Improving lives **together**

Norfolk and Waveney Integrated Care System

OUR ESTATE STRATEGY 2022-2027

Norfolk and Waveney Integrated Care System

Our Vision

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.

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1. Foreword

The development of our ICS has formed a partnership of organisations that have come together to plan and deliver joined-up health and care services to improve the lives of people living across Norfolk and Waveney. Our mission is to ***help the people of Norfolk and Waveney to live longer, healthier, and happier lives.***

We have already achieved a lot by working in partnership, this has been strengthened through our collaborative response to the COVID-19 pandemic. The past three years have seen unprecedented challenges, but also incredible stories of communities and providers working together to ensure the people of Norfolk and Waveney have the support and care they need. We want to build on the learnings from the pandemic to enhance our integrated working within the new Integrated Care System structure.

As an ICB we are a statutory NHS organisation responsible for developing a plan for meeting the health needs of our population, managing the NHS budget, and arranging for the provision of health services across Norfolk and Waveney.

One of the functions that falls under the umbrella of our ICB is the Strategic Estates team, who play a key role in planning how we will improve and adapt our estate to support and enable our health and care services meet the needs of our population.

The estate will play its part in the transformation and integration of our health and care services, and through collaborative working we will capitalise on this opportunity to redesign and create an estate suited to the needs of our ICS.

Through this five-year strategy we aim to deliver our vision of ***providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.***

Tracey Bleakley
Chief Executive Officer
NHS Norfolk and Waveney Integrated Care Board

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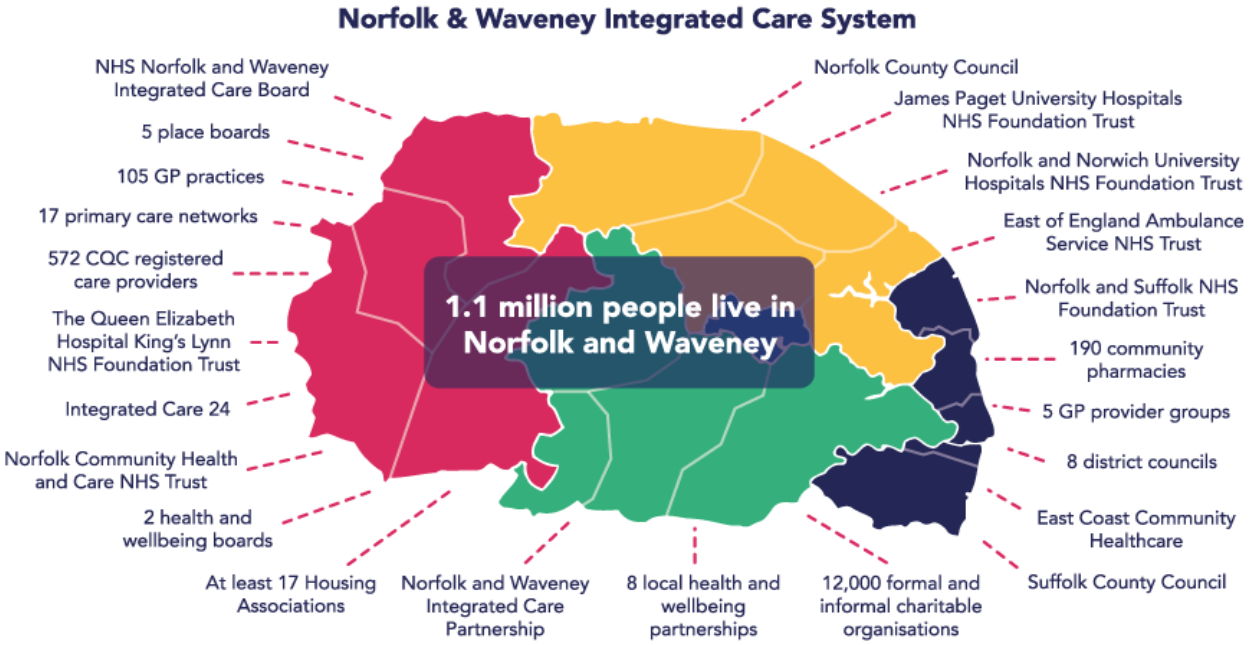
2. Introduction

The Norfolk and Waveney Integrated Care System ('the ICS') is made up of a wide range of partner organisations, working together to help people lead longer, healthier, and happier lives.

Figure 1: Our Integrated Care System at a glance



Over and above everything else we want to achieve; we have set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.
   This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.
   Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.
   Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

3. Estate Strategy Development

The Strategic Estates Team leads a strong and well-established partnership approach with colleagues working across Norfolk and Waveney, providing a solid basis for collaboration to ensure the enabling function of the healthcare estate can flourish as the ICS develops.

This system-wide Estate Strategy seeks to show how the NHS estate across Norfolk and Waveney will be transformed to support new models of care, deliver better outcomes to patients, and provide best value for money. While this is our plan for our estate, it will complement, inform, and be integral to wider integration developments between the NHS, local government, and the voluntary sector.

The strategy has been developed with system partners in three phases, as indicated in the figure below:

Figure 2: Development of the Estate Strategy

For ease of reference, this document is presented via the standard framework recognised within the Department of Health's 'Developing an estate strategy' - and answering three key questions:

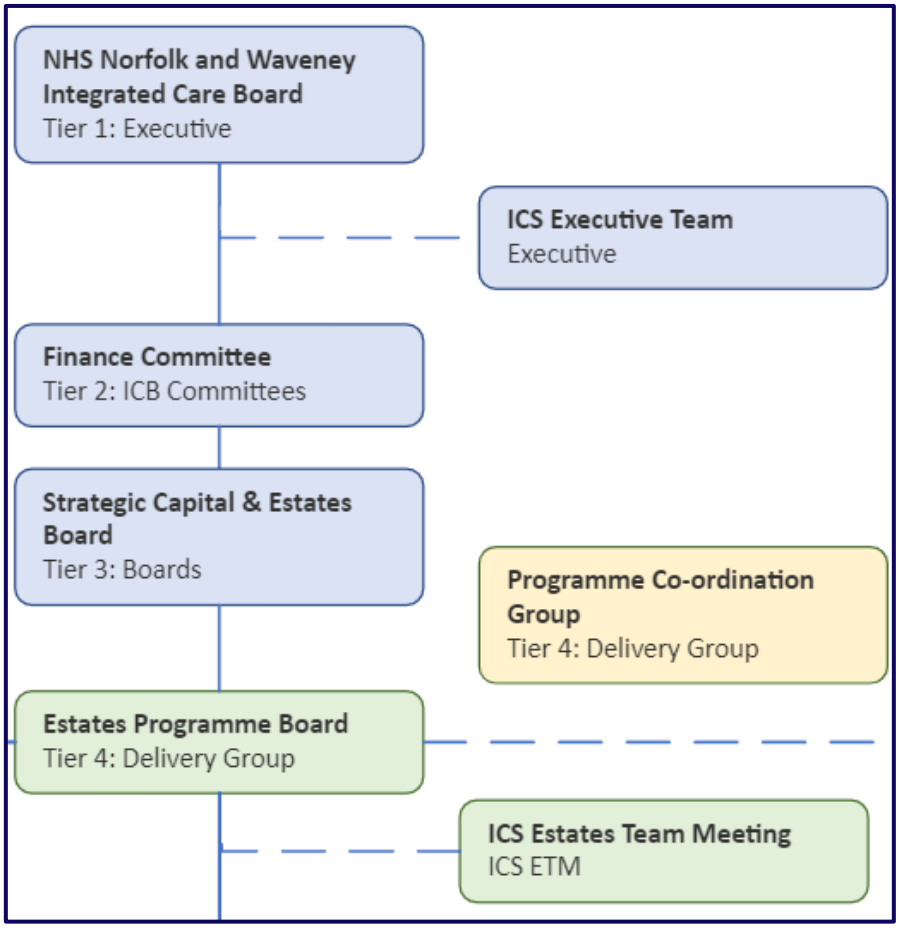
4. Estate Strategy Governance

The ICS is led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy.

We have established a robust governance process for a system-wide estates team which will enable collaborative working at a system level and make investment decisions for the benefit of the system and our population as a whole. The Estates workstream links operationally to the ICS Executive for its direction through its Senior Responsible Officer.

The Estates Programme Board is one of several operational groups within the ICB. Its main role is to bring key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney Integrated Care System to realise its vision, purpose, goals, and deliver upon its priorities. Our Estates Programme Board is comprised of members leading the estate function across system partners, including links to local authorities and One Public Estate (OPE) partners. Our NHSE/I Strategic Estates Lead is also part of our Board.

Figure 3: Estates Programme Board Governance Structure



5. National Policy, System Strategy & Local Context

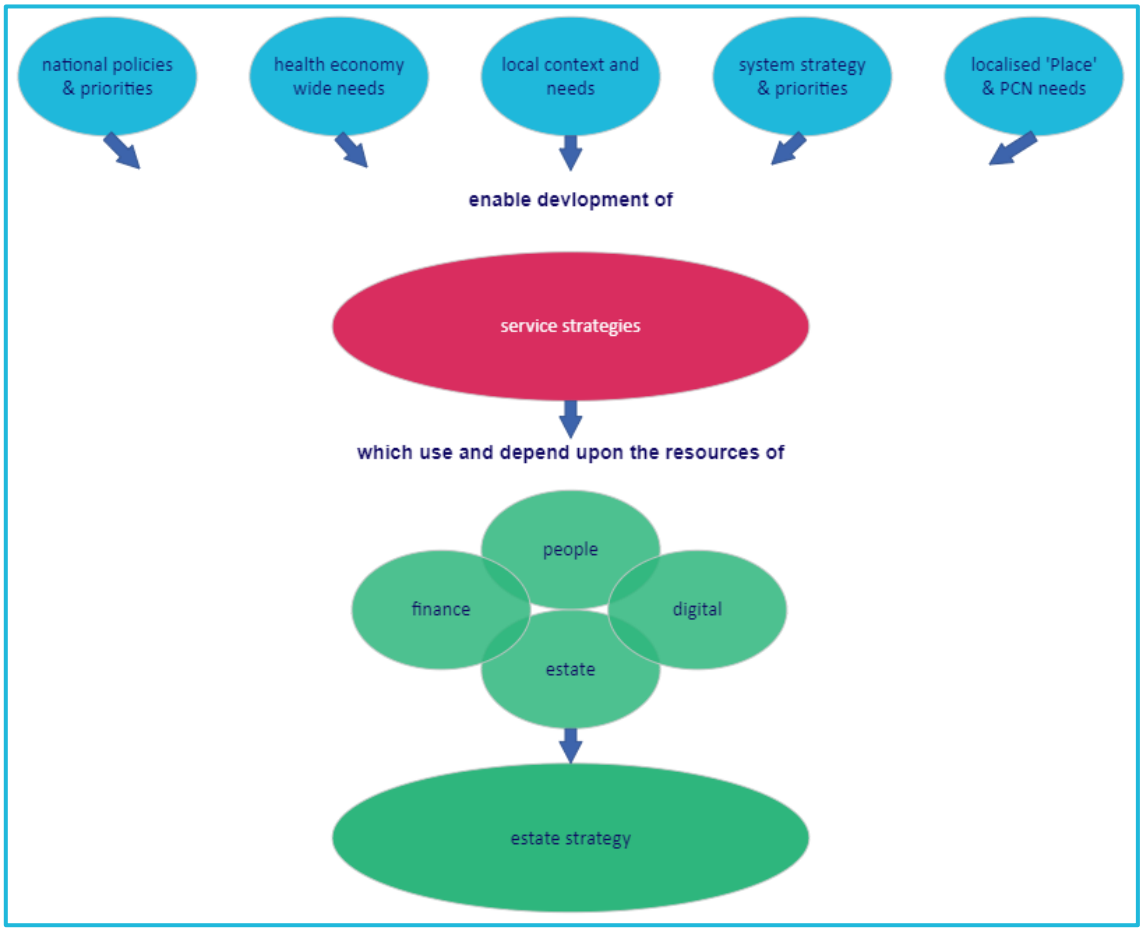
The environment within which the NHS operates is changing. The population is increasingly ageing, there are significant advances in medicine and surgery, patient expectations are changing and there is a need to harness research, innovation, and technology in delivery.

