NHS
Suffolk and North East Essex
Integrated Care Board

NHS Suffolk and North-East Essex Integrated Care Board Meeting

30 July 2024

The meeting will be held in the Elizabeth Frink Room, Endeavour House, 8 Russell Road, Ipswich, IP1 2BX.

The meeting will start at 9.00am.

Members of the public are welcome to watch the meeting live on the SNEE ICB YouTube channel.

Questions for the Board relating to agenda items can be sent to thomas.mccolgan@snee.nhs.uk before 12 noon on 25 July 2024. Questions can also be asked during the meeting by those present or watching live on YouTube at the discretion of the Chair.

Agenda

General Business

Time: 9.00am.
Item 1: **Welcome, introductions and apologies for absence.**
Purpose: to note.
Lead: Will Pope (Chair).

Time: 9.01am.
Item 2: **Notification of any questions from members of the public for response at the appropriate time on the agenda.**
Purpose: to note.
Lead: Will Pope (Chair).

Time: 9.03am.
Item 3: **Declarations of interest.**
Declarations of interest made by members of the Integrated Care Board - declarations are listed in the Register of Interests which, along with the Hospitality and Gifts Register are available on the ICB website.
Purpose: to note.
Lead: Will Pope (Chair)

Time: 9.05am.
Item 4: **Minutes of the previous Integrated Care Board meetings.**
To approve as a correct record the minutes of the Integrated Care Board meetings on 19 March 2024 and 26 March 2024.
Purpose: to confirm.
Lead: Will Pope (Chair).

Time: 9.06am.
Item 5: **Matters arising from the previous Integrated Care Board meetings and review of outstanding actions.**
Purpose: to note & endorse actions taken.
Lead: Will Pope (Chair).

Time: 9.10am.
Item 6: **General update.**
To receive an update from the ICB's Chief Executive.
Purpose: verbal update.
Lead: Ed Garratt (ICB Chief Executive).

Strategy

Time: 9.15am.
Item 7: **Dental commissioning plan progress update.**
Purpose: to note.
Lead: Peter Wightman (ICB West Suffolk Alliance Executive Director)

Time: 9.35am.
Item 8: **A proposal for West Suffolk patients to benefit from state-of-the-art facilities at Essex and Suffolk Elective Orthopaedic Centre (ESEOC).**
Purpose: to note.
Lead: Lisa Nobes (ICB Executive Director of Nursing).

Time: 9.55am.
Item 9: **Suffolk SEND Inspection Outcome Update.**
Purpose: to approve.
Lead: Lisa Nobes (ICB Executive Director of Nursing).

Finance, Performance and Scrutiny

Time: 10.10am.
Item 10: **Finance Report**
Background papers: Financial Plan 2024/25.
Purpose: to note.
Lead: Howard Martin (ICB Executive Director of Finance).

Time: 10.15am.
Item 11: **Performance report.**
Purpose: to note.
Lead: ICB Executive Team.

Time: 10:20am.
Item 12: **Board Assurance Framework (BAF).**
Purpose: to approve.
Lead: Amanda Lyes (ICB Executive Director of People and Workforce).

Governance and Corporate Business

Time: 10.25am.
Item 13: **Integrated Care Partnership (ICP) Committee update.**
Purpose: verbal update.
Lead: Susannah Howard (ICP Director).

Time: 10.30am.
Item 14: **Integrated Care Board Governance Self-Assessment**
Item purpose: to note.
Lead: Amanda Lyes (ICB Executive Director of People and Workforce)

Time: 10.35am
Item 15: **Leadership Competency Framework for Board Members**
Item purpose: to note.
Lead: Amanda Lyes (ICB Executive Director of People and Workforce)

Time: 10.40am
Item 16: **Committee Minutes and Highlight Reports**
Item purpose: to note.
Lead: Amanda Lyes (ICB Executive Director of People and Workforce)

Time: 10.45am
Item 17: **Attendance Log**
Purpose: to note and review.
Lead: Will Pope (Chair)

Time: 10.46am
Item 18: **Any Other Business**
Purpose: to note.
Lead: Will Pope (Chair)

Time: 10.47am.
Item 19: **Questions from the public – Maximum 10 minutes**
Please note questions should relate to the items under discussion and must be a question rather than statement. Where individuals deviate from this requirement they will be asked to stop and will not be invited to take any further part in the meeting.
Lead: Will Pope (Chair)

The next meeting of the Board is due to be held on **24 September 2024.**

Exclusion of the Press and Public

The Integrated Care Board is recommended to exclude representatives of the press, and other members of the public, from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

Extraordinary meeting of the NHS Suffolk and North-East Essex Integrated Care Board held online on 19 March 2024 at 5.15pm.

Present:

Voting Members of the Board:

Prof. William Pope, Chair of the Integrated Chair Board
Freda Bhatti, Partner Member – Primary Care Essex
Cath Byford, Partner Member – Norfolk and Suffolk NHS Foundation Trust (*deputy member)*
Ewen Cameron, Partner Member – West Suffolk NHS Foundation Trust
Georgia Chimbani, Partner Member - Suffolk County Council
Geoff Dobson, Non-Executive Member – Finance (Interim)
Ed Garratt, ICB Chief Executive
Shane Gordon, Partner Member – North Essex and East Suffolk NHS Foundation Trust (*deputy member*)
Dr Andrew Kelso, ICB Medical Director
Howard Martin, ICB Director of Finance
Moira McGrath, Partner Member - Essex County Council (*deputy member*)
Phanuel Mutumburi, Non Executive Member - Quality and Safety (Interim)
Lisa Nobes, ICB Director of Nursing & Clinical Quality
Janet Wood, Non-Executive Member – Audit

Regular Board Attendees:

Susannah Howard, Integrated Care Partnership Director
Amanda Lyes, ICB Director of People and Workforce
Laura Taylor-Green, North East Essex Alliance Director
Peter Wightman, West Suffolk Alliance Director
Maddie Baker-Woods, Ipswich and East Suffolk Alliance Director

Other Attendees

Andrew Dunn, Consultant Orthopaedic Surgeon, West Suffolk NHS Foundation Trust and Clinical Director Essex and Suffolk Elective Orthopaedic Centre (ESEOC)
Sam Glover, Chief Executive, Healthwatch Essex
Tom McColgan, ICB Governance and Compliance Manger (Minutes)
Paul Molyneux, Medical Director, West Suffolk NHS Foundation Trust
Simon Morgan, ICB Associate Director of Communications
Councillor Craig Rivett, Suffolk County Council
Andy Yacoub, Chief Executive, Healthwatch Suffolk

1 Welcome, introductions and apologies for absence

1.1 Apologies for absence had been received from Richard Watson (ICB Director of Strategy and Transformation), Caroline Donovan (Chief Executive, NSFT), Paul Gibara (ICB Director of Performance and Improvement), Kirsten Alderson (Member - VCSE Sector Assembly), Peter Devlin (Partner Member -

Essex County Council) and Nick Hulme (Partner Member – Chief Executive, ESNEFT).

2 Declarations of interest.

2.1 No declarations were made in addition to those noted in the register of interest published with the agenda.

3 Proposal for west Suffolk patients to benefit from state-of-the-art facilities at Essex and Suffolk Elective Orthopaedic Centre (ESEOC).

3.1 Ed Garratt, ICB Chief Executive was joined by Andrew Dunn, West Suffolk Hospital and Simon Morgan, ICB Associate Director of Communications to present the report.

3.2 Before doing so, Paul Molyneux, Medical Director at West Suffolk NHS Foundation Trust clarified that figure two within the report was incorrect and the 'Daycase procedures' row should show 50% on both sides of the table to add up to a total of 100%.

3.3 Mr Dunn spoke about the unprecedented levels of disruption on elective hospital care across the country, due to the pandemic. He said that nationally, the waiting list has surged by 61% from 4.57 million before the pandemic in February 2020 to 7.47 million at the start of this year. Reducing the backlog is one of the Government's national priorities.

3.4 Mr Dunn said based on the capacity available to WSFT, it is proposed approximately 60% of orthopaedic elective surgical procedures (1,300-1,500 per annum) from West Suffolk Hospital in Bury St Edmunds should be relocated to the-state-of the-art ESEOC in the Dame Clare Marx Centre (DCMC) at Colchester Hospital Number (may fluctuate dependent on case mix). Mr Dunn said this would leave approximately 1,300 orthopaedic procedures per year on site at West Suffolk Hospital, including all paediatric orthopaedic activity. All pre-operative and post operative care, including pre-operative assessment for West Suffolk patients would continue to be provided at WSFT and in pre-existing peripheral clinics.

3.5 Mr Dunn also highlighted a number of benefits this would bring to patients:

Waiting times – By moving to ESEOC the WSFT predicts its patients may see wait times reduce

Primary Focus on Elective Care – Delivering surgery via a surgical hub will enable teams to focus solely on the delivery of elective excellence, reducing length of stay

Revision expertise – concentrated in a regional hub; all knee revision surgery being directed to the hub

Centre of excellence – high quality services provided by specialist teams within Europe's largest elective orthopaedic centre

Increased capacity – by using this facility in addition to all available WSFT theatre capacity, additional capacity will be created, enabling more patients to be treated

Training centre – allowing the surgeons of tomorrow to be trained locally and within the system

Free up an operating theatre at WSFT – This will allow clinicians to conduct more work on elective recovery which will mean more capacity for patients to be seen faster.

3.6 Simon Morgan then outlined the proposed approach that the ICB would take in relation to the public engagement needed. Mr Morgan said the ICB and the WSFT are proposing to run a six-week public engagement exercise during May and June

3.7 He stressed the system wants to listen to people's views on the proposal and if any areas of concern are highlighted, to work with local patients to overcome those issues

3.8 Mr Morgan said an independent survey and a separate analysis report would be produced and has been in discussions with Healthwatch Suffolk and Healthwatch Essex about this already.

3.9 He also said he had discussed the approach with the Health Overview Scrutiny Committee in Suffolk, NHS England, Healthwatch Suffolk and Healthwatch Essex who are in support with this proposed approach to public engagement. He also stressed that an equality impact analysis as well as a travel plan would also be produced.

3.10 Mr Morgan provided assurance to the Board that the public engagement process would be full, meaningful, and transparent highlighting the steps that the ICB would take to publicise exercise. He also confirmed that the Board should expect to see the outcome of the engagement exercise in July 2024. Ed Garratt highlighted the public involvement work that had already been undertaken around delivering orthopaedic services at the Dame Marx Centre.

3.11 Andy Yacoub, Healthwatch Suffolk welcomed the proposal and reflected on the feedback that Healthwatch had previously gathered which suggested that 60% of patients on the waiting list for orthopaedic surgery would be willing to travel for an operation. However, 15% of patients responded that they would be unable to travel, and these patients were more likely to be living in poverty. He stressed the need to ensure that this was reflected in the equalities impact assessment and the approach to deciding who was offered operations in Colchester or Bury St. Edmunds.

3.12 Andrew Dunn responded that learning from other orthopaedic centres would be used to ensure that the roll out of services at the Dame Care Marx Centre did not unintentionally exacerbate any existing health inequalities.

3.13 The Board unanimously **APPROVED** the public engagement approach as outlined within this paper and **NOTED** the ongoing discussions pertaining to an agreed financial/activity model.

The meeting ended at 5.50pm.

NHS Suffolk and North-East Essex Integrated Care Board Meeting held on 26 March 2024, 9am at Endeavour House,

Present:

Voting Members of the Board:

Prof. William Pope, Chair of the Integrated Chair Board
Kirsten Alderson, Member - VCSE Sector Assembly
Dr Freda Bhatti, Partner Member - Primary Care Essex
Craig Black, Partner Member – West Suffolk NHS Foundation Trust (*deputy member*)
Cath Byford, Partner Member – Norfolk and Suffolk NHS Foundation Trust (*deputy member*)
Georgia Chimbani, Partner Member - Suffolk County Council
Geoff Dobson, Non Executive Member – Finance (Interim)
Ed Garratt, ICB Chief Executive
Nick Hulme, Partner Member – North Essex and East Suffolk NHS Foundation Trust
Dr Andrew Kelso, ICB Medical Director
Howard Martin, ICB Director of Finance
Moira McGrath, Partner Member - Essex County Council
Phanuel Mutumburi, Non Executive Member - Quality and Safety (Interim)
Janet Wood, Non-Executive Member – Audit

Regular Board Attendees:

Maddie Baker-Woods, Ipswich and East Suffolk Alliance
Susannah Howard, Integrated Care Partnership Director
Amanda Lyes, ICB Director of People and Workforce
Richard Watson, ICB Director of Strategy and Transformation
Peter Wightman, West Suffolk Alliance Director
Councillor Craig Rivett, ICP Co-Chair

Other Attendees

Prof. Nick Barker, East of England, Co-regional Chief Dental Officer (for item 7)
Sam Glover, Healthwatch Essex
Andy Yacoub, Healthwatch Suffolk
Tom McColgan, ICB Governance and Compliance Manger (Minutes)

General Business

The Chair noted that Peter Devlin had now stood down from the Board. The Chair thanked Peter for his work and welcomed Moira McGrath to the Board as the new Essex County Council representative.

The Chair noted that the meeting would be Geoff Dobson's last as a Non-Execuitve Member. The Board joined the Chair in thanking Geoff Dobson for his work as a board member as well as for serving as chair of the Finance and Estates Committees and sitting as a member of the Audit Committee. The Chair also thanked Jo Mael for her work supporting the Board as the

ICB Corporate Governance Manager, having previously supported the CCG governing body meetings.

1. Welcome and Introductions and apologies for absence.

1.1. Apologies had been received from: Caroline Donovan (Partner Member – Norfolk and Suffolk NHS Foundation Trust), Laura Taylor-Green (North East Essex Alliance Director), Paul Gibara (ICB Director of Performance Improvement), Ewen Cameron (Partner Member – West Suffolk NHS Foundation Trust), Kirsten Alderson (Board Member – VCSE representative) and Councillor John Spence (ICP Committee Co-Chair).

2. Notification of any questions from members of the public for response at the appropriate time on the agenda.

2.1. The Chair noted that seven questions had been received from Mr Anthony Dooley in advance of the meeting. The three relating to items on the agenda would be responded to during the relevant items. The remaining four questions would be responded to in writing outside of the meeting.

3. Declarations of Interest.

3.1. There were no declarations of interest made relating to any items on the agenda.

4. Minutes of the previous ICB Board meeting held in public on 30 January 2024.

4.1. The minutes of the previous meeting were confirmed by the Board as being a true and accurate record. The Chair noted that there were two typos and stated that the spelling of Cllr Reid and Vivian Yiu in the attendance list would be corrected.

5. Matters arising from the ICB Board meeting of 28 November 2023 and review of outstanding actions.

5.1. The Chair noted the outstanding actions on the action log:

- Andrew Kelso (ICB Medical Director) provided an update on the action relating to virtual wards stating that the virtual ward programme was strongly embedded across the system and was being monitored though the Urgent and Emergency Care Committee and so the action could be closed.
- The Chair confirmed that the written answers to the questions submitted for the last meeting would be sent to Mr Dooley and apologised that this had not already been done.

6. General Update.

6.1. Ed Garratt, ICB Chief Executive brought the following items to the attention of the Board:

- WSFT and ESNEFT's collaboration on the new Dame Clare Marx Orthopaedic Centre which had been presented to the Board at a special meeting earlier in the month.
- The improvement in performance of the Ambulance Service and Accident and Emergency departments in SNEE.
- The Board would be discussing the SNEE Dental Plan later in the meeting. The campaign group 'Toothless in Suffolk' had responded to the plan stating that they felt that it did not go far enough, and Ed Garratt stated that he would be happy to meet with them to discuss the Plan.
- The NHS Staff Survey results had been released and SNEE ICB was one of the top five best performing ICBs nationally. SNEE ICB had not seen the drop in staff satisfaction seen across many other ICBs over the previous year.
- The Integrated Care Partnership Team, the ICB, and other partners had hosted a number of events in the last few months particularly highlighting health inequalities, inclusion and cultural safety, and an event focusing on supporting Looked After Children.
- A number of individuals and teams in the SNEE ICS had won awards including Georgie Brown from WSFT who won the Allied Health Professional of the year award and the ICB's Maternity and Neonatal Team who won the maternity team of the year.

Strategy

7. Improving Oral Health in SNEE: ICB Dental Plan.

7.1. Peter Wightman (West Suffolk Alliance Director) was joined by Professor Nick Barker, East of England, Co-regional Chief Dental Officer, Andy Yacoub, Healthwatch Suffolk and Sam Glover, Healthwatch Essex to present the report.

7.2. Nick Barker and Peter Wightman spoke to a presentation included in the agenda highlighting the health inequalities present in oral health outcomes nationally and spoke to the situation in Suffolk and North East Essex including oral health inequalities and the need to increase the provision of NHS dental care.

7.3. Sam Glover stated that access to dentistry was one of the main reasons that residents contacted Healthwatch. She stressed the need to make oral health everyone's business and the impact that poor oral health had on overall health and wellbeing.

7.4. Andy Yacoub highlighted the NHS's national recovery plan referencing the fundamental challenges in dental care. He welcomed the ICB's proposed approach to making immediate improvements to access and increasing the

workforce. He drew the Board's attention to a recent study carried out by HealthWatch Suffolk into dental care.

7.5. The Chair noted that a question from Mr Dooley had been received before the meeting: "*How many patients in Suffolk and North East Essex have no access to an NHS Dental Practice?"*

Ed Garratt, ICB Chief Execuitve responded that this question had been picked up in the presentation given by Peter Wightman and Nick Barker before summarising the response included in full below:

"*This is difficult to assess as the dental practices who are open to new patients is constantly changing. Patients needing NHS urgent care can access services through 111. What we do know is the percentage of people who have accessed an NHS dentist in the last 24 months (below)*

	April 2020	**February 2022**	**October 2023**
Number of people	515,471	358,025	395,130
%	52.7%	37.3%	42.3%

"This is gradually increasing post lockdown. The UK has long had a mixed model with a strong private market in part influenced by the fact that the NHS services are not free at the point of use to most residents. This means those who can pay privately can access dental services. This is therefore a key area of health inequality.

"The plan describes at a high level the actions we are taking to seek to increase NHS dental services by around 30% over the next 3 years and thereby fully use our NHS dental finance allocation. If successful this would return the % accessing NHS services in 24 months to nearer 55%.

"We aim to ensure coverage across SNEE geographically and prioritise commissioning funds for populations of highest need."

7.6. During the course of discussion the following points were made:

i. While the introduction of technicians to perform some procedures may help to increase capacity quickly there was still a need to attract qualified dentists from private practice to the NHS. Else SNEE risked creating a two-tiered system with private dentists and NHS dental technicians. The Board noted that the SNEE Dental Plan did not see dental technicians as a replacement for dentist. Instead, technicians would take on more straight forward procedures leaving dentists to focus on more complex cases. It was hoped that this would both increase capacity and mean that working as an NHS dentist was a more interesting and professionally fulfilling job.

ii. Oral hygiene was a fundamental part of nursing care practice and ensuring that there was a consistent knowledge of oral health among nurses and care workers would help to drive improvements in oral health in general and potentially reduce demand on dental services.

iii. The Board recognised the need to ensure that the Dental Plan linked in with other ICB strategies such as the clinical strategy which was in development and the workforce strategy.

iv. There was learning that dentistry could take from GPs, particularly around the deployment of physician associates and the current work that the ICB was leading on around cultural safety and onboarding of internal recruits.

v. The Board welcomed the recognition of health inequalities in the Plan particularly the focus on looked after children, care home residents, and individuals with serious mental illness.

vi. Prevention would be key to improving oral health and the Board encouraged officers to ensure that they were working with communities, particularly those that may be harder to reach.

vii. The Board recognised that dental care was delivered as a mixed public/private model and so achieving and increase in access to around 55% of residents accessing NHS dentistry would represent a good level of provision focusing on the most deprived areas.

7.7. The Board **AGREED** to endorse the strategic priorities, and to request a regular update every four months for the remainder of 2024/25 on the dental priorities to review progress made and to escalate any key delivery risks/ issues.

8. GP Wellbeing.

8.1. Dr Andrew Kelso, ICB Medical Director introduced the report which provided details of a workshop which had been run following the death by suicide of two local GPs where work stress had been identified as contributing to their deaths. He highlighted the need to listen to feedback from GPs and to put into place sustainable and long-term programmes to support GP wellbeing.

8.2. Dr Freda Bhatti, Primary Care Essex Representative highlighting how difficult it was for GPs to manage complaints and the general lack of respect for GPs seen through complaints both from patients and secondary services. She stated that supporting GPs through the complaints system was vital.

8.3. Nick Hulme, Provider Partner – ESNEFT stated that he would be keen to explore the expansion of wellbeing support already commissioned for hospital staff to GPs. Cath Byford, Provider Partner – NSFT acknowledged that the treatment of GPs by secondary care had not always been at the standard expected and stated that NSFT would be keen to join in supporting the work suggested by Nick Hulme.

8.4. The Chair noted that the follow question had been received from Mr Dooley in advance of the meeting: *"What impact is envisaged by the employment of PAs in General Practice instead of qualified GPs, on the wellbeing of existing GPs?"*

8.5. Ed Garratt, ICB Chief Execuitve responded that: "*NHS England guidance states "Physicians Associates (PAs) are not substitutes for doctors; rather, they are specifically trained to work collaboratively with doctors and others. PAs should not be used as replacements for doctors on a rota." PAs are graduates – usually with a health or life sciences degree – who have undertaken two years of postgraduate training and work side by side with GPs. Any additional supportive capacity would improve the wellbeing and reduce stress among the GP workforce."*

8.6. Dr Freda Bhatti, Partner Member - Primary Care Essex added that she did not feel that the current regulation of PAs gave her enough confidence and her practice was not introducing the role. She did support the PA role in principle but not as a replacement for a qualified GP but with current primary care capacity issues there were occasions where PAs had been given broader remits than was appropriate. With improved regulation PAs would be a helpful addition to GP practices.

8.7. The Board **NOTED** the report and welcomed the offer from ESNEFT and NSFT to work with the ICB and GPs to provide support for GPs.

9. Report from the Chief Executive from Norfolk and Suffolk NHS Foundation Trust (NSFT).

9.1. Cath Byford, Provider Partner - NSFT introduced the report and spoke to the slides included with the agenda she highlighted the Trust's improved CQC rating and focus on four strategic priorities. She highlighted the work that was ongoing to improve learning from deaths, partnership working, and tackling racist behaviour within the Trust.

9.2. The Chair noted that the following question had been received from Mr Dooley in advance of the meeting: *"Does what was presented by NSFT confirm that on those past occasions when I asked whether Ed Garratt had confidence in the various leaderships of NSFT (to which he always replied 'yes') that his replies were at best insincere, to the detriment of service users and carers? In particular I note the creation of a 'Learning from Deaths Action Plan Management Group' years after a solicitor with vast experience of Coroner's Courts who offered to be a part of such a group was rejected by a previous CEO to contribute her knowledge for such a purpose. In my view, deaths may have been avoided; your view?"*

9.3. Ed Garratt, ICB Chief Execuitve responded that it would be fair to say that Caroline Donovan was the first Chief Executive with significant experience of running a mental health trust to lead NSFT for a number of years. He welcomed the report and stated that the ICB was committed to working with

NSFT to establish whether any deaths under the trust could have been avoided.

9.4. By way of a supplementary question, Mr Dooley asked if Ed Garratt would consider meeting with the campaign for better mental health in Norfolk and Suffolk and provided some feedback on a meeting that the campaign group had held with the CQC.

9.5. Ed Garratt stated that he would welcome a further meeting with the campaign group.

9.6. During the course of discussion the following points were raised:

i. The Board were particularly concerned about mental health support to children and young people which was wider than NSFT but was reflected in the NSFT priority to work more effectively with system partners.

ii. The SNEE ICP work on 'uncomfortable truths' in the SNEE health and care system may be of use to NSFT in helping to address the cultural issues at the Trust around racism. Suffolk County Council had also undertaken work improve culture which NSFT could use to help inform their work.

iii. The Board noted that NSFT were working to set out key performance indicators to measure improvement which would incorporate complaints data, staff survey results and feedback from the new freedom to speak up guardian. KPIs would also need to capture the impact that change within on NSFT was having on the wider systemic issues around mental health services.

iv. The Board welcomed the positive change in NSFT's approach to work on mortality including data being captured and reported with a significantly reduced time lag.

v. The Board welcomed the offer from Alliance Directors to help NSFT build links into the community and local organisations.

9.7. The Chair closed the discussion of the item by requesting that NSFT bring a progress report to the Board in September 2024.

9.8. The Board **NOTED** the report and confirmed that it continued support and engagement in the work.

10. Delegation of Specialised Services Commissioning from NHS England to Integrated Care Board.

10.1. Richard Watson, ICB Deputy Chief Execuitve and Director of Strategy and Transformation introduced the report which set out the arrangements for the ICB to take on the responsibility for commissioning responsibility for 59 specialist services. The Chair noted the engagement with the non-executive members undertaken by the transition team based at Bedfordshire, Luton

and Milton Keynes ICB. Howard Martin, ICB Director of Finance spoke to the financial implications and risk associated with the delegation.

10.2. The Board welcomed the paper, agreeing that the delegation of commissioning functions into local control presented an exciting opportunity to tailor services to local need.

10.3. The Board:

(a) **Agreed** that the ICB will be bound by decisions taken collectively with the other ICBs in the East of England in line with the Collaboration Agreement, relating to delegated specialised services.

(b) **Approved** the delegation of 59 specialised services and **authorise** the Chief Executive to sign the Delegation Agreement between the ICB and NHS England

(c) **Approved** the Collaboration Agreement between the ICBs in the East of England and NHS England to manage the commissioning of the specialised services in a joint endeavour.

(d) **Noted** the governance arrangements and the terms of reference of the Joint Commissioning Consortium.

(e) **Approved** that the Deputy Chief Executive and Director of Strategy and Transformation be appointed as the Authorised Officer representing SNEE ICB on the Joint Collaborative Consortium, with the Deputy Director of Strategy and Strategic Programmes appointed as their named substitute.

(f) **Approved** that the Deputy Chief Executive and Director of Strategy and Transformation be delegated responsibility to agree minor amendments to the collaboration and delegation agreements.

11. Annual strategic planning: annual refresh of the Joint Forward Plan and 2024-25 Priorities and Operational Planning.

11.1. Richard Watson, ICB Deputy Chief Execuitve and Director of Strategy and Transformation presented the report which set out the updates to the Joint Forward Plan for 2024/25. The ICB had undertaken a light touch review as the forward plan had only run for a year. The Annual Report would include a ‘what have we done’ section focusing on progress that had been made against the priorities.

11.2. The Board **APPROVED** the 2024-2029 SNEE ICB Joint Forward Plan and **NOTED** the update on the operational planning process for 2024/25.

12. Financial Planning 2024/25.

12.1. Howard Martin, ICB Director of Finance provided a verbal update to the Board. National planning guidance had not yet been issued but the system was working with a set of key assumptions to set a financial plan that enabled partners to live within the available budget. A clear expectation of no

workforce growth had been set by Government. The draft budget for 2024/25 showed a £22million deficit across the system with ESNEFT posting a £5m deficit and WSFT with a £17m deficit. Both trusts were working towards a breakeven position in future budgets. It was expected to take WSFT several years to reach a breakeven position. The system also had to be mindful of the significant financial challenges faced by local authorities. Even with the expected budget deficit in the coming year the SNEE system was performing well compared to other systems and was not suffering from the significant structural deficits of other systems.

12.2. Members of the Board raised the following points in discussion:

i. There was the potential to realise additional efficiencies and savings by exploring greater collaboration between organisations including developing shared services.

ii. The Board noted that both Essex and Suffolk County Council were invited to the system finance committee but that there may be a need to consider how NHS organisations could be given greater insight into adult social care finances.

iii. The Board noted that the financial health of neighbouring systems may impact on SNEE where there were joint commissioning arrangements in place.

12.3. The Board **NOTED** the verbal update.

Finance, Performance and Scrutiny

13. Finance Report.

13.1. Howard Martin, ICB Director of Finance presented the report and highlighted that the system was on track to deliver a breakeven position for 2023/24 and that it was encouraging that WSFT had delivered on their financial recovery plan. The system was expected to overspend on its capital allocation due to a change in accounting practice around leases. An additional capital allocation had been distributed to the system for 2023/24 but there was still uncertainty around 2024/25. Howard Martin also thanked Geoff Dobson and Jo Mael for their work on the Finance Committee.

13.2. The Board **NOTED** the report.

14. Performance report.

14.1. The Chair indicated that the report was taken as read and invited any questions.

14.2. Ed Garratt, ICB Chief Execuitve reflected on the improvement in urgent and emergency care performance and the need to ensure that the system understood what had driven the improvement so that it could be maintained. Nick Hulme, Provider Partner - ESNEFT responded that the work to improve

flow and discharge pathways could be replicated around the system, he was also hopeful that additional capacity would be found.

14.3. Richard Watson, ICB Deputy Chief Executive and Director of Strategy and Transformation highlighted the improvement in cancer performance and thanked both trusts for their hard work.

14.4. The Chair noted the three escalations from the quality committee and the ICB Director of Nursing and Clinical Quality and the ICB Medical Director provided a written updated attached as an appendix to these minutes.

14.5. The Board **NOTED** the report.

15. Board Assurance Framework (BAF).

15.1. Amanda Lyes, ICB Director of People and Workforce introduced the report highlighting that strategic risk 32 was new to the March edition of the BAF. She also spoke to the working being undertaken to review and manage the risk relating to system workforce and the significant revision of the risk relating to adult mental health services.

15.2. The Board **APPROVED** the Board Assurance Framework.

Governance and Corporate Business

16. Integrated Care Partnership (ICP) Update.

16.1. Susannah Howard, Integrated Care Partnership Director introduced the report highlighting the system learning programme on ‘unconformable truths’ looking at systemic injustice, the event on growing up in care, and the integrated care strategy development in light of updated NHSE guidance.

16.2. The Board **NOTED** the update.

17. Committee Minutes and Highlight Reports.

17.1. The Chair indicated that the minutes and highlight reports were taken as read.

17.2. The Board **NOTED** the committee minutes.

18. Attendance Log

18.1. The Board **NOTED** the attendance log.

19. Any Other Business

19.1. None.

20. Questions from the public – Maximum 10 minutes

20.1. The Chair noted that no questions had been received from livestream viewers and invited those in the room to ask questions of the Board.

20.2. Mrs Barbara Robinson highlighted a proposed development in north Ipswich and requested that the ICB examined the health impact assessment prepared for the development and ensured that s106 monies were earmarked for the provision of health services for the new residents.

20.3. Mrs Barbara Robinson also asked the Board to join with here in thanking Jon Renyolds for the work he carried out for the ICB. He was leaving the ICB at the end of March and would be missed by partners who had worked with him.

20.4. The Chair welcomed Mrs Robinson's praise for Jon Renyolds and the Board joined her in thanking him for his service and wished him well for the future. The Chair asked Amanda Lyes, ICB Director of Workforce and People and Maddie Baker-Woods, Ipswich and East Suffolk Alliance Director to consider how the ICB approached the developments highlighted.

20.5. Councillor Mike Ninnmey spoke to dentistry services in Suffolk and welcomed the plan stating that he felt Felixstowe was a 'dental desert'. He went on to recommend that the Board consider bringing an item to a future meeting on The King's Fund report 'Making care closer to home a reality'.

20.6. Councillor Mike Ninnmey also welcomed the opening of the full diagnostic centre in Clacton and the new facilities in Aldeburgh. However, he noted that the x-ray equipment at Felixstowe Hospital has been removed and asked what was preventing the equipment being reinstated.

20.7. The Chair invited Nick Hulme, Provider Partner - ESNEFT to respond to the question about Felixstowe Hospital. Nick Hulme noted that he had previously discussed Felixstowe Hospital with Cllr Ninnmey and stated that he would be happy to have a further conversation outside of the meeting.

The meeting finished at 12.05pm

Appendix 1 – Escalations from Quality Committee relating to Item 14 Performance Report

Escalation QC - 1

Infection Prevention & Control

A deterioration in infection, prevention and control rates was noted, along with a continued challenge for ESNEFT regarding decontamination of operating instruments. Measures have now been put in place.

ESNEFT will remain on enhanced surveillance for infection, prevention and control to gain further and sustained assurance that processes embed properly.

A robust process has been undertaken following external reviews and team meetings held to communicate actions with stakeholders.

Additional information for Board members:

ESNEFT have had a number of incidents over an 18 month period relating to poor practice in their Sterile Supply Department. This has resulted in contaminated surgical packs being identified at point of surgery and has resulted in theatre disruption and cancellation of surgery in a very small number of patients. ESNEFT have had external reviewers visit and the ICB has commissioned an external review due to start in April. ESNEFT developed a clear action plan and the incidents have reduced significantly. Clear Director oversight to ensure sustainability of improved practice.

Due to the level of hospital acquired infections and the lack of assurance of the organisation to determine routes of transmission and reduce transmission, ESNEFT IPC have been escalated to enhanced surveillance by the system quality group in line with the NQB risk management framework.

Escalation QC - 2

UEC – Patient Safety

Oct-December data demonstrated upward trends in:

WSFT 12 hr waits in ED - patient waiting times increased (Dec - 1081 ESNEFT, 979 WSH) 12-24 hr waits remained high (Dec – 904 ESNEFT, 686 WSH).

Quality visit undertaken at WSH by ADoN for UEC. Good practice and assurance noted regarding work undertaken to ensure patient safety & wellbeing, but greater Senior Clinician oversight is needed within the ED and from Speciality teams to ensure patients are moved through the ED in a timely manner. ICB have offered similar support to ESNEFT, their response is awaited.

Additional information for Board members:

Monitoring of Urgent and Emergency Quality metrics continues via the UECC.

Quality Metrics show that Emergency Department waiting times remains challenged and the data demonstrates a varied landscape, with some positive improvements to note within the most recent data from January/February.

- Time to initial assessment remained static at both ESNEFT sites, whilst WSFT demonstrated an 11minute improvement between January and February data.
- Average time to treatment increased at Ipswich Hospital, remained static at Colchester and improved at West Suffolk Hospital, although it is recognised, treatment times were compared comparison against December data for WSFT.
- Wait times for 12-hour category increased at both ESNEFT sites whilst 12-24 hour wait times increased at Ipswich but improved slightly at Colchester. West Suffolk Hospital ED reported a positive improvement in both categories between January and February.

A Quality Visit was undertaken in December at West Suffolk Hospital following a prolonged period of demand and pressure on services. Controls are in place to monitor patients within the main department and waiting room, whilst clear steps have been actioned to ensure patient safety and wellbeing. This included roll out of pressure relieving mattresses across the majors area of ED, falls bundles initiated, with high risk patients highlighted in the electronic patients record system and specific measures to further highlight this to clinical within the department e.g. risk assessment and yellow anti slip socks. Nutrition within ED has also received specific focus with a hot meals trolley now being provided for patients awaiting beds. Work is also underway between the ED team and Clinical Nurse Specialists to devise an abbreviated Dementia checklist for use within ED to ensure that the most important areas of Dementia assessment are ensured within ED, prior to full assessment being undertaken within the ward environment.

Escalation QC - 3

Patient Ambulance Transport

EMED patient transport services have moved into enhanced surveillance regarding clinical governance arrangements and how incidents and complaints are overseen. The service continues to receive complaints and concerns from patients regarding the services shortfall in time targets.

A Rapid Review meeting is planned for January and the ICB's Director of Nursing is due to meet with EMED's Chief Executive. EMED have been served a performance notice

Additional information for Board members:

The rapid review meeting was held in January with a follow up meeting planned for April to review the below actions:

1. Establish a collaborative approach between acute sites and EMED to share patient experience on the patient day into and out of hospital. This will inform joint quality improvement opportunities
2. Update EMED improvement plan to include measures of success and outcome measures

3. Co-produce the improvement plan outcomes to ensure that we are focusing on the impact our users would want to see. Review the metric of timeliness for appointment to understand impact on quality and outcomes.
4. Healthwatch Suffolk's offer of co-production training.
5. EMED to complete a deep dive into performance metrics to ensure we understand any unintended consequence of hitting target and how renal activity impacts on the overall target.

NHS
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INTEGRATED CARE BOARD
ACTION LOG

Actions arising at the meeting held on 30 January 2024:

Agenda Item	Action	Lead	Update
Integrated Care Board Performance Report.	To provide an update/ more detailed performance data around inappropriate out of area placements	Richard Watson/ Paul Gibara	May 2024
Integrated Care Board Performance Report.	To provide an update on work to tackle the waiting list for ADHD, Autism diagnosis/ support and Suffolk SEND services.	Richard Watson/ Lisa Nobes	CLOSED - A report on SEND provision is attached at item 9 on the agenda.

Actions arising at the meeting held on 26 March 2024:

Agenda Item	Action	Lead	Update
Report from the Chief Executive from Norfolk and Suffolk NHS Foundation Trust (NSFT).	To provide an update on progress.	Caroline Donovan	Update report due in September 2024
Questions from members of the public in attendance at the meeting.	A question was asked about how the ICB would ensure that there was adequate health care provision for major developments proposed in north Ipswich.	Amanda Lyes/ Maddie Baker-Woods	CLOSED - The question was also asked and responded to via an FoI request submitted to the ICB.

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NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 7
Date: 30 July 2024

Title: Dental commissioning plan progress update.

Lead Director: Peter Wightman, Director lead for pharmacy, optometry, dentistry and vaccination commissioning.

Author: Nicola Brunning, Deputy Director of Commissioning – pharmacy, optometry, dentistry and vaccination.

Purpose: To report progress made against the dental strategy and plan between April and June 2024.

Recommendation: For the Board to note the progress made.

Related item on the Board Assurance Framework: -

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1. Background

1.1 At the NHS Suffolk and North-East Essex Integrated Care Board meeting of 26th March 2024, the Board received a report and presentation around the ICB strategy and plan to improve the oral health of the population. The plan was endorsed by the Board, alongside a recommendation to share a progress update every four months in 2024/25 to review progress made and to escalate any key delivery risks/ issues plan.

The work programme includes nine workstreams and updates are given in this paper on those highlighted below in bold:

- **Prevention**
- **Workforce development**
- **Priority groups – access to dental services**
- **General dental practice – access to dental service**
- **Orthodontics**
- Community and out of hours care
- Specialist secondary care
- Paediatrics
- Other/ various

2. Prevention

2.1 A mapping exercise is underway to identify all areas of prevention activity in place across SNEE across the education, health and care sectors. This is being clinically led and the mapping will be completed in August and will help us understand 'where are we now' and to inform the next steps required to support the development of a co-produced strategy and plan.

2.2 The following prevention programmes have been funded by the ICB and commissioned by Suffolk and Essex County Councils:

- Suffolk:
  - Suffolk County Council already commission Supervised tooth brushing in twenty-five early years settings, focussed on areas of deprivation and areas of high rates of tooth decay. The ICB has funded an expansion across a further twenty-five settings for two years. A procurement is underway for the additional activity, with the expanded service estimated to start in January 2025.
  - The Assessment and Treatment Service mobile dental service for vulnerable groups is due to start in September 2024.
  - Suffolk County Council already commission The Keep Suffolk Smiling initiative with health visitors handing out toothbrush/paste packs and sharing oral health information with parents and carers at 12-month checks. The ICB has funded further information to be shared at 24-month checks.

- Essex:
  - Supervised tooth brushing (early years) is being implemented and in Q1 24/25 fourteen early years settings were trained, which is at 70% of target.
  - Young People Oral Health Champions (primary schools) have been implemented in fifteen settings, which is 43% of target.
  - Eight care homes (40% of target) have been trained and accredited to implement the Lifelong Smiles initiative and further care homes are in process of joining the initiative.

