developed during 2022-23.

We are now taking steps to ensure service provision is aligned with the I-Statements. A project is now being planned to develop an outcomes-based commissioning approach, building on this work.

An expert by experience said: "Working with NHS Norfolk and Waveney and the wider Norfolk and Waveney ICS has really helped bring the views and experiences of people who have experienced mental ill health.

"This is a fresh, new innovative approach which is valuing the views and experiences of people with lived experience."





4.0 Our Ambitions for improvement

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4.0 **Our Ambitions for improvement**

We have two timescales, the immediate priorities that are aligned with NHS planning requirements nationally and the next tranche of delegation of specialised services, and medium-term local improvements within our eight Ambitions, coupled with work to develop new models of care.

4.1 2025/2026 immediate priorities

We have summarised the immediate priorities below as they are important and form some of the first-year elements of our rolling five-year JFP.

Each year the NHS is asked to produce an operational plan detailing the activity levels, performance standards, workforce numbers and financial plans for the next 12 months. Each of these elements are triangulated to ensure consistency, for example that an increase in activity is supported by an increase in staffing, which in turn is included in the financial projections. These plans are developed together as a system, working in partnership to achieve the required aims and ambitions in the Operational Planning Guidance for 2025/2026.

The overall operational plan priority for 2025/2026 is to improve access to timely care for patients, increasing productivity and living within allocated budgets. There are many links through to the ambitions of the JFP such as:

- Improving the flow of **urgent and emergency care** patients in to and out of our services. We have said that we will work in a more collaborative way, to support community teams to respond to urgent care needs which are not life threatening but need a rapid response, which will improve how quickly emergency ambulances can respond to our most unwell patients. This in turn will reduce the length of stay in hospital, bed occupancy, and enable the emergency department to see at least 78% of patients within 4 hours; allowing ambulances to be released from waiting outside hospitals and respond to calls in the community. This is Ambition 6.
- Continue to reduce the number of people waiting for **diagnostics and elective care**. During the year the plan is to improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with all our local hospitals expected to deliver a 5% improvement against a November 2024 baseline. This and future reductions in 18 week waiting times will be achieved by working more closely together, supporting direct GP access to nationally recommended cancer diagnostic tests and utilising capacity within new system resources such as our new community diagnostic centres. This will help to improve our diagnostic performance and our 62-day cancer standard which we are being asked to improve to 75% by March 2026. This is Ambition 7.
- **Increase the amount of dental activity** by continuing to implement the key proposals set out in the national Dental Recovery Plan published in February 2024, working to deliver the additional unscheduled care appointments that are part of the 2025/2026 Operational Planning requirements. This is Ambition 2.
- Continue to **address health inequalities and shift towards prevention**. For adults this is maternity continuity of care, severe mental health checks, respiratory conditions, early cancer diagnosis and case finding and treating high blood pressure. We have identified Population Health Management priorities at a system level to address health inequalities and meet the Core20PLUS5 approach for adults and children. For adults, we have JFP objectives that focus on smoking, especially smoking in pregnancy, serious mental illness, cardiovascular disease, and early cancer diagnosis and for children and young people, asthma, epilepsy mental health and oral health. These are part of Ambitions 1, 2, 3 and 4.

- **Improve mental health and learning disability care** to reduce length of stay in acute mental health beds, increase the number of children and young people accessing services, and reduce the reliance on inpatient care for people with a learning disability and autism so they are receiving services in the community or through other ways. Ambitions 3 and 4 include objectives that are about providing alternative therapies and services, and earlier interventions provided in community settings.
- **Deliver within our financial resources and improve our productivity**, with a particular focus on reducing our spend on agency staff, reducing waste and maximising productivity. We will ensure that we continually review opportunities for improvement. This is the focus of Ambition 8.

Specialised Services

From April 2025 the ICB will receive another 11 'specialised services', legally taking on the delegated responsibility for these from NHS England. Services being delegated in 2025/2026 include specialised Mental Health and Learning Disability and Autism. The rationale for the delegation is to enable population based, end-to-end commissioning of services with decisions made closer to communities, and care provision is better joined up for the benefit of the local population of all ages.

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. Some of these services are provided locally at our hospitals in Norfolk but some are in specialist hospitals such as Great Ormond Street, Papworth or Moorfields for example.

The ICB became responsible for commissioning pharmaceutical, ophthalmic and dentistry services in 2023, and for 59 specialised services in 2024, with some screening and immunisation services expected to follow in future years. This is following the NHS England Roadmap for integrating specialised services within integrated care systems (2022). The six ICBs and partners are developing a work plan and longer-term strategy for the eastern region which is consistent with the JFP's that each ICB has published. Cardiac and cardiovascular, cancer and renal services have been identified as priority areas for review. Clinical input into the re-design of services within the existing available budgets with input from specialised provider collaboratives will be key and form part of the plans for improvement in 2025/2026.

4.2 Our medium-term ambitions for improvement

New Models of Care

Since the second JFP was published, Lord Darzi's report on the state of the National Health Service in England (Independent investigation of the NHS in England, September 2024) showed that NHS services are stretched to breaking point and that radical change is needed as incremental improvement will not resolve the challenges. In response, the government is developing a 10-year plan for health and care, based on three 'big shifts' they want to see in health and care, moving from:

- Hospital to Community Services: The biggest improvements to health and care will come from prioritising services outside of hospital. That means greater investment in the primary and community services that support people before they need hospital treatment.
- Treating sickness to preventing it: political focus on public health strategies that keep people healthy and prevent illness in the first place.
- Analogue to digital: Using digital technology to improve patient experience and outcomes and help deliver the ambition of moving care closer to home.

More locally, across the East of England, the NHS delivers health care to over 6.4 million people, covering a large and diverse urban and rural geography. Despite this diversity, NHS services face similar challenges of limited capacity to support an ageing population that is rapidly growing, high rates of multi-morbidity, rising demand, significant health inequalities, preventable long-term conditions, a need to better manage and co-ordinate care for improved patient outcomes and a workforce that needs to adapt to meet the future care needs of the people it serves. Collectively, these challenges are creating unsustainable healthcare costs.

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There is increasing demand on healthcare services from a growing population, with increasing (national annual rate of 6.1%) prevalence of multimorbidity who need support to live well, for longer. Therefore, a different model of care is needed that provides an alternative, safe and sustainable option.

This transformative approach shifts from traditional acute care to a community-based model that enhances accessibility, patient satisfaction, and operational efficiency. Our priority is to empower people by placing access to care directly in their hands, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease.

This regional approach, owned by all ICBs, sets out a new care model covering four areas of delivery and implementation:

1. **Digital Enablement:** Utilises electronic health records (EHRs) and telemedicine to enhance patient care, streamline data sharing, and reduce costs. Digital tools will improve efficiency, accessibility, personalised care, and patient outcomes, while also allowing patients to manage appointments and access health records online.

2. **Health Optimisation:** Focuses on prevention, early detection, and management of chronic conditions. It targets high-risk populations with personalised interventions to improve health outcomes and reduce healthcare utilisation.

3. **Acute Illness Management:** Integrates multi-disciplinary teams (MDTs), case managers, and a virtual hospital infrastructure to streamline patient care, reduce delays, and ensure seamless transitions. This model emphasises community-based acute care and reduces unnecessary hospital admissions.

4. **Advanced Illness Care:** Enhances quality of life for individuals in their last two years by providing personalised support, managing end-of-life care, and reducing hospital admissions through better community care.

We are working to develop our new local model of care to tackle the local, regional and national challenges. We have started to draft the framework that sets out our system approach to efficiency, productivity and transformation over the next five years. Alongside our other strategies and plans, this work will:

- Set out the overall vision for how the system will function and the key services that will be delivered.

- List the priorities for transformation (including Prevention and Anticipatory Care, the Neighbourhood Health Service, Acute Collaboration, End of Life Care, Ageing Well and Long-Term Conditions Management).

- Describe our ambition for these areas:

  - We will bring in expertise (nationally and worldwide) to help us create the very best models for our community
  - We will embed a culture of innovation and continuous quality improvement to evolve services, but we will also future proof and protect services from regular, disruptive systemic change.
  - We will start from a 2030 blank page (building up from demand, capacity and need), and then work back to fit in our current assets, existing plans and strategies and plan to fill the gaps.
  - We will balance making the necessary short-term changes and efficiencies, with the new models in mind and the aim to achieve a high performing but lower cost system.

- Describe the structures that will deliver the new models and what fundamentally will be delivered at each level of:

  - System.
  - Place.
  - Neighbourhood Health Service via our Integrated Neighbourhood Teams.

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The emerging transformation priorities are detailed below:

1

Person-centred, preventative and proactive care

Addressing health inequalities through five data-driven Population Health priority areas:

1. Smoking and smoking in pregnancy
2. Serious mental illness
3. Cardiovascular disease, diabetes and respiratory
4. Early cancer diagnosis
5. Children and young people

2

Neighbourhood Health Service

- Developed from the Community Services Review (CSR) and now a national priority.
- Designed to deliver five Strategic Impacts across physical & mental healthcare in N&W - no one organisation can deliver these on their own:

1. Proactive and personalised support from integrated teams
2. Enabling healthy communities
3. Delivering more specialist care in the community
4. Meeting local and emergency care needs
5. Transforming Care in the Last Year of Life.

3

Acute Collaboration

New Hospitals Programme
- Future Paget
- New QEH

Electronic Patient Records
- Share digital clinical records between hospitals

Acute Clinical Strategy
- Develop person-centred services, enabled through patient involvement in design
- Whole pathway approach to build integrated services with more care delivered out of Hospital
- Increase clinical capacity to deliver care within the shortest waiting time
- Intervene early to manage poor health, reduce admissions and improve population health through prevention
- Provide reliable and sustainable services by making the best use of resources
- Reduce Health Inequalities

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Eight Ambitions

For our third year and until the 10-Year Plan for Health is published, we have retained our focus on the eight Ambitions. These are evidence based and consistent with what we heard from our public engagement, planning ahead to make improvements and to get ahead of the curve with prevention. We have also looked at our local population across the course of an entire lifetime, from conception to end of life, to examine outcomes to inform where improvements could be made.

Our eight ambitions are described in more detail in this section, but this is not the only work we are doing. This JFP does not describe 'business as usual must-do's'. If we were to do this, our JFP would simply be too large and complex to be useful as a delivery plan.

As system partners we all want to use this plan because it identifies common ambitions that we can all support and will help us to drive forward improvements together. This is why we have purposely selected and made a commitment to a few achievable, measurable and impactful improvements, presented in this section as objectives, linked to each of the eight ambitions.

These objectives have been developed in response to what our data tells us, and they require a collaborative system-wide approach to successfully deliver them. As we move from having plans and strategies into delivery, most of the objectives are more specific projects with defined and measurable outcomes in the shorter term.

A summary of the eight ambitions and 21 underpinning objectives is set out in Figure 8.

Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective
1	**PHM, Reducing Inequalities & Supporting Prevention**
1a	Development and delivery of two strategic programmes: The Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action; and the Norfolk and Waveney Population Health Management (PHM) Strategy
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
1c	Early Cancer Diagnosis – Lung Cancer Screening (formerly called the Targeted Lung Health Check or TLHC Programme)
1d	Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol
2	**Primary Care Resilience & Transformation**
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan
3c	Implementation of asthma and epilepsy recommendations for Children and Young People
3d	Develop an improved and appropriate offer for Children's Neurodiversity
4	**Transforming Mental Health Services**
4a	We will 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.
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities
4c	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.
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).
5	**Transforming Care In later life**
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives
6	**Improving Urgent and Emergency Care (UEC)**
6a	Improve urgent care to improve emergency response times across all organisations
6b	Expand virtual ward services
6c	Reduce length of stay (LoS) in hospitals
7	**Elective Recovery & Improvement**
7a	Effectively utilise capacity across all Health System Partners
7b	Implement digital technology to enable elective recovery
8	**Improving Productivity and Efficiency**
8a	To deliver our Medium-Term Financial Plan

Figure 8 – summary of the eight ambitions and 21 underpinning objectives

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Framework
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Ambitions for Improvement
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Case Study

Wellbeing hubs putting mental health front and centre of the community

Wellbeing hubs across Norfolk and Waveney are breaking down barriers and putting mental health front and centre of the community.

Dr Ardyn Ross, Mental Health Clinical Lead for NHS Norfolk and Waveney said: "Having community wellbeing hubs where people can drop in, without an appointment, to discuss their health and wellbeing and any issues that are affecting their mental health is invaluable in removing the stigma around mental health.
"After all we all have mental health – sometimes it's good and sometimes we need support with it to stay well."

The fifth NHS-funded hub - REST Aylsham opened in July 2022 – joining REST Norwich and Kings Lynn and Steam House Café Gorleston and Kings Lynn.

The wellbeing hubs may be branded differently but they all have one thing in common – they're a safe space for people to get support for their mental health and wellbeing in their community. Including people experiencing significant mental distress.

With a focus on wellness, not illness, there's always a warm welcome and supportive staff to offer help, advice, or a listening ear.

The Steam House Café in Gorleston – run by Access Community Trust has been a lifesaver for Lynn White. She says: "I have a mental health problem and the staff here are absolutely brilliant. I come every day and they listen, and they are so kind and helpful. If you come in and just want to chat, you can.

"If it wasn't for this place, I'm not sure I would have coped with my health. I have dissociative disorder and I do have bad attacks and they know what to do if I have one. It's so relaxed and a perfect place to come."





Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention



Tracy Williams
Queens Nurse
Honorary Fellow Faculty Homeless and Inclusion Health
Norfolk and Waveney ICB Clinical Lead for:
Health Inequalities & Inclusion Health
Norwich Place Clinical Adviser



Suzanne Meredith
Associate Director Population Health Management
Deputy Director of Public Health, Norfolk County Council

"The aim is to enable all people to stay healthy by predicting and planning for health and care needs before they happen, and ideally preventing them if we can. By working together with partners across the NHS and other public services in Norfolk and Waveney we can make an even bigger difference to many of the factors that affect our health and improve the health outcomes for our population".

Our objectives

Delivery of two strategic programmes:

- The Norfolk and Waveney **Health Inequalities** Strategic Framework for Action.
- The Norfolk and Waveney **Population Health Management** Strategy.

Plus the delivery of three specific **Prevention** work programmes designed to tackle:

b) Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people

c) Early Cancer Diagnosis – Targeted Lung Health Check Programme

d) Cardiovascular disease (CVD) Prevention

These three programmes are consistent with the priorities identified in the PHM strategy.

What would you like to see in our five-year plan for health and care services? What matters most to you?
JFP consultation feedback: "There should be more emphasis on prevention rather than cure." "Preventative Screening needs to be prioritised too". "Focusing on early intervention and prevention by broadening opportunities for roles such as social prescribing, community connectors, champions and health workers - providing holistic support to divert demand and in doing so, building capacity in our communities". "Preventative proactive healthcare in the community through Making Every Contact Count. Education in relation to self-care and responsibility for health".

Why we chose these objectives
We are aiming to reduce the differences in outcomes we currently experience. We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the CORE20PLUS5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are smoking, especially smoking in pregnancy, serious mental illness (SMI), cardiovascular disease, diabetes and respiratory, early cancer diagnosis and children and young people. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Objective 1a: Delivery of two strategic programmes: The Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action and the Norfolk and Waveney Population Health Management (PHM) Strategy

What are we going to do?
We have developed a Health Inequalities Strategic Framework for Action and a Population Health Management Strategy, and we will continue to deliver these two strategic programmes.

Our data and insights ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for Health Inequalities and PHM together, across the Integrated Care System.

Deliver a Health Inequalities strategic framework for Action, as a first step towards a whole system approach to reducing inequalities across our Integrated Care System (ICS), with all partners. The framework is focused around three key building blocks (including the wider factors that impact on health and well-being such as housing and the environment we live in, lifestyle and inequalities in healthcare access, experience and outcomes) and at the same time to create a strong foundation in the form of conditions for success. The Framework is overseen by the Integrated Care Partnership and several leadership groups have been established to develop and implement actions plans for our key areas (our building blocks) of focus.

Deliver a Population Health Management strategy, to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy identifies five initial PHM priorities and includes plans for how we will be using data, building a PHM cycle of improvement into our work. Our approach to delivering the improvement will be at both system and at place / neighbourhood level.

This proactive approach will be focused on prevention, reducing inequalities and improving the quality of care. It will also be driven by our knowledge of local communities, and by partners working together to identify new things that can really help to improve health.

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How are we going to do it?
By working together and getting behind the priorities that have been collectively agreed by system partners and our local communities for Health Inequalities and PHM. We will be using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

We have a data hub in place to allow access to joined up data and the interpretation of that data and insight to support local teams to identify their own priorities. A Population Health and Inequalities dashboard is being developed to support the understanding of variation in outcomes and benchmark our system to identify areas for further focus. This approach is driven by the needs of local communities, and interventions designed to support them. This may also involve working across the ICS to plan new services or models of care in an integrated way across the ICS. Therefore, we need to have participation in the development process by the range of partners and stakeholders.

What action are we taking to address Health Inequalities as part of this work?
We have established strong ICS governance and programme management to implement the Health Inequalities Strategic Framework for Action. The Healthcare Inequalities Oversight Group is responsible for the delivery of the NHSE inclusion health framework, CORE20PLUS5 and NHS Anchor programmes of work, as well as our outreach and engagement with people and communities through a programme called Community Voices. We are undertaking a project to improve data quality in support of these programmes of work.

We are developing organisational improvement plans because of our 'Health Inequalities Commitment', with the ICB developing a plan that focuses on workforce and organisational development, processes and resources, leadership and governance and data, intelligence and voice.

The priorities in the PHM Strategy also focus on addressing the drivers for health inequalities across Norfolk and Waveney.

How are we going to afford to do this?
Resources may be needed to support ongoing projects, on an invest to save basis – each project to be considered on its own merits and evaluated.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

Review as required, and continue with delivery plans and monitoring of achievement against objectives including:

- Improved ethnicity data collection in primary care.
- Development of an ICB organisational Improvement Plan, alongside ICS Health Inequalities Improvement Plan by September 2025.
- Development of an outcomes framework for Population Health and healthcare inequalities.
- Development of PHM data analytical tools to support PHM and address Healthcare Inequalities.

Year 2: April 2026 – March 2027

Continued focus on reducing Health Inequalities and opportunities for prevention, based on the data and insights in respect of outcomes and population experiences, extending our PHM approach.

Year 3: April 2027 – March 2028

A continued and targeted focus on prevention and reducing Health Inequalities and continued focus on using PHM to drive improvement across the system and inform where we focus our effort.

Year 4: April 2028 – March 2029

Review and refresh both strategic documents for the future, with refreshed objectives and trajectories.

Year 5: April 2029 – March 2030

Continued delivery of plans to address health inequalities and use data to deliver proactive interventions.

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How will we know we are achieving our objective?
Delivery against the objectives in our published action plans.

Monitor progress using our Population Health and Inequalities dashboard of key measures.

Develop a programme of evaluation based on the best available data, evidence and insight to measure progress.

Objective 1b: Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people

What are we going to do?
Stopping smoking is a preventative approach to improving health for all, especially in pregnancy.

We will develop and provide specialist support that gives all pregnant women across Norfolk and Waveney the best help and advice to stop smoking at a time when they are likely to be motivated to quit, in line with the NHS Long Term Plan commitments.

Our vision reflects the nationally recommended model for stop smoking services for pregnant women and this will be provided through the development of a new midwifery led NHS-based service. Each hospital trust will have stop smoking advisers who will offer support based on what research tells us works best.

Delivery of midwifery-led stop smoking services will contribute to one of the priorities in the 10-year Health Plan that is to be published in the spring i.e. from sickness to prevention, by addressing smoking in pregnancy, which is an important underlying driver of ill-health and persistent inequalities in health.

How are we going to do it?

- The NHS working together with local authorities, service users and others through our Tobacco Dependency Working Group, Tobacco Control Alliances and the Health Improvement Transformation Group to plan how we can best make use of our shared resources and how support should be rolled out. These groups enable our smoking in pregnancy providers to come together with a range of ICS partners including public health experts, universities and researchers and the voluntary community and faith sector. This means we can take a collaborative approach to evaluating and improving quality of local support and learn from the latest evidence about what works.

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- We are focusing on health inequalities to ensure that we understand access by population sub-groups (such as age, ethnicity and deprivation) and support equity of access. We will identify barriers and opportunities for improvement through an evaluation of the service one-year post implementation. This will align with Norfolk and Waveney's Health Inequalities Strategic Framework for Action and use the data improvement and monitoring dashboards to inform any targeted health inequalities improvement work, which will be developed and monitored through reporting to the Local Maternity and Neonatal System Board.

How are we going to afford to do this?
National NHS funding has been provided to help us roll out NHS tobacco support in Norfolk and Waveney.

We received national support to trial new approaches in 2024/2025 including provision of vapes and smoking in pregnancy incentive schemes. We are waiting to hear if any further national funds may be available to help continue this.

We are also working closely with local authority Public Health teams who are providing significant support to help with the delivery of NHS smoking in pregnancy services, including help with staff training, access to Nicotine Replacement Therapy and vapes and quit support for partners and other people living with service users.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**
  - Ensure service user voice informs a review of how the services are working.
  - Working with Public Health and other partners, to review longer-term support available in the community after the baby is born.
  - Work with local authority and VCSE through partnerships at local community level to ensure good access to wider community support e.g. social prescribers and peer support groups.
  - Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.
- **Year 2: April 2026 – March 2027**

  Explore opportunities to enhance joined up working e.g. between tobacco advisors, antenatal teams and mental health support for women with perinatal mental health conditions.
- **Years 3 to 5: April 2027 – March 2030**

  This objective will be retired at the end of Year 3 as the maternity tobacco dependency service becomes fully established and will continue to be delivered as 'business as usual' and monitored along with other core maternity care, using the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve.

How will we know we are achieving our objective?
We will be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery (SATOD).

Annual Office for Health Improvement and Disparities (OHID) data for Norfolk and Waveney for 2023/2024 showed that 11.2% of mothers were smoking at time of delivery.

Quarterly data provided by NHS Digital is available to help us track changes. Data from Quarter 2 of 2024/2025 indicates a reduction to 8.8%.

We aim to see annual SATOD rates reduce by March 2026 towards the regional and national average of 9% and to reduce further to 6% by the end of March 2028.

Ultimately, the national ambition, which we share for Norfolk and Waveney, is to become 'smoke-free' by 2030 – achieved when adult smoking prevalence falls to 5% or less.

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Objective 1c: Early Cancer Diagnosis – Lung Cancer Screening (formerly called the Targeted Lung Health Check or TLHC programme)

Lung Cancer Screening is a programme designed to diagnose Lung Cancer early when treatment is more straight forward and patient outcomes are better. From April 2025, the name changes to Lung Cancer Screening to reflect the future move to a national screening programme.

What are we going to do?
Deliver a Lung Cancer Screening Programme designed to assess a patient's risk of Lung Cancer and to identify any signs of cancer at an early stage when it is much more treatable – ultimately saving lives.

The programme is being offered to people between the ages of 55 to 74 who are current or former smokers and at greater risk of lung cancer. We will initially prioritise patients in our most deprived, Core20 populations. The first phase of our expansion will focus in the more deprived GP practices in Kings Lynn and Norwich.

The programme will also incorporate smoking cessation support to encourage current smokers to quit as there is strong evidence that individuals who live in areas of high deprivation, with higher smoking rates, are likely to have particularly poor lung cancer outcomes.

How are we going to do it?

- As the programme is rolled out across Norfolk and Waveney, we will use a place-based local approach to support its promotion.
- Eligible individuals will be invited to a Lung Health Check appointment. At the Lung Heath Check a risk assessment will be undertaken which will identify if the patient is at a higher risk of Lung cancer. If the participant is at higher risk, they will be referred for a Low Dose CT scan, provided as close as possible to home. If the scan results come back with signs of anything of concern, the participant will be contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or other issues with participant's breathing or lungs is found early, treatment could be simpler and more successful.

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What action are we taking to address Health Inequalities as part of this work?
A project is underway with our Community Voices team to identify barriers that prevent access to the programme and encourage individuals from harder to engage populations to access their appointments. Learning from this project will be used to inform the approach during the expansion. A larger scale communication plan will raise awareness and encourage uptake.

Specific targeted interventions will be planned for groups where engagement in screening is difficult including prison, learning disability/autism, gypsy roma and traveller people and homeless populations.

How are we going to afford to do this?
The Lung Cancer Screening programme is funded by the National Cancer Action Team, and this is expected to continue until the system achieves 100% roll out to the baseline population in March 2029. After this it is expected that the programme will become part of the recently announced National Lung cancer screening programme.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Finish delivering lung health checks to all individuals in Lowestoft who are in the initial target group for the programme.
- Subject to capacity, commence invites for patients who have reached the age of 55, and review the risk assessment of previously lower risk patients. Risk can change over time due to increased age and changes in an individual's life (e.g. start smoking again).
- Introduce a 'maintenance' service for Great Yarmouth and Gorleston to manage individuals who age in and move into the eligible cohort and to carry out re-risk assessment.
- Continue with follow up scans for individuals at high risk of lung cancer, every 24 months until they reach the age of 75.
- Commence roll-out to the remaining 'ever smoked' group across Norfolk and Waveney, focusing initially on areas of higher deprivation.

Years 2, 3 and 4: April 2026 – March 2029

- Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who reach the age of 55, and continue with 24 month follow up scanning.
- The national target is to cover the whole eligible baseline population of approximately 138,000 individuals by the end of 2028/2029.

Year 5: April 2029 – March 2030

- Support transition of the programme to a national screening programme.
- Continue to invite patients who age in and move into the cohort.
- Continue to provide Low Dose CT scanning to all high-risk patients at 24-month intervals until they age out of the programme.

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How will we know we are achieving our objective?

The programme provides a range of management information monthly against our planned invites and conversion rates which is benchmarked against regional and national provision. We also provide quality assurance and audit data on a quarterly basis against the national quality standard. This includes our lung cancer diagnoses and other findings including other cancers.

	Baseline Position	Q1	Q2	Q3	By Q4
Uptake (%) of Lung Health Checks	36% at the start of the programme	45%	45%	45%	50%

(*) the national target for 2025/2026 is expected to increase to 55%, however the most recent uptake rate nationally is 47% to date, which is an increase of 2% in the previous 12 months.

Great Yarmouth and Waveney take-up is approximately 36% which is in line with expectation in populations with high levels of deprivation.

It is expected that uptake will increase when the project expands to the rest of Norfolk & Waveney.

Objective 1d: Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol

Early detection of cardiovascular disease forms a preventative approach to improving the health of those at risk of developing the disease.

What are we going to do?
We will provide all Norfolk and Waveney Primary Care Networks (PCNs) with real time data on their patients who have:

1) A diagnosis of CVD; or are at high risk of CVD, and

2) Risk-stratify these patients, to help Practices treat those at greatest need.

This will allow action to be taken early to prevent and reduce the negative outcomes of unmanaged CVD.

In tandem, we will be running a PHM project and contacting patients identified through a case finding tool, assisting Practices in promoting CVD prevention, and helping to reach those patients who most need intervention. There will also be some clinical input through a third-party provider to identified patients, enabling prescribing to take place.

We will seek to incorporate CVD Prevention into the New Models of Care objective following completion of the PHM project.

We will further seek to explore innovation solutions to CVD Prevention and seek to treat people earlier, out of hospital where appropriate for patients, to ensure quicker access to specialist help. Examples of this will be to increase promotion of pharmacist support for hypertension diagnosis, and technology to enable better monitoring of CVD conditions at home.

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How are we going to do it?
We will be using a national audit tool called "CVD PREVENT" to benchmark our system. A digital tool will be utilised to risk-stratify and identify specific patients on practice systems.

Our PHM Team will engage with practices and will contact patients to seek to get them to discuss their care with a relevant health professional from a procured provider. Patients will also be directed to other services that can help with lifestyle changes that promote better cardiovascular health.

Local engagement will be a key component of the CVD prevention objective. Each place has different demographics and challenges, and VCSE partners. Their engagement will be key in supporting PCNs to achieve our targets.

We will scope how Primary and Community Care services could work together to prevent CVD. Given that this objective focuses on the desire to prevent CVD before community services input is required, the greater scope will be for Primary care working with other ICS VCSE partners.

We will evaluate our findings using the audit tool and as part of our Population Health management programme evaluation. As CVD PREVENT is updated on a Quarterly basis, progress can be monitored very closely.

What action are we taking to address Health Inequalities as part of this work?
Health Inequalities will be a key criterion utilised in clinical searches for identifying at-risk patients for the PHM project.

How are we going to afford to do this?
Current funding for CVD Prevention only covers the 2025/2026 PHM project. Beyond this, no new funding has been identified or allocated to support further activities which will limit progress.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**

  Start the PHM element of the project. Provider organisation working with the ICB Protect NoW Team to contact and optimise patients.

- **Year 2: April 2026 – March 2027**

  Norfolk & Waveney metrics on CVDPREVENT to show positive impact of project, with increased rates of diagnosis of Hypertension, and better treatment to target percentages for Hypertension and Cholesterol management. Evaluation of the project.

- **Year 3: April 2027 – March 2028**

  Continual monitoring of system performance and incorporation of CVD Prevention into New Models of Care objectives.

- **Year 4: April 2028 – March 2029**

  Continued monitoring of progress.

- **Year 5: April 2029 – March 2030**

  Continued monitoring of progress.

How will we know we are achieving our objective?

In the short-term, our digital tool will enable us to track numbers of patient contacts, new prescriptions, and optimisation rates in real time.
In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events.

Data will be available via CVD PREVENT to benchmark our system. Targets for treatment will follow national NHSE operational planning guidance which will be adopted once made available each year.

Davey Heidi
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Ambition 2: Primary Care Resilience and Transformation

Ambition 2: Primary Care Resilience and Transformation



Dr Jeanine Smirl
NWICB clinical lead for primary care

"The aim is to integrate primary care services to match access with need across a wide range of services delivered by multi-professional teams. This will deliver more proactive care, preventing illness and improving outcomes, for local communities closer to home with a focus on those with the highest need."

Our objectives

a) Develop a framework and long-term plans to support.

b) Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

What would you like to see in our five-year plan for health and care services? What matters most to you?
JFP consultation feedback: "Primary care needs to be top of the list. People are attending A&E because they cannot see a GP, that needs transforming first. It's been the same for years". "Preventing and managing ill health starts in primary care." "NHS dentistry should be a priority within the primary care focus". "For me personally, primary care and specifically the GP surgery is the key priority. I believe that all the other priorities are heavily dependent on the performance of GP surgeries."

The Primary Care Commissioning Committee monitors feedback received by the ICB together with results from patient surveys and other local intelligence. This process has highlighted timely access to services and ongoing joined up, holistic care remains a priority for our population.

Why we chose these objectives
Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care is an umbrella term which includes general practice, community pharmacy, dentistry, and optometry (eye health) services.

Nationally, all primary care services are facing greater challenges than ever due to workforce shortages, alongside an increasingly complex workload. Norfolk and Waveney have an ageing workforce within general practice with approximately 30% of staff being over the age of 55. In the last 10 years, the number of dentists has declined in our area compared to the East of England region and the whole of England. This decline has a greater impact in Norfolk and Waveney due to higher levels of need, areas of deprivation and a higher number of residents in later life. Poor oral health is widely considered to be an important aspect of our general health and wellbeing and is largely preventable and can have a significant impact on quality of life, such as eating, speaking, discomfort and cause an increase in days lost from work and school. Our ambition aligns with The next steps for integrating primary care: Fuller stocktake report and the direction of travel supported by the findings published in the Darzi Report which together set out a framework for integrated care systems to work with primary care contractors to improve access, experience and outcomes for our patients and communities.

NHS England published the Delivery plan for recovering access to primary care which builds on actions designed to streamline access to care and advice. Our latest report against delivery was presented to the ICB Board meeting held in public during November 2024 and can be found here PCARP Update November 2024.

Objective 2a: Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience

What are we going to do?
We will build on the vision and principles developed for **overarching vision for those receiving, delivering or planning primary care services** across Norfolk and Waveney by creating a framework which allows service development tailored to meet the needs of local communities.

The shared vision will underpin delivery of long-term plans (both those published and those in development) for all four pillars of primary care which are: community pharmacy, dentistry, general practice and optometry.

Long-term plans will be focused on supporting delivery against key areas, including:

- Those who need care understand how they can access what they need, when they need it within their local community.
- Those delivering care can respond to the ongoing challenges and demands they face, as part of a wider primary care group of services within their local communities.
- Those planning care do so in a way that enables everyone to play a meaningful role in accessing and providing sustainable services across primary care which is the front door of our NHS.

Long-term plans will reflect the transformation required to support the government's priorities of:

- Hospital to community.
- Analogue to digital.
- Sickness to prevention.

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A **model of care framework** will be agreed to support partners who work locally at place level to consider and test new ways of organising and delivering primary care together to meet the needs of their local population. The framework will be designed to highlight interdependencies and commitments within other strategies, and map activities across all primary care long term plans to support detailed, locally owned plans for achieving better outcomes through an **integrated approach at neighbourhood level.** Joining things up and doing them together so we do them once is a key opportunity identified in the Neighbourhood Health Guidelines 2025/26.

We will build on **Pharmacy First Services** launched on 31st January 2024, the national initiative to enable community pharmacies to provide treatment, if required, **for seven common conditions** (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles and uncomplicated urinary tract infections in women) as well as hypertension and contraception. With the new pharmacy contract due in 2025 we will closely monitor impact on existing pharmaceutical service, seeking to understand from stakeholders, local intelligence and available data the best strategic approach we can take to support and grow existing services.

How are we going to do it?
- We will use of available data to understand and prioritise population need.
- We will seek meaningful engagement with professionals and providers to understand the challenges they face and the enablers required to address them.
- We will listen to service users about access and experience.
- We will focus on the role of primary care in tackling health inequalities.
- We will identify opportunities for working at scale, workforce recruitment and retention, shared systems and processes and a collective approach to estates.

Integrated working across all providers at neighbourhood level will be key to planning how we move care, where appropriate, from hospitals to communities. Our strategic framework, and annual programmes of work will focus on the building blocks to enable communities to work with primary care, community and social care provides alongside council services, public health, voluntary and community and social enterprise (VCSE) sector groups.

A key pillar for primary care integration and improving access is the national Pharmacy First Scheme, introduced at the end of January 2024.

Our Community Pharmacy Integration roles will continue work to strengthen working relationships between community pharmacy and general practice. These roles help to streamline processes to provide a better experience for people accessing Pharmacy First, and other clinical services, at their local pharmacy as well as upskilling those signposting and referring into community pharmacy.

What action are we taking to address Health Inequalities as part this work?
The work going on within primary care provides a significant contribution to reducing Health Inequalities and improving the wider determinants of health. This primary care Ambition is embedded within the action plans that are delivering the ICS Health Inequalities Framework for Action, which is part of this JFP and also Ambition 1.

How are we going to afford to do this?
We will use existing funding allocations to commission services with flexibility to deliver against agreed priorities, including targeted support for identified population needs and working at scale.

What are the key dates for delivery?

Years 1 to 3: April 2025 – March 2028

- Publish/refresh long term plans for all four pillars in line with the new 10-year Health Plan for Health (expected spring 2025).
- Continue delivery against long term dental plan to improve access to dentistry services.
- Start delivery to achieve ambitions set out in long term plans for community pharmacy and general practice by April 2026.
- Agree and publish a long-term plan for optometry by March 2026.
- Start delivery against plan to achieve agreed optometry ambitions by April 2026.

Year 4: April 2028 – March 2029

These will depend on contracts for primary care contractors from April 2025 onwards and the new 10-year Health Plan.

Year 5: April 2029 – March 2030

As above.

Davis, Heidi
24/03/2025 12:20:37

This objective will be refreshed for Year 5 or sooner, and may be retired or replaced based on current priorities at that time.

How will we know we are achieving our objective?
Publication of a Strategic Framework for Primary Care.

Publication of long-term plans for community pharmacy and general practice.

Improve patient experience of access to general practice as measured by the ONS Health Insights Survey.
Implement Primary Care Improvement Plans in line with NSHE priorities and planning guidance for 2025/2026, including:

- Reduction in unwarranted variation.
- Increased activity for Pharmacy First, and clinical services.

Objective 2b: Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years

What are we going to do?
We are now well on the way to developing a follow-on Long Term Dental Plan and taking steps to make improvements, but there is much to do and this will take a number of years.

The Long-Term Plan will set out what we plan to prioritise and outline our aims and a more strategic piece of work over the next three years. This will enable us to develop a dental strategy, as part of the wider primary care strategy which is referenced in Objective 2a.

The Long-Term Plan has some key programmes of work:

1. Develop capacity in our dental teams through our workforce
2. Improve access for everyone, but with an initial priority on children and young people and those individuals and patient groups with greatest need
3. Promote good oral health, in our population overall but especially in children and young people

NHS England published the national Dental Recovery Plan in February 2024 setting out key proposals for implementation during 2024/2025. We are now in year 2 of this plan and will work to deliver the additional unscheduled care appointments that are part of the 2025/2026 operational planning requirements.

The Long-Term Plan and the national Dental Recovery Plan work will be co-ordinated and undertaken together where it makes sense to do so. We will develop measurable outputs and milestones to track the outcomes we want to achieve for our local population through these plans.

How are we going to do this?
By working with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population.

We will extend our two-year plan by another three years and publish a five-year dental strategy for Norfolk and Waveney.

- We will use all available data to understand and prioritise the immediate dental need. This may be a clinical need or a geographical need.
- We will seek interest from current dental providers to increase the number of appointments.
- We will monitor the impact these actions have to improve access to dentistry.

We will:

- Continue to engage with the profession and the ICB's 'Dental Development Group' to hear to the challenges faced by the profession and work collaboratively with system partners and key stakeholders to find solutions to improve access to dental care.
- Listen to our patients and hear about their lived experiences, to ensure our local population has access to oral health prevention advice, working with local authorities and the voluntary sector in Norfolk and Suffolk.
- Use our population health data, Dental Data Review, and ensure our approach is evidence based, balanced to meet the needs of residents, and reduces health inequalities.
- Identify steps to retain, grow and develop our local dental workforce to meet our patients' needs. We will work with our local providers to begin to build multi-skilled dental teams, including roles such as Dentists, Dental Nurses, Dental Hygienists and Dental Therapists.

What action are we taking to address Health Inequalities as part this work?
The ICS Health Inequalities Framework for Action is embedded within our Long-Term Plan. The priorities for the first two years are to focus on children and young people and in particular geographical areas within Norfolk and Waveney that have higher levels of deprivation.

How are we going to afford to do this?
We have a ring-fenced budget for 2025/2026.

Deven Heer
24/03/2025 12:30:17

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**

  Implement the first stage of the Long-Term Plan

- **Years 2 to 4 April 2026 – March 2029**

  Continue to implement the individual elements set out in the new long-term plan and wider primary care strategy with frequent monitoring of outcomes.

- **Year 5: April 2029 – March 2030**

  Develop plans and respond to provider landscape and population need.

  Monitoring and evaluation will focus on:

  - Improved access for our population to unscheduled care, and reduced impact on Emergency Departments and other system partners
  - Improving access for our local population through management of health inequalities and for children and young people

How will we know we are achieving our objective?
Increased unscheduled care appointments in line with the 2025/2026 NHSE trajectory for Norfolk & Waveney

The number of new patients being seen and treated by an NHS dentist from April 2023 as a baseline.

Dewey, Heidi
24/03/2025 12:20:17

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Dakt... Heidi 24/03/2025 12:20:17

Case Study

Working in the Voluntary, community and social enterprises (VCSE) sector there is so much to be gained. Meet Joe.

Joe Worsley is on a Health Leadership, Graduate Management Scheme with an interest in the charity sector and was pleased to take a flexi opportunity and work at Access Community Trust. Joe helped to develop and roll out their Customer Relationship Management system which hopes to measure the social value of the work that Access do.

The Access Community Trust's vision is to promote social inclusion for the community benefit by preventing people from becoming socially excluded, relieving the needs of those who are socially excluded and assisting them to integrate into society. Aimed at young people and adults they provide a range of services from house related support, learning, development, employment and providing support with mental health and wellbeing. With social enterprises such as the STEAM house cafes offering a safe space for those in mental health crisis day and night.

Joe says "that it is important that Access can measure the social value of the work they do, so they can demonstrate the value their work provides the Community which often goes far beyond their initial remit. This will help to secure further government funding and enable them to self-evaluate where they need to further focus their efforts, continuing to reduce health inequalities by providing essential services to customers at risk of social exclusion.

The work of Access is vital as it supports complex customers who otherwise might fall through the gaps between health and social care and multiple providers. Access can support a customer's journey from sleeping rough to temporary accommodation, permanent accommodation, and employment.



Joe says, "this placement gave me a real insight into how much value the 'third sector' can bring and how much there is to be gained by integrating the Voluntary Sector and Social Enterprises such as Access, with all healthcare providers".



Ambition 3: Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

Davies, Heidi
24/03/2025 12:20:17

Ambition 3: Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)



Sarah-Jane Smedmor
Executive Director Children & Families
Suffolk County Council



Sara Tough
Executive Director Children's Services
Norfolk County Council



Tricia D'Orsi
Executive Director of Nursing,
and LMNS SRO, N&W ICB

"Our collective Ambition is that all babies, children and young people will have the best start in life, achieved through person and family centred, high quality support to enable them to 'Flourish'. We will focus on collaborative working with system partners to promote the importance of a strong start in life for children and young people. We will prioritise the voices, needs and ambitions of children and young people so they can live their happiest, most rewarding lives and meet their potential."

Dave Heidt
14/08/2025 12:20:17

Our objectives

a) Successful implementation of Norfolk's Start for Life and Family Hubs approach.

b) Continued development of our LMNS, including the 3-year Maternity Delivery Plan.

c) Implementation of asthma and epilepsy recommendations, for Children and Young People.

d) Develop an improved and appropriate offer for Children's Neurodiversity.

What would you like to see in our five-year plan for health and care services? What matters most to you?
Parents and children have told us that they want access to better information and support for their physical and mental health needs, waiting times to assessment and treatment are too long, services supporting children, young people and families should work better together and maternity care should be personalised. Services need to work together effectively to support children into their adult lives.

Why we chose these objectives
The first 1001 days of a child's life are critical, and the NHS plays a crucial role in improving the health of babies, children and young people: from pregnancy, birth, and the early weeks of life; through supporting essential physical and cognitive development before starting school through to help in navigating the demanding transition to adulthood. We know the health of children and young people is determined by far more than healthcare. A stable and loving family life, healthy environment, education, safe housing, and income all significantly influence young people's health and life chances. The outcomes we seek to achieve for children will be consistent across Norfolk and Waveney so that regardless of postcode, families can expect to have access to appropriate services. We aim to provide holistic care through design and implementation of care models that are age appropriate, closer to home and bring together physical and mental health services to support development. We can improve outcomes and make a difference through working in partnership with other organisations.

Objective 3a: Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach

What are we going to do?
Continue to implement, embed and sustain the national Family Hub (FH) and Start for Life (SfL) transformation programme across Norfolk.

This reinforces the whole family approach to provide a single access point to family support services that is integrated across health (physical and mental health), social care, VCSE organisations and education settings.