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

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

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

Figure 4: The Strategic Planning Process



National Policy, System Strategy & Local Context

The NHS Long Term Plan (LTP) (2019)
The NHS Long Term Plan sets out how the NHS will tackle the pressure its staff are facing while making extra funding go as far as possible. As it does so, it must accelerate the redesign of patient care to future-proof the NHS for the decade ahead.

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

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

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

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

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

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

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

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

National Policy, System Strategy & Local Context

The Naylor Review (2017)

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

- Systems should develop affordable estates and infrastructure plans, with an associated capital strategy, to deliver the 5 Year Forward View (5YFV) and address backlog maintenance. These plans should be supported by robust business cases. The new NHS Property Board should support the development of these plans.
- System estates plans, and their delivery should be assessed against targets informed by the benchmarks developed for this review. Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need.
- Substantial capital investment is needed to deliver service transformation in well evidenced STP (now ICS) plans. This could be met by contributions from three sources: property disposals, private capital (for primary care) and from HM Treasury.
- In line with the Carter Report recommendations, NHS estate should aim to operate within a maximum of 35% non-clinical floor space and 2.5% unoccupied or under-used space

The Health Infrastructure Plan (2019)

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

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

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

National Policy, System Strategy & Local Context

Next steps for integrating primary care: Fuller Stocktake report (2022)
The report discusses reimagining our approach to primary care estates and sets out a vision of integrated teams, providing joined up accessible care. But it also indicates that much of the general practice and wider primary care estate is not up to scratch. The focus of capital investment has been weighted towards secondary care – something that now needs to change.

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

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

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

NHS Premises Assurance Model (PAM) (2020)
The NHS PAM is a management tool, designed to provide a nationally consistent approach to evaluating NHS premises performance against a set of common indicators. It delivers a basis for assurance for trust boards, on regulatory and statutory requirements relating to their estate and related services.

- Assurance on the premises in which NHS healthcare is delivered
- Driving premises-related performance improvements throughout the system
- Providing greater understanding of the vital role that NHS premises play in the delivery of improved clinical and social outcomes

It is designed to be used locally by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners.

National Policy, System Strategy & Local Context

Our Integrated Care System

As well as our three goals set out in our introduction, like all Integrated Care Systems in England, our ICS has an overarching purpose to:

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

Our Integrated Care Strategy

Our ICP has published its transitional Integrated Care Strategy, setting the agenda for our new Integrated Care System across Norfolk & Waveney. In order to achieve our mission and goals as a partnership, its focus is across four priorities:

- Driving integration
- Prioritising prevention
- Addressing inequalities
- Enabling resilient communities

Our ICS Clinical Strategy

Our systems clinical strategy sets objectives that address the challenges, problems, and opportunities identified by patients, staff and the wider public. They detail how NHS services will work together to achieve our goals, how we plan to improve areas of health within our population, and they describe the expectations that patients and staff have highlighted they want from their NHS in Norfolk and Waveney.
In Norfolk and Waveney, your NHS will:

- Tackle health inequalities
- See you as a whole person
- Be one high quality, resilient service
- Reduce long waiting times
- Act early to improve health
- Be reliable

Our Joint Forward Plan (JFP)

Our JFP sets out how we intend to meet our statutory duty to provide health services in an integrated way, with other health-related services and social care services. The plan explains how this will improve the quality of services and reduce inequalities in access and outcomes.

This estate strategy accompanies the Joint Forward Plan, with both setting out the steps we will take to create stronger, greener buildings, enable smarter, better health and care infrastructure, and use system resources fairly and more efficiently

National Policy, System Strategy & Local Context

Our ICS People Plan

Our #WeCareTogether People Plan sets out how we will work towards our vision to have happy, healthy people providing excellent compassionate care, which in turn will enable us to achieve our system goal for Norfolk and Waveney - to be the best place to work. The plan mirrors the aspirations set out in the National People Plan (NHSE/I 2020) and is our local version.

The key objectives within our people plan are:

- Creating new opportunities for our people
- Promoting good health and wellbeing for our people
- Maximising and valuing the skills of our people
- Creating a positive and inclusive culture for our people

Our ICS Digital Transformation Strategic Plan and Roadmap

The initial focus of the digital plan is: Ensuring a common patient record system across the three acutes; Primary Care system integration; developing the Integrated Care Record; and establishing an ICS level digital team to push forwards and champion innovation.

The 5 objectives within the Digital Strategy are:

- A system approach to digital solutions
- Digitally connected working
- Using digital tools for better health outcomes
- Leveraging data for better health decisions and outcomes
- Leading innovative digital practices in health and care

National Policy, System Strategy & Local Context

Demographics

Our population in Norfolk and Waveney is on average older than the rest of England, increasing the need for health and social care support, as multi-morbidity, frailty, and risk of emergency admissions increase with age. This impacts the way we need to plan our services and infrastructure, most notably accessibility to our primary and community provision.

The past couple of years have also seen more children and young people accessing our services due to emotional wellbeing and mental health needs and gaps in learning following the pandemic. Further work is needed to support our children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing.

Housing Developments

The population across our system is growing (it is projected to grow by over 10% in the next 20 years), with migration into Norfolk and Waveney exceeding those moving out of the area, in addition, births are expected to exceed deaths. Areas that are particularly expected to receive people moving into the area are South Norfolk and pockets of areas closer to Norwich and King's Lynn. Norfolk is particularly popular for people looking to retire meaning that many new residents are likely to be older and may have multiple long-term conditions and more complex needs.

To cope with this increasing population more housing is required, however, new development places additional demand upon existing infrastructure and services such as health and social care. However, an increase in more appropriate housing, such as adapted housing as opposed to general needs housing, can reduce pressure on health and social care systems. Therefore, this strategy will need to consider the impact of this growth on estate, particularly in delivering care closer to home and how it can influence more appropriate housing to be developed.

Impacts of Covid-19

Covid-19 has disrupted and changed the way in which estate is used and the requirements for them. It has emphasised the increased need for more flexible estate that can be adaptable to new ways of working, with requirements for additional sanitisation and social distancing. Significant digital transformation in administrative roles and care delivery has supported the service delivery during the pandemic and this offers an opportunity to transition to a hybrid working model where possible in the future. This could offer an opportunity to release some of the estate for clinical service delivery or disposal, however, further analysis and planning for future ways of working will be required before irreversible changes are planned in the estate.

Climate Change

Climate change has become, and will increasingly be, an issue of vital importance to the health and wellbeing of local communities. Strategies to adapt to climate change are therefore an integral component of local planning and decision making, bringing multiple benefits to the physical and mental health of the population.

The acceleration of climate changes is and will continue to affect the health and well-being of communities around the World, including ours. The estate strategy includes focus on maintaining a comprehensive and coordinated strategy to plan and respond to climate change.

6. Key Challenges Faced: A System Perspective

Our system response to the NHS Long Term Plan has identified some of the key challenges facing health and care in Norfolk and Waveney, all of which have an impact on estate. These are listed below:

- Growing and ageing population, resulting in higher demand for services
- Areas of public health issues and concern, including significant percentage of children living in low-income families, life expectancy variation, suicide rate higher than national and regional averages, smoking levels higher than national averages, educational attainment remains below national averages, and homelessness figures are above national averages
- A geographically dispersed population and vast rural areas with challenges around access
- Tourist influx resulting in fluctuating demand
- Primary Care working to capacity, with a shrinking GP workforce, alongside GP recruitment challenges
- Hospital inpatient bed capacity struggling to meet growing demand due to longer lengths of stay, and flow and discharge challenges
- Community services struggling to meet the demand for community-based services
- Social services and home care capacity struggling to keep up with demand

Since the pandemic, the ICS Clinical Strategy work was refreshed and has highlighted a number of additional concerns and challenges as follows:

- Both clinicians and service users are concerned about the size of waiting lists, and the impact that delays to care might have on patient outcomes – there is widespread agreement that this is now the biggest challenge facing the health service
- The provision of mental health services is highlighted by service users and clinicians as a significant challenge
- Mental health services are under-resourced, making it difficult to access suitable care
- There are long standing difficulties to recruit and retain staff

Additionally, from a financial, workforce and digital point of view, there are further challenges faced by the system in Norfolk and Waveney:

- Ongoing financial deficits, particularly in the acute providers, and ambitious efficiency plans to deliver
- Existing open vacancies that we struggle to recruit to
- High staff turnover, particularly in social care and care workers
- Significant retirements in known disciplines, alongside a shrinking pool of young talent
- Managing and integrating five different generations within the workforce
- Poor digital maturity and access across Norfolk and Waveney

7. Key Challenges Faced: An Estate Perspective

Estate Condition and Functional Suitability
The condition of our estate influences the experience of those working or being treated there**.** Some of our estate is modern and well equipped, however, other parts of it are ageing and carry significant backlog maintenance, which results in high running costs and requires considerable ongoing maintenance. We also have properties that are no longer fit for purpose, unable to support new ways of working and provide the most appropriate care in the most appropriate place. Some estate remains underutilised as it does not provide the suitable, flexible, infrastructure required to align with new operational delivery models of care.

According to the General Practices Premises Policy Review paper published by NHSE in 2019, there are challenges within primary care premises to offer community and secondary care services, thereby impacting the provision of integrated care. This is because there is a lack of understanding of the current general practice and wider primary care estate, causing significant barriers to future estate planning. Much of the primary care premises in many places are not fit for purpose for current delivery or for implementing the LTP in the future.

Backlog Maintenance & Asset Management
There is significant backlog maintenance identified across key sites. The condition of our estate is mixed, with significant tracts of aged estate carrying the higher risk backlog maintenance requirement. The influx of investment to ICB estate at the commencement and throughout this strategy period will renew or improve estate condition, however, some community health sites require development and investment to ensure they continue to support and meet health and care service needs. The backlog maintenance across the acute sites cannot be fully addressed by investment from the ICB alone, therefore will be a key attribute when undertaking options appraisals and assessing value for money. Harmonising the management approach to asset maintenance and replacement through shared approaches to investment and maintenance programmes will form part of our strategy.

PFI & LIFT
Our health system has significant investment in health infrastructure provided through Private Finance Initiatives (PFI) and Local Investment Finance Trusts (LIFT) from past investment cycles. Managing and monitoring the regular investment in these assets is integral to maintaining their utilisation and suitability for current and future health needs. Current agreements are at or past their mid-point and therefore require foresight in planning the return of these assets alongside core NHS estate. Understanding the investment in and management of assets within these sites remains integral to minimising any effects from asset replacement requirements in the future.

Reinforced Autoclaved Aerated Concrete (RAAC)
RAAC has been identified as presenting high risk to the structural integrity of buildings in which they have been used. A national programme investigating the extent of the problem identified two hospitals within Norfolk & Waveney, with a third in Suffolk, and a fourth in Cambridgeshire, placing the Eastern region as having one of the highest predominance of RAAC issues. Attention has turned to review of all NHS estate used to deliver commissioned health and care services. The findings from recent and current investigations have identified significant investment challenges including the need to develop robust contingency plans for business continuity in the event of any structural failure in affected estate.

Key Challenges Faced: An Estate Perspective

Fragmented Estate Strategy and Investment Planning
Individual organisations working separately leads to duplication of effort and inefficient use of estate. Therefore, collaborative estate modelling and investment planning can help to deliver estates and financial efficiencies. There is a need to further develop and align estate strategies and investment pipelines across the ICS and at 'Place' and PCN level.

Estates & Facilities Running Cost Variation
There is unwarranted variation in our system estates and facilities running costs when compared against the Model Health System benchmarks. These variations have been identified across several hard and soft facility management services. Collaborative analysis and efficiency planning, leading to collaboratively procured services are required to remove unwarranted variation.

Tenure Variation
A significant proportion of our NHS estate is leased. Across Norfolk and Waveney around 60% of our premises are leased from either NHS Property Services, Community Health Partnerships, private, and/or other 3rd party landlords. Often, leased estate does little to facilitate integrated working and flexible service co-location due to restricted lease terms. Service delivery and commissioning need to be agile, responding to and even pre-empting changing local health and socio-economic issues at pace. The current system of occupation is onerous and inflexible.

Additionally, over 50% of GP practices are owner-occupied, therefore any proposals to improve, expand or replace their estate usually originate from the practices themselves. Not all providers are in a position to expand even if there is unmet demand.