3. Workforce development – developing a sustainable workforce

3.1 A workforce sub group has been established to support the development of a strategy and plan. The focus of the initial meeting was, '*where are we, where do we want to be, and how do we get there.*' The group recommended a workshop is arranged with a wide group of stakeholders to help co-produce the strategy and plan.

3.2 Workforce recruitment – a Primary Care Careers offer to pilot a recruitment service has been offered to all SNEE dental providers. Primary Care Careers is already working successfully with Primary Medical Care, and it is offering to assist dental providers with the recruitment process. Fifteen providers are participating in the pilot, and five providers now have roles being advertised. The pilot will be evaluated, and, if successful, will be offered as package to the ICB to support providers in the same way as Primary Medical Care.

3.3 The first cohort of twenty-four students began the Year 1 BSc (Hons) Dental Hygiene and Dental Therapy course at the University of Suffolk in February 2024 (course at full capacity). A further twenty-four students will be starting in September 2024 and 24 places will be available each September thereafter.

The University of Essex (main campus at Colchester and also teaching at Southend), has a cohort of sixty-four in each of two years of undergraduate hygiene training which is due to increase to eighty in the next intake. There are also twenty-five student therapists undertaking a further 1-year course to gain BSc in dental therapy. This number is due to increase to thirty on the next intake. All these students are in various placements in SNEE primary care practices.

4. Priority Groups – access to dental services

4.1 The Dental Priority Access and Stabilisation Service (DPASS) pilot launched in April 24. DPASS is an eighteen-month programme to improve access to dental services to the most vulnerable and in need populations of Suffolk and north east Essex.

The service is commissioned as two options and practices are renumerated for the additional appointments provided. Practices chose the option of either providing additional in-hours (flexible commissioning), or as sessions for out of hours dental appointments, treatments, and oral health stabilisation to the population during weekdays, weekends, and bank holidays.

4.2 The priority groups are:

- Urgent and Emergency Care patients
- Those awaiting any NHS procedure that requires Oral Stabilisation
- Homeless
- People with a Learning Disability and Autistic people
- Children in Care
- Care Leavers
- In-practice care for residents of Care Homes
- High Dental Risk patients
- Dementia patients
- Transient Populations including immigrants
- Sex workers

4.3 The principles of DPASS are:

Patient appointments to be made available to treat and maintain dental health, through the provision of effective, evidence-based approaches and appropriate treatment planning and prevention including a Personalised Care Plan for the priority access groups.

All patients seen under DPASS are expected to continue to be seen by the practice for all dental needs until the DPASS pilot ends.

Reducing inequalities in access and oral health for target groups set out below through the provision of services and approaches appropriate to their specific needs.

Prioritising those most vulnerable in our community.

Addressing the patients' needs and providing support through discussing and outlining choices to reach an informed consent for the agreed approach to care as well as agreeing an ongoing Personalised Care Plan with the patient.

Prioritising and managing workload to ensure timely care for urgent problems or early intervention in situations where there is a risk of deterioration in the patient's condition.

4.4 So far, eighteen providers across SNEE have agreed to participate in the pilot; ten across Ipswich and east Suffolk; four in north east Essex and four in west Suffolk. The service is accessed using signposting by:

- NHS 111
- Services supporting targeted groups
- Primary care services; GP medical practices and General Dental Practitioners (GDPs)
- Secondary care services i.e., Emergency Departments, oral and maxillofacial services, cancer and cardiac teams
- Healthwatch, PALS, SNEE dental helpdesk
- Patient direct approach to practices

To date there has been limited public communication to avoid the service being overwhelmed.

Since April, over 2,000 people in SNEE have been offered a DPASS appointment. Most people seen are under 60 years old. Whilst there are increasing numbers of people from the vulnerable groups being seen in appointments, the majority are urgent and emergency care or high-risk dental patients.

4.5 Patient feedback has been very positive:

"I have autism, and these were very nice"

"I paid £150 for emergency dentist, where I was told slight infection but no antibiotics. This got very bad over weekend to be unbearable pain. Called 111 at 6.30pm as I couldn't cope any longer and got help at am. Then had call off dentist with an appointment at Stoke dentist. Who were great ..."

"So happy with my treatment and how fast I got seen"

4.6 The ICB team continues to encourage providers to sign up to offer DPASS sessions. The team is working in partnership with the providers to learn and evolve the pilot to help ensure it can support as many of the population within the available capacity.

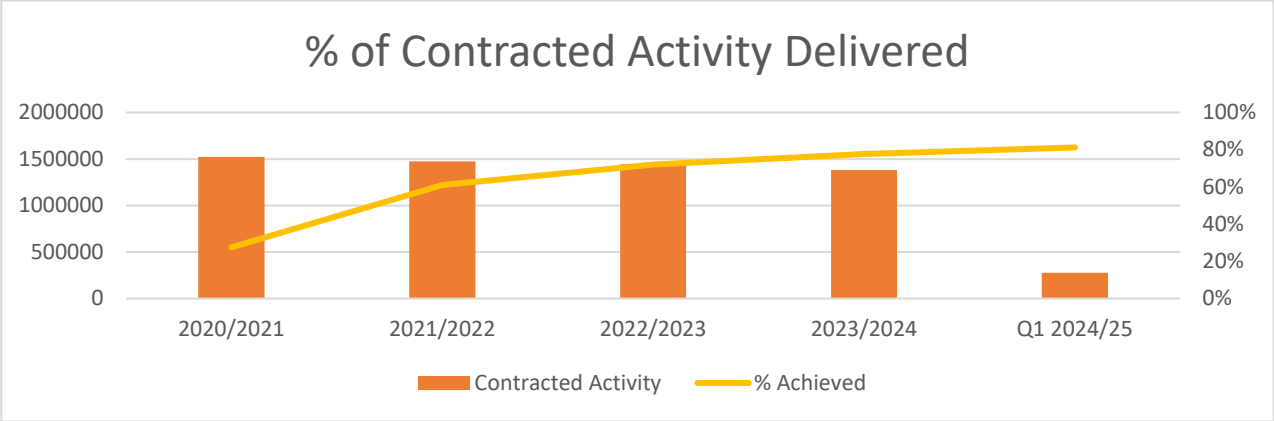
A similar model is being piloted by Mid and South Essex ICB and whilst both ICBs will evaluate their own pilots, Cambridge University has tentatively agreed to support the overall evaluation to inform the future commissioning approach through The Healthcare Improvement Studies Institute. There is also research support from Kings College Hospital London where an academic is preparing to carry out a clinical audit of all the data currently being collected. That data includes clinical data related to each appointment and sent to NHS Business Services Authority as well as patient feedback data.

5. General dental practice – access to dental service

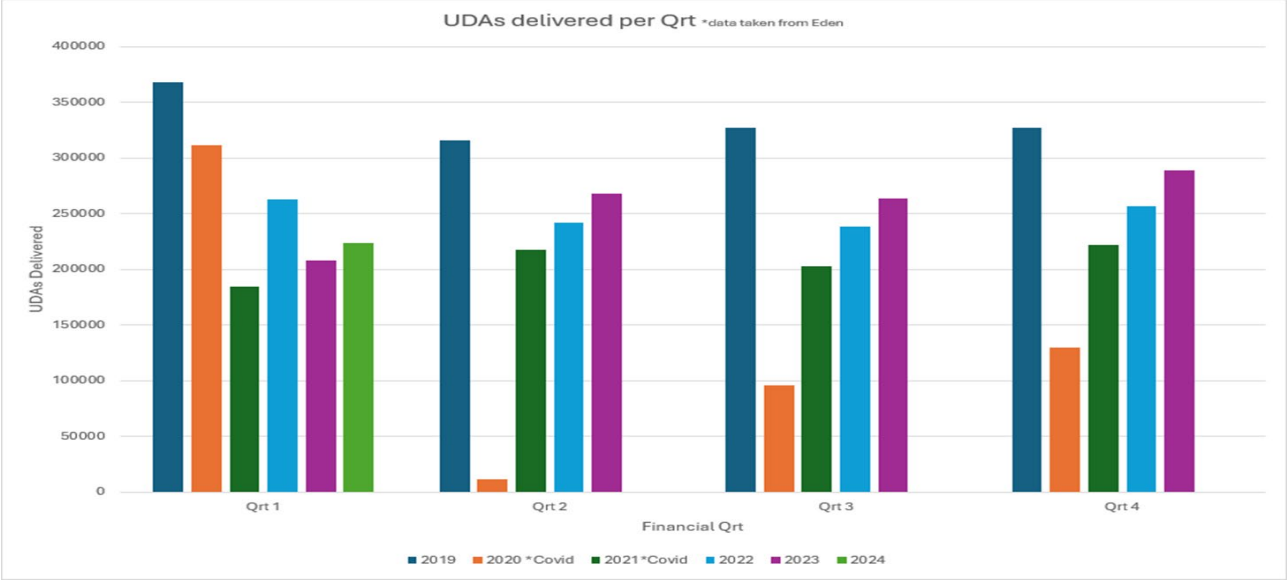
5.1 A principal aim, and a requirement of the NHS England 2024/25 operational planning guidance is to increase dental activity by '*implementing the plan to recover and reform NHS dentistry and improving units of dental activity (UDAs) towards pre-pandemic levels.' To* achieve this, the number UDAs or equivalent needs to increase by 268,000 and a trajectory was shared in the last report to achieve this over three years.

5.2 The graph below shows a 3% increase in UDAs delivered in 2023/24 compared to 2022/23.

Graph 1: SNEE, % of contracted UDAs delivered and total UDAS delivered 2020/21 to Q1 2024/25 (data source: EDEN & NHS Digital)



Graph 2: SNEE UDAs delivered per quarter, 2019 – 2024 (data source: EDEN & NHS Digital)



UDAs delivered in Quarter 1 (April to June) 2024/25 have increased by 10% compared to the same quarter in 2023/24.

It should be noted that the final outturn for UDAs delivered in 2023/24 24 is not fully available until a year-end reconciliation process has been completed with dental providers. The stated figures are a minimal level of activity, and the final figures are expected to increase the number of reported UDAs delivered.

5.6 The following examples are actions taken since March 2024 to support an increase in UDAs delivered and an increase in the number of people accessing an NHS dentist.

Examples of actions taken to increase UDAs delivered include:

- Since April 2024 an additional 8,361 UDAs have been commissioned.
- Increased and implemented a minimum price per UDA (beyond the national level).
- Introduction of the national New Patient Premium per UDA (an additional £15 or £50). Assessment of the impact of this initiative is underway.
- Implementation of the DPASS pilot, (refer to section 4).
- The opening of the University of Suffolk dental CiC in March 2024.
- Recruitment.

5.7 One provider has returned 13,213 UDAs of their contracted activity to the ICB. Following a commissioning process 2,374 of these UDAs have been redistributed to providers in the local area and a further 2,500 UDAs to providers in the wider Alliance area.

5.8 The Dental Team have produced some early insights using data available to the ICB to explore gaps in dental provision within SNEE. The team are further reviewing data to provide recommendations on areas for potential procurement of new services and increasing support to existing providers to improve access to dental services.

6. Orthodontics

6.1 An NHS Orthodontic provider served notice on two contracts in Clacton-on-Sea and in Bury St Edmunds in April 2024 which has impacted 1,700 children and young people who had either started treatment or were on the waiting list. A procurement process is in progress, and it is anticipated that the caseload will be supported to transfer to new providers to provide their care in August 2024.

7. Conclusion

7.1 Progress can be demonstrated against several strategic priorities and associated projects.

8. Key Issues and risks

8.1. The high-level challenges, risks and issues relating to dentistry were outlined in the March Board report. A wholescale review of the programme risks and issues is in progress and will be included within the revised ICB risk management process. Risks and issues will be escalated to the Board, as appropriate, in the next update report.

9. Patient and Public Engagement

9.1 There has been no engagement relating to the progress made in this report.

10. Committees and Groups

10.1. This report has not been shared with any Committees or Groups before coming to the Board.

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NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 8
Date: 30 July 2024

Title: A proposal for West Suffolk patients to benefit from state-of-the-art facilities at Essex and Suffolk Elective Orthopaedic Centre (ESEOC).

Lead Director: Lisa Nobes, ICB Executive Director of Nursing and Quality.

Author: Simon Morgan, ICB Associate Director of Communications.

Purpose: Information.

Recommendation: That the Board notes the report.

Related item on the Board Assurance Framework:

Introduction

1. This paper is to appraise the boards of the NHS Suffolk and North East Essex ICB West Suffolk NHS Foundation Trust about the six-week engagement exercise which sought views from the public on a proposal for patients across west Suffolk to benefit from state-of-the-art facilities at ESEOC in Colchester.
2. This paper provides the boards with an overview of the background, case for proposed change, the approach taken for the public engagement exercise, key themes of feedback received, as well as next stages in the process, prior to a final decision on the proposals being made by the Suffolk and North East Essex Integrated Care Board on 30 July 2024.

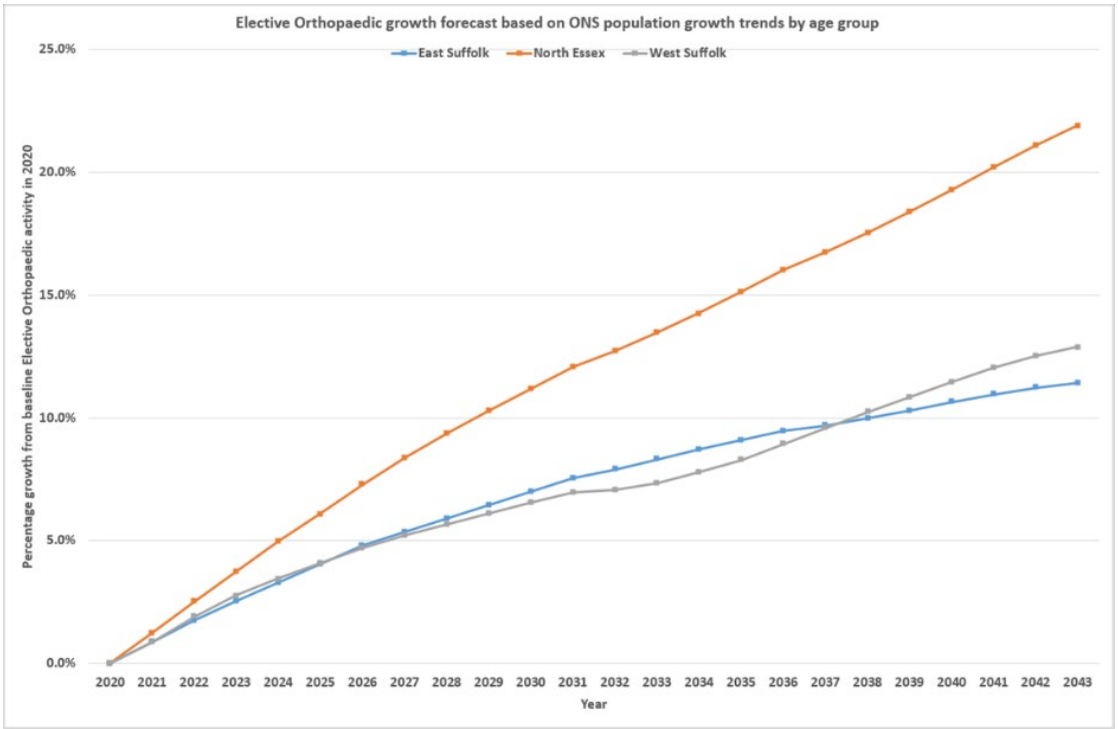
Background

3. The COVID-19 pandemic led to unprecedented levels of disruption to elective hospital care across the country. In England, the waiting list for procedures increased by 61% from 4.57 million before the pandemic in February 2020 to 7.47 million at the start of 2024. This was largely because most routine care stopped during the pandemic.
4. Recognising predicted future growth rates, the need for increased elective surgical capacity for the orthopaedic service is clear. Even without further

COVID-19 surges, additional elective surgical capacity is required to reduce excessive waiting times for patients.

5. Figure 1 shows the growth forecast expected for elective orthopaedic procedures across Suffolk and north east Essex.

Figure 1: Elective Orthopaedic growth forecast across SNEE



6. Being on such a lengthy waiting list for treatment, with many patients experiencing pain for a long period of time, significantly and adversely impacts on a person's physical and mental wellbeing. This is exacerbated further in a situation when a patient's treatment is cancelled.

7. When it opens during the autumn of 2024, ESEOC will treat patients from across Suffolk and north east Essex. For these patients, it will mean reduced waiting times for surgery which may prevent their condition from worsening as well as a reduced risk of short-notice cancellations because clinicians at ESEOC would not deal with accident and emergency patients.

What was being proposed during the engagement exercise?

8. Based on the capacity available to West Suffolk NHS Foundation Trust (WSFT), it is proposed that approximately 55% of orthopaedic elective surgical procedures (1,300-1,500[1] per annum) from West Suffolk Hospital in Bury St Edmunds should be relocated to ESEOC, approximately 30 miles away or an hour's drive from the hospital's Hardwick Lane site.

9. ESEOC is a surgical hub that is 'ring fenced', meaning that patients should not have their operations cancelled when hospitals face intense emergency pressures. In addition, it is proposed that approximately 750 day-cases relocate to ESOEC, releasing much needed day case capacity for other activity at West Suffolk Hospital.

[1] Number may fluctuate dependent on case mix.

10. Furthermore, it is proposed that all complex knee revision surgery would be performed at ESEOC.

11. The remaining 45% of orthopaedic elective activity would stay at West Suffolk Hospital. A suggested sub-specialty split is detailed below. Under this proposal, all remaining elective orthopaedic activity, orthopaedic trauma surgery and paediatric orthopaedic activity would remain at WSFT. These figures are indicative due to ongoing discussions to finalise the financial/activity model pertaining to this project

Figure 2: An indicative breakdown of procedures by surgery location (based on 2023 activity numbers[2]:

Procedures	Volume of activity to move to ESEOC	Volume of activity to remain at West Suffolk Hospital
Hip	80% (232)	20% (58)
Knee	80% (252)	20% (63)
Upper limb	50% (160)	50% (160)
Foot and Ankle	25% (28)	75% (84)
Shoulders	40% (35)	60% (50)
Day case procedures i.e., arthroscopies, removal of metal work	50% (750)	50% (750)
TOTAL INDICATIVE THROUGHPUT (CASES)	**(55%) 1,457**	**(45%) 1,165**

N.B. The above is subject to change due to the waiting list case mix, complexity and ongoing dialogue pertaining to an agreed financial model. It does not include paediatric procedures, recognising these are out of scope.

Benefits to patients

12. Should this proposal receive approval, there would be several benefits to patients across west Suffolk. These include:

- **Waiting times** – By moving to ESEOC the WSFT predicts its patients will see reductions in wait times for surgery.

- **Primary Focus on Elective Care** – Delivering surgery via a surgical hub will enable teams to focus solely on the delivery of elective excellence, reducing length of stay.

- **Revision expertise** – concentrated in a regional hub; all knee revision surgery being directed here.

- **Centre of excellence** – high quality services provided by specialist teams within Europe's largest elective orthopaedic centre

- **Increased capacity** – by using this facility in addition to all available WSFT theatre capacity, additional capacity will be created, enabling more patients to be treated across all surgical specialities.

[2] Numbers may fluctuate dependent on case mix and complexity.

- **Training centre** – allowing the surgeons of tomorrow to be trained locally and within the system.

- **Free up an operating theatre at WSFT** – This will allow clinicians to conduct more work on elective recovery which will mean more capacity for patients to be seen faster.

Approach to patient and public involvement

13. In March 2024, the ICB Board gave its approval for a six-week public engagement exercise to take place between Monday 20 May to Sunday 30 June 2024, led by the ICB with strong support from WSFT and Healthwatch Suffolk.

14. The ICB engaged with the Suffolk Health and Overview Scrutiny Committee and NHS England on the engagement approach – both were in support.

15. Healthwatch Suffolk was commissioned to independently analyse and report on the findings of the engagement survey. Healthwatch Suffolk staff also attended engagement events and helped promote the survey to their community contacts.

16. There were six main objectives to the public engagement exercise:

    a) To develop and deliver an effective and inclusive exercise which allows people to give their views on the impact it will have on them;

    b) To share with the public a clear narrative that describes the reasons for the proposal;

    c) To actively engage and develop relationships with stakeholders to increase their understanding of the system's aims to reduce the waiting list and meet the demand of the growth of the population by the proposal;

    d) To incorporate ideas/suggestions from patients/the public into plans;

    e) To have due regard to the need to reduce inequalities;

    f) To meet the requirements of the Public Sector Equality Duty – to eliminate discrimination and promote equality of opportunity for people with protected characteristics.

17. An Equality and Health Inequalities Impact Assessment, as well as a travel impact assessment, was completed prior to the engagement period by WSFT in line with the Public Sector Equality Duty and has been available in the public domain throughout. This assesses the potential impact of the changes to various inclusion groups, including those with protected characteristics under the Equality Act (2010).

18. As part of the engagement exercise, the following activities took place to capture views from local people:

Survey

19. Healthwatch Suffolk developed a survey to gather the views. This was co-produced with local people and patient participation groups. Please see the Section on "Key Findings" below which describes the survey and the development approach taken.

Public facing leaflet

20. An A5 document which sets out what the proposal is, why it is being proposed and how it will benefit patients was produced. This document was available in

various formats including easy read, electronic, paper copy and audio. Paper copies were also available and shared at events.

Text messages to everyone on the orthopaedic waiting list

21. Two SMS messages were sent from WSFT to all patients on the orthopaedic waiting list (~4000) throughout the period. The first was sent on week commencing 20 May as follows:

West Suffolk NHS is proposing to move around 55% of planned orthopaedic surgery to a new state-of-the-art centre based on the Colchester Hospital site. To find out more about the plans please [click here].
It is very important that our patients can give feedback about these plans. Have your say by [completing the survey]. If you would like a survey in a different format, please contact Healthwatch Suffolk on 0800 448 8234.
Please note that plans for your surgery will continue as discussed with the team caring for you, and you should await contact from your care team to discuss individual circumstances, including where your surgery might take place. If you have any concerns, you can contact PALS on 01284 712555 or PALS@wsh.nhs.uk.

22. A second was sent week commencing 24 June as follows:

It's not too late to have your say about plans to move around 55% of planned orthopaedic surgery from West Suffolk Hospital to the new centre in Colchester. Please take part in our engagement survey to give feedback on how this could impact you or those you care about by following this link [link] or contacting Healthwatch Suffolk for free on 0800 448 8234. You have until 30 June to take part.

Mini exhibitions

23. Mini exhibitions were organised (as opposed to traditional town hall format meetings) so people could have one-to-one discussions with lead clinical consultants, NHS communications and engagement staff and learn more about the proposal from exhibition stands. They were also invited to complete a survey at each venue and were able to take information away with them. The mini exhibitions took place at the following venues:

- Saturday 8 June, 10-12noon, The Apex, Bury St Edmunds, Charter Square, Bury St Edmunds IP33 3FD
- Tuesday 11 June, 10-12noon, Newmarket Racing Centre, Fred Archer Way, Newmarket CB8 8NT
- Tuesday 11 June, 2.30-4.30pm, Innovation Centre, Croxton Rd, Thetford IP24 1JD
- Wednesday 12 June, 6-8pm, Haverhill Arts Centre, High Street, Haverhill CB9 8AR
- Thursday 13 June, 2-4pm, Kingfisher Leisure Centre, Station Road, Sudbury CO10 2SU
- Friday 14 June, 5-7pm, New Bury Community Centre, 1 Charles Pl, Bury St Edmunds IP32 6TD
- Tuesday 18 June, 10-12noon, Main Hall, St John's Centre, St John's Close, Mildenhall IP28 7NX
- Tuesday 25 June, 2-4pm, Brandon Leisure and Health Hub, Church Road, Brandon IP27 0JB

24. Different locations, days and times of the day were chosen to accommodate the needs of local people and add flexibility to the engagement offer. The total number of people who visited our mini exhibitions was 290.

Online events

25. Two online events took place, at 5pm on Wednesday 5 June and 10am on Saturday 15 June, which allowed local people to access the sessions without needing to travel. Clinical colleagues from WSFT and the West Suffolk Alliance director were present and available to answer people's questions about the proposal. Recordings of the online events were uploaded onto the ICB's website - Essex and Suffolk Elective Orthopaedic Centre public engagement 2024 - NHS Suffolk and North East Essex ICB

Locality meetings

26. Representatives from the NHS across Suffolk have attended several existing locality meetings and community groups to speak to members about the proposal and the engagement. The meetings included partner organisations and stakeholders from the Voluntary, Community, Social Enterprise and Faith sectors across west Suffolk and south Norfolk. During each meeting, representatives shared the case for change and outlined how people were able to share their feedback. At the end of the agenda item, representatives invited questions from the groups they visited and encouraged stakeholders to spread the word amongst their networks. Please see Appendix 1 for a list of the locations and groups visited.

Outreach pop-up stands in supermarkets/libraries and GP surgeries

27. Outreach and pop-up stands were organised in busy areas of high footfall. These included supermarket entrances, libraries, shopping areas and community hubs. Colleagues from within the system spoke to passers-by and invited them to complete a survey. These locations were purposefully chosen as the most effective ways of reaching our intended audiences.

How we communicated the engagement

Advertorial in local press promoting the proposal

28. A half page advertorial was placed in the Bury Free Press titles (Newmarket Journal, Mildenhall, Bury, Thetford, Haverhill, Diss and Suffolk Free Press editions).

29. This editorial advert explained what was being proposed and how people could give their views - Sponsored feature: Have your say on a proposal for local patients (suffolknews.co.uk)

30. The same advert appeared on the social media platforms of Iliffe (which publishes the Bury Free Press titles). This helped to further amplify the coverage.

31. Dates of advertisement and social media campaigns – 16-23 May and 6-13 June.

32. Figures 3 and 4 show the reach this advertorial had.

Figure 3 - 16 May 2024

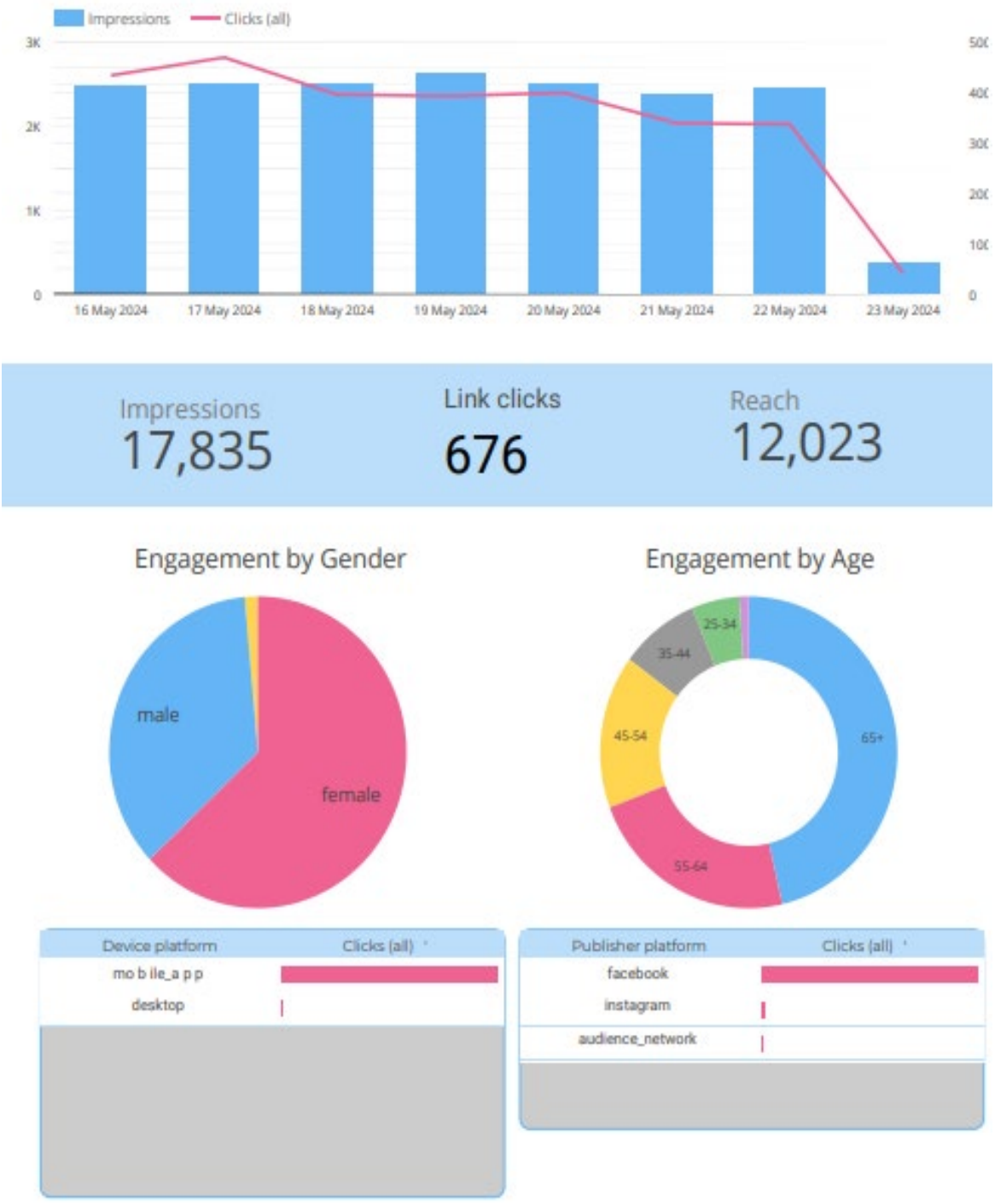
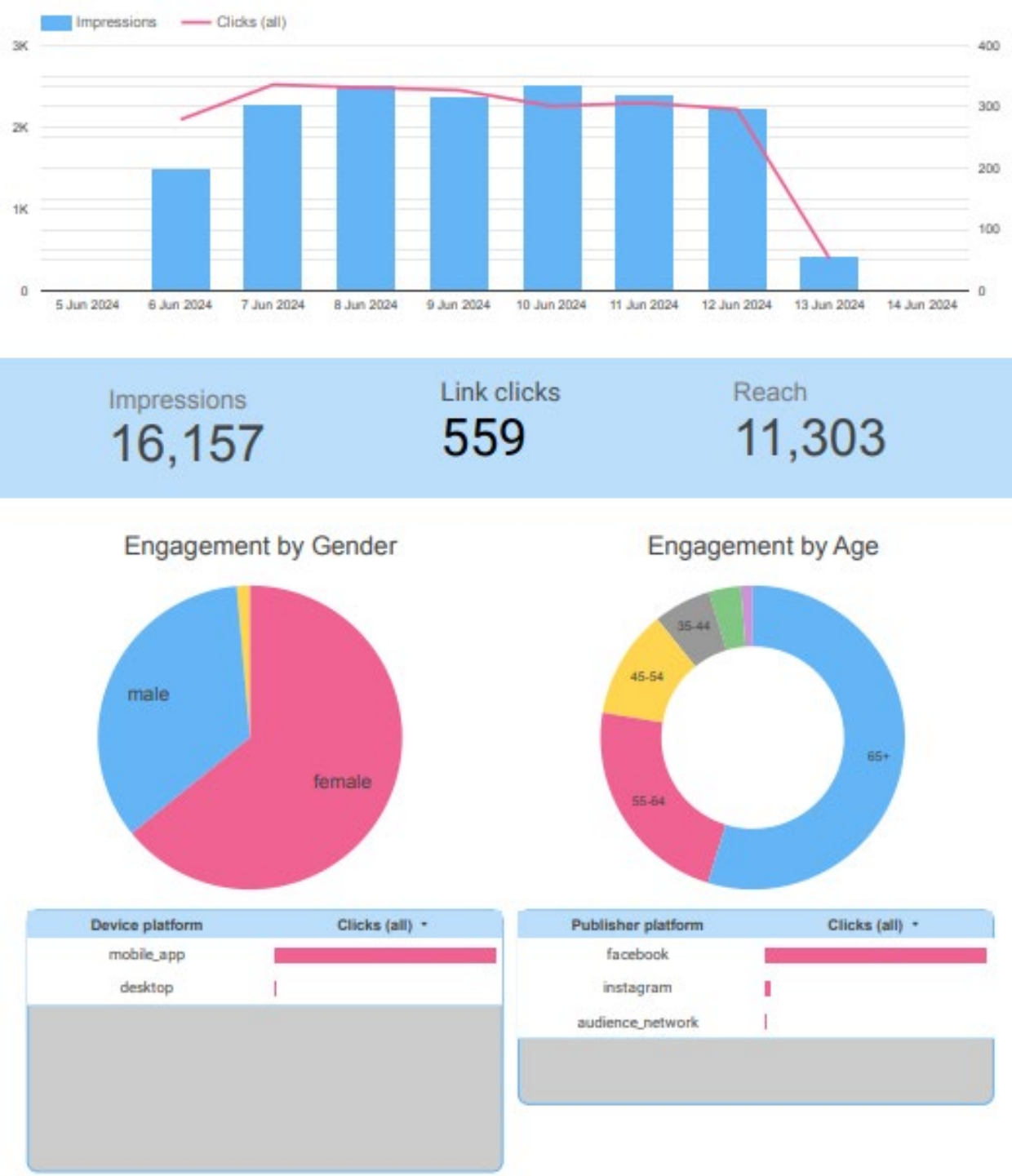


Figure 4 - 6 June 2024



Press releases

34. Three press releases were issued by the ICB which included links to the engagement page of its website and the Healthwatch Suffolk survey. These press releases were timed to be issued at the start of the engagement period as well as midway through the process. A third release was published in the week of the closing date to remind people. Each press release had quotes from clinical leads as well as those colleagues responsible for the engagement exercise and are included below:

14 May 2024 - Views sought from west Suffolk patients on orthopaedic proposal - NHS Suffolk and North East Essex ICB

10 June 2024 - Still time to give views on West Suffolk Hospital orthopaedic surgery move proposal - NHS Suffolk and North East Essex ICB

25 June 2024 - Orthopaedic proposal deadline is 30 June – please give your views by then - NHS Suffolk and North East Essex ICB

Media coverage and press releases

35. In addition to the editorial advert, there was widespread coverage (both in print and broadcast) which reported the engagement in local and regional media outlets. Examples of coverage are below:

- 19 March – BBC - West Suffolk Hospital plan to move operations to Colchester - BBC News
- 20 March – EADT - Bid to cut surgery waiting times using Colchester Centre | East Anglian Daily Times (eadt.co.uk)
- 20 March – Suffolk News - Hundreds of operations at West Suffolk Hospital in Bury St Edmunds could be moved to new Essex and Suffolk Elective Orthopaedic Centre at Colchester Hospital (suffolknews.co.uk) Suffolk News includes Bury Free Press, Newmarket Journal, Haverhill Echo, Diss Express, Mildenhall and Thetford editions of BFP and Suffolk Free Press
- 20 March – Healthwatch Suffolk – New NHS plans aim to reduce orthopaedic elective care waits in west Suffolk by transferring care to north Essex - Healthwatch Suffolk
- 20 March – Colchester Gazette – Colchester Hospital new unit could welcome Suffolk patients | Gazette (gazette-news.co.uk)
- 26 March – EADT – West Suffolk Hospital patients willing to travel to Essex | East Anglian Daily Times (eadt.co.uk)
- 14 May – Suffolk News – https://www.suffolknews.co.uk/bury-st-edmunds/news/how-to-have-your-say-on-plans-to-move-hundreds-of-operations-9366028/
- 20 May – BBC News - West Suffolk views sought on NHS procedures moving to Essex - BBC News
- 21 May - Proposed move of surgeries to Essex and Suffolk Orthopaedic Centre | Gazette (gazette-news.co.uk)
- 28 May – Second story on ITV Anglia – walk round centre, interview with Andrew Dunn, promotion of engagement
- 8 June – Bury Free Press - https://www.suffolknews.co.uk/bury-st-edmunds/news/first-public-engagement-on-plans-to-move-hundreds-of-operati-9369693/
- 12 June – BBC Radio Suffolk – https://www.bbc.com/news/articles/cljj5yd59gdo

ICB stakeholder briefings

36. Information about the proposals were shared in fortnightly stakeholder briefings that go to all ICB stakeholders and shared among all councillors within the west Suffolk area as well as strategic partners and members of the public.

- Edition 1 - https://sway.cloud.microsoft/O6JxewOaIHAQ5w5d
- Edition 2 - https://sway.cloud.microsoft/EYcW7nm0z9d4Je4m
- Edition 3 - NHS Suffolk and North East Essex - Stakeholder and councillor briefing - 26 June 2024 (cloud.microsoft)

Posters

37. To increase local awareness about the engagement events, specially produced posters were place in local shops, community centres, public houses and other facilities in towns and villages in west Suffolk. E-flyers that promoted the engagement were also produced and shared on social media and templated materials allowed system partners to promote the outreach stands.

Community Facebook pages

38. A mixed response was received to the request of posting details about the engagement on local community Facebook pages. Some administrators allowed this to happen – and we remain grateful for their support. Other groups rejected the request, which we of course respect. Those groups which did support us meant we were able to gain further reach into local communities.

Communications toolkit

39. A toolkit was developed in conjunction with local Patient Participation Groups within Suffolk. This included consistent messaging about the engagement exercise, the case for change and template news articles and social media posts. In addition artwork for the posters and social media assets were included. A set of slides for GP/hospital waiting room screens was also developed. The toolkit and screen slides were shared with hospital and GP waiting room areas as well as councillors, patient groups, stakeholders and staff via the ICB stakeholder briefing. Thanks to colleagues from the Botesdale PPG for support in developing this resource.

Virtual tour

40. As part of our approach to involve people, the Director of the Essex and Suffolk Elective Orthopaedic Centre agreed to feature in a short film. This gave viewers an update on how building work is progressing at the centre.

Involving seldom heard communities

41. The NHS in Suffolk has been in touch with several support groups which represent seldom heard groups within the county to promote the engagement and to ask for details and the link to the survey to be shared with their membership. The system is grateful to BME Suffolk, BSE4BL, Aspire Black Suffolk, Ace Anglia, Anglo Chinese Cultural Exchange, Communities Together East Anglia, Bury Multicultural Women's Group, PHOEBE and Suffolk Refugee Support among many others for their support.

42. A reminder about the closing date for responses was shared with them during the final week of the engagement. Other groups that we engaged with included Thetford U3A, Hard of Hearing Club in Haverhill, Breathe Easy Support Group, Haverhill Terrific Tuesday Dementia Support Group, Jam Community Pot, Chronic pain support group, Lymphodema support group, Cancer Services User Group, Woolpit Traveller site visit, 'Legs Matters' public health event.

43. We have also been in touch with prominent local community representatives and have shared our stakeholder briefings with them for their awareness.

44. While the engagement survey did attract a high number of responses, 127 people did not state their ethnicity.

Health Scrutiny Committee

45. The ICB remains grateful for the support it has received from Suffolk Health Scrutiny Committee. It has previously discussed the proposed approach for an engagement exercise with the Chairman, Vice Chairman and Business Manager (Democratic Services) Officer, who in turn arranged for informal views to be obtained from the wider Committee membership at an early stage. The Committee also received information formally at its meeting on 17 April including details of the proposed engagement plan. During the Health Scrutiny Committee meeting on 17 July, NHS representatives informed members about some of the main areas of feedback from the engagement exercise as well as outlined the next steps and recommendations.

Responses

46. Healthwatch Suffolk was appointed to oversee the process of gathering responses. This ensured an independent approach was taken to gathering responses and analysing findings and trends of data.

47. A total of **2,218** responses to the survey were received between 20 May and the close of the engagement on the 30 June.

Design of survey

48. Co-production of the survey took place in April and May 2024. Healthwatch Suffolk worked with the Suffolk and North East Essex ICB and WSFT to define the objectives and key topics for the engagement, and to ensure that communication of the survey was accessible to as many people as possible. The West Suffolk PPG Chairs Collaborative Network shared a draft with their members for comment, resulting in additional questions focussed on travel and patient choice.