The emphasis will be on sustaining and better integrating holistic support for families in their local community through enhancing the seven existing family hub sites. Building on the success of the past three years, year four of delivery will focus on several key elements including evidencing the impact of the support offered to families, widening the support for families with special educational needs and/or disabilities, addressing health inequalities by targeting activities and support offers and further enhancing integrated neighbourhood approaches across health, education and social care to meet whole needs of families.

Virtual services will also be available through the family hubs approach.

How are we going to do it?
Through improved data sharing arrangements and a more joined up approach to 'whole family' needs, whatever part of the system families' access.

Through FH sites and the FH network, co-located teams will be working alongside each other to provide support.

Through prioritising prevention and early intervention by providing holistic advice and guidance to families at the earliest opportunity when families engage with Family Hubs. This will also include the signposting to self-care resources, and the opportunity to link with others, including peer support workers for mutual support.

Dover Heidi
24/03/2025 12:20:17

What action are we taking to address Health Inequalities as part of this work?
A significant focus of the FH and SfL programme over the past three years has been addressing health inequalities. In year four of the programme, we intend to continue to expand this offer by focussing on under-represented groups across several of our workstreams and particularly the parent carer panel. A significant focus will be placed on a 'hyper-local' approach to delivery of support with integrated neighbourhood approaches to ensure support is delivered closer to home reducing inequalities in access and the postcode lottery of service provision historically.

How are we going to afford to do this?
A fourth year of funding from the Department of Health and Social Care and Department for Education has been announced which will be in place until March 2026. Alongside this, evidence of meeting additional minimum requirements will be expected of local services.

The funding required to develop and implement the family hub and start for life approach in Norfolk is secured through a grant to the host agency, Norfolk County Council. There continues to be an added requirement for Partners (resource expertise) across the system, including within the health system, to collaborate to ensure the most effective support is in place to benefit families.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Development of clear communications to ensure families and children understand what support is available to them and how they can access services when they need them, closer to home.
- Strengthening the network of support surrounding children and families to enable faster recognition of needs and a joined-up approach to meeting them – with a focus on developing a "think family approach" across the system.
- Increase accessibility of support, including proactive outreach to those families currently facing inequalities in access.
- Joining-up pathways and service offers within local communities to ensure families' experience of accessing services is smoother and more aligned.
- Further development of our workforce to ensure all partners, including peer supporters, can respond to the needs of families, no matter their professional background, with an ambition to only tell their story once.

Years 2, 3 and 4: April 2026 – March 2029

To be defined by local plans developed with system partners and include sustaining the transformation programme beyond the extended funding period.

Year 5: April 2029 – March 2030

The objective will be retired as it will become business as usual.

Davey, Heidi
24/03/2025 12:20:17

How will we know we are achieving our objective?

The programme team is currently working with the DfE/DHSC to ensure impact associated with the first three years of this transformation programme can be showcased and sustained into year four.

At a local level a performance measurement dashboard has been developed to track the identified KPIs across the programme and for each individual work strand and this will continue to be refined throughout the next 12 months, for example:

1. Feedback from families on Start for Life and Family Hubs offer (e.g. inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services).
2. 90% access integrated referral pathways tell story once and 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback.
3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements).
4. Families receiving help to manage financial challenges (measured through Department of Work & Pensions advisors embedded in Family Hubs).
5. Families accessing non funded services.
6. Parents accessing Start for Life and Family Hub services have improved understanding of the contribution to child's wellbeing, achievement and school attendance. Measured increase in number of families receiving support and increase in school attendance.
7. Families with SEND receive early support reducing escalation measured through reduction in Education Health and Care Plan (EHCP) and needing access alternative provision.
8. Improved health and development outcomes for babies and children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes).

Objective 3b: Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan

What are we going to do?
The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

NHS England published a three year delivery plan for maternity and neonatal services in Spring 2023. It sets out four themes that underpin how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. 2025/2026 is the third and final year of the delivery plan and is cross referenced in the 2025/2026 Operational Planning guidance.

There is a Norfolk and Waveney action plan that sets out how we will deliver the themes within the delivery plan, and this is reported to the Commissioning and Performance Committee. These are embedded into the work of the LMNS through programme delivery in transformation, quality and safety, strategy and business as usual. Good progress has been made on filling maternity workforce vacancies as part of the delivery plan, reducing from 9% to 0.5% over the past two years.

The JFP talks about the importance of enabling functions and digital is a key enabler for this Objective. Go-Live of the Electronic Patient Record (EPR) will support health care professionals and women and their families when they move location and are in touch with different parts of the health care system. This will align with the analogue to digital aim of the 10-year Health Plan that we expect to see published in the Spring.

Davey, Heidi
24/03/2025 12:20:17

How are we going to do it?
Beyond the three-year delivery plan there are transformational ideas emerging from the fledgling Speciality Clinical Network (SCN) for Perinatal care. This is looking at a shared vision for services and will test out service model options for new models of care / pathways, best practice and joint business planning across the three acute hospitals to begin with, and then with other partners outside the hospital setting. The SCN is taking a data led approach and both the LMNS and the SCN are committed to working together to transform services. This collaborative way of working is described more broadly in Section 6 of the JFP and SCNs are an enabler in the delivery of the Acute Clinical Strategy.

The LMNS will continue to oversee the quality and safety of maternity services. We will share learning and development, informed by the experiences of people using maternity services. This will include access to postnatal physiotherapy and a focus on reducing in smoking during pregnancy, which is an objective within Ambition 1. We will continue to work with the Family Hubs that are also part of this Ambition 3. We will ensure our Maternity and Neonatal Voices Partnerships (MNVPs) are representative of the population and the LMNS can evidence continued co-production with service users of service improvement.

What action are we taking to address Health Inequalities as part of this work?
Our LMNS equity and equality action plan Maternity Equity and Equality - Norfolk and Waveney ICS is a five year plan that will be monitored, reviewed and updated to ensure:

- Equity for mothers and babies from Black, Asian and Mixed Ethnic groups
- Those living in the most economically deprived areas
- Race equality for staff
- Development of co-produced equity and equality action plans to support the CORE20PLUS5 approach.

How are we going to afford to do this?
The Local Maternity and Neonatal System will work together to ensure best use of available funding including additional allocations from previous years.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**
  - Continue to implement the Three-Year delivery Plan for maternity and neonatal services.
  - Progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
  - Commissioning review of LMNS services.
  - System working with the Norfolk & Waveney Acute Hospitals Collaborative Speciality Clinical Network (SCN) for Perinatal Care.
- **Years 2 to 5: April 2026 – March 2030**
  - EPR Go Live for maternity.
  - Service delivery in partnership with the acute SCN for Perinatal Care.

How will we know we are achieving our objective?

Davey, Heidi
24/07/2025 12:20:17

Implementation of the Three-Year delivery plan for maternity and neonatal services.

Objective 3c: Implementation of asthma and epilepsy recommendations, for Children and Young People

What are we going to do?
We will work alongside clinically led professional networks to implement the recommendations of two bundles of care:

1. Asthma
2. Epilepsy

Asthma: We are committed to enhancing asthma care for children and young people (CYP), with a particular emphasis on addressing disparities in the most deprived areas and ensuring the inclusion of health groups that are often underserved. Our approach will include exploring and implementing evidence-based strategies to improve service delivery and intervention outcomes. A key focus will be on improving inhaler technique through new equipment and education programmes, ensuring that CYP and their families are equipped with the knowledge and skills to use inhalers effectively and in turn, reduce the reliance on reliever medication.

Epilepsy: We will prioritise access to psychological support (subject to funding), to continue supporting the mental health and emotional needs of CYP with epilepsy, and their families. We will also work to increase awareness of epilepsy to reduce stigma, improve early recognition of symptoms, and promote understanding of the condition. We are committed to improving the support available to children with epilepsy and their families by expanding access to educational resources, coordinating care across healthcare and education systems, and offering practical guidance to empower families in managing the condition effectively. These efforts aim to ensure holistic, inclusive, and equitable care for all individuals affected by epilepsy, fostering improved health and quality-of-life outcomes.

This links to CORE20PLUS5 which is explained in section 3.4. Asthma and Epilepsy are two of the '5' focus clinical areas.

Daly, Heidi
26/03/2025 12:20:17

How are we going to do it?
We will expand the collaboration achieved in year one and work alongside Place based leads to drive forward plans using local teams and expertise.

We will continue to support children with asthma and epilepsy to access activities within their communities and remain well while doing so through delivery of better care across clinical and non-clinical services, including access to condition specific training.

We will continue to support improved independence to self-manage conditions and access to skilled advice and support to keep children out of hospital.

What action are we taking to address Health Inequalities as part of this work?
We are committed to addressing health inequalities for CYP in the most deprived quintiles and ethnic minority groups who often face barriers to care. We plan to develop strategies to ensure that services and interventions are tailored to meet the specific needs of these groups.

How are we going to afford to do this?
We will work with partners to understand the resource that is available and seek to align this to deliver the most effective outcomes.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Seek to extend psychological support for CYP with epilepsy in the NNUH & QEHKL.
- Undertake a comprehensive review of the psychological support offer available for long-term conditions. Evaluate the effectiveness of current provision, identify gaps and ensure an equitable service.
- Seek to increase specialist nursing capacity across trusts.
- Seek to implement agreed care pathways across epilepsy services.

Years 2 and 3: April 2026 – March 2028

Seek to implement a sustainable psychological support offer for CYP with long-term conditions.

Year 4: April 2028 – March 2029

To be defined by local plans developed in collaboration with system partners. At this point the Objective may be business as usual.

Year 5: April 2029 – March 2030

To be defined by local plans developed in collaboration with system partners. At this point the Objective may be business as usual.

Davey Heidi
24/03/2025 12:20:17

How will we know we are achieving our objective?

- Decreased hospital admissions for asthma for young people aged 10-18.
- Decreased hospital admissions for epilepsy for children and young people aged 0-19.
- Reduction in the use of reliever medications.
- 20% of CYP from deprived areas have asthma care plans in place.
- Link for indicators.

Objective 3d: Develop an improved and appropriate offer for Neurodiversity

What are we going to do?
Through a collaborative of system leads responsible for children's services, we will formally review and improve the clinical and non-clinical offer of support for our neurodivergent population.

This programme will:

- Improve data monitoring and intelligence.
- Improve pathways to support for assessment, and treatment.
- Identify and address skills gaps in the existing education, health and care workforce.
- Improve quality of clinical pathways.
- Improve access to evidenced based information and advice.
- Increase access to support for mental health needs.

How are we going to do it?
We will increase awareness of health inequalities for neurodivergent young people.

We will work with organisations that see patients to improve data monitoring and reporting for autistic young people accessing their services.

We will improve governance of this programme of transformation through the system collaborative for CYP.

We will develop a joint plan for action to reduce waiting times, integrating process improvements and innovative service delivery models.

We will test the delivery of whole-school approaches to support neurodiversity and expand if proven effective.

We will provide tools to self-manage conditions and access skilled, high-quality advice and support to reduce the need for specialist interventions.

Davey, Hazel
24/03/2025 12:20:17

We will work with parents and carers to ensure those with lived experience are involved in the co-production of improved services.

We will introduce a digital offer of support and training, enabling universal services to provide better support to children and young people.

We are committed to improving the quality of clinical pathways by incorporating the latest evidence-based research into treatment protocols and support strategies.

We will enhance training and upskilling initiatives for the education, health, and care workforce to embed high-quality, innovative practices into everyday service delivery.

We will co-produce services with parents, carers, and stakeholders, and evaluate the effectiveness of innovative practices, such as whole-school approaches to neurodiversity.

We will enhance data monitoring and intelligence to guide quality improvements and ensure strategies are informed by robust evidence.

What action are we taking to address Health Inequalities as part of this work?
We will actively raise awareness of the disparities in health outcomes for neurodivergent young people, ensuring these inequities are prioritised and addressed within the broader system.

Improving data monitoring and reporting: By collaborating with organisations that see and support neurodivergent young people, we aim to enhance data collection, monitoring, and reporting to identify and address gaps in service provision.

Engaging with Lived Experience: Working closely with parents and carers, we will co-produce solutions that reflect the lived experiences of neurodivergent young people and their families, ensuring interventions are equitable and meet their needs.

Improving Access to Support and Services: We will provide tools and resources to self-manage conditions, reduce reliance on specialist interventions, and increase access to high-quality advice and support.

Testing Whole-School Approaches: Pilot programmes in schools will address neurodiversity inclusivity at the community level, ensuring every child receives the necessary support regardless of background or location.

How are we going to afford to do this?
This Objective is funded within existing resources and supported through a process of prioritisation.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Implement changes to commissioned pathways.
- Launch pre-diagnostic and training offer for families and Education settings.
- Evaluate Mental Health offer pilot.

Year 2: April 2026 – March 2027

Use evaluation and learning to develop the future service.

Years 3, 4 and 5: April 2027 – March 2030

To be defined by local plans developed in collaboration with system partners.

How will we know we are achieving our objective?

- Improved patient experience evidenced through feedback with families.
- A reduction in waits to specialist services.
- Increase in 'appropriate' referrals to services.
- Reduction in complaints regarding barriers to accessing care.
- Number of unique users of the digital library.

Outcomes

- Improved experiences for children and young people of health and care pathways.
- Improved attendance at school.
- Improved access to digital resources online and accepted referrals for sensory needs.
- Improved access to specialist advice and therapy through increased interventions.
- Improved access to assessments of need.
- Improved access to universal training for non-clinical professionals and parents/carers.

Davey Heidi
24/03/2025 12:20:17



Ambition 4: Transforming Mental Health Services

Davey Lloyd
24/03/2025 12:20:17

Ambition 4: Transforming Mental Health Services

"Our aim is to ensure that people of all ages can access timely and responsive support for all their emotional wellbeing and mental health needs. Working together with partners across health, care, VCSE and our experts with lived experience, we will offer person centred care at an earlier stage, and provide services that are compassionate, holistic, and responsive guiding people towards better mental health".



Dr Ardyn Ross,
Clinical Mental Health Lead, N&W ICB

"We look forward to being equal partners in the implementation of the JFP, using lived experience insight to ensure better mental health outcomes for everyone. The JFP will be delivered alongside existing services and builds on current and ongoing improvement plans. We hope the JFP will lead to joined-up, timely, ongoing care and personalised support for the people in our communities. Including addressing mental health inequalities for people who have little or no support. We hope the JFP will mean more people, including unpaid carers and staff, are more connected to wellbeing support and the right care for them."

N&W ICS Mental Health Transformation Expert by Experience Reference Group, May 2023

Our objectives

a) We will 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.

b) Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

c) 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.

d) We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).

Davey, Heidi
24/03/2025 12:20:17

What would you like to see in our five-year plan for health and care services? What matters most to you?
People with experience of mental health services and others who responded to a recent survey said, 'We must put more focus on prevention and invest in this area, including de-stigmatising mental health - we must see looking after our mental health the same as eating 5 fruit and veg a day'. They also told us:

- They want to be empowered to access intervention and holistic wraparound care, which supports long-term recovery.
- They want to "experience person-centred care, and be treated as an individual, rather than as a diagnosis".
- They want choice in how care is delivered and a focus on "what matters to me", instead of "what's the matter with me".
- They want their diagnosis to be only one part of their health journey. Their other physical and/or mental health conditions, as well as life events, may impact on their current state, which needs to be considered.

Children and young people have developed a Mental Health Charter and have told us that what matters to them is that services will care, staff will support and be well supported themselves, the right help, right time, right way, treatment will be personalised to meet individual needs, communication will be effective and young people will have a voice.

Why we chose these objectives
Mental health conditions can have **a substantial effect on all areas of life, such as school or work performance, relationships with family and friends and the ability to participate in the community**. People with mental health conditions often experience human rights violations, discrimination, and stigma. Key vulnerable groups who may be affected by poor mental health include children, young people and families, people who experience long term conditions and men experiencing financial and economic constraints and/or relationship breakdown. Improving the offer of proactive and preventive support is a priority outcome for this ambition, where we aim to intervene quickly and broaden the range of specialist support offers to enhance recovery.

Kayleigh Liddi
24/03/2025 12:20:17

Objective 4a: We will 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.

What are we going to do?
There are three priority activities:

1. Develop a structure for mental health literacy, to enhance and expand skills and knowledge on emotional wellbeing and mental health.
2. Co-produce, implement and promote tools and capacity to support good mental wellbeing.
3. Co-develop a refreshed Norfolk and Waveney Suicide Prevention Strategy and action plan.

How are we going to do it?
Building on the targeted grant programme for vulnerable groups and the health promotion campaign 'Take 5', we will develop two complementary workstreams that will empower our people and communities to look after and improve their wellbeing:

A community mental health literacy workstream will be developed to inform our workforce, people and communities about wellbeing and mental health. This will promote activities to keep people well and enable them to access services if needed. Training and resources will be aimed at:

- Increasing skills to recognise and address wellbeing concerns.
- Enabling individuals to effectively manage their own wellbeing.
- Building capacity across the wider system, including in the VCSE sector to manage wellbeing within the community.

This will build on existing approaches focussed on children and young people.

Mental Health Literacy activity and related plans to improve population mental health resilience, are in progress. Activities are underway to establish a set of wellbeing measures to support this work, and this will provide our workforce, people and communities with the tools to increase and maintain wellbeing; focusing on a range of wellbeing initiatives such as a targeted sleep campaign to provide practical solutions in managing mental health and wellbeing.

These commitments work with existing prevention initiatives such as digital wellbeing tools, support for schools and families, Family Hubs, Community Wellbeing Hubs and NHS Talking Therapies.

The Suicide Prevention Partnership has co-produced a refreshed five-year Norfolk and Waveney Suicide Prevention strategy, with anticipated key themes for action around Self Harm, Bereavement and Primary Care pathways for people with depression – as informed by audits. We continue to raise awareness, deliver campaigns to reduce stigma, provide accessible training, and invest in community support for at-risk groups. There is commitment to continue monitoring outcomes through Suicide Prevention Audits, and real time surveillance on self-harm and suspected suicides.

What action are we taking to address Health Inequalities as part of this work?
The entire focus of this objective - improving mental health literacy, to enhance and expand skills and knowledge on emotional wellbeing and mental health; implementing and promoting tools and capacity to support good mental wellbeing; and contributing to delivery of the Norfolk and Waveney Suicide Prevention Strategy, is designed to address the health Inequalities experienced by communities across Norfolk and Waveney that are currently underserved, across all three objective deliverables.

How are we going to afford to do this?
We continue to explore opportunities to use existing resources to deliver this provision, which has impacted on timescales to date. We will seek to identify what can be achieved through improved partnership working at no/low cost and scope where additional resource would improve delivery.

What are the key dates for delivery?

- **Years 1 and 2: April 2025 – March 2027**
  - Plan implementation of Mental Health Literacy Programme.
  - Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy.
- **Year 3: April 2027 – March 2028**
  - Implement the resilience framework and deliver initiatives i.e., impact of sleep and tools to improve sleep quality, and continue to deliver mental health literacy.
- **Year 4: April 2028 – March 2029**
  - Review the suicide prevention strategy.
  - Evaluate the jointly funded suicide prevention programme.
- **Year 5: April 2029 – March 2030**
  - Implement actions based on evaluation of joint funded initiatives.
  - Continuous improvement of the Mental Health Literacy programme.

How will we know we are achieving our objective?

There will be a measurable change in self-reported mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores.

Rates of suicide and self-harm will decrease.

Davey Heidi
24/03/2025 12:20:17

Objective 4b: Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

What are we going to do?

- Further integration into the wider Adult MH programme of work.
- Establish a Children and Young People (CYP) system.
- Collaborate and participate in the Suffolk Mental Health.
- Collaborate to help plan services for CYP in Waveney.

Adult Mental Health System Collaborative

Identify opportunities to work collaboratively, using available data, intelligence, and insights, which focus on improving mental health and wellbeing of adults and older people.

Children and Young People System Collaborative

Implement the Thrive model through close working between the Norfolk and Suffolk MH CYP collaboratives, which are on a county council footprint. Making the structural, operational, and cultural changes required to deliver community based multi-disciplinary teams, working across organisations, to ensure collective support to meet the emotional wellbeing, mental and physical health needs of the child or young person and their family.

How are we going to do it?

Embedding a new approach that:

- Focuses on early intervention and prevention – moving the resource and support further upstream, providing support to more people at an earlier stage and freeing up specialist support.
- Focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions.
- Moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves.

Davenham 24/3/2023 12:20:17

What action are we taking to address Health Inequalities as part of this work?

We will review our pathways against the most recent evidence and guidance to improve quality and ensure that health inequalities are reduced by understanding gaps and barriers to access. We will work with under-represented groups to ensure equity of access.

How are we going to afford to do this?

We intend to make use of existing resources in a different way. For example, existing community-based teams would be upskilled to support people and families with early dementia, which will free up capacity within the specialist teams to support people with more complex needs and reducing the existing specialist waiting lists. This process will be repeated for other conditions and for children and young people too.

Through a collaborative approach, system partners working with children and young people will seek to align collective resource to reduce duplication, increase quality and value and strengthen services. A collective focus on early help and prevention will support a 'left shift'.

What are the key dates for delivery?

Year 1: April 2025 - March 2026

- Integration into the wider Adult MH programme of work and associated governance structure; reviewing the membership and ToR of the MH Strategic Oversight Board, and potentially the sub-groups that feed into it.
- Continued checking back with adults with mental health needs, and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs.
- Following contractual considerations, consider movement towards a more provider-led collaborative/alliance approach across both Norfolk and Suffolk.
- Further develop the CYP System Collaborative to include associated priority areas including support for neurodiversity and Special Educational Needs and Disabilities.
- With partners, review CYP system governance to embed CYP System Collaborative approach in Norfolk and Suffolk.

Year 2: April 2026 – March 2027

- Continued integration of services within mental health and wider system pathways, so that people have their wellbeing and mental health needs met seamlessly.
- Embedding delivery of the adult mental health programme, through the Objectives in this Ambition.

This objective will be retired at the end of Year 2 and become business as usual within the Adult MH programme of work.

Davey, Heidi
24/03/2025 12:20:17

How will we know we are achieving our Objective?
Access to support is streamlined, responsive and coordinated for:

- Adults with mental health needs.
- Children or Young Person with emotional wellbeing, mental and physical health needs.

Services will be inclusive and responsive to all children and young people with a particular focus on support neurodivergent individuals and their families.

The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented.

We will see an increase in the numbers of children accessing mental health support at an earlier stage and a reduction in admissions to inpatient provision.

Objective 4c: Establish a Children and Young People (CYP)'s 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

What are we going to do?
We have launched an Integrated Front Door (IFD) to support Children and Young People (CYP) aged 0-25 years with an emotional wellbeing or mental health need to access the right support at the right time. This will be a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support. Following consultation with CYP and families this new service will be called "Norfolk & Waveney access to mental health advice and support 0-25yrs". The aim is that children and young people and their families will have immediate guidance and/or timely support based on an understanding of need, to allow them to flourish.

It will provide:

- **Self-Care** support, through digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources.
- **Improved access to advice and guidance** through a single telephone number, and offering timely, single session interventions where clinically appropriate.
- **Request for Support** – One trusted pathway for children, families, and professionals to ask for emotional wellbeing and mental health support. The clinical team will assess every request for support and promptly allocate to the most appropriate service offer to meet the needs of children and young people if required.

How are we going to do it?
System partners work collaboratively within a strategic alliance, ensuring that services are committed to working together to provide the best possible care and support for CYP and their families. This is in line with the Thrive principles, with children and young people at the centre of delivery and resources wrapped around them, enabling them to Flourish.

What action are we taking to address Health Inequalities as part of this work?
We are developing system metrics to ensure activity is captured and reported at demographic level so that we can ensure health inequalities are addressed. A "Mind the Gap" meeting between providers has been established to ensure any CYP whose needs cannot be met with reasonable adjustments can be discussed and an agreed care plan put in place to meet their needs.

How are we going to afford to do this?
This programme of work is established and resourced through Mental Health Investment Standard funding.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**
  - Continue to onboard system pathways, including "Early Help and Family Support" delivered by Local Authority partners.
  - Implement Single Session approaches to ensure CYP can have their needs met in the most efficient way.
- **Year 2: April 2026 – March 2027**

  Develop and embed Artificial Intelligence (AI) and machine learning solutions to improve efficiencies across the IFD.
- **Years 3 to 5: April 2027 - March 2030**
  To be defined by local plans developed in collaboration with system partners.

How will we know we are achieving our Objective?

We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.

Davey Heidi
24/03/2025 12:20:17

Objective 4d: We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN)

The term "Dual Diagnosis" in this Objective, is used to define the experience of those with Mental Illness and substance misuse.

What are we going to do?

Complex Emotional Needs*:

1. Develop a Strategic Plan of Action for people with Personality Disorder/ Complex Emotional Needs in Norfolk and Waveney, including the development of a collaborative pathway.
2. Increasing access to psychological therapy for people with complex emotional needs, wherever they present.

Dual Diagnosis:

3. Develop and implement a recognised dual diagnosis pathway - with consideration to other issues, social or physical that are commonly associated with experience of Mental Illness and substance misuse.

*We are using the term Complex Emotional Needs to encompass people who have previously been described as having a diagnosis of personality disorder or experience of complex Post Traumatic Stress Disorder (PTSD).

How are we going to do it?
Providers and stakeholders will engage those with lived experience at all stages, from design to delivery, to improve access and care for people with dual diagnosis and Complex Emotional Needs, inclusive of those with Neuro Diversity.

A "no wrong door" approach will be developed with system partners to make pathways inclusive, accessible and flexible to promote recovery and independence. Partners will work collaboratively to cover unmet needs.

We will continue to develop mental health provision in primary care, embed the Strategic Plan of Action for people with Personality Disorder/Complex Emotional Needs and pathway, and assist system partners to work collaboratively to support people with dual diagnosis.

We will work more closely as system partners to join up care and help to improve the experience of people with complex needs.

What action are we taking to address Health Inequalities as part of this work?
We will review our pathways against the most recent evidence and guidance to improve quality and ensure that health inequalities are reduced by understanding gaps and barriers to access. We will work with under-represented groups to ensure equity of access.

How are we going to afford to do this?
We will seek to identify what can be achieved through improved partnership working ensuring that any available funding maximises quality, impact and value. We will work within existing resource, and/or scope where additional resource would improve delivery further.

What are the key dates for delivery?

Year 1: April 2025 – March 2026
Complex Emotional Needs
- Strengthen integrated pathways and joint working between providers.
- Develop a Strategic Plan of Action for people with Personality Disorder/Complex Emotional Needs in Norfolk and Waveney.
- Complete a review of patient experience and identify any unmet need.
- Review the offer for carers of people with Complex Emotional Needs, identifying gaps with a view to improve provision.

Dual Diagnosis
- Develop principles to support partnership working.
- Draft a coproduced strategy.
- Begin to implement an integrated mental and substance misuse pathway to improve access and increase inclusion.
- Review training needs to inform expansion of dual diagnosis training programme.
- Review the experience of people with Dual Diagnosis leaving prison, inpatient institutions and other out of system placements, to improve continuity of care.

Waveney Health
24/03/2025 12:20:17

Year 2: April 2026 – March 2027

Complex Emotional Needs

- Co-produce a set of recommendations to improve inclusion and access for under-served groups and marginalised communities.
- Expand existing training offer to professionals and carers, helping them to identify and respond appropriately to people with co-occurring needs.
- Co-produce a set of recommendations to improve the offer for carers of people with Complex Emotional Needs based on the review of need.

Dual Diagnosis

- Complete a digital options appraisal to improve service access.
- Review pathway and protocol to inform practice and ensure a suitable offer for people of all ages.

Year 3: April 2027 – March 2028

Complex Emotional Needs

Evaluate service user and system outcomes to inform future planning and ensure continual quality improvement.

Dual Diagnosis

Evaluate service user and system outcomes to inform future planning and ensure continual quality improvement.

Year 4: April 2028 – March 2029

Complex Emotional Needs

Develop a plan to improve service user and system outcomes and quality of care and workforce and service delivery.

Dual Diagnosis

Continue to implement improvements to quality of care and patient experience, addressing identified gaps.

Year 5: April 2029 – March 2030

Complex Emotional Needs

Continue to implement improvements to quality of care and patient experience, addressing identified gaps.

Dual Diagnosis

Not applicable as this work is concluded in 2029/2030.

How will we know we are achieving our Objective?

Complex Emotional Needs:

- 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide.
- Increase in numbers of service users able to access a psychologically informed intervention outside of NHS Talking Therapies and secondary care offer.
- A reduction in presentations to Emergency Departments for patients with Personality Disorder.

Dual Diagnosis

- Achieve an increased number of referrals (as per Year 1 plans and trajectory) accepted via the dual diagnosis pathway.
- A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems.

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Dakota Heidi 24/03/2025 12:20:17

Case Study

Lydia and Sandra: Our experience of the accessible vaccine clinic

Lydia has a learning disability and uses Makaton to speak so having someone to sign with her is important too.

Lydia just had her covid vaccine she was very frightened of vaccines. She has never had any before all attempts have been unsuccessful. We had tried seven times at various vaccination centres and with a specialist team that came into the school as well and it got to point where she couldn't even walk into the building.

Lydia was so anxious and frightened, even at the vaccination centres she wanted to sit down and be happy to take her cardigan off but the minute she knew there was a needle coming in a little tray, she'd run out the room. She even had her friends come and help too; she was still too scared. A kind nurse gave us the details of the accessible clinic.

It was helpful to have a call and talk about what she needed before coming. When we arrived, she was so incredibly happy seeing the lovely room and toys. As discussed on the phone call she got to practise with the needle. Slowly being introduced to what the needle was like, I just could not believe it just watching the nurse run the needle gently up and down her arm and not being frightened. I just can't believe she has had it, we tried so many times. It was so quick it was and it did not hurt said Lydia. Lydia was so happy and looking forward to coming back. I just do not believe it so thank you so much. Having a clinic for people with learning disabilities is so important.





Ambition 5: Transforming Care in Later Life

Daisy, Heidi
24/03/2025 12:20:17

Ambition 5: Transforming Care in Later Life

"Our aim is to simplify, improve and integrate health and care for people in later life (including at the end of their life) across Norfolk and Waveney. We want to design our services with and for the people of Norfolk and Waveney, to support them to have the best possible quality of life."



Dr Olga Emmerson
Associate Director of Planned Care and Cancer Transformation
NHS Norfolk and Waveney Integrated Care Board



Ian Hutchison
Chair/ Senior Responsible Officer for Ageing Well Programme Board Chief Executive Officer of East Coast Community Healthcare

Our objective

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

What would you like to see in our five-year plan for health and care services? What matters to you most?
Feedback from our Norfolk and Waveney Dementia Round Table Event from patients with lived experiences - *My care needs to be continuous with regular check-ups; I want services to work proactively together so the treatment is of the whole person rather than just the diagnosis. I want to only have to tell my story once. Training for both wider healthcare staff and carers should be improved, and public awareness of Dementia should be improved.*

Davey Heidi
24/03/2025 12:20:17

Feedback from Active NoW Falls Prevention highlights significant improvements in both physical and mental well-being. Participants reported increased confidence in mobility, with one saying, "I feel more confidence when walking, I don't use my stick as much." Others noted enhanced balance, with one sharing, "I feel more confident walking up and down stairs." Many found the sessions beneficial, "The sessions have been extremely beneficial to both my physical and mental health."

An 82-year-old participant added, "I'm 82 and have the exercise bug, I will continue to exercise for as long as possible now!" Several others mentioned feeling stronger and more confident, with comments like, "I'm getting up and down from the chair easier" and "I'm walking with more confidence and much easier".

Why we chose these objectives
Our population is older than in most systems, but a lot of our services have not been designed with older people in mind and may not be known to, or easily accessed by the people who need them. Currently the available support from statutory, voluntary, and charitable services is often unknown to the person, confusing or complicated to access. This can mean that people don't always know what they can do to prevent ill health or get the help they need until far too late. So, we want to design and connect services to inform and support people as they age.

With a focus upon prevention and ageing well, we want to make it easy for people as they age to access the right preventative intervention or support as soon as they need it. We want to simplify and join up the different types of services, social assets and amenities near to people, and delivered as close to home and as early as possible.

By making it easy to access support and by removing the barriers between the different types of support available, we will work together to enable people, as they age, to maintain their independence and preserve their quality of life for longer.

Since April 2024, we have now established four core working groups which will focus on implementing these objectives:

1. **Frailty focussed acute care:** Supporting our hospitals to recognise frailty and ensure that their services are designed around the needs of the individual with frailty and their carers, to extend healthy older life and independence.
2. **Dementia focused care:** Preventing cognitive decline, diagnosing earlier and with a single point of access and improving the quality and coordination of care, as close to home as possible.
3. **Care Homes & Housing with Care:** Improving care, supporting residents to live as independently as possible and reducing unplanned admissions from care homes and supported accommodation.
4. **Prevention:** focusing on health promotion and prevention to support people to keep healthier for longer.

Objective 5a: To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives

In 2024 the Ageing Well Strategic Framework was published with the objective to provide a shared vision and strategy with older people.

From April 2025 we will be focussing on the implementation of core priorities we have identified as a result of engagement with members of lived experience, service leads and our partner organisations such as Norfolk County Council and charitable organisations.

What are we going to do?
Our vision is that Norfolk and Waveney will be a place where people in later life and their carers:

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

This year, we will work together with our NHS providers, voluntary, community and social enterprise partners, members of our community, and our public health teams in Norfolk and Suffolk to:

- Integrate digital technology innovations that will support people in care homes.
- Review Frailty and Dementia services across the geography to improve triage and combined assessments.
- Support people to take control of their health through health promotion and awareness campaigns.
- Support the care market through admission avoidance schemes.
- Provide a multi-disciplinary assessment of all people with frailty attending our hospitals as an emergency, to prevent admission where possible, reduce length of stay where admission is required, and to seek opportunities to prevent further health problems.
- Utilise the Enhanced Health and Care Framework to promote healthy living, nutrition, hydration, and oral health support.
- Offer opportunities for the care market to come together through the development of a clinical champions network.
-

To support us, we will use the principles of the World Health Organisation's Age Friendly Communities to shape services and the environment that people age and grow old in to optimise health and wellbeing.

How are we going to do it?
We will research innovative digital systems that support earlier identification of older people with suspected conditions of Frailty & Dementia.

We will integrate digital technology to support residential and nursing homes in their ability to identify residents whose health is deteriorating and improve seamless communication with healthcare.

We will review and redesign Frailty and Dementia pathways to allow for greater communication, combining assessments and identifying people earlier in their health journey whilst supporting the upskilling of staff. We will consider findings from recent public health reports and services that may need to be delivered differently based on deprivation, public transport access and other core inequities of health.

We will promote healthy ageing and awareness of these conditions and through webinars, education support packages, newsletters and wider communications to both staff and the public and take a collaborative approach to winter prevention communications.

We will develop a dashboard to monitor the impact of these changes.

What actions are we taking to address Health Inequalities as part of this work?
The programme aims to enhance patient and carer experience and health outcomes by tailoring healthcare and social service provision to local needs. Instead of uniform pathways, the ICB and partners will adapt pathways to address local health inequalities and deprivation issues, improving access and awareness for all patients, particularly those in our CORE20Plus5 population areas.

How are we going to afford to do this?
Simplifying access and focusing on early and local intervention will reduce long term need and costs e.g.by preventing unnecessary ambulance call outs and hospital admissions.

Co-designing services with older people to focus on maintaining independence will reduce costs long term, but we will need to divert funding toward prevention, early intervention and planning for the future, reablement and care at home.

Co-ordinating services using a system-wide perspective will deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system.

We will also actively seek new external monies / funds to support people in later life where possible.

What are the key dates for delivery?

Year 1: April 2025 - March 2026
Innovation and prevention

- Develop pathways that support multi-professional triage for older people, with a focus on Dementia and Frailty services, so that they can receive support through one stop or combined assessment and, treatment wherever possible, and in the most appropriate setting.
- Develop a unified frailty virtual ward pathway across all of our hospital partners to provide an at-home alternative to hospital admission for suitable patients.
- Planning for older age - supporting people to take control of their health and maintain healthy older life and reduce the period of time spent in frailty.
- Place-based approaches to proactive support for those identified at risk of poor outcomes in older age.
- Support places and organisations to improve age friendly practices.

Year 2: April 2025 – March 2026:
Reflect, Review, Replan

- Fully integrated care for people living in residential or supported living environments using technology where appropriate.
- Integrate pathways for older people, with a focus on Dementia and Frailty services.
- Work with the acute hospital collaborative to align the current frailty advice lines so that all people have access to this service across system.
- Improve the accessibility of Dementia identification so all care providers can identify the people they are caring for who have a diagnosis.
- Ongoing use of the strategic framework to address gaps in provision across our system.
- Ongoing use of the framework to identify opportunities for prevention and early intervention.

Davey, Heidi
24/03/2025 12:20:37

What are the key dates for delivery?

Year 3: April 2027 - March 2028

- Achieve "Age Friendly" status across Norfolk and Waveney, working with residents, local organisations and government bodies and the national Centre for Ageing Better with the aim of ensuring older people are valued and able to live well throughout later life.
- Increase the awareness of Dementia and Delirium for staff delivering care across the geography.

Year 4: April 2028 - March 2029

- Implement further initiatives focussed on prevention of falls and integrating this care.
- Integrate Rapid Assessment units across three acute hospitals for Frailty and Ambulatory Care.
- Redesign pathways to support care at home and improve integration with residential and nursing homes.

Year 5: April 2029 - March 2030
Develop and implement workforce strategies with the three acute hospitals to deliver equity of workforce provision for Frailty.

How will we know we are achieving our objective?

- All statutory providers signed up to the Dementia Charter by April 2025.
- Increased Dementia diagnosis "rate" based on diagnosed patients versus the estimated number of people living with Dementia by March 2027.
- Increased use of a standardised frailty scoring tool across the ICS to ensure better understanding of individuals' needs by March 2026, enabling specific support to be put in place at an earlier stage.
- A reduction in the number of ambulance conveyances and unplanned admissions from care homes and residential homes by March 2027.
- An increase in the number of ReSPECT forms in place for patients with frailty by March 2027.

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Dakota Heidi 24/03/2025 12:20:17

Case Study

Virtual ward prevents admission to hospital

John is an 84 year old man with long standing issues with his breathing. John was referred to the Virtual Ward by his GP when his breathing became difficult for the third time in 3 months. Both times this had happened before, he had ended up in the hospital emergency department which John found distressing and disorientating, and on one occasion he had been admitted to the hospital for 8 days.

John's GP referred him to the Virtual Ward during an emergency appointment at the surgery. The virtual ward hub accepted the referral and as part of his onboarding, they reviewed his health care records to gain more information about what had happened during his previous admissions and multiple A&E attendances. Remote monitoring equipment was delivered and setup for John at home within two hours of being onboarded. An initial assessment including blood tests were performed in John's own home to confirm the reason for John's deterioration. The virtual ward team developed a management plan and agreed this with John and his family using joint decision making.

John started treatment that day, and remained at home but with daily calls, 24/7 monitoring and two further home visits before he was "discharged" from the virtual ward. Before that happened, the virtual ward team, John and his family also agreed a long term health care plan to try to prevent the need for further A&E attendances and hospital admission.





Ambition 6: Improving Urgent and Emergency Care

Ambition 6: Improving Urgent and Emergency Care

"The aim is to ensure that the population we serve receive the right care, in the right place, whenever they need it. Everyone should receive the best care that meets their needs whether they access that care through their GP, 111, 999 or by walking into an Emergency Department (ED)"



Dr Lindy-Lee Folscher,
ICB specialty advisor for UEC

Our objectives

a) Improve emergency ambulance response times and ensure patients are seen more quickly in the Emergency Department by meeting the required % of patients being admitted, transferred or discharged within 4 hours.

b) Expand virtual ward services as an alternative to an inpatient stay.

c) Reduce length of stay (LoS) in hospitals.

What would you like to see in our five-year plan for health and care services? What matters most to you?
JFP consultation feedback: "Involve other services such as the ambulance service when making your 5-year plan as when all the other services fail it's always the ambulance service picking up the pieces". "Next best thing is more rehab beds for step down patients who do not require an acute bed but are simply not well enough to be at home independently. "Really investing in digital health is crucial to ensure joined up, continuity of care". "Easier access to Primary Care services closer to home services in the community to prevent hospital admission or facilitate early discharge home from hospital."

Dave Weldon
14/03/2025 12:20:17

Why we chose these objectives
We want our population to be confident that whenever they have an urgent care need or an emergency happens the local NHS is there to rapidly respond. We will continuously improve our emergency and urgent care services and adapt to our population's changing needs, taking advantage of new technologies and develop trusted relationships across all health and care organisations in Norfolk and Waveney.

We know our population wants to receive care at home and avoid stays in hospital where it is safe to do so and the evidence tells us this is best for people too, avoiding deterioration in mobility through bed-based care or hospital acquired infections. Two of our priorities focus on keeping more people at home through enhancing joint working and collaboration between community teams and ambulance services as well as expanding our virtual ward that has technology at the heart of it. Our third priority is making sure that where hospital is the best place for people to be cared for, there are quick, integrated processes to get people home with the support they need to recover.

Objective 6a: Integrate urgent care to improve emergency response times across all organisations

What are we going to do?
We will work with the ambulance service, integrated urgent care providers and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will improve how organisations work together and collaborate to support community teams to respond to urgent care needs which are not life threatening but need a rapid response, thereby allowing the ambulance service to better respond to serious issues that are a threat to life or limb and are emergencies.

This will result in more 999 calls being safely and appropriately transferred to others, including community services. Where the community is best resourced to respond the patient will be visited from a member of the local NHS team. This could be from a community nurse or therapist as part of the 2-hour urgent community response team (UCRT), virtual ward or pharmacy, or a telephone assessment with an urgent care doctor or nurse. Community teams will work with senior medical specialists who will advise on treatments and can access rapid-access clinics and same day appointments at hospital.

For patients with an urgent same day care need this will mean an increasing number of patients able to safely stay at home, supported by local health and social care teams to remain safe.

How are we going to do it?
Appropriate urgent 999 calls will be digitally transferred to community teams for place-based teams to respond. The Norfolk and Waveney unscheduled care co-ordination hub (UCCH) will have clinical consultations with patients who have called 999 and ambulance crews on scene who are responding to a 999 call, to agree if there is a clinically appropriate alternative to hospital. This will allow crews to move on to their next call whilst UCCH arranges to get the patient to the alternative service.

We will work with clinicians in the ambulance service, the community, urgent care and out of hours doctors, primary care and others to develop the framework and digital capability to identify and transfer patients from emergency services to urgent community services.

Our response teams will be integrated, allowing them to work across organisations to share skills and make a greater impact by jointly responding and coordinating care and sharing resources.

This will be modelled and delivered to meet the needs of the local population. It may mean local variation in how services are set up across Norfolk and Waveney but the outcome will be the same; a rapid response from a clinician suitably skilled to assess and treat the patient.

For health and care professionals working in urgent and emergency care services this means consistent and standardised access points, a single access route for alternatives to emergency care and easier referral mechanisms to transfer patients between services, which will further support workforce satisfaction and retention.

What action are we taking to address Health Inequalities as part of this work?
As described above, there will be some local variation in how services are set up however the outcome for all urgent and emergency care services across Norfolk and Waveney will be the same.

How are we going to afford to do this?
We are working together as a system with all our partners to make sure our resources are used to support transformation and deliver the care our patients need in the right place at the right time.

What are the key dates for delivery?