Within the GP Premises Review it was identified that there is a lack of clarity or understanding around the responsibilities of all parties involved in estate ownership and occupancy, leading to responsibilities such as maintenance not being fulfilled. A maintenance backlog will reduce the financial value of the property, its value for future use and any proposal for investment.

Commercial Challenges
Leasehold properties have higher estates running costs and IFRS 16 (International Financial Reporting Standard) requires a lease to recognise a right-of-use asset, representing its right to use the underlying leased asset, and a lease liability representing its obligation to make lease payments. Therefore, an appraisal of the need to use a leasehold estate will need to be carried out and plans should be developed about the future use of estate based on a comparison of estates running costs, patient access and service requirements.

The new IFRS 16 accounting standards will create a further dilemma for the ICS in terms of balance sheet treatment of leases and assets which will require assessment of the ICS appetite for entering leases and exploring leasehold ownership etc.

Lack of supported living accommodation for learning disabilities and autistic patients
There is a lack of accommodation that meets the needs of those living with learning disabilities and autism, enabling them to live independently. More specialist accommodation is required for those people with multiple complex needs.

8. Where we are now

In order to identify where we want to be and how we might get there, we first need to understand where we are now.

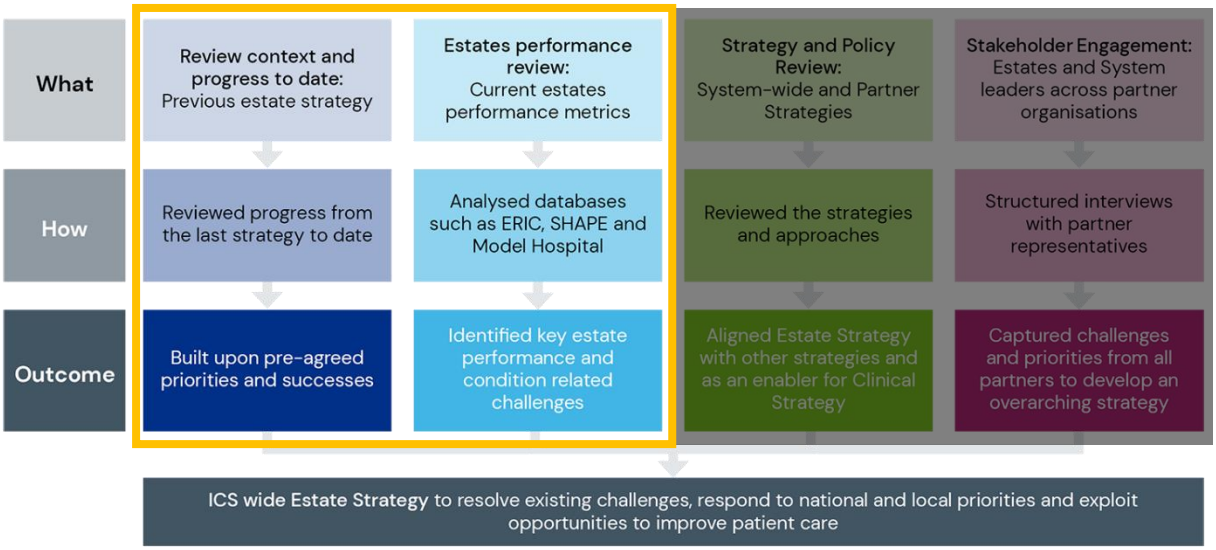
Across Norfolk and Waveney there is a large and varied estate. Commissioned Health & Care in Norfolk & Waveney is delivered from circa 1600 locations. Health & Care services are often associated with primary service locations such as GP practices, hospitals for acute, community & mental health services, health centres and other community locations. However, the wider estate also consists of care homes, pharmacies, dentists, opticians, children's centres, and independent hospitals and treatment centres. This strategy embraces the breadth and diversity of health and care estate, meeting the challenges outlined and implementing a comprehensive collaboration of estate use and development.

It is important to note that, although we are in a new world of integration, the data and focus throughout the strategy is primarily on the directly commissioned services and its managed estate (Primary GP & provider NHS Trust estate). The strategy seeks to coordinate, enable, and influence the development of all estate used directly in the provision of commissioned NHS health & care.

In working together as a system, we have an opportunity to utilise our combined estate to support the transformation of services and new ways of working. We can bring health care, social care, and third sector services together for the community, in a more integrated and collaborative way.

This 'where we are now' section focus' on the first two columns of figure 5 below. It articulates progress to date since 2018 and provides an overview of our current estate and its performance.

Figure 5: Development of the Estate Strategy – Where we are now



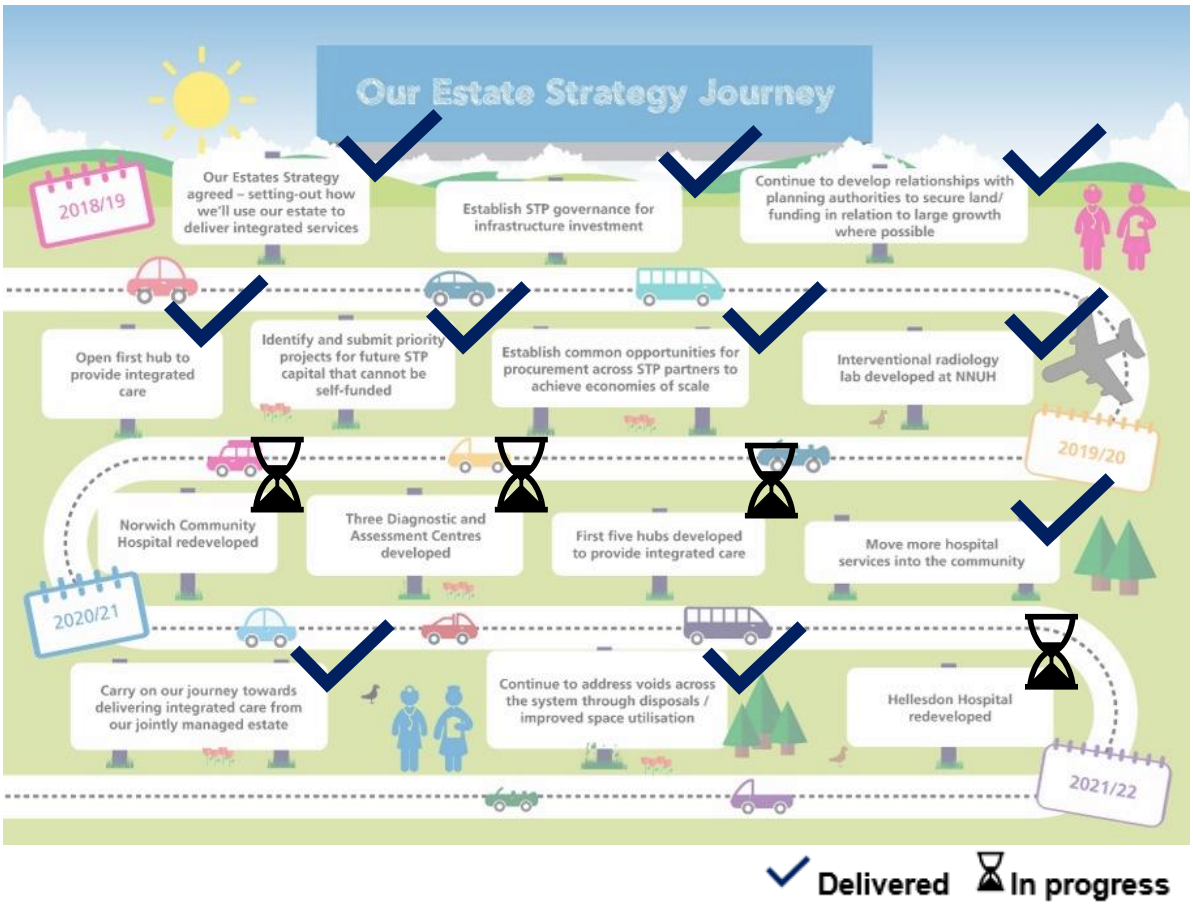
Where we are now

Our 2018 Estate Strategy Journey: Context and progress to date

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

Our 2018 workbook contained an 'estate strategy journey', providing a high-level roadmap of what we wanted to achieve throughout the strategy period. The figure below has been annotated to highlight our accomplishments, as well areas that remain in progress.

Figure 6: 2018 Estate Strategy Journey



An update on those that are in progress

The ICS was successful in its initial case to obtain capital funding for three of the four projects marked as 'in progress'. Business cases will be submitted throughout 2022-23, with completion planned for March 2024.

An expression of interest has been submitted for the development of Norwich Community Hospital (as a part of the New Hospital Programme), and we await an outcome from NHS England.

Where we are now

Reviewed Progress 2018-2022: Pre-agreed priorities and successes

The table below builds on from figure 6 and provides a high-level overview of accomplishments throughout our previous strategy period.

It articulates successful funding bids; the amount of investment made and/or in the pipeline; the additional resource and developed governance; and the improved data sets and digital tools available.

Table 1: 2018 – 2022 accomplishments

Successful £25.2m Wave 4B funding application to support Primary & Communtiy Care Hubs	Successful £69.7m Wave 4B funding application to support Diagnostic Assessment Centres for the 3 acute providers	Successful £38m Wave 4B funding application to support Hellesdon Hospital new wards development
Over £4m of ETTF capital invested into Primary Care infrastructure	Successful New Hospital Programme application for James Paget	Significant capital allocations to support RAAC remedials at James Paget and Queen Elizabeth Hospitals
Successful £23m funding application for Community Diagnostic Centres	5-year Capital Investment Pipeline developed, prioritised and agreed	Successful application to be part of the CHP Primary Care Data Gathering pilot
Successful application to be part of the Savills housing growth mapping pilot in SHAPE	8 surplus sites disposed, removing voids and generating capital income	Introduction of a Primary Care Estates Team
Green Plans developed and published by Trusts, the ICB, and the ICS	Recruitment of a core ICB Estates Team	Over £3m of capital investment earmarked for health infrastructure through CIL and/or S106
Development of the HUDU tool to help calculate the impact of housing growth and support healthcare planning	Operational delivery plans for estate strategy and green plans developed and agreed	Development of an ICB Capital Investment Procedure to help align and prioritise system investment

Where we are now

Our Estate: Location, Overview & Performance

Figure 7 below highlights the totality of estate used by GPs and NHS Trusts across Norfolk and Waveney. This snapshot is taken from our Strategic Health Asset Planning and Evaluation tool (SHAPE).

SHAPE is a web enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy. Its analytical and presentation features can help service commissioners and estate planners to determine the service configuration that provides the best affordable access to care.

Figure 7: Mapping of GP and NHS Trust estate (Key = Green – GP, Red – NHS Trust)

Circa. 330 properties are used by GPs and NHS Trusts to deliver care across Norfolk and Waveney. A significant proportion of these properties are utilised by several partners.

The image above maps our property portfolio, inclusive of NHS owned estate, GP owned estate, leased estate (including NHSPS, CHP, and private), as well as sessional use.

It should be noted that some figures may differ when reporting performance figures for NHS Trusts in table 2 below, due to the format of our Estates Return Information Collections (ERIC). ERIC does not monitor premises smaller than 150m2, and therefore is likely to omit smaller and sessional use properties. ERIC also omits GP estate.

Where we are now

Table 2 provides a high-level overview on a number of our key performance metrics.

Table 2: Current estates performance metrics

332 properties occupied	> 480,000 square metres utilised	3.9% of NHS estate is empty or underutilised	60% of NHS estate is over 30 years old, with 10% pre-1948
37.9% of NHS estate is non-clinical	Almost £135,000,000 of backlog maintenance	Around 60% of GP estate is over 30 years old	Circa. £220,000,000 Estates & Facilities running costs
45,970 tonnes of Co2 emissions from building energy and water	6 sites surplus to requirements and listed for disposal	84.6% of floorspace used by the NHS is owned by the NHS	Circa. 50% of practices are GP owned
Average PLACE score of 91.23%	18% of Trust occupied floorspace not functionally suitable	19% of surveyed GP estate not functionally suitable	Circa. £1,000,000 costs associated with void or underutilised CHP and NHS PS estate

A number of data returns, collections, and submissions are in place to help us report and monitor performance. We will continue to ensure that this data is maintained and improved accordingly.