Data collection

49. Healthwatch Suffolk hosted the anonymous feedback form on its website with signposting links from the ICB's main web page as well as links from social media posts. This supported translation of the survey using built-in Google translate. Paper copy forms were also made available for use in communities, as well as a flyer using a QR code. A paper copy Easy Read format was also produced. Healthwatch Suffolk engagement officers were available to support independent capture of people's experiences at events hosted by the ICB.

Reporting

50. Healthwatch Suffolk will produce a summary PDF report and PowerPoint summary about people's views and experiences to be shared with NHS leaders and the public. The report will be published on Healthwatch Suffolk's website and shared with the SNEE ICB and WSFT boards.

Key findings

51. The following section provides an overview of key themes across the survey.

Five main positive findings from the data:

- 48% of respondents were positive about the proposal overall. In the free text data, the most common reason for positivity was the impact ESEOC would have on reducing wait times and the risk of cancellations. This was mentioned by 30% of respondents.

- People living in some postcode district areas such as Sudbury and Lavenham (CO10, 75%), Stowmarket and Stowupland (IP14, 62%), Hadleigh and Milden (IP7, 64%) and Eye and Thorndon (IP23, 59%) were more likely to be positive about the proposal overall.
- Many people already have the support they need to be able to travel to ESEOC. 64% said that they would get a lift from family or friends.
- People who were already waiting for elective surgery at WSFT were much more likely to be positive overall (59%) than members of the public not on waiting lists (40%). They were also:
    - more likely to say they would get a lift to ESEOC (73% compared to 54%).
    - less likely to indicate distance from their home was important for their choice of provider (48% compared to 67%).
- In the free text data, 13% of people said they were motivated by receiving their operation quickly, rather than the distance they needed to travel. For people who are waiting for a long time, or living with pain, they may prioritise having their operation sooner over other considerations.

Five areas of concern:

- 35% respondents were negative about the proposal overall. 17% were neither positive nor negative. In the free text data, the most common reason for negativity was the additional time or distance to travel. This was mentioned by 47% of respondents.
- Travel and transport were the top concerns in the survey. 12% of people currently waiting for elective care at WSFT said that they did not know how they would travel to ESEOC. This figure was 25% for members of the public not waiting for elective care.
- 28% of respondents said in the free text comments they would find it difficult or impossible to get a lift to ESEOC. Common reasons for this included not feeling they could ask their family or friends to travel the increased distance to ESEOC, or not having close friends or contacts local to them to ask for a lift.
- 7% said that they would use public transport to get to ESEOC. However, when the survey advised people that they could not drive or use public transport after surgery, 83% of those said they could not get a lift home or were unsure.
- In addition to their travel options, people felt that the proposal and increased distance to travel would have an impact on:
    - their family or carers being able to visit them (15%)
    - travel cost (11%),
    - being able to arrive on time for early appointments, or driving home in the dark or winter months (5%),
    - the environment (1%).

Demographics:

52. The following section provides a summary of who has responded to the survey (figures from Healthwatch Suffolk).

- People were asked to identify whether they were currently waiting for elective care, were a carer, or a member of the public:
  - 54% (1,204) of people who responded to the survey were members of the public not caring for someone waiting for elective care or waiting for elective care themselves.
  - 37% (822) were patients waiting for elective orthopaedic care at WSFT.
  - 5% (110) were carers or relatives of someone waiting for elective care.
  - 2% (47) were patients waiting for elective orthopaedic care at another provider.
  - 1.4% (31) were patients for waiting for elective orthopaedic care at ESNEFT

- 80% of responses were from people aged 55 or above. This comprised:
  - 18-24 0.3% (7)
  - 25-34 2% (47)
  - 35-44 6% (123)
  - 45-54 9% (189)
  - 55-64 22% (443)
  - 65-74 31% (637)
  - 75-84 26% (521)
  - 85-94 4% (72)
  - 95+ 0.1% (3)

  Total 2,042

- 42% (941) identified an additional support need including having difficulties with mobility, a long-term condition or illness, a physical disability, mental health difficulty, sensory impairment, learning disability, autism or dementia.

- 95.4% of responses are from people who identified as White English/ Welsh/ Scottish/ Northern Irish. Other ethnic groups in the response were:

Category	**Number**	**Number**
White - English/Welsh/Scottish/Northern Irish/British	95.4%	1919
White – Any other White background	2.2%	44
White – Irish	0.9%	19
Mixed / Multiple ethnic groups – White and Black Caribbean	0.3%	6
Mixed / Multiple ethnic groups – Any other mixed/multiple	0.2%	4
Mixed / Multiple ethnic groups – White and Black African	0.2%	4
Mixed / Multiple ethnic groups – White and Asian	0.1%	3
Asian / Asian British - Indian	0.1%	3

Asian / Asian British – Any other Asian background	0.1%	3
Black / African / Caribbean / Black British - African	0.1%	2
Black / African / Caribbean / Black British - Caribbean	0.1%	2
Asian / Asian British - Chinese	0.05%	1
Asian / Asian British - Bangladeshi	0.05%	1
White – Gypsy or Irish Traveller	0.05%	1
Total answered		**2012**
Did not answer		206

206 people did not report their ethnicity and are not included in the percentages above.

Area

The survey has received responses from many areas across the system and beyond. These included:

Area	Postcode	Number	Percentage
Bury St Edmunds (south, west and town centre)	IP33	258	11.87%
Diss, Winfarthing	IP22	240	11.04%
Sudbury, Lavenham	CO10	230	10.58%
Ixworth, Thurston	IP31	191	8.79%
Elmswell, Cockfield	IP30	152	6.99%
Stowmarket, Stowupland	IP14	146	6.72%
Newmarket, Ashley	CB8	133	6.12%
Mildenhall, Culford	IP28	132	6.07%
Haverhill, Barnardiston	CB9	127	5.84%
Bury St Edmunds (north and east)	IP32	113	5.20%
Brandon, Lakenheath	IP27	106	4.88%
Thetford, Barnham	IP24	91	4.19%
Barrow, Shimpling	IP29	64	2.95%
Eye, Thorndon	IP23	51	2.35%
Hilborough, Feltwell	IP26	23	1.06%
Thorpe Abbotts, Pulham Market	IP21	13	0.60%
Hadleigh, Milden	IP7	11	0.51%

Ely (east and city centre), Barway	CB7	9	0.41%
Burwell, Waterbeach	CB25	8	0.37%
Needham Market, Creeting St. Mary	IP6	8	0.37%
Halstead	CO9	6	0.28%
North East Ipswich	IP4	6	0.28%
Felixstowe, Trimley St. Martin	IP11	5	0.23%
Banham, Larling	NR16	4	0.18%
Woodbridge, Melton	IP12	4	0.18%
Bures, Alphamstone	CO8	4	0.18%
South East Ipswich, Ravenswood	IP3	3	0.14%
North West Ipswich, Akenham	IP1	3	0.14%
Attleborough, Little & Great Ellingham	NR17	3	0.14%
Fulbourn, Great and Little Wilbraham	CB21	2	0.09%
Colchester	CO1	2	0.09%
Watton, Shipdham	IP25	2	0.09%
Copdock, Belstead	IP8	2	0.09%
Saxmundham	IP17	2	0.09%
Harleston, Mendham	IP20	2	0.09%
Ely (west), Aldreth	CB6	1	0.05%
South West Ipswich, Belstead	IP2	1	0.05%
Witham	CM8	1	0.05%
South Lowestoft	NR33	1	0.05%
Beccles, Worlingham	NR34	1	0.05%
North Lowestoft	NR32	1	0.05%
Greenstead, Highwoods	CO4	1	0.05%
Harlow, Old Harlow	CM17	1	0.05%
Shotley Peninsula: Capel St Mary, Chelmondiston	IP9	1	0.05%
Villages N and E of Dereham: Bawdeswell, Bylaugh	NR20	1	0.05%
Coggeshall, Earls Colne	CO6	1	0.05%
Clacton-on-Sea, Jaywick	CO15	1	0.05%
Brightlingsea, Wivenhoe	CO7	1	0.05%
Tiptree, Kelvedon	CO5	1	0.05%
Bungay, Topcroft	NR35	1	0.05%
Aldeburgh	IP15	1	0.05%
Kirton, Nacton	IP10	1	0.05%
Total answered		2,173	100.00%

Next stage

53. The engagement exercise concluded on Sunday 30 June 2024. The Integrated Care Board and the board of WSFT will consider the public feedback collated before a final decision is made by the ICB Board on Tuesday 30 July.

Recommendations from independent analysis

In light of the feedback received, Healthwatch Suffolk recommends that the system considers the following:

To avoid inequality of access, it would be important for the system to consider:

- **Transport and travel** – finding solutions for those without the means to travel to ESEOC, making sure people can get to their surgery (proactive solutions, help with travel costs or access to information about possible reimbursement).
- **Communicate to patients about what the ESEOC is** and help them to know what to expect from going there (e.g., where it is geographically, what would happen when they are there, car parking charges). Ensuring this is accessible to all.
- **Access, choice, flexibility and patient rights** – the system needs to clarify who is able to receive their operation at West Suffolk Hospital and who would receive it at ESEOC. Who could choose to stay at WSFT and who would decide? How would people ask? Primary Care would need to be equipped with this knowledge so they can pass this on to patients at the point of referral.
- **Carers/family visits** – ensure consideration is given towards visiting (both for carers and for families) particularly those who are vulnerable patients who will have their procedure at ESEOC. Ensuring there is support in place so they can stay nearby overnight, dependent on the patient's length of stay.
- **Support for vulnerable people** – ensure there is support available for vulnerable people (such as those living with dementia or a learning disability). Ensuring the environment is as friendly as possible if they need accessible support.
- **Share the learning** – ensure learning from public feedback relating to issues such as transport, travel, access, carer needs, communications and support for those who are vulnerable, are used in the development of any future centralised care hubs.

Appendices

Appendix 1 – Groups and locations attended

DATE	VENUE	NO. OF ATTENDEES
W/C 6 MAY		
Thursday 9 May, 2.00pm-3.30pm	Sudbury Locality meeting	38
W/C 13 MAY		
Monday 13 May, 10.00am-11.00am	SNEE PPG Chairs Network	4 PPG Chairs
Tuesday 14 May, 9.30am-11.00am	Health & Wellbeing Network	21
Tuesday 14 May, 5:30pm - 7:00pm	Legs Matters' public health event	
Wednesday 15 May, 1.30pm	Mildenhall & Brandon locality meeting	15 (representatives from Suffolk Police, CAB, Council, PCN, Grove Surgery, Food banks, CAS)
Wednesday 15 May, 2pm	NHS England regional assurance workshop	42
W/C 20 MAY		
Wednesday 22 May, 2.15pm	Sporting Memories Meeting	52
Thursday 23 May, 10.30am-12.30pm	Newmarket locality meeting	30
Thursday 23 May, 10.30am-12.30pm	Outreach stand	30
Thursday 23 May, 1.30pm-2.00pm	West Suffolk Council briefing	5
Friday 24 May, 10.30am - 12pm	Traveller site visit	1
W/C 27 MAY		
Wednesday 29 May, 10.00am-12.00pm	Outreach stand	66 people spoken to and a further 92 surveys taken for distribution in community centres etc.
Wednesday 29 May and Thursday 30 May	Outreach stand	Day 1 - Spoke to circa 71 people and included 150 leaflets in packs
Thursday 30 May, 10.00am-1.00pm	Outreach stand	Circa 40 people
Friday 31 May, 9.30am	Cancer Services User Group	6 spoken to

Saturday 1 June, 8.00am-12.30pm	Outreach stand	Circa 30 - all had received the text to those on the waiting list
W/C 3 JUNE		
Monday 3 June, 9.00am-11.00am	Outreach stand	111
Monday 3 June, 10.00am-1.00pm	Outreach stand	Cancelled - 30 paper surveys given at another Stowmarket venue
Monday 3 June, 1.30pm	Bury locality meeting	Email sent to all attendees with toolkit, survey, posters and locality meeting presentation
Monday 3 June, 7.00pm	Lymphoedema support group	17
Tuesday 4 June, 9.00am	Babergh Councillors briefing	4
Tuesday 4 June, 10:00am	Outreach stand	Paper surveys at Lakenheath Practice, Brandon library, Brandon GP Surgery, Boots Pharmacy
Wednesday 5 June, 9.30am-11.30am	Outreach stand	
Wednesday 5 June, 10.30-12noon	North East Essex Town and Parish Meeting	16
Wednesday 5 June, 5pm	Online public meeting	8
Thursday 6 June, 10.00am-12.00pm	Outreach stand	25
Thursday 6 June, 10.30am-12.30pm	Thetford PLACE Meeting	17
Friday 7 June, 9.00am-11.00am	Outreach stand	10
Saturday 8 June, 10.00am-12.00pm	Mini Exhibition	150
W/C 10 JUNE		
Monday 10 June, 10.00am-1.00pm	Outreach stand	3
Tuesday 11 June, 10.00am-12.00pm	Mini exhibition	
Tuesday 11 June, 2.30pm-4.30pm	Mini exhibition	10

Wednesday 12 June, 10:00am - 12:00pm	Outreach stand	23
Wednesday 12 June, 10.00am-1.00pm	Outreach stand	5
Wednesday 12 June, 6.00pm-8.00pm	Mini exhibition	6
Thursday, 13 June, 11:00am - 12:30pm	Outreach stand	20
Thursday 13 June, 2.00pm-4.00pm	Mini exhibition	50
Thursday 13 June, 5.00pm-6.00pm	Governors briefing	16
Friday 14 June, 5.00pm-7.00pm	Mini exhibition	30
Saturday 15 June, 10.00am	Online public meeting	0
W/C 17 JUNE		
Monday 17 June 9 - 10am	West Suffolk Hospital entrance	25
Monday 17 June, 10.00am-1.00pm	Outreach stand	30
Tuesday 18 June, 10.00am-12.00pm	Mini exhibition	10 people attended. 25 surveys handed out at Morrison's and 50 given to Julie on St John's Centre reception to go to other groups.
Wednesday 19 June, 10.30am-12.00pm	Communication hub meeting	30
Wednesday 19 June, TIME TBC	Haverhill locality meeting – venue tbc	40
Thursday 20 June, 3.00pm-4.00pm	Chronic pain support group	12
W/C 24 JUNE		
Monday 24 June, 10.00am-11.00am	Jam Community Pot	12
Monday 24 June, 11.00am-1.00pm	Outreach stand	10
Tuesday 25 June, 11.00am-2.00pm	Haverhill Terrific Tuesday Dementia Support Group	17
Tuesday 25 June, 2.00pm-4.00pm	Mini exhibition	14
Wednesday 26 June, 1.30pm-2.30pm	Breathe Easy Support Group	5

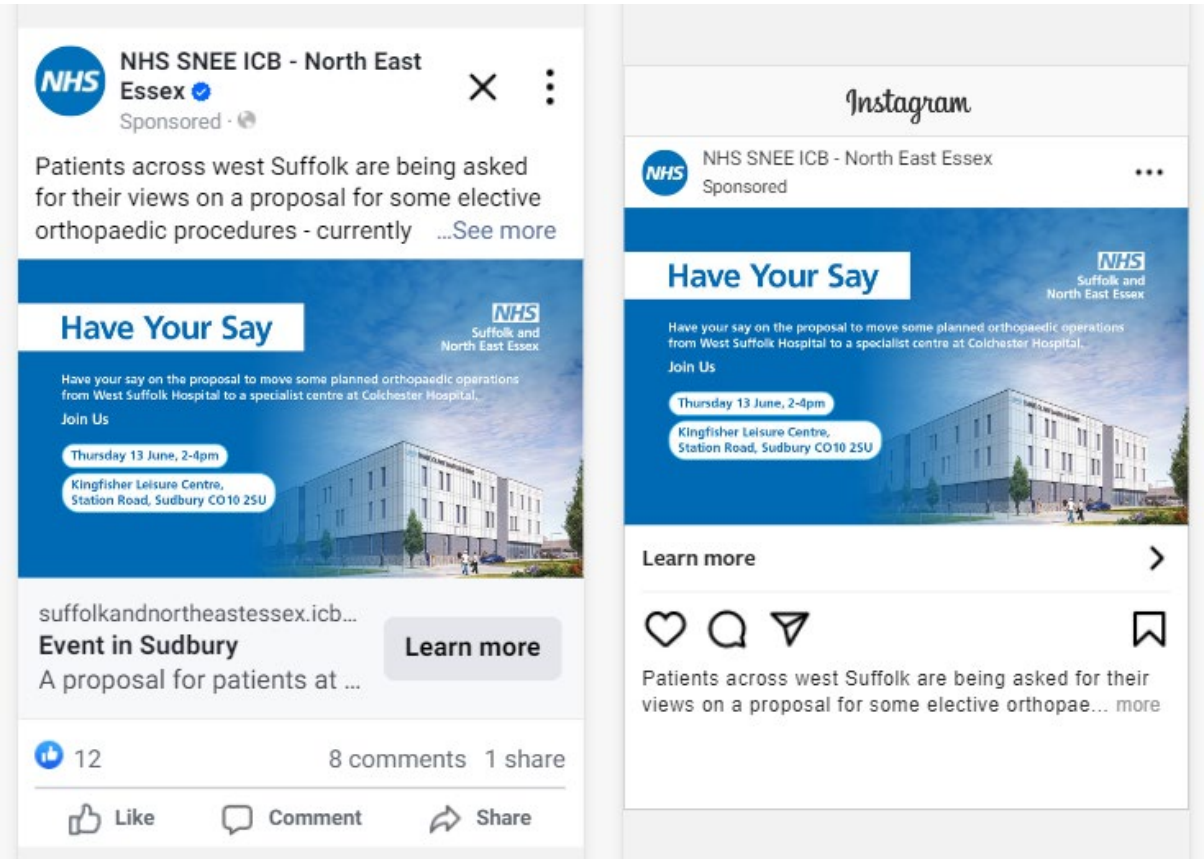
Wednesday 26 June, 3.00pm-4.00pm	Hard of Hearing Club	16
Thursday 27 June, 10.00am-11.30am	Thetford U3A	8 and 20 surveys taken to U3A monthly meeting taking place on 28 June
Thursday 27 June, 10.00am-12.00pm	Outreach stand	16 and 24 taken away to neighbours
Friday 28 June, 10.00am-12.00pm	Outreach stand	

Appendix 2 – Promotion of engagement using social media

To support the ESEOC engagement the ICB ran a Meta ads campaign between 21 May and 25 June 2024. A total of £480 was allocated for the campaign.

Ad creative

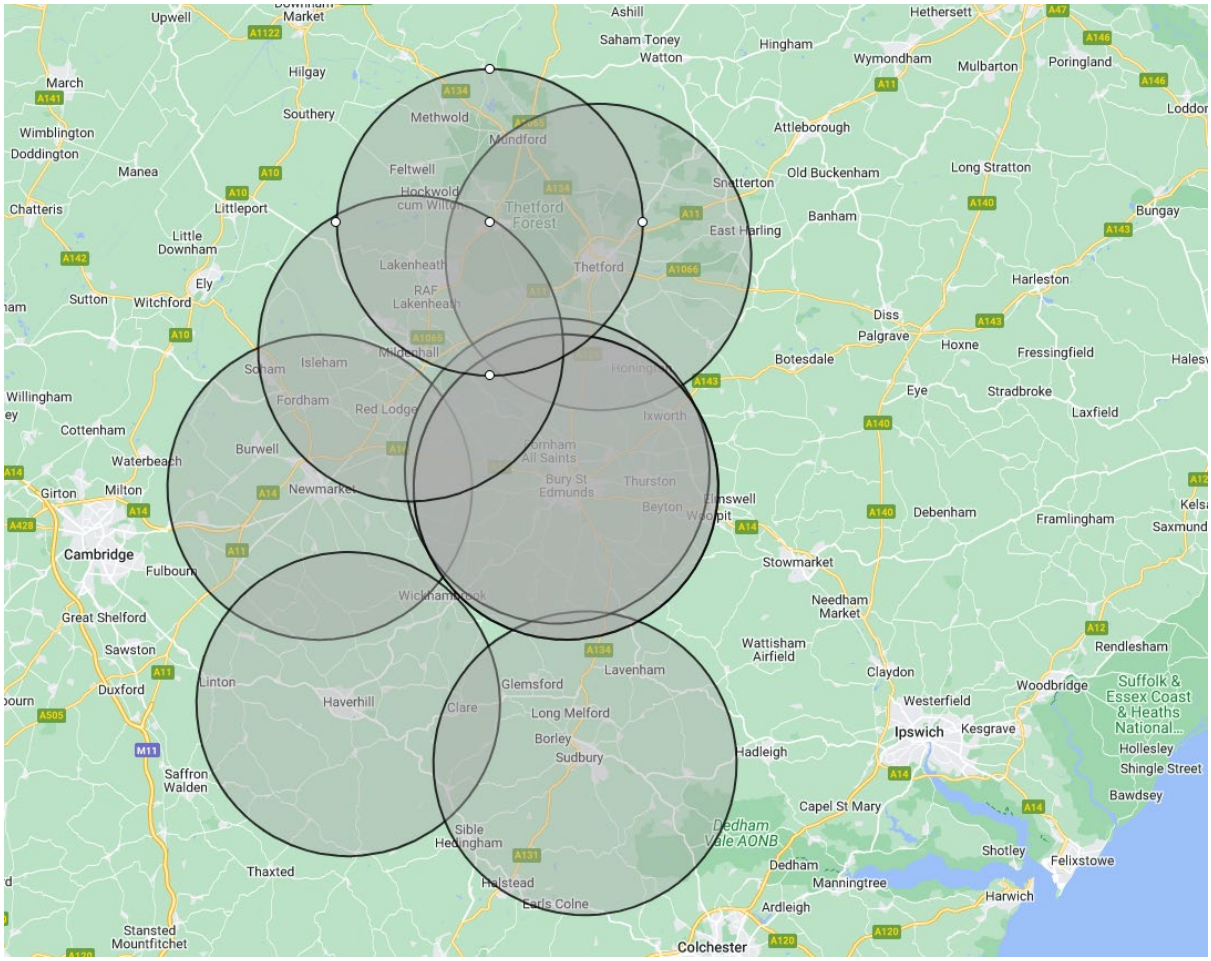
The ICB ran eight ads: each one promoting one of the mini exhibitions. Here is a preview of how some of the ads were displayed.



Targeting

The target audience was all people aged 18 and over living within an eight mile radius of one of the mini-exhibition venues. A map showing the coverage of the ads:

-



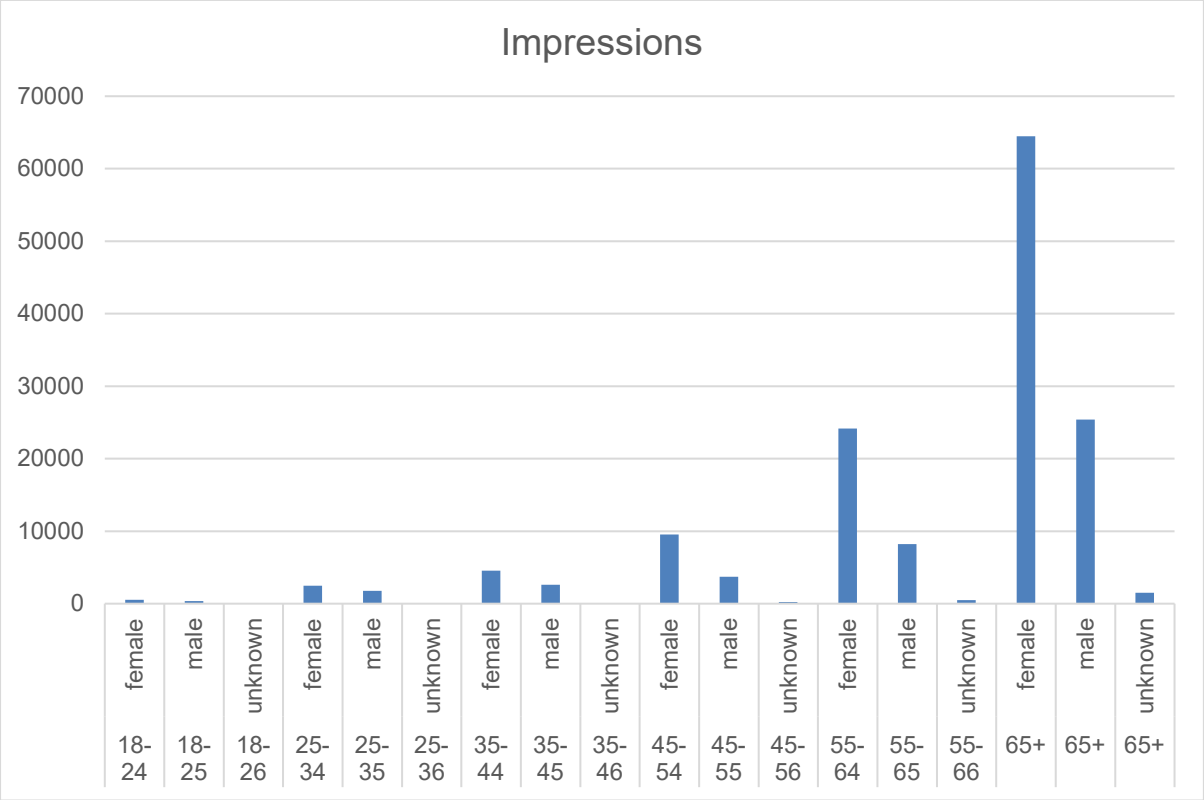
Results

Total number of people reached: 56,374
Total number of impressions (the number of times the ads were seen): 150,316
Total number of clicks through to the web page from the ads: 1,713
A breakdown of impressions by age and gender below.

Age	Gender	Impressions	Impressions (% of total)
18-24	female	548	0.36
18-25	male	346	0.23
18-26	unknown	15	0.01
25-34	female	2474	1.65
25-35	male	1776	1.18
25-36	unknown	78	0.05

35-44	female	4567	3.04
35-45	male	2597	1.73
35-46	unknown	69	0.05
45-54	female	9555	6.36
45-55	male	3705	2.46
45-56	unknown	246	0.16
55-64	female	24169	16.08
55-65	male	8234	5.48
55-66	unknown	509	0.34
65+	female	64496	42.91
65+	male	25412	16.91
65+	unknown	1520	1.01

Most of the ads were seen by females. The age range which was most frequently exposed to the ads was 65+.



Elective orthopaedic care engagement (west Suffolk)

Independent evaluation

healthwatch Suffolk

Healthwatch Suffolk

Your local health and social care champion

We seek to capture people's experiences, views and ideas related to the delivery of local health and social care services and support. We work together with local decision-makers to consider people's feedback and improve standards of care.

For more information about us or to find feedback about local services, please visit our website (**www.healthwatchsuffolk.co.uk**).

Our trusted insights

Our team are local leaders in inclusive co-production, engagement and research with people and communities. Our insights help health and social care systems to make better decisions about how care is provided to people across Suffolk, and further afield.

For more information about our services, please visit www.healthwatchsuffolk.co.uk/theres-more-to-us. You can also email research@healthwatchsuffolk.co.uk or call freephone 0800 448 8234.

This evaluation

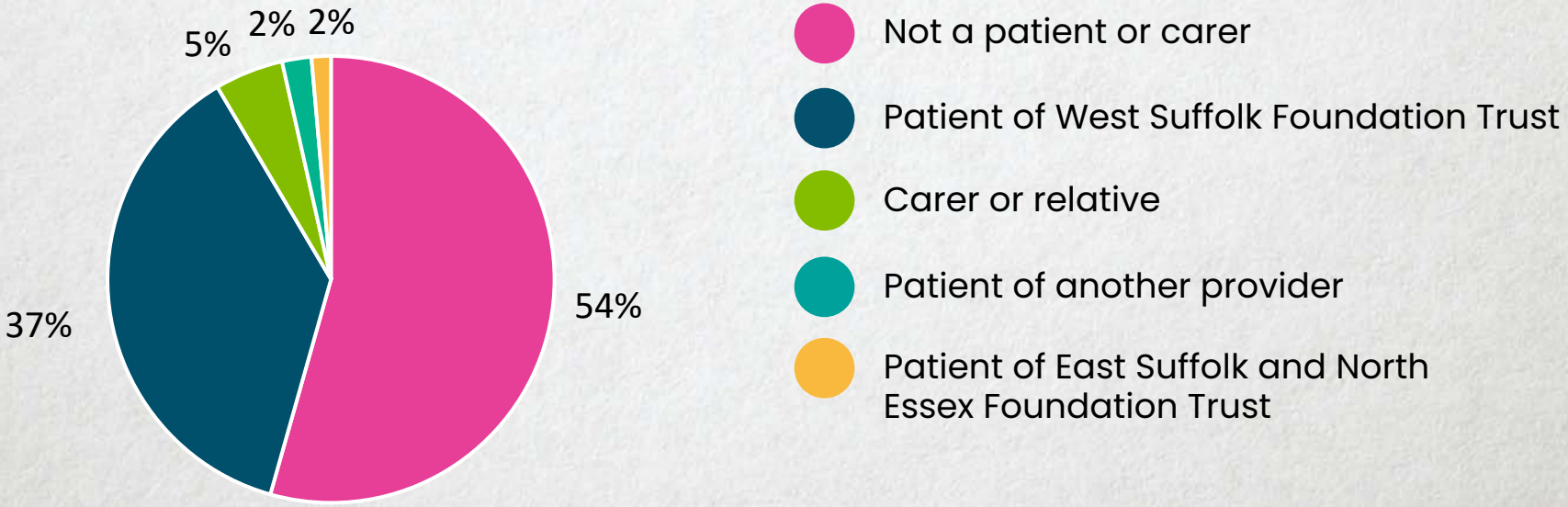
Objectives of this research

- The key aims for the engagement were to understand how people feel about the proposals overall, and how the proposal is likely to impact (positively or negatively) on their experience, treatment, and care.
- HWS co-produced the engagement tools together with the Suffolk and North East Essex Integrated Care Board ICB [SNEE ICB] and West Suffolk Foundation Trust [WSFT], hosted data collection, completed independent analysis and produced a report for consideration by the SNEE ICB Executive Board (July 2024).
- The engagement activity and promotion was led and coordinated by the SNEE ICB. This took place via direct communications e.g. letters and texts, social media and public engagement events.
- HWS supported communication activity and attended public events.
- Surveys were available online, in paper copy and as an easy read format.

Who responded & where?

Most respondents (54%, 1,204) were members of the public, not patients or carers waiting for orthopaedic treatment.

37% of respondents were patients waiting for orthopaedic surgery from the West Suffolk Foundation Trust (822). A smaller number of respondents identified as carers or relatives of a patient waiting for orthopaedic treatment (5%, 110).



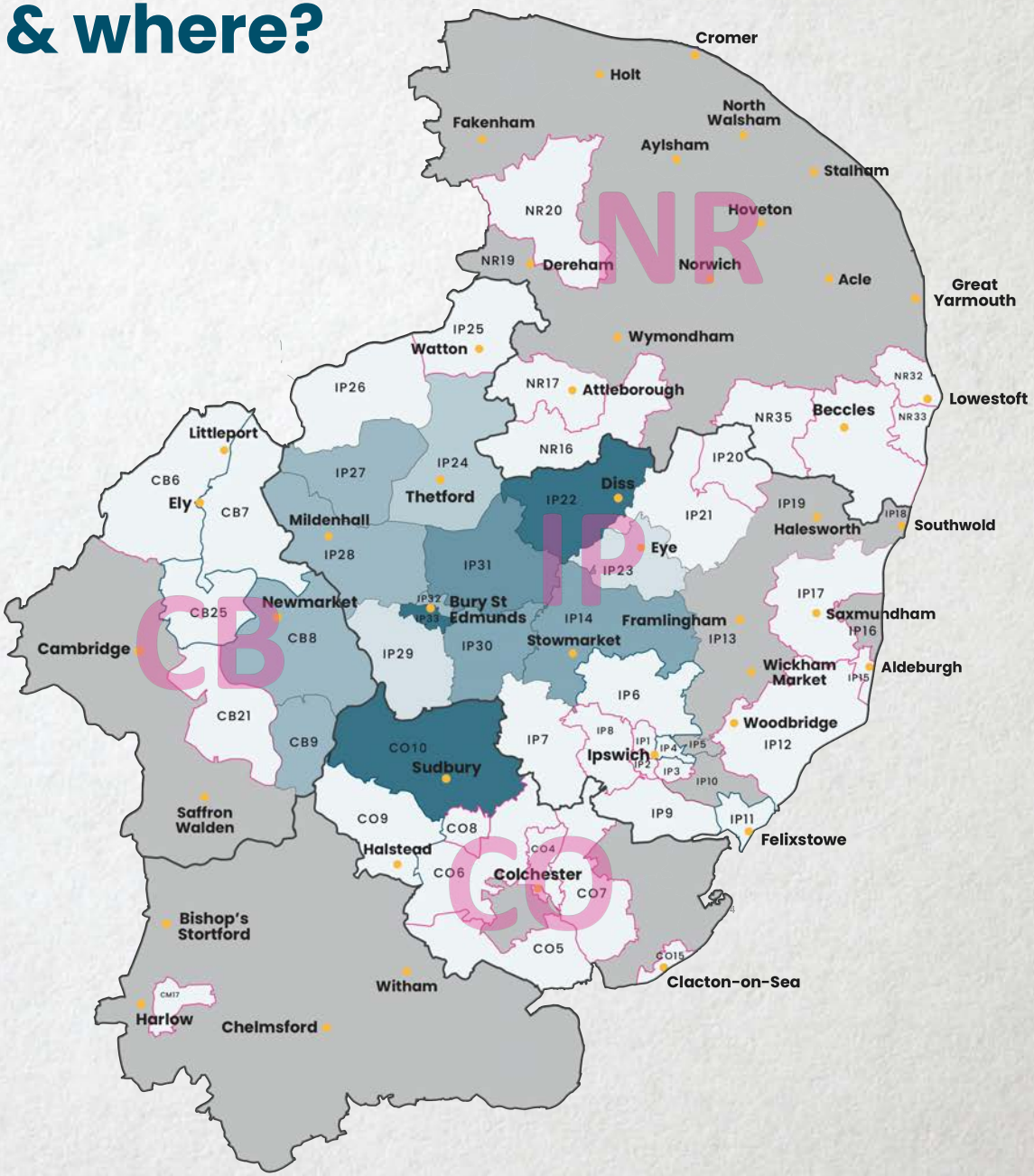
Who responded & where?

Postcode district

The map shows the percentage of responses from each postcode district (of those who provided the first part of their postcode).

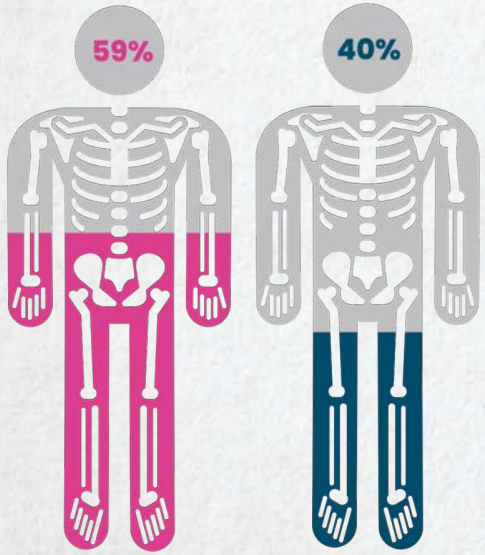
- 11 districts received responses from 100 people or more.
- 35 districts received responses from 10 residents or less.

Darker tones indicate higher response rates (up to 12% of total sample).

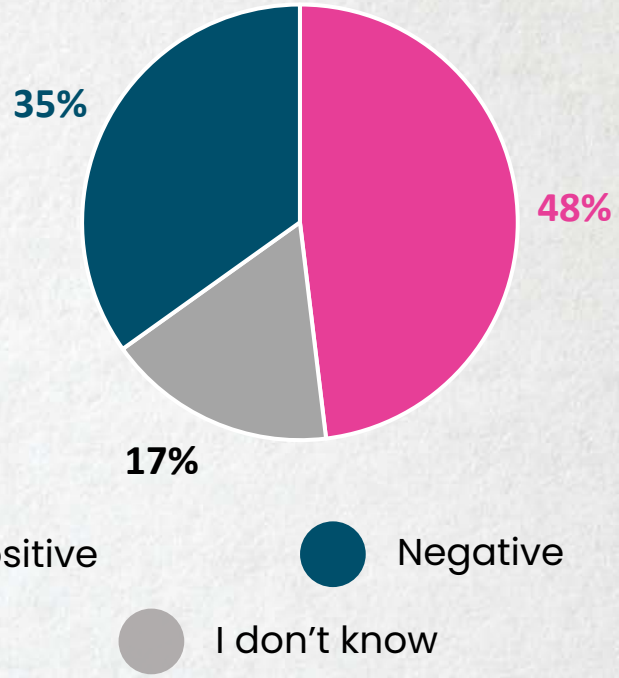


Overall sentiment

Almost half of respondents (48%, 1,041) were positive about the proposal.



59% of people waiting for elective orthopaedic surgery at WSFT were positive about the proposal compared to 40% of members of the public.



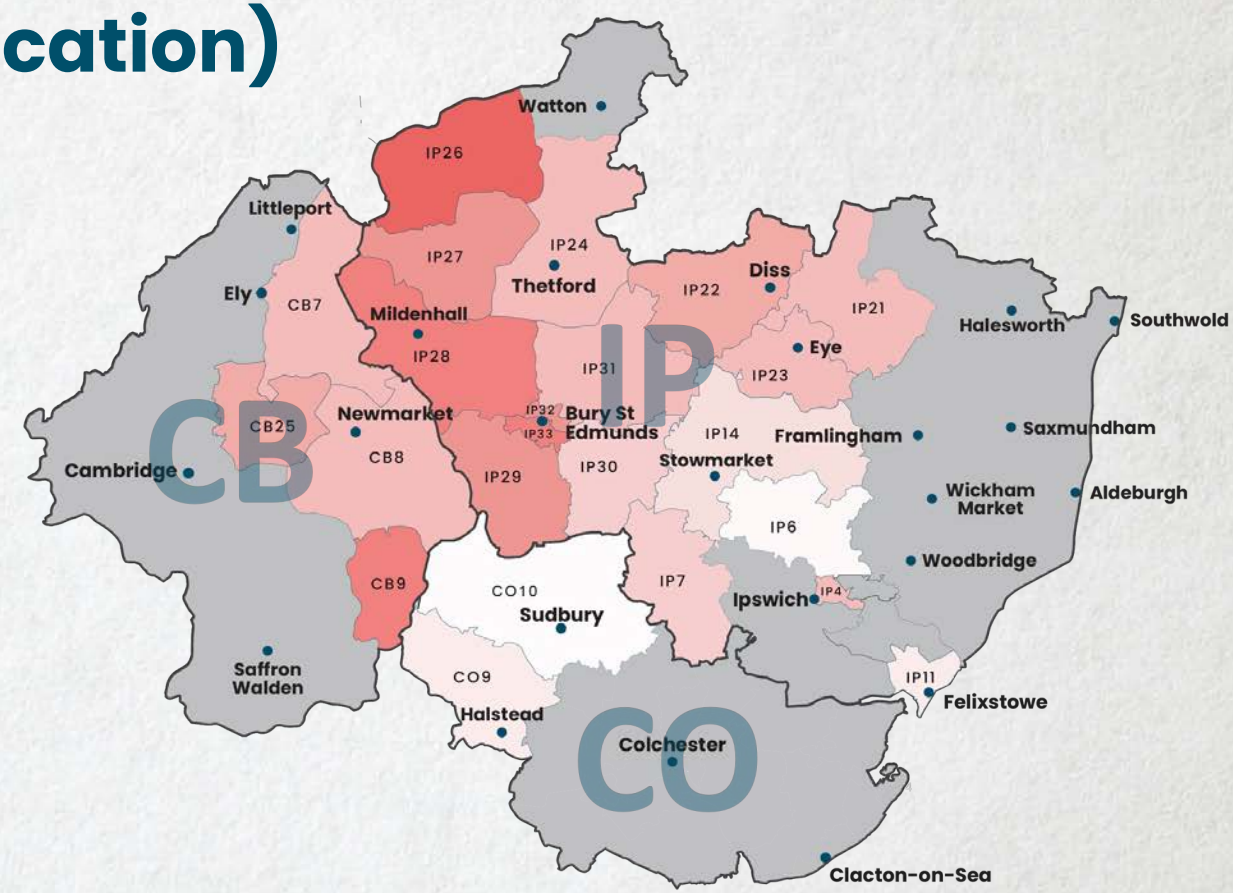
People who reported having additional support needs were less likely to be positive.