Years 1 and 2: April 2025 – March 2027
Continued integration of urgent and emergency care provision, further collaboration across system partners, including VCSE to increase the support available.

Year 3: April 2027 – March 2028
Fully embedded model of integrated urgent care in place across Norfolk and Waveney ensuring patients get the right care in the right place whenever the need arises.

Year 4: April 2028 – March 2029
Objective to be reviewed / retired.

Year 5: April 2029 – March 2030
Objective to be reviewed / retired.

How will we know we are achieving our objective?

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/2026 compared to 2024/2025.
- Improve Category 2* ambulance response times to an average of 30 minutes across 2025/2026.

*National description of Category 2:
C2 - Emergency. These calls will be responded to in an average (mean) time of 18 minutes, and within 40 minutes at least nine out of 10 times (90th percentile)

Dakal Ltd
27/03/2025 12:20:17

Objective 6b Expand virtual ward services

What are we going to do?
Virtual wards provide hospital-level care in people's own homes or the place they call home, including care homes. This includes providing urgent access to hospital-level diagnostics, delivering hospital-level interventions and providing care through daily multidisciplinary input. They are for people with acute care needs who would otherwise be in hospital.

During 2025/2026 we will review the virtual ward provision with the intention to create one Virtual Hospital, with three wards; East, West and Central, to ensure that wherever patients live in Norfolk and Waveney they will have equal access to a virtual ward, improved efficiency and value for money, increased levels of admission avoidance and identified longer term developments.

We will work with the whole provider community - Primary, Community and Acute care, 999 and 111 (CAS), embedding virtual ward as part of an integrated urgent care 'pre-hospital' model with enhanced clinical oversight that enables services to safely support patients outside of hospital, and deliver better outcomes for patients.

How are we going to do it?
Virtual Ward is still relatively new and is an area of both national and local focus for research and innovation. Our clinical leads are closely linked into developments, ensuring that locally we build on national best practice.

What action are we taking to address health inequalities as part of the work?
We are reviewing our existing models to ensure there is a standard approach across all providers to be able to visit patients at home and support patients who might be at risk of digital exclusion.

How are we going to afford to do this?
Virtual Ward has an allocation of national funding. The review will include how existing funding can be spent as effectively as possible to support more patients on virtual wards.

Daisy Yadi
31/03/2025 14:28:17

As our Virtual Ward expands, we anticipate there will be corresponding changes in where urgent care activity is managed, increasingly this will be outside of hospital settings.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**
  System review of virtual ward and development to increase capacity, improve efficiency, reduce unwarranted variation.
- **Years 2 and 3: April 2026 – March 2028**
  Further evaluation and monitoring to continuously improve the service.
- **Year 4: April 2028 – March 2029**
  Objective to be reviewed / retired.
- **Year 5: April 2029 – March 2030**
  N/A

How will we know we are achieving our objective?

By March 2026 the aim is to have 330 Virtual Ward beds available across Norfolk and Waveney, compared to 170 Virtual Wards beds in March 2025.

As well as increasing the number of Virtual Ward beds we want to increase the occupancy of the beds to a minimum of 80% at any time.

Objective 6c: Reduce length of stay (LOS) in hospitals

What are we going to do?
We will continue to improve discharge planning to reduce the length of time spent in hospital unnecessarily. We will support our population to take the next step in recovery and rehabilitation after a period of illness, in a place where they can be as active and independent as possible and stay connected to the people and activities that matter most to them.

If things have changed while someone has been in hospital and home is no longer the right place for a person to live, we will work together to plan what that will look like.

The date and time for discharge home will be agreed in advance, ideally at the point of admission to hospital. This allows us to set expectations and plans with carers, loved ones and/or family members. We will better join up care to support the return home through providing a supply of medication and a discharge letter to share with the GP so they know what help and support is needed at home.

Better discharge planning helps to reduce length of stay in hospital and the risk of changes to mobility through long lengths of time spent in a hospital bed. This increases the ability to return home and maintain independence while ensuring hospital beds are available for the sickest residents within our population.

How are we going to do it?
Through local partnerships, health and care providers will work together to embed the 'home first' principle when planning to leave hospital. Nurses, doctors and social workers will work with patients and their families to plan next steps.

We will build on the process improvements underway that are maximising the care available to our communities. These are showing improvements, and our next priority is to have the right capacity and right type of beds and care available in the community when people need them. To do this we need to ensure we understand the requirements of our population both now and in the future.

Bailey, Heidi
27/03/2025 11:20:17

In the longer term, there will be a stable and sustainable model of care for discharge support more generally, but particularly for discharge Pathways 1 to 3, which are pathways for patients who require support following a hospital stay.

What action are we taking to address Health Inequalities as part of this work?
Social, economic and environmental impacts are considerations within the model of care for discharge and these will be different according to where patients live. The place-based approach is key to being able to deliver this as local knowledge is key, with support from other sectors including housing, primary care and the voluntary sector.

How are we going to afford to do this?
In 2025/2026 the national Better Care Fund is being targeted towards reducing length of stay as one of its three headline metrics. This is a fund that is delivered in partnership with local authorities. More broadly, reduced length of stay will reduce the risk of patients deconditioning, reducing costs associated with long term complex care packages and residential care.

How will we know we are making a difference?

- Reduction in length of stay is the key outcome metric of this programme and we should see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds.
- An increase in numbers of patients discharged each day.
- Deconditioning and readmission rates will fall.
- We can stop using surge and escalation beds to manage day to day pressures.

What are the key dates for delivery?

- **Years 1 and 2: April 2025 - March 2027**
  Deliver a stable and sustainable model of care for discharge. Focus on discharge Pathways 1 to 3, for patients who require additional support following a hospital stay; ensuring there is better patient choice and communication with carers so that decisions can be made together.
- **Year 3: April 2027 - March 2028**
  - Digital maturity fully embedded.
  - A model of care that meets demand.
- **Year 4: April 2028 to March 2029**
  Ensure the system is operating a model of care that meets demand.
- **Year 5: April 2029 to March 2030**
  - Review and refine models of care based on outcomes, both short and longer term.
  - Ensure that parity of discharge is achieved across physical and mental health.

How will we know we are achieving our objective?
We will monitor our acute hospital average Length of Stay and aim to reduce this to 7 days.

Davey Heidi
24/03/2025 12:20:17

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Dakota Heidi 24/03/2025 12:20:17

Case Study

Lung health checks launched in a drive to save more lives

Past and current smokers in Great Yarmouth are being invited to an NHS lung health check in a drive to improve earlier diagnosis of lung cancer and save more lives.

With one of the highest mortality rates for lung cancer in England, Great Yarmouth is one of 43 places across the country to launch the Targeted Lung Health Check programme.

The initiative means around 13,750 past and current smokers aged 55 to 74 years of age in Great Yarmouth are being invited to a lung health check by their GP. This will identify lung cancer earlier than it would have been otherwise.

People diagnosed with lung cancer at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late.

A patient who has had a lung health check, said: *"This is an excellent scheme and I was so pleased to be invited to attend this check up. Prevention is always better than the cure and this is a great example of the NHS, working together to help identify cancer much earlier. I am so grateful."*





Ambition 7: Elective Recovery & Improvement

Ambition 7: Elective Recovery & Improvement

"The aim is to work together to improve access and quality of elective care for the people of Norfolk and Waveney with a focus on addressing inequalities".



Matt Dooley
Executive Director of Commissioning and Performance and Senior Responsible Officer for elective recovery across Norfolk and Waveney

Our objectives

a) Effectively utilise capacity across all health system partners.

b) Implement digital technology to enable elective recovery.

What would you like to see in our five-year plan for health and care services? What matters to you most?
JFP consultation feedback: "Reduced waiting times for urgent surgery for things that are not necessarily life threatening, but which have a massively detrimental effect on our ability to hold down a job, function at a basic level, and live independently without the need to constantly rely on people for support".

Why we chose these objectives
Our patients and communities identified this as their main concern whilst we carried out engagement on the Norfolk and Waveney ICS Clinical strategy - reducing long waiting times and improving access through elective recovery was very important to them. To improve patient safety, outcomes, experience and improve the welfare of our population it is imperative that across Norfolk and Waveney we reduce long waits for elective (planned) care, cancer backlogs, and reduce our waiting times for those needing diagnostic tests. This is likely to also reduce demand on our Urgent and Emergency Care system. These are also national ambitions. We recognise that fully recovering elective activity is a longer-term piece of work.

We are working to improve cancer care across Norfolk and Waveney by strengthening key pathways, addressing workforce challenges, and enhancing early diagnosis. Our focus is on ensuring timely access to treatment, improving service capacity, and reducing delays in detecting and diagnosing cancer.
By taking a system-wide approach, we aim to deliver better outcomes and experiences for patients.

This will mean that complex health care is seen and treated at an acute hospital whilst less complex but potentially 'life limiting' health concerns may be treated elsewhere. This links to and aligns with the work we are doing around the way people are referred for diagnostic testing and/or treatment in the community or via the local GP.

Davey, Heidi
24/03/2025 12:20:17

Objective 7a: Effectively utilise capacity across all health system partners

What are we going to do?
We will identify and utilise all available capacity to ensure residents access the right service, at the right time in the most convenient and suitable location. Through working in partnership, we will identify whole system transformational opportunities to reduce waiting times, deliver care in more convenient locations and provide a more patient centric service.

We will continue to reduce health inequalities in access, outcomes, and experience for our population and ensure this is supported by a strong workforce, digital capabilities and is co-produced with all partners including the residents and patients.

We will

- Deliver more diagnostic care.
- Deliver more elective care.
- Increase day case elective procedures.
- Reduce cancer backlogs.
- Reduce unnecessary outpatient follow up appointments.

How are we going to do it?

We will deliver more diagnostic care
With national funding, Norfolk and Waveney have developed four new Community Diagnostic Centres (DCS's), now partially or fully operational. These centres will:

- Enhance accessibility by bringing diagnostic services closer to local communities.
- Enable GP direct access to diagnostic tests.

These centres and other areas of elective care rely on availability of skilled workforce therefore, we will work with system leads to strengthen workforce support and planning.

We will optimise what we do and share best practice to standardise procedures, processes and pathways to increase productivity, efficiencies and clinical quality.

Initiatives that support the best use of resources, such as a recent volunteer-led initiative to help more people attend their diagnostic appointments, will continue to be explored.

We will deliver more elective care

- We will increase capacity through Elective Hubs at our acute hospital sites.
- We will continue to maximise our capacity where possible, through 'Mutual Aid' - whereby patients are asked if they would be happy to be treated at any of the three acute hospital trusts in Norfolk and Waveney if their treatment can be completed sooner – and using the independent sector where resourcing allows.
- We will encourage and support sharing of best practice, appropriately increasing standardisation of procedures, pathways and support functions.

Increasing rates of 'day case' elective procedures

- We will use national best practice initiatives such as High-Volume Low Complexity (HVLC) and Get it Right First Time (GIRFT) to enable, where appropriate, full benefit from 'Day Case Care' for planned care procedures.
- We will reduce and minimise cancellations of planned care procedures.

Reducing cancer backlogs

- We will use evidence-base, risk-stratification and work with experts, including patients, to improve pathways and experience of care. This includes improving dermatology pathways and management of breast pain, for example.
- Continue to embed system-wide the nationally defined Best Practice Timed Pathways (BPTP) for cancer, and the Non-Specific Symptoms pathway to improve efficiency, diagnosis, and patient experience.
- Work with workforce leads to address our workforce needs.
- Ongoing work to raise awareness and training to support the national cancer guidance and to reduce variation in quality of urgent suspected cancer referrals.

Reducing unnecessary outpatient follow up appointments

- We will empower patients to book, manage and request (or initiate) a Follow Up appointment – this is using Patient Initiated Follow Ups (PIFU) – based on discussion with clinicians about what and when is expected after their

treatment or surgery. This will free-up clinical time and allow people to manage their care.

- Increased use of digital support will reduce duplication and streamline administration of cancer pathways. This links to Electronic Patient Record and the virtual Single Point of Access and business planning for the C the Signs system.

What action are we taking to address Health inequalities as part of this work?

Work with health inequalities services, providers and partners at Place to support vulnerable and disadvantaged patients, especially those with multiple long-term conditions, to access services.

Undertake regular review of local waiting list data, as well as data on people not attending appointments, to understand areas of variation potentially relating to inequality, deprivation and ethnicity and using wider CORE20PLUS methodologies. This will also include improving the quality of data recorded for individuals, so we can better understand need.

Utilise patient forums and local health inequalities working groups to establish service provision which meets the needs of service users.

How are we going to afford to do this?

National capital funding has been secured through the development of local plans and business cases to support the establishment of Elective Hubs, Community Diagnostic Centres, and Diagnostic Access Centres. These programmes have allocated the necessary capital to build and operationalise these sites and their associated services.

How will we know we are achieving our objective?
We will work to achieve national targets:

Elective, by March 2026:

- 60% of patients receive elective treatment within 18 weeks.
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list.
- Increase the proportion of patients receiving their first elective care appointment within 18 weeks to 67%.

Cancer, by March 2026:

- Improve performance against the headline 62-day standard to 75%.
- Improve performance against the 28-day Faster Diagnosis Standard to 80%.

Daisy Heidi
27/01/2025 12:20:17

What are the key dates for delivery?

Year 1: April 2025 – March 2026
- Support direct GP access to nationally recommended cancer diagnostic tests.
- Develop a system approach to deliver nationally defined best practice cancer pathways.
- Develop career pathways to support recruitment and retention.
- Maximise utilisation of capacity in new system provision, such as CDC's operating CDCs to 12-hour, 7-day.
- Use national minimum standards for patient experience in elective care to inform next steps.
- Expand the use of Patient Initiated Follow-Ups across outpatient services.

Year 2: April 2026 – March 2027
- Plan transition of activity closer to communities.
- Strengthen system collaboration to tackle wider health inequalities affecting elective care.
- Assess how Community Diagnostic Centres and Elective Hubs are improving access to care and reducing inequalities.

Years 3 to 4: April 2027 – March 2029
- Review the benefits of Elective Hubs and CDCs.
- Explore further collaborative opportunities to enhance elective recovery, including developing workforce pathways.

Year 5: April 2029 – March 2030
Complete a system-wide review of elective care and digital innovation efforts, using lessons learned to shape long-term NHS planning beyond 2030.

Objective 7b: Implement digital technology to enable elective recovery

What are we going to do?
Digital is a key enabler for improvements in health and care in Norfolk and Waveney and our ICS Digital Strategy sets out clear priorities for improvement that drives and support elective recovery and improvement. By enhancing patient engagement, streamlining care pathways, and improving efficiency, we can ensure better access to treatment and improved health outcomes.

- Patient Engagement Portal is being rolled out across all three hospitals; an online platform that improves communication between patients and healthcare providers, improves experience and facilitates more timely access to outpatient care.
- The shared Electronic Patient Record will allow clinical teams to see records across all three Norfolk and Waveney hospitals, ensuring access to real-time patient information. This will help reduce delays, support decision-making, and improve the overall efficiency and safety of elective care delivery.
- Expanding the use of digital platforms, such as the NHS App.
- Optimising Advice & Guidance Services – Exploring digital solutions to improve collaboration between primary care and hospital specialists, ensuring timely and effective patient referrals.

Davey,Heidi
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How are we going to do it?
We will explore expansion of the Patient Engagement Portal across more specialties and access via the NHS App - simplifying access to key healthcare information.

We will help reduce missed appointments through new digital communication tools that make it easier for patients to manage their appointments.

The shared Electronic Patient Record will help reduce delays, support decision-making, and improve the overall efficiency of elective care delivery.

What action are we taking to address Health Inequalities as part of this work?
Aligned with national ambitions to empower patients through the use of digital tools such as expanding use of the NHS App – we will consider and take steps to address barriers to digital health that may be experienced by some. This work will further connect with the wider digital health transformation across our system, and its work to address access and inclusion.

How are we going to afford to do this?
- No additional major funding is required – The technology and systems needed are already in place.
- The Patient Engagement Portal and NHS App integration are part of ongoing digital transformation programmes, meaning they are being delivered within existing budgets.
- The Electronic Patient Record implementation is fully funded as part of a collaborative programme across all three hospitals.
- These digital improvements will make healthcare services more efficient, enabling patients to access care more easily while reducing administrative pressures—freeing up staff time to focus on patient care.

What are the key dates for delivery?

- **Year 1: April 2025 – March 2026**
  - Continued rollout of the Patient Engagement Portal.
  - Expansion of automated patient communication tools.
  - Introduce targeted measures to reduce missed appointments.
  - Implementation of a shared Electronic Patient Record.
  - Pending business planning, integration of the C the Signs system as the single repository for urgent suspected cancer referrals in N&W.
- **Year 2: April 2026 – March 2027**
  - Further expand PEP functionality.
  - Review the impact of missed appointment reduction measures.
  - Pilot AI-powered tools to reduce missed appointments.
  - Embed the Electronic Patient Record.
  - Evaluation and business planning for the C the Signs system.
- **Year 3: April 2027 – March 2028**
  Deploy virtual consultations and AI decision-support tools.
- **Year 4: April 2028 – March 2029**
  Evaluate the impact of digital innovations (e.g., PEP, AI tools), using insights to guide future improvements and identify new opportunities to further improve elective care.
- **Year 5: April 2029 – March 2030**
  Conduct a full system review of digital innovations, evaluating their impact to shape NHS Norfolk and Waveney's future digital strategy.

How will we know we are achieving our objective?

Davey, Helen
24/03/2025 13:20:17

We will measure success through:

- Reduce missed appointments rates to 4% or below by March 2026.
- Increase the uptake of PIFU pathways to 5% of outpatient attendances by March 2026.

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Dakota Heidi 24/03/2025 12:20:17

Case Study

Shared Care Record sets to transform care in Norfolk and Waveney

The Shared Care Record is a way of bringing together the most important records from the different organisations involved in the health and care of our people and communities in Norfolk and Waveney.

These records are then visible to frontline health and social care professionals, at the point of care, in a read-only view. Our aim is to help our frontline health and care services by providing important information about you and your care, from your interactions with the following professional care services:

- GP
- NHS 111/out of hours service
- community services
- emergency department
- outpatient appointment
- hospital stays
- maternity service
- mental health practitioner or care practitioners

Patients' information will only be made available when needed at the point of care and will only be used by staff members with a legitimate basis to do so. The Norfolk and Waveney Shared Care Record helps meet this aim by reducing the time needed to learn about important health and care information, particularly in a time sensitive situation.

This can be particularly helpful when patients, their families and carers may not be able to answer specific health and care questions.





Ambition 8: Improving Productivity & Efficiency

Ambition 8 Improving Productivity & Efficiency

"Our ambition is to find ways we can work together more effectively and become more efficient, whilst driving forward service improvements to meet the needs of our local population. It is about saving money and delivering better services and quality outcomes for our population"



Andrew Palmer
Executive Director of Strategy and Deputy CEO
NHS Norfolk & Waveney ICB

Our objective

To deliver our Medium-Term Financial Plan.

What would you like to see in our five-year plan for health and care services?
Lord Darzi's rapid investigation into the NHS (November 2024) report highlights a fall in productivity and efficiency since the COVID pandemic, and the frustrating impact that this has on both patients and staff. This ambition is about systematically reviewing what we do and delivering transformation. In parallel we must have a process in place to support local prioritisation decisions as part of this wider ambition to improve the way we deliver our services.

Why we chose these objectives
There is a clear requirement in the 2025/2026 priorities and operational planning guidance (see Section 4) for the NHS to live within our means, reduce waste and streamline processes to maximise productivity. This ambition directly contributes to one of the "triple aims" of the NHS which is about having regard to the wider effect of decisions made about the provision of health and care. Efficiency and sustainability of use of resources is one of those aims.

Davey, Heidi
24/03/2025 12:20:17

Objective 8a: To deliver our Medium-Term Financial Plan

What are we going to do?
The aim is to deliver our Medium-Term Financial Plan. This is one of our Legal Duties and is described in Part 2 of the JFP. This timescale acknowledges the scale of the financial challenge ahead.

Productivity and efficiency improvements will be driven by the data and focussed on clinical leadership with our staff.

How are we going to do it?
We will undertake a continuous programme of systematic productivity reviews that are focused, embed clinical leadership and will achieve quality outcomes.

Workforce and Digital are key enablers to this. These were in the 2023/2024 and 2024/2025 JFP and this work will be consolidated and accelerated. Reducing spend on temporary staff and support functions by improving processes is a key driver for change within the 2025/2026 operational planning guidance. The Electronic Patient Record Systems will contribute to productivity once fully implemented, this is our biggest piece of digital transformation we've ever undertaken.

We have access to the Model Health System Model Hospital which allows NHS organisations to compare themselves with each other and look for unwarranted variances. Opportunities to improve productivity and outcomes identified by Getting it Right First Time GIRFT benchmarking and NHS IMPACT are also being reviewed.

What action are we taking to address Health Inequalities as part of this work?
Programmes of work that deliver service change, transformation and prioritisation include a review of the impact on health inequalities. By using joined up data through a PHM approach we can target the outcomes we want to achieve at system level.

Davey, Hayley
24/03/2025 12:20:17

How are we going to afford to do this?
This work will contribute to productivity and support our financial re-set.

What are the key dates for delivery?

Year 1: April 2025 – March 2026

- Providers and the ICB will assess and respond to the NHSE EoE productivity packs.
- There will be a pro-active and regular Productivity Review with each of our Providers that is two-way dialogue. This will be led through Key Lines of Enquiry developed by the ICB and the Providers, sharing national best practice.
- These will be benchmarked, and tracked using national benchmarking tools, reported via a Productivity Dashboard or Report at the Financial Recovery Board.

Years 2 to 5: April 2026 – March 2029
This approach and the scale of the transformation will be reviewed in light of the Spending Review and longer-term plan for the NHS as part of the 10-Year Plan for Health.

The benefits of the EPR system will be realised during 2026/2027 with a full year effect.

How will we know we are achieving our objective?

- Delivery of our Medium-Term Financial Plan.
- Improvement in clinical productivity in our Trusts measured through benchmarking.
- Reduction in spend on bank and agency staff.
- Progress made from Analogue to Digital – go live of the Electronic Patient Record in Q4 of 2025/2026.
- Progress will be monitored through the Financial Recovery Board with updates to the ICB Finance Sub-Committee.

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Case Study

What should quality feel like? Meet Charlie



Charlie, aged 19, has been a family carer for most of her life and a member of Norfolk Young Carers' Forum, supported by the charity Caring Together as part of Norfolk and Waveney ICS. The Forum helps to recognise the lives of young carers and ensure that health, care and education services across Norfolk understand their needs. The Forum has carried out surveys of young carers and ran a conference for people working across the health and care system. Forum members have recorded videos, shared their experiences and reviewed all of the materials which are used in carer-awareness training. Charlie has put a lot into the forum, and got a lot out of it too.

Charlie says: "At first I was surprised they gave a 15-year-old the responsibility of doing the lectures, but I'm used to it now. It's still nerve-wracking but I know exactly what I am doing. I was a shy kid, but when I joined the Forum, I felt a real surge in confidence; it gave me a voice. In the Forum, everyone accepts who you are. Everyone is in a similar boat. They all just get it. I've made a lot of friends that I will be friends with for the rest of my life and pushed me to do what I want to do."

Charlie's caring role continues and when she reflects on five years in the Forum, she is positive about the changes that have happened in that time. She remains committed to driving further change for young carers.



5.0 When we expect to deliver

Davey, Heidi
24/03/2025 12:20:17

5.0 When we expect to deliver

For each of the Objectives, we have developed a series of key milestones.

As this is a rolling five-year plan it builds on the progress that was made during 2024/2025 financial year.

Figure 9 illustrates the overall profile of work being undertaken and deliverables across a five-year period. The green boxes indicate there is work being undertaken, the amber boxes illustrate where there are interdependencies with other workstreams and the grey boxes indicate when the objective is expected to be reviewed or concluded.

Year 1 relates to the financial year that starts 1 April 2025 and ends on 31 March 2026.



Dakin, Heidi
24/03/2025 12:20:17

		Timeline for delivery				
Ambition	**Ambition Objective**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
1	**PHM, Reducing Inequalities & Supporting Prevention**					
1a	Development and delivery of two strategic pieces of work: A Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action; and a Population Health Management (PHM) Strategy					
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.					
1c	Early Cancer Diagnosis – Lung Cancer Screening (formerly called Targeted Lung Health Check or TLHC programme)					
1d	Cardiovascular disease Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol.					
2	**Primary Care Resilience & Transformation**					
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience.					
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.					
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**					
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.					
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan.					
3c	Implementation of asthma and epilepsy recommendations, for Children and Young People.					
3d	Develop an improved and appropriate offer for Children's Neurodiversity					
4	**Transforming Mental Health Services**					
4a	We will 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.					
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities					
4c	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.					
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).					
5	**Transforming Care In later life**					
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives					
6	**Improving Urgent and Emergency Care (UEC)**					
6a	Integrated urgent care to improve emergency response time across all organisations					
6b	Expand virtual ward services					
6c	Reduce length of stay (LoS) in hospitals					
7	**Elective Recovery & Improvement**					
7a	Effectively utilise capacity across all Health System Partners.					
7b	Implement digital technology to enable elective recovery					
8	**Improving Productivity and Efficiency**					
8a	To deliver our Miedum-Term Financial Plan					

Figure 9 – outline programme plan for the JFP objectives

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Case Study

Reducing isolation and depression by increasing connections in the community

Anne is a 77-year-old lady who regularly attended her GP surgery. She has had to deal with several health conditions including cancer, diabetes, angina, and back pain after surgery.

Anne had been feeling isolated, depressed, and just wanted human contact to help her with these feelings. Anne's GP referred her to a Social Prescribing Link Worker.

The Link worker helped Anne, by forwarding her to a local befriending project in the area. The project aims to connect people to reduce loneliness and isolation by hosting walk and talk sessions. Anne now attends these sessions once a week and really enjoys them.

Anne feels a lot happier now, has reduced her social isolation, gained greater confidence and a wider social network. She also feels fitter, evidenced through lower blood sugar levels. Anne now attends fewer GP appointments.



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6.0 How are we going to work together differently?

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6.0 How are we going to work together differently?

How we work together differently is critical to the ambitions and objectives because it signals the change required to successfully deliver our plan.

1. **Place based approach** - clearly defined remit, responsibilities and decision making. Be clear about what we do at System level and what would be more effectively determined and delivered more locally in our communities.

2. **Provider Collaboration** – confirming our Acute hospital, Mental Health and integrated Community Collaborative arrangements, so we understand their remit, responsibilities and decision making.

3. **Existing ICS Strategies** – ensure everything we do is aligned with strategic commitments that we have already agreed such as those set out in our Integrated Care Strategy and Joint Health and Wellbeing Strategy, Population Health Management, Health Inequalities, Clinical, Digital, Quality, Estates, Research and Evaluation and Net Zero Green strategies and our People Plan. The existing Strategies and ambitions in our JFP need to all pull in the same direction.

4. **Empowerment** – defining the functions and responsibilities at system level and those more suited for local determination, to unlock the benefits afforded to ICBs and ICSs, creating the conditions for change and moving our system from responding, to innovating.

5. **People and Culture** – continue to develop inclusive partnerships as our leaders work together to facilitate a climate of improvement for all our teams as they deliver the ambitions of our JFP.

6. **Engagement and co-production** – listening and facilitating inclusive participation with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services.

7. **Our Voluntary, Community, and Social Enterprise (VCSE) sector as system partners** - integrating VCSE provision into our design and delivery models for services.

The 2022 Health and Care Act established the legislative framework to promote better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration.

Working in this way allows health and care providers, including voluntary sector organisations and primary care, to arrange themselves around the needs of the population rather than planning at an individual organisational level, in delivering more integrated, high-quality, and cost-effective care.

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6.1 Our place-based approach

We are committed to the principle of 'subsidiarity'. Described simply, if we can do something better locally, then we should do so, using our place-based approach. We want to build relationships around communities themselves, where local people are involved and take an active part in creating the solutions.

We have five Place Boards and eight Health and Wellbeing Partnerships (HWPs) shown on the map below in Figure 9. The Place Boards and HWPs have complementary roles.

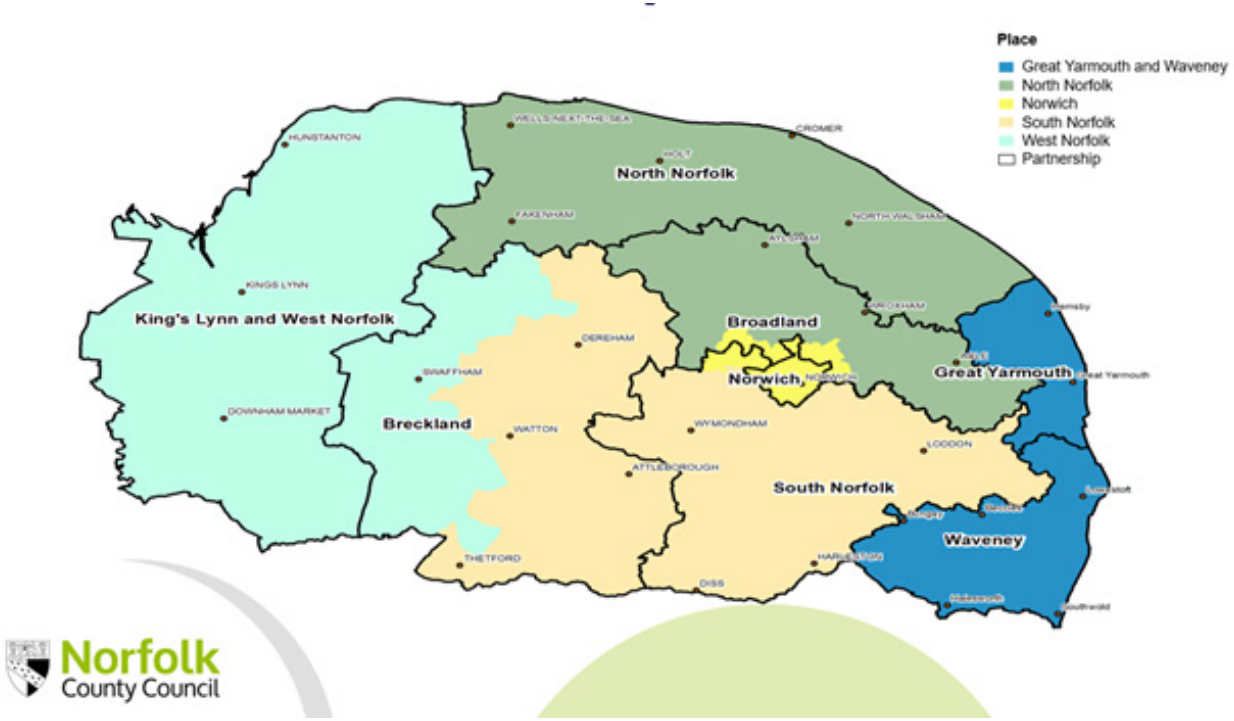

Figure 10 – Five Place Boards and eight Health and Wellbeing Partnerships map

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- **Place Boards** bring together colleagues from health and care to integrate services, with a focus on effective operational delivery and improving people's care.
- **Health and Wellbeing Partnerships,** established on district council boundaries, seek to address the wider determinants of health and wellbeing by bringing together colleagues to focus on greated integrated working between county and district councils, the VCSE sector, health organisations, and other partners. The HWPs are optimally positioned to reduce health inequalities and focus on prevention through collaboration and empowering resilient communities to address the wider detriments of health.

The place-based approach has a proven track record of delivering improvements for local people, especially in prevention, intervening upstream to anticipate issues before they become a problem, providing an integrated community response and connecting communities together.

Our Place Boards are delivering against all eight of the JFP ambitions and are also involved in working up some of the details around our two new hospitals (part of the national New Hospital Programme) at the James Paget in Gorleston-on-Sea and the Queen Elizabeth in King's Lynn.

Furthermore, there are opportunities for Place Board and HWP to work together on their common priorities such as reducing health inequalities. West Norfolk Place and King's Lynn and West Norfolk HWP are working together to develop West Norfolk into a 'Marmot Place'. This includes working directly with Professor Sir Michael Marmot and his team at the Institute of Health Equity to produce a report for West Norfolk detailing where health inequalities lie and what actions are needed from partners to tackle them.

We acknowledge that the place-based approach has significant potential to support the three priorities within the new 10-Year Health Plan for the NHS, but particularly 'from hospital to community' and 'from sickness to prevention'.

The responsibility map in Figure 11 supports our principles and overall direction of travel. This approach sets out an intent and a signal that if we can deliver locally in our communities we will.

The HWPs have developed a strategy for each area across a two to five-year period and action plans developed to ensure delivery. Future plans will be determined through place-based health and wellbeing strategies for the 2025/2026 period and beyond, developed with reference to key strategic priorities from the district they serve and the ICS vision to reduce health inequalities and drive integration. Current priorities are set out in Figure 12 and all of them can be linked to at least one of the ambitions in the Joint Forward Plan. The HWPs have some resources allocated to them through funding from the Contain Outbreak Management Fund, Better Care Fund and Active NoW. In 2025/2026 Public Health are providing funding to enable HWPs to focus on prioritising prevention and driving integration. Adult Social Services are working with HWPs to develop a new model of prevention for older people via place-based Proactive Interventions. We are also reviewing the resources that are available to support the place-based approach, with support from clinical and care professionals.

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Setting the Strategy

(Assessing need, priority setting and resource allocation)

ICS
- Integrated Care Strategy for Norfolk and Waveney
- Joint Forward Plan and transformation priorities
- Business planning
- Medium Term Financial Plan
- ICS Strategies e.g. clinical, research, estates, digital, people plan, population health

County
- Care Market strategy
- Joint Health and Wellbeing Strategies
- Joint Strategic Needs Assessments

Place
- Bring partners together to align priorities

Securing Services

(Specifying outcomes, designing services, shaping the structure of supply e.g. procurement)

Regional
- Commissioning of highly specialised services

ICS
- Commissioning of services, e.g. planned care, urgent and emergency care, primary care, community services, acute, MH and LD&A
- Prioritising services
- Procuring services
- Contract management

Place
- Taking a lead on service re-design/ specifications/ outcomes
- Bottom-up input from local needs assessments and intelligence about health inequalities

Delivering Services

(Managing demand and capacity, delivering transformation and improvement)

ICS
- Co-ordinating recovery plans and Winter Plans
- Innovation Network
- Convening e.g. data sharing agreements, business intelligence and information, governance support, estates, wider digital functions, workforce, project management and communications and engagement

Place
- Providing a local response via partnership working e.g. with the voluntary, community and social enterprise sector, district councils, health and wellbeing partnerships

Monitoring and Evaluation

(Managing performance against agreed outcomes and seeking users' views)

ICS
- Commissioning and Performance Committee
- Evidence and Evaluation Hub
- Quality Management Approach

Place
- Bringing the lived experience to the fore
- Case studies

Assurance

(Assuring quality, safety and governance)

Regional (NHSE)
- Tiering meetings
- ICB review meetings
- NHS Overnight Framework
- Investigation & Intervention regime (I&I)

ICS
- ICB Board and the Board Assurance Framework linked to the 8 JFP Ambitions
- Underpinned by Sub-Committees of the Board e.g. Commissioning and Performance, Patients and Communities, Finance, People, Quality and Safety etc

Figure 11 - Responsibility Map

Partnership	Priorities
Breckland	Through inclusivity, innovation, and engagement: • Prevent Cardiovascular Disease • Improve Mental Health • Tackle issues arising from alcohol dependency and other alcohol related concerns.
Broadland	• Mental Health and Wellbeing • Resilient and Healthy Communities • Access and Prevention Cross-cutting themes: Covid-19 Recovery and Cost of Living Crisis.
Great Yarmouth	• Health Inequalities • Supporting Educational Attainment, Skills and Aspirations • Tackling Vulnerable and Exploitation • Reducing Loneliness, Isolation and Social Exclusion.
King's Lynn and West Norfolk	• Enhance Mental Health and Wellbeing • Improve Weight Management • Reduce alcohol consumption Cross-cutting themes: Prevention, Address Health and Wellbeing Inequalities, Engagement and Collaboration.
Norwich	• Social and economic wellbeing: Food equity, Social Mobility • Physical and mental HWB: Mental health and social isolation in targeted populations, Physical activity • Community resilience and voice: Hearing community voices, Community access to support.
North Norfolk	• Older people • Mental Health • Health Inequalities.
South Norfolk	• Mental Health and Wellbeing • Resilient and Healthy Communities • Access and Prevention Cross-cutting themes: Covid-19 Recovery and Cost of Living Crisis.
Waveney	A new strategy for Great Yarmouth and Waveney is being developed which may change Waveney HWPs priorities. However, the current sub-groups are: • Physical Activity • Children and Young People • Healthy Hearts • Prevention.

Figure 12 - Health and Wellbeing Partnership priorities

In summary we are clear about the role of the place-based approach in delivering the medium to longer term priorities in the Norfolk and Suffolk Joint Health and Wellbeing Strategies and the eight ambitions in the Joint Forward Plan, but we cannot do everything at once. However, we are pulling in the same direction and aiming for the same things, whilst ensuring the place-based approach can respond to local needs.

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6.2 Provider Collaboration

This section focuses on partnership arrangements between Trusts who are working together and at scale across multiple places or locations, with a shared purpose. We are on a journey to develop the potential of provider collaboration, which is an important part of successful ICS working.

Acute hospital collaboration
The Norfolk and Waveney Acute Hospital Collaborative (N&WAHC) is a Provider Collaborative formed by the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospitals NHS Foundation Trust and the James Paget University Hospitals NHS Trust.

The N&WAHC was formed in 2020 to enable the acute trusts to work even more closely together to deliver shared objectives, align decision making and strengthen collaboration across Norfolk & Waveney.

The N&WAHC's vision is that, by working together, we will provide you with high quality hospital care when you need it, supporting you to get the care and treatment you need. Closer partnership working will allow us to more closely integrate patient pathways and provide equitable access for all patients to sustainable, high quality acute care and deliver against our objectives:

- We will listen to what you say and work together to build health services which meet your needs and the needs of our local communities across Norfolk and Waveney.
- Together, we will support our staff to have rewarding careers and a good experience working in our hospitals.
- Public money will be used efficiently to provide better, safer and faster care across Norfolk and Waveney.

To improve efficiency, standardise practices, and enhance patient care in delivering against this vision, the three hospitals are exploring the benefits of moving to a group model for hospital governance. Closer integration of governance frameworks across the three hospitals will offer flexibility, advantages, and opportunities for collaboration, enabling the delivery of consistent care quality and outcomes. This analysis and potential options will be developed and embedded throughout 2025/26 and will be designed in support of our current activities summarised below.

Current Activities

Implementation of Community Diagnostics Centres: We have delivered three new Community Diagnostic Centres across Norfolk & Waveney. This £86m programme will create new, digitally linked, imaging diagnostic facilities with standardised practices and collaborative working across the three acute sites. The first centres at JPUH and QEH opened July and September 2024 respectively, and the NNUH centre opened in February 2025. A fourth centre is due to open at Northgate Hospital in Gt Yarmouth in two phases, in April and June 2025.

Joint delivery of an Acute Clinical Strategy through the development of Specialty Clinical Networks with a focus on working in partnership with the ICS to implement priority pathways in 2025/2026.

Our agreed acute clinical ambitions align directly to the ICS clinical strategy objectives and set out how acute clinical services will be delivered across Norfolk & Waveney, setting our shorter and longer-term ambitions for:

1. Delivering acute services more effectively out of the acute hospital setting and/or in collaboration with our Place health and care partners.
2. Optimising the efficiency of service delivery between the three acute trusts in N&W for the care that must be delivered from an acute hospital setting.
3. Acute specialties to operate with common standards, procedures and technology, removing unwarranted variation and assisting workforce development.

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Development of two new hospitals: Collaborative work on the planning for the two new hospitals planned for Kings' Lynn and to serve the Great Yarmouth and Waveney area, which are part of the national New Hospitals Programme. We are committed to working together to ensure that our hospitals provide high quality and resilient services, meeting the current and future needs of our patients.

Collectively deliver a **single Electronic Patient Record (EPR)** across the N&WAHC: Within a comprehensive digital programme to streamline operations, improve communication, and enhance patient care, we will implement a single EPR in the three acute hospitals by 2026. This will enable efficient sharing of patient information and enhance clinical decision-making, all of which will improve patient experience, timeliness of care and clinical outcomes.

Delivering shared clinical pathways 2025/2026: We are committed to working with our wider System Partners to focus on delivery of transformational change in the clinical priority areas of maternity services, stroke, and cancer services and oncology. We are working closely with partners to define new models of care that will provide sustainable and safe care within Norfolk and Waveney. You can read more about our approach to this in Section 4 of the JFP.

An aligned approach to transformational change across the N&WAHC: We are developing a collaborative approach to transformational change management which will be delivered through the development of common approaches to Project Management Office functions, alignment of Quality Improvement approaches and continuing to build a network of transformational change professionals across all three acute providers.

The N&WAHC is integrated with and supports Ambitions throughout the JFP. For example, the adoption of a tri-acute EPR is a key workstream within the ICS Digital Roadmap, Community Diagnostic Centres will support elective recovery and improvement (Ambition 7), and shared transformation methods will underpin the service change necessary to improve our productivity and efficiency as a system (Ambition 8).

6.3 Our partners' plans and existing ICS plans

A key principle of the JFP is that it builds on existing local strategies and plans. By lining up our efforts and doing a few key things well, once, at system level and in a co-ordinated way with partners, ensures we are using these strategies to best effect.

All the strategies refer to collaboration and / or integration with partners, the importance of developing and encouraging our staff to be the best version of themselves that they can be for our local population and offer the best quality services we can, and how we must ramp up the pace of digital transformation in Norfolk & Waveney.

Partner Plans
The table on the next page shows the consistency of messaging and alignment between our partners strategies and plans and the JFP.