The key data sources utilised to provide an overview of current performance are listed below:

- ERIC - Estates Returns Information Collection - NHS Digital
- PAM - Premises Assurance Model - NHS England
- PLACE - Patient-Led Assessments of the Care Environment - NHS Digital
- Surplus Land Return - NHS Surplus Land - NHS Digital
- Greener NHS - Greener NHS - NHS England
- PCDG - Primary Care Data Gathering

9. Where we want to be

Our Vision

To provide 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.

Our vision will be driven through robust system wide estate planning, providing the direction towards an accessible, quality, sustainable and efficient estate that acts as an enabler to deliver transformed services for the local population.

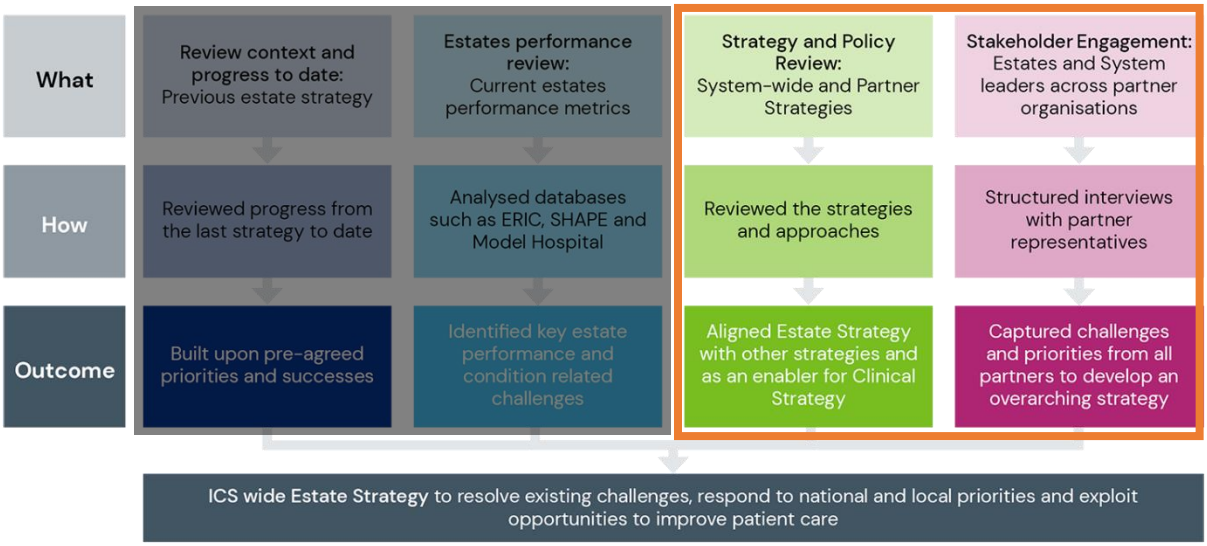
This section builds on the understanding of where we are now and begins to form a route map that articulates where we want to be.

It aims to answer the following questions:

- how can we enable and support local strategy and priorities?
- how can we respond to local drivers and impacts?
- how can our estate support the response to system challenges?
- how can we manage and remove estate specific challenges?
- how will our estate look and perform in 5-years' time?

Our 'where we want to be' section focus' on the second two columns of figure 8 below. It articulates review and alignment to system and partner strategies and stakeholder engagement that help capture and agree challenges and priorities.

Figure 8: Development of the Estate Strategy – Where we want to be



Where we want to be

Supporting and enabling our integrated care strategy

Our systems Integrated Care Strategy is created by the ICP. The strategy is a key document for all ICS partners to develop their strategies and plans from and sets out the challenges and opportunities we face that can only be addressed by partnership working and joint approaches.

For us to accomplish our purpose as an ICS and deliver our goals, the ICP have developed the following priorities.

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

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

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

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

The estate function has a big part to play in supporting and enabling these priorities. Through delivering our vision and strategic objectives we will support the ICS and provide its essential estate needs.

We will enable the integrated care strategy by:

- Developing a collaborative and joined-up approach to estates and facilities, ensuring our assets enable integrated accessible services
- Ensuring that our estate supports the provision of preventative models of care
- Work 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
- Reducing the negative impact of wider determinants of health by providing equitable access to care
- Delivering our Green Plan to reduce our carbon footprint and emissions, and tackle the negative impact this has on our health and our communities

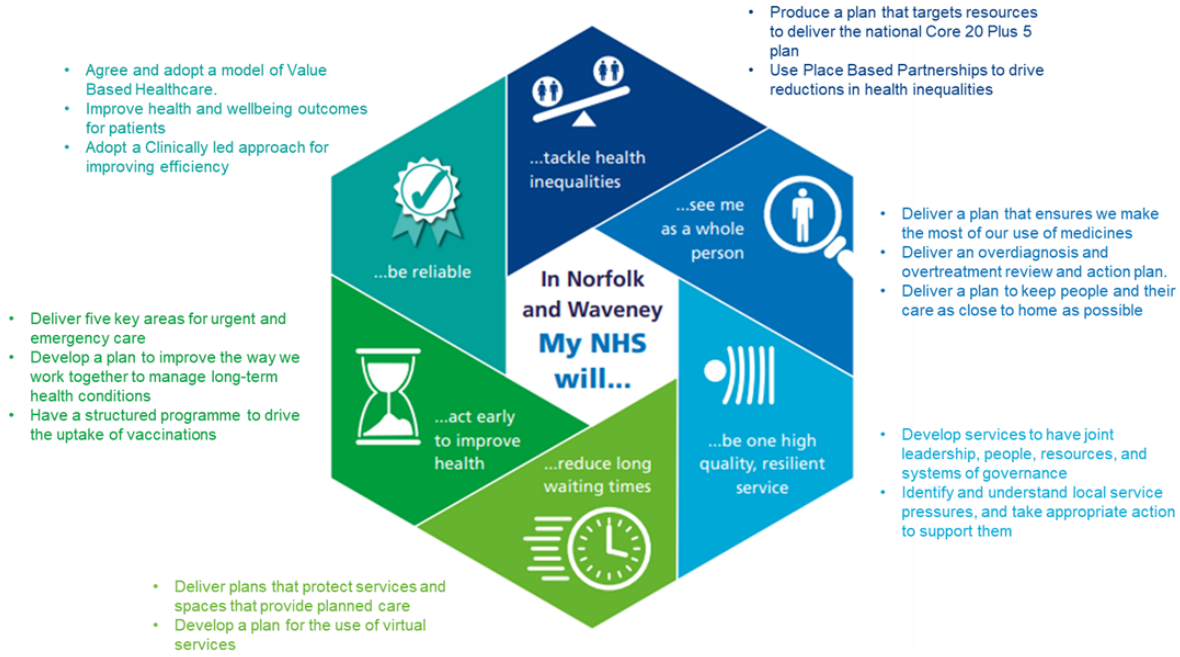
Where we want to be

Supporting and enabling our system clinical strategy

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

A summary of these objectives are set out in the figure below.

Figure 9: Summary of Clinical Objectives



This Estate Strategy is integral to supporting and enabling the five-year clinical plan. It seeks to promote innovation as a positive and proactive approach to delivering improved quality, efficiency, sustainability, and enabling the ICS to support its essential estate needs.

In the same way we aim to support the Integrated Care Strategy, we will enable the clinical strategy by:

- Ensuring that our estate supports the provision of preventative models of care
- Supporting delivery of care locally, in the community through 'Place' and PCNs
- Enabling relocation of services closer to areas of high need, where clinically appropriate, and supported by investment decisions
- Ensuring that our estate supports access to services for all our population
- Reducing the negative impact of wider determinants of health by providing equitable access to care
- Supporting integration of physical, mental health, community and social care by co-locating services and providing flexible shared spaces
- Ensuring that our estate adaptation to climate change is supported by investment and management decisions that enable clinical service strategies and sustain the operation of health and care

Where we want to be

Supporting and enabling a response to the challenges faced by the system

Acute services and infrastructure

Our acute hospitals, along with our wider health and care services and infrastructure, are under unsustainable pressure due to rising demand related to the demographic shift, forecast activity growth and resultant gaps in capacity to meet the demand for acute services. There have been big increases in the number of people visiting emergency departments and being admitted to hospital in an emergency.

The following describes our plans for addressing these concerns across acute care.

Efficient and effective acute care

- Our hospitals will focus on patients who need specialist or emergency care
- We know most patients are more likely to recover better and more quickly from surgery or hospital treatment at home, in their own bed; therefore, we aim to discharge patients as soon as they no longer need to stay in hospital for their care
- We aim to expand and utilise virtual wards and reablement / intermediate beds in the community to support the discharge of patients
- We will reduce acute attendances and admissions by improving earlier intervention and better care coordination, including self-care and prevention initiatives
- Appropriate activity provision will move from acute settings and closer to people's homes

Acute Collaboration

- Whilst there is a requirement to retain three individual hospitals due to the size of Norfolk and Waveney, and the number of people living here, our three hospitals will work even closer together in the future and operate increasingly as one overall acute hospital system
- Greater collaboration and cooperation between our hospitals will offer more benefits to patients and help maintain strong local services
- To improve the care people receive at our hospitals we continue to join up the teams who provide some of our specialist services

Ambulance services and infrastructure

The East of England Ambulance Trust (EEAST) is the urgent and emergency responder, providing paramedic support and conveyances to emergency departments on each day of the year through six counties which make up the East of England, including Norfolk and Waveney.

The Trust provides a range of non-emergency patient transport services to and from hospitals, treatment centres and other similar facilities for patients who cannot travel unaided because of their medical condition or frailty.

The Trust also operates a traditional model of ambulance stations supported by standby locations, without depots or response posts. Over time, the agenda would be to use integrated or shared health and welfare facilities. The Trust is embarking on a major modernisation programme that will impact their estate, fleet, logistics and working environment. This will respond to the asset challenges we face and develop a plan aligned to strategic drivers e.g. Net Zero Carbon, Carter efficiencies, workforce sustainability.

Where we want to be

Primary and community services and infrastructure

In line with our System clinical strategy, there is a need for greater collaboration between primary care and community services; therefore, Primary Care Networks (PCNs) will provide the vehicle for delivering collaborative working amongst front-line staff. PCNs will work closely with community and mental health colleagues, and social care staff to improve services for local people. They will offer improved access to an extended range of services, recruit additional health staff, and help to integrate primary care with wider health and community services.

Our local priorities are:

- To provide integrated 'out-of-hospital care,' with a focus on prevention, self-care and supporting people to live well at home for longer. Our community-based providers, NCHC, NSFT, CCS, EEAST and ECCH, are working with PCNs to develop their integrated service models / PCN Estate strategies, ensuring that services and estate are aligned to meet the needs of local communities.
- To reduce pressure on emergency hospital services by identifying the most vulnerable and high-risk patients requiring focused and in-depth interventions.
- Workforce development and skill mix opportunities to deliver a more responsive and accessible NHS (in line with national directive on seven day a week working), for example GPs heading a team which includes different health workers such as physician associates and medical assistants. This will enable general practice to have more capacity to support delivery of more complex care.

The increased integration of primary, community, mental health and social care staff may influence the size and type of wider community estate. Where necessary, community providers will relocate service activity to primary care, or proposed community located care hub and spoke models, whilst retaining core estate to provide more specialist and focussed care, which may include relocation of activity from acute sites.

To support this, we will invest in health hubs, formed from new and existing community-located assets, and may be comprised of more than one building in a 'Place' level setting. They will offer the opportunity to implement modern technologies and address digital deprivation across the ICS, acting as exemplars for other services within each locality.

Health & care estate will be developed to maximise integrated generic spaces in community settings. Bookable clinical and non-clinical rooms will act as a flexible resource for the wider health and social care community.

Development or disposal of estate identified as surplus to NHS requirement will be conducted on a phased basis, considering the emergent needs for health and care service strategies and other public sector requirements.

Where we want to be

Mental Health services and infrastructure

The vision for mental health services is to improve access to urgent and emergency care when required; integrate with social care and physical health services; and promote early intervention and prevention.

The pandemic has intensified the urgent need to support mental health services as both the public and clinicians are aware of the impact that the pandemic has had on many people's mental health, especially children and young people. To deliver this vision partners will need to work together focusing on the wider determinants of health to enable the best possible outcomes for residents.