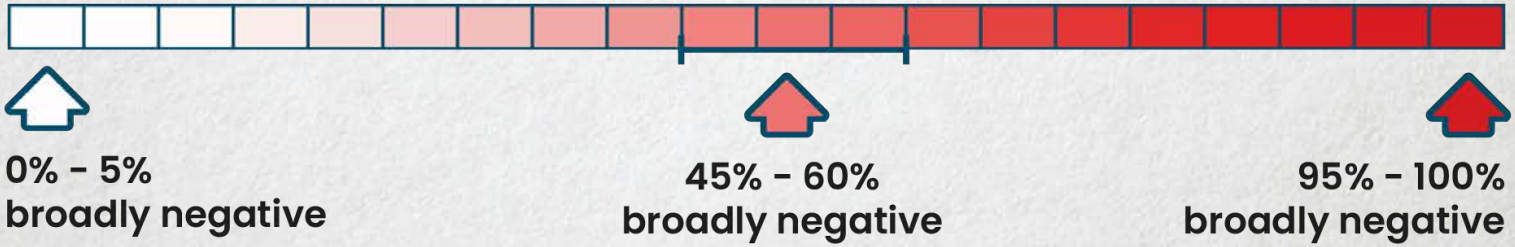
This included those living with a disability, mental health difficulty or long-term condition (46% of people who had problems with their mobility were positive, compared to 56% of those reporting no additional support needs).

Sentiment (location)

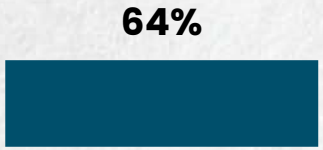
The map shows the percentage of respondents who said they were broadly negative about the proposal within postcode districts.

Districts are only highlighted if more than five responses were received.





A few key findings



Lift from friends/family

I don't know

20% said they did not know how they would travel to ESEOC. Most would be able to get a lift.

Respondents preferred **waiting times** over travel distance when choosing a provider for their care. Being familiar with a hospital, having a preferred surgeon, or risk of cancellation were chosen less often.

Waiting times

Distance from home

60% **said would be 'a little' or 'very' worried about travelling in the dark (in winter months or evenings).**

Respondent priority – travel & transport

Finding solutions for those who have difficulties with transport

- Leaders must find solutions for those who may not have the means to travel to the ESEOC (e.g., through challenging financial circumstances, lack of support networks, rural isolation, poor transport links to Colchester and other factors).

- Although many can get themselves to the ESEOC (even if it may be inconvenient to do so), it is clear transportation issues may critically determine whether some people in local communities can easily access surgery in the future without intervention.

- Proactive solutions should be sought where possible (e.g., arranged transport from the WSFT site or expanded non-emergency patient transport services), but people should also be informed about how they can get help with the cost of transport where eligible.

“I have spoken to a local taxi company who have advised me that the cost of a taxi one way (Brandon to Colchester) would be approximately £120.

“This is a huge sum and does not include parking fees or waiting charges.”

Respondent priority – access, patient choice and flexibility

Commissioners and WSFT must consider where flexibility on surgery location may be important for some patients and build this into service access policies.

Key questions:

- Are there any patients for which travel to ESEOC may not be considered reasonable, and who are they?
- Who will make decisions about patient preferences on flexibility and choice?
- How do we make sure people are aware of how they can request such flexibility based on their individual circumstances?

At the point of referral for orthopaedic surgery, NHS staff in primary care must be prepared to inform people about what these plans will mean if they choose to have their surgery delivered by the WSFT.

That includes detail about waiting times and risk of cancellation based on chosen site, any flexibility on choice that may apply and how people can ask for that, rights on patient choice, transport help, alternative options to ESEOC and other such information.

“I would find it very difficult to travel to Colchester as I live alone with no relatives able to get me there, so it would not be ideal for me.

“Although, I think a lot of people would benefit from not having to wait so long for surgery. I don’t have any options as I just would not be able to get there.”

Respondent priority - communication

People will welcome practical and clear information about accessing the ESEOC and what to expect when attending for surgery. This may help to reduce anxieties about visiting an unfamiliar hospital or location and help to make sure people understand how the service will operate.

This includes key information about pre and post-operative care (and where it is located), as well as practical information about travel to the centre, parking (e.g., charges), what to expect on arrival and how to prepare for a visit.

Such information may help people to feel more comfortable about their visit to the centre, particularly older and vulnerable patients who have expressed worry about visiting a place that is not known to them.

“As mentioned earlier, I have mental health issues, so anything that is outside my normal routine or unfamiliar surroundings makes me very anxious. Being incontinent, the longer the journey, the more problems with being able to locate a toilet.”

Respondent priority – family carers & visiting

NHS leaders must ensure the needs of formal and informal family carers have been considered and offer flexibility on location where required. This might include accommodating those with specific service accessibility needs or for whom familiarity with staff and the environment may be important (e.g., access to a known LD liaison lead).

Where people may require the daily in-person support of their family carer, an extended stay at the ESEOC may present unique challenges. Digital solutions may not be effective under these circumstances, and therefore, carers may face lengthy daily travel and increased expenses. Support with being able to stay nearby or flexibility on the location of surgery may be important to help people access their surgery.

Digital solutions should be explored to ensure people can connect with their friends or family if they cannot visit the ESEOC during the patient's stay.

"My young person is autistic. My concerns are around how these and other more vulnerable patients are treated.

"Obviously, they are known to the LD nurse at WSH, reasonable adjustments etc. How would this be managed by Colchester? Has provision been made for essential family carers to stay with the patient in Colchester? Are rooms big enough for this?

"These patients already have worse outcomes for health care and much as they can choose to stay local, that may lengthen the waiting times when if there aren't reasonable adjustments this is beyond the patients control...

"Please make sure that you consider those with autism and learning disability who need essential carers with them. We don't mind the distance but we'd need a parent to stay."

Respondent priority – support vulnerable people

Accessible care and support is important in any NHS service. It helps people to feel comfortable during their say and ensures people's needs are met. Flexibility on choice of surgery location may be important where people can demonstrate that their needs, or the needs of a person they care for, are not suited to travel to the ESEOC.

It will be important that there is a focus on helping people to attend if they have specific care or support needs (e.g., ensuring the ESEOC is dementia friendly) and that people know how they can request help with, for example, translation or interpretation if needed.

People's care and support needs should be noted before any transfer of a person's surgery to the ESEOC, so that staff know how to meet those needs in advance within the centre. Information about attending ESEOC (and patient choice) must be available in formats appropriate to people's needs so that everyone can access it fairly.

“I have no family who live nearby. I am not prepared to ask friends or neighbours because the distance is too far, and neighbours have their own health issues.

“There is no direct public transport link to Colchester from Rickinghall. I would try and get a bus to Diss, but there is a long walk and a hill to the station.

“I am visually impaired (certified), so uncertain how I would obtain tickets as I find the internet too difficult to use.”

healthwatch Suffolk

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Published July 2024

Independent analysis

Elective orthopaedic surgery (west Suffolk) review

Published July 2024

healthwatch Suffolk

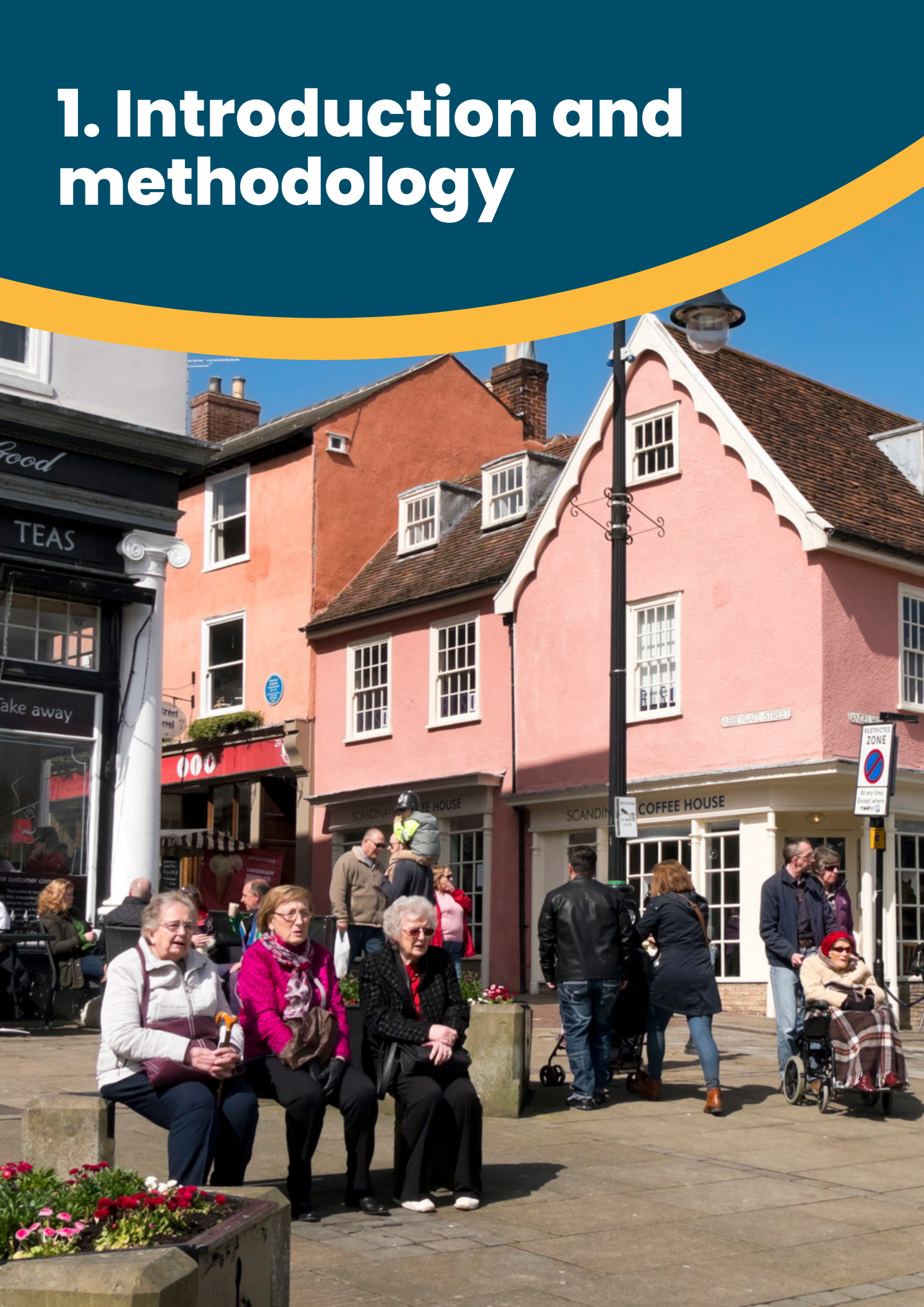
Trusted Insights

Contents

Navigate this report.

This independent analysis has been compiled by Healthwatch Suffolk CIC. The project was commissioned by Suffolk and North East Essex Integrated Care Board to shape and inform decision-making about the future of elective orthopaedic care in west Suffolk.

1. Introduction and methodology



About Healthwatch Suffolk CIC

Healthwatch Suffolk CIC is a social enterprise delivering insight to shape local NHS and social care. We passionately believe that listening and responding to people's lived experiences is vital to create health and care services that work for everyone.

We collect and share lived experience to improve standards of health and social care in Suffolk, regionally and nationally. Our independent role is enshrined in law, supported by trusted data and embedded in local integrated care systems by established relationships with partners.

Our service is founded on long-standing values of transparency, accountability and accessibility. We want everybody to feel equally valued, listened to, seen and heard.

Our core purpose is to...

Collect and share lived experience to influence better standards of health and social care.

We live and breathe...

Co-production in everything possible. We are inclusive, transparent, accessible, and accountable. We believe passionately that listening and responding to lived experience is vital to create health and care services that meet people's needs.

For more information about our role, and how we are inclusive, please visit our website.

Introduction (the proposals)

In March 2024, the NHS in Suffolk published proposals to move around 1,500 planned orthopaedic operations (such as hip, knee, foot and ankle surgery) each year from West Suffolk Hospital (West Suffolk Foundation Trust) to the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) in Colchester, Essex.

The ESEOC is an Elective Surgical Hub and is part of a scheme to provide hundreds more operating theatres and around one thousand beds nationally. The surgical beds in these hubs are kept free for patients waiting for planned operations, reducing the risk of short-notice cancellations because of other emergency admissions. The ESEOC will provide 72 additional beds and eight state-of-the-art operating theatres year-round in Colchester and will be unaffected by pressures in other parts of the hospital.

For those who may have their surgery at the ESEOC, the plans include that:

- pre-operation appointments and assessments will still happen at a West Suffolk site.
- only people's surgery and immediate aftercare will happen at ESEOC.

- orthopaedic surgery at the ESEOC will be undertaken by West Suffolk surgeons (unless there are any unforeseen issues, such as staff sickness).
- Around 45% of orthopaedic surgery will remain at West Suffolk Hospital, including all surgery for those under the age of 18.

The NHS considers that the plans are likely to benefit patients by reducing overall waiting times for patients waiting for elective procedures at the WSFT, and ensuring care is delivered by a specialist team focused on orthopaedic procedures.

However, it is also recognised that the new centre's distance from West Suffolk Hospital may impact those who need to travel further for their treatment. This may include that people face challenges with travel distance as well as the availability and cost of transport in their area. This is particularly important because clinicians advise people not to drive or use public transport following orthopaedic surgery.

It is possible to learn more about the detail of the NHS plans on the SNEE ICB website (https://suffolkandnortheastessex.icb.nhs.uk/elective/).

This report and the role of Healthwatch Suffolk

This report presents the results of an extensive NHS public engagement exercise completed about the proposals between 20th May and 30th June 2024

The role of Healthwatch Suffolk

The NHS Suffolk and North East Essex Integrated Care Board (SNEE ICB) asked Healthwatch Suffolk to independently gather, analyse and report on people's views about the proposals for orthopaedic surgery in west Suffolk.

The public engagement about the proposals has been led by the SNEE ICB, with strong support from the West Suffolk Foundation Trust and Healthwatch Suffolk teams.

How people's views were gathered

Healthwatch Suffolk co-produced a short survey to capture people's views. Co-production was inclusive of:

- Patient Participation Groups aligned with local GP practices in west Suffolk communities (via the West Suffolk PPG Chairs Collaborative Network).
- NHS leaders within the SNEE ICB and WSFT, including those responsible for the management of orthopaedic elective care, leading consultants and members of the ICB executive Board.
- WSFT communication and engagement leads.

The anonymous survey included a series of closed and open-ended questions, enabling both quantitative and qualitative data to be gathered. A concise approach was required to maximise engagement and ensure the survey would be suited to distribution and completion at public events and meetings.

The survey was hosted on the Healthwatch Suffolk website (an embedded web form) and promoted widely.

Questions in the survey sought to:

- assess overall levels of sentiment about the proposals;
- understand people's likely travel choices if their surgery happened in Colchester;
- capture feelings about the proposals and the support people might require to attend surgery in Colchester;
- explore factors that would influence a person's choice of provider for orthopaedic care;

Limited data regarding demographics and locality was also gathered with consent.

People were informed about the opportunity to respond in a variety of ways, including (but not limited to):

- Social media promotion.
- Posters and flyers in communities.
- Press releases and paid advertorials.
- Website and newsletter features.
- Public engagement events.
- Attendance at local groups.

Communication and engagement activity was led by the SNEE ICB, with support from the WSFT and Healthwatch Suffolk. The most common sources of responses are shown in the table below.

Source	Count	% of sample
Text messages from West Suffolk Foundation Trust	546	29%
Social media (NHS)	185	9.8%
Social media (Healthwatch Suffolk)	177	9.4%
Nextdoor app	103	5.5%
NHS staff or information stand	91	4.8%
Whatsapp or other messaging applications	88	4.7%
Healthwatch Suffolk newsletters	81	4.3%
Word of mouth	77	4.1%
Newspaper or newsletter	76	4%
Healthwatch Suffolk staff in communities	69	3.7%
GP surgery	63	3.3%
Hospital letter	56	3%
Patient Participation Groups	46	2.4%
Village hall, community centre or leisure centre	26	1.4%
Posters in the community	23	1.2%
Attendance at a local group or meeting	16	0.8%

Table 1: The source of responses.

Healthwatch Suffolk staff joined NHS leaders at public engagement events to support independent capture of people's views.

Data limitations

When interpreting the data, it is important to consider the following limitations of the engagement and survey approach.

Efforts to protect anonymity of respondents have limited the extent to which people's responses could be explored across localities. For example, only the first part of a person's postcode was gathered which means place-based analysis was only possible to postcode district level.

Whilst it is anticipated that the proposals are likely to affect our most deprived communities, the survey did not include an accurate way to identify levels of deprivation within the sample (e.g., the survey did not ask about levels of income and the lack of a full postcode means the data could not be explored at Lower Super Output Area level).

Awareness of travel options and costs may have been low amongst the sample. For example, information was not provided in the proposals about the eligibility criteria of non-emergency patient transport services, or the potential cost of a taxi or other public transport (for the journey to hospital). Therefore, people's judgments about transport issues are entirely subjective (based on their own experience and knowledge), though no less valid. People were informed that clinicians advise people not to drive or use public transport home after their operation.

When considering the data set overall, it is important to acknowledge that people's views and opinions are influenced by their frame of reference and therefore people may not be an accurate predictor of their future behaviours. Those who are currently not waiting for orthopaedic care may lack understanding of how living with a condition or ailment requiring orthopaedic

surgery can impact their lives, and therefore their survey responses would not account for this. We cannot claim with certainty that a person's overall view on the proposals would not change based on future experience (e.g., of living with pain or limited mobility).

To account for this, the differences between responses from respondent and demographic groups (e.g., those who are currently waiting for care, and those who were not) are reported in detail throughout this report. Caution should be exercised when interpreting the data from respondent groups with small sample sizes.

Some data within the report has been presented as a map. While this is a useful way to highlight potential trends in data, it is important to note that sample size will vary significantly across postcode districts. Therefore, the extent to which the data visualised may be considered representative of the population within each postcode district area will vary too. Our map on page 12 indicates where response rates may be geographically lower.

Although the engagement was extensive and inclusive of multi-ethnic communities and other demographies, the sample of respondents is not representative of the Suffolk and north east Essex population. More detail regarding the diversity of respondents (e.g., respondent age, ethnicity and locality) is included from page 10.

It was important to ensure that communication about the survey was not exclusively targeted at online communities. Therefore, one thousand posters featuring a QR code were distributed widely in west Suffolk communities.

In addition, hard copy surveys were made available (including an easy read format designed by Healthwatch Suffolk) for distribution at public events hosted by the SNEE ICB. Hard copy surveys were also shared by Healthwatch Suffolk staff during their standard community engagement activity in the period and local Patient Participation Groups linked with GP practices in west Suffolk.

Who took part (sample demographics)?

Age profile

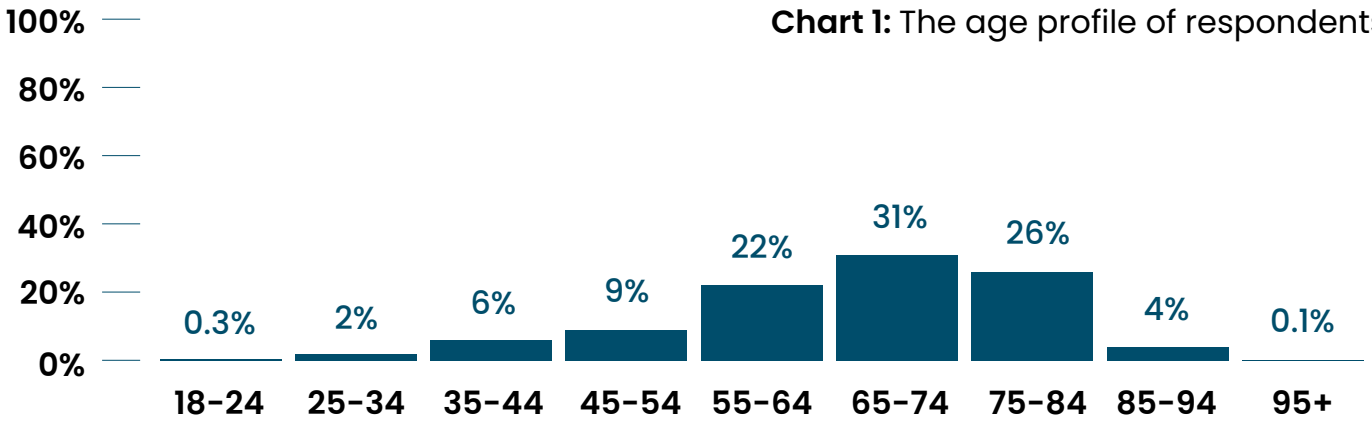


Chart 1: The age profile of respondents.

Ethnicity

There are 1,068,045 people registered with general practitioners (GPs) across SNEE (277,077 in west Suffolk). Of the population whose ethnicity is known, the majority are white (94.7%). Further, census data from 2021 revealed that the percentage of the west Suffolk population that are not White English, Welsh, Scottish, Northern Irish or British has increased from 13.7 per cent in 2011 to 17.8 per cent in 2021.

Responses to the survey from people who identified with an ethnicity other than White or White British were very low, accounting for just 1.19% (24 people) of the sample overall. Therefore the views herein are not representative of known diversity within the SNEE or west Suffolk population, although it is reasonable to expect that responses from White or White British people would be most prominent within the data set.

It is important to note that 206 people did not provide information about their ethnicity. It is unknown whether those respondents might reflect higher levels of diversity in the sample. Please see table three for more detail about the sample.

Vulnerabilities

People were asked if they identified with a list of vulnerabilities shown in the table below. A majority of the sample did not identify with any of the vulnerabilities listed. Of those who did, most said they had difficulty with their mobility or were living with a long-term condition or illness.

	Count
None of these	938/36%
Long-term condition or illness	565/22%
Difficulty with mobility	542/21%
Physical disability	248/10%
Mental health difficulty/diagnosis	78/3%
Sensory impairment	73/3%
Learning disability	23/1%
Autism	15/1%
Dementia	9/0.3%

Table 2: Responses to 'Please tick all of the statements that apply to you' (vulnerabilities).

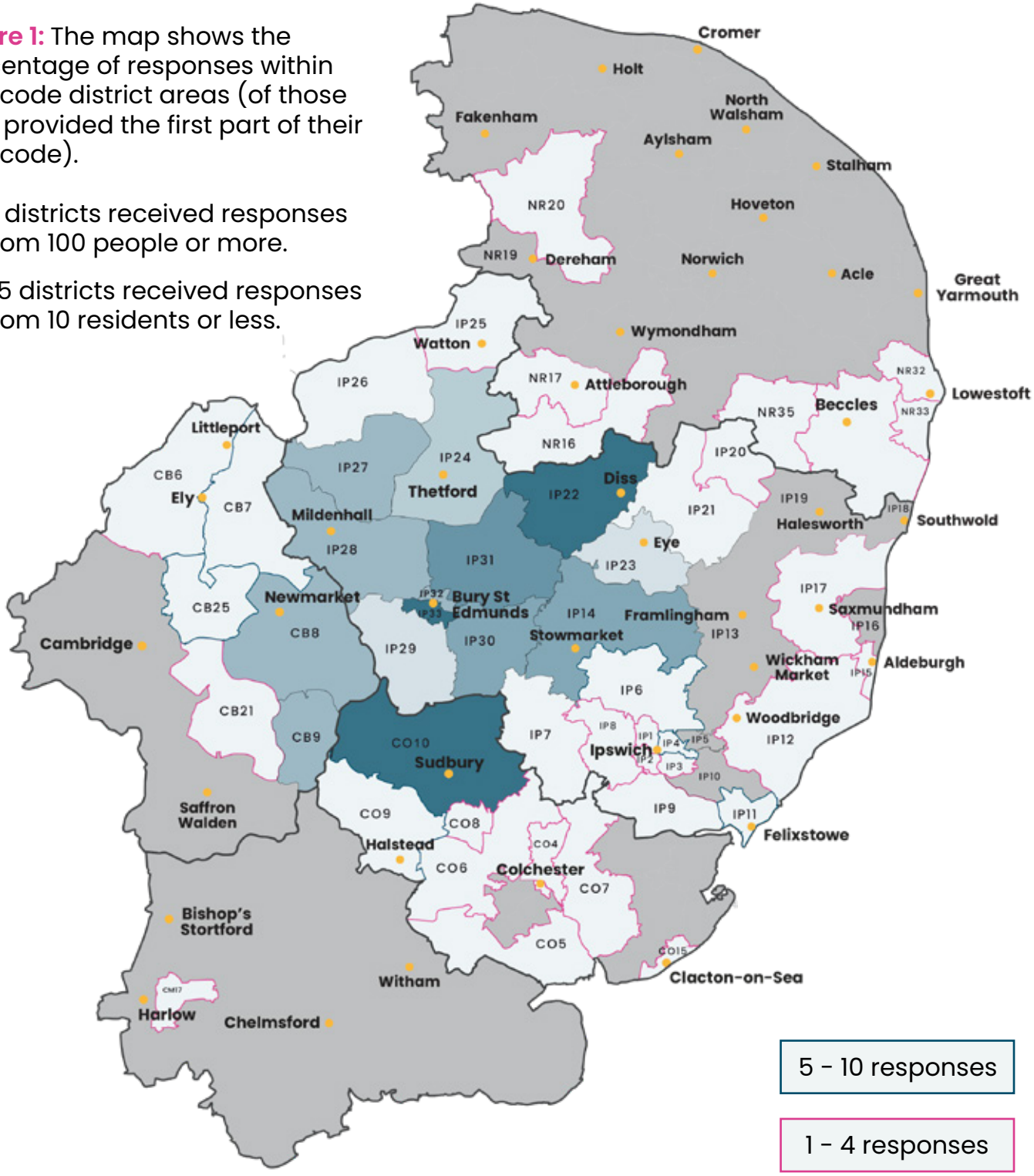
Ethnicity	Count	% of sample
White - English/Welsh/Scottish/Northern Irish/British	1,919	95.4%
White - Any other White background	44	2.2%
White - Irish	19	0.9%
Mixed / Multiple - White and Black Caribbean	6	0.3%
Mixed / Multiple ethnic groups – Any other mixed/multiple	4	0.2%
Mixed / Multiple - White and Black African	4	0.2%
Mixed / Multiple - White and Asian	3	0.1%
Asian / Asian British - Indian	3	0.1%
Asian / Asian British – Any other Asian background	3	0.1%
Black / African / Caribbean / Black British - African	2	0.1%
Black / African / Caribbean / Black British - Caribbean	2	0.1%
Asian / Asian British - Chinese	1	0.05%
Asian / Asian British - Bangladeshi	1	0.05%
White – Gypsy or Irish Traveller	1	0.05%
Total answered		**2,012**

Table 3: The ethnicity of respondents.

Respondent locality

Figure 1: The map shows the percentage of responses within postcode district areas (of those who provided the first part of their postcode).

- 11 districts received responses from 100 people or more.
- 35 districts received responses from 10 residents or less.



Up to 15% of sample (325 responses or less)

6% - 9% of sample

Less than 1.5% of sample (33 respondents or less)

Postcode district	Count	% of sample
IP33	258	12%
IP22	240	11%
CO10	230	11%
IP31	191	9%
IP30	152	7%
IP14	146	7%
CB8	133	6%
IP28	132	6%
CB9	127	6%
IP32	113	5%
IP27	106	5%
IP24	91	4%
IP29	64	3%
IP23	51	2%
IP26	23	1%
IP21	13	1%
IP7	11	<1%
CB7	9	<1%
CB25	8	<1%
IP6	8	<1%
CO9	6	<1%
IP4	6	<1%
IP11	5	<1%
NR16	4	<1%
IP12	4	<1%
CO8	4	<1%
IP3	3	<1%
IP1	3	<1%
NR17	3	<1%
CB21	2	<1%
CO1	2	<1%
IP25	2	<1%
IP8	2	<1%
IP17	2	<1%
IP20	2	<1%
CB6	1	<1%
IP2	1	<1%
CM8	1	<1%
NR33	1	<1%
NR34	1	<1%
NR32	1	<1%
CO4	1	<1%
CM17	1	<1%
IP9	1	<1%
NR20	1	<1%
CO6	1	<1%
CO15	1	<1%
CO7	1	<1%
CO5	1	<1%
NR35	1	<1%
IP15	1	<1%
IP10	1	<1%
Total answered		**1,748**

Table 4: The location of respondents (postcode district).

2. Results

Patients and members of the public

Most respondents were members of the public (e.g., neither patients or carers of a person waiting for orthopaedic treatment).

In total, **37%** of people were patients waiting for orthopaedic treatment from WSFT. A small number of respondents were carers or relatives of someone waiting for orthopaedic treatment.

More information is shown in chart two below.

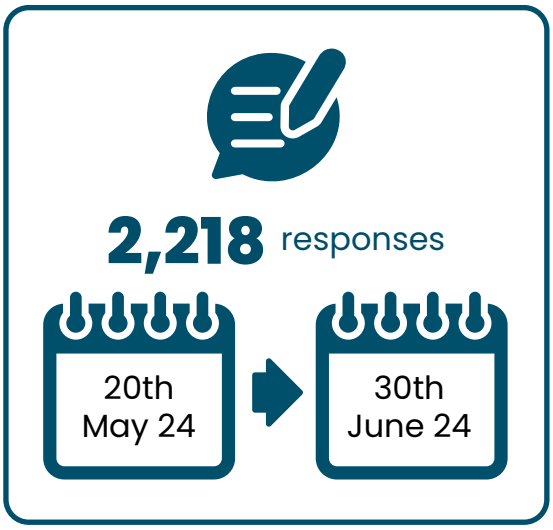


Chart: Respondent groups (Patients, carers and the public)

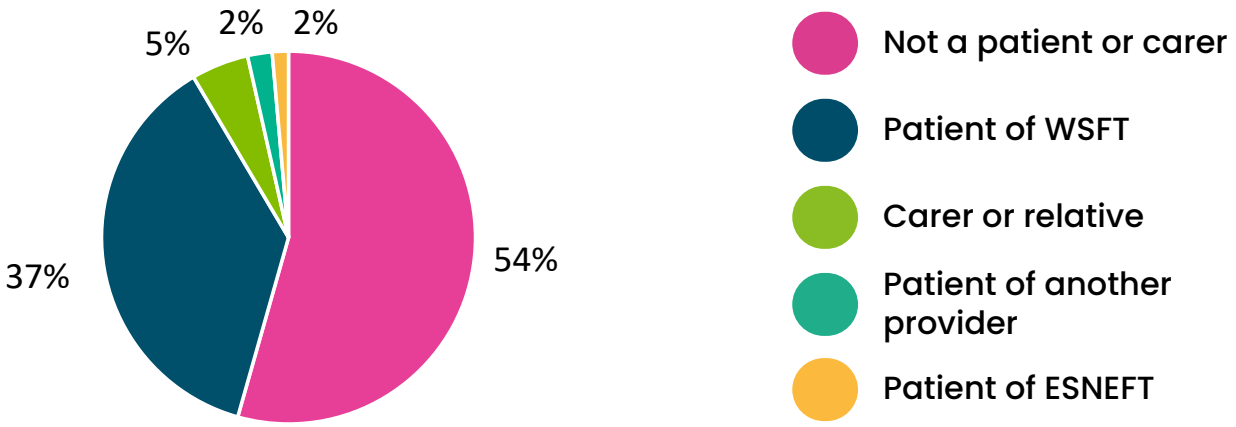


Chart 2: The percentage of respondents who identified as patients, carers or members of the public.

Category	Number
Not a patient or carer	1,204
Patient of the West Suffolk Foundation Trust (WSFT)	822
Carer or relative	110
Patient at another provider	47
Patient of the East Suffolk and North Essex Foundation Trust (ESNEFT)	31
Total answered	**2,214**

Table 2: The percentage of respondents who identified as patients, carers or members of the public (all categories).

Overall sentiment about the proposal

Respondents were asked to consider whether they were broadly positive, neither positive nor negative, or broadly negative about the proposal.

Almost half of respondents (**48%, 1,041**) were positive about the proposal, while the other half were either undecided (**17%, 369**) or negative (**35%, 755**).

Sentiment about proposal	Number
Broadly positive	1,041 (48%)
Neither positive nor negative	369 (17%)
Broadly negative	755 (35%)
Total answered	**2,165**

Figure 2: The map shows percentage of respondents who said they were broadly negative about the proposal by postcode districts. Districts are only highlighted if more than five responses were received.

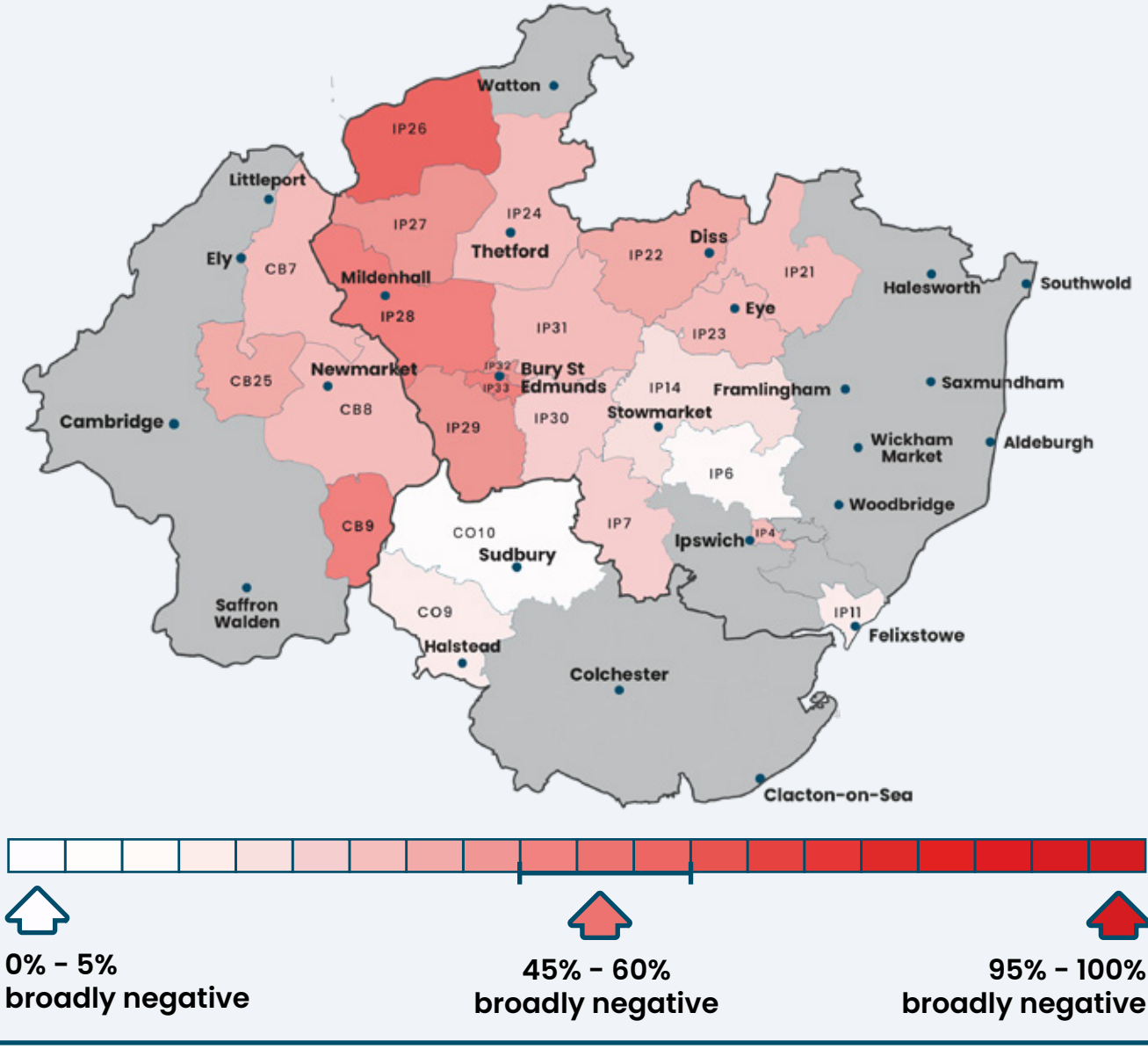


Chart: Overall sentiment about the proposals

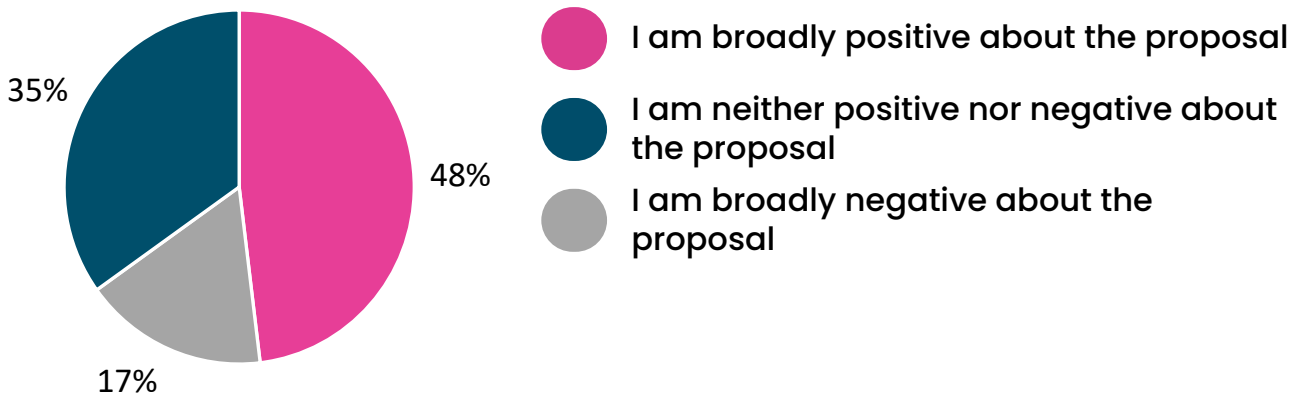


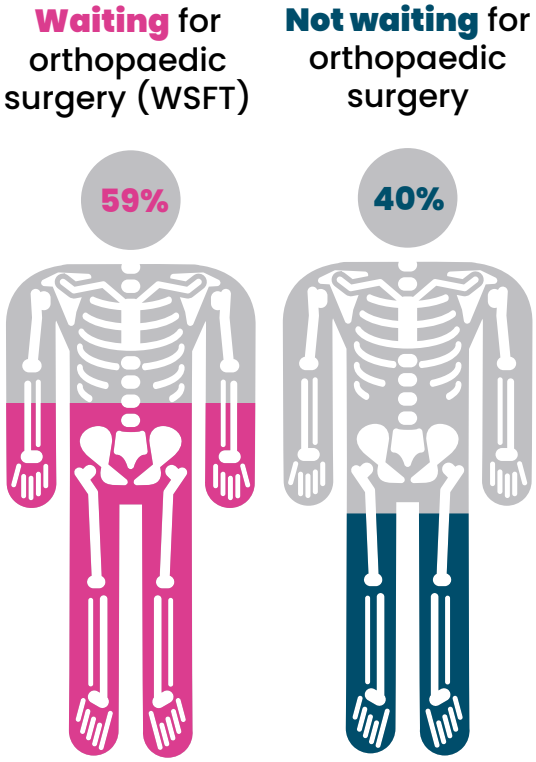
Chart 3: The percentage of respondents who said they were either positive, negative or undecided about the proposals.