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Partner Plans	Alignment with the JFP
Norfolk County Council Better Together for Norfolk Strategy	Norfolk County Council's guiding principles, commitments, and plans for delivery aim to improve the quality of life for Norfolk residents through collaboration, innovation, and prudent resource management. These three areas of focus are referred to within the JFP as part of the five-point approach to delivery, within Part 2 Legal Duties and Ambition 8.
Norfolk County Council Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council	Ambition 3 is dedicated to Improving Services for Babies, Children and Young People. It acknowledges that the health of this group of our local population is determined by far more than healthcare and sets out objectives that aim to improve their outcomes.
Suffolk County Council Corporate Strategy 2022-26	The key objectives from Suffolk County Council comprise promoting and supporting the health and wellbeing of all people in Suffolk, strengthening Suffolk's economy, protecting and enhancing Suffolk's environment and providing value for money for the Suffolk taxpayer. These four pillars are delivered through considered, prudent financial management and these are all aligned with the JFP as we strive to improve productivity, efficiency and sustainability. Suffolk County Council will lead this agenda by example as the strategy highlights the council's commitment to ensure Suffolk enhances its reputation for collaboration, innovation and delivery. Collaboration is a key theme within the JFP as it's about delivering outcomes that can only be achieved by working together.
Norfolk and Norwich University Hospital NHS Foundation Trust Caring with PRIDE Strategy	The approach that the strategy sets out in the areas of investing in people and how they work, continuously improving quality and becoming more digitally enabled are all areas that chime with the JFP. How we improve is a key tenet of the JFP as well as what we do to improve, and the NNUH strategy reflects this.
James Paget University Hospitals NHS Foundation Trust Strategy	The strategy refers to reducing health inequalities and the role of the hospital as an anchor institution, as well as a specific priority about digital transformation, and collaborating with partners both at system and place. These are key elements of the JFP, which is cross-referenced within the JPUH strategy.
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust Strategy	The strategy refers to addressing health inequalities and the role of the hospital as an anchor institution with specific strategic objectives in relation to becoming a digitally enabled organisation and collaborating with communities and partners. Both the ICS clinical strategy and the JFP are cross-referenced, together with the Norfolk & Waveney Acute Hospital Collaborative.
Norfolk & Waveney Acute Hospital Collaboration (NWAHC) Joint Acute Clinical Strategy	The acute clinical strategy is one element of the N&WAHC work. The ten design principles of the strategy already align well to the governments three shifts of hospital to community, analogue to digital and from sickness to prevention. Collaboration is a central thread within the strategy. The acute collaborative is referenced in section 6 of the JFP as it is a key vehicle for delivering change.
Norfolk and Suffolk NHS Foundation Trust's Strategy	NSFT works across Norfolk and Suffolk and is commissioned by both ICB's. The strategy references both the Norfolk & Waveney and the Suffolk & North-East Essex JFP's. The strategy includes wording from Ambition 4 which is about Transforming Mental Health Services, giving a direct read across from one strategy to the JFP. This further evidences the principles of all partners aligning collective efforts to deliver on some key areas that we have agreed.
East Of England Ambulance Service NHS Trust's Corporate Strategy	EEAST strategy sets out how we will evolve our role, not just as responders, but as leaders who can drive innovation and collaboration across our region. It sets us on a new path, not only continuing to improve but embracing bold, new approaches to the way we work. It calls for us to pull in the same direction, aligning to the same shared missions. And it shows how we are moving forward with a renewed commitment to working with system partners in developing alternative pathways and delivering care closer to home. The strategy links with Ambition 6 of the JFP for improving urgent and emergency care.
Norfolk Community Health and Care NHS Hospital Trust's Strategy	NCH&C is a key partner in the delivery of the JFP particularly within the Ambitions to Improve Urgent and Emergency Care including reducing length of stay, virtual wards and community first, Primary Care Resilience and Transformation where we are seeking to join up services and Transforming Care in Later Life.
East Coast Community Healthcare's (ECCH) Strategy	The focus on subsidiarity where if we can do something better locally, then we should do so, aligns with section 6.1 of our JFP. The principle of simplification and partnering with others aligns with other Ambitions more generally as we set out plans to deliver improvements together and improve ways into finding the right services, first time.

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Our existing ICS strategies

Existing ICS plans and strategies also support the eight Ambitions in the JFP as enablers. As they are refreshed, they will shift with the direction of national and local policies, including the forthcoming 10-year Health Plan.

Norfolk and Waveney ICS strategies have been through wide consultation and are agreed with system partners. The JFP ambitions lean into the infrastructure that these enablers can provide, particularly the role of digital, workforce and estates. Some of the key existing ICS Strategies are highlighted below.

The Norfolk and Waveney Integrated Care System covers the whole of Norfolk and part of Suffolk. Norfolk and Suffolk each have their own joint health and wellbeing strategy:

- Norfolk's Joint Health and Wellbeing Strategy (which is also the Integrated Care Strategy for Norfolk and Waveney)
- Suffolk's Joint Health and Wellbeing Strategy

There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy. We can see the theme of collaboration running through our partners plans and the JFP as described in the previous section, the importance of health inequalities in our work which we have reinforced within each of the eight Ambitions in 2025/2026, and encouraging communities and our local population to be resilient through our place-based approach.

Norfolk priority	Suffolk cross-cutting themes
Driving integration	Greater collaboration and system working
Prioritising prevention	Prevention: stabilising need and demand
Addressing inequalities	Reducing inequalities
Enabling resilient communities	Connected, resilient and thriving communities

Guidance on the development of JFPs makes it clear that ICPs are required to build on these Joint Local Health & Well-Being Strategies, which are a statutory requirement, and the JFP is a delivery mechanism for these strategic priorities.

Digital Transformation Strategic Plan and Roadmap
All our Partner's Plans refer to digital transformation. Moving from paper-based patient records to electronic ones in our three acute hospitals is the start of one of the biggest pieces of digital transformation work the Hospitals have ever undertaken. You can read about it here. There have been many successful digital programmes delivered in Norfolk & Waveney over the past two years.

A Shared Care Record is live in all provider organisations and is being accessed by an average of 7,500 staff each month, helping 44,500 patients to tell their story only once.

All GP Practices have digital access methods for patients, and have new Cloud Telephony systems, improving resilience and providing patient call-back ability.

Over half the population of Norfolk & Waveney use the NHS App, viewing GP records 400,000 times in a month and requesting 900,000 prescriptions. The 3 Acute Hospitals are sharing outpatient appointment information via the NHS App.

Virtual Wards and remote monitoring technologies are enabling patients to receive care in their own homes, and integration with clinical systems used in practices and out of hours services is making the observations recorded more accessible to clinicians.

Norfolk County Council has developed an award-winning Tech Skills for Life program to help members of the community engage with technology. The coaches help with many tasks such as using Smartphones, or shopping online.

Norfolk County Council is using AI technology to identify people at risk of falls. Once identified, people are then contacted and offered a range of support such as assistive technology or help with mobility.

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These are just a few examples of digital innovations in Norfolk & Waveney.

Nationally, data has become an increasingly vital part of health and care delivery. It supports the insight we can have into what is happening, which leads to better decisions earlier, and better outcomes. We have invested in a 'Data Hub' driven by new, national data standards as well as regional and local requirements. We can simplify, standardise, collate and link the data sets, providing the capability to connect what the data tells us, and aggregate it for strategic and tactical analysis, decision making and reporting to enable us to achieve our goals, drive quality improvements and to support front line services in the delivery of safe, effective, and person-centred care.

You can read the Digital Transformation Strategic Plan and Roadmap here.

Delivery of all the Ambitions require digital as an enabler to a greater or lesser extent. Using data to evidence delivery of the JFP Ambitions has been part of our design of the objectives.

People Plan
Workforce development is a key priority for all our partners and is referenced in their strategies and plans. Central to our People Plan is the development of cultures where staff feel valued and supported to deliver outstanding care to patients and service users; in doing so it enables the service transformation in our JFP Ambitions 2 to 7 and is integral to the productivity improvements in Ambition 8. A key supporting initiative will be the continued development of an ICS-wide approach to leadership and management development to foster a "One Workforce" approach.

Multi-professional educational and training investment plans with sufficient clinical placement capacity will be required to maintain education and training pipelines. These will be supported by increased apprenticeship opportunities to "grow our own", along with a continued focus on retaining staff through enhanced support for their health and wellbeing, and the embedding of a more flexible approach to work. Part 2 of the JFP provides greater detail on how we will fulfil our duty to promote education and training, along with our plans to Train, Retain, and Reform our workforce in line with national policies for workforce transformation.

In addition, the People Plan contains several programmes to improve efficiency and productivity across the system as part of Ambition 8. Further reduction in bank and agency spend is required to meet national efficiency targets; integrated workforce plans across providers are being developed at a system level to align with the 2025/2026 operational planning requirements referred to in section 4.

You can read the current Norfolk and Waveney People Plan here.

Estates
Our Estate Strategy is being refreshed to incorporate the latest NHS Our Estate Strategy has recently been refreshed to incorporate the latest NHS England guidance for System Estates Infrastructure Strategies. Our system strategy is also reinforced by individual NHS Trust, GP Primary Care, and PCN estate strategies.

Our buildings and estate infrastructure play a vital role in achieving the systems mission and ambitions, and our ten-year strategy sets out how we will enable this and deliver our vision of providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

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

Our refreshed Estates Infrastructure Strategy is framed around four key goals: to improve access; to improve quality and condition; to improve environmental sustainability; and to improve efficiency. More detail on our strategy, goals and alignment to national and local priorities can be found in Part 2 of the JFP.

You can read the Estates strategy here.

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Net Zero Green Plan
The NWICS Green Plan drives our journey toward achieving the Net Zero NHS between 2040-2045 through actions such as:

- Supporting Primary Care Network (PCN) development in ways that promote integrated services, closer to home (Ambition 2)
- Developing Family hubs (Ambition 3)
- Primary Care Hub projects (Ambition 2)
- Community Diagnostic Centres (Ambition 7)
- An expanding virtual ward service enabling patients to recover and be monitored at home (Ambition 6)

Other parts of our Green plan include digital transformation such as our electronic patient record programme, optimising medicines to minimise impacts on the environment such as our inhalers programme and changing to inhaler types that exclude harmful propellants. We also use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing. The ICB has a legal duty as to climate change and our response to this is set out in Part 2 of our JFP.

You can read the Net Zero Green Plan here which is about to undergo a refresh programme.

Quality Strategy
Our Quality Strategy provides a clear focus on improving care quality and outcomes, using insights around health inequalities and population health to ensure services are safe and sustainable for future generations, underpinned by continuous development of clinical leadership, quality governance, management and assurance, research, evaluation and innovation. Quality is a key theme throughout the delivery of the objectives within the eight Ambitions in the JFP.

This can be illustrated by the following examples:

- Using quality input into service development to ensure mental health services are included in wider physical health initiatives, to reduce health inequalities and promote prevention (Ambition 1) for people experiencing serious mental illness, as well as clinical quality input to the design of new pathways of care, e.g. the Dual Diagnosis pathway for substance misuse and mental health, as part of transforming mental health services (Ambition 4).Working alongside general practice, pharmacy, optometry and dental partners to take forward local, regional and national primary care resilience, improvement and transformation opportunities (Ambition 2), supporting and enabling clinical input and leadership.
- Triangulating quality assurance insights; including clinical effectiveness, safety, experience of care and learning from harms and mortality, to support and inform urgent and emergency care (Ambition 6) and elective (Ambition 7) improvement priorities.
- Empowering staff and service users to work together to improve the quality and safety of services and pathways. A good example of this is the Norfolk & Waveney Integrated Care System (ICS) Glove Reduction project which is driving a reduction in the unnecessary use of non-sterile gloves across the system, to achieve efficiencies (Ambition 8), as well as benefits for sustainable green care and patient experience.

You can read the Quality Strategy here.

Clinical Strategy
Our clinical strategy has six objectives setting out "what my NHS will do" in Norfolk and Waveney. Each of the six clinical strategy objectives can be clearly mapped against the JFP ambitions and we have adopted this approach to ensure we are consistently focusing on the same things and do not duplicate effort or reporting requirements.

You can read the Clinical Strategy and a comprehensive "You said, we did" analysis of Year 2 here.

The ICS clinical strategy, digital roadmap, the Estates strategy and Net Zero Green Plan are inter-dependent and refer to each other which gives the JFP a good foundation to build upon. The acute clinical strategy referred to in section 6.2 uses the ICS clinical strategy as its over-arching framework to ensure our workplans are aligned.

Research and Innovation
Research and Innovation can transform how we deliver care and support better use of resources to address differences in life

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expectancy, health outcomes and preventable causes of disease. Evidence from national research projects, as well as local evaluations and quality improvement projects from our system, can help us choose the best services and ways of working to address unequal health outcomes. This is one of our Legal Duties and is set out in Part 2 of the JFP. We have cross referenced Research and Innovation into the JFP Ambitions and Objectives as part of this year's refresh and priorities align directly with the JFP.

You can read the Research and Innovation Strategy here.

Medicines Optimisation
Medicines optimisation is crucial to the NHS as it ensures the safe, effective, and efficient use of medicines, improving both patient outcomes and financial sustainability.

Medicines represent the second-highest area of NHS spending after staffing; optimisation helps to manage costs while maintaining high standards of care and getting the best value healthcare for the population.

In Norfolk and Waveney, we address five key areas:

1. Quality & Safety – focuses on minimising medication errors and adverse events, ensuring that patients receive the safest and most effective treatments. Promotion of continuous improvement through monitoring, evaluation, and implementation of best practices.
2. Interface & Formulary – works to agree and improve the use, governance and commissioning of medicines.
3. Population Health & Data Analysis – uses local population data to inform strategic direction, monitor targets, and identify opportunities to improve efficiencies & health inequalities through targeted initiatives.
4. Clinical Experience & Delivery – collaboration with primary care and community healthcare professionals including Primary Care Networks to enhance patient outcomes by promoting value-based decisions using data and evidence-based guidelines.
5. Repeat Prescribing and Support - provides support and advice to GP practices to improve the quality and efficiency of repeat prescribing systems.

All the medicines optimisation key areas are enablers of the JFP Ambitions. For example, prescribing low intensity statins as a preventative measure, de-prescribing where appropriate and focusing on alternative therapies for some mental health conditions, asthma and epilepsy bundles of care for children and a focus on medicines as an area of spend across all areas of the NHS in Norfolk & Waveney as part of Ambition 8.

Ageing Well, Population Health Management and Health Inequalities Strategic Frameworks
During 2024/2025 three Strategic Frameworks were published that were as a direct outcome from Ambitions within last year's JFP.

You can read them here: Strategic Frameworks and they are also referred to in the Achievements Section 5.0.

6.4 Empowerment

We will ensure our system is designed to both preserve accountability, at the right level, and free our leaders to innovate and transform care to deliver the best outcomes for our population, underpinned by a quality improvement approach using the right data to support service improvement and transformation across all levels of our system.

We will define the functions and responsibilities most effective delivered together at a system level and confirm those more suited for local determination to meet local needs. Getting this balance right will unlock the benefits afforded to Integrated Care Boards and Integrated Care Systems, creating the conditions for genuine change and will move our system beyond responding to challenges, into innovating and truly transforming care.

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6.5 People and culture

Change happens when people work together differently.

Our Organisational Development (OD) Programme will improve performance and effectiveness to shape a thriving Norfolk and Waveney ICS. We will focus on relationships with and between people and organisations we work with, the culture and processes, and support our leaders to navigate the challenges and complexity of working across organisations to consolidate and align organisational goals with shared vision and purpose for an integrated Norfolk and Waveney system. The foundation of strong relationships, a deep sense of community, a desire to make the system work for the local population of Norfolk and Waveney and, positive developmental work with key stakeholder groups and Boards across the ICS are the bedrock of our maturing ICS.

Specifically, we have implemented, and continue to build on, our 'Collective Culture' programme of compassion and inclusion to support managers, leaders and teams across our system. We are working with all of our Boards and key stakeholder groups to develop mature working relationships and structures to support the goals and ambitions of the ICS, embedding our Leadership Framework, incorporating the new NHS Code of Practice, to support the people that are leading the changes; and evaluate and review our actions with the aim of planning and co-creating the next phase of the maturity journey.

An integral part of the People and Culture enabler is the way that **clinicians and care professionals** (CCPs) are involved in decision-making. This ultimately improves the quality outcomes and experience of our local population, and it is also recognised nationally as best practice. The CCP voice is included in every decision-making group across the ICS – no decision regarding the care we provide or commission is made without formal consideration by a CCP.

We are implementing a **Leadership Framework and 10-point CCP manifesto which is on our website** CCPL Programme to take action on the 5 core principles for effective clinical and care professional leadership. New **CCP** leadership roles have been aligned to each of the ambitions outlined in the Joint Forward Plan with a focus on areas highlighted in the national Core20PLUS5 agenda, further strengthened by leadership development and wider training as we continue to establish a Norfolk and Waveney pipeline of suitably trained, supported and empowered CCPs.

We have also developed an ICS Quality Faculty, focusing on coordinating our training and support programmes in quality improvement and evaluation across the system. As we create an inclusive and empowering culture of improvement, they will bring this community of CCPs together, acting as a role model for this new culture.

You can read more about the Quality Faculty in part 2 of the JFP under the legal duty to improve quality of services.

We will focus on embedding a culture of innovation across the ICS and support the system to have an integrated innovation culture based on learning from, and sharing with, each other. We recognise that developing and nurturing an integrated innovation culture across a system is an evolving process, but we aim to position the importance of innovation as a central, shared concern. We will use a multi-level approach across the system to grow innovation culture and capacity, this includes a system-wide vision for innovation, sharing of innovation across teams and providers, upskilling staff across all levels, and working with external organisations. You can read more about our plans for innovation in part 2 of the JFP under the legal duty to promote research and innovation.

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6.6 Engagement and Co-Production

Norfolk and Waveney are committed to listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services. We believe that all feedback has value and should be supported through a spectrum of participation methods (Figure 13):



Figure 13 - spectrum of participation

All partners are talking and listening to people and communities every day. Our vision is that people would tell their story of lived experience once and it is heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address the key issues for our system. This puts us in a very strong place to work with our people and communities around our JFP.

We are working with system partners to align and develop a broad range of participation methods:

- The Norfolk and Waveney Community Voices (NWCV) Programme. NWCV works with trusted communicators – "people like me" - to speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney.
- Each Place Board has access to some light touch support to support them to engage with their communities. Working with people and communities at 'place' level will support all the different voices of our people and communities to be part of local decision-making, as conversations about 'the place where I live' are often much richer.
- Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system and to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.
- Communications and engagement support is being given to the Norfolk and Waveney VCSE Assembly.

The ICS website hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. It offers a place for all system partners to share live participation opportunities, as well as signposting to information, describing our approach to working with people and communities and feeding back on what we will do as a result of what you have said.

Communications and engagement work, at a very local level, is key to developing ongoing relationships with people and communities and our new networks for engagement will be vital in supporting the work of the Joint Forward Plan.

One particular area of participation that we want to develop further with partners is around the promotion of true co-production. This refers to a process of shared power to effect change.

Examples of co-production exist in Norfolk and Waveney:

- Development of a co-production hub as part of our People and Communities hub to share examples from the system, to promote co-production principles and to signpost to support materials.
- Development of a Norfolk and Waveney Mental Health Co-production strategy and interactive toolkit Mental Health Co-production strategy for lived experience to effectively influence ICS mental health transformation, services and support.
- The Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities. This is in partnership with Norfolk County Council Adult Social Care.
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement, research and health inequalities.

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6.7 Our VCSE Sector as system partners

Norfolk and Waveney benefits from a broad and diverse VCSE sector in which there are over 3,600 registered charities, 220 community interest companies and 124 registered societies with their offices based in Norfolk and Waveney. Many of these organisations have been born of local communities of interest or geography, responding to the local and emerging specialist needs to provide not for profit services and support. Many of these organisations will focus on early intervention and preventative services, empowering communities to build resilience and maintain control of their own lives. Alongside this are thousands more informal or unregistered organisations – often providing vital services and support to their local communities.

Our VCSE Assembly launched in July 2022 with a headline objective to connect this rich and diverse public benefit across the overarching mission for Norfolk and Waveney ICS. The Assembly provides the sector with a space in which VCSE leaders can sit alongside statutory ICS partners and have a shared agenda across local health and care priorities. Our current VCSE Assembly model aims to ensure suitable connectivity within our emerging ICS governance arrangement, enabling collaborative decision making and effective partnering.

The VCSE sector in Norfolk and Waveney continues to face a 'perfect storm' of rising running costs and reduced fundraising income against a backdrop of increasing demand for services and wider ICS financial pressures. More and more VCSEs are facing tough decisions as they try to maintain their public benefit mission, inevitably capacity must be reduced and in a growing number of cases services are being forced into closure. With the establishment of our Assembly, we have an opportunity for ICS partnership and strategic alignment across Ambition 1 in our JFP. This could start to shift demand away from intervention and it will help our residents live longer, healthier, and happier lives.

At its heart, the VCSE Assembly is the vehicle through which our ICS will shape the development of effective strategic and operational partnerships across the diversity of our VCSE sector. The graphic below (Figure 13) sets out how the listening and involvement work of the Assembly is being augmented; through the support, nurturing and development work of our VCSE infrastructure organisations and through improved collaboration, co-production and shared governance as an integral part of our ICS.



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Our ICS building blocks	Primary functions & responsibilities	Desired outcomes
Empowering Communities Partnership & CAS Support, nurture,develop	• Grow and enable volunteering for the ICS. • Build VCSE sector capacity & capability through practical advice, support & training. • Advocate widely on behalf of the sector and supporting sector collaboration. • Raise awareness of and support the sector to access funding and income sources. • Support the sector to maximise funding to provide sustainability and resilience. • Provide financial support to VCSE organisations seeking to grow, expand or innovate their services. • Provide opportunities for the sector to meet & collaborate for peer to peer support, and share insights.	**The collective ambition is to embed effective collaboration and partnership working between all ICS partners.**
Norfolk and Waveney VCSE Assembly Listen and involve	• Develop innovative engagement mechanisms to connect the sector into the ICS, focused on health inequalities and prevention - developed at system, place and neighbourhood levels of our ICS. • Increase the influence and participation of the sector in the collaborative design and innovative delivery of health and care services within the ICS. • Lead development of a MoU between ICS partners based on 5 priority areas of; equal partnering, sustainable resourcing, digital integration, data sharing & consistent evidence and evaluation.	**Closer working will support us to achieve our shared goals and priorities, and enable our ICS to harness the expertise, insight and innovation of the VCSE sector.**
Norfolk and Waveney ICS & VCSE Integration Collaborate, co-produce and embed	• Embed the sector in ICS governance to ensure involvement in system-wide workstreams, place-based partnerships, primary care networks and provider collaboratives. • Support sector sustainability through strategic investment and market development. • Commit to upholding the ambitions of the MoU developed in partnership with all ICS partners. • Lead a system-wide approach to developing and sustaining effective social prescribing. • Collaboratively develop a new approach to health and social care VCSE commissioning.	**N&W needs a VCSE sector that is vibrant, sustainable and resilient, is seen and treated as an equal partner and fully integrated into our ICS at system, place and neighbourhood levels.**

Figure 14 – building effective partnerships with the VCSE sector

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VCSE Assembly Development
An initial focus on place-based VCSE representation through the first pilot year of the Assembly has helped to build a strong blueprint for improved partnering across some parts of our system. Moving into the second year of the Assembly, this model was adjusted to reflect the ways of working across the ICB and our Places, and we have continued to learn from this. With a new VCSE Assembly Chair in place (October 2024), we will explore how we can maximise place-based representation so local voices are heard at a system level. We have also recognised a need to strengthen the way in which VCSE experience, and the lived experience of the communities which we serve, is brought to our ICS strategic framework.

Facilitating the effective development of an Assembly operating model, alongside suitable Assembly Board memberships continue to demonstrate our shared ambition to respond to the national ICS commitment which highlights the VCSE sector is a key strategic partner. They have an important contribution to make in shaping, improving, and delivering services, and developing and implementing plans to tackle the wider determinants of health.

Health Inequalities Strategic Framework for Action
The VCSE sector was extensively engaged in the development of this framework, setting an approach for the way in which such lived experience is brought to the development of other ICS wide strategies. A newly formed Health Inequalities and VCSE Partnering team will both champion the roll out of this framework and the engagement of the VCSE sector in its delivery.

Impact and evaluation
So many conversations keep coming back to building a shared understanding of the value that improved VCSE partnering will bring to our system. To support this, we will continue to work collaboratively with both VCSE and statutory partners to develop a new approach to VCSE sector commissioning, as well as exploring how we best partner with the sector, and support sector resilience. There are numerous local examples of health and care commissioners working together with VCSE organisations, to deliver improved outcomes for our population.

Feedback from the sector and commissioners confirms to us that having an effective ICS VCSE commissioning strategy would enable us to do more. A further priority for the VCSE Assembly is to work with ICS partners to understand how VCSE led work, alongside prevention activity delivered by ICS statutory bodies can support with long term cost savings and enable us to move towards achieving the goals of the new 10- year Health Plan for the NHS, primarily the shift from sickness to prevention. Following the publication of our Health Inequalities Strategic Framework, we will have more opportunity to understand and monitor the impact of preventative and early interventions for members of our local population who are in greatest need of support.





7.0 Commitment to achievable, measurable and impactful improvements

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7.0 Commitment to achievable, measurable and impactful improvements

The improvements we make are quantitatively and qualitatively measured through system Programme Boards and monitored using a Programme Management Office (PMO) approach, reported to the ICBs Commissioning and Performance Sub-Committee, the Integrated Care Partnership and Health & WellBeing Board in annual plans and on our ICS website. A summary of key metrics is shown in Figure 14.

Our commitment is to listen to the people who use our services to hear if we are successfully improving the health and care for the people and communities of Norfolk and Waveney and in doing so deliver our JFP ambitions.



Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective	How will we know we are achieving our objectives?
1	**PHM, Reducing Inequalities & Supporting Prevention**	
1a	Delivery of two strategic programmes: The Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action and the Norfolk and Waveney Population Health Management (PHM) Strategy	Delivery against the objectives in our published action plans. Monitor progress using our Population Health and Inequalities dashboard of key measures.
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people	We aim to see annual smoking at time of delivery rates to reduce by March 2026 towards the regional and national average of 9% and to reduce further to 6% by the end of March 2028.
1c	Early Cancer Diagnosis – Lung Cancer Screening (formerly called the Targeted Lung Health Check or TLHC programme)	We will track the number of invitations sent, and how many of these invitations result in people attending for a lunch health check (we call this a 'conversion rate'). We also provide quality assurance and audit data on a quarterly basis against the national quality standard. This includes our lung cancer diagnoses and other findings including other cancers.
1d	Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol	In the short-term, our digital tool will enable us to track numbers of patient contacts, new prescriptions, and optimisation rates in real time. In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events. Data will be available via CVD PREVENT to benchmark our system. Targets for treatment will follow national NHSE operational planning guidance which will be adopted once made available each year.
2	**Primary Care Resilience & Transformation**	
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience	Publication of a Strategic Framework for Primary Care Publication of long-term plans for community pharmacy and general practice Improve patient experience of access to general practice as measured by the ONS Health Insights Survey. Implement Primary Care Improvement Plans in line with NSHE priorities and planning guidance for 2025/2026, including: • Reduction in unwarranted variation. • Increased activity for Pharmacy First, and clinical services
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.	Increased unscheduled care appointments in line with the 2025/2026 NHSE trajectory for Norfolk & Waveney The number of new patients being seen and treated by an NHS dentist from April 2023 as a baseline

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Figure 15 final metric summary (continues overleaf)

Ambition	Ambition Objective	How will we know we are achieving our objectives?
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**	
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.	The programme team is currently working with the DfE/DHSC to ensure impact associated with the first three years of this transformation programme can be showcased and sustained into year four. At a local level a performance measurement dashboard has been developed to track the identified KPI's across the programme and for each individual work strand and this will continue to be refined throughout the next 12 months, for example: 1. Feedback from families on Start for Life and Family Hubs offer (e.g. inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services). 2. 90% access integrated referral pathways tell story once and 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback. 3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements). 4. Families receiving help to manage financial challenges (measured through Department of Work & Pensions advisors embedded in Family Hubs). 5. Families accessing non funded services. 6. Parents accessing Start for Life and Family Hub services have improved understanding of the contribution to child's wellbeing, achievement and school attendance. Measured increase in number of families receiving support and increase in school attendance. 7. Families with SEND receive early support reducing escalation measured through reduction in Education Health and Care Plan (EHCP) and needing access alternative provision. 8. Improved health and development outcomes for babies and children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes).
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan	Implementation of the Three-Year delivery plan for maternity and neonatal services.
3c	Implementation of asthma and epilepsy recommendations for Children and Young People.	• Decreased asthma related hospital admissions for young people aged 10-18. • Decreased epilepsy related hospital admissions for children and young people aged 0-19. • Reduction in the use of reliever medications • 20% of CYP from deprived areas have asthma care plans in place. • Increased access to epilepsy specialist nurses in the first year of care.
3d	Develop an improved and appropriate offer for Children's Neurodiversity	• Improved patient experience evidenced through feedback with families. • A reduction in waits to specialist services. • Increase in 'appropriate' referrals to services. • Reduction in complaints regarding barriers to accessing care. • Number of unique users of the digital library.
4	**Transforming Mental Health Services**	
4a	We will 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.	There will be a measurable change in self-reported mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores. Rates of suicide and self-harm will decrease.

Figure 15 final metric summary (continues overleaf)

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Ambition	Ambition Objective	How will we know we are achieving our objectives?
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities	The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented. We will see an increase in the numbers of children accessing mental health support at an earlier stage and a reduction in admissions to inpatient provision.
4c	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.	We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN)	Complex Emotional Needs • 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide. • Increase in numbers of service users able to access a psychologically informed intervention outside of NHS Talking Therapies and secondary care offer. • A reduction in presentations to Emergency Departments for patients with Personality Disorder. Dual Diagnosis • Achieve an increased number of referrals (as per Year 1 plans and trajectory) accepted via the dual diagnosis pathway. • A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems.
	Transforming Care in later life	
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives	• All statutory providers signed up to the Dementia Charter by April 2025. • Increased Dementia diagnosis "rate" based on diagnosed patients versus the estimated number of people living with Dementia by March 2027. • Increased use of a standardised frailty scoring tool across the ICS to ensure better understanding of individuals' needs by March 2026, enabling specific support to be put in place at an earlier stage. • A reduction in the number of ambulance conveyances and unplanned admissions from care homes and residential homes by March 2027. • An increase in the number of ReSPECT forms in place for patients with frailty by March 2027.
6	**Improving Urgent and Emergency Care (UEC)**	
6a	Integrate urgent care to improve emergency response times across all organisations	• Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/2025. • Improve Category 2* ambulance response times to an average of 30 minutes across 2025/2026.
6b	Expand virtual ward services	By March 2026 the aim is to have 330 Virtual Ward beds available across Norfolk and Waveney, compared to 170 Virtual Wards beds in March 2025. As well as increasing the number of Virtual Ward beds we want to increase the occupancy of the beds to a minimum of 80% at any time.
6c	Reduce length of stay (LoS) in hospitals	We will monitor our acute hospital average Length of Stay and aim to reduce this to 7 days.

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Figure 15 final metric summary (continues overleaf)

Ambition	Ambition Objective	How will we know we are achieving our objectives?
7	**Elective Recovery & Improvement**	
7a	Effectively utilise capacity across all Health System Partners	We will work to achieve national targets: Elective, by March 2026: • 60% of patients receive elective treatment within 18 weeks. • Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list. • Increase the proportion of patients receiving their first elective care appointment within 18 weeks to 67%. Cancer, by March 2026: • Improve performance against the headline 62-day standard to 75%. • Improve performance against the 28-day Faster Diagnosis Standard to 80%.
7b	Implement digital technology to enable elective recovery	• Reduce missed appointments rates to 4% or below by March 2026. • Increase the uptake of PIFU pathways to 5% of outpatient attendances by March 2026.
8	**Improving Productivity and Efficiency**	
8a	To deliver our Medium-Term Financial Plan	• Delivery of our Medium-Term Financial Plan. • Improvement in clinical productivity in our Trusts measured through benchmarking. • Reduction in spend on bank and agency staff. • Progress made from Analogue to Digital – go live of the Electronic Patient Record in Q4 of 2025/2026.

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Figure 15 final metric summary

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Glossary

A glossary of terms for the Joint Forward Plan is available here.

We have also developed a list of the latest acronyms and terms that are used in the NHS and on our social media channels for the Integrated Care System (ICS). It is available on the ICS website here.

Sources

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Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Joint Forward Plan 2025/26-2029/30

Part 2: Legal duties and other content

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Describing the health services for which the Norfolk and Wavney ICB proposes to make arrangements

Our Joint Forward Plan (JFP) sets-out how we will meet the physical and mental health needs of the population and how we will transform services over the next five years.

The plan sets-out eight ambitions, aligned to the priorities in the Integrated Care Strategy for Norfolk and Waveney, which is also our Joint Health and Well-Being Strategy for Norfolk.

Our eight ambitions for improvement

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

The eight ambitions are explained in detail in the JFP, including clear objectives, trajectories and milestones.

Over the next five years we will provide more preventative care. We will better use data to identify people who could benefit from a particular course of treatment or support, and then contact them before problems arise or their condition worsens. We will proactively reach out to people with support and information about health conditions and importantly, other issues, like debt and housing, which really affect people's health and wellbeing.

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Duty to promote integration

Collaboration

Our approach to collaboration more broadly, enables and supports our duty to promote integration. Chapter 6.0 of Part 1 of the JFP describes this, including our place-based approach, working with VCSE partners and the Assembly model, as well as how our statutory partners are collaborating with each other more formally in their work.

One example from Great Yarmouth and Waveney Place is Community Collaboration which is a health and care forum. This programme of work builds on the existing Great Yarmouth & Waveney Primary Care Homes (PCH) team model which is made up of nurses, therapists and social care staff who work together to support clusters of GPs (Primary Care Networks). There are four PCH teams across Great Yarmouth & Waveney. Achievements to-date include the development of aims and principles for future integrated neighbourhood working. This will further bring together community health, social care and mental health services together at a neighbourhood level, building on the PCH model with links to District and Borough Councils and the VCSE sector.

Better Care Fund (BCF)

The BCF is a nationally mandated programme with the aim of joining up health and care services, so that people can manage their own health and wellbeing and live independently. The policy framework was updated in January 2025 to reflect the government's commitment to reform via a shift from sickness to prevention and from hospital to home, by supporting people to live independently. The guidance can be found here: Better Care Fund policy framework 2025 to 2026 - GOV.UK.

Dr Lex Heijd
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The BCF has been nationally aligned to the Operational Planning submission, so BCF funded service developments are integrated with other health and adult social care services. How the BCF has been spent in previous years has been reviewed in readiness for 2025/2026 and will support the work to align with these two refreshed policy objectives in our submissions. Reducing average length of discharge delay is a key focus and this is one of the JFP Objectives within Ambition 6, Improving Urgent and Emergency Care.

Joint Posts

There are joint posts within the system that work across local authorities and health, for example in the Children and Young people team.

Delegated Commissioning

Within Chapter 4.0 of Part 1 of the JFP we describe the transition of services from NHSE. The first tranche was primary care services and has extended to specialised services, with more services to follow. The rationale for delegation is to enable end to end commissioning of services and that care provision is better joined up. Ambition 2 Primary Care Resilience and Transformation is working up joint delivery plans for dental and primary care services and is one example of this duty in action.

Duty to have regard to wider effect of decisions

The triple aim requires NHS bodies to consider the effects of their decisions on:

- people's health and wellbeing (including inequalities in that health and wellbeing)
- the quality of services
- the sustainable and efficient use of resources.

Here is a summary of how we developed our plan in line with the triple aim and how the triple aim will be accounted for in ongoing decision-making and evaluation processes:

People's health and wellbeing:

- Our two local Joint Strategic Needs Assessments (JSNAs) and a case for change have provided the foundation for ensuring that our Integrated Care Strategy and this plan are evidence-based, as set-out in the 'Why are we doing this?' section of this JFP.
- The case for change supports us to prioritise the actions we will take over the next five years to improve people's health and wellbeing, resulting in our eight ambitions and the clear objectives that sit underneath each ambition. The life course diagram in Part 1 of the JFP provides a visual of where we are making progress and where there is more to do.
- We use a wide range of mechanisms to help us measure our progress with improving the health and wellbeing of local people, to understand the effectiveness of the decisions we have made and to help us decide what we need to do next. These will include future JSNAs, our quality objectives and processes, and the work of the ICB's committees including the ICB's Patients and Communities Committee which supports us to ensure we understand the views of local people and communities.
- The newly formed ICS Health Inequalities Steering Group is accountable to our Integrated Care Partnership (rather than the ICB) which, demonstrates the buy in to this work from across all partners. This supports a wider approach to the effect of decisions. The work we have been doing is described in the legal duty to reduce inequalities.

The quality of services:

- This plan has been developed in line with our quality objectives and processes, which are detailed in our Quality Strategy and outlined in the legal duty to improve quality of services. One example of how the wider impact of decisions has been brought together is through a refresh and review of our ICB Quality Impact Assessment and Equality and Health Inequalities Assessment approach, which brings both considerations in parallel.
- Alongside this, the CQC's assessments of individual providers / services and our Integrated Care System, will help us to collectively understand and drive improvement in the quality of local health and care services.

The sustainable and efficient use of resources:

- This plan has been developed in line with our Medium-Term Financial Plan to ensure that it is costed and affordable, and that it supports our system to achieve our duty to deliver financial balance.
- Our Medium-Term Financial Plan sets-out how we will create more efficient services through integration, innovation, and better use of data to improve productivity, ensuring that we spend every pound effectively.
- We have a Chief Finance Officer forum which ensures that our planning is coordinated, and our progress is measured together, helping us to really understand where we can drive efficiencies and avoid cost-shunting between organisations.

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In addition, all ICB Board and committee reports are required to set out the implications and risks of decisions on a range of aspects. Reports include the impact on clinical outcomes and the quality of care, delivery of the NHS Constitution, financial and performance implications and environmental and equalities impacts.

Overall, the duty aims to foster collaboration between local health and care organisations in the interests of the populations they serve. To achieve this, we have effective governance arrangements and clear processes in place. We continue to work on the cultural change needed, and as outlined in this plan, are on a journey to accomplish this, supported by an organisational development plan.

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Financial duties

The ICB and its NHS partner organisations have collective local accountability and responsibility for delivering NHS services within the financial resources available.

The revenue finance and contracting guidance sets out that each ICB and its partner trusts must exercise their functions in respect of each financial year with a "Collective duty to act with a view to ensuring that":

- the capital resource use limit set by NHS England is not exceeded
- the revenue resource use limit set by NHS England is not exceeded

Capital resources describe the funds assigned to improve the infrastructure of the NHS, for example replacing large pieces of medical equipment or building a new hospital and health and social care facilities. Revenue funding is for the ongoing provision of healthcare services on an annual basis, for example paying the salaries of NHS staff and the consumable items such as needles and dressings.

Capital resource planning and approvals

Capital resources are distributed via the Norfolk and Waveney Strategic Capital Board (SCB), which includes representatives of all NHS providers, as well as speciality experts in digital and estates as well as a clinical representative. All parties across the system identify their priorities and the SCB considers these. Examples of high priority investment programmes could be those where the CQC has reported that an area or location is now unfit for modern patient care, or national priorities and ring-fenced money for elective recovery, such as Diagnostic Assessment Centres.

Davey Heidi
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Once the SCB has determined the priorities it makes a recommendation to the Finance Committee and the ICB Board for approval. ICBs and their partner NHS trusts and NHS foundation trusts are also required to share their joint capital resource use plans and any revisions with each relevant Health and Wellbeing Board and NHS England.

Once approved, organisations have the authority to proceed and spend the capital resource on the agreed schemes and this is monitored and reviewed by the SCB and ICB Finance Committee. Any in-year negotiations on under or potential over-spends and redistribution of capital resources are considered by the SCB and reported to the ICB Finance Committee in the same way.

In addition, capital performance is also reviewed at the Chief Finance Officers forum (chaired by the ICB Chief Finance Officer) which comprise the Directors of Finance from each of the NHS partners, together with any subject matter experts.

Revenue resource planning and approvals

Most of the Norfolk and Waveney revenue resource is already committed to hospitals and services, since running these services is an ongoing commitment. From the annual planning perspective, each NHS organisation is required to produce a financial, activity and workforce plan that delivers the overall objectives set out in the annual planning guidance.

To determine the final annual revenue plan, each organisation considers and prepares its financial position with regards to the allocations and requirements as set out in the annual Revenue Finance and Contracting Guidance documents. These documents indicate specific factors such as tariff changes, growth funding, efficiency and convergence requirements which are managed through the annual planning round.

The Chief Finance Officer forum is the initial place where organisational and system wide revenue financial plans are assessed, scrutinised and challenged with peers. The process is collaborative; system wide transformation schemes and other strategic system wide investments and disinvestments are included to create the complete annual revenue plan. The plan is then considered across a range of groups including with the NHS partners themselves, at the ICS Executive Management Team and with the chief operating officers and workforce leads. Once individual NHS provider boards and the ICB Board are satisfied

that the NHS Norfolk and Waveney system revenue plan is complete, it is then submitted to NHS England for final approval.

During the year operational delivery of the plan and achievement of financial objectives are manged via the Chief Finance Officer forum and the ICB Finance Committee, both meet and review progress on a monthly basis.

For a number of years the system has operated with an underlying financial deficit, which means that overall annual expenditure on health and social care services is greater than the resources available. This has been managed by utilising in-year underspends to maintain the financial performance. The consequence of this is that whilst it may be able to deliver financial balance on an annual basis, it is unstainable for future years.

Where financial plans are not being delivered or are at risk of not being delivered, the first action is to review within the organisation and across the system collectively. We are working to a system control total, so the accountability for the under or overspend is shared and collective decisions have to be made as to how to manage this through risk/investment sharing. The overriding management approach is to set a robust budget from the outset, with realistic transformation opportunities profiled across the year, with mitigations, escalation and ongoing dialogue so there is transparency and visibility of any emerging divergence from plan.

Ratification for any subsequent decisions or changes to the plan would be via the ICB Finance Committee and the ICB Board, working with NHS England during this time.

Davey, Heidi
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Due to the financial pressure experienced in 2024/2025, NHS England has placed the Norfolk & Waveney system into the Investigation and Intervention (I&I) regime. The purpose of this additional regulatory oversight is to support the ICS deliver improvements to the system's financial sustainability. A number of actions have been undertaken including the creation of a system wide Financial Recovery Board to support the delivery of proposed expenditure reductions. To ensure only essential expenditure occurs, all requests more than £15k are referred to "triple lock". The "triple lock" process consists of three tiers of panel: individual organisation, then ICS, then NHSE. These triple lock panels scrutinise pay and non-pay expenditure requests to ensure the system is receiving the best value for money and that all expenditure is necessary.

External consultancies have also been engaged with a brief to generate rapid expenditure reductions for 2025/2026 as well as other transformation opportunity that can impact on the longer term over the next five years.

Ambition 8 is focused on productivity and efficiency and all the ambitions within the JFP include a statement about their affordability to ensure they are aligned with the Medium-Term Financial Plan.

Duty to improve quality of services

The Norfolk and Waveney ICS Quality Strategy which you can read here outlines our quality priorities and makes a commitment to the people of Norfolk and Waveney to deliver quality care, based on what matters most to the people using our services and the friends and family who support them.

The ICS Quality Strategy is underpinned by continuous development of the ICS model for clinical leadership, quality governance, management and assurance, and research, evaluation and innovation. It is championed and led by the ICB Executive Director of Nursing, as executive lead for Quality and Safety, working closely with the wider Executive Management Team and the system's Chief Nurse Network.

The implementation plan for the strategy is progressing with defined objectives for the year ahead. Socialisation across the system has taken place with ICB Board approval.

Well-led through a culture of compassionate leadership

There is clear evidence that compassionate leadership results in more engaged and motivated staff with higher levels of wellbeing, which in turn results in higher quality care.

For leadership to be compassionate, it must also be inclusive; promoting belonging, trust, understanding and mutual support across our system. This needs to be delivered by a compassionate culture that underpins these values and develops people into effective leadership roles. From a quality perspective this means that we will support and empower people to work in a way that is transparent, accountable, and reflective.

Davey Heidi
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Norfolk and Waveney Allied Healthcare Professional (AHP) Council and Faculty continues to provide a system platform for the development of AHP leadership skills, as well as a scaled-up coordination and delivery arm for Health Education England opportunities for AHP skills, training and leadership development.

Norfolk & Waveney Clinical and Care Professional (CCP) Leadership Framework puts CCP leadership at the heart of our discussions at every level of our system so that it becomes integral to our culture and how we work together. This is described in the section on People and Culture in the JFP.