Suggestions for improving mental health services available to patients include:

- Extra resource to support greater community provision
- Earlier intervention as a patient's condition develops to reduce the risk of conditions worsening and becoming entrenched, for example, in eating disorders
- Direct extra resources to the communities and age groups most in need especially children and young people
- Reduce fragmentation of mental health services across multiple providers
- Revised offer to reduce 'medicalising' someone when they present. This means seeing and treating the 'whole person' and taking the time to understand how mental health and physical conditions are often interrelated and properly understood when someone seeks help. Wherever clinically possible to treat and support patients with therapies that do not involve prescribing medicines
- Commissioning services to reflect the interrelated nature of mental and physical conditions

In order to make the suggested improvements, our estate will play a key role in supporting prevention. Mental Health services have already begun to work in a more integrated way with primary care services by developing and promoting new primary mental health roles at PCN level. We will ensure we have the correct infrastructure model in each locality through the five mental health and wellbeing hubs being developed alongside primary and community health and wellbeing hubs. This will allow for creating a more joined up approach to care and better continuity between urgent care and community services. The hubs will support a reduction in referrals to crisis teams and subsequently reduce the number of people attending hospital for emergency care.

Where we want to be

Estate Strategic objectives

To realise our vision, we need to set objectives that address the challenges, help respond to system priorities, and enable local strategies. The following strategic objectives provide a framework and the principles for controlling the development and transformation of our estate to ensure that any changes directly meet the requirements of our staff, patients, and visitors.

The figure below highlights our four strategic objectives, and the subsequent pages provide listed aspirations for each.

Figure 10: Summary of Estates Strategic Objectives

Where we want to be

Improving Access

- Delivering capacity to enable the movement of services into the community and ability to deliver care closer to home.
- Implementing operational hub & spoke models to deliver integrated, multidisciplinary working.
- Developing a resilient and digitised estate to support remote consultations, separation of flows and to sustain elective services which may be otherwise impacted by a business continuity event such as a pandemic.
- Access to shared space for our staff across Norfolk & Waveney that is not restricted by organisational boundaries.
- Delivering One Public Estate (OPE) initiatives to offer local integrated services aligned to the communities they serve.
- Identified locations for the wider workforce to see patients and for shared admin teams to work together e.g., shared business hubs for back-office staff.
- Ability to operate seven days a week and enable out of hours access.
- Flexible, accessible space to enable virtual consultations for those in areas of digital poverty and for clinicians to undertake virtual consultations.
- Access, spaces and environments designed for the consideration of people with disability of all types, supporting flexible access and arrangements for use.

Improving Quality & Condition

- Improved effectiveness, efficiency, safety, governance, and the patient's experience of the estate and reduced associated risks.
- Provide safe, functionally suitable estate, supported by efficient services whilst specifically resolving capacity and RAAC issues at two of our acute hospitals.
- Improved condition and functional suitability of core and flex estate through targeted investment.
- Provide fit for purpose estate, addressing backlog maintenance across our system.
- Hubs designed to facilitate Multi-Disciplinary-Team working and all the requirements of the different clinical, therapeutic, social care services to be provided.
- Maximise the benefit of investing in and developing our staff and patient wellbeing, and ability to build facilities and environments that aid welfare.
- Provide estate that offers an improved working environment for the workforce and contributes to successful recruitment and retention programmes that sustain our workforce.
- Provision of enhanced estate that is suitable to train staff including use of essential equipment.
- Estate that meets the needs and requirements for Healthcare Worker Housing and Incubator Homes.
- Facilities that incorporate digital infrastructure.
- Development, design and build of estate that is aligned to Department of Health's Health Building Notes (HBNs) and Health Technical Memoranda (HTMs), Building Research Establishment Environmental Assessment Method (BREEAM) standards, and utilises Modern Methods of Construction.
- Collaboratively procured supporting services that deploy innovation and secure value for money in scale and scope.

Where we want to be

Improving Sustainability

- Embedding net zero principles within everything we do.
- Aligning all estates and facilities programmes with the deliverables in the Estates Delivery Plan.
- Ensuring all new builds and estate improvements are compliant with the Net Zero Hospital Building Standards
- Managing agreed localised supply chains that minimise impacts on carbon emissions.
- An in-depth understanding of system and partner carbon footprints across Norfolk and Waveney, and knowledge of investment needs to decarbonise our estate & facilities services.
- Harnessing digital technology and systems that support and streamline services, resources, and expand our ability to reduce carbon emissions.
- Expanding innovative services providing care closer to home and digitally enabled care, whilst reducing and removing health inequalities.
- Prioritise investment that further enhances services in our local communities.
- Expanding our approach to engagement and development of our system workforce, to help define and deliver carbon reduction initiatives and broader sustainability goals.
- Provide green and biodiverse spaces that promote health and recovery for our patients, staff, and visitors.

Improving Efficiency

- Reducing our estates and facilities running costs through establishing annualised rolling programmes for efficiency.
- Improved utilisation of core estate and the reduction of spend on tail estate through rationalisation and disposal.
- Collaborative approach to procurement driving efficiencies and cost reduction via streamlined procurement; economies of scale; reduced duplication; standardised contracts, frameworks and specifications which are fit for use and available to all ICS organisations.
- A clear framework for capital investment decisions and infrastructure planning.
- Reinvesting disposal proceeds back into the system to support improvements, upgrades, and addressing backlog maintenance issues as prioritised.
- Collaborative approach to workforce driving efficiencies and cost reduction via collaborative workforce planning; reduced duplication; standardised contracts, policies, job descriptions and specifications which are fit for use and available to all ICS organisations.

Where we want to be

Estate SMART performance objectives

Our SMART (Specific, Measurable, Achievable, Relevant, and Timely) objectives help further define the 'where we want to be' and provide the indicators against which we can monitor our progress towards 'what good looks like'. The objectives set out in the table below are aligned to the drivers and challenges set out earlier in this strategy, are aligned to Model Health System benchmarking, and indicate our targeted improvement during the 5-year strategy period.

Table 3: SMART Performance Objectives

Indicator	Baseline Performance	Target
Non-clinical NHS Estate***	37.9%	30%
Empty/Underutilised NHS Estate***	3.9%	2.5%
Investment in multi-disciplinary hubs	-	20%
Investment to reduce backlog***	4.39%	10%
Non-functionally suitable Trust estate***	18%	10%
Non-functionally suitable GP estate **	19%	10%
Estates & Facilities cost per m2***	£474	£MHS*
Emissions from building energy & water ***	45,790 tCo2e	35,000 tCo2e
Investment in energy efficiency schemes***	< 1%	5%
Investment in technology to improve access	-	5%
RAAC & Critical Infrastructure Risk Backlog	-	plans to eradicate by 2035
Infrastructure Development Plans	-	plans developed by 2024

***NHS Trust estate only – data from ERIC and Model Health System
**GP estate only – data from Primary Care Data Gathering
*£MHS refers to the target being the Model Health System benchmark due to year-on-year fluctuation

10. How we get there

To plot 'how we get there' we will use the information and objectives of the preceding stages to develop a realistic and feasible roadmap to our future estate.

This section will highlight the key programmes of work and investment needs in order for us to realise our vision, deliver upon our strategic objectives, respond to challenges, and act as an enabler to our colleagues delivering care to our patients.

It aims to answer the following questions:

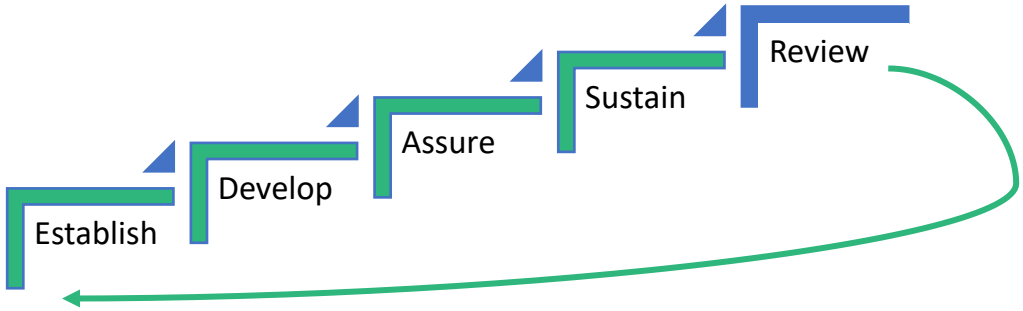
- how will we respond to and deliver against national policy and drivers?
- how will we enable and support local strategy and priorities?
- how will we incorporate local drivers and impacts into our planning?
- how will our estate support the ICS to overcome system challenges?
- how will we manage and/or eradicate estate specific challenges?
- what investment is required to realise our vision and meet our targets?

Strategic Enablers and Programme Delivery

To direct our journey, the Estates Management Team has established a set of strategic enablers that will drive the delivery of our strategy and its objectives.

Our strategic enablers provide the foundation of our estate strategy and annual operating plans. Delivery is coordinated through a continuous cycle of development and built around an annual core theme that focus' on incremental improvement. Figure 11 illustrates the five-year cycle.

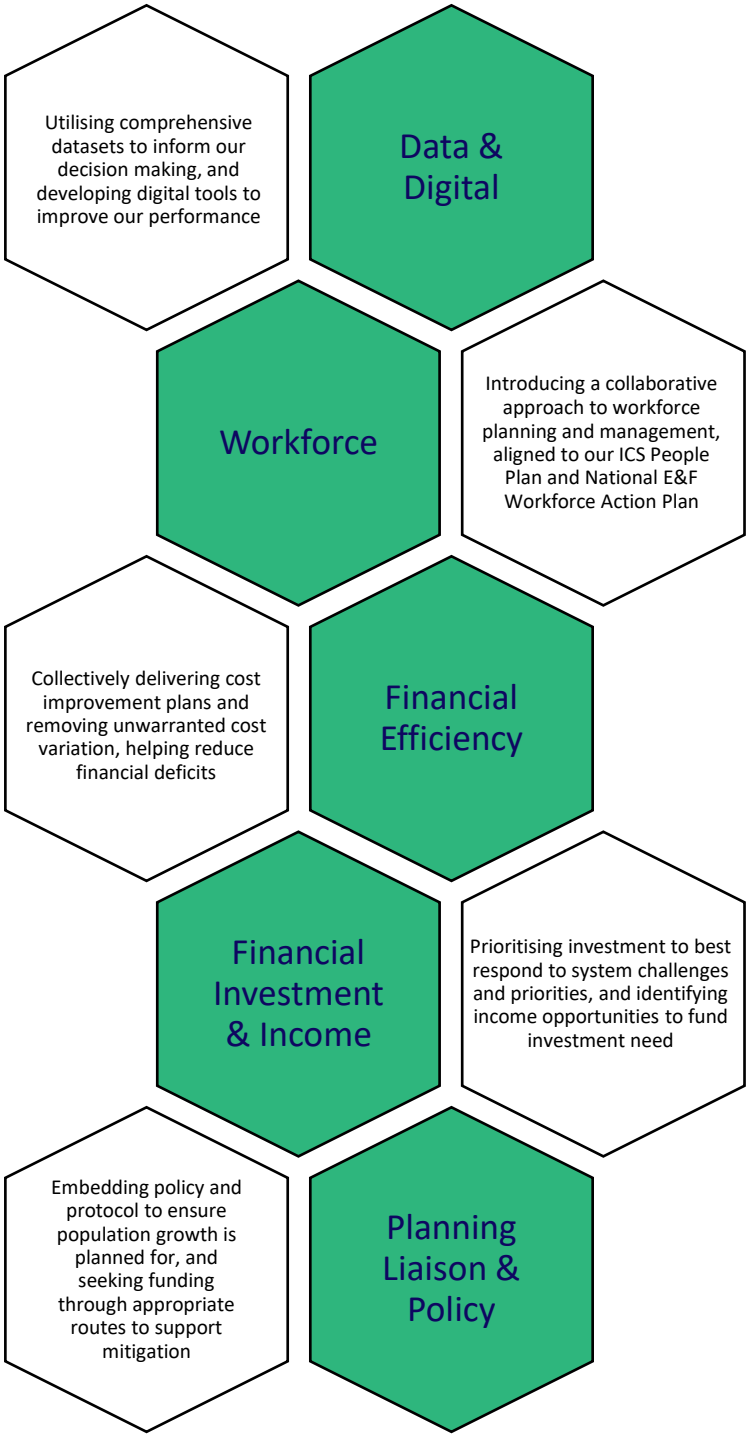
Figure 11: 5-year Development Cycle



How we get there

Figure 12 highlights our five enablers and introduces each one. Additional detail on our five-year development cycle and strategic enablers can be found in our annual Estates Operating Plans.