Overall sentiment and demographics

Overall sentiment about the proposal varied by demographics. Notable findings included:

- **Patient status** - People waiting for elective orthopaedic surgery from any hospital were more likely to be positive about the proposal overall than carers of waiting patients or members of the public. For example, 59% of patients waiting for care from WSFT (483) were positive, compared to 40% of members of the public not waiting for elective care (463). Amongst carers of someone waiting for elective care, 45% were positive about the proposal (50).

- **Age** - Overall positivity about the proposal appeared to increase with age, with those aged 55 and above most likely to be positive. For example, 55% of 55 – 64 year olds were positive (241), compared to 38% of 45 – 54 year olds (71).



People waiting for elective surgery from WSFT were **more likely to be broadly positive or neutral** about the proposals than those not on any waiting list.

The two age groups most likely to be positive about the proposal (55 – 64 year olds and 65 – 74 year olds) were also the most likely to report that they were waiting for elective care (46%, 205 and 44%, 283 respectively).

Chart: Overall sentiment about the proposals (Age)

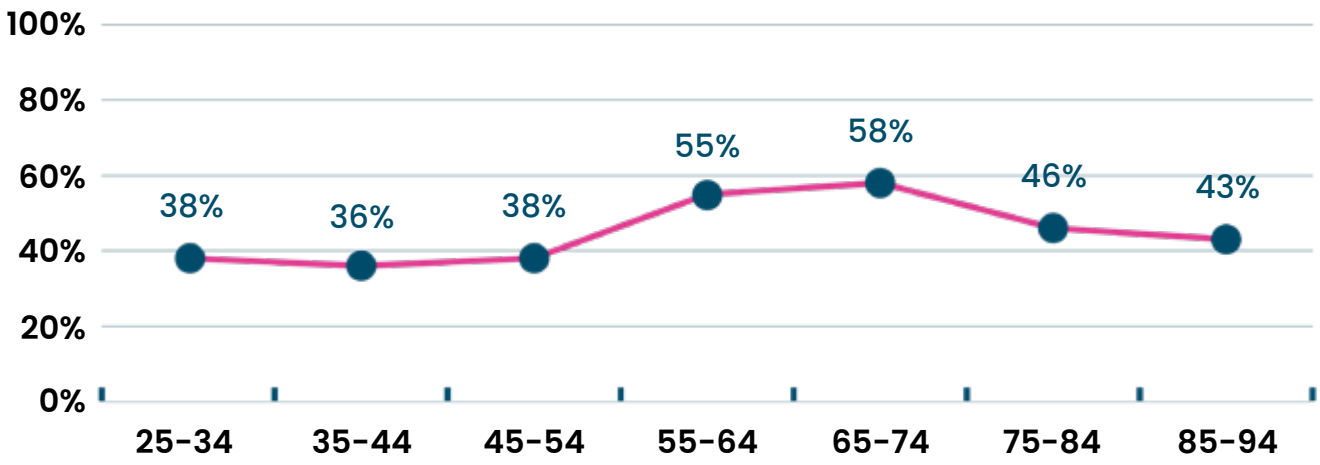


Chart 4: The percentage of respondents who said they were **positive** about the proposals and their age.

- **Additional support needs -** People who reported having additional support needs were less likely to be positive about the proposals.

  People who had a diagnosed mental health difficulty (32%, 25), a physical disability (36%, 86), or a learning disability (39%, 9) were the least likely to be positive about the proposal overall. Forty-six percent of people who had difficulties with their mobility (86), and 43% of people with a long term condition or illness (235) were positive about the proposal. This compared to 56% (515) of those reporting no additional support needs.

Chart: Overall sentiment about the proposals (Support needs)

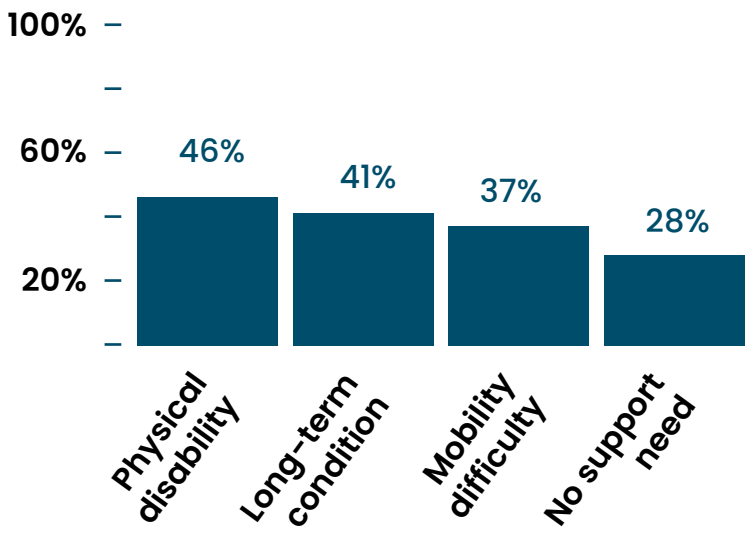


Chart 5: The percentage of respondents who said they were **negative** about the proposals and identified support needs.

- **Ethnicity** - Positivity varied by ethnicity. However, low sample numbers make it difficult to compare groups.

  There were 50% of people from White/White British backgrounds (976) who were positive about the proposal, compared to:

  - 50% (eight) of people from Mixed Multiple ethnic backgrounds;
  - 67% (two) of people from Black/Black British backgrounds;
  - 25% (two) of people from Asian/Asian British backgrounds.

Overall sentiment and locality

Looking at the whole sample, respondents in some areas of west Suffolk were less likely than others to be positive about the proposal. However, there was not a clear single trend that all areas of west Suffolk were negative about the proposal. Overall, many areas were mixed in their sentiment breakdown.

Areas where respondents were more likely to be negative than positive about the proposal were:

- Bury St Edmunds (south, west and town centre) (IP33)
- Mildenhall and Culford (IP28)
- Haverhill and Barnardiston (CB9)
- Brandon and Lakenheath (IP27)
- Hilborough and Feltwell (IP26)

Areas where respondents were more likely to be positive than negative about the proposal were:

- Sudbury and Lavenham (CO10)
- Ixworth and Thurston (IP31)
- Elmswell and Cockfield (IP30)
- Stowmarket and Stowupland (IP14)
- Newmarket and Ashley (CB8)
- Thetford and Barnham (IP24)
- Eye and Thorndon (IP23)
- Thorpe Abbotts and Pulham Market (IP21)
- Hadleigh and Milden (IP7)

However, area trends were different for people already waiting for elective care at WSFT. In almost every area with a response rate over five, people waiting for elective care from WSFT were more likely to be positive than negative about the proposal.

Exceptions to this trend were in IP33 (Bury St Edmunds south, 48%), IP27 (Brandon and Lakenheath, 34%), IP28 (Mildenhall and Culford, 44%), IP32 (Bury St Edmunds north, 49%) and IP26 (Hilborough and Feltwell, 29%).

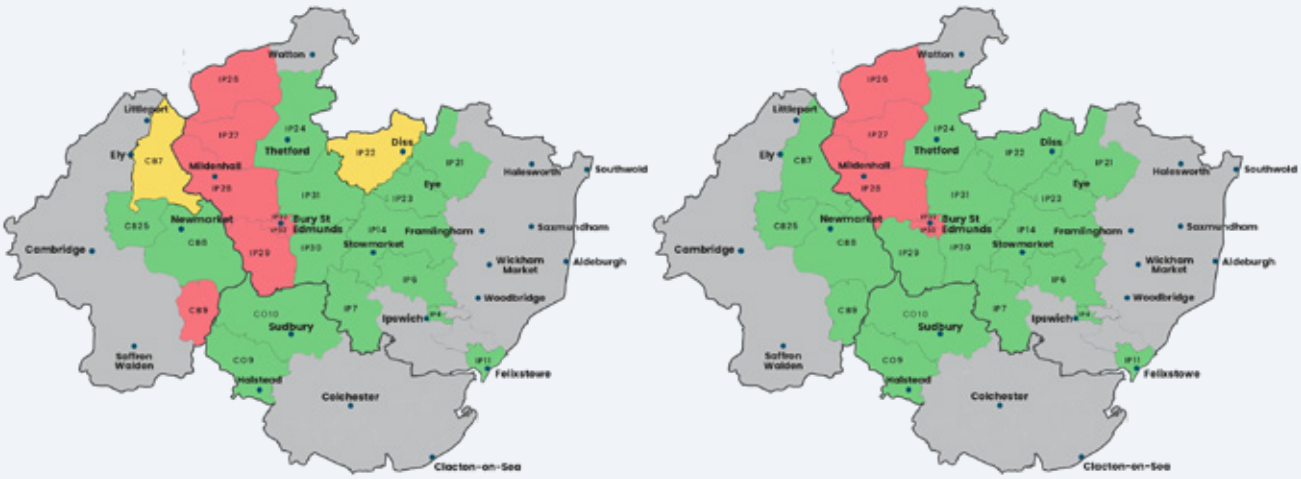


Figure 3: The map shows a comparison of dominant sentiment (where any proportion of those negative, neutral or positive overall is highest) in each postcode district. The maps shown relate to all respondents (left) and those waiting for elective care from the WSFT (right). Sentiment dominance may only be very marginal in some localities.

In general, those waiting for elective care from the WSFT were more likely to be broadly positive about the proposals, even if located in areas where negativity about the proposals was highest within the whole sample.

Area	Post-code	Positive	Neutral	Negative	Count
Bury St Edmunds (south, west and town centre)	IP33	39%	15%	46%	254
Diss, Winfarthing	IP22	38%	24%	38%	226
Sudbury, Lavenham	CO10	75%	15%	10%	225
Ixworth, Thurston	IP31	55%	13%	31%	186
Elmswell, Cockfield	IP30	51%	19%	30%	152
Stowmarket, Stowupland	IP14	62%	15%	24%	143
Mildenhall, Culford	IP28	37%	16%	47%	131
Newmarket, Ashley	CB8	47%	19%	34%	128
Haverhill, Barnardiston	CB9	31%	21%	48%	121
Bury St Edmunds (north and east)	IP32	42%	13%	45%	113

Brandon, Lakenheath	IP27	36%	24%	41%	106
Thetford, Barnham	IP24	44%	22%	34%	91
Barrow, Shimpling	IP29	42%	13%	45%	64
Eye, Thorndon	IP23	59%	8%	33%	49
Hilborough, Feltwell	IP26	26%	17%	57%	23
Thorpe Abbotts, Pulham Market	IP21	46%	23%	31%	13
Hadleigh, Milden	IP7	64%	9%	27%	11
Ely (east and city centre), Barway	CB7	33%	33%	33%	9
Burwell, Waterbeach	CB25	50%	13%	38%	8
Needham Market, Creeting St. Mary	IP6	88%	0%	13%	8
North East Ipswich	IP4	67%	0%	33%	6
Halstead	CO9	83%	0%	17%	6
Felixstowe, Trimley St. Martin	IP11	80%	0%	20%	5
Banham, Larling	NR16	0%	25%	75%	4
Bures, Alphamstone	CO8	100%	0%	0%	4
Woodbridge, Melton	IP12	75%	25%	0%	4
Attleborough, Little & Great Ellingham	NR17	0%	33%	67%	3
North West Ipswich, Akenham	IP1	67%	33%	0%	3
Colchester	CO1	50%	0%	50%	2
Watton, Shipdham	IP25	100%	0%	0%	2
Copdock, Belstead	IP8	100%	0%	0%	2
Harleston, Mendham	IP20	100%	0%	0%	2
Fulbourn, Great and Little Wilbraham	CB21	50%	50%	0%	2
Cont. - Areas with only one response are shown in the appendix.					

Table 3: The location of respondents (postcode district) and their overall sentiment about the proposals.

Free-text responses

There were three key free-text questions in the survey:

1. Q4 - 'Please tell us how these proposals could affect you, your family, or someone you care for?'
2. Q10 - 'Is there anything else you would like to tell us about your transport options to and from ESEOC?'
3. Q11 - 'What support would you need if your procedure was transferred to ESEOC?'

Most responses to question four about how the proposals were likely to affect people's lives were focused on the issue of travel or transport to the ESEOC. Therefore, for the purposes of analysis, the comments in response to question four were merged with those recorded against question 10.

This approach merged 3,042 individual responses into a data set consisting of over 1,785 comments from 1,204 people. This allowed for a more valid view of the respondent's overall views and experiences. All written comments were analysed for key themes that are summarised in the table below.

Impact focus

It should be noted that a limitation of the wording of the questions is that they prompt a focus on issues and impacts. This focus was important because commissioners wanted to explore how people's lives may be impacted by the proposals and to ensure people had the space to report them in the survey. However, the questions may lead people to be less balanced in their overall answers, and this may explain an apparent incongruence between the levels of overall positivity about the plans observed in the quantitative data and the much lesser quantity of positive responses in written feed-back.

Theme / Issue	Count	% of comments
Travel, journey time and distance	**980**	**55%**
Distance positive	30	2%
Distance neutral	112	6%
Distance negative	838	47%
Getting a lift from family or friends	**586**	**33%**
Cannot get a lift	180	10%
Getting a lift - positive	91	5%
Getting a lift - negative	315	18%

Waiting times	**534**	**30%**
Visiting and support networks	**276**	**15%**
Public transport	**260**	**15%**
Cost	**201**	**11%**
Appointment timing	**84**	**5%**
Specialist care centre	**82**	**5%**
Staff impact and quality of care	**63**	**4%**
Familiar with the hospital	**54**	**3%**
Parking	**54**	**3%**
Pre/post-op care at WSFT	**43**	**2%**
Impact on carers	**42**	**2%**
Environment	**22**	**1%**

Table 4: Summary of themes.

The following section summarises each of the key themes.

Themes are not presented in order of size. Positive themes (waiting times and specialist care) are presented first.

Waiting times

General positivity

The proposal's potential impact on waiting times was the most significant positive theme in the data. Of the total responses to the free-text questions, 30% of the sample (534 people) were positive about the potential for reduced waiting times for orthopaedic elective care.

Many comments were generally positive about the impact of the proposal on NHS elective care wait times. People frequently reflected on the pressures facing the NHS and NHS care backlogs. Often, generic comments about wait times were from people not currently waiting for elective care.

> *"This plan sounds well thought out in that patients awaiting elective surgery will have more confidence that their operation will not be delayed because of local hospital bed crisis."*

> *"This would have no negative impact. Any facility that improves the length of time awaiting treatment is to be applauded."*

> *"I really like the idea of shorter waiting times and less risk of cancellation. The idea of more training opportunities for staff sounds great. It should also be more cost-effective than buying services from private hospitals that are working to make a profit."*

> *"We are equidistant from Colchester and Bury. Anything which speeds up waiting lists must help. My brother is about to go privately for a hip replacement as he cannot put up with the pain any longer."*

Context and waiting for care

In addition, 13% of the total sample (237) described how their experience of waiting for elective care was a motivation to be optimistic about the proposals.

People discussed the impact of waiting for elective care on their quality of life (e.g., because of pain). Many were willing to accept the impact of increased travel distance in favour of reduced waiting times.

> *"Would go anywhere to have a knee replacement. As I live on my own, I would be very grateful to have no pain."*

> *"It sounds like I will get treatment earlier than the current waiting time, which will mean I'm not going to be suffering the horrendous levels of pain I'm currently in. It should help my son, who is currently my main carer, he would then be able to get a full-time job."*

> *"With such a long waiting list at West Suffolk Hospital… I would welcome getting my hip operation earlier. It's been two years since my diagnosis… Daily life is very difficult and painful."*

> *"I feel if I am able to have the same great care and understanding of my condition, and it gives me the opportunity to gain my health and mobility again and crack on with living some adventures, this is a major plus."*

Cancellations

A small number of respondents felt ESEOC would reduce the risk of operations being cancelled. Due to their low numbers, these were also included in the broader wait times theme.

> *"If the operations get performed sooner, then it is a good move."*

"Improves the chances of surgery going ahead sooner, without rearrangement or cancellation, so enables better planning of lifts, work, etc. No, there are good road links, and lifts can be organised (or taxis)."

"Hopefully, it will be a shorter waiting time. Dedicated hub, no cancellations. Patients in and out quickly."

Specialist Centre/ Care

Positivity about ESEOC as a specialist centre for orthopaedic care was mentioned by 82 respondents (5% of the total sample).

Comments that were positive about ESEOC as a specialist centre often included a reference to the quality of services. For some, receiving the highest possible surgical quality was more important than the location of their procedure. These respondents were happy to accept impact from travel distance in favour of increased service quality.

"Colchester is nearer my house, so it will be a positive outcome for me. I feel as long as surgery is performed by qualified well-trained professionals, and patients get the treatment they need and deserve, the place it is at is not so relevant."

"If I was to need my knee to be replaced again, then if I was to be seen at the new centre, it would be awkward for visitors and to be collected afterwards. But if it was the best place to be seen, then I suppose we would cope with the distance from home."

"Travelling will be an issue but, given appropriate notice, I should be able to make suitable arrangements. As long as the centre is professional and safe - I would not worry about location."

People also commented about the potential for being treated at a 'centre of excellence'. They welcomed the fact that staff at ESEOC would have specialist knowledge and that access to the best quality care was a benefit for them if they needed a procedure.

Often, these comments were also linked with those about the positive impact of the ESEOC on reducing wait times.

"I see this as a positive step forward, having all the equipment and expertise on one site, should ensure trained staff are available as well as surgeons with the correct skill set and easily accessed assistance if needed."

"In an extremely positive way. Shorter waiting times and a state-of-the-art hub. It is a 'no-brainer'. If you are in pain, you will be willing to travel rather than wait a longer period of time for your operation regardless of the distance."

"Centres of excellence are essential, plus there is a greater skill base to treat and rehab."

"I do not have a lot of family so not having visitors would not bother me.

"My main concern would be that I would be receiving the best surgical procedure and post-operative care. Whether that is at the West Suffolk Hospital, or another hospital does not bother me."

"A dedicated centre would be good in that hopefully all the facilities will be in one place. I think it is a good idea."

Travel, journey time and distance

General negativity

Travel was the most prominent theme in the survey comments. Nearly half (42%, 746 people) of respondents were negative about the increased distance, time or inconvenience of travelling to ESEOC.

Many of these negative comments were general. For example, respondents either stated that the journey would be too far for them to travel or said how many miles or hours they would have to travel. Many compared the distance they needed to travel to ESEOC with shorter journeys if their operation or care was planned at WSFT.

Most comments that were generally negative about transport or distance explained the impact of this in specific ways (e.g., the lack of public transport options or the cost of taxis). They are explored in the themes below.

"It is a long way to go, whereas West Suffolk Hospital is so close. I would not want to travel that far."

"Would be a two-hour trip to bring relative to new centre – difficult when to have time out of work to bring relative as two hours only accounts for travel time."

"Colchester is an hour away from my postcode. To ask that someone drive me to Colchester and then potentially drive back again the same day or within a few days would add at a minimum four hours of driving to their day."

"I am waiting for an arthroscopy on my knee, and West Suffolk Hospital is five miles away from my home. I will not be travelling 30-plus miles to Colchester under any circumstances. My partner runs his own business and works in Bury St Edmunds and can drop me off at West Suffolk Hospital and collect me again later. If I have to go to Colchester he would lose a whole day."

“If it speeds up waiting times it must be a good thing. Although I appreciate it involves travel a purpose build unit seems a good way forward.

“If you have family or friends able to help that’s brilliant, but it would be more difficult relying on public transport.”

Vulnerability and frailty

One hundred and thirty-eight people (8% of the sample) said they were elderly, had a disability or health condition, or were vulnerable in their comments. Other respondents were concerned about the potential impact of the proposals on vulnerable or elderly people but did not necessarily identify as being vulnerable themselves.

Many felt the plans would make their journey to surgery much harder. For example, it was common for elderly people to say they (or their immediate family or support networks) were unable to drive, or could not drive over a long distance or at night. These comments often included a reference to a requirement or reliance on other sources of transport help, such as hospital transport.

> *"It will be too far for most patients to travel. This will only be for the young fit patients with no complications. Very misleading anyone who has an extensive medical issues will not be suitable and will still be on the waiting list. Hospital transport you have to meet the criteria most people will not meet it due to the nature of patients that will be operated on in Colchester."*

> *"Hubs are the way forward in delivering best practice care more efficiently. The elderly will worry about these issues as they tend to stress about driving in the dark and driving to places they are unfamiliar with. Reassuring them at pre-assessment will reduce anxiety."*

> *"I am elderly which would affect my family travelling to Colchester plus my husband who is partially sighted. We do not have any transport either. Don't like travelling too far. No transport in Red Lodge."*

> *"We are older people and I am disabled. Transport, especially by myself, is already difficult, especially at certain times of day. Our concern is regarding transport to and from the facility. Post-surgery is definitely a concern if a patient does not have anyone to take them home."*

Travel distance

Distance to travel was a prominent theme in people's responses. In total, 55% of the sample mentioned it, of which 30 were positive, 112 were neutral and 838 were negative.

Only a small number of people (8% of the sample) were either positive or neutral about travel distance (143).

Positive comments (2%, 30) reflected that a total journey time was likely to be shorter to ESEOC than WSFT. However, there were very few of these comments overall. Neutral comments (6%, 113) generally reflected that ESEOC and WSFT were an equal distance from the respondent's locality or that people were not concerned about the distance they had to travel.

> *"Living in Needham Market, travelling to Colchester would be an advantage."*

> *"I feel that these proposals would be beneficial to our family as it would mean less travelling distance for us and hopefully would mean that any planned surgery would be less likely to be cancelled."*

> *"If it means operations are done quicker, I'll go anywhere. Colchester*

isn't an issue from Sudbury. Colchester and WSH are equal distances from my house."

Sixty-eight respondents (4% of the total sample) mentioned concerns about travel distance and the journey home after surgery. Respondents felt that extended journey times post-surgery could impact their recovery or lead to potential pain or discomfort. Some people contextualised their comments by explaining their previous travel experience after surgery.

"Concerned about having to travel from Colchester to home if I had surgery – don't think I would want to spend an hour in the car."

"The long-distance home will impact my recovery. I worry about pain relief, having to travel over an hour home and the lack of mobilisation in this time period. Should I arrive home, and the pain be so bad I am unable to manage or get out of my car, will I then have to travel back to Colchester for help, or will my local hospital be expected to pick up the pieces when it goes wrong?"

"The distance to travel home after surgery. I had spinal surgery in Ipswich, but the journey home was very painful and twice as long as the journey from Bury St. Edmund's. I think treatment should be closer to home unless it is a real specialism."

"Having had two hip replacements (privately), I know how uncomfortable the journey home is. A 43-mile-plus journey could cause significant discomfort."

Getting a lift from family or friends

"I have just had foot/ankle surgery at WSH and would have found it impossible to have had to travel some 30-odd miles to Colchester before and after the operation, let alone any close follow-up appointments.

"It was difficult enough just the 15 painful miles back."

Whilst many comments about travel to ESEOC generally referred to the potential of increased journey time or distance, some respondents elaborated on their travel options.

Getting a lift - Positive

33% of respondents (586) described their ability to get a lift to the ESEOC from their family, friends, neighbours, or other informal sources of support. These are referred to as family and friends below.

For some, getting a lift was not something they predicted would be a cause of concern if they needed to travel to the ESEOC for an operation. In total, 91 (five percent) were positive about getting a lift to the ESEOC, and they generally referenced people who could offer a lift to the ESEOC if required (e.g., a partner, friend, or relative).

It should be noted that many more people indicated an ability to obtain a lift when responding to the closed-ended question in the survey about this subject than those who made a positive reference to the theme in their open-ended responses.

> *"I have no travel issues. It's not that far to travel. My husband would willingly take me and visit too."*

> *"I am waiting for hip and knee replacement, in a lot of pain; being able to have surgery quicker at the new hub will be great for me, I have family who are able to drive me wherever I need to go, so that's not a problem."*

> *"Not worried about travel arrangements as my wife or one of my daughters would be able to bring me and pick me up."*

> *"Although the travel to Colchester is a long way my daughter is able to take me, and I would rather have the operation sooner and for the waiting times to reduce. My daughter would need to take some annual leave to be able to take me but she is happy to do that."*

Getting a lift - Negative

Of the total sample, 18% said they would find it difficult to get a lift from their family or friends for various reasons (315).

Some felt they could not ask their family or friends to travel the increased distance to ESEOC. For example, they estimated that it could be at least a four-hour round trip for someone to drop them off, return home, and collect them again.

> *"I live alone and do not have family nearby. It is too far to expect friends who may be a similar age to visit or take me to and from Colchester. If friends are unavailable, I could take a bus/train or taxi to WSH or Addenbrookes. I dread the thought of being in hospital with no one to support me or ensure that all was well. It would just not be possible to travel transport both for me and a friend or relative to visit."*

> *"My husband does not drive. It would be much harder for me to find a person to take me to Colchester for my surgery rather than West Suffolk Hospital. I could not ask a neighbour to take me that far and then also bring me home it would be extremely difficult."*

Others expressed concern about calling upon the time of friends and family

"I have had both knees replaced at WSH and relied on friends for transport to and from the hospital. They will not be able to do the 60-mile round trip to Colchester. Visiting will also not be possible. You cannot keep moving treatment centres further away from your patients; this is not in any way patient or customer-focused."

because of the impact on their work or childcare arrangements. In some cases, people did not feel those they would rely on would be able to take time away from these responsibilities to give them a lift because of the distance involved.

"...Whilst the patient would receive sick pay, family members/friends may incur loss of earnings to transport others to and from Colchester. Some may also have caring or childcare responsibility, making an 80-mile round trip not possible compared to a more local journey."

"I am scheduled for a double hip replacement and feel that the distance involved would have a significant effect on me as I will be recovering from one op and within weeks travelling the significant distance again for second surgery. My husband is a taxi driver who has regular contacts that he is committed to. This means his time is restricted, and he would find it very difficult to make trips to Colchester during the day and visiting, etc., would also be very restricted because of the distance involved. Family and friends could easily drop me off, collect me and or visit if I were at WS"

"I'm already having to travel an hour to Suffolk Hospital for my care instead of receiving it in Norfolk, where I live. To suggest that be moved to over two hours away in Colchester is ridiculous... We cannot afford for both me and my wife to take whole days off work to get me to Colchester if I cannot drive myself, as well as paying for childcare before/after school times to accommodate travel time. It's simply not feasible."

"Too far to travel for my wife who is disabled and does not drive aged 78, and I work full time aged 74. The journey would be very uncomfortable for her by car."

Finally, some mentioned that asking for a lift could be difficult because people's friends may be elderly themselves, or people may be isolated without close friends or family nearby they would trust to give them a lift.

"My husband is 82 years of age. I am 73 years of age. I feel to have to travel

> ***"It is very far away. I think this would be really worrying for patients who wouldn't have their family/friends/carers nearby.***
>
> *"For those who don't have easy access to transport, would transport be provided by the NHS? If not, taxis would be very expensive, and public transport would be awful for people to travel on who are either suffering with orthopaedic injuries or recovering from surgery as it can be very busy (people pushing etc.) and not very smooth, and also unreliable."*

long distance could be quite stressful for us both. We live in a small village. Our friends and neighbours are all elderly. Winter is bad for street lighting. Our own families do not live anywhere around us."

"The extra distance to travel could pose a serious problem. We are in our 70s, and I will have a long drive if my husband has to go to Colchester. The A14 is notorious for road closures. I don't like driving far these days, and the distance to Colchester, to get my husband there, would be of considerable concern to me."

"Many people requiring orthopaedic surgery will be elderly, often living alone. Getting to the hospital, such a long way away, could be very difficult or too expensive. Not everyone has family nearby or neighbours able to give up a morning or afternoon to take or fetch back from hospital more than 30 miles away. A taxi is more than £100 for this type of journey."

Some respondents said that while they had a partner or family member who could drive, they would feel uncomfortable or be unable to drive for long distances, on unfamiliar roads, or in the dark. Four per cent of the total sample (71 respondents) said they or their support network were not confident about travelling on large and busy roads like the A12 and A14 or on rural roads.

"It is too far to travel for surgery. The roads are rural, and the journey is in excess of an hour and a quarter each way. If a patient is unable to drive themselves home after surgery, this means a relative has to take them to the hospital and return home, drive back to the hospital to pick them up and then take them home. More than 5 hours driving in one day which is expensive, potentially dangerous in the winter and environmentally unsustainable. In addition, this means a relative has to take a day off work to take and pick up the person from the hospital."

There were also mentions about the additional cost of travel in this theme, but these are described in more detail below.

"Travelling to West Suffolk Hospital from Haverhill without the ability to drive is difficult enough – having to get someone to drive you there is far enough, never mind having to get someone to drive you all the way to Colchester. Can be far too expensive."

Cannot get a lift

Whilst 18% of the sample would find it challenging to ask for a lift to the ESEOC, a further 10% (180) felt it would not be possible at all. Many of these comments referenced similar themes to those explored above, including the increased cost of travel or transport (e.g., parking and fuel), appointment timings, the travel route and problems with needing to rely on elderly or vulnerable friends or relatives unable to travel distance themselves.

Some noted that they, or their partner, did not drive. Some may even be the only driver in their family. Some said that people in their support network were elderly or lived too far away to be able to give them a lift. Others felt they had no friends, family or support networks they could trust or rely on to give them a lift to the ESEOC at all.

"Living on my own at 75! and with limited transport available, I would not

like to get a train or taxi to Colchester for both admission and coming home."

"I would find it very difficult to travel to Colchester as I live alone with no relatives able to get me there, so it would not be ideal for me. Although, I think a lot of people would benefit from not having to wait so long for surgery. I don't have any options as I just would not be able to get there."

"Travel to the new hub would be an issue. There is no public transport from Haverhill to Colchester. It would be too far for my elderly friends to take/collect me. It would be too far for the family to provide transport and prohibitively expensive to hire private transport."

"I have no family who live nearby. I am not prepared to ask friends or neighbours because the distance is too far, and neighbours have their own health issues. There is no direct public transport link to Colchester from Rickinghall. I would try and get a bus to Diss, but there is a long walk and a hill to the station. I am visually impaired (certified) so uncertain how I would obtain tickets as find internet too difficult to use."

Visiting and support networks

There were 15% of the sample (275 people) who felt distance to ESEOC was a barrier for their friends, family or other members of their support network to visit them. Many of these comments were general, for example that friends or family members would find it 'difficult' to visit.

"If I was to be seen at the new centre, it would be awkward for visitors and to be collected afterwards. But if it was the best place to be seen then I suppose we would cope with the distance from home."

Being able to receive visits was often referenced alongside other themes, such as distance to travel or difficulty travelling by large or rural roads. Some people were worried about being able to attend ESEOC if their friend or relative had a problem with their procedure (e.g., if an emergency resulted from their surgery).

"It is very far away, I could not travel there easily, even for a one-off appointment. Family cannot afford to spend the time travelling to visit me especially in the week, so I would have little to no contact with them. They can walk to West Suffolk, to Colchester they would have to park or use public transport."

"If my relative used it, I could not get there quickly if they needed me. Is there an intensive care facility at the new hospital should something go wrong?"

Some respondents said friends or family did not drive or lacked transport options to get to ESEOC.

> **"I would not be able to get to Colchester or home. I do not have any options for travelling to or from Colchester."**

"Only problem is my wife does not drive, so visiting would be a problem."

"How does this help relatives of patients having surgery who don't have transport. How do they visit?"

"My wife wouldn't be able to visit and would get stressed out… She suffers from anxiety as it is and would not travel that far alone but would be able to walk up to the West Suffolk Hospital to visit me and see that I'm OK. So, she then wouldn't worry."

Problems with visiting arrangements (particularly in the event of an extended hospital stay) led some respondents to express concern about a potential impact on recovery and overall wellbeing. Some said that the impact of distance on visiting could lead to feelings of being isolated at a time people may need the emotional support of those closest to them.

"As I don't drive, it would be impossible to get to and from Colchester by public transport. It would also make it extremely difficult for friends and family to visit if a stay in hospital was required, thus causing isolation and probably affecting recovery period/time. What options!"

"I know that orthopaedic surgeries generally involve only short stays in hospital. However, for those patients who experience complications requiring longer stays, family and friends may be prevented from visiting again by the distance, time and cost involved. Having no visitors could be quite detrimental to patients' wellbeing and recovery."

"Cannot expect friends to drive that far especially knowing the A12 visitors help with recovery. No idea how patient would get there by public transport and hospital transportation costs taxpayer money without impact on environment. Old people would feel abandoned so far from friends or relatives leading to depression and all that entails. It's bad enough being old without being shoved miles from things we know. Why not send 18-year-old there and let oldies stay where they know? The cost to NHS a taxi far too expensive no direct public transport."

Impact on carers

There were 42 respondents (2% of the total sample) who considered the potential for an impact from the proposals on people's caring responsibilities or childcare. While this was not a large theme in the data, it is important to note these experiences to understand barriers that carers and families may face accessing care at ESEOC.

Comments from carers referred to the challenge of being further away from the person they care for (see comments about family visits above). However, a few mentioned a specific need for additional support to be in place. This might include the provision of overnight stays within the ESEOC for carers supporting people, or other adjustments according to the needs of the person they care for.

"My concerns relate to distance. My partner has advanced Parkinson's and when she needed emergency hip surgery last year after a fall she suffered from post-operative delirium and spent three weeks in hospital. I had to spend a large part of every day

with her to make sure she had enough support. A 10-mile trip each way was fine, but as I get older, a drive to and from Colchester would be a struggle and make it harder for others to visit. But I appreciate the need for new beds and the importance of certainty for people on waiting lists."

"On a personal note, my husband has Parkinson's, and I am his carer. So, further away would definitely cause me a problem. I have had one knee operation already and had to rely on my daughter to collect me from hospital. But as she is a teacher, this also proves problematic. Concerns would be about how to travel there and back. The weather or dark would not be an issue if someone else if transporting. But would be concerned about how my husband with Parkinson's would be cared for."

A few carers mentioned the challenge of arranging alternative support for their loved ones if they needed surgery, or if they needed to visit or drop off a relative at ESEOC.

"I can't drive and my son who needs the operation needs me round the clock he has a close bond with his siblings, and they are all younger so it wouldn't be logistically possible to visit."

"As a carer of my husband with dementia, it would be difficult for us to travel all that way for an older person. We're not as confident as we were. My husband would be completely lost in a new environment and the long travel. I would want to go with someone and would ask family for a lift, but they all work and have their own lives. I wouldn't be keen to go to Colchester, it would be stressful."

> **"My young person is autistic. My concerns are around how these and other more vulnerable patients are treated. Obviously, they are known to the LD nurse at WSH, reasonable adjustments etc. How would this be managed by Colchester? Has provision been made for essential family carers to stay with the patient in Colchester? Are rooms big enough for this? These patients already have worse outcomes for health care and much as they can choose to stay local, that may lengthen the waiting times when if there aren't reasonable adjustments this is beyond the patients control. In reality no one bothers to read hospital passports and act accordingly… this really needs to be considered. Please make sure that you consider those with autism and learning disability who need essential carers with them. We don't mind the distance but we'd need a parent to stay."**

Some people described how the total travel time to get to the ESEOC for a procedure could be difficult to manage alongside childcare responsibilities (e.g., school runs or other out of school commitments or activities).

"If or when a family member needs surgery, we wouldn't have transport required to attend in Colchester. We share one car and have two children to transport to and from school. If one of us required an operation, the other would need the car to meet the needs of the children and would not, therefore, be able to be chauffeur to the person having a procedure. We like having surgeries available in our local town, and this is one of the reasons we chose to live near a hospital. Both of my children have medical needs and access support at West Suffolk; whilst this isn't orthopaedic at present, we are fully aware that any of us could need this at any time. In addition to this, I have elderly relatives in the town who are on the list for this surgery, and it isn't feasible for them to be travelling this great distance either. I'd be really disappointed to see these services move further away."

"Colchester is over 1.5 hours away. I have two young children who are at school. I would rely on my partner driving me to the hospital for my possible operation, that my children have huge disruption to their day by either not going to school, or attending breakfast and after school clubs at a huge expense. Its completely absurd. Its not feasible."

"I would not want to be taken to Colchester to have surgery away from my husband and children. We only have 1 car and the likelihood of getting free transport is null. My husband would have to take time off from work to take me and pick me up. I wouldn't want to be so far from home in an unfamiliar environment. I would find it very stressful having to juggle getting to and from Colchester. This in my mind would have a negative effect on my recovery. I wouldn't want to have to decide - am I in so much pain I have to suffer mentally and go to Colchester. Or do I suffer with physical pain to use the local hospital for an appointment that I may wait for that could be cancelled anyway."

Appointment timing

Eighty-four respondents (five percent of the sample) expressed that it would be difficult to arrive for an early appointment at the ESEOC due to distance and travel options or travel in the dark or winter months following discharge.

Respondents were aware of the requirement to arrive early for surgery (for example, arriving at ESEOC at 7am) and felt it would be difficult for them to commit to this when considering their travel options. Some felt the timing of appointments may be difficult or inconvenient for family members or carers required for lifts whilst others felt it could be impossible to arrive within expected timings (e.g., due to unavailability of public transport options and appropriate timetables).

"The move would make it incredibly difficult to get a family member to the hospital for the usual early morning slot. This would probably involve a 5:30 start (if not earlier) alongside needing to take unpaid time off work to enable this to happen, given the inability to

use public transport pre and post-op… Public transport would be incredibly difficult with multiple changes either by bus or train. They also wouldn't run early enough to arrive in time for a morning list."

"I would definitely have to rely heavily on the goodwill of friends to offer transport to a further surgical venue. I would rely on friends goodwill as my partner does not drive. This may mean a very early start for them if I had a 6am admission time."

Also included in this theme were comments from respondents who felt that it was difficult for them, or their support network, to travel to ESEOC in the dark or in winter. This appeared to be a consideration for mostly older respondents. Most of these comments referred to driving in these conditions, but some also felt it could be a risk to travel by public transport in the winter too.

"We are both elderly, 75 and 84 years old. No relatives nearby and getting to Colchester would be a problem. We can both drive, but night driving could be an issue. Unfamiliar roads especially in winter not ideal."

"Two years ago, I was offered surgery in Colchester as an alternative to Bury St Edmunds, which I opted for. My experience would make me think twice about taking that option again. Travelling after day surgery late at night back to Newmarket with sickness from the anaesthetic is not something I would recommend, as well as having to leave Newmarket early in the morning when it was still dark. It was a very long day both for me but also for my husband who had to drive to Colchester and back twice. A lot of people requiring surgery may be older and their partners are likely also to be older and driving at night isn't easy for the older generation. Public transport from Newmarket to Colchester would not be easy or reliable . After surgery to travel back by train requiring two change, plus taxi rider, wouldn't be very wise."

Public transport

There were 260 respondents (15% of the sample) who left a comment about difficulties using public transport to travel to ESEOC.

The survey let people know that they would not be able to travel home from their procedure using public transport. However, a relatively large number of the free-text comments about the impact of the proposal and transport to ESEOC still mentioned the availability of public transport links. Some respondents recognised they would not be able to use public transport on the way home from their operation.

Some respondents did not drive or have access to a lift. Some felt that they would either rely on public transport or non-emergency patient transport if required to attend ESEOC.

"As I get older, I am concerned that I may be forced to attend a hospital which is difficult to reach. I do not have a driving license, so I have to rely on public transport. Living west of Bury St Edmunds, travelling to Colchester would take several hours using poor and unreliable trains, buses and taxis."
"If I had surgery in Colchester, I would have to take a train and taxi which is costly. Unless free transport to and

from the venue would be provided by the hospital."