The regional East of England Clinical Senate also continues to provide opportunities for collaboration and clinical leadership through cross-system working and strategic alliances, bringing together health and social care leaders, professionals, and patient representatives to provide independent advice and guidance to commissioners and providers on specific transformational work.

Alongside developing leadership skills across our system, we continue to build system structures that allow us to identify and grow leadership talent across our clinical and non-clinical staff groups and provide a platform for our workforce voices, ideas and skills for collaborative quality improvement.

Improving Care Quality and Outcomes

Quality Management Approach
While ownership of quality within services, networks, and organisations needs to start internally, the system will be able to facilitate quality management at scale when required, to improve safety, health and wellbeing for the local population and share learning and good practice. Clear and transparent accountability and decision-making for and by system partners is essential, particularly when serious quality concerns are identified. A new framework has been developed to clearly set out the ICB approach to identify and respond to emerging quality concerns across pathways, organisations and systems. The Deteriorating Quality framework highlights the link between high quality care and robust and effective strategy, workforce engagement and financial management. This framework will provide a reference point for the continuous development of our shared system approach to quality oversight, assurance, and support across partners and is currently being socialised and integrated across the wider system.

Our key partners in quality include people, communities, and carers, professionals and staff, NHS and independent provider organisations, commissioners and funders (including NHS England), CQC and other regulators, Healthwatch, research and innovation partners and the voluntary, community and social enterprise (VCSE) sector.

The **ICS Quality Faculty** brings system partners together to share insight and good practice in quality improvement (QI). The forum enables colleagues from across the system to share projects and obtain support from a network of QI professionals. Staff from across the ICS can access QI training within their organisation. The ICB is developing its own QI training programme that will be accessible to all system partners (including the VCSE). In its system convening role, the ICB also co-ordinates and supports the sharing of cross-organisation QI projects to ensure that improvements are spread across the system.

Being people-centred is a key part of our quality journey and culture of improvement, acknowledging the value of people's lived experiences as a powerful driver for change. If our co-production work is effective, our people, communities and ICS partners will be able to see that:

"The voices of our people and communities are looked for early, when planning, designing and evaluating services."

"People feel listened to and empowered. They can see the difference their views and insight have made"

Davey, David
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Healthwatch Norfolk and Suffolk are key partners in designing, facilitating and reporting on coproduction, offering expert independent advice and developing coproduction skills and confidence. Co-production is referenced in section 6.6 within the JFP.

Quality and addressing Health Inequalities

Quality supports key elements of our populations' health and longer-term health outcomes by enabling the delivery of safe, timely, accessible and evidence-based care and support. A Population Health Management approach within quality also prompts us to:

- Look at what influences quality and length of life across the whole life course.
- Understand people's health behaviours and improve patient experiences of care.
- Support a healthy standard of living for all, whilst also understanding the 'social gradient' and working to reduce disparities in health outcomes.
- Understand the impact of health conditions on the demand and need for healthcare and the role of high-quality treatment and support as a prevention for further illness.

An example of where quality improvement and reducing health inequalities work has been brought together by the ICB over the past year is the refresh and review of our ICB Quality Impact Assessment and Equality and Health Inequalities Assessment approach. Robust and action-focused impact assessments are key to ensuring that quality and equity are central to ICB decision making and bringing together the two elements streamlines governance and enables quality and health inequalities considerations to be made in parallel, with clear recommendations to support sustainable commissioning. These impact assessments are supported by organisational policy and report into the ICB Quality and Safety Committee.

Further information on Population Health Management, Reducing Inequalities and Supporting Prevention can be found in the legal duty to reduce inequalities.

Safe System

Defining and Measuring Quality and Patient Safety

We continue to develop and refine our Quality Dashboard as part of a wider review of our Integrated Performance Report and reporting structure. The dashboard will continue to evolve with a focus on ensuring that the way we measure impact of the strategy reflects patient and staff voices and what matters most to people living and working in Norfolk and Waveney. We will work with our local authorities to ensure we have a consistent approach to data and insights as they relate to shared priorities, including social care quality and Flourish outcomes for children, young people and families.

NHS Patient Safety Incident Response Framework

The ICB continues to work closely with system partners to deliver the principles and functions of the national framework, which outlines the way the NHS responds to and learns from patient safety incidents. This work underpins the development of a joined-up approach to safety management across our system, in line with the NHS Patient Safety Strategy. We continue to support opportunities for partners to work together collectively and share learning, as well as reaching out to the independent and VCSE sector, building on successful NHS Trust implementation last year.

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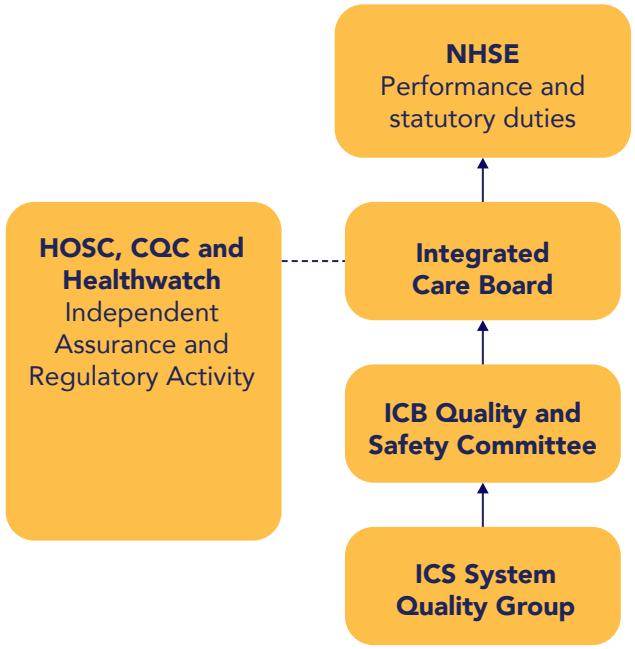
Quality Governance and Escalation

Governance and escalation arrangements for quality oversight are developing across our system, linked to regional quality oversight arrangements:



The **ICS System Quality Group** enables routine and systematic triangulation of intelligence and insight across the system, to identify ICS quality concerns and risks. It provides a forum to develop actions to enable improvement, mitigate risk, measure impact, and facilitate the testing of new ideas, sharing learning and celebrating best practice. It is part of an escalation structure that goes up to the National Quality Group and its form and function aligns with National Quality Board guidance.

The **ICB Quality and Safety Committee** has accountability for scrutiny and assurance of quality governance and the internal controls that support the ICB to effectively deliver its statutory duties and strategic objectives to provide sustainable, high-quality care. The Committee also has delegated authority to approve ICB arrangements and policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes. This includes arrangements for discharging statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services. Representation from system partners enables a collective overview of quality and safety risks, to ensure they are addressed and that improvement plans are having the desired effect.

The following portfolios report into the Quality and Safety Committee on a regular basis:

- ICS System Quality Group
- Safeguarding Partnerships
- Local Maternity and Neonatal System
- ICS Learning from Deaths Forum and Medical Examiners
- ICS Infection Prevention & Control and Antimicrobial Stewardship Partnership
- ICB Research and Evaluation Team
- ICS Quality Management Faculty
- ICS transformation workstreams, including Urgent and Emergency Care, Mental Health, Children and Young People and Learning Disabilities & Autism

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Sustainable System

As a system we recognise the impact of social and environmental challenges, including carbon footprint, within healthcare. Sustainability continues to be a theme running through quality improvement and innovation, service user engagement and workforce skills development. There is more about our Net Zero Green plan later in these legal duties.

Improving Pharmacy, Optometry and Dental services

Over the past year we have continued to embed and develop the way we work with our community pharmacy, optical, and dental partners, to ensure that we have robust oversight of access, quality and outcomes relating to these elements of primary care. We are working alongside service providers to support and facilitate cross-system working to deliver transformation and continuous improvement; driven by local, regional and national priorities and initiatives.

Delegation of Specialised Service Quality Oversight

Within Part 1 of the Joint Forward Plan we describe the transfer of the commissioning responsibility for specialised services. Within our region, we have a centralised team hosted by Bedford, Luton and Milton Keynes ICB who have an overarching view of these pathways across regional boundaries and lead on day-to-day quality assurance activities on behalf of all ICBs. As an ICB we are part of the collective oversight, with our regional colleagues, to ensure that we can focus on the quality and safety of care, as it relates to specialised services delivered in Norfolk and Waveney, as well as ensuring that specialised care delivered elsewhere in the region is accessible and meets the needs of our Norfolk and Waveney population. Transfer of responsibilities will enable greater opportunities for the management of patient pathways and collaboration between quality and commissioning of the entire pathway.

Duty to reduce inequalities

We are already taking action to reduce health inequalities across Norfolk and Waveney, but we want and need to do more. This is reflected in our 'Population Health Management, Reducing Inequalities and Supporting Prevention' JFP Ambition 1. We have met the initial objective of developing a Health Inequalities Framework, collaborating widely across the Integrated Care System (ICS).

We developed our Health Inequalities Strategic Framework for Action, in collaboration with our partners across the ICS. This Frameworks sets out how we plan to organise ourselves, what we will focus on, and our first steps we plan to take to embed a whole-system approach to tackling health inequalities.

The scope is broad, considering the action required to address healthcare inequalities, as well as the wider determinants of health including lifestyle factors and living and working conditions.

Our Framework includes our approach to reducing healthcare inequalities, including implementation of the NHSE Health Inequalities Improvement Framework 'Core20plus5' approach for adults and children. We will be aligning this with our ICS clinical strategy which you can read here and the FLOURISH children and young people framework which you can read here.

As part of the Framework we have been developing detailed action plans for the next 12 months for each of our three building blocks of living and working conditions, lifestyle factors and healthcare inequalities, ensuring that we strengthen our foundation to create the conditions for success and deliver our strategic ambitions over the next 10 years.

We have strengthened the leadership and governance within our system, establishing an ICS Health Inequalities Steering Group accountable to our Integrated Care Partnership. Three leadership groups have been established, alongside a VCSE Assembly, to develop and implement action plans for each of the building blocks.

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Using data to identify the needs of communities experiencing inequalities

We use local data to identify the needs of communities experiencing inequalities in access, experience and outcomes. Part 1 of our JFP refers to this in the context of a life course approach.

In addition to the people living in the 20% most deprived communities in Norfolk and Waveney (The "Core20" in the Core20Plus5 NHS approach to reducing health inequalities) and those with protected characteristics, we have identified the following "Plus" groups of people who also experience poorer health outcomes and for whom we will focus our programmes of work:

- People living with a learning disability and autistic people.
- People from Minority Ethnic groups, such as Eastern European Communities.
- Inclusion Health groups (including people experiencing homelessness, drug and alcohol dependence, Asylum seekers and vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups).
- Coastal and rural communities where there are areas of deprivation hidden amongst relative affluence.
- Young carers and looked after children/care leavers.
- Armed forces communities.

We have recently reviewed and launched a refreshed Equality and Health Inequality Impact Assessment process, which underpins all decision making and is overseen by an expert panel. This process systematically assesses the impacts on populations experiencing inequalities, and we are supporting our workforce through drop-in sessions and the development of a training and advocacy programme and support delivery of our duties under the Equality Act. This is cross referenced in the legal duty to improve quality of services.

We are developing our Network for NHSE Core20 Ambassadors across the Norfolk and Waveney system, with 40+ Ambassadors identified for the recent third cohort, alongside approximately 30 Ambassadors that are part of the alumni programme.

We have established a Core20Plus5 programme group to oversee and implement our approach to both the adult and children and young people's health inequality improvement framework and have developed a data dashboard to understand variation across our system and places. To support our ability to use data to inform our decisions we are implementing a data quality project, with an initial emphasis on improving the recording of ethnicity data in primary care.

We have established a NHS Anchors Leadership Group, bringing together the health inequalities leads from our NHS providers to develop our organisational and NHS Anchor Improvement Plans, having undertaken NHS Provider Health Inequalities Board Maturity Assessments. We are sharing good practice and understanding common challenges so that we might collaborate on solutions.

Working with and listening to people experiencing inequalities

It is vital that alongside using data, local people and under-served communities inform our decision-making and the development of services. Section 6 of our JFP sets-out our approach to working with local people and communities, including our "Community Voices" programme and how we will work with and listen to people who experience health inequalities.

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The five strategic priorities for healthcare inequalities

There are five national priorities for reducing healthcare inequalities. The following is a summary of the work we are doing against these:

Priority 1: Restore NHS services inclusively

- Continuing to review inequalities data as part of elective recovery programme and ambition
- Developing an Equalities Impact Assessment and action plan for the elective recovery programme

Priority 2: Mitigate against digital exclusion

- Implementing our digital transformation strategic plan and roadmap that is referenced within the digital and data content of these legal duties. Alongside our core digital initiatives, we will implement a set of underpinning system-wide enablers that include digital and data skills and inclusion, supporting health literacy for all and working closely with colleagues in local government.

Priority 3: Ensure datasets are complete and timely

- Improving recording of ethnicity data and other protected characteristics, to allow better analysis of health inequalities and targeting of interventions. This is detailed in our PHM section with the development of our data hub.
- We will be developing a dashboard to support our requirement under NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006), which we will undertake collaboratively with our NHS trusts. This new requirement was published in November 2023 and identifies key information on health inequalities. We are required to evidence our response through our annual reports.

Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)

- **Vaccine inequalities** – a programme to improve the uptake of vaccines, including flu and COVID-19 including data analysis, using local and national data resources; a roving model has been developed to target and achieve positive outcomes for underserved communities; development of Wellness Hubs to make every contact count and to offer a wider range of immunisations to local children and young people.
- **Core20PLUS5** – co-ordination and monitoring of progress against all Core20Plus5 programmes, including data analysis and dashboard development.
- **Clinically focused projects** including: addressing inequalities in cancer screening uptake in our most at risk communities; Cardiovascular disease, NHS Health Checks; Smoking and Physical Activity.

Priority 5: Strengthening leadership and accountability

The Health Inequalities Strategic Framework for Action includes a clear governance and accountability structure for our ICS to lead our efforts to reduce inequalities. This includes a Population Health & Inequalities Board to provide oversight to our Healthcare Inequalities priorities.

The Population Health & Inequalities Board oversees:

- The implementation of our healthcare inequalities work programme, including our action to implement the Core20Plus5 and Inclusion Health framework, NHS Anchors work programme and development of our outreach models.
- Ensure compliance and evidence of impact/reporting related to the Public Sector Equality Duty, Equality Delivery System and NHSE Statement on Information on Health Inequalities.
- Community Voices, which builds capacity in our VCSE sector to have conversations about health and care in communities of interest through trusted communicators, providing a mechanism for insights to be gathered to inform future strategy, planning and decision making and improve access to services.

It is important that we recognise the role of the five Place Boards and eight HWPs across Norfolk and Waveney in identifying and addressing health inequalities, including the wider determinants of health. This role will be reflected in our Framework and work programmes, with a focus on providing the infrastructure to enable and empower the place-based approach.

Davey, Heidi
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Duty to promote involvement of each patient

The Norfolk & Waveney Integrated Care System (ICS) supports the delivery of the Universal Personalised Care Model. It champions current developments and existing local good practice in personal health budgets, shared decision making and personalised care and support plans, as well as social prescribing. Our ethos is to support people to stay well for longer. We do this by utilising and encouraging the use of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences, focusing on population health, one individual at a time.

Norfolk & Waveney ICS is encouraging a new relationship between people, professionals and the health and care system. Our focus is to ensure the health and wellbeing of the population in Norfolk and Waveney by involvement in their own care. This is achieved through appropriate care pathways, having access to the relevant support mechanisms and ensuring that the link to these is seamless. This shifts the power and decision making so people feel informed and empowered to have a voice, and control of health and wellbeing outcomes that are important to them.

Norfolk & Waveney ICS strives to involve patients, their families and carers in all decisions regarding their physical, mental and wellbeing health outcomes and shape individualised personalisation. Our aim is for personalised conversations around someone's health and wellbeing to happen at all ages and in all parts of the health and care system, to achieve the individual's vision and goals. In addition, to ensure all our partner organisations across the system involve patients and their families to shape, improve and develop services. Norfolk & Waveney ICS has recognised the positive impact of place-based care on patient experience and focuses on expanding place-based care within communities.

Navigating the local health system can be complex for patients, so we will work with our GP practices in Primary Care Networks to promote conversations and discussions where patients can access the relevant support mechanisms that promote mental and physical health for our residents. We will ensure that the patient has access to all services through one conversation to avoid unnecessary burden for our residents. By having a single pathway or source, this will allow our patients to be in receipt of joined-up care at the first point of contact without duplication. Alongside this, social prescribing within Primary Care is recognised as a valuable resource to patients and their families and carers, which supports informed decisions and enables them to take action to address their non-clinical health needs and wider determinants of health.

The Joy Social Prescribing system is being rolled out to VCSE providers who are commissioned by PCNs under the social prescribing programme. This will enable information to be shared securely between VCSE organisations and GP practices and will provide VCSE organisations with more access to information to enable them to deliver services. It is planned that the Joy system will in time provide a link to the Shared Care Record (please refer to the Legal Duty about Digital and Data).

The strength of personalised approaches is demonstrated through current good practice in maternity services and with our carers as demonstrated in the case study example below, where shared decision-making discussions are documented on a Personalised Care and Support Plan with all the vital information of a 'what matters to you' conversation being entered.

Personalisation for carers

When a person goes into hospital, it can be a challenging time for their carer. Many carers want to be involved, informed, and continue to provide care. Carers are real experts and know the person they care for well, including complex conditions, learning or communication difficulties or memory loss. They often know about medication, side-effects and how the patient wishes to be cared for.

In 2022, Norfolk and Waveney acknowledged a gap in communication and provision of carers support. A thorough and wide-ranging process of co-production commenced comprising of carers, system engagement leads and chaired by a carers organisation "Carers Voice". A 'Carers Identity Passport' was launched on Carers Rights day (24th November 2022), including 'Carer Awareness training' which has also been developed with experts by experience involved in design and delivery. A clinician who was part of the co-production work said, *"Thank you to everyone for sharing their experiences, highlighting things that have not gone so well and letting us listen and learn and improve."*

Duty to involve the public

Our mission is to help the people of Norfolk and Waveney to live longer, healthier and happier lives. We are passionate about working with people and communities to achieve this.

Our approach to Working with People and Communities is available on our website, including as an Easy Read summary. It has been tested with our local people and partners and continues to develop and adapt over time, as needed. The original draft received very positive feedback from NHS England when assessed in 2022 and singles us out as a national exemplar for our work with inclusion health groups. You can read the full feedback from NHS England here.

In Norfolk and Waveney, our approach is for partner organisations to work together, with the public, to share insight and learning. This makes the best use of our resources and ensures that the voices of local people, especially some of our quieter voices and underserved communities, are heard and shared as widely as possible.

One way we achieve this is for patient experience and engagement leads to meet regularly, as they have done for several years. This provides an opportunity for people working in NHS provider trusts to meet and share practice across the system. The meetings are also a chance to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.

The ICS website has become a focal point for communications and engagement activity since the ICS was formed in July 2022. It is well designed, easy to navigate and is becoming a trusted source for information or links to information.

The website now hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. It includes live projects from across the system that give local people the opportunity to participate, and it previously helped promote engagement on our priorities for our Joint Forward Plan. The You Said, We Did/We Will/We Can't section is designed to feed back on the difference participation has made, and the Co-production Hub provides a place to showcase and share examples of good practice in using co-production techniques.

Our Norfolk and Waveney Community Voices (NWCV) Programme works with trusted communicators to speak with communities who may not already engage with the NHS and other statutory bodies, to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney.

To ensure that the voices of people and communities are at the centre of decision making and governance, at every level of the ICS, our Executive Director of Patients and Communities oversees all the work with our people and communities. The Executive Director is a participant in ICB Board meetings and is a member of the ICB's Executive Management Team.

The ICB's Communications and Engagement Team supports the people and communities work and offers professional support and guidance for the day-to-day and transformational work undertaken by ICB staff.

The Patients and Communities Committee has been meets every other month in public. The committee reports into the ICB Board and works closely with the Communications and Engagement Team to ensure all duties to involve are discharged. The committee applies the 'so what' principle to the insight received by the ICB to ensure it leads to change.

Savvy Hadi
24/03/2025 17:20:17

Duty as to patient choice

Norfolk and Waveney ICS is committed to ensuring that patients have the right to choice of GP and service provider. Patients are provided with the necessary information to ensure that they are choosing the most appropriate service provider for their specific needs and requirements, and that they are able to take an active part in the decision-making process about their care.

Information about patient choice at the point of referral is on the Norfolk & Waveney ICS website.

It is essential to provide realistic options that enable patient choice, particularly for individuals living in areas of deprivation or rural locations with limited public transport. This must be a priority when commissioning new services. For instance, the placement of new facilities like Community Diagnostic Centres should prioritise accessibility, featuring convenient locations and extended operating hours.

Additionally, expanding the range of services available closer to patients' homes or leveraging technology to deliver care remotely can greatly enhance accessibility. Equality Impact Statements play a vital role in this process by helping to identify and address the specific needs of diverse patient groups. These statements ensure that services are designed to be inclusive and accessible, ultimately enabling equitable healthcare delivery for all.

The ICB introduced a new knowledge repository, Knowledge NoW, in April 2024. The website is available to healthcare professionals and the public and contains details of all the services available in the Norfolk and Waveney, including community services, voluntary services, and independent sector providers. The repository is used as the central source for all referral forms, clinical pathway information, waiting times and patient information leaflets etc. The updated search facility will make it quicker, and easier for GPs, clinicians and patients, to identify the best service for their needs and have the right information available to help patients make an informed choice about their care and treatment. The website meets the Accessible Information Standard formats with a wide range of documents available in different languages.

Not all patients can access digital technology which means they may not be able to access services such as virtual outpatients or virtual wards. The ICS continues to work with partners to reduce the impact of digital exclusion by ensuring that patients still have a choice to access services on a face-to-face basis.

Elective recovery is one of our eight ambitions, and reducing variation in waiting times across the ICS is a key part of this, supported by a single waiting list approach. This includes a reduction in the variation of waiting times across Norfolk and Waveney. The aim is to address this by developing a single waiting list for the three acute hospitals NNUH, JPUH, QEHKL.

Many patients may not be aware that they have the right to choose an alternative hospital if their wait for treatment exceeds 18 weeks. We are using a range of social media platforms to raise awareness about this right, and GP practices have been provided with resources to support the offer of informed choice. The ICS has also taken a proactive approach by contacting patients who have been waiting a long time to confirm if treatment is still needed and to offer the option of being seen elsewhere.

Our ICB patient choice coordinators work closely with Acute Hospitals and Independent Sector Providers to help patients access faster care through alternative providers. This approach ensures that all residents of Norfolk and Waveney have a choice of where they are treated, with the aim of reducing overall waiting times.

Duty to obtain appropriate advice

The ICB and its partner NHS trusts and foundation trusts have strong relationships with and significant involvement from clinical and care professionals, including public health colleagues, which enable the organisations to obtain appropriate advice to effectively discharge their responsibilities. This involvement is evident in our JFP, which is based on evidence provided by public health and shaped by the knowledge and experience of a wide range of clinical and care professionals.

Membership of the ICB Board includes the Director of Nursing, the Medical Director, a member nominated by primary care (currently a GP), representation from the VCSE sector, the Director of Adult Social Services for Norfolk and the Director of Public Health for Suffolk (the Director of Public Health for Norfolk is also a participant in Board meetings).

In addition to the ICB Board, clinical and care professionals are involved in the ICB's committees, the boards of our trusts and foundation trusts, our Integrated Care Partnership, Health and Wellbeing boards, place-based arrangements, the system's Executive Management Team, and in projects and programmes of work.

We have a comprehensive Clinical and Care Professional Leadership Programme to further develop our approach. This is explained in more detail in section 6. As part of this, the ICB has conducted a review of its clinical advisors to ensure the organisation has the right expert advice to effectively discharge its functions effectively.

All our work with professionals is complemented by research, evaluation, co-production, engagement, consultation and co-production with local people: this includes the involvement of experts by experience.

Davey, Heidi
24/03/2025 12:20:17

Introduction to duties to promote research and innovation

Research and innovation can transform how people receive health and care services. The Norfolk & Waveney Integrated Care System (ICS) Research and Innovation Strategy. developed with system partners, describes four principles:

- Focused on our communities
- Driven by a confident and capable workforce
- Collaborative and co-ordinated
- Embedded in everything we do

These underpin our approach to research and innovation.

Action plans are being developed for each principle. These will describe the key activities, timeframes and outcome measures which we will collectively implement so that research and innovation contributes to our population leading happier and healthier lives. The ICS research leadership group will ensure board-level awareness and support for the strategy within their respective organisations, including all NHS providers, recognising this is key to further build and embed a pro-research and innovation health and care environment. In doing so we will capitalise on our fantastic assets, including the University of East Anglia (UEA) which has a large Faculty of Medicine and Health Sciences and a health and care workforce of over 55,000 people.

Davey Heidi
24/03/2025 12:20:17

Duty to promote research

Norfolk & Waveney ICS is committed to embedding a culture of research and evidence use for the benefit of our communities and workforce. Health and care research is fundamental to our health and wellbeing. It provides the evidence base for how services are designed and delivered and helps us to tackle unequal health and care outcomes.

Our workforce benefit from opportunities to become involved in research, including those provided by national and regional infrastructure such as the National Institute for Health and Care Research (NIHR) and the Regional Research Delivery Network (RRDN). Locally developed schemes such as the James Paget University Hospital Embedded Research, Evaluation and Quality Improvement Scholarship Programme (funded by NICHE anchor institute at the University of East Anglia) and the joint Norfolk and Norwich University Hospital/University of East Anglia Clinical Associate Professor scheme demonstrate the commitment to supporting our workforce. We will continue to embed and support these schemes and will use the insights gathered as part of the strategy action plan development to ensure any future local schemes reflect the needs of our workforce. We plan to align these locally and nationally developed opportunities with local workforce planning to make research opportunities accessible to the health and care workforce.

Alongside the Regional Research Delivery Network (RRDN), we will work collaboratively to ensure commercial research opportunities are available to our workforce and our population. This will directly support the national vision to increase clinical trial activity in the UK, embed national initiatives such as National Contract Value Review (NCVR) and maximise opportunities to build on our existing infrastructure through, for example, the NIHR capital investment calls.

Dave.Enfield
24/03/2025 12:20:17

The Norfolk and Waveney vaccine hub will support the delivery of the national vaccine innovation pathway. We are also committed to working with the East of England Shared Data Environment (SDE) team to ensure strategic alignment between Norfolk and Waveney ICS strategic data infrastructure initiatives and the SDE.

Working with NHS partners, Voluntary, Community & Social Enterprise (VCSE) organisations and the RRDN, we have received Research Engagement Network (REN) Development funding from NHS England to deliver multiple projects to increase the diversity of those taking part in and engaging with research. Training about research has enabled trusted communicators to talk to communities so we can hear what matters to them. Their views have been used to shape research funding applications and we are committed to an ongoing feedback loop so communities understand how the information they provide is used in research planning. We will continue to support robust engagement with communities when research teams are developing their funding applications and our dedicated Community Engagement Co-ordinator will continue to work with system partners including the Citizen's Academy at UEA and VCSE organisations.

Norfolk & Waveney ICB established the Evidence and Evaluation hub to address increased demand to support decision making. The Hub will continue to ensure that research evidence is used by decision makers by producing bespoke, accessible evidence briefings. The Hub team will also continue to support and conduct evaluations, the results of which help understand intended or unintended outcomes and identify areas for improvement.

Duty to promote innovation

Innovation is central to addressing the challenges facing our health and care system. Innovation is a broad term, and to us, means new ways of doing things which could be a new technology or treatment, a new service, or an existing service in a new setting. The Norfolk & Waveney Integrated Care Board (ICB) has a statutory duty to promote innovation in the provision of health and care services.

We know that innovation can greatly improve healthcare and can lead to services being more cost-effective. It is useful to champion new ways of working to ensure our services are more reflective of the changing needs of our local population.

Innovation is a cross-cutting theme, and we aspire for it to be integral to everything we do. We wish to ensure that the opportunities for receiving innovative services are equitable across the ICS and we aim to support the adoption, evaluation and spread of innovations.

Our Head of Innovation, jointly funded by Health Innovation East (HIE) continues to help the ICB to meet the statutory duty to promote innovation across the ICS. In collaboration with HIE and our continued status as a NHSE funded Clinical Entrepreneurship Innovation Sites (InSites), we will support the system to optimise innovation culture, readiness, selection, implementation, spread and sustainment. We will continue to host and facilitate a regular innovation network of stakeholders and provide innovation learning opportunities to support collaboration and sharing of innovation needs, solutions and projects across the system The aim of this network is to accelerate the use of innovation equitably across the ICS through partnership working, focussed on our local priorities as identified by community voices, Joint Strategic Needs Assessments, our Joint Forward Plan and other strategies and frameworks. The network will also encourage and grow local innovation/ innovators by supporting them to access support from Health Innovation Networks and identify funding opportunities. We also aim to establish further links with industry to support the use of innovations to overcome local healthcare challenges.

Using our Norfolk & Waveney ICS innovation values-based culture model, we will continue to support and develop competencies for our system innovation champions and working with the ICS Executive Management Team to ensure that innovation, as part of wider improvement, is embedded in provider plans.

Using our Norfolk & Waveney ICS Innovation pathway we will support teams to identify innovation needs alongside local communities (through initiatives such as community voices) and work with partners such as HIE and the NHS InSites programme to scope and match innovations that are of value and support the needs of our local population. We work with teams to support them to implement, evaluate, adopt, and spread innovations. We understand that identifying innovation needs, matching them to suitable innovations that are safe, equitable and impactful to our local population and then implementing these, can be a complex process. By working together, we can match innovations to the identified needs. We will emphasise the importance of evidence, cost-effectiveness, safety, impact and reducing health inequalities in our selection of innovations. We will support due diligence and procurement processes to ensure that innovations are implemented as effectively and safely as possible.

Implementation of science principles and strategies will be used to support the adoption, evaluation, spread and sustainment of innovations into practice where these are deemed safe, impactful and provide value to our local population and the system.

We will also work with programme teams and commissioning teams to ensure that innovation scoping / horizon scanning informs commissioning, planning, and contracting activities. We will work with teams across the ICB and ICS to plan the integration of innovation activities into future planning rounds and local prioritisation processes.

Duty to promote education and training, and other information about our workforce plans

#WeCareTogether, the Norfolk and Waveney People Plan

#WeCareTogether, the Norfolk and Waveney People Plan for 2020-2025, sets out our ambition for the Norfolk and Waveney system to be the best place for health and social care staff to work. We recognise that a refresh of the strategy is required to embed several new NHS and Social Care workforce strategies and policies, notably the NHS Long Term Workforce Plan (June 2023), the Messenger Review (June 2022), and the Future of HR and OD report (Nov 2021), as well as key learnings from the pandemic.

#WeCareTogether refresh

While turnover rates have largely returned to pre-pandemic levels, sickness absence remains higher. Despite the significant reduction in vacancies in Adult Social Care, there continues to be an over-reliance across the ICS on bank and agency staff and international recruitment to meet the increasing care needs of an ageing population across the ICS. The refresh of #WeCareTogether will take a collaborative system approach to building the capacity, capability, competencies, and career structures to create a 'One Workforce' approach across our ICS.

We will ensure our plan is evidence-based and closely aligned to finance and activity planning as set out in our operational planning submission.

The 10 ICS People Function Outcomes

The 10 ICS People Function Outcomes are set-out in 'Building strong integrated care systems everywhere: guidance on the ICS people function'. In all areas of transformation, we will take a long-term view using evidence-bas. In all areas of transformation, we will take a long-term view using evidence-based modelling to re-design entry routes into careers. This will help to create a workforce who are not just clinically trained, but also have a greater understanding of population health and inequalities, so that staff treat the whole person with compassion and care.

This work will include updating the way we attract and retain staff, refreshing education programmes (including life-long learning and quality improvement), changing the shape of existing services and developing new ones, and using technology to take on tasks (not jobs) to release capacity. The activities below will form a key part of the #WeCareTogether refresh to deliver an integrated workforce across health and social care.

Our work towards the 10 ICS People Function Outcomes can be summarised as follows:

1. Supporting the health and wellbeing of all staff

We know that if staff feel safe and supported with their physical and mental wellbeing, they are better able to deliver excellent health and care. Over the last four years, as individual employers and as a system, we have significantly strengthened the support for our workforce's wellbeing. The challenges of the post-Covid-19 recovery, the increased level and acuity of demand for health and social services, and system flow challenges, along with above average vacancy levels, continue to impact the wellbeing of our workforce. Low morale, attrition from reduced levels of learners, burn- out, and moral injury are growing challenges which we must address openly across health and social care.

Our ICS-wide Health and Wellbeing Plan (2023-2028) is based on analysis of a wide range of data including staff survey results, Workforce Race Equality Standard (WRES) and Disability Equality Standard (DES) data, and the qualitative analysis of the Health and Wellbeing Framework diagnostic in each NHS organisation. Over the last 18 months we have worked with partners to update policies and procedures and improve access to health and wellbeing support. Using a share, standardise, and scale approach, several health and wellbeing initiatives have been implemented across the system. These include encouraging a culture of flexible working, financial support schemes, trauma-based coaching programmes for frontline leaders, and becoming a

menopause-friendly employer (2023) with over 80 members of staff trained as menopause advocates. The next stage in the system's menopause journey is to broaden this workstream to encompass all Women's Health initiatives, with an ICS Women's Health Initiative group leading the Norfolk & Waveney system in securing accreditation.

The Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment in the workplace from colleagues and third parties. The Safeguarding Team is leading a workstream, fully supported by the Workforce team, to meet the requirements of the NHS England Sexual Safety Charter, which it signed up to in 2024.

Further work is being completed at a system level to adopt a common approach to the use of Health and Wellbeing passports and to develop a moral injury e-learning package, which should be available for all staff from April 2025.

It has also been identified that there is a lack of consistency in health and wellbeing reporting. The intention is to create a new health and wellbeing dashboard in 2025 so that individual organisations and the ICS will be able to monitor the implementation of initiatives. This will also facilitate collaboration across the system by identifying partners' areas of good practice and opportunity.

Restorative and Justice Culture

Central to our ICS HWB Plan is the building and embedding of a Restorative and Just Culture (RJC) and developing compassionate and transformational leadership with a collective resilience approach. A system-wide approach to RJC has been agreed and a training package developed, which will be digitised and scaled up over the coming year. We are collaborating and learning as system partners how to establish a restorative and just culture by promoting civil and respectful behaviours. These can enhance a sense of psychological safety, and improve retention of staff, through supporting a more compassionate and inclusive culture. Partners have subscribed to regular monitoring of the approach to ensure effectiveness is measured on a regular basis.

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The key areas of building and embedding a RJC, further developing compassionate and transformational leadership with a collective resilience approach and becoming an accredited menopause-friendly employer have been pulled together into a Collective Culture programme. The programme will be launched in February 2025 with the keynote speakers including Sidney Dekker, the author of "Just and Learning Culture", and Rich Cook, CEO of Mindset Practice.

2. Growing the workforce for the future and enabling adequate workforce supply

Our integrated workforce planning approach is multi-faceted and relies on each of the 10 People Function outcomes being aligned. Working with health and social care partners to 'check and challenge' plans, we will identify system level opportunities and challenges. Our Careers Faculty will act as our assurance group, monitoring the activity required to outreach to our local communities to develop and promote opportunities for careers in health and social care. Our Careers Faculty will set out our vision for engaging with our local communities, as well as the underpinning values to support that vision: alignment, accessibility, collaboration, inclusivity, and being place-based.

Supporting our role as an Anchor Institute, we will ensure our Health and Care Academy leads our engagement work, linking learners from across the system with relevant experiences and pathways to equip them with the skills to pursue a career in health and social care.

A robust action plan will enable us to deliver the ambitions of the Long-Term Workforce Plan, by developing the means and resources to engage with our local population and build networks that facilitate meaningful and supportive interventions.

3. Supporting inclusion and belonging for all, and creating a great experience for staff

The Norfolk and Waveney culture for inclusion continues to develop, but we recognise there is much more to do over the coming years so that our people may thrive and develop in compassionate and inclusive environments. Despite some significant improvements, the last Workforce Race Equality Standard (WRES) report for the ICS highlighted continued significant challenges for our

staff from ethnic minority backgrounds, centring around harassment, bullying or abuse from patients, their relatives, and the public. It also highlights higher than average levels of discrimination for these staff from a manager/team leader or other colleagues in the last 12 months. The WRES does also highlight areas of best performance, notably career progression in non-clinical roles.

Anti-racism

Over the last 18 months we have worked as system to deliver the NHS East of England Anti-Racism plan, with a particular focus on refreshing recruitment practices to remove bias and widen participation from applicants from more diverse backgrounds. We have developed staff networks across protected characteristics and increased education and knowledge through the launch of our Equality, Diversity and Inclusion Resource Hub, which is open to both the workforce and the public.

Widening our EDI lens

We recognise that in addition to racism, the ICS needs to focus on women, age, and the impact of inequalities for our coastal populations. Our ambition is to bring together the pillars of health inequalities, population health management and workforce so that we can consider this cultural transformation holistically. A key objective of our ICB Change Programme is to ensure that our organisational infrastructure enables us to work effectively with system partners and our local communities to tackle our biggest challenges, including racism and inequalities.

Creating a great experience

The NHS staff survey has highlighted three key themes of safety, recognition and compassion. Staff experience is an organisational responsibility but as an ICS we are committed to ensuring that our 'One Workforce' ambition allows us to work with partner organisations to establish some shared core principles for staff experience. Board review of employee engagement data is already high, with all local NHS trusts reviewing the data at least quarterly and most monthly. All local NHS trusts either have or are developing a culture improvement plan, compassionate conversation tools, and a recognition action plan as key elements of their plans to improve staff experience further.

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4. Valuing and supporting leadership at all levels, and lifelong learning

We will continue to invest in leadership and management development programmes, mentorship opportunities, and other initiatives to support the growth and development of our staff right across the ICS, particularly to ensure our leaders are representative of the workforce and population we serve. The health and wellbeing of our leaders will be a core thread of all programmes to ensure people have the tools and support to remain resilient.

The continued development of a system-wide approach to Leadership Development and management training remains a priority. Common leadership standards and shared learning across the ICS will strengthen delivery of a "One Workforce" culture. Higher quality leadership will also directly improve system working and organisational cultures, as measured by CQC "Well-led" scores, and indirectly improve recruitment, retention, and patient care. All local NHS trusts either have or intend to adopt the NHS Leadership Way. Embedding Scope for Growth across the ICS, including some PCNs, will be a particular focus in 2025/2026. Our partner organisations are actively engaged in ensuring all leadership and management training is tailored appropriately, notably for Adult Social Care.

A Senior OD Practitioner has been recruited to the ICB to deliver our systems leadership and talent development plans. These include Norfolk & Waveney piloting Talent Timebanking in the East of England: a unique platform for connecting talent and providing development opportunities across health and social care.

5. Leading workforce transformation and new ways of working

In 2024/2025 our ambition was to use the "Upscaling HR services" programme to deliver more efficient and effective HR services that released time to care and supported the Norfolk & Waveney "Improving Lives Together" programme. Our strategy and planning were informed by insights from Newton Europe and Viridian that recommended a focus on efficiencies, notably in bank and agency staffing and through the digitisation of recruitment processes. This was underpinned by work on embedding a restorative and just culture and strengthening leadership development, in recognition of their critical contribution to improving productivity. This work formed JFP Ambition 8, Improving Productivity and Efficiency.

The deteriorating financial position has refocussed HR effort on immediate cost reductions, notably bank and agency expenditure and restructuring organisations locally. In 2025/2026 the key drivers of improved HR productivity will focus on continuing to support a reduction in bank and agency expenditure, reducing the time to hire, and removing duplication of effort and costs in the development and delivery of management training and leadership development.

In line with the ICS Digital strategy, we will support service redesign through better use of technology to enable new ways of working and make the most of people's skills and time.

6. Educating, training and developing people, and managing talent

In line with the Long-Term Workforce Plan, the Norfolk and Waveney education strategy aims to provide the roadmap to support our ambition to **Train, Retain,** and **Reform** our workforce:

Train: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, notably to deliver more doctors, dentists, nurses and midwives, as well as developing new roles to meet the changing needs of patients better and support the ongoing transformation of care.

Retain: ensuring that we keep more of the staff we have within the health service by supporting staff better throughout their careers, notably during the critical first 2 years, increasing the opportunities for our staff to work flexibly in ways that suit them and patients, and above all continuing to improve the culture and leadership across NHS organisations.

Reform: improving productivity by working and training in different ways; building teams with broader skills, focussing education and training to deliver more staff in the roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology. This frees up clinicians' time to care and increases the flexibility of their deployment to provide the care patients need more effectively and efficiently.

Public Pack
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Education is recognised by Norfolk & Waveney as a key driver in developing our staff and equipping them to deliver quality care now and in the future. The development of new roles will be key to supporting our education and workforce plans.

7. Driving and supporting broader social and economic development

Our health and social care organisations collectively employ the largest number of staff in Norfolk and Waveney. The ICS takes seriously its responsibilities as the largest "employer brand" to create a vibrant local labour market, promote local social and economic growth, and to help address the wider determinants of health and inequalities. Investment in our local "Anchor Institutions" will accelerate delivery of this ambition over the next few years. In partnership with our local Higher Education Institutions we are taking a research-led focus to the recruitment, retention and continuous development of our clinical workforce. This is a separate Legal Duty and is set out within this Part 2 in further detail.

8. Transforming people services and supporting the people profession

The integrated care system's financial position has refocussed the "Upscaling HR" programme on initiatives that will deliver immediate cost savings, rather than those that are longer term, but more transformative. However, the ICS remains committed to delivering the vision in "The future of NHS human resources and organisational development" of refocussing HR effort from transactional to higher value transformational activities, notably organisational development and workforce transformation. Where possible, key initiatives will be delivered as "business as usual" through collaboration with existing resources across the ICS.

The focus in 2025/2026 will be on completing the development of a consistent approach to leadership development and core management training across the ICS to support our "One Workforce" ambition. In addition, we will continue to simplify and standardise recruitment processes to accelerate the time to hire, improve staff and applicant experience, and release resources for more value-added activities. This work will identify opportunities to leverage digital technology, but any significant digital investment is unlikely before 2026/2027.

The ICS supports the development of the HR function as a more professional resource, with individual trusts starting to assess the competency and training needs of their HR teams. At a system level, the ICS is about to complete the development of a standard set of definitions for the core HR metrics (vacancies, sickness absence etc) and has committed to implementing the new broader set of national metrics when they are available, including the measures of customer satisfaction and HR impact.

9. Leading coordinated workforce planning using analysis and intelligence

The annual operational planning requirement includes a workforce planning submission which is aligned to national operational priorities and available finances for the following financial year.

We realise that the annual submission of plans in isolation is not enough and have implemented an evidence-based, integrated and inclusive approach to workforce planning. This includes regular review of progress against plans with our partner organisations and applying the additional lens of education commissioning to scrutinise future workforce supply.

Feedback has been positive, with partners welcoming the regular review of how we commission education programmes, the retention and career development plans for our clinical learners, and our ambition to reduce bank and agency spend further.