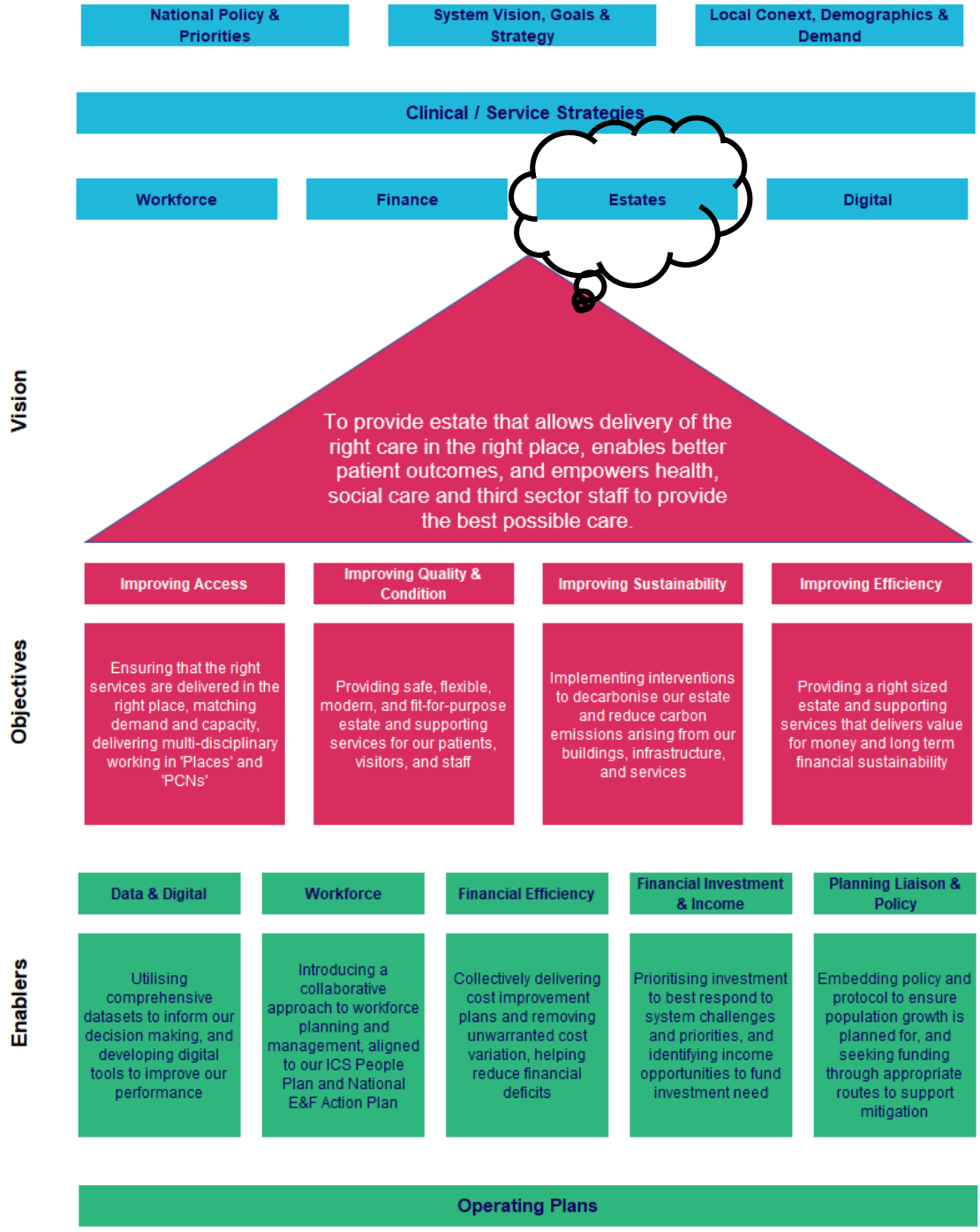
Figure 12: Summary of Estates Strategic Enablers



How we get there

The figure below illustrates our Estate Strategy. It highlights how our vision, objectives and enablers come together to enable the clinical strategy, support the wider drivers, and respond to local context and challenges faced.

Figure 13: Our Estate Strategy at a glance



How we get there

Creating an estate that delivers our vision

As outlined in the key challenges, too much of the NHS estate is not fit for purpose. This type of estate cannot deliver on the ambitions of the NHS Long-Term Plan and therefore poses risks that perpetuate health inequalities and inequitable access to services for patients.

Therefore, categorising estate into 'core', 'flex' and 'tail' will help to invest in the right estate, use buildings more effectively and dispose of the estate which is no longer suitable to deliver services.

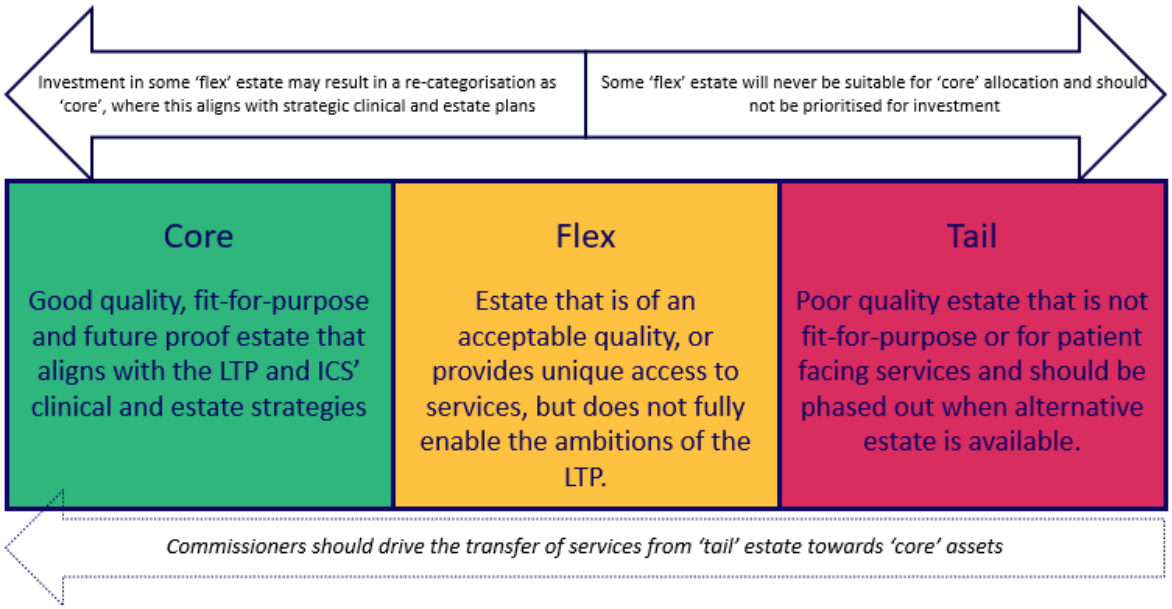
Whilst we have an initial categorisation of the estate within Norfolk and Waveney, we will need to go through a validation process with lead stakeholders to continue the process of re-categorising estate as we invest in flex estate to either bring them up to 'core' standard, or tail estate that is then to be disposed of after a short-term period.

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 by working at a provider level to understand how this can be done.

The development of PCN level service and estate strategies will be key to our understanding of estate need at a local level.

The figure below defines the 3 categories, articulates how investment will be prioritised, and the placement of services towards 'core' estate.

Figure 14: Estate Categorisation



How we get there

Delivering our strategy through prioritised capital investment

NHS capital continues to be constrained and funding for large scale reconfiguration projects and new builds can be difficult to secure. As an ICB, we have a capital pipeline that is kept live and up to date through the Strategic Estates Group. The pipeline spans all developments for primary; community; mental health; and acute health providers.

The outline five-year capital programme is submitted to the Strategic Capital Board, ICB Board and NHSE/I for approval on an annual basis, as part of the Annual Business Planning process.

The ICB prioritises investment using an agreed prioritisation matrix, ensuring investment is aligned to estate strategy and objectives; enables the ICS and wider strategies and priorities; and responds to the challenges faced both as a system and an estates function. Investment made will enhance services in our local communities, improving the condition and functional suitability of core and flex estate.

Provision will be made in the ICB's capital programme for schemes to restore the ICB's infrastructure to an effective operational state (Backlog Maintenance Programme). There is significant backlog maintenance across our main sites. The backlog maintenance across the acute sites cannot be fully addressed by investment from the ICB alone; therefore, this will be a key attribute when undertaking options appraisals and assessing value for money. During the strategy period specific focus will be developed on the completion of asset life cycle plans across our PFI / LIFT estate to ensure condition is managed and maintained.

Individual organisations working separately leads to duplication of effort and inefficient use of estate. Therefore, collaborative estate modelling and investment planning can help to deliver estates and financial efficiencies.

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

The Capital Investment Policy sets out the annual planning process for capital investment, the methods for implementing agreed investments and the process for proposing additional projects not included in the annual plan.

How we get there

Delivery of prioritised capital projects

Table 4 below lists the principal programmes of investment within the ICB with funding routes and the anticipated completion dates.

Table 4: Development of estate (principal programmes with funding routes identified)

Project	Completion anticipated
Primary Care Hubs (£25.2m Wave 4B funding) These hubs will provide integrated care closer to where people live. This funding will provide two new build facilities, in King's Lynn and Rackheath, as well as extension/alteration to sites in Sprowston and Thetford.	March 2024
Hellesdon Hospital (£38m Wave 4B funding) To provide new inpatient wards at Hellesdon Hospital. This will see three new 16 bedded mental health wards, as well as refurbishment of two existing 16 bedded wards. It will increase bed capacity from 65 to 80.	March 2024
Diagnostic Assessment Centres (£69m Wave 4B funding) Developing DACs for each of the three acute trusts. The DACs will aid rapid diagnosis and assessment. They will be located within the acute sites, but patient flow will be separated to maintain service continuity in case of an infectious outbreak.	March 2024
Community Diagnostic Centres (£23m diagnostic funding) These facilities will act as the spoke sites, supporting the DACs. They will deliver additional, digitally connected, diagnostic capacity, providing all patients with a coordinated set of diagnostic tests in the community.	March 2024
Priscilla Bacon Hospice (£12.5m Charitable Funds) To deliver modern palliative care facilities in Norwich. We will deliver a new 24 bed palliative care unit adjacent to the NNUH, replacing the aged 16 bed unit at Colman Hospital.	March 2024
James Paget Hospital (New Hospital Programme funding) We have received seed funding to develop and submit plans for a new hospital in Gorleston, through the New Hospital Programme. The vision is to develop a modern health and care campus specifically designed to serve the region.	March 2030
RAAC failsafe works (circa. £100m RAAC funding) Investment to implement an extensive plan to extend the life span of the Reinforced Autoclaved Aerated Concrete (RAAC), in the short to medium term at Queen Elizabeth and James Paget Hospitals.	March 2025
Community bed capacity (circa. £20m national funding) Investment to provide 50 community beds in modular build on the Norwich Community Hospital site. Development to increase capacity of reablement / intermediate beds in the community to support patient discharge.	Spring 2024

How we get there

Responding to Critical Infrastructure Risk – Backlog Maintenance

NHS Estate in Norfolk & Waveney is managed through five main providers, who each report the condition of their estate through annual estate data returns (ERIC). The condition of primary care estate has also begun to be assessed through condition surveys and will be added to the overall investment requirements during the period of this strategy.

Our ICB has witnessed an unprecedented growth in its recorded backlog maintenance across NHS estate over the last five years. Backlog increased from £50.4M (2017/18) to £165.7M (2021/22), driven largely by significant step change in high and significant risk requirements in two of the acute hospitals (James Paget and the Queen Elizabeth). This was realised in and impacted estate plans in 2019, following the introduction of the RAAC Programme. Outside of this backlog has remained steady in its growth / reduction through investment made by Trusts.