Others noted that public transport from their area would not be an option at all. Where respondents said that public transport would not be an option, this was usually because of a perception of poor public transport links or that the time the journey would take via public transport simply would not be practical.

"I assume that people living in villages such as Lakenheath will be provided with transport to this new location? Normally, such operations as hip, knee replacements only mean a short stay. If lucky, an overnight stop. But should it be necessary to stay in the hospital longer, then how are visitors going to get there? Will there be a direct bus route or train? Although Lakenheath no longer has a train service, except on weekends during summer months, to allow passengers to get to the RSPB site. Will patients be offered a choice of where they wish to have their operation, and should they choose West Suffolk Hospital will this be possible? There should be a direct route, but living in a village, this is probably not possible. It would mean having to get to Mildenhall and then hope there would be a direct route."

"Impossible to get to Colchester by public transport and I have no relative who could take me. Why move services from our local hospital?"

"I don't think I would be able to use the Colchester hub as I am a driver but you aren't allowed to drive after surgery, nor use public transport. I have no available family or friends in this area and the neighbours here don't make eye contact, let alone speak. I don't have any options other than not to attend. Even if you were allowed to travel on public transport, it wouldn't be practical from Lakenheath. Using a taxi would be too expensive, it's about 60 miles one way, so a 120-mile total trip when you are not feeling well isn't feasible either. I had to travel to Addenbrookes from here and that was a total cost of £90 for 60 miles, 4 years ago. So, I guess 120 miles would be at least £180. Patients will suffer because of this idea as it's far to go and impossible to get to."

"It is a long way from our village. No way to get there other than driving, which would be too far for many . No local transport available to the Hub... I certainly wouldn't drive there in winter or bad weather."

"Travel to the facility, family likely being unable to visit due to the distance, cost of transportation if you don't have anyone able to drop you off or collect you. Travel time is an issue. A car journey is over an hour usually.

"No direct public transport from where I live, there lots of changes including bus and train. Expense."

"This is over an hour's drive from Haverhill, Suffolk. It would be inconvenient because of the distance and poor public transport links for patients and visitors. This is over an hour's drive from Haverhill, Suffolk. Which is an inconvenience, especially as the public transport links are dire to say the least. And we are only 20 minutes from Addenbrookes in Cambridge."

People expressed that it could take several hours to reach the ESEOC by public transport and that this could potentially require changes of transport along the route. Another concern was that public transport may not be available to arrive for early appointments.

"How would you expect me to return after day surgery for carpal tunnel on my wrist, to my home two miles out of Bury St Edmunds town centre, when I have to catch a bus back from the hospital back to Colchester, then to Bury St Edmunds and the hourly bus service to my home stops at 6pm?... It would be impossible for me to return home the same day on public transport. I strongly object to the plans suggested for people from rural Suffolk to have their surgery, needing two trains, a bus and a long walk home each way if I had to go to Colchester Hospital!"

"Getting to the West Suffolk is bad enough, but getting to Colchester Hospital is abysmal... We don't have many options; public transport is useless or non-existent. Car is our only guaranteed form of transport."

"If my treatment has to be done in Colchester, I will be unable to make my own way to the hospital as it is a lot further from my home and this will cause me more stress than I can handle at the moment. For me to be able to get to Colchester, I would have to get a minimum of 3 buses followed by a train. Then I would probably have to get a taxi home as there is no late buses to my village."

Cost

A total of 201 respondents (11% of the total sample) were negative about the increased cost of travel to ESEOC.

Many negative comments about cost referred to travelling to ESEOC by taxi. In fact, eighty-eight respondents (5% of the whole sample) were negative about the potential cost of getting a taxi to ESEOC. This is important because a taxi may be the only viable transport option for those unable to obtain a lift from friends of family, or who do not meet the criteria for access to non-emergency patient transport services.

Some stated that they could not afford a taxi to ESEOC from where they lived, whilst others commented generally about how high they felt the costs for a taxi from their area was likely to be (in some cases, estimating costs of hundreds of pounds). Just 12 people (0.7% of the sample) said they would use a taxi to ESEOC if required.

"I have arthritis in my hip. I have seen my GP and a physiotherapist, and although I am not on a waiting list for a hip operation, that is a possibility in the future. I have no family in this area and few friends who have cars. I drive and use public transport a lot, but as this is not advised, post-op return transport could be a challenge, or a very expensive taxi."

It was common for people to suggest the cost of a taxi to the ESEOC could be hundreds of pounds.

> "I have spoken to a local taxi company who have advised me that **the cost of a taxi one way (Brandon to Colchester) would be approximately £120.** This is a huge sum and does not include parking fees or waiting charges. "

"I am a widow and live alone in Bury St Edmunds with my family hundreds of miles away, and I can't believe that I might have to go to Colchester for an operation. There is no way that I would consider that as I would have to return home under my own steam with no support at any stage... A taxi is a ludicrous option due to the cost."

"It would cost to get to Colchester if no one could drive. Taxis are beyond the ability of most older people to pay."

"This would turn a 15-mile drive into a near 50-mile drive. As the only driver in my house, this would make it nearly impossible for me to have visitors during my stays in the hospital. It would make it more expensive to get to and from the hospital and would induce increased anxiety for myself and my partner during my treatment. It would also mean I have to pay for a taxi to bring me home after treatment. 15 miles in a taxi I can save for. 50 miles is nigh on impossible for me.... Colchester is not an option for me."

Others were worried about the additional costs incurred for travelling further to ESEOC by anyone who was giving them a lift. Some reflected on the need to reimburse people for assisting them to the ESEOC (e.g., petrol or parking money) and that this could be a barrier for them to attend.

Some individuals mentioned that financial circumstances could make it challenging for people to afford these increased costs, and that it could result in impacts on other aspects of their lives (e.g., nutrition or heating homes) known to be wider determinants of people's health and wellbeing.

"It would be too far to travel to appointments. I'm a low-income single parent; I just couldn't afford the travel costs involved. I wouldn't be able to ask anyone to take me that far. It would be very stressful relying on public transport to get that far."

"It's also an additional financial burden (additional miles even if they do have a car). For the socio-economically deprived, an additional £10 on petrol means missing meals / turning the heating off etc, and a taxi would be beyond their reach. This is my transport options - I'm young and not financially or socially deprived. Make sure you

offer ways for those unable to access the internet/focus groups to give their feedback, or your consultation will be very one-sided."

"Getting to a local train station from here is almost impossible. There are no buses for two miles. We get taxis when necessary, but the costs are crippling. Further, it would mean travelling from 8 am to get to the bus stop, then a bus to a station, a train to Ipswich, then a train to Colchester, then a bus to the hospital. It would mean a whole day of travelling. The expense would be impossible. We have diabetes – what about getting food and drink? We wouldn't be home until dark. It would be terrible for us."

"I'm concerned about transport to and from the new hospital if I need to use it. I would have to seek public transport or fund a taxi, which would be expensive… I do not know what the future holds but if I am struggling financially, I may not be able to afford to travel there."

“I don’t think I would be able to use the Colchester hub as I am a driver but you aren’t allowed to drive after surgery, nor use public transport. I have no available family or friends in this area and the neighbours here don’t make eye contact, let alone speak. I don’t have any options other than not to attend. Even if you were allowed to travel on public transport, it wouldn’t be practical from Lakenheath. Using a taxi would be too expensive, it’s about 60 miles one way, so a 120 mile total trip when you are not feeling well isn’t feasible either. I had to travel to Addenbrookes from here and that was a total cost of £90 for 60 miles, 4 years ago. So guessing for 120 miles would be at least £180. Patients will suffer because of this idea as it’s far to go and impossible to get to.”

The impact on staff

Sixty-three respondents (4% of the total sample) expressed concern about the proposals' potential impact on staff. Several sub-themes were associated with this theme, and they are listed below.

Workforce impact

Some people expressed concern that the proposals may lead to challenges with the recruitment and retention of NHS staff in West Suffolk. Others did not view the 'centre of excellence' status of the ESEOC as a solution to long-standing NHS recruitment challenges.

> *"Cost to local services- reducing the attractiveness of our hospitals and community services as employers."*

> *"If it becomes a centre of excellence with the best Doctors and Nurses then I am fully supportive of it. However, where will it leave the current T/O teams at say West Suffolk Hospital? Will the good teams here be then seen as second-rate, and they leave for pastures new? Thereby running the department down over time as no specialist will want to work in a second-rate area."*

> *"Further concerns arise around maintaining skills mix, when staff at ESEOC are only dealing with the straightforward simple cases, and not working on more complex procedures and/or traumas. Likewise, staff at WSH are not being exposed to implants/equipment/procedures carried out at ESEOC and will become less knowledgeable regarding them when revisions are required. I feel that, in the end, patient care will suffer for the sake of people's political ambitions, and we will see no long-term effect in the reduction of waiting lists until the NHS decides to address the real issue, which is recruitment and retention of staff."*

> *"Having centres of excellence doesn't work. Look at the cancer service hubs. Our local hospital of excellence is Addenbrookes and they are struggling with no capacity and not enough Oncologists or staff!!"*

> *"I wonder if the staff who will be working there are new staff, or will they be from Colchester and other hospitals? If this is the case, then treatment at those places will suffer from a lack of staff. Also, most surgeons work as a team. Will they bring their own team with them? If they don't, then I imagine it*

> **"Staffing and their needs would an issue… What time of day will those people already working in Bury need to get up and leave home to get to work? If partners are working, are we supposed not to be aware of their needs? Those with family and children will struggle. If staff have children in school or childcare, how will they get there and back in time? Are you going to allow flexible working hours or provide on-site child care? I suspect not."**

would be difficult to operate in the same efficient way at their usual place of work."

Staff travel impact (expenses/lost time)

Comments questioned whether the plans had accounted for increased costs and lost time due to staff travel and commuting. Some reflected on the potential of increased pressure on staff wellbeing because of longer working hours (accounting for a new commute) and less time to cope with family demands (such as childcare).

"It would be much better to invest in the services at West Suffolk Hospital and expand them to all of west of Suffolk, east Cambridgeshire, and south Norfolk. This would be a much cheaper option, as with the current plan, staff travelling from West Suffolk will have to be paid for their time and travelling expenses."

"Clinics begin early in the morning, around 7am. So, that will mean a very early start for patients and staff. I am particularly concerned about the impact on healthcare staff who do not live near Colchester. Indeed, many live nearer to Norfolk. That will make for extremely long working days, exacerbated by travelling on poor infrastructure such as the A12."

"The cost and time impact on the NHS and staff - extra travel for staff and surgeons will cost the NHS more in fuel and time as well as have a detrimental impact on wellbeing and work-life balance as commuting will be longer."

"I wonder how cost-effective it is that your surgeon travels to Essex rather than Suffolk."

"...the impact of West Suffolk surgical and theatre staff. Their travel times to ESEOC are considerable and could reduce clinical time available. Travel times to Colchester from the West at peak times can be considerable."

Continuity of care

A limited number of respondents highlighted concern about how continuity of care may be interrupted by the practical delivery of this new service, including how staff time is managed and technical systems (e.g., for sharing notes across sites). This included concerns about the potential loss of follow-up with the consultant leading the operation because of how their time may be divided between delivering surgery at ESEOC and follow-up care in west Suffolk.

"I also don't like the thought of a consultant doing procedures across the two sites, meaning patients won't always get their post-op care from their own consultant e.g. if they were operating at a different site the next day."

"I am concerned about the operating surgeon only being available on the day of surgery, as they may have commitments at WSH the following day, and this leading to delayed clinical engagement and detection of complications."

"Early postoperative complications will present to the WSH regardless of where the surgery was performed; if the surgery was in Colchester then how will the WSH team access information about the perioperative course i.e. how will electronically accessible information be made available in a timely manner?"

A couple of comments linked to the issue of continuity of care highlighted concerns about whether the plans address how emergencies resulting from orthopaedic surgical risk may be managed by the ESEOC.

> *"Will it have an intensive care unit? The majority of hip and knee replacement patients are 65+ with lots of other problems and generally unfit because they can't exercise due to their hip/ knee. They need to have an intensive care unit in the building. It is major surgery on elderly, deconditioned people. What safety netting will you have in situ?"*

> *"I also worry if you have underlying health issues. Emergency care facilities would probably be better in the West Suffolk Hospital than in a dedicated orthopaedic hub. I can see there are advantages as your operation would not be cancelled due to an emergency and it's very nice to have your own room. It does concern me and I would rather be at the West Suffolk Hospital."*

Familiarity with the hospital

A lack of familiarity with the ESEOC, and the Colchester hospital site, was a concern for 54 respondents (three percent of the sample). In some cases, people cited this as potentially significantly adding to their stress when they are likely to be worried about their health and welfare.

General comments about geography

This theme is inclusive of non-specific references to a lack of familiarity with the local area around Colchester.

> *"We do not know the area around Colchester at all."*

Provision for vulnerable patients or relatives

This included the idea that people with specific illnesses or vulnerabilities may appreciate familiarity with staff who know their needs, facilities, and environments. People also reflected on how a lack of familiarity with the ESEOC may cause distress for loved ones with vulnerabilities, such as a mental health diagnosis or frailty, and issues for carers who need to be close to those they care for.

> *"As a carer of my husband with dementia, it would be difficult for us to travel all that way as an older person. We're not as confident as we were. My husband would be completely lost in a new environment and the long travel. I would want to go with someone and would ask family for a lift but they all work and have their own lives. I wouldn't be keen to go to Colchester, it would be stressful. "*

> *"My family members also are very frail and find it more reassuring to have the same consultant or nurse at pre-op appointments to the surgery date itself. The nurses know the patients and their ways more than a stranger."*

> *"In order for me to have surgery, I will need transport to and from hospital. My husband has a mental health issue and can only drive on known routes so Colchester is out of the question."*

> *"How can my partner get to Colchester, and how can friends and family visit? My partner can hardly walk, so making her sit in a vehicle for a long period would not be beneficial to her needs.*

Secondly, she is partially blind, so being in unfamiliar surroundings would be upsetting for her. The additional cost and time to travel 60 miles also has to be considered."

"As mentioned earlier, I have mental health issues, so anything that is outside my normal routine or unfamiliar surroundings makes me very anxious. Being incontinent, the longer the journey, the more problems with being able to locate a toilet."

"I have PTSD, and my good husband is my rock and protector. When I had surgery at West Suffolk Hospital, staff were amazing in supporting him with me and recovery. My fear is my support network won't be accepted at another hospital."

"My husband has mild memory issues and would find travelling to a strange area challenging, whether to visit or collect following surgery."

Anxiety, stress and confusion

Many felt that a lack of familiarity with the ESEOC would be a cause of anxiety, stress or confusion in their lives.

"...they may very well feel discombobulated in such an unknown environment with no familiar landmarks."

"...the unfamiliarity of another hospital can cause anxiety and stress."

"I am currently waiting for an appointment for a carpel tunnel injection and would find having to go to Colchester, a town I have no knowledge of, extremely difficult and distressing."

"Having to go to Bury St Edmunds is not easy, but at least I know the town and how to get to the hospital . When you are 80 and of a nervous disposition having to go to Colchester would make me think it is easier to put up with the pain and hope it gets no worse."

"Just too distressing on top of all the anxiety surrounding surgery to be shipped off like some piece of meat to a hospital miles away where people have no knowledge or understanding of where you're from. Each county needs its own orthopaedic centre or centres. Surely with the population explosion this should be essential."

Perception of the hospital

Linked to this theme, several people made comparisons as to their overall perception of the hospital sites, though it was unclear if this was always based on experience. It was clear people appreciated the WSFT, which they viewed as a valuable, local and friendly hospital.

"The distance to get to Colchester hospital. It is a long way and the A12 is horrendous for traffic. West Suffolk Hospital is a lovely compact, friendly hospital, whereas Colchester feels large and clinical."

"It's massively far away - how would we help our family with transport, care or visits? Colchester Hospital is massive and impersonal. I don't have any transport options- it would not be possible for me."

Parking

A total of 54 comments referenced parking issues (3% of the sample). Much of this feedback was generic (e.g., simply listing 'parking' amongst other concerns about the proposals). However, several specific problems associated with parking were considered across the sample.

Parking charges

Some people expressed the view that the cost of parking may not be affordable for patients and visitors alike. This included that the cost of parking would be compounded by other travel costs (e.g., fuel) people may face because of the plans.

> *"I have a husband who is currently able to drive. I am no longer able to undertake journeys of any distance on roads I do not know. When he had his cataracts treated (at a clinic in Ipswich) I was unable to take him, so he paid over £100 for a taxi to take him, wait for him to have his procedure, then bring him home again, at a cost of over £100 for each eye. No mention is made of any hospital transport being available, nor the cost of a companion (driver) parking a car for orthopaedic procedures and waiting at Colchester. I would like to know costs and availability."*

> *"Family cannot afford to spend the time travelling to visit me especially in the week, so I would have little to no contact with them. They can walk to West Suffolk, to Colchester they would have to park or use public transport. E-zec medical/hospital transport have often been unreliable."*

> *"Travelling to Colchester would be the main concern. Being old, distress of finding someone to drive the three-hour round trip and not being able to offer petrol money as I am on a limited income and that's before the parking fees. Just would not go."*

> *"I live next to the West Suffolk hospital. If my wife and family need to travel to Colchester to visit me, I think the car parking should be provided for free. Since my family will be taking me/ visiting and collecting me, could the car park fees be waived? Especially as the extra fuel costs incurred."*

> *"West Suffolk Hospital you can ask in social media, ask neighbours if they can give you a lift - you certainly can't do this to Colchester! 59 miles at least 75 minutes each way - not acceptable. Not for families, and not for patients - to bring someone for their surgery, you have 120-mile round trip and costs associated with this, plus parking when at the hospital. You need to buy at least a tea or coffee too, it's too much."*

Parking capacity at existing sites

Some had previously experienced problems with car parking at the Colchester Hospital site or assumed existing parking facilities may be overwhelmed by increased traffic because of the plans.

> *"Travelling would not be an issue for me but I am aware that there is currently massive issues around parking at Colchester Hospital it is often impossible to find a parking space. This new centre will obviously add to this unless there is provision for a dedicated parking site for this new building. Having to rely on friends or family for*

transport and as already stated there ability to find a parking space."

"Also I know the parking is already horrendous at Colchester, so this also needs sorting before taking in more cars with patients. You do not mention the lack of parking, which should be sorted first."

Not being familiar with parking facilities

Lack of familiarity with hospital parking facilities was also cited as a potential source of additional patient stress.

"Travelling from Thetford to Colchester would be far from ideal for me, I struggle enough to reach Ipswich comfortably. That takes into account my physical health, but it will also cause me considerable mental stress having to make sure I can park, get to the hospital itself, and find my way around. Very often, I need someone with me, which, again, travelling such a distance is not ideal at all."

Pre and post-operative care at the West Suffolk Foundation Trust

A total of 43 people reflected on the importance of local pre and post-operative care (two percent of the sample). Whilst this had been considered in the NHS plans, it was clear there was a mixed understanding about this amongst the sample. This included:

- General questioning about whether follow-up care would happen at the ESEOC.
- Concern about how complications in treatment or care may be managed.
- Responses from those who thought all their treatment and care would happen at the ESEOC.
- Concern that the plans may result in a total loss or downgrading of orthopaedic care at West Suffolk Hospital.
- For some, local post-operative care was a condition of their acceptance of the proposal.

These comments may suggest that people need to be proactively directed to improved information about how the transfer of care will work between NHS sites and services.

Examples of comments included:

"Post operative complications who deals with them once your home?"

"As long as post-operative follow-up appointments are still undertaken at West Suffolk Hospital, I will have no objection to attending the hub in Colchester for elective orthopaedic surgery if this will speed up the waiting times."

> **"Car parking is dreadful at Colchester and could cause issues unless there is specific parking for the new centre. I would like family to visit, but they would have to drive! And park!!"**

"It is a good idea in practice, but what happens to people in outlying villages who don't drive and live alone? My friend has recently had a hip replacement, so I know first-hand that it is not easy to look after someone post-surgery, let alone have to travel to Colchester for appointments and follow-up care."

"I have in the past used WSH to both receive emergency & elective treatments. Moving operations away from WSH is, in my opinion, dangerous as it sets a precedent for reducing available local healthcare, which, especially in a rural community, is hugely important. With most orthopaedic surgery, there is an amount of time in hospital post-surgery to have physio assessments, etc., and doing this more than 30 miles from WSH is not good for anyone."

"In the eventuality of requiring surgery, I would be happy to have the procedure done at the new centre. It would require travelling some, but I have no issue with being taken by a relative and have no visitors until back in Suffolk. My concern is-post operative care. Pain management, transfer to West Suffolk Hospital, bed availability should it be needed as not ready to go home and communication between the centre and West Suffolk medical team."

"I had hip surgery at the West Suffolk in 2023 after which I had a wound infection for three months which required me to visit my surgeon at the West Suffolk every week and sometimes twice a week. My husband had to take me as I couldn't drive. We could never have done that if I had to go to Colchester. Much too far for all concerned."

Environmental impact

The potential environmental impact of the proposal was considered by a total of 22 respondents (one percent of the sample).

These comments, relatively few across the sample, reflected how the plans appeared to contradict national and local ambitions to reduce carbon emissions by significantly increasing the distance people would need to travel. Some felt the proposals did not assess how the plans may affect the environment.
Examples of comments included:

"The additional travel to Colchester, especially if the patient is staying more than a day or two, would create significant additional carbon and or pollutants."

"Sustainability and environmental impact will be huge. Considering we are supposed to be aiming for carbon neutral, what does patient and staff transportation contribute to this?"

"It would mean further travel, and there seems to have been no work done on the impact of the extra travel on greenhouse gas emissions and, therefore, global warming. I am concerned about the likely increase in greenhouse gas emissions."

"As we try to improve our energy efficiency and green credentials this project completely flies in the face of that asking staff, patients and their relatives to travel significantly greater distances. The vast majority of staff & patients will have to drive, and some don't have a car and not everyone drives."

“Sustainability and environmental impact will be huge. Considering we are supposed to be aiming for carbon neutral, what does patient and staff transportation contribute to this?”

Influences on provider choice

People were asked to identify (from a pre-defined list) some of the factors most likely to influence their choices regarding a provider of orthopaedic treatment.

Most felt waiting times (70%, 1530) and distance from home (60%, 1,310) were important influences on their choice of provider. Having previous care from a provider (31%, 440), or having a preferred surgeon (27%, 584) were less likely to be rated as important factors.

Chart: Factors influencing choice of surgery provider (all respondents)

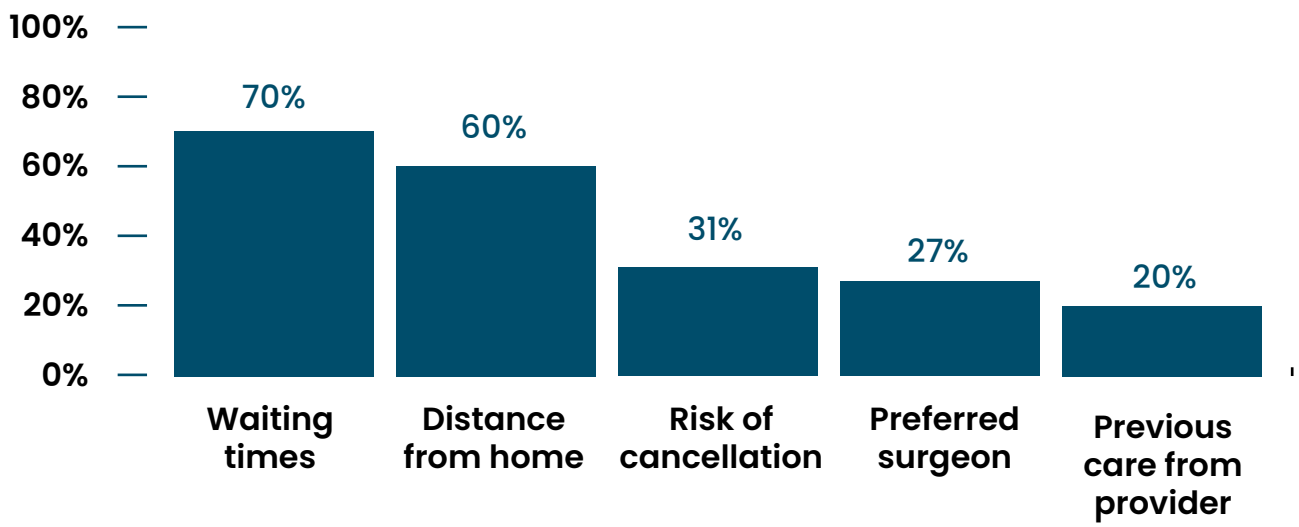


Chart 6: Responses to 'Please tick the most important factors that influenced, or would influence, your choice of provider'.

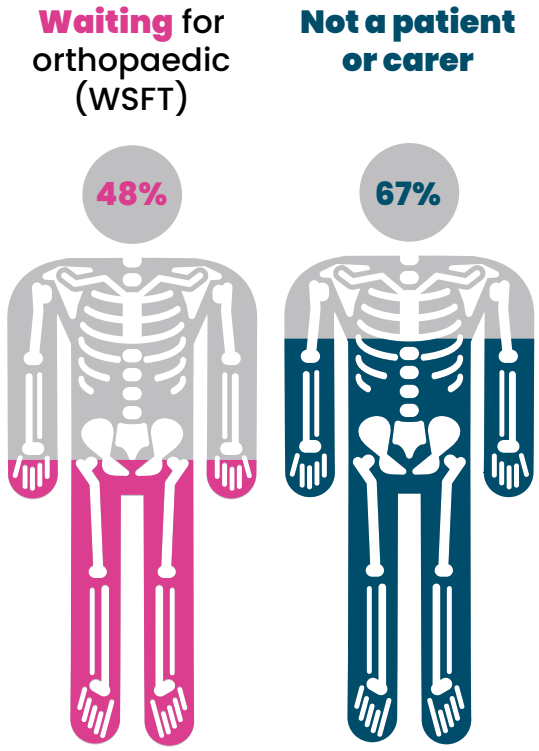
Category	Number
Waiting times	1,530
Distance from home	1,310
Risk of surgery cancellation	682
Having a preferred surgeon for a procedure	584
Receiving previous care from a provider	440
Total answered	**2,190**

Table 5: The number of respondents who selected various pre-defined influences over their choice of surgery provider.

Overall sentiment and demographics

- **Patient status** - People who said they were waiting for orthopaedic care at WSFT were much less likely to say distance from their home was an important influence over their choice of provider (48%, 394) than members of the public who were not waiting for care (67%, 801). WSFT patients were also slightly more likely to indicate that waiting times were important in their decision (72%, 595) than members of the public (67%, 810).

- **Age** - Waiting times and distance from home were the most common influences on all age groups. However, across the whole sample, age did not appear to influence the importance of these factors in a linear way. People aged 55 – 64 (54%, 241), 65 – 74 (53%, 336), or 75 – 85 (60%, 315) were slightly less likely to select distance from home as an important influence on their choice of provider.



Distance appeared to be slightly less of a priority for those who were currently waiting for orthopaedic care from West Suffolk Foundation Trust.

Chart: Factors influencing surgery provider choice and respondent age (waiting times and distance)

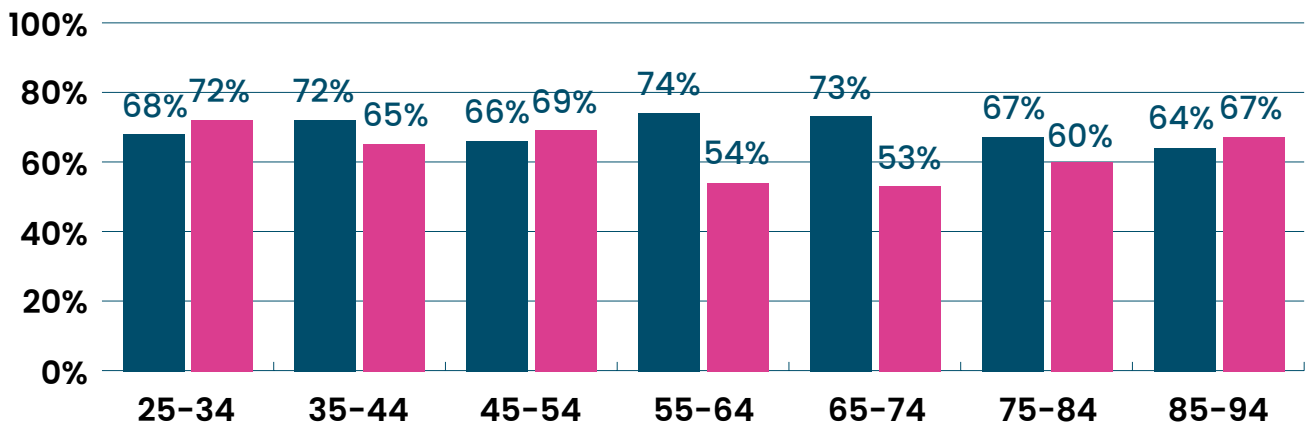


Chart 7: The percentage of respondents who selected various pre-defined influences over their choice of surgery provider.

- **Additional support needs** - People with additional support needs were slightly more likely to indicate that distance from their home was important to provider choice (62%, 581), compared to 53% of people without additional support needs (499). They were also slightly less likely to suggest waiting times were important to them (67%, 628) than people with no additional needs (75%, 696).

Key influences on provider choice by area

Waiting times and distance to travel were consistently selected as important regardless of location.

In some areas, a slightly greater percentage of respondents indicated waiting times were important, rather than the distance of the provider from their home. These included:

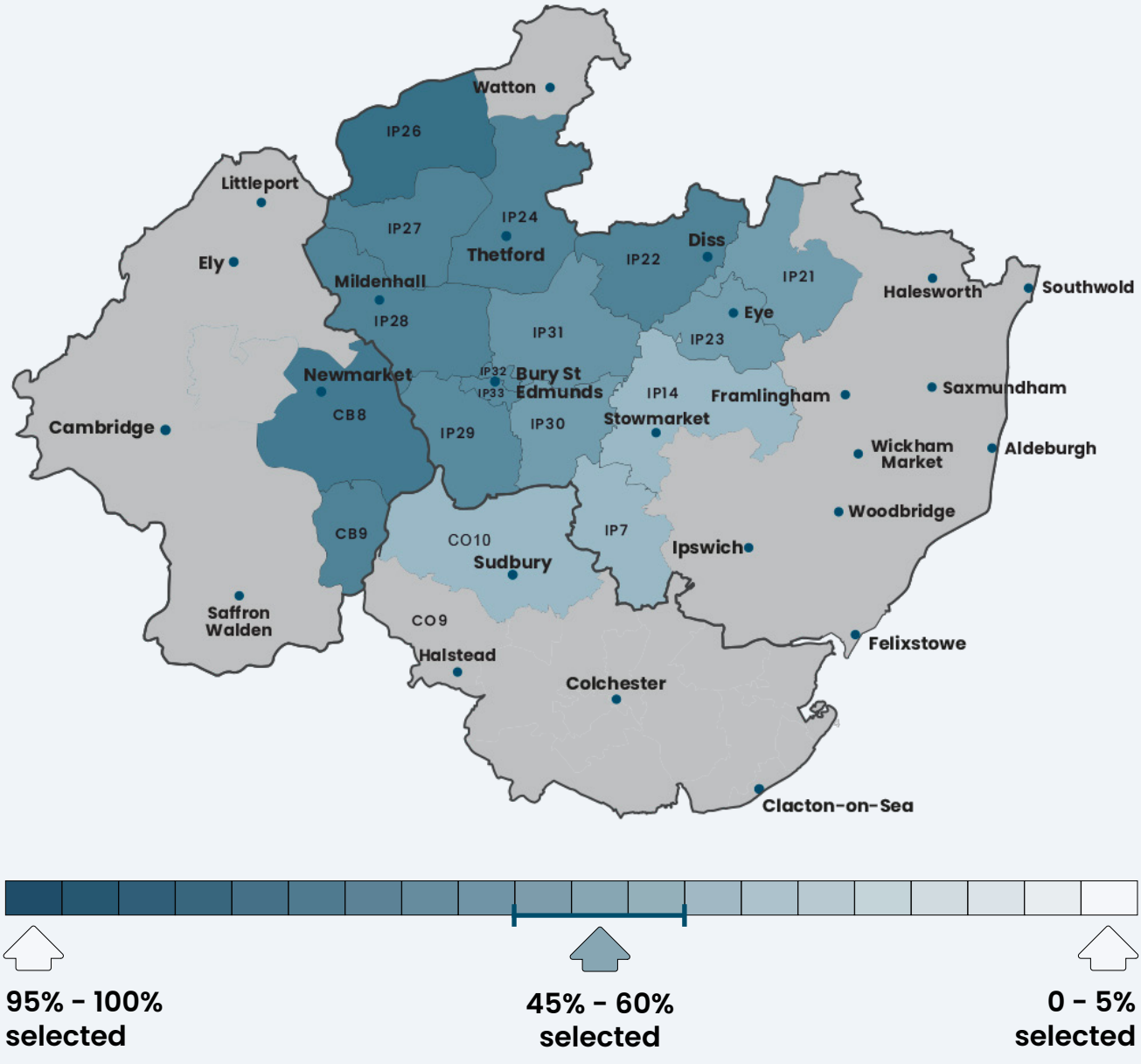
- Sudbury and Lavenham (CO10)
- Stowmarket and Stowupland (IP14)
- Eye and Thorndon (IP23)
- Thorpe Abbotts and Pulham Market (IP21)
- Hadleigh and Milden (IP7)

Some variation in the selection of distance as an important influence on provider choice is shown in the map overleaf.

Where was distance an important influence on people's choice of provider?

Figure 4: The map shows the percentage of people who selected distance from provider as an important influence over their choice of a provider for surgery. Darker blue tones indicate that a higher percentage of people selected this option when responding to the question 'Please tick the most important factors that influenced, or would influence, your choice of provider'.

Postcode districts are shown if more than ten responses were recorded in the area.



Willingness to wait longer

The survey asked 'If West Suffolk Hospital is your preferred provider for surgery, would you be willing to wait longer for your operation if you did not want to travel to Colchester for the procedure?'

Around a third of the sample (36%, 769) were willing to wait longer for their operation if it meant their surgery could take place at West Suffolk Hospital. However, a slightly greater proportion of respondents were unwilling to wait longer (40%, 842). About a quarter (24%, 513) did not know.

More information is shown in the chart below.

Chart: Willingness to wait longer to stay at WSFT

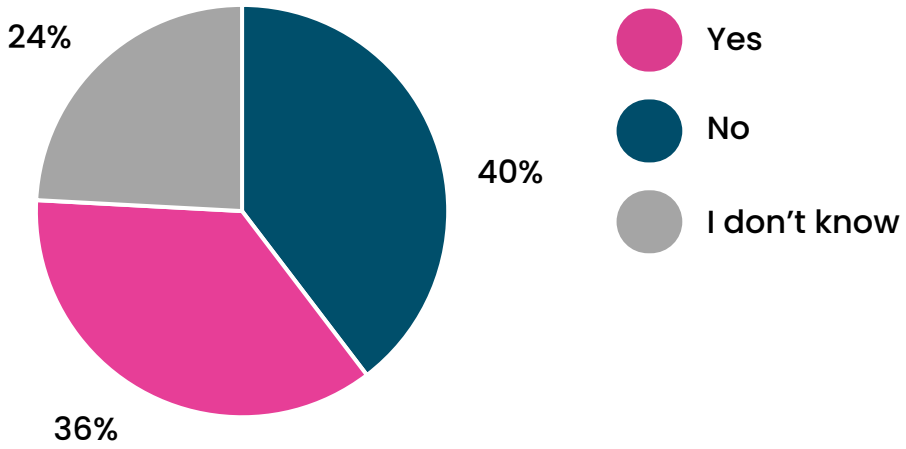


Chart 8: If West Suffolk Hospital is your preferred provider, would you be willing to wait longer for your operation if you did not want to travel to Colchester?

Category	Number
No	842
Yes	769
I don't know	513
Total answered	**2,124**

Table 6: The number of respondents who said they would be willing to wait longer for surgery if their procedure could take place at WSFT.

Willingness to wait longer and demographics

- **Patient status** – responses to the question about willingness to wait varied by whether respondents were a patient waiting for elective care.
    - There were 42% of members of the public (not waiting for elective care) who said that they would be willing to wait to have their procedure at WSFT (479).
    - There were 28% of people already waiting for WSFT who said they would be willing to wait for WSFT if they did not want to travel to Colchester (223).
- **Age** - There was no notable trend in the age profile of respondents who said they were willing to wait. People aged 55 – 64 (35%, 150), 65 – 74 (30%, 186) and 75 – 84 (35%, 174) were slightly less likely to say they were willing to wait longer if it meant they did not have to travel to Colchester for their operation than other groups, such as those aged 45 – 54 (39%, 72) and 35 – 44 (45%, 53).
- **Additional support needs** - Having additional support needs did not appear to affect people's willingness to wait more or less time based on the location of their operation. Of people with additional support needs, 36% said they would be willing to wait for their procedure at WSFT (325). This compared to 34% of people who did not have an additional support need (305).
- **Ethnicity** – Willingness to wait for a procedure at WSFT varied somewhat by ethnicity. However, low sample numbers make it difficult to compare groups. There were 35% of people from White or White British backgrounds (674) who said they would be willing to wait, compared to:
    - 31% (five) people from Mixed Multiple ethnic backgrounds
    - 50% (four) people from Asian/Asian British backgrounds.
    - None of the three people from Black/Black British back-grounds who answered the question said they would be willing to wait.

Willingness to wait longer and locality

There was some variation in how willing people were to wait for their procedure at WSFT by postcode district. Areas where respondents were more likely to be willing to wait to have their procedure at WSFT included:

- Bury St Edmunds, south, west and town centre - 42% (IP33)
- Diss and Winfarthing - 42% (IP22)
- Mildenhall and Culford - 42% (IP28)
- Newmarket and Ashley - 41% (CB8)
- Haverhill and Barnardiston - 43% (CB9)
- Bury St Edmunds, north and east - 47% (IP32)
- Brandon and Lakenheath - 38% (IP27)
- Barrow and Shimpling - 43% (IP29)
- Hilborough and Feltwell - 55% (IP26)

Likely modes of transport

The survey asked people to indicate (from a pre-determined list), the most likely means by which they would travel if their operation took place at the ESEOC in Colchester. For context, people were informed that clinicians would not recommended travel home by public transport following an orthopaedic procedure.

Most people said that they would ask for a lift from friends, family or neighbours (64%, 1376) if they had a procedure planned at the ESEOC. Getting a taxi was selected the least often (5%, 101), whilst a substantial minority of respondents said they would need to rely on non-emergency patient transport services (15%, 330).

One in five people (20%, 434) said they did not know. More information is show in the chart below.