Looking further ahead, our workforce priorities for the next five years include; increasing the number of assistant and associate roles, rapidly building a pipeline of younger people (18+ years old) coming into health and care roles and supporting the training and development of our staff across the system, which is a key driver in retaining our staff and in ensuring that they have the clinical, operational and digital skills needed to deliver care to our patients.

The opportunity to participate in research enhances job satisfaction and contributes to improved recruitment and retention rates. We will work with our colleagues in the Research and Innovation team, provider Research teams and education providers to support research schemes within Norfolk and Waveney to deliver better health outcomes.

Finally, we recognise that fully integrated working across health and social care is a significant challenge. The recently developed national workforce plan for Social Care, with its focus on Train, Retain, and Reform, is welcomed as a significant step towards greater alignment of workforce development across health and social care. We will continue to work in partnership with Norfolk and Suffolk County Councils to promote opportunities to attract and retain our ICS workforce.

10. Supporting system design and development

Our approach to delivering this outcome is set out in section 6 of our Joint Forward Plan about people and culture.

Duty as to climate change

Climate change poses an existential threat to the whole planet and Norfolk and Waveney is not immune from the consequences. Taking decisive action to reduce our adverse contribution to climate change will save lives, improve people's health and benefit health services.

The organisations responsible for health and care in Norfolk and Waveney are continuously making steps towards more sustainable ways of operating. Our system's Green Plans take this further, establishing the ideas for achieving Net Zero, and meeting the commitment set out in the Climate Change Act 2008 and the Environment Act 2021.

Our Green Plan for the Norfolk and Waveney Integrated Care System sets out how the NHS will work together and with system partners towards Net Zero, by sharing best practice and collaborating. By working together to deliver our Green Plans, we will deliver against the targets and actions in the 'Delivering a Net Zero NHS' report, as well as the four core purposes of an ICS by:

- **Improving outcomes in population health and healthcare:** Adopting activities and interventions which slow the associated health impacts of climate change will help to improve population health.
- **Tackling inequalities in outcomes, experience and access:** Supporting action to address poor air quality, which disproportionally affects vulnerable and deprived communities through higher prevalence of respiratory illnesses.
- **Enhancing productivity and value for money:** Improving energy efficiency and using renewable energy sources across the ICS estate footprint will reduce long-term energy bills for the NHS and local councils.
- **Helping the NHS support broader social and economic development:** Ensuring NHS procurements include a minimum 10% net zero and social value weighting will help to achieve this, as will adhering to future requirements set out in the NHS Net Zero Supplier Roadmap. Council procurements similarly place emphasis on reducing scope 3 carbon emissions and both the NHS and county councils require that bidders for contracts valued at over £5m per annum have a carbon reduction plan in place.

Davey Heidi
24/03/2025 12:20:17

Governance

Over the last three years, green plans have progressed but ambitions have had to be kept realistic to align with available resources. Progress on delivery of our Green Plans is co-ordinated by the ICS Green Plan Delivery Group. The group membership is made up of focus area subject matter experts from across the system ICS and Green Plan leads from our member organisations.

Workforce and Resources

We cannot deliver our Net Zero ambitions without our workforce. It is therefore vital that the system continues to inform, mobilise and train our staff so that they have the knowledge and skills required to help us on our journey. Net Zero is a priority and, accordingly, is led at Board level by the ICB Executive Director of Finance.

The system is engaged with the regional Greener NHS team and neighbouring integrated care systems to learn and share ideas and best practice. Through the green plan delivery group work the subject matter experts and sustainability leads collaborate to develop enable ICS Green Plan and Operating plan delivery.

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Adapting to the impact of climate change

There is a time lag between cause and effect in the climate system which means that we will continue to be affected by past emissions for years to come. Consequently, adapting to the impacts of climate change is important for business continuity. Strategies to adapt to climate change are therefore part of local planning and decision making, bringing multiple benefits to the physical and mental health of the Norfolk and Waveney population.

Norfolk and Waveney already experience the effects of considerable coastal erosion and is subject to many flood areas associated with increases in sea levels. Many of the impacts of climate change, including those for health, will be felt locally.

Both county councils have broader responsibilities for adaptation. These include steps to promote nature recovery, mitigate flooding and support sustainable development.

Green Plan Refresh 2025-2027

During 2025, NHS organisations and the ICB will be updating our green plans as part of the three-year cycle. Key NHS guidance is due in Spring 2025 that will provide the framework for realistic expectations of delivery.

Addressing the particular needs of children and young people

Leadership has been identified in health and social care to drive forward the agenda and to ensure that the voice of children, young people and families is represented at the most senior level. The Children and Young People's Strategic Alliance Board provides oversight and assurance and is underpinned by thematic sub-groups leading on priority workstreams. The Norfolk and Waveney System Collaborative is well established and there is a joint commitment to working in partnership and actively seeking opportunities to develop shared services and jointly utilise available resource.

The voice of babies, children, young people (BCYP) and their families

We have invested in a participation and recovery model to ensure that transformation of services is co-produced and enables children and young people to hold us to account through strong and well-established forums. This enables children and young people to be heard by those who commission and deliver services in both Norfolk and Suffolk. We also have well-established parent carer forums to ensure the voices and needs of parents and carers are included in our planning and delivery of support.

Working with partner organisations, we can link in with seldom heard groups such as CYP with special educational needs and disabilities, looked after children, care leavers, youth advisory boards and asylum seekers. This allows us to ensure that the experience of all our communities is captured and help to shape the future support to enable the best start in life.

Darley, Heidi
23/09/2025 12:20:17

Data and insight

Our system approach, and the ongoing monitoring of its delivery, will be increasingly informed by data and evidence. We are developing a systematic, whole-partnership monitoring framework, alongside the FLOURISH outcomes, to enable the Strategic Alliance to track progress against each outcome and overall, using data and evidence.

This will enable system understanding and oversight of where babies, children and young people are waiting to access care and support, and to inform our focus areas for recovery including access to mental health support, diagnostic delays, workforce information and an ability to focus system resource to the greatest areas of need.

Reducing health inequalities

The CORE20Plus5 approach (described in the **Duty to Reduce Inequalities** section) will support us to ensure that healthcare inequalities improvement is built into our strategies, policies, initiatives and programmes.

In addition to those areas identified within Core20PLUS5, our Flourish strategy Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council identifies four priority areas for system focus:

- Prevention and early help
- Mental health and emotional wellbeing
- Special Educational Needs and Disabilities (SEND)
- Addressing gaps in learning following the pandemic

Safeguarding

All systems have a statutory duty to safeguard. As part of the All-Age Safeguarding Team, the Designated Safeguarding Children and Looked After Children (LAC) teams influence, advise and support us to ensure it accords with the principles of the Children Act 1989 and is aligned to the Norfolk and Suffolk Safeguarding Children Partnership and priorities. The Teams ensure health and care services meet the statutory requirements of Section 11 of the Children Act 2004. Working Together to Safeguard Children 2023 has refreshed the principles of the multi-agency safeguarding arrangements. Norfolk & Waveney ICB continue to be one of the three statutory partners working with a clear vision to safeguard babies, children and young people. The designated safeguarding children team ensure effective participation in the Norfolk safeguarding children partnership on behalf of the ICB and will continue to support local safeguarding arrangements with the update of this legislation. The priority continues to ensure 'safeguarding is everyone's' business' and remains at the heart of service delivery.

Our safeguarding teams work in collaboration with all partners in Norfolk and Waveney in the early identification of children at risk, including risk of exploitation and serious youth violence and recognition of all types of abuse and non-accidental injury promoting the needs of looked after children, those within the youth justice system and unaccompanied asylum seekers. Integrated working will support colleagues to work and communicate effectively across organisational boundaries, to ensure safety and provide child-centred care.

Dave Hedi
24/03/2025 12:20:47

The Safeguarding Team provides training to primary care colleagues on how to recognise clinical presentations that are safeguarding relevant. This will assist GPs to prioritise safeguarding meetings, and to efficiently complete requested reports. Primary Care engagement in safeguarding is further strengthened by the current Family Hubs model and is vital in the multi-agency development of early intervention and prevention work with families, children and young people.

Going forward our teams will drive greater integration through matrix working and multi-agency collaboration. Digital solutions to enable safeguarding information to be disseminated will be further developed and sharing data will be integral to the partnership approach.

Safeguarding professionals will advocate for BCYP, and champion early intervention and prevention services to avoid long term damage that has implications across society. We aspire to be a trauma-informed system, recognising the importance of the early days of a child's life and development, and impact of adverse childhood experience on long term health and economy.

Serious youth violence is an increasing concern amongst the multi-agency safeguarding system. Partners contribute to the ongoing planning and implementation of strategies alongside and through the serious violence duty to try and mitigate the risks to the young people, their families and networks.

Continuing care for children and young people, including palliative and end of life care

The Council for Disabled Children describes a vision of a society in which "children's needs are met, aspirations supported, their rights respected, and life chances assured" (https://councilfordisabledchildren.org.uk/about-us). This underpins the work of our Children and Young People's Continuing Care Team where the aim is to achieve "gloriously ordinary" lives for the BCYP.

Continuing care packages are required "when a child or young person has needs arising from a disability, accident or illness that cannot be met by existing universal or specialist services alone" (National Service Framework for Children

and Young People's (CYP) Continuing Care 2016, p5). Unlike adult continuing healthcare packages, which are entirely NHS funded, these packages can be jointly funded with education and social care and are very complex.

Norfolk & Waveney ICB currently offer two main approaches to the provision of continuing care: either a personal health budget (PHB) or a commissioned package of care, delivered by agencies procured specifically for care of children.

Palliative care is a low volume, but significant part of the care delivered to BCYP with continuing care needs. Our fast-track system complies with statutory guidance.

Partners have developed joint commissioning and quality oversight arrangements to ensure that all agencies are working together to meet the holistic needs of BCYP and their families. We collaborate regarding quality assurance and improvement and work together to develop provision closer to home.

Special Educational Needs and Disabilities (SEND)

The Children and Families Act 2014 is a statutory framework for the integration and personalisation of services for children and young people that require education, health, and care services. To fulfil this statutory duty, we work collaboratively with children and young people with SEND and their families, alongside education and social care services to provide the right support. This must be using the key principle of co-production and be person centred.

Harvey, Hayley (NHS WAVENEY ICB - 26Y) 24/03/2025 10:21

This includes identification of children and young people with SEND and to enable them to access everyday activities with the right support and adjustments. We share support and resources across agencies for those on NHS waiting lists and up-skilling those working with children and young with key neurodevelopment difficulties, such as autism. We are committed to developing the wider workforce on key areas of SEND and to support workers to understand their duties and responsibilities. Children and young people with SEND are a vulnerable group and work will continue to drive equity of services and resources by raising awareness of the need and duty on services to make reasonable adjustments.

There will be key contact points across the health system to provide communication and support for children, young people and their families on health pathways. This will ensure families, young people and those working in education and the care system know where to go to get NHS health advice and resources.

We will continue to ensure that there are opportunities for children, young people and their families to contribute to service development and to ensure their lived experience is heard and understood.

There is a programme to review and improve health pathways. Publications on local websites and Just One Norfolk will also be reviewed and improved.

Working with local authorities and wider stakeholders, we will further develop the SEND annual survey, increase the survey response rate and disseminate the learning to further influence commissioning.

Joint quality assurance visits will take place into complex needs schools to further strengthen quality improvement and build confidence within settings to manage heath / medical needs.

Work continues to strengthen the use of shared data and analysis to inform commissioning of services for children and young people with SEND.

We aim to have a multi-agency SEND training platform that is accessible to all stakeholders, including children, young people and their families. We will develop a shared understanding and vision across children, young people and adult commissioning to ensure SEND is seen as everyone's business.

Partnership working will be strengthened through active participation in the SEND Partnership and Improvement Boards, multi-agency working, and we will feed in regional and national systems to develop innovations and initiatives.

We will work as a system to become needs led and not medical and diagnostic driven. We will build confidence in the services and resources available by celebrating difference and individuality.

Please refer to duty to reduce inequalities regarding system work for Autistic children and adults and people with a Learning Disability (LD).

Children and young people's mental health

We aim to improve emotional wellbeing and mental health through early identification of need and the promotion of initiatives that increase resilience. This aims to ensure children and young people are supported earlier around their wellbeing needs and reduce the burden on specialist mental health services in the future.

Through the Strategic Alliance, decisions are made at a system level. Challenges within the system are discussed and resolved in collaboration, and priority areas identified:

- Improving and simplifying access to emotional wellbeing and mental health support for all 0-25 years old through a single integrated front door, known as the Advice, Support and Access service. This is Objective 4c in the JFP.
- Building on the use of the digital platforms, we will ensure all CYP have access to self-help resources and information about resources and support within Norfolk and Waveney.
- Providing early support in schools through Mental Health Support Teams; by 2030 we aim to have 100% coverage of mental health support teams across all schools in Norfolk and Waveney.
- We will adopt a whole family approach to meeting mental health needs across Norfolk and Waveney, with a focus on communities and primary care.
- Mobilisation of a Professional Therapeutic Pathway to maximise system capacity and address health inequalities and to support CYP who need a different approach to have their needs met.
- Continue to focus on supporting CYP with an eating disorder including Avoidant Restrictive Food Intake Disorder (ARFID), with a focus on early identification and support.
- Providing 24/7 assessment and care to children and young people presenting in a crisis through an Integrated Practice Model, bringing together system partners to support children and young people with complex needs that present in crisis.
- Developing a system-wide workforce plan to ensure we have the skills to meet presenting need, and to inform our approach to new roles and training programmes.

Continued development of our Local Maternity and Neonatal System (LMNS)

This is part of Objective 3b within Ambition 3 – Improving Services for Babies, Children, Young People and developing our Local Maternity and Neonatal System (LMNS). You can read more about this in Section 4 of Part 1 of the JFP.

The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

Alongside this, NHS England published a single delivery plan (SDP) for maternity and neonatal services in April 2023 and we are implementing the four themes.

The LMNS will continue to put in place the infrastructure needed to enable roll-out of Midwifery Continuity of Carer, so it is the default model for all women. This will ensure that 75% of women of Black, Asian and Mixed ethnicity and from the most deprived neighbourhoods are placed on pathways.

Davey, Hodi
24/03/2025 12:20:17

Addressing the particular needs of victims of abuse

Partners across Norfolk and Waveney consider the needs of and provide support to victims of abuse (including victims of domestic abuse and sexual abuse, both children and adults).

We have important arrangements in place in Norfolk and Waveney for partnership working on this agenda. The Norfolk & Waveney Integrated Care Board (ICB) is an active member of our two local Community Safety Partnerships:

- Norfolk County Community Safety Partnership (NCCSP), which sits under the jurisdiction of the Office of the Police and Crime Commissioner for Norfolk (OPCCN).
- East Suffolk Community Partnership (ESCSP), which is hosted by the Suffolk County Council.

The Serious Violence Duty (SVD) has been scoped through these partnerships, with both strategies published in January 2024.

The ICB Safeguarding teams currently support the three acute hospital trusts to meet their responsibilities to supply anonymised assault data to the Community Safety Partnerships. With the SVD now live, this reporting stream will be enhanced to meet the new responsibilities.

The ICB is represented on the Norfolk Domestic Abuse and Sexual Violence Group (DASVG) by the designated safeguarding professionals (who represent the health sector).

The designate all-age Safeguarding Team chair the Norfolk and Waveney Domestic Abuse and Sexual Violence Health Action Forum, a sub-group of the DASVG. Within this forum, health provider organisations are joined by colleagues from specialist domestic abuse and sexual abuse agencies, as well as from public health and mental health services. The forum ensures that the health system is sighted on all the available support services and resources to be able to meet their responsibilities in these areas of work.

The ICB is represented by the Safeguarding Teams at the DASVG's Adult and Children's sub-groups and has strong links with the Office of the Police and Crime Commissioner for Norfolk (OPCCN), the Norfolk Integrated Domestic Abuse Service and similar forums within the Suffolk system representing the Waveney population.

Here are some examples of the work we are doing as a system in N&W, and ways in which the ICB is delivering against its duty to address the particular needs of victims of abuse:

- The ICB actively participated in agreeing priorities and finalising the two SVD Partnership strategies which were published in January 2024. There is further detail and links to the strategies in the legal duty to address the particular needs of victims of abuse. On the annual anniversary of this publication, the ICB is engaged in the review of the local Serious Violence Strategies.
- The ICB joined other key system partners in signing up to the White-Ribbon pledge championed by the OPCCN. This is a commitment to a zero tolerance of domestic abuse and unacceptable behaviours by our workforce and towards the development of a strategy where there is a particular focus on addressing and working to prevent men's violence towards women and girls. The ICB has committed to jointly lead this piece of work with Norfolk Constabulary.

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- All Norfolk and Waveney NHS Trusts and the ICB have signed the pledge to the NHSE Sexual Safety Charter. The ICB is now leading a programme to ensure that the services it commissions are adopting the pledge requirements.
- The ICB Safeguarding named GPs continue to provide resources and are liaising with colleagues in specialist domestic abuse and sexual violence roles to deliver training and learning from Domestic Abuse Related Death Reviews (DARDRs).
- The ICB has nominated a Domestic Abuse and Sexual Violence (DASV) Lead who is engaging in the newly formed national network workshops.
- The ICB is actively engaging in the Domestic Homicide Review Scrutiny process.
- The ICB has conducted an internal domestic abuse survey where over 150 respondents provided answers to questions that will now shape how the safeguarding and Human Resources teams can support staff to identify, acknowledge and report cases of domestic abuse.
- The ICB DASV Lead has close working ties with the NHSE commissioned sexual assault referral centre Lead, and both individuals work together in a number of forums including the police led Rape and Serious Sexual Offences Scrutiny Panel.
- The ICB commissions a range of health specific pathways within a portfolio designed to support children and young people who are victim to serious violence. This includes but is not limited to talking therapies for victims of and witnesses to sexual violence, trauma informed mental health provision and targeted support for children exposed to and at risk of displaying harmful sexual behaviours.
- The ICB also engages with relevant Suffolk workstreams, with NHS Suffolk and North East Essex ICB safeguarding Leads.

The Serious Violence Duty (SVD)

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In December 2022, guidance on the Serious Violence Duty was published by the Home Office. The 'lead' authority for meeting the Serious Violence Duty in Norfolk is the OPCCN, while in Suffolk it is the county council. Each lead agency has convened a partnership group that the ICB attends through its Safeguarding Adult and Children and Young People's Teams.

The ICB actively and fully engages with the two Serious Violence Duty Partnerships. You can find the strategies here:

You can find the strategies here:

Norfolk: https://www.norfolk-pcc.gov.uk/assets/Norfolk-Serious-Violence-Duty-Strategy-January-2024.pdf

Suffolk: https://www.suffolk.gov.uk/asset-library/suffolk-serious-violence-strategy-2024-27.pdf

This is going through annual review in conjunction with current local adoption of prevention partnerships.

The ICB is actively engaging in the Duty to Collaborate as required by the Victims and Prisoners Act 2024. This will be exploring health's role in the commissioning of relevant services.

Services within the scope of the NHS Standard Contract must comply with the Domestic Abuse Act 2021 and associated guidance from April 2023.

Implementing any joint local health and wellbeing strategy

The Norfolk and Waveney Integrated Care System covers the whole of Norfolk and part of Suffolk. As upper-tier local authorities, Norfolk and Suffolk each have their own joint Health and Wellbeing Strategy:

- Norfolk's Joint Health and Wellbeing Strategy (which is also the Integrated Care Strategy for Norfolk and Waveney): https://improvinglivesnw.org.uk/wp-content/uploads/2024/06/Integrated-Care-Strategy-2024-.pdf
- Suffolk's Joint Health and Wellbeing Strategy: https://www.healthysuffolk.org.uk/asset-library/Health-and-Wellbeing-Strategy-22-27.pdf

Both strategies were light touch refreshed during 2024/2025 and confirmed as being current, reflecting the most recent Joint Strategic Needs Assessments. There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy:

Norfolk priority	Suffolk cross-cutting themes
Driving integration	Greater collaboration and system working
Prioritising prevention	Prevention: stabilising need and demand
Addressing inequalities	Reducing inequalities
Enabling resilient communities	Connected, resilient and thriving communities

Davey Heidi
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The Joint Forward Plan (JFP) is a delivery mechanism for these local health and wellbeing strategies and the Norfolk and Waveney Integrated Care Strategy is specifically referred to in section 1 of the JFP.

We are committed to the implementation of both strategies and the JFP sets out how health services in Norfolk and Waveney will do this. We will continue to involve the Health and Wellbeing Boards through the annual refresh of our JFP and publication of their respective opinion on the JFP. As part of the development of the Norfolk & Waveney Integrated Care Board's Annual Report, the organisation reports to the Health and Wellbeing Boards on how they contributed to delivering the priorities in each Joint Health and Wellbeing Strategy.

In June 2024, the Norfolk Health and Wellbeing Board also received a co-authored report that showed the progress made against each of the priorities through the combined efforts of system partners, which included work undertaken through the JFP.

Digital and data

We are committed to investing in and using technology to improve people's health, wellbeing and care. Our Digital Transformation Strategic Plan and Roadmap sets-out how we will digitise services and connect them to support integration. This will enable new ways of working that can increase efficiency, improve patient experience and outcomes, plus reduce workforce burdens, and help to address health inequalities.

This diagram sets-out our vision and strategic priorities for Norfolk and Waveney:

The plan and roadmap are in line with national guidance, such as the NHS Long Term Plan and the NHSX What Good Looks Like framework, as well as the Digital Health and Social Care Plan. The 10-year Health Plan will include the specific aim of making the shift from analogue to digital.

The digital plan and roadmap are a key enabler to the delivery of the eight ambitions in the JFP. Each ambition is co-dependent with digital and our plans for improvement are consistent so we can ensure all our efforts are joined up and focused in the right areas. You can read more about this in Section 6.

Vision: our overarching aim
A digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.

To realise our strategic vision, we have developed five strategic objectives for the next three years.



Together
Use digital technology and skills to work more efficiently and collaboratively across standardised systems

Connect
Provide effective and joined-up care through systems integration and streamlined information flows

Activate
Empower citizens with greater visibility and control over treatment and care journeys

Understand
Use data to drive decisions and harness population health insights

Innovate
Adopt a clear pathway for digital innovation and research to support the transformation agenda

Davey Lee
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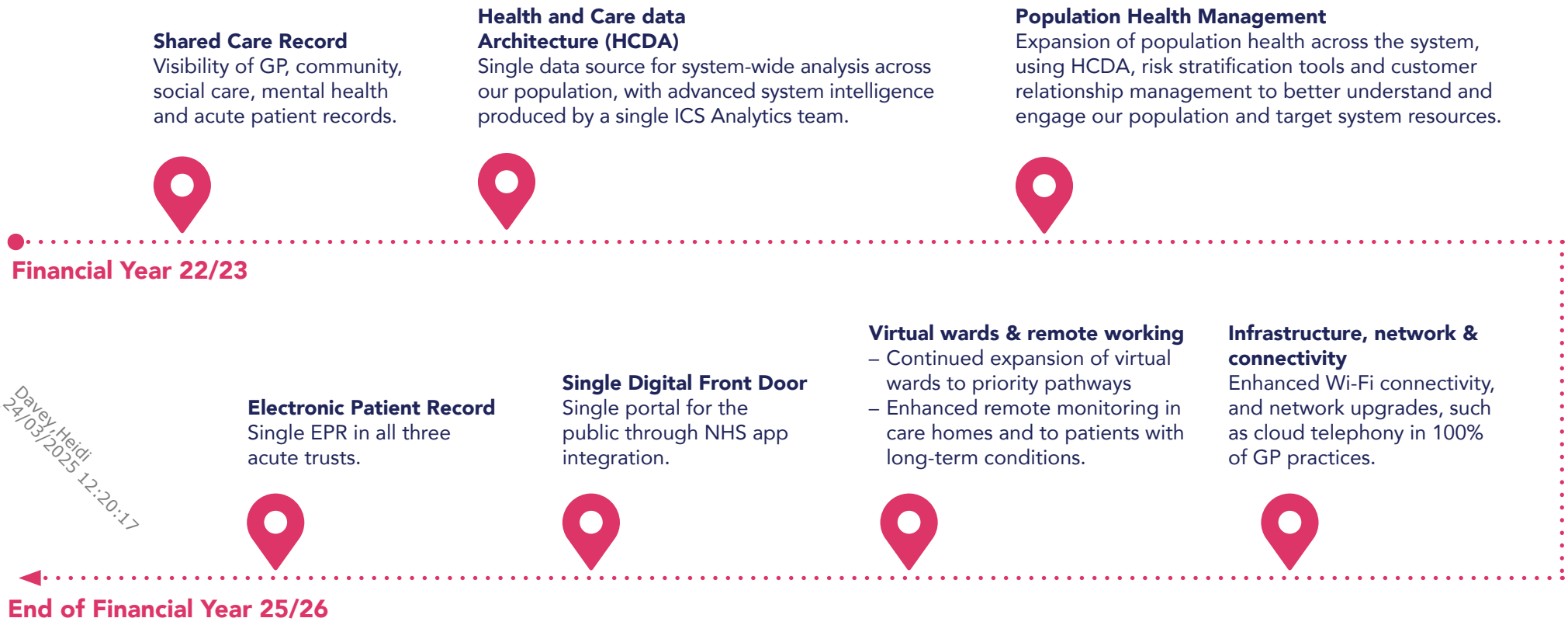
Using digital systems, we will:

- Enable people to access their health and care records securely, quickly and when they want to see information or data.
- Support clinical and strategic decision making through technology, providing health and social care organisations who deliver care access to relevant, accurate and up-to-date information.
- Improve system wide IT services to increase safety and people's health and care experiences, whilst reducing duplication and waste.
- Support and empower people to maintain their health and wellbeing through digital solutions.
- Enable health and care staff and services to provide the best care in all settings, particularly via the use of mobile technology.
- Ensure personal health and care information is kept safe and secure.
- Invest in the infrastructure and technologies needed to help drive improvements to services and provide better care.

Digital Transformation Strategic Roadmap

Digital will enable transformation across all care settings, including outpatients.
Our roadmap details the key milestones:



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The Norfolk and Waveney Shared Care Record is now live in all three Acute Hospitals, Norfolk County Council, the Community providers, all GP Practices, Norfolk & Suffolk Foundation Trust, and IC24, the 111 and Out of Hours provider. Usage has reached 7,500 staff per month, accessing the records of 44,500 patients. There are many examples from clinicians of how the information available is saving them time and helping with clinical decision making. Work continues to extend the range of data included in the record and to deliver access to more staff, with the next planned go live giving access for Norfolk Hospices.

The last year has seen the Electronic Patient Record (EPR) implementation across the three Acute Hospitals make good progress. The software is available to staff locally and is being configured ready for use. Clinical areas throughout the hospitals are planning patient pathways and looking at how the new system will best support the delivery of care.

Uptake of the NHS App in Norfolk & Waveney has reached 56%, an increase of 5% in the last year. In an average month, there are 700,000 logins to the App, around 900,000 repeat prescriptions are requested and 400,000 patients view their GP record. All three Acute Hospitals are signed up to the Wayfinder project which means that outpatient appointments and documents are shared via the NHS App.

GP Practices have also been supported to deliver the modern general practice model, enabling patients to request assistance by digital methods and to be signposted to the right help for their issue.

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In the last year, 86 GP practices have been supported to move to cloud-based telephony systems, increasing resilience and available lines, and introducing patient call-back. Feedback from both practices and patients has been good. Funding for the telephony systems was provided by NHS England. Cloud telephony is now available in 100% of GP Practices in Norfolk & Waveney.

GP Practices have also seen the completion of major improvements to infrastructure. In a programme supported by funding from the NHSE Future Connectivity Programme, practices have had full fibre connections installed and broadband is now available throughout practice premises. This includes the availability of GovRoam which means that laptops or tablets being used by staff from other organisations that visit practices, such as Midwives and Paramedics, can connect automatically saving valuable time and creating a seamless working experience.

Remote access technology in care homes continues to be supported, with developments over the past year bringing integration with GP clinical systems, making it more straightforward for practice staff to see the remote observations taken by care home staff. Together with GP Connect, this is giving clinicians in out of hours services better information to support clinical decisions and is enabling people to stay in their own homes and receive care there. The Virtual Wards programme is also enabling people to stay at home with support and monitoring which supports Ambition 6, Improving Urgent & Emergency Care.

The data hub is now live (this used to be called Health Care Data Architecture or HCDA in the digital roadmap), which has the capability to link data sets together, giving us the capability to look at trends at a population level. There is anonymous, aggregated and identifiable data, which can be mapped for different purposes. This is a key enabler to support Ambition 1 in the JFP, Population Health Management, Reducing Inequalities and supporting prevention.

Implementation of the digital road map is in step with the JFP and other ICS strategies. It provides some of the infrastructure to enable the delivery of Ambitions across all the areas, and many of these are cross-cutting. Implementation of the digital roadmap is in step with the JFP and other ICS strategies. It provides some of the infrastructure to enable the delivery of Ambitions across all the areas, and many of these are cross-cutting.

Estates

Our Estates Strategy sets-out how we will create stronger, greener buildings, enable smarter, better health and care infrastructure, and use system resources fairly and more efficiently. It is based on extensive engagement, and a review of clinical strategies and investment requirements across the ICS.

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

To realise our strategic vision, we have developed four key goals:

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

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System-wide, Person-Centred Estate

We have a significant part to play in supporting and enabling the delivery of a system-wide person-centred estate that serves the needs of all its users, enhancing both patient and staff experience.

We will enable the integrated care strategy through our estate objectives by:

- Developing a collaborative approach across the NHS to estates and facilities service provision, ensuring our assets enable integrated accessible services.
- Ensuring our estate supports the provision of preventative models of care.
- Working with local planning authorities and public health to ensure their programmes of work and ours are linked and we cooperatively help people live in healthy places, promote healthy lifestyles, prevent ill-health and reduce health inequalities.
- Support delivery of specialist housing programmes that enable people to remain independent and reduce demand on services.
- Enabling relocation of services closer to areas of high need, where clinically appropriate, and supported by investment decisions.
- Delivering our Net Zero Green Plan to reduce our carbon footprint and emissions and tackle the negative impact this has on health and our communities.

Managing the Estate Portfolio

The Estates Programme Board is an enabling service function within the ICS. It brings key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney ICS to realise its vision, purpose, goals, and deliver upon its priorities. Through our system wide estates collaboration we inform investment decisions for the benefit of the Norfolk and Waveney population.

To help manage our estate portfolio we have developed a complete inventory of estate that enables us to assess the location, ownership, capacity and utilisation, age and condition, value and running cost, and the energy performance of our occupied estate. This has allowed us to pinpoint specific metrics and rate performance against our objectives, such as areas of backlog maintenance and critical infrastructure risk, non-functionally suitable estate, underutilised estate, and high running costs.

The core, flex and tail framework has also been applied. Identifying what assets are core, flex, and tail forms a basis for investment planning and operational service planning. It will enable us to direct the use of resources, scheduling activities and so on. We will then be able to rationalise estate where there is tail estate to be disposed of.

Empowered and Skilled Estates Workforce

To provide an effective, safe, and efficient service, now and in the future, we need to have the right estates and facilities resource and expertise available. The ICS Estates workstream aligns its plans with the Norfolk and Waveney People Plan, as well as the national estates and facilities workforce strategies and action plans.

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Net Zero Estate

Our Net Zero Green Plan is described in the Legal Duty as to climate change.

Emissions resulting from NHS building energy, water, and waste account for 11% of our total emissions, and 55% of the emissions we control directly. The Estates 'Net Zero' Carbon Delivery Plan provides a managed approach that will embed and enable the decarbonisation of the estate across the ICS.

Working through the ICS Net Zero Oversight Group, we will explore and implement interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.

Adapting to Climate Change

Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for our health and care estate is two-fold:

Health and Wellbeing:

- Investing in and managing estate that avoids negatively impacting the physical and mental health and wellbeing of our population.
- Flexibly managing our estate so that our health and care system can respond to different volumes and patterns of demand.

Operational delivery:

- The system infrastructure (such as buildings and transport) and supply chain (for example fuel, food and care supplies) need to be prepared for and resilient to weather events and other crises.

Transformed Models of Care

Transforming through the national New Hospital Programme
The New Hospital Programme delivers Government investment in the replacement of aged NHS hospital estate across the NHS. Norfolk and Waveney have been successful in securing funding that will see the planned rebuilding of the James Paget and Queen Elizabeth Hospitals. These investments will transform patient experience, providing innovative and modern and highly equipped hospitals from which our clinical services will continue to go from strength to strength.

Transforming through digital infrastructure and SMART buildings
The use of digital infrastructure and technology is important in delivering our vision and objectives. Digital innovation and enhanced infrastructure, devices, and information systems will help form SMART buildings that advance the experiences of our building users, improve sustainability, and drive financial efficiency.

SMART buildings will monitor, measure, and manage key aspects of a building's fabric and operational use, providing the data and knowledge to drive improvement. Good estates and facilities management can be ensured through the ongoing monitoring of maintenance, operations, and utilisation data generated by SMART building technology.

Digital infrastructure and platforms will include proactive use of digital systems to improve the performance, reliability, quality, and productivity of our estate, and reduce reactive and backlog maintenance costs. This is consistent with our Digital Strategy and Roadmap.

Approved
Heidi
24/03/2025 12:20:17

Infrastructure Design and Investment

Improving integration through One Public Estate
One Public Estate (OPE) is an established national programme delivered in partnership by the Office of Government Property and the Local Government Association. We have been an integral part of this programme for a number of years and we will continue this work. The OPE Board provides practical and technical support and funding to councils and other public organisations to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners.

We will continue to work with our partners through OPE to design and deliver integrated infrastructure solutions that serve the needs of both health and care.

Procurement / supply chain

The Norfolk and Waveney Procurement Collaborative (NWPC) continues to synchronise purchasing under a formal agreement to buy in common wherever possible. As our frontline teams work more flexibly across different locations, this has helped us improve clinical effectiveness through use of standard equipment and products across all our sites.

This collaboration delivered over £5m of procurement savings in 2024/2025 and will continue to ensure we get the very best value from our non-pay spend.

The three acute hospitals have stated a commitment to work under shared executive leadership. Similarly, NCHC is developing its own plans to work more closely with Cambridgeshire Community Services NHS Trust. NWPC will remain at the forefront of collaboration and will review its delivery model to ensure it aligns with new accountability arrangements and takes full advantage of new opportunities to purchases at the optimum scale.

Reviewed and updated category strategies for each of our key spend areas will continue to identify opportunities for product range consolidation, volume aggregation and commitment to strategic supplier partnerships across the system to support the development of integrated patient pathways. Acute Clinical Networks are now in place and category leads are already working closely with these to co-develop clinically informed category strategies. The system-wide Clinical Product Evaluation Group remains in place to ensure purchasing decisions take every opportunity for standardisation across Norfolk and Waveney where appropriate. This is now supported by the system's first clinical procurement specialist, a matron embedded in procurement, to bring direct insight of product usage into purchasing discussions.

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We will also continue to ensure we leverage NHS influence and scale at levels to secure the best commercial deals for Norfolk and Waveney. We will collaborate regionally with partners across the East of England where this makes sense and are already starting to purchase at increased scale where we have joined clinical networks such as the Eastern Diagnostics Imaging Network and East Coast Pathology Alliance. We will continue our support for the NHS England strategy of using NHS Supply Chain wherever possible, so that nationally there is the greatest opportunity for the NHS in its entirety to leverage its national buying power.

We are fully engaged with NHS England's Strategic Framework for the NHS Commercial sector and will ensure our procurement services are assessed and showing improvement against the UK Government's Commercial Continuing Improvement Assessment Framework. The NNUH and joint NCHC / NSFT procurement teams were both accredited as 'better' (level 3 out of 4) in 2023 and QEHKL as 'good' (level 2 out of 4). The ambition remains for all procurement teams to reach the level of better or best (the top level) by 2027.

The implementation of the new Procurement Act 2023 was delayed by the government until February 2025. We have taken this opportunity to review and further align our procurement processes to not only ensure compliance with the new regulations but to increase our ability to work effectively together. A key change arising from the new procurement act will be increased transparency of our ongoing spend through competitive processes and management of contracts.

We will continue to deliver on our value and sustainability commitments. For all contracts over £5m per annum, we require the supplier to provide a carbon reduction plan. We will also ensure our procurement tender activity supports UK government social value targets set out in the National Procurement Policy Statement, the Greener NHS Programme to deliver a net zero health service and the drive to eliminate modern day slavery. This is consistent with our Net Zero Green Plan which is within the legal duty as to climate change.

We have skilled and experienced commercial professionals available across the NWPC partners, with several 'MCIPS' qualified staff which is the gold standard for procurement. NHS England has announced funding for an NHS Commercial

Learning & Development Centre of Excellence which will invest in increasing commercial skills of our people across the NHS, not just procurement, as commercial acumen is a growing key strategic competence required across all departments.

The ICB continues to directly host its own procurement function. This predominantly manages procurements for healthcare and non-healthcare services, reflecting the commissioning responsibilities of the ICB. The focus of the ICB procurement team is to ensure that the ICB complies with the legal requirements for awarding service contracts that deliver the best services for patients at the best value for the system. The Provider Selection Regime introduction has meant that the ICB has made changes to its procurement processes to reflect the new requirements. The new regime is intended to deliver greater flexibility to support collaboration in the delivery of services in the Norfolk and Waveney system.

As separate legal entities and to reflect the different obligations of commissioning and provider organisations, to-date the ICB and provider collaborative procurement functions have operated independently. These teams are, however, in regular dialogue and work together to identify the most efficient and effective routes to complying with our responsibilities under legislation to the benefit of the whole system. The way in which procurement activities are undertaken will continue to be reviewed to ensure that the procurement function is being delivered in the most effective way.

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Population Health Management (PHM)

Population Health Management (PHM) is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and wellbeing.

Our ICS Population Health and Inequalities Board is leading the implementation of a new strategy for PHM. This is a specific objective within Ambition 1 of the Joint Forward Plan.

The new strategy sets out our ambitions in relation to the delivery of population health management, our priorities and plans for a system level programme and our approaches for all partners within the system to take forward their own programmes of PHM, focussing on local communities.

By focussing on prevention and health inequalities, and by partners working together to identify new things that can really help to improve health, the strategy supports people to live as healthy a life as possible. It impacts on the way we plan, prioritise and deliver care. The PHM approach is a way we can act together to improve health and wellbeing, making the best use of the resources we have available to us, removing barriers and supporting integrated working across our system.

The strategy sets out our approaches to use joined up data and information to better identify and understand the health and care needs of our population, to identify opportunities for improvements and put in place targeted interventions to support these.

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We are aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for our most deprived populations.

We are also seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Our approach is also driven by the needs of local communities and interventions designed to support them. We will support Place-led projects to deliver local priorities and to support working with wider partners to develop joint initiatives to address the wider determinants of health, such as housing.

Our strategy includes the need for evaluation to measure progress and impact. Progress reports will be received by the Population Health and Inequalities Board, led by our Executive Medical Director, which has a broad membership of ICS representatives, including County Council, adult social care and Children's Services, Public Health, NHS providers, and place board and health and wellbeing partnership representatives.

We have identified initial PHM priorities at a system level to address health inequalities and meet the Core20PLUS5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are:

- Smoking, and smoking in pregnancy
- Serious Mental Illness
- Cardiovascular disease, diabetes and respiratory
- Early cancer diagnosis
- Children and Young People

Our Norfolk & Waveney ICB PHM team have achieved a number of improvements as part of our "Protect NoW" programme of work. This programme is a collaboration between NHS organisations, local authorities, the voluntary sector and independent partners working across Norfolk and Waveney. It comprises a growing number of projects, each focused on optimising physical and/or mental health and wellbeing. Alongside clinical leadership, our PHM digital supplier provides the bespoke data analysis, technical solutions and digital platforms that underpin the "Protect NoW" projects.

Projects to date have included topics such as:

- **COVID-19 vaccination uptake** – Increasing vaccine uptake and gaining insight into how we can support people to take up the vaccine offer.
- **Falls prevention** – Engaging with people who are vulnerable to having a fall or waiting for a hip or knee operation and assessing if any adaptations or equipment are required, in partnership with the Local Authority Home Adaptations team.
- **Pain management** – Triaging patients on the pain waiting list so that those suffering the most pain are prioritised.
- **Improving Access to Psychological Therapies (IAPT) uptake** – Increasing referrals to the wellbeing service and addressing clinical variation.
- **Cervical screening uptake** – Increasing the uptake of Cervical Cancer Screening – reducing inequalities and unwarranted clinical variation.
- **Long Covid clinic design** – Gaining insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from the community provider.
- **Diabetes prevention** – Increasing referrals into the National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.
- **Priority Patient Review** – Reducing hospital admissions through primary care risk alerts. This pilot aimed to demonstrate that the proactive management of patients with reversible risk across six clinical pathways would result in reduced hospital admissions.
- **ActiveNOW** – focused on supporting health and care professionals to quickly and easily refer patients into suitable physical activities based on their needs.
- **Digital Weight Management Programme** – increasing the numbers of people referred to this national programme, to improve healthy weight in people with diabetes and hypertension.
- **Warm Homes** - working with local councils to support eligible individuals to access grants for home energy efficiency.
- **Maternity Social Prescribing** - raising awareness with families of the free services and support available during pregnancy and after their baby is born.

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- **Support for people living with Dementia** - linking up people living with dementia with our District and County Council partners to discuss help available to support their health and wellbeing and their carers.
- **NHS Health Checks** - increasing the numbers of eligible people who take up the offer of a NHS Health Check, to help prevent cardiovascular disease.

More details on our PHM strategy and our programme of work can be found on our Norfolk and Waveney ICS website: Population Health Management - Norfolk & Waveney Integrated Care System (ICS).

To better understand the health needs of our population and plan and deliver the PHM programme in an integrated way, we need to further develop our infrastructure that underpins it. The development of this infrastructure is closely linked to our Norfolk & Waveney ICS digital strategy.

Currently, data is mostly held within separate organisations, and this limits the ability to see the bigger picture. PHM will be optimised when we can join up data sources (including hospital, general practice and social care) to analyse need and plan care at a population level. This includes accessing linked-up data across our system using the ICS's new data hub. More details about how we are doing this can be found in our Digital Transformation Strategic Plan and Roadmap.

Clear and robust information governance systems and agreements enable us to share and analyse data safely and appropriately. As we develop our PHM programme, we will be ensuring that our cross-system information governance systems and safe access controls are clear and communicated to all partners and break down existing barriers to sharing data.

Access to such data will allow us to undertake sophisticated analysis, modelling future demand, and using techniques known as "population segmentation", "risk stratification" and "financial risk modelling"- identifying where we can make the most impact and supporting more personalised care. We will be supported to do this by skilled analytical support from our ICS-wide intelligence function. We will also be training our wider workforce to interpret the available information and identify their own, more local, priorities for action.