50% of Primary care estate has been surveyed and has revealed a total backlog maintenance cost of circa £863,000, with £150,000 of this assessed as high and significant risk. Backlog maintenance and the responsibility for maintaining GP and primary care estate is dependent on the ownership model and the lease terms, where they exist.

PFI / LIFT estate is maintained in optimum condition as part of ongoing cost during the lifetime of the agreement. As these parts of NHS estate reach their mid to end point it will become increasingly important to ensure the management of the asset lifecycle is integrated into NHS Estate management. This approach will mitigate the risk of estate returning to the NHS that has any accumulated backlog value or has not been developed to maintain its functional suitability.

Investment to reduce and remove Backlog Maintenance

This estate strategy sets a SMART target of annually investing 10% of our backlog value to remove and reduce backlog maintenance. Meaning if our backlog maintenance is £100M, we will invest at least £10M removing and reducing it. Analysis shows that during the recent strategy period (2018-2022), ICB investment varied between 6.7% (2018/19) to 10.6% (2019/20).

Backlog values will also change annually as the estate condition is subject to wear & tear, other investments are made, disposals take place, and new acquisitions are made.

Currently estate owners assess estate condition on different timelines, using six facet surveys. During the next strategy period these surveys will be coordinated to provide assessment at fixed points, enabling consistent planning and investment to take place across the ICB.

During this strategy period we will develop and embed coordinated approaches that monitor and manage estate condition based upon survey and other measures (to include PFI/ LIFT), and embracing principles that develop the sustainability of all estate used in the delivery of NHS services (e.g. building standards, utilisation and functional suitability improvement).

Through a combination of broadening the scope of measured condition, targeted investment to remove and reduce high and significant risk backlog maintenance and incorporation of managing PFI / LIFT building asset management, we will aim to reach a fully mitigated position in NHS Estate by 2030.

How we get there

Responding to Critical Infrastructure Risk – Reinforced Autoclaved Aerated Concrete

NHS Norfolk & Waveney ICB has two significant occurrences of RAAC in its estate. Detailed technical survey has resulted in significant programmes of investment in two sites to ensure structural integrity remains safe and managed in the short and medium term. These programmes will remain ongoing during the period of this estate strategy. There is a need to review and resolve the outstanding issues on the existing sites where RAAC exists, managing these as a key part of system risk and investment requirement. The two hospitals where RAAC exists are Queen Elizabeth Hospital (QEH), King's Lynn and James Paget Hospital (JPUH), Great Yarmouth.

Attention has turned to the long term, and replacement of the two hospital sites has been identified as the long-term solution. The National Hospital Programme introduced by government has incorporated the James Paget hospital to be funded, however, the Queen Elizabeth Hospital also requires urgent modernisation due to these structural issues related to RAAC. The hospital was built in 1980 with 80% of the estate constructed with prefabricated sections and RAAC plank structure. These buildings were only designed to last 30 years. Early expression of interest made by the QEH to join the extended National Hospital Programme awaits determination.

During 2022/23 the JPUH site replacement programme is being developed through business case stages. This work is being mirrored by QEH with a view to progressing both replacements in similar timescales, subject to successful business case stages.

Early indication of a national approach to standardising design and construction of replacement hospitals may influence the scope and extent of future investment, and thus impact on the way in which future services maybe delivered and placing emphasis on use of existing capacity within NHS estate, particularly within community settings.

The NHS has extended its assessment of the RAAC risk across its estate from which NHS Care is commissioned and this is expected to identify all additional risk (if any) during 2022/23. During 2022/23 further desktop appraisal of all estate used by NHS commissioned health and care services will identify any other prevalence of RAAC. Where required, site inspection will be conducted during 2023 to quantify presence and extent of use. The programme of eradication will be adjusted during 2023/24 to accommodate additional action required in all NHS estate. Options for tackling may include investment, service relocation and 'make safe' programmes.

How we get there

Transforming through the National Hospital Programme (NHP)

The NHP delivers government investment in the replacement of aged NHS hospital estate across the NHS. Within the programme RAAC affected estate has been included for replacement and has included the James Paget Hospital. An extension of the programme includes a bid to bring the Queen Elizabeth Hospital into the replacement programme, and outcome on this is awaited during 2022/23.

The NHP is transformational in its scale and vision and is not simply about re-providing existing estate. In defining the size, type and scope of replacement infrastructure, every opportunity is taken to secure the benefits, including:

- incorporating new ways of working through sustainable models of care
- investment in new technology and innovation
- maximising attainment of Net Zero ambition
- aligning infrastructure to our long-term clinical plans, bringing health and care closer to the community in which is required

Planning has to date developed through site development plans at both JPUH and QEH, involving relocation of each hospital to land within existing site curtilage. Working across clinical and commissioning teams, each Trust is undertaking significant change in how services maybe provided and where. Developing detailed understanding of NHS estate, and other estate use opportunities in local government, retail and public building settings forms part of the response that supports reform of sustainable care models and pathways. Design of service delivery between partners across secondary, primary and community care is and will lead to new delivery models. Current use of ‘community hubs’ or ‘hubs and spokes’ to provide accommodation that supports services will continue. There will be a change in focus in how these centres might operate by:

- offering flexible access to modern generic clinical facilities that operate around the clock
- supporting mobile service delivery, allowing access to fixed facilities whilst improving the reach of mobile services
- removing onerous occupancy models, permitting providers flexibility in cost and service terms
- improving access for NHS staff to welfare facilities, particularly in rural settings
- improving patient & visitor experience in thoughtful environments, with access to services and facilities that encourage access and improve health
- connecting NHS estate through shared services (e.g., logistics) and infrastructure (e.g., digital capability, accessible electric vehicle charging)
- securing the optimum return for the NHS £ spent on operating its estate, delivering modern and well-maintained health and care environments.

Working across local government, the NHS will utilise every opportunity to integrate with other public buildings which may offer additional benefit for patients, staff, and visitors within community hub buildings.

How we get there

Transforming through Digital Infrastructure and SMART buildings

The use of digital infrastructure and technology is a key part of our journey 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:

- space booking systems and motion sensors to monitor and inform building use, providing improved access to flexible space, for all colleagues across the ICS, support new models of care, and increasing the utilisation of core estate
- sensors to monitor and inform on environmental conditions such air quality, temperature, humidity, noise etc; ensuring our buildings provide the environments in which the experience and wellbeing of our building users is enhanced
- building management systems to monitor, inform and manage building energy and utility use, helping reduce the emissions from our buildings and meet our Net Zero targets
- proactive maintenance management systems to improve the performance, reliability, quality, and productivity of our estate, and reduce reactive and backlog maintenance costs
- smart signage, apps, and other software to support wayfinding, accessibility, and improve the flexibility of our estate and its use for our staff, patients, and visitors

How we get there

Responding to workforce challenges through housing initiatives

As a way of supporting recruitment and retention, we are working to develop housing initiatives in partnership with One Public Estate, local authorities, housing associations and housing developers. There are currently existing residential accommodations associated with our acute estate providers. The ICS will review the use and management of residential accommodation at the acute trusts, and in other settings (community, social care and other public sector agencies), to support our workforce with their accommodation needs. At the current time there are three initiatives that are being developed: Healthcare Worker Homes, Incubator Homes for health professionals, and Flexible Nursing Accommodation.

Healthcare Workers Homes and Incubator Homes are new initiatives that are being developed locally. Our plans for the homes for key workers are linked to the overall workforce and clinical strategies and aim to support recruitment and retention.

Healthcare Worker Homes

Healthcare Worker Homes will be separate and distinct from Key Worker Housing as they will be for the specific purpose of housing health and care workers and not the wider community of Key Workers. At the current time, the proposed definition of a health and care worker are those who are:

- A provider of frontline healthcare on an NHS contract or that supports delivery of NHS services within the health and care sector and has a role identified within the local workforce gap analysis (non-administrative roles).
    - Care Workers (in the community or within residential or day care settings)
    - Nurses (Acute, primary and community nurses)
    - GPs (including registrars)
    - Social care workers
    - Midwives
- The terms on which housing will be offered are yet to be agreed.

Incubator Homes

The benefit of this type of accommodation is that higher paid professionals moving from out of area or abroad will not have to sell their existing property and will be fully supported in a relocation. Therefore, as they arrive in a new area to take a new role, they will know where they will be living, where their children will go to school, where the local amenities are located and how to join local groups and clubs of interest. This provides the ability for the recruit to fully experience the role with less risk knowing their existing home remains and that they and their family, where applicable, will be supported in all aspects of the relocation and that they have up to two years to get to know the area to find a suitable longer-term home for the future.

Flexible Nursing Accommodation

To adapt to the demand for nursing accommodations, units will be designed to modern standards that enable real flexibility. Building on successes across the country, where investment is agreed, the ICS will seek to deliver such units with the concept of repeatable design that enable single persons accommodations with shared facility to be easily converted to single flats for future rental or resale. Initial emphasis will be on the development and use of existing and wider accommodation stock that supports service operations.

How we get there

Improving integration through One Public Estate (OPE)

One Public Estate is an established national programme delivered in partnership by the Office of Government Property (OGP) and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners.

The OPE has three core objectives:

1. Creating economic growth (new homes and jobs).
2. Delivering more integrated, customer-focused services.
3. Generating efficiencies, through capital receipts and reducing running costs.

The Norfolk OPE:

- Uses public sector property assets as a catalyst to transform Norfolk public services.
- Supports public sector asset holders within the local areas to better manage their land and buildings by encouraging a more collaborative approach.
- Facilitates partners with co-production of services, service re-design and sharing resources.
- Supports growth and regeneration by releasing public sector land and buildings.
- Works to modernise and make more suitable/flexible and increasing utilisation of the public sector property estate.
- Reduces property costs and generating income streams to reduce dependence on grant.
- Generating capital receipts for reinvestment in services or the repayment of debt.
- Has generated investment in health estate development, enabling development master plans and team integrations to complete.

We will continue to work with the one public estate to ensure:

- Investment is prioritised to support areas of growth where there are inadequate existing facilities.
- Investment is prioritised where it supports clinical transformation and service delivery.
- Inefficient or functionally unsuitable buildings are disposed of in conjunction with estates rationalisation.
- Innovative approaches to the delivery of healthcare services reduces demands on the healthcare estate, e.g., use of technology.
- Only undertaking new build where opportunities to rationalise and / or maximise use and efficiency of the existing estate have been realised.

How we get there

Managing population growth in collaboration with local planning authorities

A collaborative and innovative relationship must continue to underpin the relationships between the ICB and local authorities to ensuring the delivery of services to residents. The partnership we have with them will play a key role in making shared decisions on how to use resources, design services and improve population health at 'Place' level.

Through partnership, local planning authorities, health partners, the ICB and Public Health Norfolk maintain a formal engagement protocol *('The Planning in Health Protocol')* to ensure that the principles of promoting health and well-being through the local planning systems are implemented across Norfolk and Waveney.

We will continue to work with local planning authorities and ensure the impacts on health and care services are measured and managed as our population and the requirement for our services continue to grow. Financial contributions through Community Infrastructure Levy (CIL) and Section 106 Agreements (S106) will continue to be sought and aligned to our Capital Investment Pipeline to ensure infrastructure and capacity grows in line with demand.

Where possible, we will also work with local authorities to establish a tariff-based approach. This will work by agreeing a flat rate per dwelling and reviewing end of year housing trajectories to calculate the financial contributions for health that year. This will help to develop a proactive approach and enable better planning and alignment of contributions towards investment needs.

We are working with councils within Norfolk and Waveney to develop Infrastructure Delivery Plans (IDPs) which identify a high-level estate strategy for health and social care infrastructure in response to population growth and housing developments planned for in local plans. IDPs set out detail for the type, location and scale of development and are driven by the various needs of the area, which in turn will be set out in place based PCN estate strategies. The plans are an important consideration when dealing with planning applications which allow us to improve our ability to understand needs and make decisions. It allows the health system to build an understanding of healthcare estate across Norfolk and Waveney and how this estate is managed and developed to mitigate the impacts of population growth, and what investment would be required to put the mitigation in place.

IDPs are developed by reviewing the proposed housing growth for the area, aligning the estate strategies across all health partners to understand the infrastructure needs and thus creating a capital investment plan for the ICB estate. Working with the LPAs, the IDPs are agreed and cited within the LPA local plan as the NHS response to planned development over the course of at least five years.