Chart: Respondents' likely mode of transport to the ESEOC

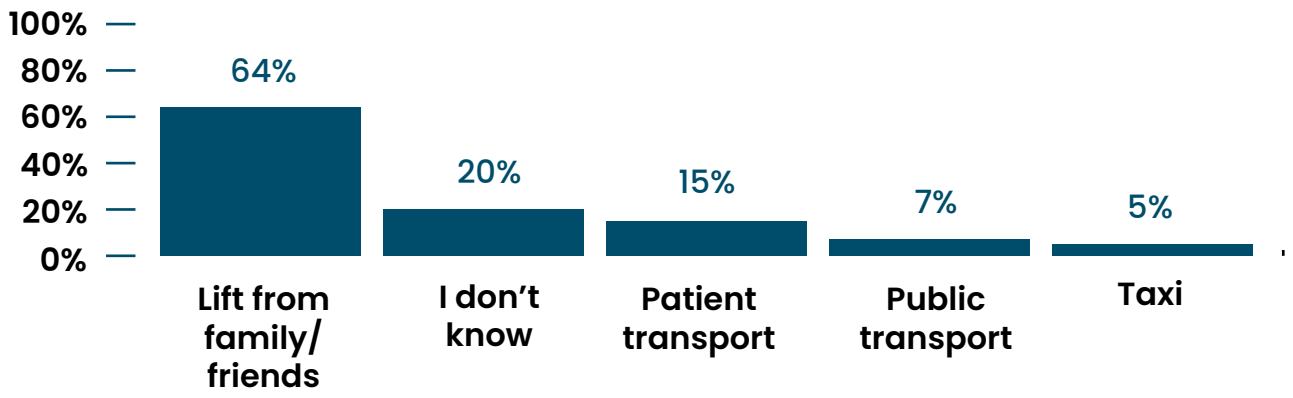


Chart 9: 'If you had a planned procedure at the new Essex and Suffolk orthopaedic centre (ESEOC) in Colchester, how would you be likely to travel there?'

Category	Number
Lift from family or friends	1,376
I don't know	434
Patient transport	330
Public transport	161
Taxi	101
Total answered	**2,148**

Table 7: The number of respondents who selected various pre-defined influences over their choice of surgery provider.

Likely modes of transport and demographics

- **Patient status** - Asking for a lift was the most frequently selected method of travel regardless of whether someone was a patient waiting for care, or which service provider they were waiting for. The key findings were:
    - Respondents who were not currently waiting for elective care (54%, 650) were much less likely than patients waiting for orthopaedic care (73%, 601) at WSFT to say that they would ask for a lift to ESEOC.
    - Respondents who were not currently waiting (25%, 307) were more likely to say that they did not know how they would travel to ESEOC than patients waiting for WSFT (12%, 100). They were also more likely to say they would request or rely on non-emergency patient transport (19% [229], compared to 9% [76] of patients waiting for care from WSFT).
- **Age** - Asking for a lift was the most selected response across all age groups. Reliance on public transport appeared to generally decrease with age. Broadly, older age groups were less likely to be uncertain about how they would travel to ESEOC than younger people. Reliance on non-emergency patient transport services did not appear to be linearly related to age, although people aged over 75 were more likely to select this option.
- **Additional support needs** - People with additional support needs were less likely to say they would be able to get a lift to ESEOC (58%, 541) than people without additional support needs (72%, 674). They were more likely to say they would request or rely on non-emergency patient transport to get to the ESEOC (18% [172], compared to 11% [102] of respondents without additional support needs).

Chart: Respondents' likely mode of transport to the ESEOC (Age)

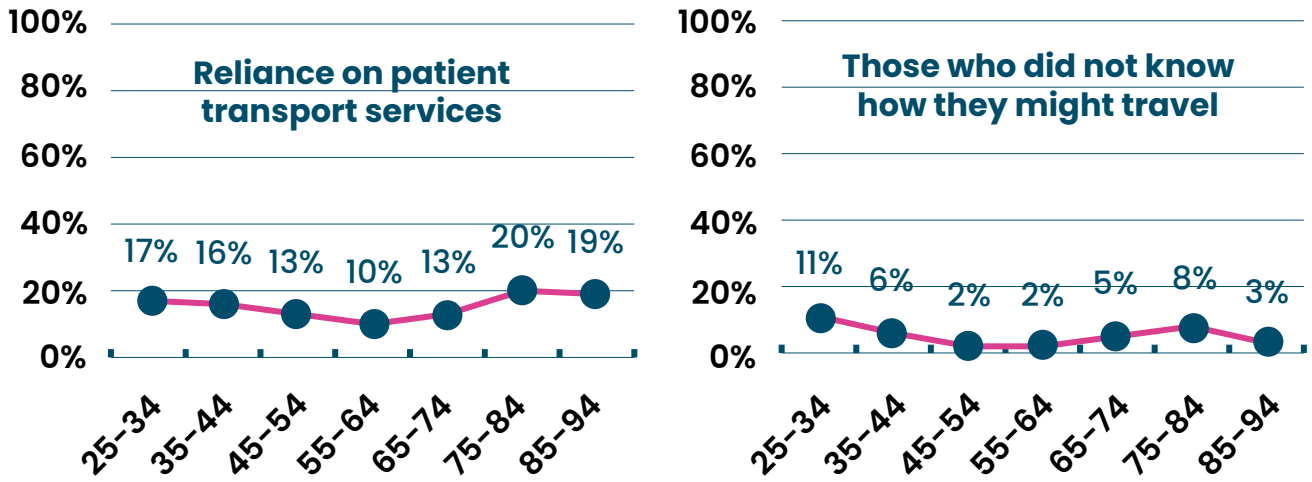


Chart 10 and 11: How age influences likely modes of transport to the ESEOC.

Getting a lift home

The survey asked whether respondents could get a lift home from their procedure if they could not drive themselves or use public transport.

Whilst most indicated that they would be able to get a lift from friends, family, or a neighbour after their operation (26%, 1181), one in five (20%, 433) felt this would not be possible. Roughly a quarter of respondents (26%, 554) were unsure.

More information is shown in the chart below.

Chart: Indication as to whether respondents could get a lift home from the ESEOC

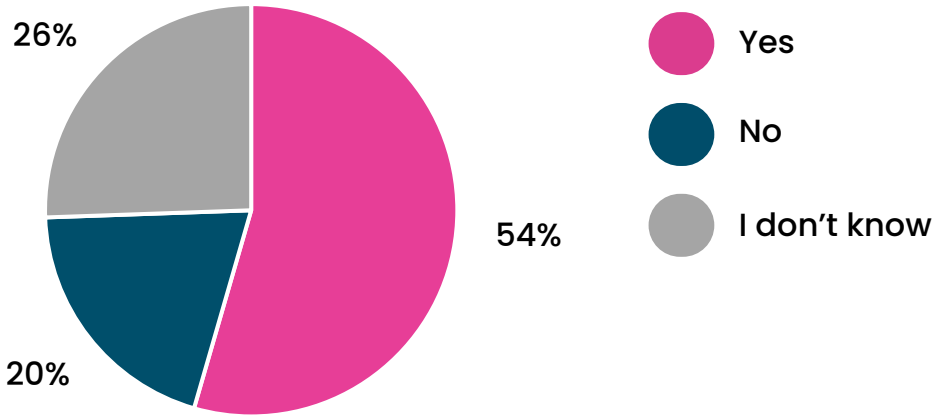


Chart 12: 'Clinicians advise that people will not be able to drive or use public transport themselves following orthopaedic surgery. Would you be able to get a lift from friends, family or neighbours?

Category	Number
Yes	1,181
No	433
I don't know	554
Total answered	**2,168**

Table 8: The number of respondents who selected various pre-defined influences over their choice of surgery provider.

Getting a lift home and likely mode of transport

- Amongst those who said they would use public transport to get to ESEOC, 37% indicated they would not be able to get a lift home. A further 46% said that they did not know.
- Only two percent of people who would get a lift to ESEOC said they would be unable to get a lift home. A further 17% said they did not know.

Chart: Indication as to whether respondents could get a lift home from the ESEOC and their likely mode of transport to the ESEOC

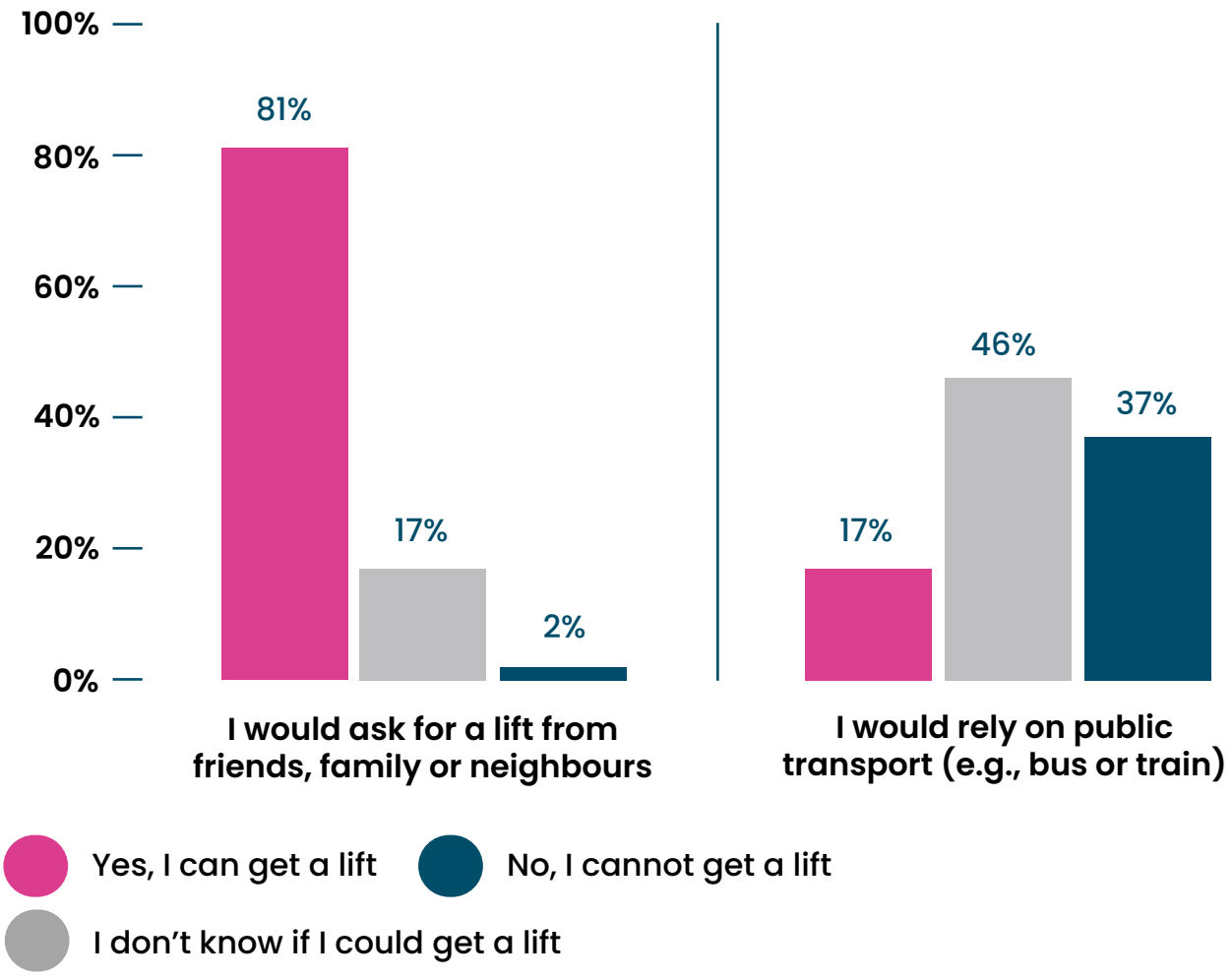


Chart 13: Preferred method of travel to ESEOC and whether respondents can get a lift home.

Worries or challenges for planned care at the ESEOC

People were asked about challenges they might have if their orthopaedic surgery was scheduled at Colchester.

People were slightly more likely to be worried about being away from their support networks (36%, 794) and travelling in the dark (38%, 897) than other factors. More information is shown in the chart below.

Chart: To what extent would you worry about the following?

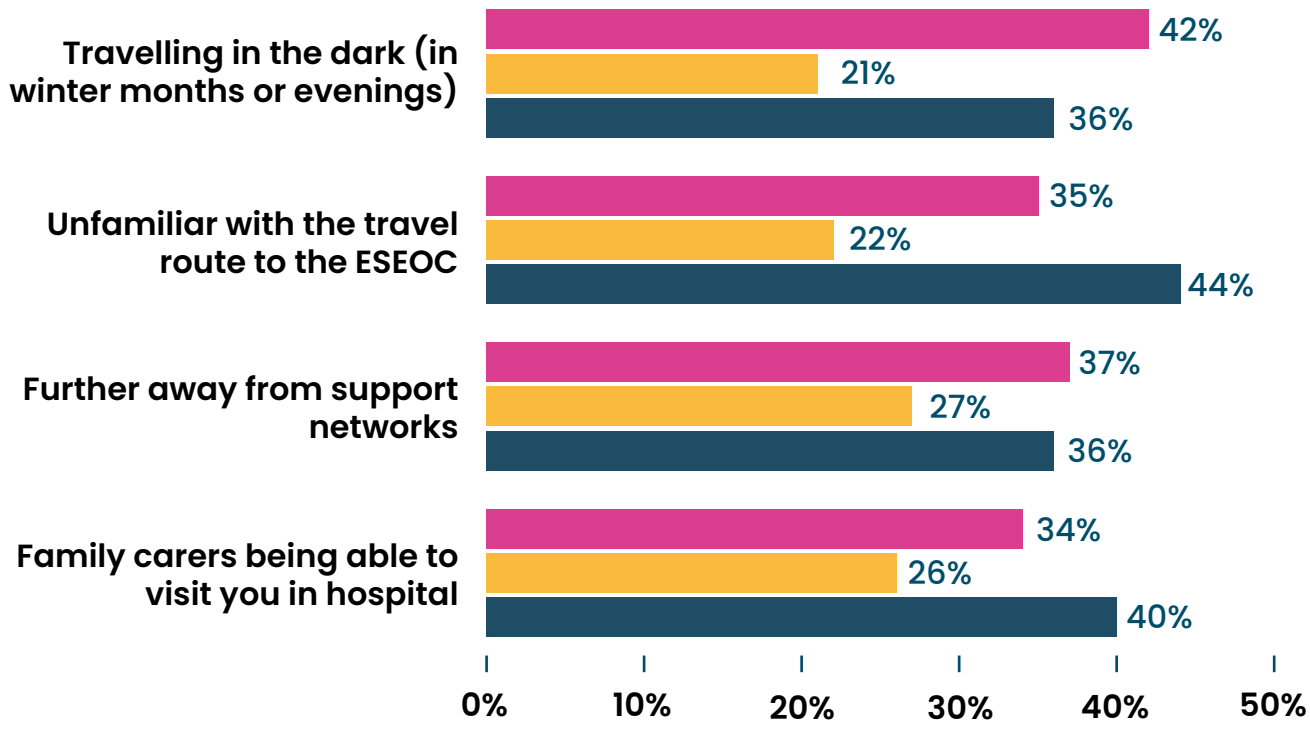


Chart 14: 'To what extent would you worry about the following?'

60% said they would be **'a little' or 'very' worried** about travelling in the dark (in winter months or evenings).

Category	Very worried	A little worried	Not worried at all
Travelling in the dark (in winter months or evenings)	867	554	735
Unfamiliar with the travel route to the ESEOC	768	577	794
Further away from support networks	927	461	742
Family carers being able to visit you in hospital	775	455	897
Total answered			**2,189**

Table 9: The number of respondents who responded to each statement, and how they answered.

Worries and area

Travel and transport were key concerns for respondents in the qualitative data.

Concerns about travel were grouped together to show which areas are most likely to be worried. People who were 'very worried' or 'a little worried' about travelling in the dark or being unfamiliar with the travel route were grouped into a single category of respondents who were 'worried about travel'.

Areas in which respondents were more likely to be worried about travel included:

- Bury St Edmunds (south, west and town centre) - 73% (IP33)
- Diss, Winfarthing - 75% (IP22)
- Ixworth, Thurston - 64% (IP31)
- Newmarket, Ashley - 72% (CB8)
- Mildenhall, Culford - 70% (IP28)
- Haverhill, Barnardiston - 74% (CB9)
- Brandon, Lakenheath - 75% (IP27)
- Hilborough, Feltwell - 87% (IP26)
- Thorpe Abbotts, Pulham Market - 85% (IP21)

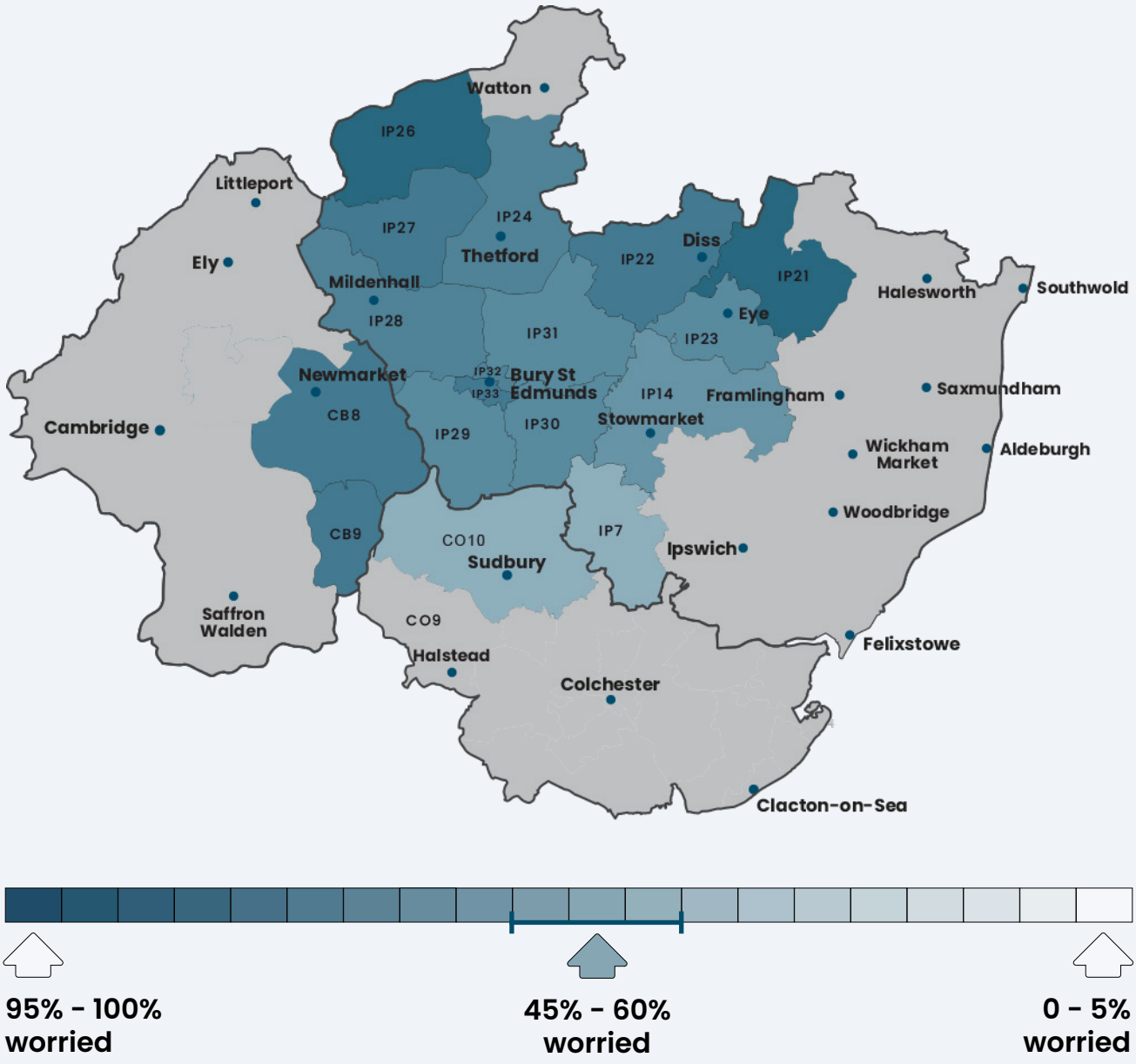
Areas in which respondents were less likely to be worried about travel included:

- Sudbury, Lavenham - 42% (CO10)
- Stowmarket, Stowupland - 58% (IP14)
- Hadleigh, Milden - 45% (IP7)
- Needham Market, Creeting St. Mary - 25% (IP6)

Where were people worried about travel?

Figure 5: The map shows the percentage of people who said they were worried about travel. People who were 'very worried' or 'a little worried' about travelling in the dark or being unfamiliar with the travel route were grouped into a single category of respondents who were 'worried about travel'. Darker blue tones indicate that a higher percentage of people were worried in the postcode district..

Postcode districts are shown if more than ten responses were recorded in the area.



Free text analysis – what support do people need?

The final free text question in the survey asked: 'What support would you need if your procedure was transferred to ESEOC?'

There were 1,437 responses, of which 23% (337) suggested they would not need any support to attend their procedure at ESEOC, and three percent (48) said they did not know what support they would need.

> *"No support required."*

> *"No more than if it was in Bury or Ipswich."*

Some respondents (4%, 52) concluded that they would be faced with a choice about whether to have their operation at all if their support needs could not be met. These comments indicated an apparent unwillingness to attend an operation at the ESEOC, with some suggesting they would cancel their operation or decide to wait longer for an operation elsewhere.

> *"I don't want to be seen at Colchester."*

> *"I wouldn't consider having my procedure to ESEOC under any circumstances because I would have to deal with the aftermath alone."*

> *"If that is the risk, then I will ask for referral to Addenbrookes. No chance of me considering the ESNEFT Colchester route. I feel like this is direct discrimination asking this of me as I do not have a support system."*

> *"I would wait for my procedure at West Suffolk."*

Key themes about support needs are shown in the table below.

Theme / Issue	Count	% of comments
Transport to ESEOC	592	41%
Support networks	192	13%
Post-operative care	88	6%
Financial support	57	4%
Transport for visitors	42	3%
Information in advance	30	2%

Table 10: Summary of themes.

Transport to ESEOC

A total of 41% (592) of comments indicated a need for support with transport to or from appointments at ESEOC. This theme was applied broadly to respondents who said they specifically required hospital transport, or who stated they would face challenges organising their own journey to Colchester.

Some respondents felt they would require hospital transport because of the distance and lack of alternative options.

> *"The availability of hospital transport would be one solution to the issues of travel to any remote site."*

> *"Would not be able to attend unless non-emergency hospital transport was provided."*

> *"Transport to and from ESEOC, as there is no public transport links I am aware of as of yet."*

Although some respondents may have family or friends who could transport them to and from their procedure, this could depend on availability and the time of the appointments, and some felt that this was too much to ask given the distance.

> *"Without a car, transport would be needed. Asking friends and family to take you 15 miles is one thing. Asking them to take you 45 miles is another. The extra stress on top of an operation would be unacceptable, especially for the elderly."*

> *"Guarantee that I would be provided timely transport to the location should I be unable to call in favours."*

Support networks

A total of 13% (192) of comments described how people would need to rely on the good will of friends, family or neighbours to get to the ESEOC. These comments highlighted the importance of support networks in accessing ESEOC.

Some respondents felt confident they had family, friends or neighbours who could help with access to procedures at ESEOC, including with transport and emotional support.

> *"I am lucky that I have family who would support me."*

> *"I believe I would have good family and friends support."*

> *"I think (family) would support me with essential travel, for the return journey, even if they might not visit."*

Some respondents expressed concern about the possible impact of the proposals on the lives of those they would turn to for support. They described work and other commitments, health issues, and other reasons why this could negatively affect family members, friends, or neighbours.

> *"Friends or family. Not convenient."*

> *"Heavily rely on others (who are not in the best of health either!)"*

> *"Finding family or friends to take me as they all work, it's a lot further than going to West Suffolk Hospital but if it means getting out of pain I would find a way round it."*

Post-operative care and support

A total of six percent (88) of respondent's comments referenced potential needs regarding post-operative care. Overall, respondents sought reassurance that they would receive quality aftercare and support from various services to aid recovery or stated the importance of this.

Some respondents discussed the importance of quality post-operative care following the procedure.

> *"High quality and efficient management of my clinical needs and postoperative recovery."*

> *"Good face to face aftercare."*

> *"Aftercare if I become unwell following surgery and cannot go home."*

Some respondents discussed how they would prefer their post-operative care to be local to them. Such comments reflect that messaging about the proposals (e.g., that post-operative care would take place at sites in West Suffolk) had not been fully appreciated by all respondents or people need reassurance about this.

> *"Guarantee of more local follow-up and post-op support as it would be very difficult to undertake one-hour-long journeys for each appointment."*

> *"Aftercare at West Suffolk Hospital and not Colchester due to the travel times, and potentially having to rely on lifts from friends and family whilst being unable to drive during the recovery period."*

> *"Perhaps offering aftercare nearer home – say at West Suffolk Hospital – would ease worried minds about having the surgery in Colchester."*

Some respondents felt they would require social or community care following their procedure. This included services to support recovery, such as physiotherapy, and services to support physical and emotional needs.

> *"Perhaps social care, physiotherapy, occupational support, reassurance that if there was a problem I would not have to return to Colchester."*

> *"Help at home until I can drive."*

> *"If available, several days/nights in a convalescent home (or comparable facility)."*

Financial support

Financial support was mentioned in four percent (57) of responses. People highlighted the potential for additional costs associated with the move to ESEOC and suggested they would like support with those costs. Some comments included costs for things like accommodation, food, and parking. However, most respondents wanted financial support for transport. This included that transport provided should be affordable or cost-free or that there should be compensation for fuel.

> *"A free of charge transfer from West Suffolk Hospital or home to Colchester and back. This is all done to be convenient and cheap for the NHS so why should patients have to suffer?"*

> *"Taxi to be provided for and paid for maybe, don't see any other way, or keep the surgery at West Suffolk."*

> *"Help with fuel costs?"*

Transport for visitors

Related to transport, three percent of comments (42) discussed how issues associated with transport could affect the extent to which family or friends are able to visit or support people during their stay at the ESEOC.

Some respondents expressed general concern about family and friends being unable to visit people at the ESEOC, making the experience more difficult without moral support.

> *"If you had to stay overnight, then the chances are you wouldn't have visitors. This could add to the anxiety and stress of surgery."*

> *"I would need help getting there, which even if I could get, would leave me without emotional support before and after the operation."*

Respondents felt that transport arrangements should also apply to friends, family, and carers for emotional and physical support.

> *"Full transport for myself and friends/ family - a regular direct taxi bus."*

> *"Transport for patient to and from, transport for family visits to and from."*

> *"Would need hospital transport for both myself and my caregiver for both operation and aftercare, the additional travel time would mean additional expenses in pet sitting/pet care, not affordable for pensioners. This would create additional stress."*

Information in Advance

A relatively small sample of people (two percent, 30) expressed that they would like information about the ESEOC (e.g., about transport options, their procedure, and appointment times) in advance. Such comments included that people wanted to receive detail about their procedure in plenty of time to plan transport and adjust to the change of location.

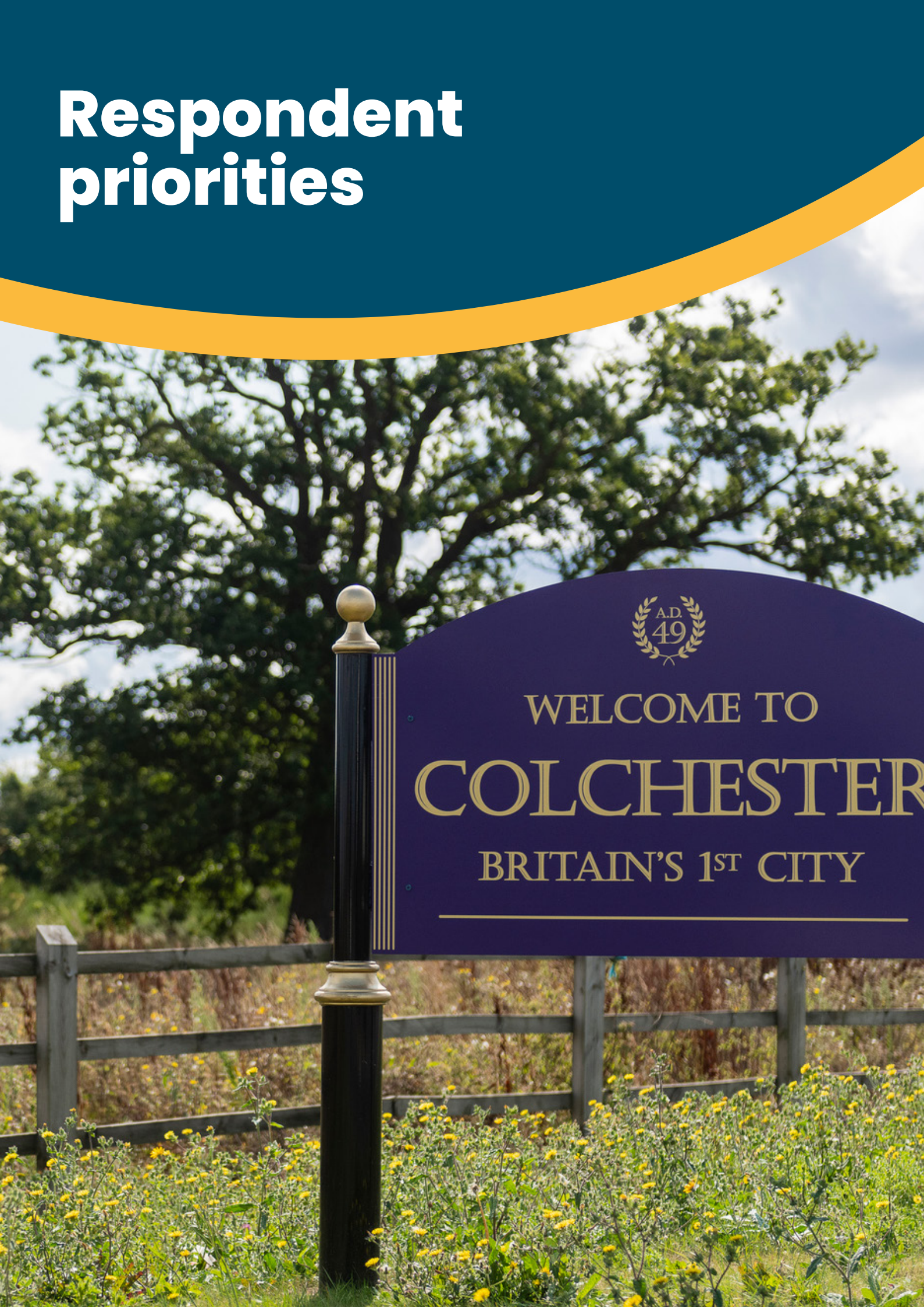
> *"Information about the centre and its facilities. Knowing how long I will need to be there so my family can factor time off work to pick me up as it will be a longer drive."*

> *"Just enough notice to mentally adjust to the change of site."*

In addition to this, many of the comments to question 11 were framed as questions. For example, 'Where would post-op care be provided?', and 'Would there be aftercare?'. These comments reflect a current lack of understanding in the sample about the detail of the plans and some of the areas people would like to see clarified.

“Access to WiFi to interact with family and friends. Possibly comfortable mini bus type ambulance back to local hospital as would consider taxi or lift being more reasonable to get home maybe reduce costs to NHS.”

Respondent priorities



Summary

Overall, many people were optimistic about the potential benefits of the proposals. This included the ambition for the ESEOC to become a 'centre of excellence' in orthopaedic care and its potential impact on local wait times for elective care. This was particularly true of those already waiting for orthopaedic care and experiencing how such a wait for an operation can affect people's lives.

The impact of waiting for elective care was evidenced in research completed by Healthwatch Suffolk in 2022 (https://healthwatchsuffolk.co.uk/ourresearch/electivecare/). This showed that people's lives were affected in multiple ways, with consequences for their overall well-being, relationships, caring responsibilities, mental health, and much more. It must be acknowledged that the context of waiting for elective care is likely to influence people's responses to this survey and the likelihood that they may support the plans overall.

Despite evidence of agreement with the proposals' core benefits, the plans represent genuine and significant challenges for some people. If not addressed, this may lead to potential inequality of service access and, for some, the potential for missing out on surgery.

People have described how inequality may result from factors including:

- **Financial circumstances** – being able to afford transport and associated costs to and from surgery (e.g., public transport to the ESEOC).
- **Access to transport** – determined by criteria for patient transport access, whether people own a car or have someone they trust who can give them a lift.
- **Availability of support networks and isolation** – the extent to which people can draw upon the support of friends, family or other networks to get to their operation (e.g., getting a lift).
- **Transport links** – some parts of Suffolk and north east Essex lack any direct means of getting to the ESEOC, which can leave people with limited, expensive or no transport options.
- **Mobility, frailty and vulnerability** – travel distance may impact those who could experience pain or discomfort on long journeys before and after their operation. Others may struggle with transportation over longer distances, or at night (e.g., older people may be reluctant to drive more than short distances, or away from familiar roads local to where they live).
- **Caring responsibilities** – distance and changing environments may present unique challenges for people with caring responsibilities.

The purpose of this independent analysis is not to provide recommendations regarding the advancement of these NHS plans. Instead, this report provides insight

into the level of support for the proposals overall, as well as a set of respondent priorities (listed below) to help NHS leaders make the best possible decisions regarding the future of orthopaedic care in Suffolk and north east Essex.

Respondent priorities

To avoid inequality of access to orthopaedic surgery in SNEE, it will be important for local NHS leaders to consider the respondent priorities listed below.

Transport and travel

This is the most critical area of feedback about these proposals.

Leaders must seek to find solutions for those who may not have the means to travel to the ESEOC (e.g., through challenging financial circumstances, lack of support networks, rural isolation, poor transport links to Colchester and other factors). Although many can get themselves to the ESEOC (even if it may be inconvenient to do so), it is clear transportation issues may critically determine whether some people in local communities can easily access surgery in the future without intervention.

Proactive solutions should be sought where possible (e.g., arranged transport from the WSFT site or expanded non-emergency patient transport services), but people should also be informed about how they can get help with the cost of transport where eligible.

Access, choice, flexibility and patient rights

Commissioners and WSFT must consider where flexibility on surgery location may be important for some patients and build this into service access policies.

Key questions:

- Are there any patients for which travel to ESEOC may not be considered reasonable, and who are they?
- Who will make decisions about patient preferences on flexibility and choice?
- How do we make sure people are aware of how they can request such flexibility based on their individual circumstances?

At the point of referral for orthopaedic surgery, NHS staff in primary care must be prepared to inform people about what these plans will mean if they choose to have their surgery delivered by the WSFT. That includes detail about waiting times and risk of cancellation based on chosen site, any flexibility on choice that may apply and how people can ask for that, rights on patient choice, transport help, alternative options to ESEOC and other such information.

Communication

People will welcome practical and clear information about accessing the ESEOC and what to expect when attending for surgery. This may help to reduce anxieties about visiting an unfamiliar hospital or location and help to make sure people have understood how the service will operate. This includes key information about pre and post-operative care (and where it is located), as well as practical information about travel to the centre, parking (e.g., charges), what to expect on arrival and how to prepare for a visit.

Such information may help people to feel more comfortable about their visit to the centre, particularly older and vulnerable patients who have expressed worry about visiting a place that is not known to them.

Family carers and visitors

NHS leaders must ensure the needs of formal and informal family carers have been considered and offer flexibility on location where required. This might include accommodating those with specific service accessibility needs or for whom familiarity with staff and the environment may be important (e.g., access to a known LD liaison lead).

Where people may require the daily in-person support of their family carer, an extended stay at the ESEOC may present unique challenges. Digital solutions may not be effective under these circumstances, and therefore, carers may face lengthy daily travel and increased expenses. Support with being able to stay nearby or flexibility on the location of surgery may be important to help people access their surgery.

Digital solutions should be explored to ensure people can connect with their friends or family if they cannot visit the ESEOC during the patient's stay.

Support for vulnerable people

Accessible care and support is important in any NHS service. It helps people to feel comfortable during their say and ensures people's needs are met. Flexibility on choice of surgery location may be important where people can demonstrate that their needs, or the needs of a person they care for, are not suited to travel to the ESEOC.

It will be important that there is a focus on helping people to attend if they have specific care or support needs (e.g., ensuring the ESEOC is dementia friendly) and that people know how they can request help with, for example, translation or interpretation if needed.

People's care and support needs should be noted before any transfer of a person's surgery to the ESEOC so that staff know how to meet those needs in advance within the centre. Information about attending ESEOC (and patient choice) must be available

in formats appropriate to people's needs so that everyone can access it fairly.

Share the learning

NHS leaders should ensure learning from public feedback relating to issues such as transport, travel, access, carer needs, communications and support for those who are vulnerable, are used in developing any future centralised care hubs.

“My husband has had four hip replacement operations in the past, all carried out at the West Suffolk. Whilst I approve of this in theory, my concerns are the fact that we are already 15 miles from the West Suffolk, so travelling time would increase as would travel costs. This would certainly impact if the attendance time on the day of surgery was 7am as it usually would be. Would transport be provided if there was nobody to take him there? Likewise it would be a longer journey post op when travel in a car increases the risk of dislocation too. My husband has had three strokes and might need me for communication purposes, and we do not know the area around Colchester at all.”

We will be making this report publicly available by publishing it on the Healthwatch Suffolk website.

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If you require this report in an alternative format, or language, please contact Healthwatch Suffolk on 0800 448 8234 or by email to info@healthwatchsuffolk.co.uk

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Suffolk and North East Essex Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 9
Date: 30 July 2024

Title: Suffolk SEND Inspection Outcome Update

Lead Director: Lisa Nobes, ICB Execuitve Director of Nursing and Richard Watson, ICB Deputy Chief Execuitve and Execuitve Director of Strategy and Transformation.

Author: Garry Joyce, Deputy Director of Transformation Children and Young People

Purpose: To provide an update on the work undertaken following the inspection of SEND services in Suffolk.

Recommendation: That the Board notes the report.

This report was originally published on 21 May 2024 ahead of the 28 May 2024 Board meeting. The ICB meeting on 28 May was cancelled due to the announcement of the general election and the commencement of the pre-election period from 25 May 2024.

1. Background

1.1. In 2014 new statutory guidance was issued covering children and young people aged 0-25 years with special educational needs and disabilities, this was the SEND code of Practice 2014 and as part of the changes a new inspection regime was also introduced which new joint inspections between Ofsted, CQC and HMI, the remit was to inspect a system i.e. Education, Health and Social Care on the delivery of the SEND code of practice, Suffolk was inspected in 2016 and 2019.

1.2. In 2022 a national review was undertaken entitled SEND review: right support, right time, right place as a response to the widespread recognition that the system was failing to deliver for children, young people and families as expected within the 2014 SEND code of practice. The result of the review was the publication of a new Area SEND inspection framework and handbook (Area SEND inspections: framework and handbook - GOV.UK (www.gov.uk)) which also changed how inspections would be undertaken.

1.3. In October/November 2023 Suffolk was inspected under the new regime and the local area partnership (Suffolk County Council, Suffolk and North East Essex ICB and Norfolk and Waveney ICB) received notification on Monday 30th October 2023 that the inspection would commence immediately and last for 3 weeks. The inspection concluded on Friday 17th November 2023.

1. The local area partnership's arrangements typically lead to **positive experiences and outcomes** for children and young people with SEND. The local area partnership is taking action where improvements are needed.

2. The local area partnership's arrangements lead to **inconsistent experiences and outcomes** for children and young people with SEND. The local area partnership must work jointly to make improvements.

3. There are **widespread and/or systemic failings** leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently.

1.4. There are 3 possible outcomes for a SEND inspection:

1.5. The result for Suffolk (50238584 (ofsted.gov.uk)) was number 3 highlighted above which highlighted a number of priority actions and areas for improvement that the system needed to address, they are:

Areas for Priority Action
The LAP should work more collaboratively and effectively to improve strategic planning. This needs to deliver systems with measurable impact that will create better experiences and outcomes for children and young people with SEND. In particular they should urgently improve: • the robustness and impact of governance • the rigour of quality assurance approaches, so that these give the information leaders require to address weaknesses effectively • the frequency and quality of multi-agency working • the management of transitions and planning for adulthood for children and young people, starting in the earliest years, and across services in education, health and care, including putting steps in place to reduce NEET, so that they are better supported to lead fulfilling lives.
Local area partnership leaders should cooperate to take urgent action to improve the timeliness and quality of the statutory EHC plan processes, EHC plan needs assessments, and EHC plans and annual reviews, particularly using annual reviews to amend the quality of existing EHC plans where required. This should ensure that plans meaningfully capture the views and aspirations of children and young people with SEND and their families, so that they get the right support at the right time.
Areas for Improvement
Leaders across the partnership should use performance data and information effectively to inform their evaluation, sufficiency planning and joint commissioning of SEND services.