System Development

To create the change that we want to see and to make the most of the opportunity arising from becoming an Integrated Care System, it is vital that we look at and understand what needs changing in our governance, processes, leadership and culture. Information about our plans for developing and strengthening how our system works can be found in the following sections of this plan:

- **Neighbourhood level working**: Working at this very local level is a theme throughout our ambitions and underpinning objectives which are about ensuring provision is very accessible, is what our population needs, and finding out what matters most so it can be delivered as effectively as possible. The continued development of our integrated neighbourhood teams is an important part of this and our plans for developing these teams are set out in section 4.0 of our Joint Forward Plan, under Ambition 2: Primary Care Resilience and Transformation. Neighbourhood health guidelines are part of the 2025/26 operational planning resources with an expectation that these are progressed in advance of the publication of the 10 Year Health Plan.
- **Place level working**: Our place-based approach is set out in Section 6.1 of our JFP.
- **Closer working between providers of health and care services**: Our plans for working collaboratively are set out in Section 6.2 of our JFP.
- **Working with the Voluntary, Community and Social Enterprise (VCSE) sector**: Our plans for developing how we work with the sector, including through our VCSE Assembly, are set out in Section 6.7 of our JFP.
- **Improving the quality of care**: Our plans for how our system will build our capability to identify and address quality challenges are set out in the section about quality of services, included in these legal duties.
- **Our financial performance**: Our plans for how our system will build our capability to identify and address financial challenges are set out in our financial duties, included in these legal duties.
- **New models of care:** These plans are being developed and complement the work being undertaken through the New Hospital Programme to build two new hospitals: the James Paget and the Queen Elizabeth. Part 1 refers to new Models of Care.
- **Delivery of the JFP:** The JFP has been adopted by the ICB and system partners as a strategic vehicle for change. Getting behind the eight Ambitions to bring everything together and lean into these common Ambitions has been a helpful system development tool. System partners have cross referenced the JFP in their own strategies and plans and as part of provider collaboration.

Our Integrated Care Partnership (ICP) was built on the well-established Norfolk Health and Wellbeing Board, incorporating additional members from Suffolk to cover the Waveney part of our system and the chairs of our place boards to further strengthen the relationships and links between system and place level.

A significant amount of work was done in 2024/2025 on the ICB's organisational review. The new structure will enable the ICB to better support system working and collaboration. The structure takes account of the organisation's new functions and role as a convener of the system, as well as what we have collectively learnt since the organisation was formed in July 2022. While the review was challenging for the organisation and hard for staff, the benefits to the system and to local people will be felt in 2025/2026 and beyond.

For Norfolk and Waveney to be a really thriving system, staff need to be supported to work in different ways and this is why we have put in place a comprehensive organisational development programme for our system and for staff at all levels. Specific programmes of work have been developed for the ICB Board, the ICB's senior managers and the system's Executive Management Team, along with training packages and support for the wider workforce, all of which is complemented by the Clinical and Care Professionals' Leadership Programme.

This organisational development work started well before the Health and Care Act (2022) came into force and has played an important role as our system has moved towards greater collaboration over the past few years. The work will continue as our system develops and matures.

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Supporting wider social and economic development

We recognise our role as anchor institutions to explore opportunities to collaborate and influence the wider determinants of health within the heart of communities. This ranges from creating opportunities to listen and hear the voice of citizens, sharing data to alleviate respiratory conditions and improve the quality of housing, to accessing and signposting to partners' skills, training and employment pathways to grow our system's workforce and creating a vibrant local employment market.

Our Health Inequalities Strategic Framework for Action describes the role our system has in the social, economic and environmental factors that impact on health and wellbeing outcomes. It recognises the role of Anchor organisations, and there is a clear action for our ICS to undertake a baselining exercise to understand our current position and where we need to make improvements. We have established an NHS Anchor Leadership Group, which brings together leads from across the NHS, and we are utilising the 'How Strong is Your Anchor' toolkit developed by University College London partners to undertake this baselining exercising and develop a local Anchor Charter and Improvement Plan. As part of our NHS Anchor work, and alongside our VCSE Assembly, we will be developing a social value framework that informs our procurement and contracting approach.

We have established a 'Living and Working Conditions' leadership group responsible to our Integrated Care Partnership, which brings together local government, VCSE sector and health colleagues to progress our system approach to having positive impacts on the wider determinants of health.

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Working collaboratively with our partners in local government, health, Department of Work and Pensions and the VCSE sector we are building leadership capacity through the 'WorkWell' programme to establish an ICS work and health partnership and develop our future plans in response to the Government 'Get Britain Working White Paper'. A 'Health and Work Strategy Group' has been established to develop a system strategic plan for work and health integration, led by the ICB and Norfolk County Council and reporting to the 'Living and Working Conditions Group'. Our Community Voices programme is working with VCSE partners to build understanding of the barriers and enablers to workforce opportunities in primary and secondary care within Core20plus communities, to raise awareness of opportunities to support future employment practices.

We will utilise tools such as the Community Voices programme to listen to communities and empower them to be their own agents for change, utilising their insights to influence the services and interventions we develop.

This group connects the work of the eight Health and Wellbeing Partnerships (HWPs) which play a significant role in supporting decision making that reflects community need, assets and strengths, and are referenced in 6.1 of part 1 of the JFP. They provide a platform to engage a wide range of partners at a local level, that can support the design and transformation of services which support the wider determinants of health, whilst ensuring appropriate interconnectivity and integration at a local level. Place Boards support the integration of health and social care and have a role to play in the development and implementation of our Anchors Framework.

Through our HWPs and Place Boards strong equitable relationships exist with local government. Working together we can influence, support and add value to a wide range of programmes that seek to improve access to green spaces, provide access to our collective facilities to support health and wellbeing, support local regeneration and generally provide opportunities for residents to support their own health and wellbeing.

Norfolk and Waveney
Integrated Care Board

Agenda item:18

Subject:	**Commissioning & Performance Committee (CPC) Report**
Presented by:	**Hein van den Wildenberg, Non-Executive Member and Chair of CPC**
Prepared by:	**Diane Smith, Head of Collaborative Commissioning and Performance**
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 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 29th January 2025.

Committee:	Commissioning and Performance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update on 29th January 2025	Meeting held in private on 20th February 2025 0900 – 1200 via MS Teams. Verbal updates from the 23rd January 2025 meeting were shared at last ICB Board meeting in public, and where appropriate have been captured in here for completeness. A further CPC is scheduled for the 20th of March 2025. 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.

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	• 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: Board Assurance Framework (BAF) • 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 • BORR21 - Risk to CYP health due to long waiting times at NNUH for paediatric podiatry surgery • BORR22 - System wide gaps in Speech and Language Therapy Provision • BORR26 - ICB application of sustainable commissioning and compliance with procurement regulations Operational Risk Register (ORR)

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	• ORR10 - Tier 3 and 4 weight management. • ORR15 - System failure to meet access standards for cancer diagnosis and treatment It was noted that the move to InPhase to collate and provide a risk 'database' needs further development of simple view of risk when reports are pulled off the system and ensuring all risks have assigned individuals to update actions and controls. A risk summary paper has been developed to provide committee with an 'at a glance' view of proposed changes or escalations. There was suggestion to incorporate a very high-level highlight report to accompany this.
Key items for Board to take note of:	**1.** (January) The committee reviewed and approved Terms of Reference (ToR) for the working group 'Provider Performance and Planning Oversight Group' which feeds to Scheduled Care Board – these change reflect health inequalities and revised membership. **2.** The Performance Report was reviewed - please note that the Board will receive a further updated report but the meeting schedule means CPC meet 6 days prior to Board, therefore the following reflects discussion in February: ➢ **Elective**: - Improvement continued across the period, with reducing numbers of people experiencing long waits, however this remains behind the nationally set ambition. The complexity of needs can make scheduling challenging, but each Trust has active pathway management in place. This is supported by NHS England through the *'tiering'* meetings for which all our hospitals are in a tiering support mechanism. - Working through planning and new standards, while continuing to work through long waits – as we head in March with a number of people still experiencing a 65-week wait. Planning has shown we have a significant amount to do to achieve an 18-week position while we maintain a focus on long waiting times also. Norfolk and Waveney performance against the 18-week standard can be seen in the performance pack. ➢ **Cancer**: An improvement was also seen in Cancer waiting times, with delivery against the 28-day Faster Diagnostic Standard improving by 2.5 percentage points. Variance across providers and specialities remains. ➢ **Diagnostics:** times remain challenging across the system. While planning for 2025/26 does not require this metric to continue, locally the diagnostics timeframe is a key determinant of other areas of performance as well as

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	patient outcomes and satisfaction, therefore will remain a key focus in the system. A deep-dive into diagnostics was received by the sub-group, Provider Performance and Planning Oversight Group. ➢ **Mental health**: Daily review of inappropriate Out of Area Placements remains in place, with very senior approval of any placements out of area and recruitment for a lead clinician to support patient flow. A bed audit is currently underway to learn where to re-focus efforts and inform the next steps. An internal review of Dementia assessment clinics, the procedures and capacity across the Norfolk and Waveney teams is underway. ➢ **Community**: work continues to ensure accurate and informative reporting of community performance position. ➢ **Learning Disability and Autism:** A further inpatient admission during the period of reporting. Discharges are reliant on having access to appropriate accommodation and a healthy care market. National ambition is to reduce to 29 people in admission by the end of March 2025. ➢ **Urgent & Emergency Care (UEC)**: Plans have been in place to manage pressure and it's impact, and there is now a review of effectiveness those plans is underway. Connection with community to support alternatives to admission is particularly important for category-2 ambulance response performance. A focus on whole system 'flow' is important, with potential focus on key population groups at high risk of admission. Latest data reflects challenges with infectious disease impacting patients and staff through the festive period. ➢ **Children and Young People (CYP):** There is an ongoing focus on long-waits. Collaboration with VCSE and Local Authority partners was highlighted as being a highly effective aspect of models of support. ➢ **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:** There was no representation available for the February meeting. It was noted that utilisation of most specialised beds for mental health and learning disabilities and autism is also higher than planned. There is a further meeting of the JCC at the end of February. ➢ Work continues with reporting leads, Business Intelligence teams and the Commissioning and Performance team to develop a report which will include

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	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. This will include prompts for subject area leads completing the narrative aspects to consider the quality and health inequalities associated with the performance measure. The new format will also connect performance metrics with the Board Assurance Framework and Constitutional performance areas. 3. **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. 4. **Planning:** Planning is moving quickly since publication of first guidance documents 28th January. The committee noted that sequencing of steps to enable a collective view and triangulation of information is key. Planning leads outlined the timeline for the 'draft' and final submissions (27/02/2025 and 27/03/2025 respectively) and the closer alignment of timelines for the submission of the Better Care Fund. The committee noted that challenges presented by the planning for 2025/26 are of a scale that are beyond being achieved by individual organisations taking action in isolation, and that a system approach will be vital to success. There was further emphasis made on ensuring interdependencies are considered and risks of unintended consequences of decisions are minimised through collective review and decision making. 5. **Delegation of Specialised Commissioning:** the ICB is currently finalising the delegation agreement for 2025/26 – this is where NHSE transfers the power and commissioning authority for further specialised commissioning activities. 6. **Joint Forward Plan (JFP):** The ICB is currently refreshing the JFP as per annual cycle and reflecting the three shifts set out nationally – hospital to community; analogue to digital; treatment to prevention. The NHS ten-year plan is expected to be published in the spring and may impact future focus. 7. **New Models of Care:** Discussions are active at the time of the committee between provider and ICB Chief

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	Executive Officers to develop an approach to New Models of Care that is an appropriate 'fit' for Norfolk and Waveney. This will need to tie in several live system-wide pieces of work. Further clarity is expected through March. 8. **Escalations** January: Scheduled Care Board identified escalations to the Committee. No other programme boards identified escalations. Representatives of other programme boards have been asked to ensure the committee is the recognised escalation route to the Board and utilised appropriately. February: Medicines Optimisation Programme Board shared an escalation report to highlight potential pressures resulting from NICE guidance, though none were formally escalated to the committee for support. 9. **Performance Management Framework (PMF):** The January committee received and reviewed the PMF and supported sign-off of this, with a planned review 6-months from agreement at the Board to reflect planning changes for 2025/26 and reflect operational learning. The PMF was subsequently reviewed by Quality and Safety and Primary Care Commissioning Committee to ensure comprehensive cover for all areas with performance oversight. The March 2025 Board will be asked to ratify for publication. 10. **Policy audit:** Committee received a report from the corporate governance team outlining the policies in remit for oversight at C&PC – none are currently due for review. The February committee deferred a review of the Patient Choice Policy to enable alignment with recently published guidance '*National elective access policy*'. 11. **Committee in public**: discussion in January committee identified the intention for the committee to hold a part in public would be established with a target implementation of May 2025.
Items requiring formal approval of Board:	None
Confirmation that the	Yes.

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meeting was quorate:	

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.

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NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 19

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**Hein van den Wildenberg, Non-Executive Member and Deputy Chair of PCCC**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 2025**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee from the March 2025 committee meeting.

Committee:	Primary Care Commissioning Committee
Committee Chair:	Ian Wake, Local Authority Member
Meetings since the previous update on 29 January 2025	11 March 2025.
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, and since 1 April 2023 the commissioning of dental, pharmaceutical and optometry services under a Delegation Agreement with NHS England. All committee papers can be found here.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks	**BAF02 – Primary Care Resilience and Transformation Inphase 00000032** **Current mitigated score – 5x4=20**

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relevant / aligned to this Committee:	Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities. Our high-level outputs include: • Developing a vision for providing accessible enhanced primary care services • Improving patient outcomes and experience • Stabilise dental services and setting a strategic direction for the next five years Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals. There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores. The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers. Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population. This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services.

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	As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers. **BORR08 – secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services) Inphase 00000029** **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 Inphase 00000025** **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 Inphase 00000023** **Current mitigated score – 4x4=16** • There is a risk to the resilience of general practice due to several factors including workforce pressures and increasing workload (including workload associated with secondary care interface issues).

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	• There is also evidence of continuing poor behaviour from patients towards practice staff, leading to retention and recruitment issues. • There is an increasing risk of collective action following the BMA referendum where the GP contract and associated uplift was rejected. Writing referral letters (rather than using standard forms) and applying working limits of 25 face to face appointments per day per clinician appear to be the most common actions adopted in the early weeks of action. • The national GP contract price uplift does not cover the required increase in meeting the minimum wage. The DDRB recommendation has been accepted and will be paid in September payments. • The LMC has written to practices to cease uncommissioned work associated with MGUS monitoring and Advice and Guidance. Further communications are likely. • Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. • This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience. • This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services. **BORR27 The resilience of Community Pharmacy Inphase 00000056** **Current mitigated score – 4x4=16** • Identified as a risk on 1st September 2024 and introduce to GPCPODG in October 2024. Formal summary provided to the Primary Care committee on 11th March 2025. • There is a risk to the resilience of community pharmacy due to several factors including financial viability and workforce pressures listed below • The current Community Pharmacy Contractual Framework (CPCF) remains in negotiation with the

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	Department of Health. The future of Pharmacy funding and the commissioning landscape remains uncertain reducing the ability for both the ICB and contractors to strategically plan for the future. It is important to acknowledge that community pharmacy are almost totally reliant on the funding received from the CPCF with no additional funding for estates, digital or training provided leaving them more financially vulnerable. • The introduction of an unsustainable contract could ultimately lead to an increase in the number of permanent pharmacy closures within the ICB which reduces the accessibility of pharmacy services to our population. It could also lead to a reduction in service provision including both core and advanced • The uncertainty around the new funding arrangements has led to a NPA ballot around collective action which was supported by over 90% of all voters. The collective action confirmation remains on hold until the new contract is formally announced. This could see a reduction on opening hours and a reduction in non-contractual services such as delivery services and the provision of compliance aids which could have significant patient impact. • Medicines supply shortages are not only causing additional workload but, in many cases, medicines are having to be dispensed at loss with the prices being above that of the drug tariff price, again leading to financial uncertainty. Almost 64% of contractors surveyed by Community Pharmacy England (CPE) say they are operating at a loss. • The community Pharmacy workforce is unstable with a high vacancy rate. Increasing focus is on the provision of clinical services, which requires workforce transformation. This is complicated by the economic pressures and uncertainty for providers. • The rurality of Norfolk and Waveney does mean that this risk is significantly projected due to the geographical distance between existing providers
Key items for assurance/noting:	Members received reports on the following areas: • **A strategic digital report** was noted. Updates were provided on the progress of the infrastructure upgrade programme, the delivery of Cloud-based Telephony to 86 practices as part of the improving access programme and noted 58% of eligible

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	patients (over 548k people) now have the NHS App. • **Primary Care Workforce Recruitment and Retention Programme Strategic Report** was noted and members were impressed at the breadth and success of the work programme delivered to date. 93% of GP practices are now learning organisations which has increased both our placement capacity for medical students and our GP educators by 25%. • **NHS Planning Guidance for primary care** was noted along with the timeframes for submission. The focus for primary care was on improving access to general practice and dental appointments. • **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 10 was forecasting an £8.9m overspend. This was mainly due to unidentified efficiencies in prescribing, the ARRS budget (due to receive £3.75m in Month 11) and prior year commitments in LCS spend. • **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.
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 medicines management risk was transferred to the Commissioning and Performance Committee. A new risk for special care dentistry was approved and would be added to the ORR. The impact of national insurance increases across all 4 primary care contractor groups would be monitored in relation to the resilience risks. • **Henoch Schonlein Purpura LES** – members approved a new LES which would support practices in providing monitoring for children with this condition. This would be rolled out from 1 April. • **Terms of Reference** – members approved minor revisions to the ToRs to reflect Pharmacy First, to clarify local authority membership for Norfolk and

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	Suffolk County Councils and to clarify the wider strategic primary care responsibilities and assurance role of the Committee. These would now go to Board for approval.
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: Hein van den Wildenberg, ICB Board non-executive member, Deputy Chair Patricia D'Orsi, executive director of nursing, ICB 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

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Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

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Norfolk and Waveney
Integrated Care Board

Agenda item: 20

Subject:	**Governance Handbook - Proposed Changes**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Heidi Davey, Head of Corporate Governance**
Submitted to:	**ICB Board Meeting**
Date:	**26 March 2025**

Purpose of paper:

The ICB Board is being asked to approve amendments to the Governance Handbook's to include detail of individual role responsibilities to authenticate the ICB Seal and updates to the Conflicts of Interest Policy following updated guidance issued by NHSE in September 2024.

Executive Summary:

Introduction
The Governance Handbook is designed to support and supplement the ICB Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The approved version of this document will become version 9.

Changes made to the document are summarized below:

Sections 1 – 4 – no change

Section 5 - Scheme of Reservation and Delegation

This section sets out the functions reserved to the Board, functions delegated to an individual or Committees and functions delegated to other bodies or to be exercised jointly.

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Changes have been made to the section titled 'decisions and functions delegated by the board to individual board members and employees' to include permissions to

authenticate the use of the ICB seal to the Chief Executive, Executive Director of Finance and the ICB Chair. In addition, noting that the Chief Executive is responsible for establishing a procedure for the use of the seal and to keep (or nominate a manager to keep) the seal secure.

Sections 6 and 7 – no changes

Section 8 updates to the Conflicts of Interest Policy

The ICB's policy has been reviewed and updated following an update published to NHS England's Managing Conflicts of Interest in the NHS guidance.

The following changes have been made and are now included within the policy:

Section 11: Management in common situations	• Narrative added advising that prizes (cash and cash alternatives) must not be accepted by ICB staff or anyone working for or representing them. A trophy or accolade may be accepted. This has been included in the policy following learning after an issue arose in late 2024. • A new section has been added in relation to Clinical Private Practice.
Section 14. Managing Conflicts of Interest through the Commissioning Cycle	• Information added in relation to the Provider Selection Regime (PSR).
Section 15. Joint working	• Narrative added to confirm that Joint Committees need to clearly document governance arrangements to ensure conflicts of interest are identified.
Appendix A: DOI template	• The template has been updated to reflect the version used for this year's DOI collection.

The Committee of Interest Committee approved the changes at the meeting of 6 February 2025.

Sections 9 onward – no change

Appendix A – Primary Care Commissioning Committee Terms of Reference
The proposed minor amendments to the Primary Care Commissioning Committee Terms of reference are designed to ensure flexibility for Local Authority representatives from Norfolk and Suffolk respectively and to clarify the wider strategic primary care responsibilities and assurance role of the Committee.

Proposed changes to the current terms of reference are as follows:

Attendees

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4.6 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings subject to s.4.7:

- ICB Board Partner Member – Providers of Primary Medical Services

- Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
- Executive Director of Patients and Communities
- Director of Primary Care
- One practice manager (or other suitably experienced individual) from primary medical services and one individual from (NHS) primary dental services
- Representatives from Local Authority Public Health teams in Norfolk and Suffolk
- Healthwatch Norfolk
- Healthwatch Suffolk
- Local Authority representative – Norfolk
- Local Authority representative – Suffolk

Section 6.1

NHS England has delegated to the ICB authority to exercise the primary care commissioning functions in accordance with section 13Z of the NHS Act with specific obligations set out in Schedule 2 of the Delegation Agreement and general obligations set out below:

In delivering its responsibilities set out below, the Committee is responsible for delivery and oversight of the following

- The primary care strategic framework,
- Joint Forward Plan for primary care aims;
- annual NHS England Operational Plan relating to primary care; and
- assurance with NHS England Primary Care Commissioning Assurance Framework.

Schedule 2D: Pharmaceutical services and local pharmaceutical services

Norfolk and Waveney ICB remains responsible and accountable for the provision of this service and for the direct commissioning, management and quality of local pharmaceutical services and commissioning of Pharmacy First services in Norfolk and Waveney.

Appendix B – Commissioning and Performance Committee Terms of Reference

The proposed minor amendments to the Commissioning and Performance Committee terms of reference are designed to ensure that information governance, cyber security and high-risk operational risks and any mitigation plans are reviewed by the Committee.

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Proposed changes to the current terms of reference are as follows:

6.9 The Committee will review and monitor those risks on the Board Assurance Framework and Board Operational Register which relate to commissioning and performance, information governance, cyber security and high-risk operational risks

and ensure the ICB is kept informed of significant risks and mitigation plans in a timely manner.

Recommendation to the Board:

The Board is asked to approve the amendments to the ICB Governance Handbook as detailed in the report above.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining it's reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

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

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Agenda item: 21

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:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 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 January 2025. Since then, many teams have been reviewing and updating their risks.

Please find attached a copy of the following (as at 17 March 2025):

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

The ICB has now gone live in using Inphase. Therefore, the risk reference numbers below now relate to the Inphase system.

Attention is directed towards the following notable changes:

Board Assurance Framework (BAF)

Risk	Changes/actions required
Ref 8 (BAF01): Health inequalities and Population Health Management	• **Risk not reviewed in month**
Ref 32 (BAF02): Primary Care Resilience and Transformation	• Risk reviewed in month
Ref 7 (BAF03): Barriers to full delivery of the Mental health transformation programme (CYP)	• Target delivery date overdue (30/11/2024)
Ref 6 (BAF04): Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	• Risk reviewed in month
Ref 31 (BAF05): Increasing numbers of older people with complex health needs in Norfolk & Waveney	• Risk reviewed in month

Ref 3 (BAF06): System / Urgent & Emergency Care (UEC) Pressures	• **Risk not reviewed in month**
Ref 10 (BAF07): Elective Recovery	• Risk reviewed in month
Ref 27 (BAF08): Achieve the 2024/25 financial plan	• Risk reviewed in month

Recommendation to the Board:

The Board are asked to note the contents of this paper.

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

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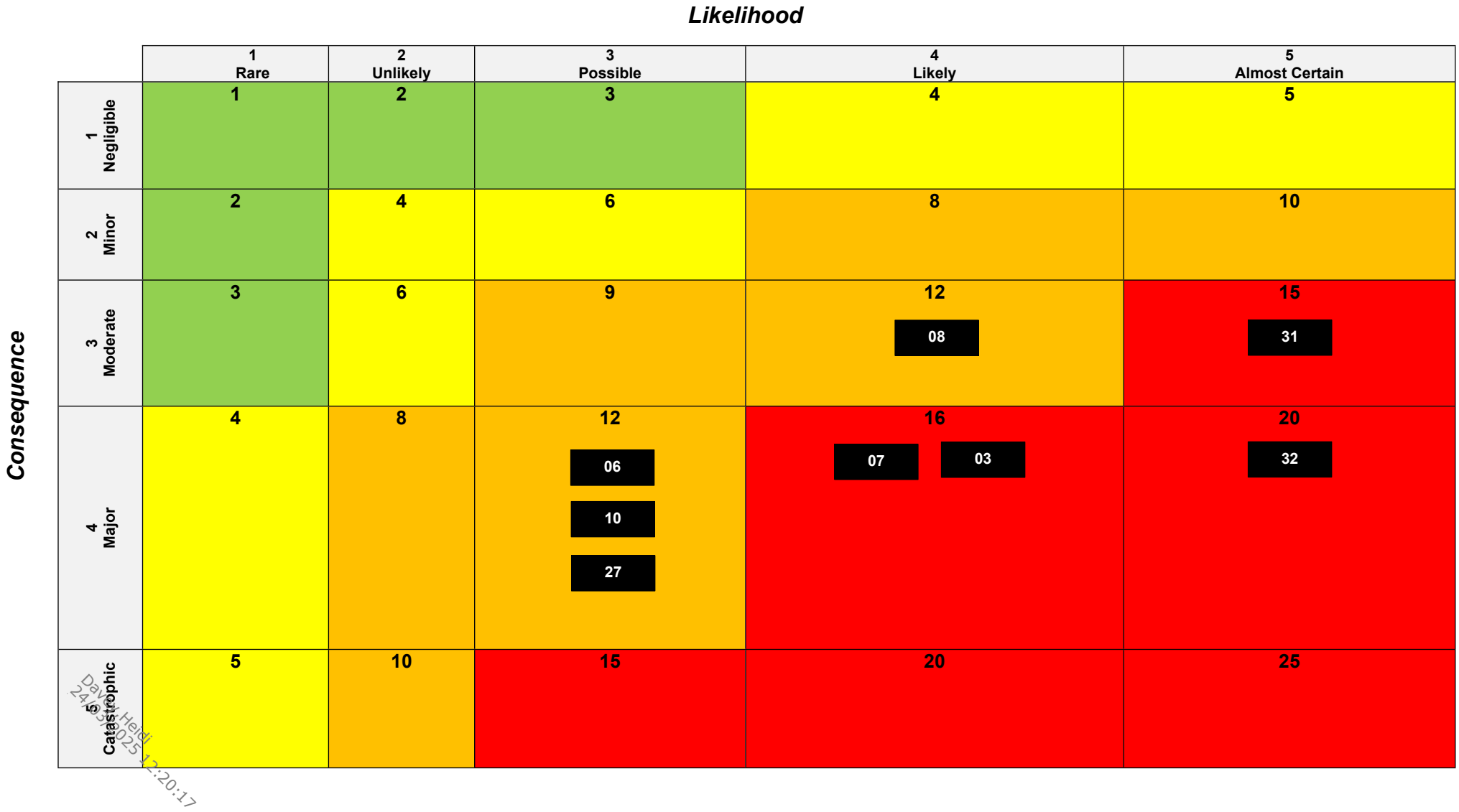
Appendix 2: Risk visual

Board Assurance Framework risks
Board Operational Risk Register risks



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NWICB - Board Assurance Framework Summary page

Risk Id	Risk Title
Ambition 1: Population Health Management, Reducing Inequalities and Supporting Pr	
8	Health inequalities and Population Health Management
Ambition 2: Primary Care Resilience and Transformation	
32	Primary Care Resilience and Transformation
Ambition 3: Improving Services for Babies, Children and Young People and Developi	
7	Barriers to full delivery of the Mental health transformation programme
Ambition 4: Transforming Mental Health Services – Adult Mental Health	
6	Barriers to delivering equitable, safe and consistent care in adult ment
Ambition 5: Transforming Care in Later Life	
31	Increasing numbers of older people with complex health needs in Norfolk
Ambition 6: Improving Urgent and Emergency Care	
3	System / Urgent & Emergency Care (UEC) Pressures
Ambition 7: Elective Recovery and Improvement	
10	Elective Recovery
Ambition 8: Improving Productivity and Efficiency	
27	Achieve the 2024/25 financial plan

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Risk Owner	Risk Committee	Date Risk Identified	Target Delivery Date	Target Score	1
evention					
Frankie Sword	Patients and Communities Committee	01-jul-22	31-mar-25	4	12
Mark Burgis	Primary Care Commissioning Committee	29-aug-24	31-mar-27	12	
ng Our Local Maternity and Neonatal System (LMNS)					
Tricia D'orsi	Commissioning and Performance Committe	01-jul-22	30-nov-24	8	16
Jocelyn Pike	Commissioning and Performance Committe	01-jul-22	31-mar-25	8	16
Frankie Sword	Patients and Communities Committee	20-jun-24	31-mar-28	12	
Mark Burgis	Commissioning and Performance Committe	01-jul-22	31-mar-25	12	16
Andrew Palmer	Commissioning and Performance Committe	01-des-22	31-mar-25	12	12
Steven Course	Finance Committee	10-mai-23	31-mar-25	12	12

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2024 - 2025 Monthly Risk Rating										
2	3	4	5	6	7	8	9	10	11	12
12	12	12	12	12	12	12	12	12	12	
			New	20	20	20	20	20	20	
16	16	16	16	16	16	16	16	16	16	
16	16	16	16	16	16	16	16	12	12	
	New	15	15	15	15	15	15	15	15	
16	16	16	16	16	16	16	16	16	16	
12	12	12	12	12	12	12	12	12	12	
12	12	12	12	12	12	12	12	12	12	

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NWICB Board Assura

Risk Id	Risk Title
3	System / Urgent & Emergency Care (UEC) Pressures

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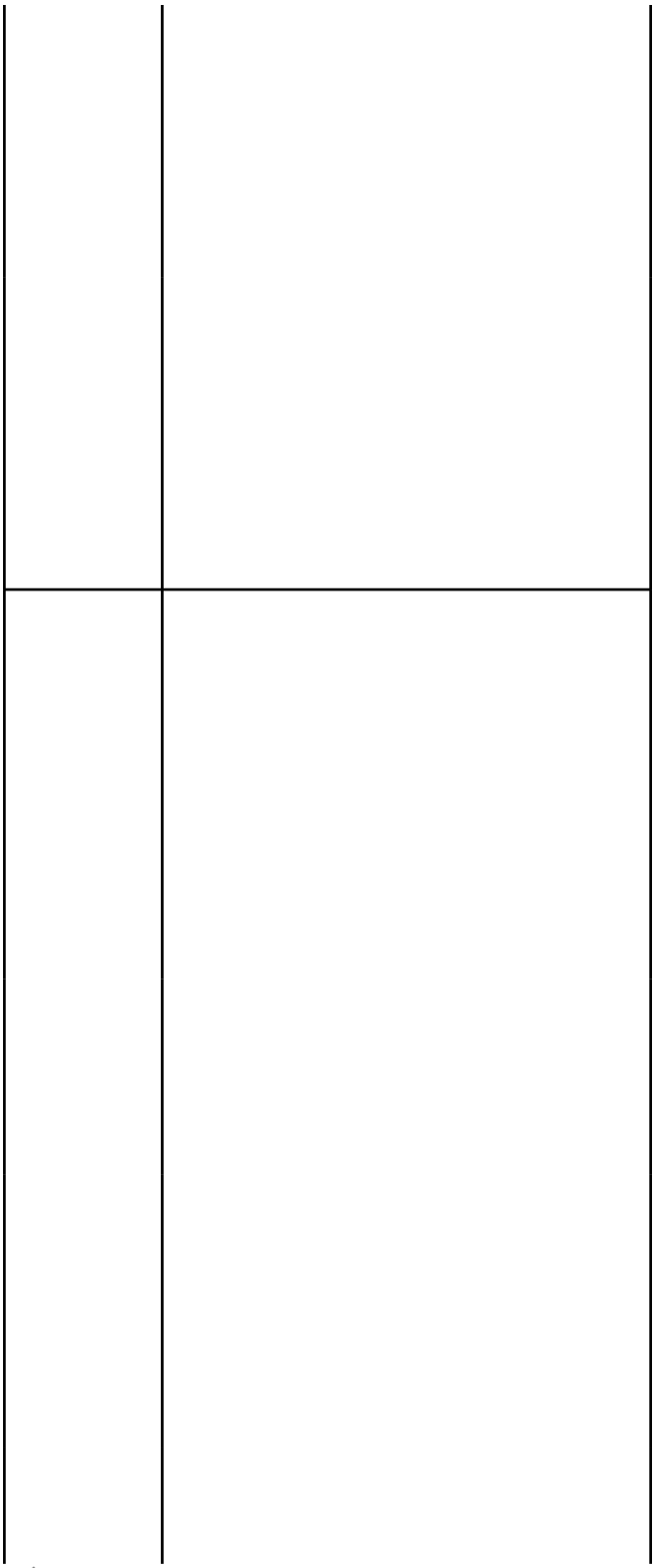

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6	Barriers to delivering equitable, safe and consistent care in adult mental health

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7	Barriers to full delivery of the Mental health transformation programme (CYP)	

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8	Health inequalities and Population Health Management

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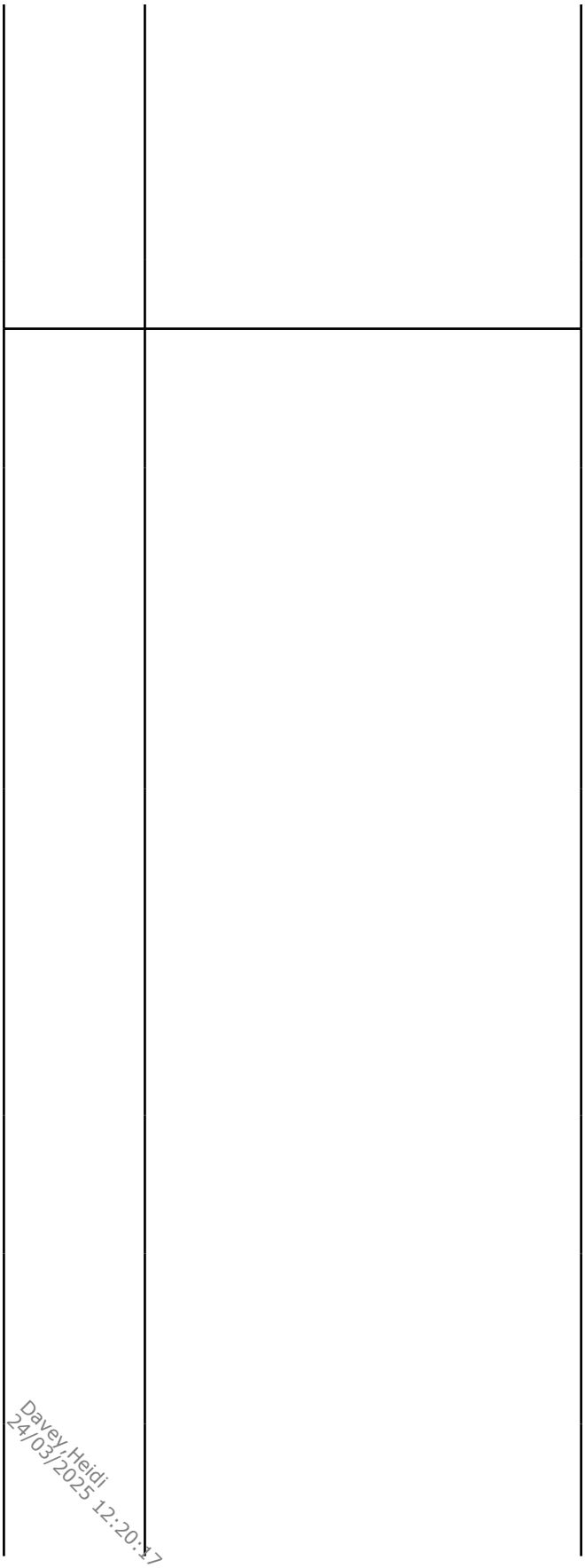

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10	Elective Recovery
27	Achieve the 2024/25 financial plan

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31	Increasing numbers of older people with complex health needs in Norfolk & Waveney

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32	Primary Care Resilience and Transformation

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ance Framework

Description

There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity in the right care setting to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms.

This could lead to worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside.' The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed. In turn, this congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls

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unable to be released to respond to 999 calls.

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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

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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

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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

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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

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.

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.

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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

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

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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.

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Risk Owner	Risk Committee	Operational Lead	Date Risk Identified
Mark Burgis	Commissioning and Performance Committee	Ross Collett	01-jul-22

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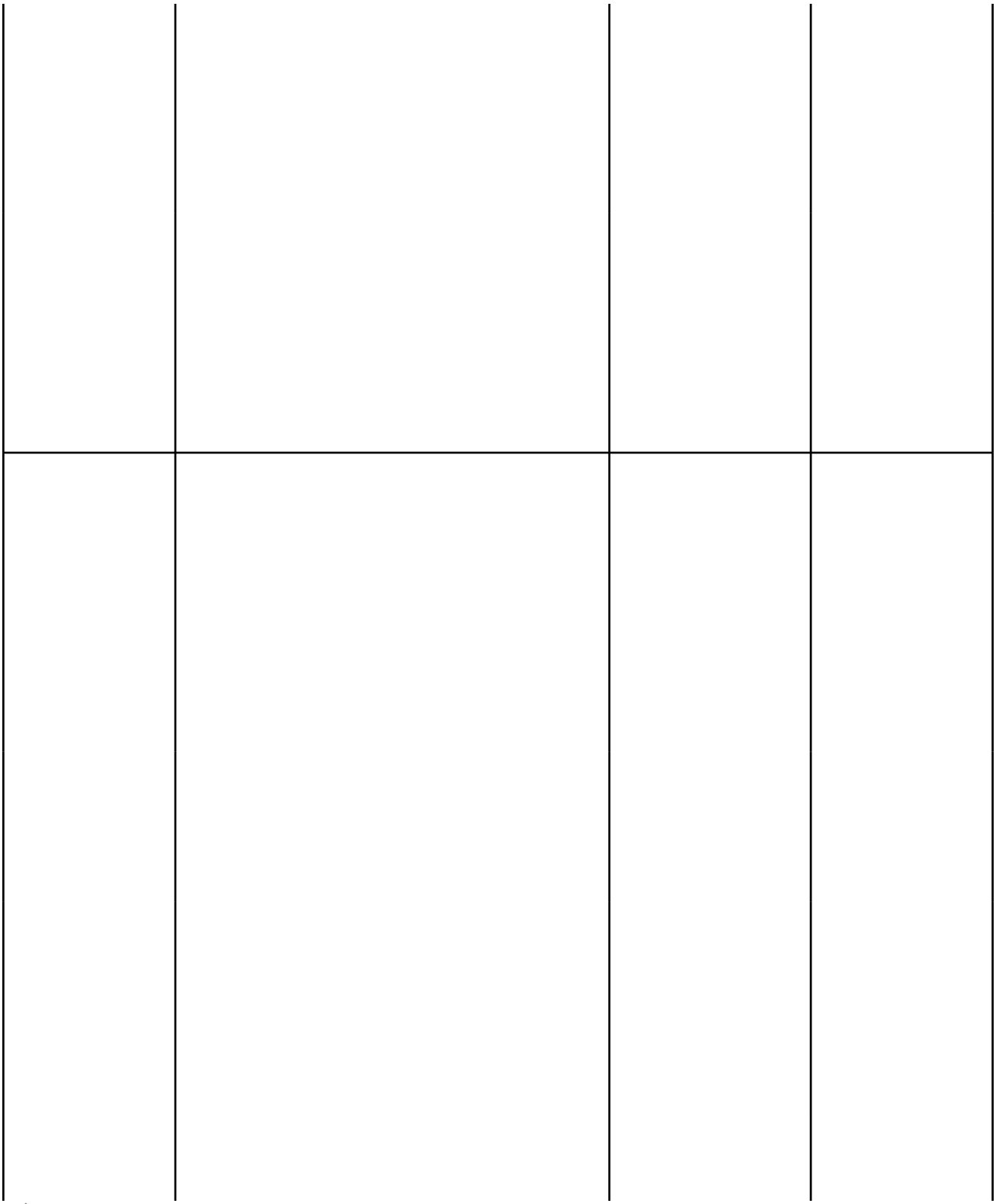

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Jocelyn Pike	Commissioning and Performance Committee	Mark Payne	01-jul-22

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Tricia D'orsi	Commissioning and Performance Committee	Rebecca Hulme	01-jul-22

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Frankie Swords	Patients and Communities Committee	Suzanne Meredith	01-jul-22

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Matt Dooley	Commissioning and Performance Committee	Diane Smith	01-des-22
Steven Course	Finance Committee	Emma Kriehn-Morris	10-mai-23

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Frankie Swords	Patients and Communities Committee	Janice Shirley	20-jun-24

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Mark Burgis	Primary Care Commissioning Committee	Sadie Parker	29-aug-24

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Target Delivery Date	Unmitigated Score	Mitigated Score	Target Score
31-mar-25	20	16	12

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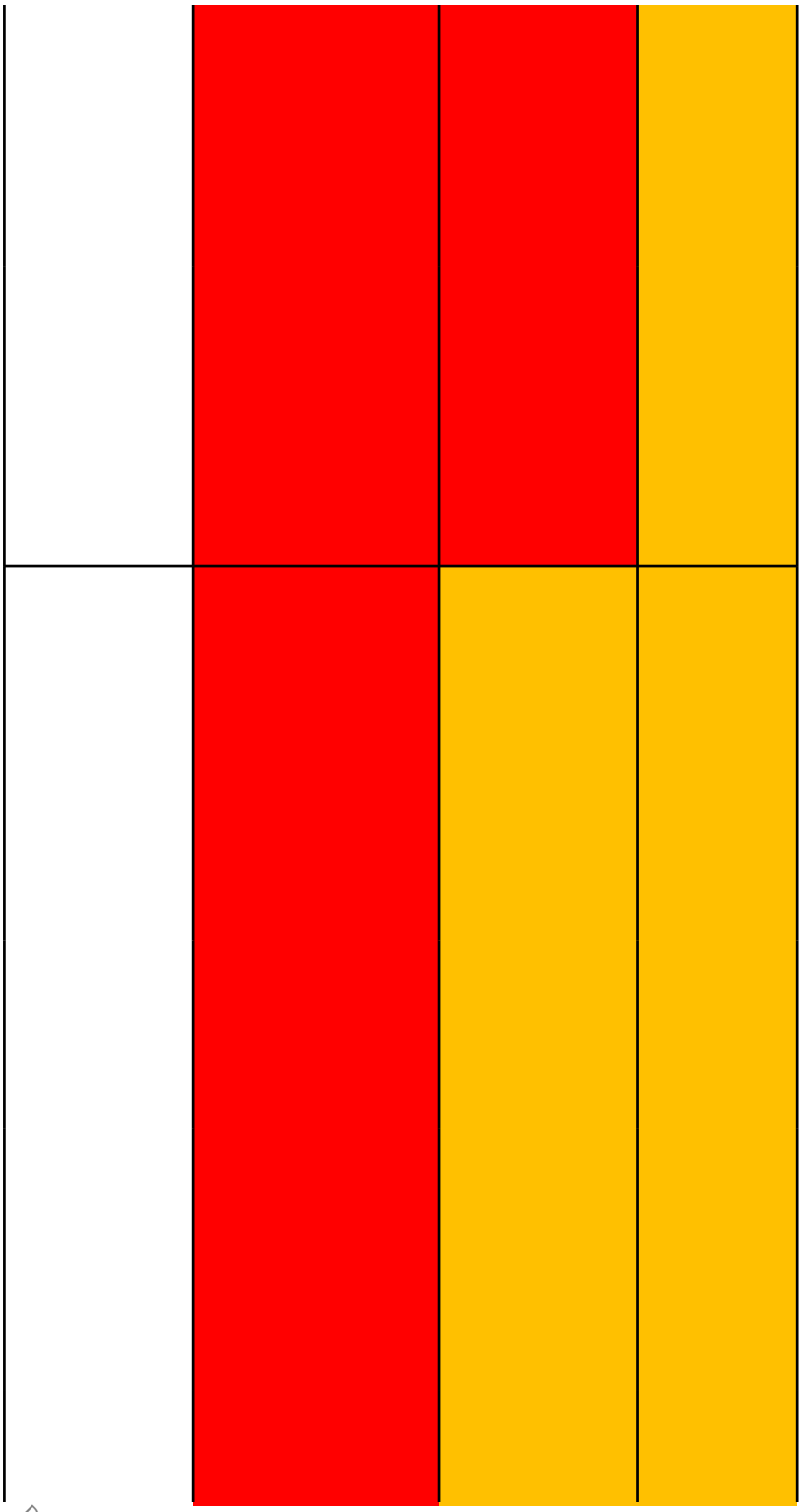