We will work with the councils to ensure they play a key role when developing new facilities to deliver co-location and integration of health and social care services, local authority services, community healthcare, police, fire, and ambulance personnel.

How we get there

Achieving Net Zero Carbon through our Green Plan

Climate change poses an existential threat to the whole planet and we, in Norfolk and Waveney, are not immune from its wide reaching and devastating consequences. Taking decisive action to reduce our contribution to global climate change will save lives and benefit the health services of tomorrow.

Nationally, the NHS has made ambitious commitments to be net zero by 2045. In Norfolk and Waveney, we must play our part in meeting this critically important commitment.

The ICS Green Plan provides a co-ordinated and strategic approach to the Net Zero Programme and sets out how we will embed, respond to, and help deliver the ambition of becoming the world's first 'net zero' national health service.

Emissions resulting from our 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 together we will explore and implement interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.

To do this we will:

- Ensure that all estates and facilities programmes and projects are aligned with the deliverables in the 'Estates 'Net Zero' Delivery Plan.
- Strive to reduce our consumption of natural resources through targeted investment, education, campaigns, and processing of waste materials.
- Manage investment needed to decarbonise our estates and align funding accordingly.
- Ensure all large build / retrofit projects are compliant with Net Zero Building Standards.
- Drive further carbon footprint reduction attributed to estates and facilities through strategic reduction of back-office estate, underused space, and rationalisation of surplus, where appropriate.

Adapting to Climate Change

Acting on adaptation will improve the resilience of our services and the communities they serve, lessen the burden of illness and disease, and reduce health inequalities.

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 (e.g. buildings, transport) and supply chain (e.g. fuel, food, care supplies) need to be prepared for and resilient to weather events and other crises.

How we get there

Improving supported and independent living accommodation with Norfolk County Council

Norfolk County Council has two programmes to increase the number of specialist housing in Norfolk. Specialist housing has a clear evidence base to reduce pressure on health and social care.

We will align opportunity with the Norfolk County Council programmes to utilise health assets to advance opportunities for health and social care needs. We are also working alongside NCC with providers to focus on priority developments that will address:

- Reducing the number of people in hospital
- Reduction in GP appointments
- Reducing delayed discharges and create a more joined up approach with housing partners
- Secure suitable long-term housing options for a range of identified needs
- Providing a distinctive offer that enables people to live as independently as possible
- Reducing the number of cases where accommodation is required at short notice
- Assisting with strategic decision making on where housing is developed and type

Supported Living Programme

The County Council's Supported Living Programme supports the development of Supported Living Housing across Norfolk and providing appropriate housing options for people to improve the health and wellbeing of individuals which can reduce health and social care revenue costs. People with a Learning Disability and Autism and their families/carers suffer from difficulties finding the right accommodation to meet their needs, enabling them to live independently. We will aim to use health assets to develop opportunity for wider health needs and return value to health for investment in estate development.

There is limited accommodation specifically designed for people with a Learning Disability and Autism in Norfolk, although some plans are in place to develop accommodation options, more specialist accommodation is required for those people with multiple, complex needs.

Independent Living

In October 2018, NCC approved a capital fund of £29m to facilitate the development of Independent Living (extra care housing) in Norfolk. The council recognised the need to increase both the range and volume of housing options for older people and is committed to helping older people live independently for as long as possible. The evidence for this type of housing to reduce pressure on health and social care is well documented and includes evidence of a reduction in A&E admissions, a reduction in falls, an increase in wellbeing and mental health, and a reduction in GP appointments.

Led by Norfolk County Council, the programme works closely with housing developers, providers, and local councils to increase extra care housing provision in the county. Extra care housing schemes include a variety of features depending on the scale, location, and stated purpose of individual developments. Development of ICS estate continues to consider alignment to this programme, liaising with developers to identify schemes that deliver stronger health outcomes to Norfolk residents.

How we get there

Developing a commercial plan in response to the challenges faced

Reflecting on the challenges presented to the ICB regarding the impact of IFRS 16 accounting standards on leased estate, the organisation balance sheet, and subsequently on CDEL, there is a need to develop a strategy that allows for the most robust treatment of land assets and leased estate that manages the uncertainty of IRFS 16 impact, and the disposal opportunities for surplus land. Table 5 below looks at the proposed mitigations in response to the commercial challenges and risks raised.

Table 5: Commercial challenges and proposed mitigation

Risk	Mitigation
New IFRS 16 accounting standards and its impact on CDEL and leasehold portfolio	Estate wide lease and occupancy review to determine all forms or lease, contract, service agreement to develop awareness of liabilities including schedule of leased spaces with a complete accounting review and policy for each leased space.
Retaining surplus land ownership as opposed to freehold disposal	NHS Estate Code compliant freehold land disposal with favourable overage and clawback provision is still the optimal route with max benefit and low risk. Retained land subject to either land leases (on-balance sheet) or Special Purpose Vehicles (SPVs) are now more difficult to justify the Trust property/equity interest is off balance sheet.
Impact on balance sheet as liabilities from new and transitionary leases, contracts, and service agreements	Treasury are looking at issuing advice and guidance on this, and there is the potential for Treasury to fund the negative impact to Trusts and ICB, but this is not confirmed.
- Use of operating companies, development companies and Special Purpose Vehicles - There is a risk of kick back from Treasury and NHSE saying no to complex legal entities	There are still opportunities for SPVs that are structured to benefit the health economy. The easier route and more likely to enable upfront capital receipt and payment through overage and clawback is freehold disposal subject to planning. Asset level masterplans to be produced to formalise and articulate the need for certain legal entities to deliver new infrastructure. Infrastructure development plans setting out system estate strategies to inform programme business cases will increase traction through Treasury and NHSE plus help with engagement with local authorities and DHSC.
- ICB appetite for taking on leases on a head leaseholder basis - Challenge of resource and funding for fulfilling this requirement	NHS PS and CHP will still be viable lease holding vehicles for holding and managing leases as head lessee. Still too early for the ICB to consider lease holding interests as a standalone entity

How we get there

Realising the benefits from new ways of working

Our understanding of the efficiency benefits arising from Covid pandemic working and the working from home impacts on non-clinical estate has matured and the table below shows several opportunities and benefits arising from the effects of pandemic working, particularly working from home and the impact on corporate accommodation.

The workforce has been forced into a new way of working due to the pandemic and reflecting on the lessons learnt from a shift in mindset and activity can afford the ICS with certain opportunities to create long term benefits to the regional health economy including staffing and estate performance.

Table 6: Opportunities and benefits from new ways of working

Opportunities	Benefits
Opportunity for a mindset change to facilitate more vibrant, innovative cultural shift	Agile working policy to reduce occupancy space requirement and drive occupancy efficiency
Development of a team charter to set out the offer and behaviours for all staff	Occupancy cost savings through rationalising estate and co-locations with other existing corporate functions.
Opportunity for staff to balance freedom to choose with responsibility to meet business need	Optimisation of space for clinical use
Opportunity to manage performance on results and outcomes rather than presence	Reduction in carbon footprint and contribution to Net Zero carbon target
Opportunity to refurbish and improve existing estate	Potential benefit of capital receipt through freehold disposal
Data driven decisions to prioritise areas of focus	Enhanced work life balance for staff and a drive to improve health and wellbeing, create a happier, more engaged workforce
Opportunity to gather all provider approaches to new ways of working together	Greater flexibility around working hours and sites, improved access for patients and flexibility for staff
Opportunity to articulate best practice to form common solutions	Decrease levels of absence

How we get there

Communication and Engagement

The essence of this estate strategy is captured within our core strategic objectives:

- **Improving Access** – Ensuring that the right services are delivered in the right place, matching demand and capacity, delivering multi-disciplinary working in 'Places' and 'PCNs'.
- **Improving Quality & Condition** – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff.
- **Improving Sustainability** – Implementing interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.
- **Improving Efficiency** – Providing a right sized estate and supporting services that deliver value for money and long-term financial sustainability.

To deliver this we will continue to work with colleagues across local government, developing opportunity to achieve these objectives.

Development and use of the Health in Planning Protocol will continue to manage and underpin our engagements with the planning process and the development of our communities across Norfolk & Waveney, enabling us to plan sufficient facilities for the delivery of health services.

Change through investment will continue to be supported by engagement with users of our estate in the planning, delivery, operation, and use of the estate.

During the period of the strategy, we will:

- Engage with staff to develop estate that meets service objectives, supports their wellbeing, and promotes sustainable travel and access for all
- Communicate with service users, groups representing service users, volunteers and public on development of health estate, through showcase events, consultations, and accessible information
- Engage with health service providers and commissioners to incorporate this strategy into the delivery and commissioning of health services

Support from our partners, staff, patient, and visitors is critical to the successful delivery of this strategy and long-term goals, therefore communication and engagement remains key. We will need to engage with a view of inspiring people to find out more about what they want, how they can support and contribute to this work, and how we can achieve the very best in health and care estate.

We will continue to manage and maintain strong communications and engagement programmes as part of the annual estate planning process, and align this strategy and its objectives to staff, patients, visitors, and stakeholders and allow them to engage with the estate development agenda across the ICS.

How we get there

Monitoring and Review

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

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

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

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

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

11. Bibliography

Schedule of documents aligned to and/or cited throughout the strategy

Department of Health – Developing an estate strategy

The NHS Long Term Plan (LTP)

Delivering a Net Zero Health Service

The Naylor Review – NHS Property and Estates

The Health Infrastructure Plan

Next steps for integrating primary care: Fuller Stocktake report

NHS Premises Assurance Model (PAM)

Norfolk & Waveney Transitional Integrated Care Strategy

Norfolk & Waveney Integrated Care System Clinical Strategy

Norfolk & Waveney Integrated Care System People Plan

Norfolk & Waveney Integrated Care System Digital Strategy

NHS England and Improvement People Plan

NHS England Estates and Facilities Workforce Action Plan

General Practices premises policy review

Norfolk & Waveney STP 2018 Estate Strategy Workbook

Estates Operating Plan

Capital Investment Policy

Government Property Strategy 2022-2030

The Planning in Health Protocol

Norfolk & Waveney Integrated Care System Green Plan

Estates Net Zero Carbon Delivery Plan

Net Zero Operating Plan

Norfolk County Council Specialist Housing Programme

Bibliography

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Improving lives together
Norfolk and Waveney Integrated Care System

Table 7: Programmes to Drive Delivery

This table shows how our delivery programmes contribute and algin to our strategic objectives, enable ICS, care and clinical strategies, and respond to the wider challenges we face.

	Programmes to drive delivery	Improving Access	Improving Quality & Condition	Improving Sustainability	Improving Efficiency	ICS Vision & Goals	Integrated Care Strategy	Clinical Strategy	People Plan	Digital Plan	Growing and ageing population	Geographically dispersed population	Waiting lists and impacts of delayed care	Demand & capacity mismatches	Provision of mental health services	Workforce challenges	Financial deficits	Poor digital maturity	Estate condition & functional suitability	Backlog maintenance	RAAC	Fragmented estate strategy & investment planning	Estates & Facilities running cost variation	Tenure variation	Commercial challenges	Lack of supported living accommodation
Key Programmes	Creating an estate that delivers our vision	√	√	√	√	√	√	√	√		√	√	√	√	√	√	√		√	√	√	√	√	√	√	
	Delivering our strategy through prioritised investment	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
	Delivery of prioritised capital projects	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
	Responding to Critical Infrastructure Risk - Backlog Maintenance	√	√	√	√	√	√	√	√										√	√	√					
	Responding to Critical Infrastructure Risk - RAAC	√	√		√	√	√	√	√										√	√	√					
	Transforming through the National Hospital Programme (NHP)	√	√	√	√	√	√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√		
	Transforming through Digital Infrastructure and SMART buildings	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√		√	√	√	√	
	Responding to workforce challenges through housing initiatives	√	√			√	√	√	√							√										
	Improving integration through One Public Estate (OPE)	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√			√	√	√		√
	Managing population growth in collaboration with local planning authorities	√	√	√	√	√	√	√			√	√		√								√				
	Achieving Net Zero through our Green Plan			√	√	√	√	√	√	√																
	Improving supported living accommodation with Norfolk County Council	√	√			√	√	√			√	√	√	√					√			√				√
	Realising the benefits from new ways of working	√		√	√	√			√	√						√	√		√			√	√			