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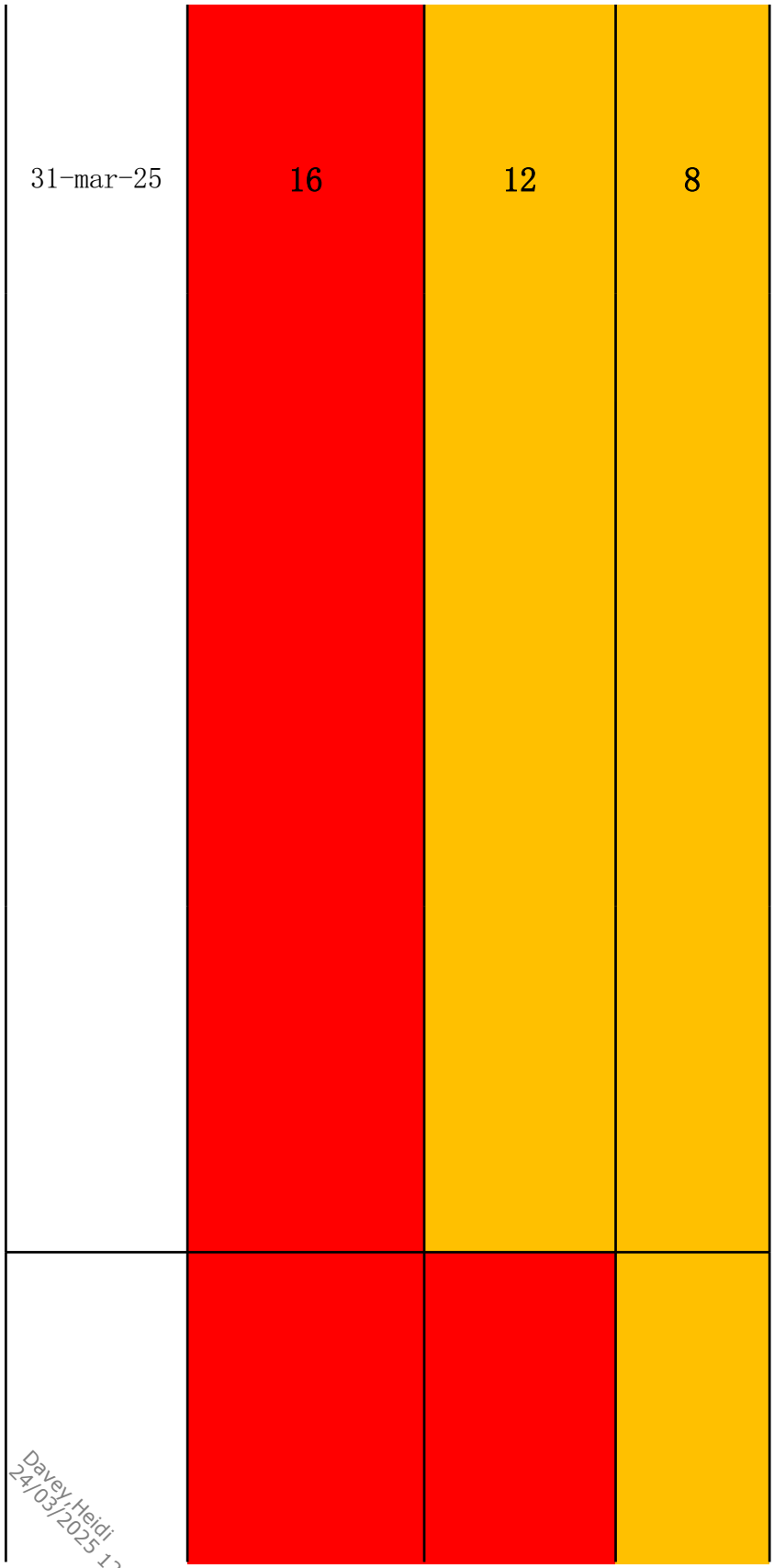
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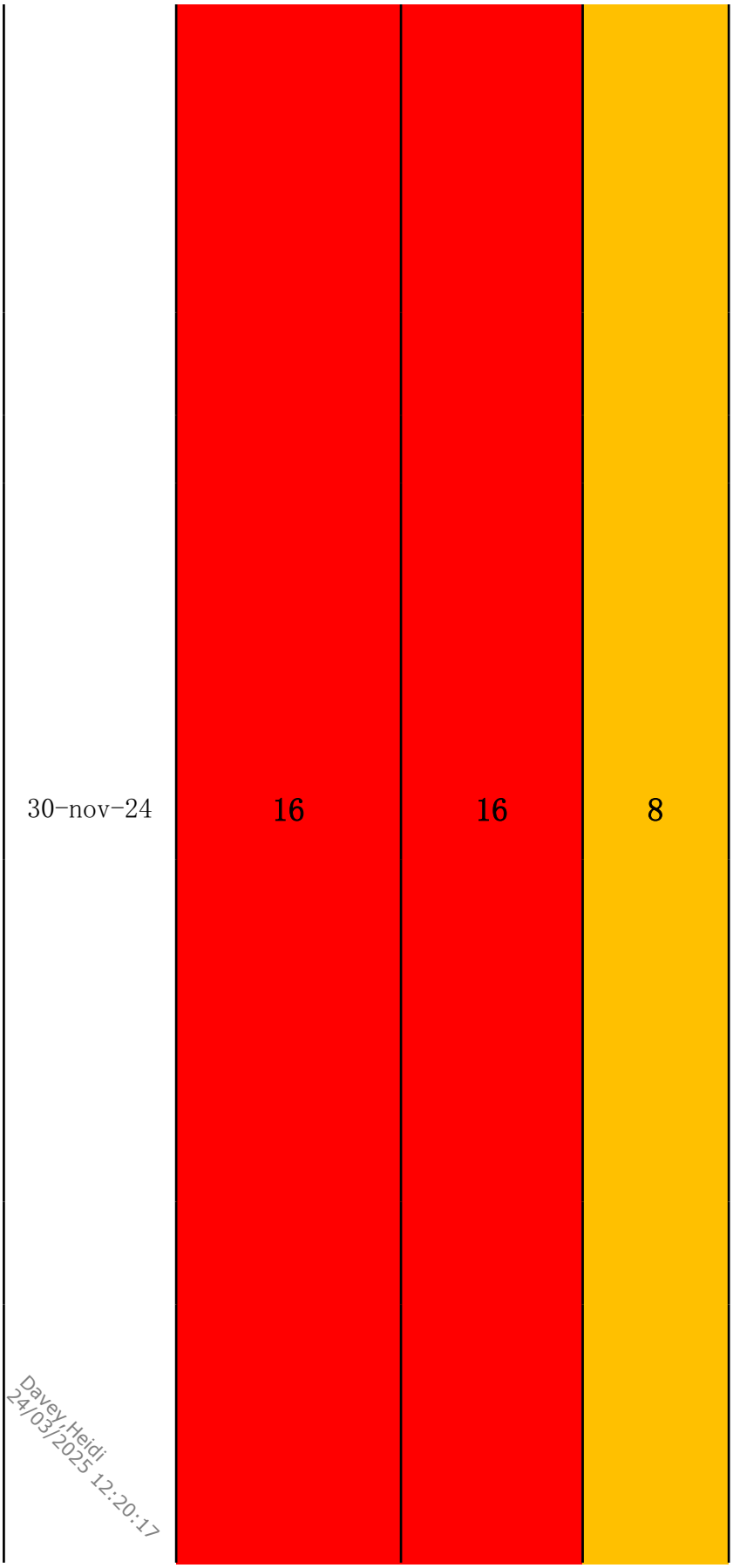
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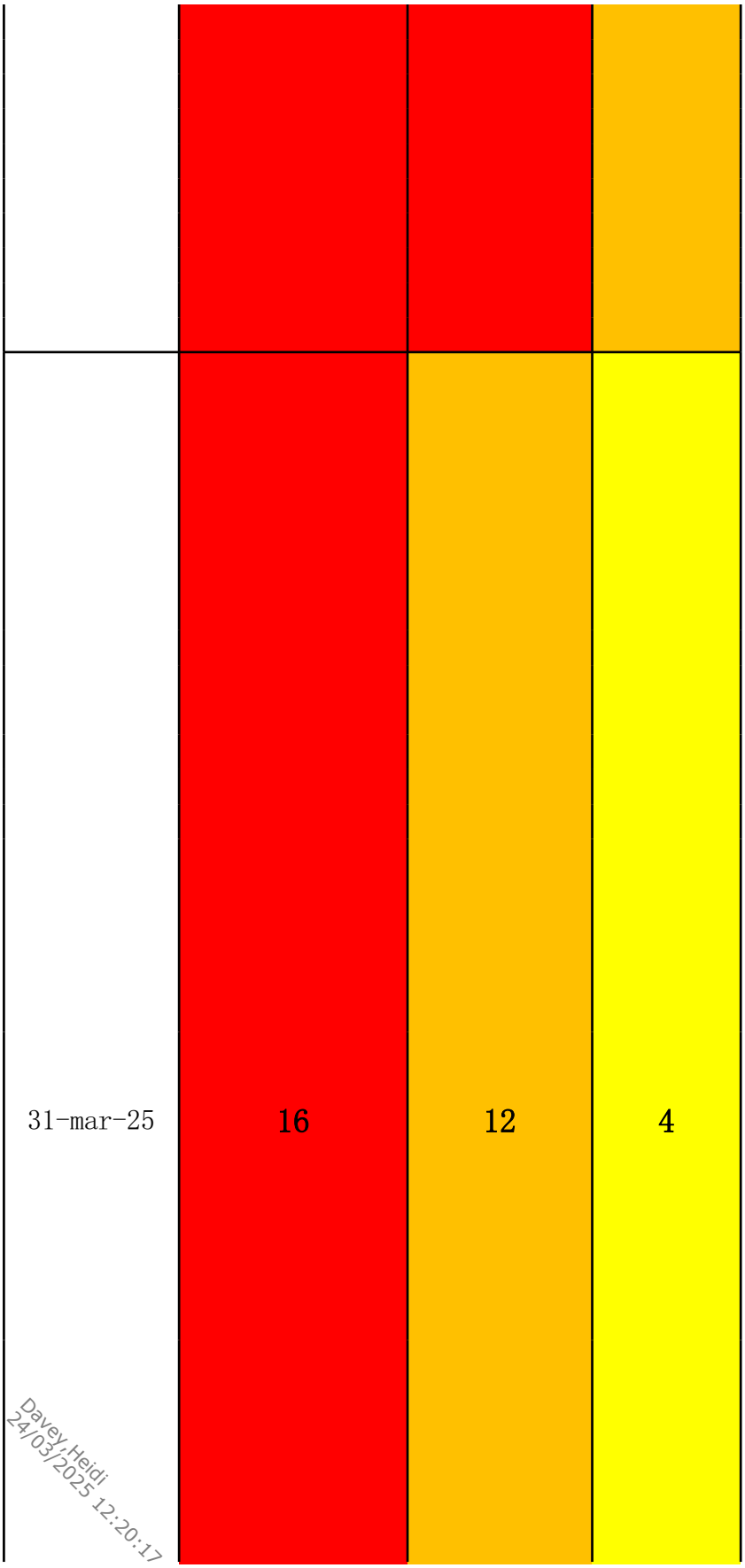
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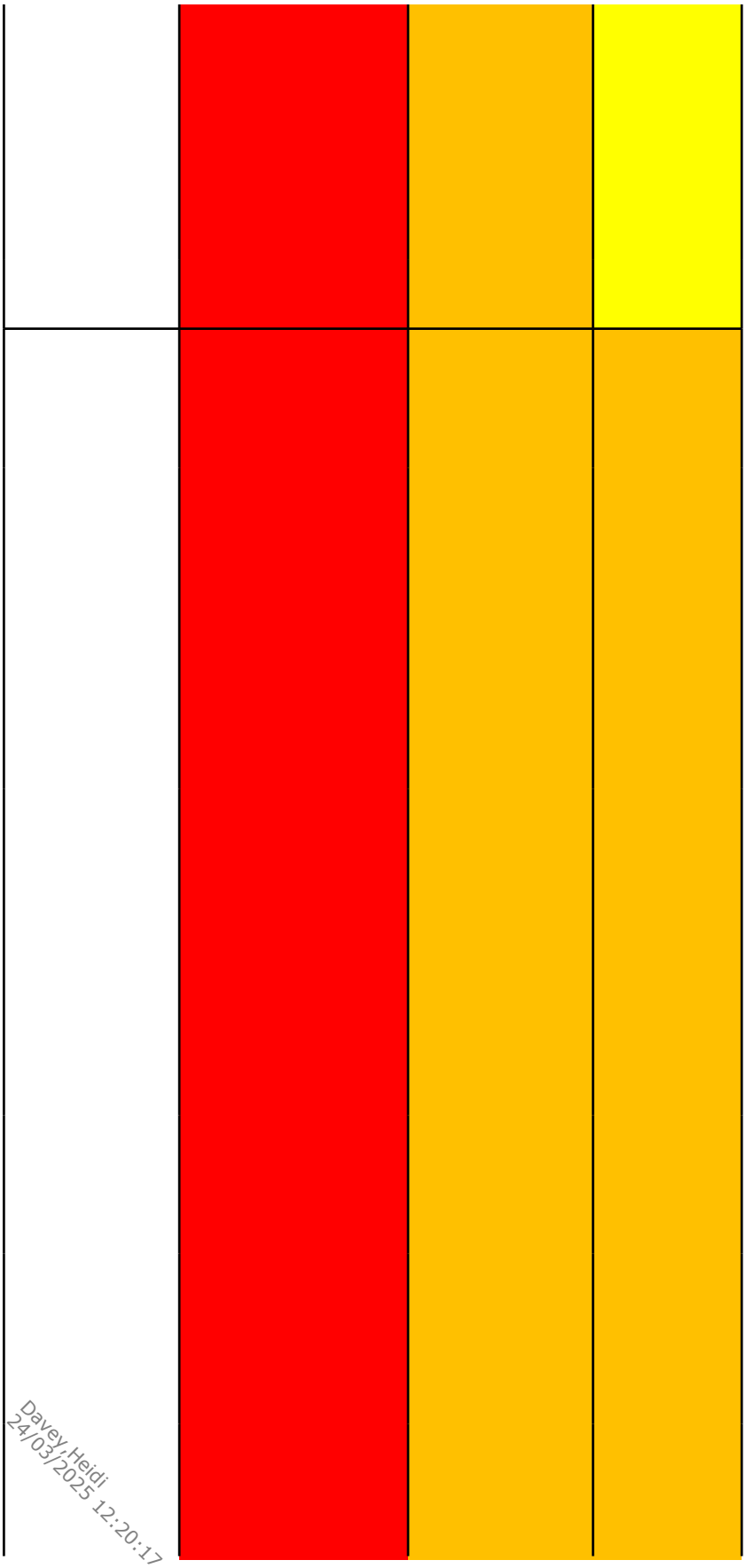
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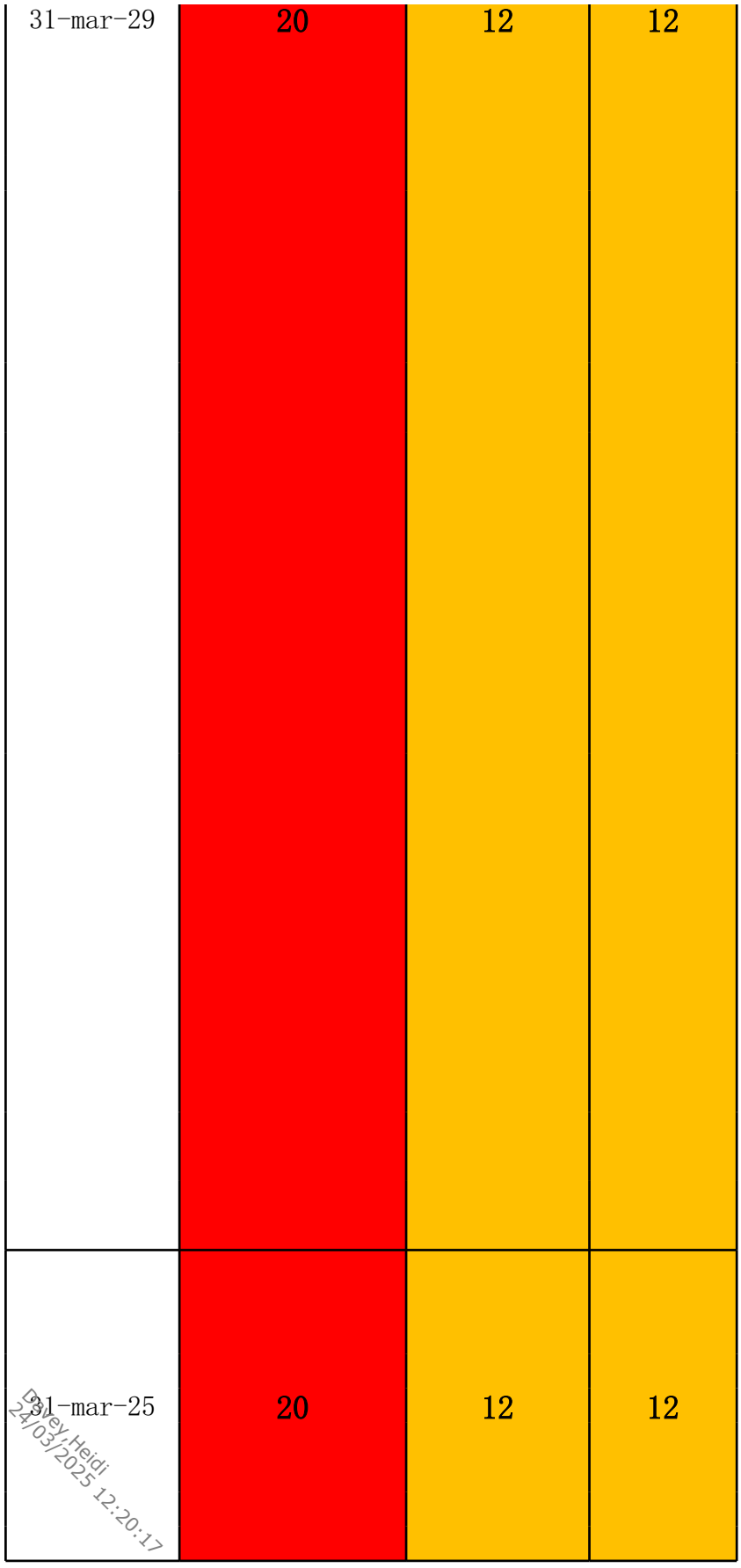
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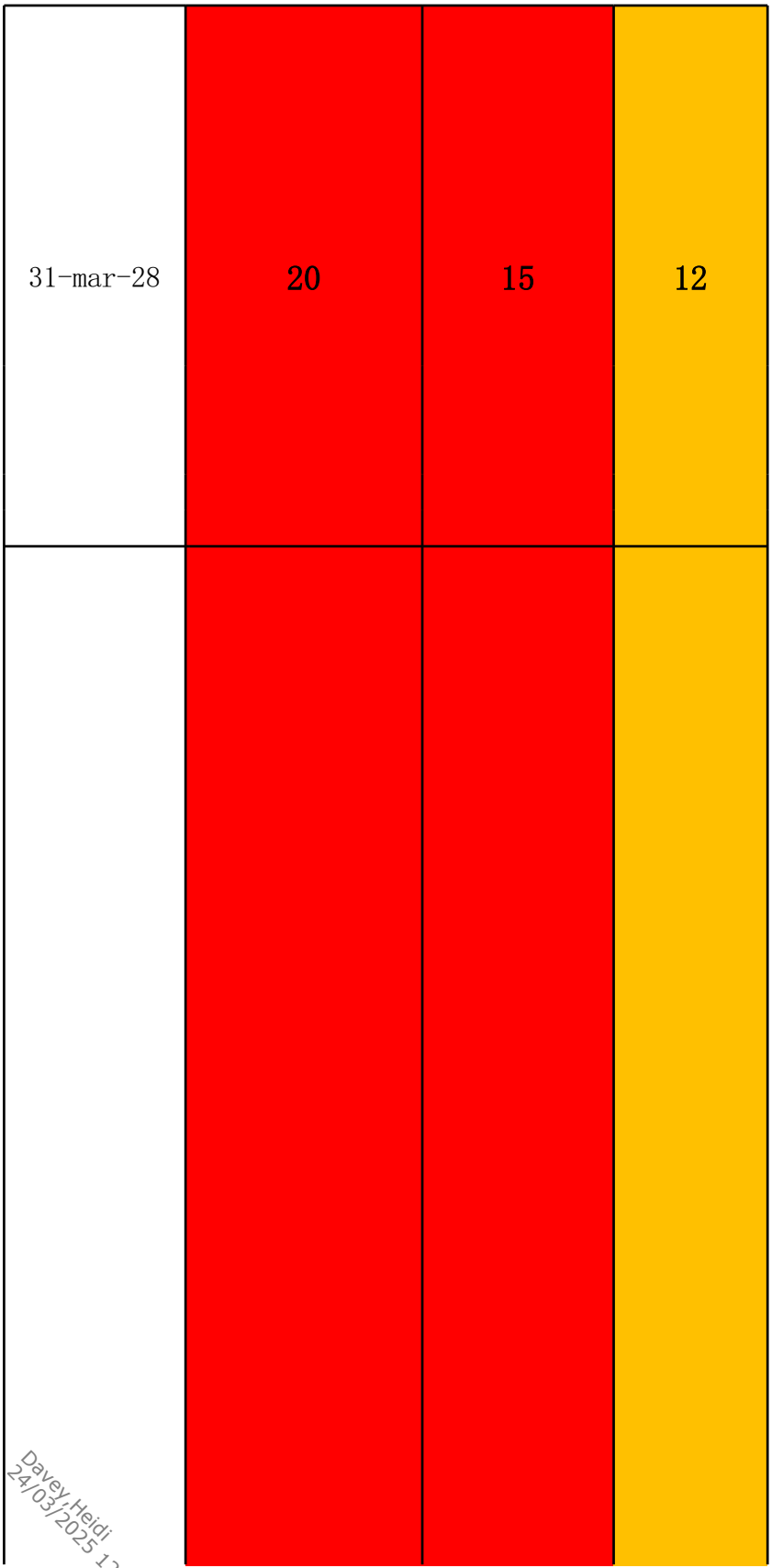
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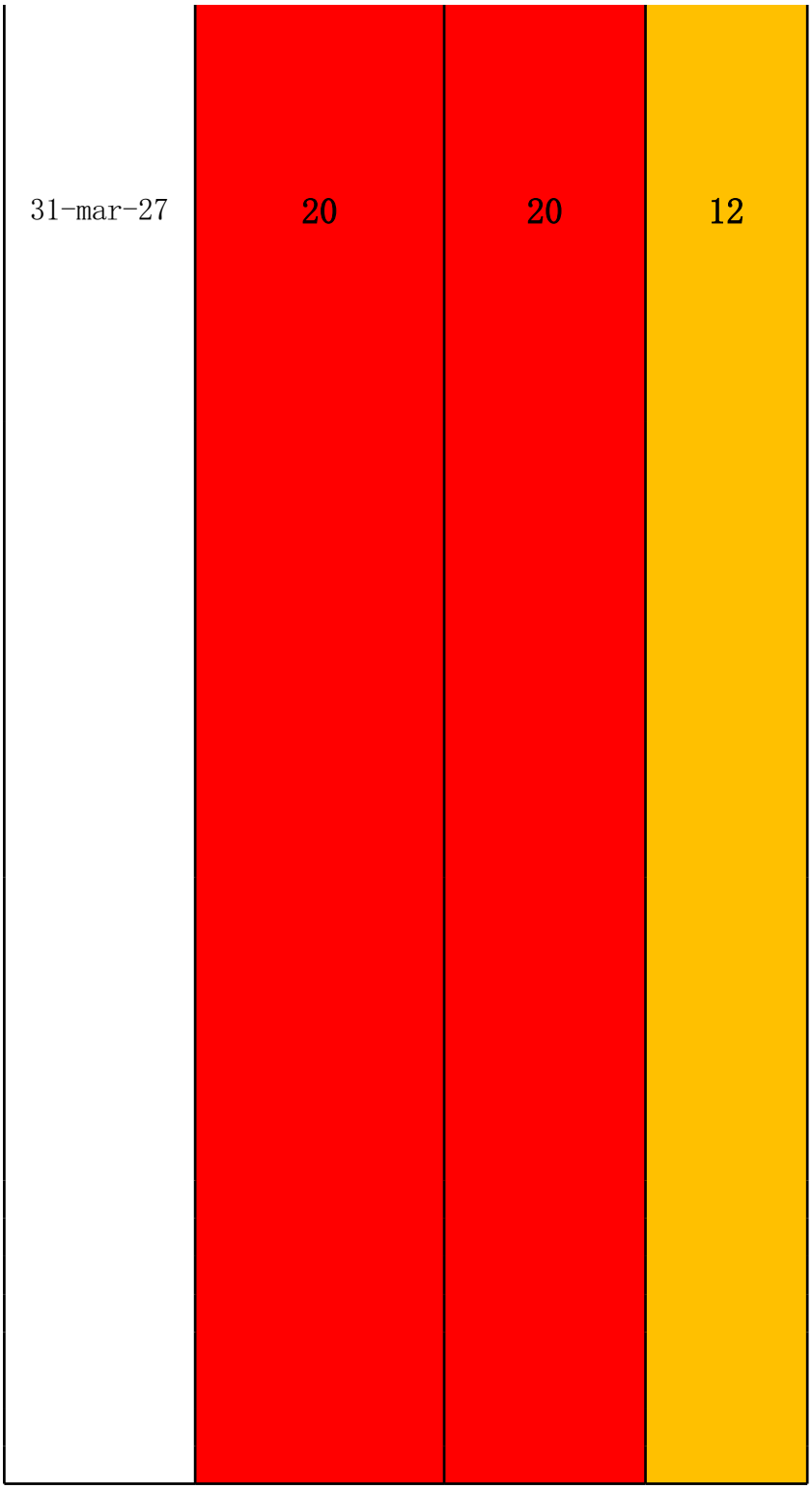

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Control Description

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.

•Hospital 'Admissions Avoidance': A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that patients who have an 'urgent' care need are seen in a timely way in the right care setting, the core services are:

o111 / 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.

oUnscheduled 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

oThere 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.
oEach of the three UEC Alliances have a programme of work focussed on increasing flow and rate of discharge.
o 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 n signs of improvement, however this needs to embed and sustain before further risk reduction.

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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
oCohorting: A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital. oRapid 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. oEscalation / Surge Beds: Acute and community providers have created additional temporary escalation spaces / surge beds through internal operational changes and using some winter funding. This additional capacity has been maintained in to 24/25. oAll acute hospitals have ambulance handover plans to improve handover performance and
Finance & Planning working group meet monthly to drive robust financial arrangements and deliver planned MHIS investment
System wide governance framework in situ
NSFT lead CMHT, CRHT and Inpatient plan transformation programmes.

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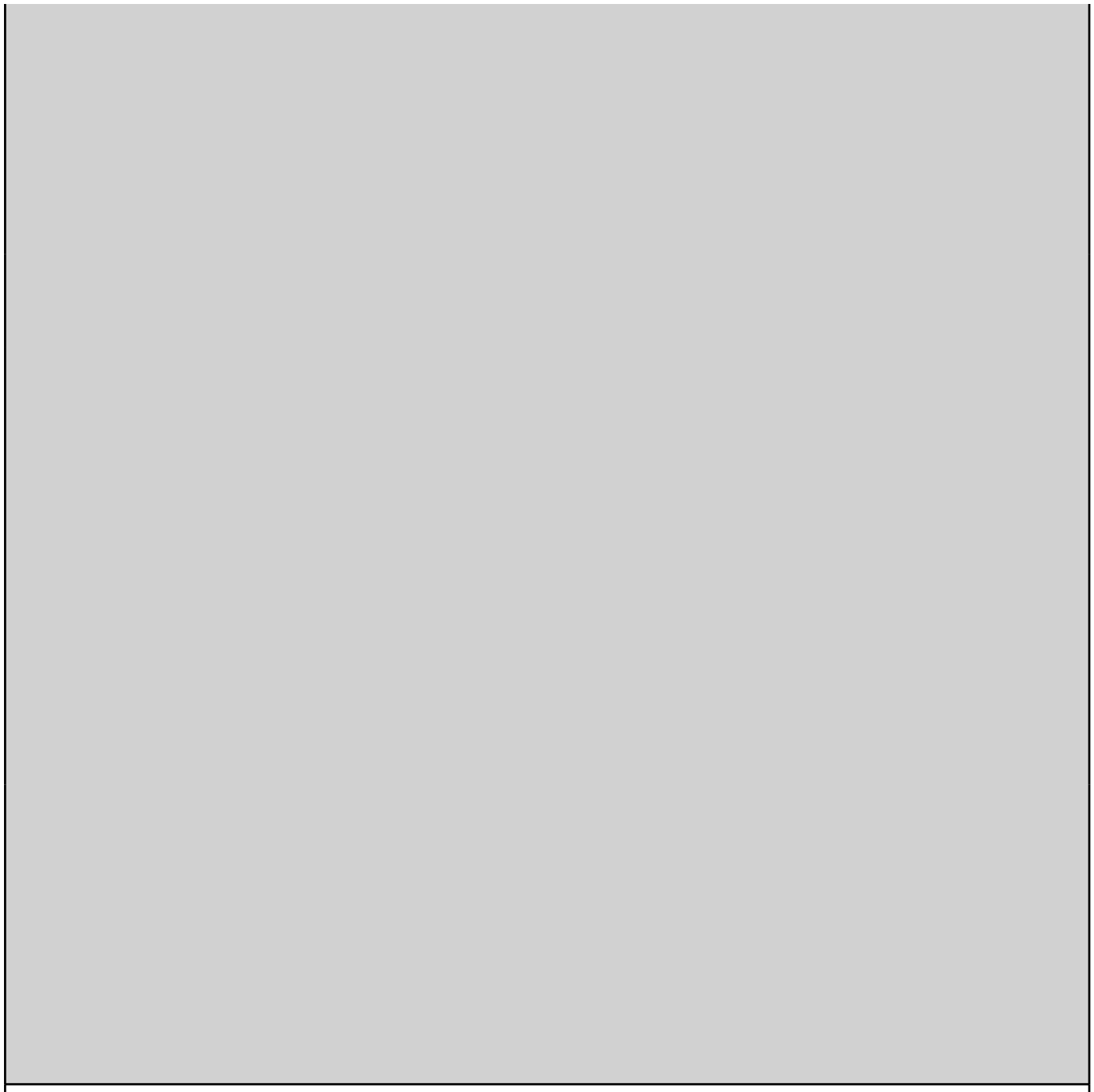

Dedicated CYP strategic commissioning team now in place

Davey,Heidi
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Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk
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
All age Eating Disorder Strategy
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.
Financial slippage is being mitigated against protecting our ability to maintain MHIS investment
Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person
Effective System wide governance framework

Daley Heidi
27/03/2025 12:20:17

Commitment from system partners to adopting Thrive approach - mental health needs being considered and addressed in wider health and social care settings
Implementation of system wide transformation programme
Additional partnership working with VCSE
Additional capacity within Professional Therapeutic Pathway in place
Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood
Enhanced support offers for 18-25-year-olds in wellbeing hubs.
Gender Identity Service in place
Integrated Front Door phase one and two in place
Intensive day support unit now open for eating disorders and parent support offer in place.
Professional Therapeutic Pathway in place
Community Voices gathering insights into HI and connecting with local communities to help address.
Datahub Population Health dashboards in place to support reporting and population health management approaches
External factors that impact on "Plus groups" (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed
Health and wellbeing partnerships and place boards overseeing local work programmes.
Health Inequalities & VCSE Partnering team appointed to lead health inequalities work
The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development
The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP.
ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG
Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board. New Assembly Chair appointed.

Davies (HBC)
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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
Unified process of clinical harm review and prioritisation in line with national guidance.
EMT agreement to commission elective capacity through independent sector providers.
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
The Provider Productivity and Planning Oversight Group and the Scheduled Care Board have been established to to oversee all workstreams to improve performance and reduce harm.
Each Provider has completed waiting list validation, all patients clinically prioritised.
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.

Davey,Heidi
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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.
Extending the use of insourcing and outsourcing opportunities to create capacity.
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
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.
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 quality and reduce variation in urgent suspected cancer referrals.
Mutual aid process agreed to enable patients to transfer to alternative providers using existing capacity - extended to include all providers via national digital mutual aid system DMAS.
New theatre capacity opened at NNUH in December 23. Additional orthopaedic capacity at NNUH (NaNOC) opened in July 2024 and JPUH is due to open spring 2025.
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).
Detailed plan for 2024/25 approved by Board and submitted to NHSE/I as part of the break-even system plan.
Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis.
Monthly Finance Report presented to Finance Committee and Board.
Reviews of inquiries (RLOLS) 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.
ICS Medium Term Financial Model has been developed on consistent assumptions.
Monthly monitoring of risks and mitigations, reported to NHSE/I.

Davey, Hardi
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Increased focus upon early intervention (identify and intervene)
Increased focus upon upstream prevention and remaining active
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
Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support joined up primary care; including access to sustainable dentistry and general practice services.

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Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care.
Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC.
A long-term dental plan has been published, with delivery monitored through PCCC.
ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams.
Performance/quality management and reporting in place.
Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings.
Ring fenced budgets and commissioning targeted to simultaneously support population need and resilience.
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.
System Interface Group and matrix working in place to support national requirements for self-assessment.
Strong relationships in place with local representative committees across all primary care services.

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Action Description
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 Jan 25 - 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.
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. Jan 25 - 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.
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. Jan 25 - 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

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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 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.

Jan 25 – With the commitment to recurrent funding in place plans are now progressing to

Community Transformation: Stocktake of Community Transformation (3-year LTP funded transformation programme) underway to understand current position regarding recruitment, activity and spend against original transformation ambition and plans. Working with NSFT to strengthen and embed the model going into 24/25. Timeline extended to accommodate totality of work. Effective primary care engagement and delayed CMHT diagnostic is a risk to delivery.

We continue to support NSFT (who are leading this work) to coproduce a revised model with Primary Care, to ensure the model is sustainable and effective.

25/11/24 - Community Transformation Service Development Funding - 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

Phase 1 of the N&W Long term Plan (LTP) funded MH Transformation Programme Plan completed 31/03/24. Phase 2 with focus on integration of new services and pathway development. Continued co-production with partners and Experts by Experience and Clinical Reference Group is central to sustaining and embedding positive change.

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

Focus on MH Workforce and development of new roles central to success of LTP funded transformation funded programme. Several challenges to embedding localised integrated approach (as described in N&W MH workforce strategy published in 2021) including transition from Health Education England to Work, Training & Education at regional level, as well as local focus on ICB restructure. Paper presented to Strategic Oversight board and action agreed to review workforce oversight and set up a MH workforce group. Progress delayed due to restructure, date for completion extended. Met with Workforce Lead lack of organisational capacity and operational readiness currently to progress this action. Plan

Right Care, Right Person (RCRP); ICB Leads working in partnership with Norfolk and Suffolk Constabularies. RCRP launched in Norfolk in early June. Suffolk Police went live October 2023. All workstreams have gone live with daily meetings to review any issues and learning. No significant issues reported to date

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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.

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

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

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)

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.

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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
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
Additional capacity within Professional Therapeutic Pathway identified using winter funding. Monitor impact through waiting list updates.
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.
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. 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 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
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


Cross-sector organisational sign-up to the Health Inequality Framework commitments.
Organisational baseline assessments are underway with a good response from the VCSE. This is informing the ICS Health Inequalities improvement plan.
The ICB improvement plan will be presented at the March ICB Board meeting.
ICB panel for QIAs and EHIAs established to assess current impact assessments being undertaken by the ICB, with PMO process supporting this.
A new Population health and Inequalities strategic dashboard has been developed and released.

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Planning guidance and reforming elective care guidance (2025/26) to be operationalised into Norfolk and Waveney improvement plans, with agreed trajectories and appropriate triangulation.
Headline submission outlines some areas not forecast to meet the nationally expected standards. Final submission 27/3/2025

65 week position as per KLOE (26/2/25)

oJPUH (2025) - Feb: 170. March: 88
oNNUH (2025) - Feb: 343 (increased from previous forecast 260), attributed to staffing challenges and late patient cancellations and unfit. March: 164 (increase from previous forecast 148) due to carry-over from prior month increase.
QEH reporting 0

ICS forecast date to reach 0 is 31/03/2025.

The 78 week forecast position across the ICS (26/2/25):
•NNUH (2025) - Feb: 15. March: 5
•JPUH (2025) - Feb: 11. March: 0
QEH reporting 0

Opening and full functionality at the planned Community Diagnostic Centres (CDC's) will decrease the pathway to diagnostics, an interdependent step to treatment and therefore the RTT standards being met

Provider Productivity and Planning Oversight Group is establishing working groups to address key areas that support elective recovery, such as diagnostics, productivity and demand management. Leads and members to be confirmed, scheduling to be established.

Highlight the challenge in utilising all capacity in elective care, including new facilities such as NANOC / CDC's / Ortho Elective Hub, due to workforce shortages. This incorporates challenges experienced by provider sin securing workforce resource sign-off through triple lock process.
To escalate to the appropriate group

Daisy Heidi 24/03/2025 12:20:17

Review of all mitigations and recovery actions to support the financial delivery to plan.

Review of monthly and year to date performances and assess forecast out-turn evaluated risks and mitigations

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Ageing Well Programme Blueprint developed to establish priorities and align workstreams and agreed at Programme Board

Dementia Charter to be signed by all statutory organisations and self-assessments completed by all providers to understand gaps in service delivery and what organisations must improve. 6/7 signatures received although executive leads have been nominated.

Develop appropriate system Dashboard with all core workstream metrics

•Oct

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

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.

•Jan

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.

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Nov/Dec 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. Jan 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
Nov/Dec 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 me Jan 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.
The focus for the remainder of the current financial year will be on developing a strategic framework for primary care. This will be set 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

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Action Owner	Action Start Date	Action Due Date
Ross Collett	16.03.2023	31.03.2025
Ross Collett	16.03.2023	31.03.2025
Ross Collett	16.03.2023	31.03.2025

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Ross Collett	29.08.2024	31.03.2025
Mark Payne	20.04.2022	31.03.2025
Mark Payne	29.04.2022	31.03.2025
Mark Payne	29.04.2022	31.10.2024
Mark Payne	29.08.2023	31.01.2025

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Mark Payne	25.11.2024	31.03.2025
Mark Payne	25.11.2024	31.03.2025
Mark Payne	25.11.2024	31.03.2025
Mark Payne	25.11.2024	31.03.2025
Rebecca Hulme	08.11.2023	31.03.2025

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Rebecca Hulme	08.11.2023	31.03.2025
Rebecca Hulme	02.01.2024	31.03.2024
Rebecca Hulme	02.01.2024	11.01.2024
Rebecca Hulme	06.11.2022	31.03.2025
Rebecca Hulme	25.08.2023	31.03.2025
Rebecca Hulme	02.02.2024	31.03.2024

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Shelley Ames	31.01.2025	31.03.2025

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Diane Smith	03.02.2025	31.05.2025
Diane Smith	22.04.2024	31.03.2025
Diane Smith	22.04.2024	31.03.2025
Diane Smith	28.11.2024	30.06.2025
Diane Smith	13.02.2025	30.04.2025
Diane Smith	03.02.2025	30.04.2025

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Emma Kriehn-Morris	31.07.2024	04.01.2024
Emma Kriehn-Morris	01.04.2024	31.03.2025

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Janice Shirley	04.11.2024	31.03.2025
Janice Shirley	04.11.2024	31.03.2025
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Sadie Parker	28.10.2024	28.02.2025

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Norfolk and Waveney
Integrated Care Board

Agenda item: 22

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Audit and Risk Committee Chair**
Prepared by:	**Amanda Brown, Associate Director of Corporate Governance**
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board Meeting**
Date:	**26 March 2025**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period January 2025 to February 2025.

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.* • ***11 February 2025***
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: An update was provided to the meeting on the current financial position by the Executive Director of Finance. **Briefing by Executive Director of Nursing and Director of CHC** An update on Continuing Healthcare processes and actions was provided to the meeting and discussed. This is a challenging area of work. Challenges include freeing up clinical time to allow clinicians to do clinical work, reducing

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	backlogs, using software effectively to support workload and financial grip. The ICB works with local authority colleagues to ensure clear processes and applying the framework appropriately so there is joint understanding and responsibility. There is also a joint post with the council to ensure good working relationships as well as appropriate challenge on a day-to-day basis on decisions. Joint training is also undertaken to ensure a consistent approach. **Briefing by Executive Director of Data and Digital – cyber security** This presentation discussed the increasing cyber security threat faced by the NHS. These threats highlight the critical importance of robust cybersecurity measures to protect data and ensure continuity of healthcare services. The discussion noted that there were strong interdependencies across the NHS system. This was highlighted by an incident in one provider that impacted other organisations. It is essential that work in this area identifies common standards and risk approach across the Integrated Care System. To support work in this area a desk top exercise recently took place on the response to a cyber-attack and a lot of learning has been taken from this to implement processes. It was also recognised that staff need to complete and remain up to date with appropriate training. Whilst most cyber security breaches can be prevented by simple steps it is essential for organisations and staff to always remain vigilant. The meeting also discussed the need for a risk capturing cyber security matters be included in the Board Assurance Framework. In addition, the Committee discussed the following items: *Briefing by Executive Director of Finance* *Internal Audit Progress Report and Internal Audit Strategy 2025/28 and Annual Plan 2025/26* *Counter Fraud Service Progress Report* *External Auditor's Report* *Losses & Special Payments and Duplicate Payments* *Information Governance Senior Information Risk Officer Report* *Board Assurance Framework* *Committee Self-Assessment Part 2* *Assurance Report for Annual Report and Accounts – timelines and responsibilities* The following items were presented to the Committee for information: o Conflicts of Interest Committee Update o Internal Audit Reports

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	○ Review changes to standing orders, SFIs etc ○ Report on any urgent Board decisions and non-compliance with the Standing Orders ○ TIAA Client Briefing Notes ○ Review changes to accounting policies/significant judgements ○ Audit and Risk Committee Annual Plan
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

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