The local area partnership should engage effectively and widely with children and young people and their families, developing effective communications systems, and acting to address parents' and carers' concerns at an early stage, to reduce dissatisfaction and reduce the need for parents and carers to have to follow formal routes.
Leaders across the local area partnership should ensure that providers of services for children with social and emotional well-being, mental health and neurodiverse conditions work jointly to meet the needs of and improve outcomes in these areas for children with SEND.

1.6. As a result of the inspection the SEND partnership were required to draft a Priority Action Plan (PAP) to demonstrate how we will address the issues raised (see appendix A), this was submitted to the DfE and has been agreed with them.

1.7. The result of the inspection means that we will be subject to regular meetings with the DfE to monitor progress, the first of which will be late June 2024, as well as 6 monthly stocktake meetings with both DfE and NHSE leading to a re-inspection around June 2025

1.8. As a partnership we have also revised the Suffolk SEND strategy which now runs to 2029 as included in Appendix B.

1.9. In addition to the Suffolk SEND inspection we also anticipate that there will soon be an Essex SEND inspection, however as they are unannounced it is difficult to say exactly when it will occur.

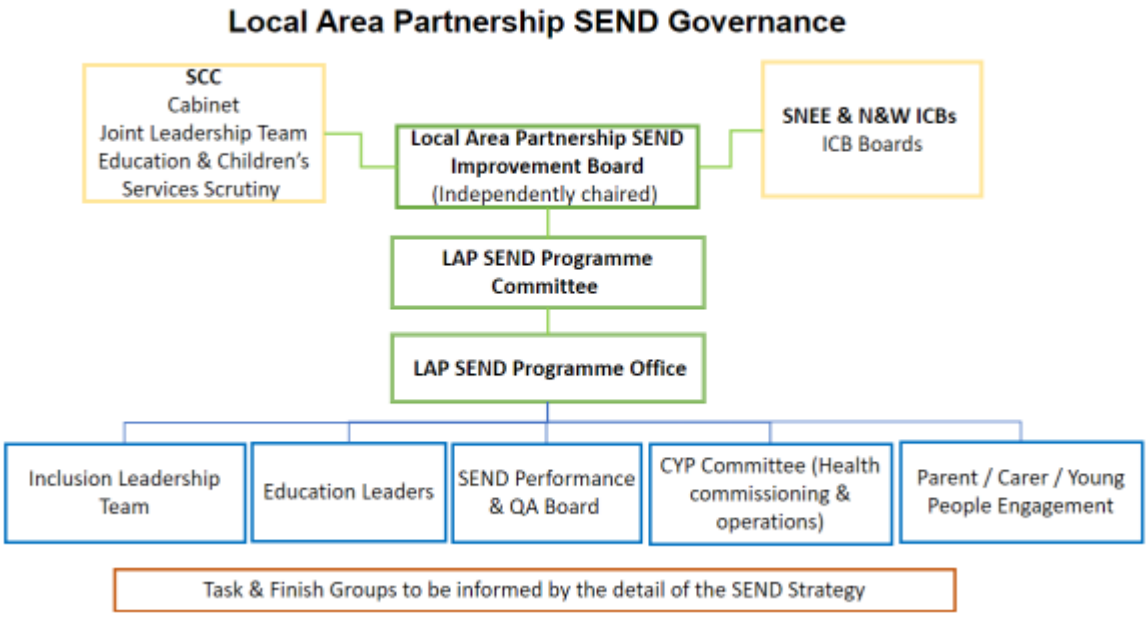
2. Key Issues and risks

2.1. There are 3 key areas of work that will impact directly on delivery of the PAP that the ICB is focused on and they relate to:

- Strategic partnership working and governance (part of the first priority)
- Improving waiting times and outcomes for children and young people specifically around autism and ADHD
- Improving waiting times and outcomes for children and young people relating to emotional well-being and mental health

Strategic partnership and governance

2.2. The way the system holds itself to account for SEND has been reviewed and a new governance structure has been agreed as the diagram below illustrates:



2.3. The partnership has already appointed an independent chair for the improvement board which will monitor the system response to the PAP, the programme committee and programme office will closely monitor the detail of the PAP and be held to account by the improvement board.

2.4. The improvement board will also be presented with a high level performance dashboard to enable monitoring of improvement against trajectories on a number of key areas.

Autism and ADHD

2.5. There has been a considerable amount of work around creating a Neurodevelopmental pathway for the children and young people of Suffolk over the last few years which included the provision of support for children, young people and families while waiting for assessment. The pathway has faced a number of issues, some local and some national which has seen the waiting times for assessments grow to unacceptable levels which is highlighted within the SEND inspection outcome letter.

2.6. The ICB has made a commitment to reduce waiting times for assessments and working with the providers agreed additional investment in February to enable both West Suffolk Foundation Trust and Norfolk and Suffolk Foundation Trust to outsource some of the assessments to trusted commissioned providers. The procurement process is nearing completion and once completed the services will begin to work through the backlog of children waiting for assessments. We will monitor the progress on a monthly basis and report to the SEND improvement board.

2.7. The ICB has also agreed investment with ESNEFT as we are experiencing similar increases in demand and waiting times across north east Essex.

2.8. The total additional investment for waiting list initiatives across the ICB is £2.2m.

2.9. There has also been a marked increase in the number of referrals coming through to the services and in recognition of that the ICB also approved additional investment to increase capacity within the services to enable better management of referrals and prevention of the creation of future backlogs. The total additional investment across the ICB to support the increased capacity is £1.1m.

2.10. There are national issues around the number of Community Paediatricians currently available and the future forecast is likely to decrease so with that in mind we are also working with the current service looking at potential new models of delivery. At the same time, we are also looking at the current pathways with both providers and how we can utilise them more efficiently to ensure a smoother process for families in the future.

2.11. The continuing investment into the voluntary sector to provide support services for families while waiting across the ICB has been a success and we are now in the process of evaluating all services prior to a re-procurement exercise commencing in the Autumn 2024 with expected awards of new contracts from August 2025. The total investment across the ICB has been £1m recurrently since 2021.

Emotional well-being and mental health

2.12. Mental health services have benefitted from the Mental Health Investment Standards for a number of years which has enabled us to grow the range of services available within Suffolk.

2.13. We have successfully embedded Mental Health Support Teams across the ICB with expected coverage to reach 49% by January 2025 which will see a total investment of just over £4.4m.

2.14. The mental health services within Suffolk have had a number of issues around recruitment and retention of staff which along with the national trend around greater demand for services has seen waiting lists rise. The ICB working with the trust looked at long term requirements of the service and invested an additional £1.2m in staffing during 2023/24, these posts have now been filled and we have a monitored recovery trajectory in place with the trust which will see waiting times fall to within expectations by November 2024.

2.15. As a system we are reviewing the delivery of mental health services across Suffolk with a particular focus on embedding a new conceptual framework around how the system can work better together to meet the needs of children and young people that require support around emotional well-being and mental health.

2.16. We have seen the introduction of a new eating disorders service which is now fully established and will soon be supported by the implementation of a new ARFID (Avoidant/restrictive food intake disorder) pathway launching this summer.

3. Patient and Public Engagement

3.1. Coproduction is a strength within the work undertaken by health in SEND and will continue to be at the heart of everything we do. During the inspection it was identified as being inconsistent across the partnership so we within the ICB have committed to embedding it further across the partnership and to help us achieve this we are utilising a dedicated resource to lead on culture change around coproduction, gaining a better understanding of strategic coproduction and also coproduction relating to individuals. We will be undertaking a piece of dedicated work with Suffolk County Council looking at the process of learning from complaints and how the learning is applied.

3.2. Suffolk Parent Carer Forum is one of our coproduction partners and has a wealth of lived experience that we will utilise while making changes to services impacting on children with SEND, we have committed to attending all open forum events that they run which enables us to gain first hand experiences from families, the next one being 19th June 2024.

3.3. Although this report primarily focuses on the recent Suffolk SEND inspection and resulting priority action plan we do need to reference that our work with Essex parent carer forum is as strong as it is with Suffolk and that one of our recent pieces of work with Essex resulted in the production of a parental guide to NDD which has since been replicated in other areas including Suffolk (Supporting Your Neurodiverse Child (essexfamilyforum.org)).

4. Future updates and monitoring

4.1 There will be regular monitoring of the PAP within Suffolk through the new governance arrangements, there will also be six monthly stocktakes by DfE and NHSE in relation to progress against the plan. There will also be a re-inspection by June 2025 probably.

4.2 There is likely to be a SEND inspection of Essex in the very near future which the board will need to be updated on following publication of the outcome.

Version: FINAL

Suffolk SEND Local Area Partnership Priority Action Plan

February 2024

NHS Suffolk and North East Essex Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

Suffolk County Council

Contents

Introduction

This action plan sets out how the Suffolk SEND Local Area Partnership (LAP) will address the priority actions and the areas for improvement identified by the Area SEND inspection carried out in November 2023 by Ofsted and CQC.

The Suffolk SEND LAP oversees the planning and commissioning of local education, social care and health provision to meet the needs of children & young people with special educational needs and disabilities in Suffolk. It is made up of:

- NHS Suffolk and North-East Essex ICB
- NHS Norfolk and Waveney ICB
- Suffolk County Council

The LAP works closely with the wider SEND Partnership including the Suffolk Parent Carer Forum and other parent/carer representatives, schools, colleges, health delivery services and community services.

Link between Priority Action Plan and SEND Strategy

This Priority Action Plan has a specific focus on addressing the priority actions and the areas for improvement identified through the Area SEND inspection that took place in November 2023.

These actions will form a part of the Suffolk SEND Strategy and associated Action Plan for the Local Area Partnership which include a range of wider developments to support the delivery of our vision and ambition.

Independently of the Area SEND Inspection, the Suffolk SEND Strategy was being developed to replace the previous strategy which was in place 2021-23. The timeline for developing the new SEND Strategy 2024-28 has been brought forward to align better with the production of this Priority Action Plan. By the point of submission of the Priority Action Plan on 7 March 2024, co-production around the new Suffolk SEND Strategy will have reached the stage of establishing **WHAT** needs to be done including setting specific and measurable targets over the next 18 months. Further co-production in the remainder of March 2024 will need to take place to establish in more detail **HOW** it will be done.

Consultation Feedback from parents/carers and young people has identified 4 priorities for the new SEND Strategy.

Feedback from Families	**Strategic Priorities**	**Inspection Priority Actions and Areas for Improvement**
Better communication with families	Communication & Information	Effective engagement with Parents/Carers & Young People
More Specialist Education Provision	Right support, at the right time	Sufficiency Planning
Shorter waiting times including for EHC plans, Annual Reviews and health support	Quality and Timeliness	Timeliness and quality of EHC Process Social & emotional wellbeing, mental health and neurodiverse conditions
Improved planning for change as children and young people move across stages of their education	Planning for Change	Transitions & Preparing for Adulthood
Key Enablers Governance & Strategic Planning Quality Assurance Multi Agency Working Staff Resources Development of Liquid Logic Case Management System Performance data and Outcomes Framework		

These priorities from families closely align with the findings and Priority Actions required by the Area SEND Inspection.

The Area SEND Inspection in November 2023 found widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the Local Area Partnership must address urgently.

The following table shows key areas where improvement is needed from the Area SEND Inspection and links them to the four strategic priorities that have been identified from the SEND Strategy Co-production that is currently underway.

Findings from the Area SEND Inspection	Link to SEND Strategic Priorities
• Communication is poor and coproduction is not embedded enough.	**Communication & Information**
• Unidentified and unmet needs sometimes manifest in behaviours which too frequently result in many not accessing mainstream settings, because of exclusion or absence.	**Right support at the right time**
• The weaknesses in statutory EHC plan processes lead to widespread and systemic gaps in service provision.	
• Academic outcomes for those with SEND limit opportunities.	
• There is not enough specialist provision to prevent out of authority placements.	
• Multi-agency working is not consistently embedded.	
• Assessments for support take too long and are not always accurate enough.	**Quality & Timeliness**
• The quality of EHCPs is variable.	
• Waiting times are too long.	
• Annual reviews do not happen often enough.	
• Transitions between settings and services is not consistently good.	**Preparing for Change**
• Families are not aware enough of things to do outside of education, training or work. In some parts of the county there are few clubs. Some young people, especially those in rural areas, do not know what options they have for social contact, and experience isolation as a result.	
• Families need more access to some services, such as early intervention for mental health.	
• There is inconsistent quality of services and clarity of commissioning arrangements.	
• Preparing for Adulthood is not good enough. Too many children and young people with SEND become NEET.	

The Inspection also identified areas of effective practice, as follows: -

- There are many individual practitioners who build up a careful picture of children and young people's needs.
- Many children and young people receive helpful support at the point of crisis.
- There are effective programmes to help pupils with low attendance or at risk of exclusion.
- Parents praise some aspects of community support, for example Activities Unlimited.

- In some areas, the LAP has worked successfully to improve services –redesign of therapy services.
- New Local Offer website, and the new portal intended to improve the EHC plan process.
- Valuing SEND is showing early signs of impact.
- The SEND training schools receive is helpful.
- Helpful early intervention to support schools.
- High needs funding to schools to support children and young people with SEND without the need for an EHC plan.
- Several health teams support families sensitively and successfully, meaning families receive strong support at a very difficult time.
- Dynamic Support Register transitions.
- Many providers, i.e. schools and colleges, praise their relationship with the LAP.
- If children and young people meet thresholds, they get very strong social care support.

This Priority Action Plan as part of the wider SEND Strategy and Action Plan addresses the areas for improvement and builds on the areas of effective practice.

We are committed to making these changes. People in Suffolk have had a SEND system that has not worked well for a long time. We must address the areas of weakness found in the inspection with a particular focus on the difference we can make as a Local Area Partnership to the experiences and outcomes of children, young people and families.

Children and families need to be placed at the heart of everything we do, with young people and their families integrated at every level, ensuring they are heard, and their experiences valued. We must also strengthen governance, quality assurance and joint leadership, and invest in the resources needed to consistently deliver good quality SEND Services. This is at the heart of our vision and our Local Area Partnership, co-produced SEND Strategy that is in development.

Governance

We will strengthen the Governance of SEND in Suffolk so that:

- there is clear joint leadership with specific accountability and drive to achieve the plans to improve.
- the voice of children is at the heart of everything we do.
- there is clear understanding of the lived experience of children and families.
- co-production is embedded.

The **Local Area Partnership SEND Improvement Board** will meet bi-monthly for the first six months until September 2024, then quarterly, to hold partners and Officers to account for achieving progress at pace towards the SEND Strategy objectives, including delivery against the Priority Actions and areas for improvement from the Area SEND Inspection.

Members of the Board

Independent Chair
Chief Executive, SNEE ICB
Chief Executive SCC
Chief Executive, N&W ICB
Cabinet Member Education & SEND
Cabinet Member Social Care
Cabinet Member Public Health
Suffolk Parent Carer Forum (SPCF)Representative
Director Children & Families (DCS)
Executive Director SEND, SNEE ICB
Executive Director SEND, NHS Norfolk and Waveney ICB
Assistant Director (AD) Inclusion
AD Social Care
AD Skills, Education & Learning
AD CYP, SNEE ICB
Head of Service Intelligence Hub
Education Providers Representation
AD Adults Services
DfE Department Case Lead
DfE SEND Advisor
NHS England SEND Advisor
SENDIASS

Coordination – SEND Programme Manager

The **Local Area Partnership SEND Programme Committee** will meet monthly for the first six months until September 2024, then bi-monthly to oversee the operational delivery of the LAP SEND Priority Action Plan and the wider SEND Strategic Plan.

Members of the Committee

AD Inclusion (SRO)
AD CYP, SNEE ICB (SRO)
Parent/Carer Representative(s) (SPCF)
Young Person Representative(s)
SENDIASS Representative
Education Providers Rep
AD Social Care
AD Skills, Education & Learning
Director, NHS Norfolk and Waveney ICB
SEND Programme Manager
ICB Programme Manager
SEND Workstream Chairs
AD Learning Disabilities (Adults)
AD Nursing CYP, Community Health SCC
Head of Programmes CYP

Coordination – SEND Programme Manager/Project Manager

The **SEND Programme Office** will meet monthly to co-ordinate the workstreams delivering the SEND Programme

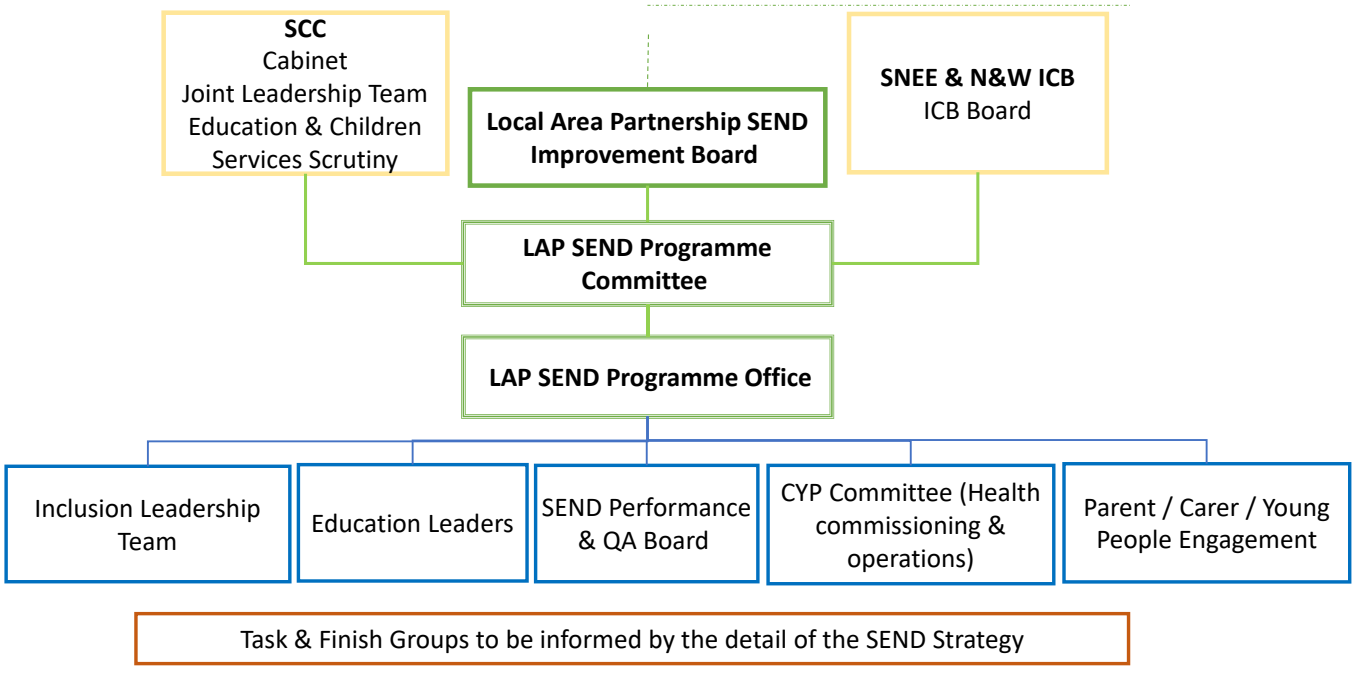
Members of SEND Programme Office
AD CYP Nursing & Community Health
AD Inclusion
AD CYP SNEE ICB
Director CYP, NHS Norfolk and Waveney ICB
SEND Programme Manager
Designated Social Care Officer
Designated Clinical Officers, NHS SNEE & N&W ICBs Head of SEND Family Services

In Attendance
Workstream leads and members as applicable

Coordination – SEND Programme Manager

The join-up across SEND Governance is shown below:

Local Area Partnership SEND Governance



**The lower tiers of this SEND Governance will continue to evolve as the detail of the SEND Strategic Plan is completed through co-production and consultation.*

Priority Action Plan

Priority Action 1	**Overall Partnership Leadership for this priority**
The LAP should work more collaboratively and effectively to improve strategic planning. This needs to deliver systems with measurable impact that will create better experiences and outcomes for children and young people with SEND. In particular they should urgently improve: • the robustness and impact of governance • the rigour of quality assurance approaches, so that these give the information leaders require to address weaknesses effectively. • the frequency and quality of multi-agency working. • the management of transitions and planning for adulthood for children and young people, starting in the earliest years, and across services in education, health and care, including putting steps in place to reduce NEET, so that they are better supported to lead fulfilling lives.	<u>Governance</u> Director Children & Families Services, SCC Director NHS SNEE ICB Director NHS N&W ICB <u>QA, Multi-Agency Working, Preparing for Adulthood</u> Assistant Director Inclusion, SCC Executive Chief Nurse for NHS SNEE ICB Director CYP, Maternity and Safeguarding, NHS N&W ICB

#	Action	Milestones	Owner	Evidence of Impact
1.0	**Objective:** Strengthen the governance and strategic planning of SEND in Suffolk to provide clear joint leadership, more specific accountability and drive to deliver the priorities to sustainably improve outcomes for children and young people and improve the experience of the SEND system for families **Impact for children and families:** Strengthened Governance of SEND in Suffolk will mean improvements to SEND Services are prioritised, resourced and driven forward in a timely and effective way with a clear focus on the impact they have on the experience and outcomes for children and young people with SEND and their families. **This is in part linked to SEND Strategy Priority 3: Quality and Timeliness with other Actions included within Key Strategic Enablers**			

#	Action	Milestones	Owner	Evidence of Impact
1.1	Agree and implement new SEND Improvement governance arrangements	1/3/24 Initial meeting of Shadow SEND Improvement Board 30/4/24 Governance Structures fully in place	Cabinet Leads DCS ICB CEOs	• New Governance arrangements are effective in driving the Priority Action Plan and wider Strategic Action Plan so that improved outcomes and a better experience for families from the SEND process are realised, as evidenced through the Suffolk SEND and AP Data Set. • Partners understand roles and responsibilities. • Clear lines of accountability and oversight provide high support and high challenge as evidenced through the minutes of the meeting.
1.2	Finalise the new SEND Strategy 2024-28 that sets priorities for action, establish clear ownership, timescales and outcomes and can be tracked and measured	7/3/24 Draft SEND Strategy March 2024 Co-production incorporating feedback from consultation. 06/24 Final SEND Strategy published	AD Inclusion, SCC Deputy Director of Transformation SNEE ICB Director SNEE ICB Director N&W	• Partners can be held to account for progress against the strategy which will help overcome barriers and drive progress. Evidenced through the achievements of the tracked outcomes.
1.3	Review partnership arrangements to improve the effectiveness of joint working accountability and coproduction with as many families as possible.	03/24 Review	DCS ICB CEOs	• Improved joint working arrangements drive co-ordinated change and ensure more children receive the right help at the right time from the right person in a way that is joined up across the system.
1.4	Work with schools and education providers to identify representatives to join the new SEND Improvement governance arrangements	03/24 further engagement with education leaders	DCS AD Inclusion AD Education, Skills & Learning	• Joint work informed by education leaders will help ensure changes translate into better outcomes and experiences for children.
1.5	Partnership review of key performance information to develop data set informing the outcomes framework	By 30/4/24	AD Inclusion, SCC	• Partners have a shared ownership and mutual understanding of the indicators which track

#	Action	Milestones	Owner	Evidence of Impact
1.6	Develop outcome framework and measures to align with the Priority Action Plan and the new SEND Strategy and publish this *(Also shown as Action 9.2)*	By 08/24	Deputy Director of Transformation SNEE ICB Director N&W	outcomes for children and young people rather than just activity. • Leaders work more collaboratively with a collective ambition that focuses on things that are most important to and for children, young people and their families. • Stakeholders, including parents and carers will see, through clear, published performance information and Suffolk SEND and AP Data Set the progress being made by the SEND system in Suffolk. • Leaders and partners understand children, young people and families lived experience better and use this to improve services. Evidenced through surveys, feedback and 'You said, we did'.
1.7	The SEND Improvement Board uses performance information to assess and challenge progress and deliver improved outcomes for children and young people with SEND and their families.	From 5/24		
1.8	Work with education leaders to develop strategies to improve inclusion and outcomes for children with SEND including through supporting with: High quality teaching Training Suffolk Inclusion Toolkit (Valuing SEND, SENCO Inclusion Tool Kit, Analysis of Additional Needs Tool) Ordinarily Available Provision Delivering Better Value	See Strategic Action Plan for further detail of the progress of each of these initiatives	AD Inclusion AD Education, Skills and Learning	• Improved progress and attainment for young people with SEND measured by national indicators and direct feedback and tracking of pupil progress. • Reduction in the number of children with SEND excluded. • Survey results indicate that parental satisfaction increases regarding schools' ability to meet need.
1.9	Within SCC, taking forward through the Council's budget approval route, additional funding requests of £4.4m for 2024/25 and £3.4m in 2025/26 and 2026/27 to increase	15/2/24 Full Council Agreement to the overall budget 27/2/24 Cabinet agreement to the detail	DCS Cabinet Member for Education & SEND	• Resources are in place to improve the quality and timeliness of EHCPs and Annual Reviews and the supporting processes. Additional resourcing will mean: ○ Decisions on EHCNA in 6 weeks remain at

#	Action	Milestones	Owner	Evidence of Impact
	capacity within SCC statutory SEND Service.	of the additional investment deployment for SEND services		99% ○ Number of draft plans issued by 16 weeks increases. ○ Number of final plans issued by 20 weeks increases. ○ Average number of weeks to finalise EHCPs decreases. ○ Increase in the number of Annual Reviews held within time. ○ QA processes indicate quality is good for new plans and updated plans following Annual Reviews.
1.10	Recruitment, Induction and Training of the planned 46 new practitioners supporting SCC Inclusion Services takes place. Maintenance training ongoing for all staff in Family Services *(Also shown as Action 6.1)*	03/24 Recruitment activity commences following Cabinet agreement to the detail of the additional investment deployment for SEND services. 09/24 Final cohort (those that may come from schools' backgrounds) of additional agreed staffing fully in place. 12/24 Induction Training complete for final cohort	AD Inclusion supported by Head of SEND Family Services, SCC and SEND Programme Manager	• Communication and compliance are improved for the statutory processes evidenced by a reduction in complaints on the theme of communication.
2.0	**Objective:** Strengthen SEND quality assurance approaches to provide the information leaders require to: i) identify what is working well so this can be embedded and built on. ii) identify and effectively address what is not working well.			

#	Action	Milestones	Owner	Evidence of Impact
	Impact for children and families: Strengthened QA approaches will ensure EHC plans, reviews and transitions are of consistently good quality and make purposeful progress address towards meeting education, health and care needs. **Benchmark Data** Feedback from parents/carers: to what extent did the final EHC plan largely or fully take account of your views. *Metric ID: SCC data. Survey following EHC Final Plans* Academic Year 22-23 75% Average Score from QA Audit of New Final EHC Plans *Metric ID: SCC data QA Audit Cycle Reports* Calendar Year 2022 17.3 out of 20 Calendar Year 2023 16.7 out of 20 **This is directly linked to SEND Strategy Priority 3: Quality and Timeliness**			
2.1	Review and strengthen the multi-agency partnership SEND QA and Performance arrangements and Board with a workplan of: • collaborative audits of children's files. • thematic audits. • practitioner workshops. • peer review. • learning from national best practice. • 'Close the loop' processes follow up to ensure learning is embedded.	Strengthened Board, TOR and Forward Plan by 1/5/24	Head of Programmes, CYP	• Good practice is identified to build on. Gaps in performance and development needs are identified and addressed so that the quality of practice improves. • Collaborative Case Audits and Thematic audits demonstrate continuous and sustained improvement in the quality-of-service delivery (How much did we do? How well did we do it? What difference have we made?)
2.2	Continue/further develop the parent/carer feedback survey after issuing the first draft EHCP.	On-going, feedback reviewed at QA & Performance Board	Progress & Quality Assurance Manager SCC	• Feedback is received for at least 20% of EHCPs issued and learning is used by the SEND QA & Performance Board to improve practice through staff training, guidance and evidence of change through feedback.

#	Action	Milestones	Owner	Evidence of Impact
				• Increase % parent/carers reporting the EHC Plan Largely or Fully took account of their views. • Increase in the % of parent/carers finding contact helpful
2.3	Develop and implement audit tools which evidence practice and impact for children and families using the Outcomes Framework building on the case audit tool developed to support the Area SEND Inspection	03/24 Case Audit tool refined and agreed. 04/24 Case Audit tool implemented. From 04/24 Additional tools developed to support wider auditing	Progress & Quality Assurance Manager SCC	• Audit tools provide an accurate assessment of good practice and areas for improvement which in turn inform system-wide change
2.4	Continue the audit cycles for new EHCPs.	On-going, feedback reviewed at QA & Performance Board	Progress & Quality Assurance Manager SCC	• Multi-disciplinary collaborative (involving both the practitioners and the parent/carer and young person voice) case audits of 40 new EHCPs are undertaken each term which evidence and inform continuous practice improvement and consistency. • Increase in quality evidenced through increasing the Audit score of new Final EHC Plans • Audits evidence the voices and ambition of children and young people in shaping their plans.
2.5	Establish a collaborative audit process to regularly review a sample of children's case files incorporating multi-agency, young person and parent/carer views	In place from 1/6/24	Progress & Quality Assurance Manager SCC	• Multi-disciplinary collaborative case audits of 20 EHCPs following the Annual Review are undertaken termly which inform practice improvement and consistency. • Audits evidence the voices and ambition of children and young people and recognise their progress. • Audit findings reviewed and actioned at SEND QA & Performance Board resulting in improvement in SEND services.

#	Action	Milestones	Owner	Evidence of Impact
2.6	Demonstrate progress towards outcomes for children by collating progress against EHCP outcomes as schools progressively adopt electronic Annual Reviews recording that will feed into the Liquid Logic Case Management system	By 30/4/24 Revised Annual Review Form launched to schools with more defined outcome progress scaling. 1/5/24 Introduce new recording format to schools and start recording outcomes on Liquid Logic when AR received. 1/9/24 Pilot School adopts electronic Annual Review process. Subject to a Liquid Logic development (date as yet unknown) to allow multiple SENCOs to submit Annual Reviews, phased transition of all schools to adopting electronic Annual Reviews	Programme Manager SEND, SCC	• Progress against EHC plan outcomes can be collated and aggregated to provide evidence of children's progress towards outcomes in their EHCPs. • Electronic annual review and use of the on-line portal recording enables improved communication around Annual Reviews for schools and families.
2.7	LAP to: • evaluate existing mechanisms for CYP and families feedback across education,	From 1/7/24, On-going, feedback reviewed at SEND QA & Performance Board	AD Inclusion, SCC AD CYP SNEE ICB	• A common set of simple to collect measures is embedded throughout the EHC process and used at an aggregate and individual child level to demonstrate what is working and where practice

#	Action	Milestones	Owner	Evidence of Impact
	health and social care. • agree a simple process to collate feedback from families throughout their SEND journey to provide, at an aggregate level, a measure of whether things are improving and as a basis for discussion and review at an individual child level.			needs to improve.
3.0	**Objective:** Agree and embed clear expectations for co-ordinated multi-agency working with children and young people across the Area SEND Partnership **Impact for children and families:** Families will benefit from a working with a group of professionals from different disciplines that work in a co-ordinated way to meet the needs, and achieve the outcomes, in a child or young person's EHC plan. **This is directly linked to SEND Strategy Priority 2: Right Support, Right Time**			
3.1	Review and adopt best practice around having a lead co-ordinating practitioner for each individual child or young person with complex situations adopting best practice using a Team Around the Child approach.	Embed this in a phased way from 1/9/24	SEND Programme Manager to co-ordinate	• Lead co-ordinating practitioners are progressively identified for children with complex situations. This supports families with the join-up of services.
3.2	Ensure high quality partner agency contributions to new and amended EHCPs	On-going	AD Inclusion supported by DCO oversight DCSO oversight	• Improved and consistent system for DCO sign-off of draft plans with content in Section G increasing compliance and quality of EHCPs. • System for DCSO to check plans with content in Sections H improving quality of EHCPs. • Advice audits evidence improved quality and the voice of the child or young person in advice. • Audits evidence NHS and Social Care contributions are present where appropriate in Annual Reviews

#	Action	Milestones	Owner	Evidence of Impact
				• All those involved with the child or young person will know who is involved and know where to go to access more help if needed. • EHCPs will have taken account of and reflect the range of advice received leading to improved plan quality evidenced through audits.
3.3	Include specific analysis of multi-disciplinary working in collaborative case audits	From 04/24 in line with the reviewed case audit tool. On-going, feedback reviewed at SEND QA & Performance Board	Progress & Quality Assurance Manager SCC	• Case audits evidence appropriate join up across services and timely involvement/attendance at key meetings. • Case audits inform systemic improvements in multi-disciplinary working
3.4	Set up a programme and hold multi-agency training and workshops to reinforce joined up working and quality advice	From 06/24	Designated Officers (DCOs and DScO)	• Attendance and feedback following training. • Evidence of impact of the training seen in audits of children's cases
4.0	**Objective:** Ensure consistently good processes supporting transition in Education, Health and Care, including from Early Years to Primary, Primary to Secondary and Secondary to Further Education and clarity among partners about their responsibilities. **Impact for children and families:** Families and education practitioners will be better informed about the needs of children and their progress towards outcomes in the previous phase of education so that they can take this into account in their planning and delivery. **This is directly linked to SEND Strategy Priority 4: Preparing for Change** **Benchmark Data** Phase Transfers (pre Yr11/Post 16) 15 February 2024 99% (93% in 2023) Phase Transfers (Post 16) meeting 31 March 2023 54% (32% in 2022)			
4.1	Responsibilities of each partner in respect of transitions will be co-produced,	April-September 2024 Consultation	AD Education, Skills & Learning	• Responsibilities are clear across partners. • Pathways are embedded within all agencies

#	Action	Milestones	Owner	Evidence of Impact
	documented and embedded to support children and young people in preparing for change across stages of education, health and care.	31/10/24 Revised transition documentation in place	Director for CYP, Maternity & Safeguarding N&W ICB AD CYP SNEE	recognising the support needed for key changes in a child or young person's life. • Annual Reviews incorporate Moving into Adulthood plans from year 9 onwards. • Audits evidence Transition responsibilities are fulfilled
4.2	Continued improvement in meeting Phase Transfer deadlines are sustained to enable children, young people and families the time to prepare.	30/6/24	Head of SEND Family Services	• Sustain the good performance in meeting the 15 February (pre-16) Phase Transfer deadline. • Improve performance meeting the 31 March (post 16) Phase Transfer deadline. • Increase in the % of Phase Transfers with named setting.
4.3	Maintain summer and autumn term visits to every school to support transitions to primary and secondary	In place, on-going	Inclusion Heads of Service	• Audits of transitions are positive from perspective of families, children and settings. • Indicators show successful placements such as increased attendance, reduced breakdowns in placements, reduced suspensions
	Actions included further below are also directly relevant in achieving this objective: • Annual Review improvements			
5.0	**Objective:** Develop Preparation for Adulthood pathways that support young people with SEND to maximise continued engagement in education, training and employment and support independent living skills **Impact for children and families:** Young people are better prepared for post-16 transitions including volunteering, living independently, optimising health and being visible and valued individuals in their local communities. **This is directly linked to SEND Strategy Priority 4: Preparing for Change**			

#	Action	Milestones	Owner	Evidence of Impact
5.1	Undertake a Preparing for Adulthood (PFA) strategic review to understand how the SEND system can best support in preparing young people for post-16 transitions and develop a plan	30/9/24 Conclude PFA Strategic Review 12/24 Specific plan in place	Preparing for Adulthood Lead	• The analysis of what is working well and what needs to improve informs strategic plans. • Preparing for Adulthood Training informed by the review is rolled out supporting education, health and care providers and practitioners. • Transitions Guide continues to be maintained and extended informed by the review as a valued source of information for young people and families. • More young people with SEND are in sustained education, training or employment
5.3	Work with post-16 providers, young people and families to review the sufficiency (provision type, range, geography) of post 16 education and training provision to meet needs and attract young people to remain in education, training or to achieve employment	12/24 Conclude Sufficiency Review	Preparing for Adulthood Lead,	• Findings from the sufficiency review and plan result in a better range of provision meaning more young people with SEND engage in education, training or employment post 16.

Priority Action 2 Local area partnership leaders should cooperate to take urgent action to improve the timeliness and quality of the statutory EHC plan processes, EHC plan needs assessments, and EHC plans and annual reviews, particularly using annual reviews to amend the quality of existing EHC plans where required. This should ensure that plans meaningfully capture the views and aspirations of children and young people with SEND and their families, so that they get the right support at the right time. **This is directly linked to SEND Strategy Priority 3: Quality and Timeliness**	**Partnership Leadership** Assistant Director Inclusion, SCC ICB Director SNEE ICB Director N&W

#	Action / Deliverable	Milestones	Owner	Evidence of Impact
6.0	**Objective:** Sufficient, well-trained resources are in place so that the EHC Plan process functions well **Impact for children and families:** A well-functioning EHC Plan process helps ensure children and young people get the right support at the right time.			
6.1	Recruitment, Induction and Training of the planned 46 new practitioners supporting SCC Inclusion Services takes place. Maintenance training ongoing for all staff in Family Services *(Also shown as Action 1.1)*	03/24 Recruitment activity commences following Cabinet agreement to the detail of the additional investment deployment for SEND services. 09/24 Final cohort (those that may come from schools' backgrounds) of additional agreed staffing fully in place. 12/24 Induction Training complete for final cohort	Head of SEND Family Services, SCC	Additional resourcing will mean: • Number of EHC plan drafts issued at 16 weeks increases. • Number of final EHC plans issued by 20 weeks increases by September 2025 to National average. • Average number of weeks to finalise EHC plans decreases. • Maximum time to issue EHC plans decreases. • Annual Reviews are held within time. • QA processes indicate quality is good for new plans and updated plans following Annual Reviews.
7.0	**Objective:** EHCPs are issued within 20 weeks, are of good quality and incorporate the views and aspirations of children, young people and families **Impact for children and families:** Timely, good quality EHCPs help ensure children and young people get the right support at the right time. **Benchmark Data** % of new EHC Plans issued within 20 weeks, excl. exceptions *Metric ID: 2214, Department for Education* Cal Yr 2022 Suffolk **22.8%** England 49.1% Next Publication May 2024 SCC Data for month of January 2024 (not annual) • 31% of draft Plans issued within 16 wks.			

#	Action / Deliverable	Milestones	Owner	Evidence of Impact
	• 21% of Final plans issued within 20 wks. • Average time to issue 33 weeks, 6 days. **Target** In line with national performance for the issuing of final EHCPs within 20 weeks by September 2025. Milestone targets to be set within SEND and AP Data Set.			
7.1	Rigorously track the progress, including through the weekly strategy meeting and weekly supervision, towards finalisation of EHC Plans making use of the Business Intelligence dashboards designed for this.	In place, on-going	Head of SEND Family Services, SCC	• Audits evidence delays in EHCPs are minimised and improved timeliness. Leads/ Area Managers are escalating any known risks to timeliness and taking swift actions to address
7.2	Weekly meeting with Deputy Principal EP and Deputy Head of SEND Services to ensure processes and systems are running smoothly and reduce risk of any delays to allocation of an Educational Psychologist	In place, on-going	Deputy Principal EP Deputy Head of SEND Family Services	• Improved timeliness of EHCPs within 20 weeks • Reduced average time to issue an EHCP
7.3	Use of a third-party contractor providing plan writing services and additional hours to support writing of new EHCPs	In place, on-going	Head of SEND Family Services, SCC	• Improved timeliness of EHCPs within 20 weeks. • Reduced average time to issue an EHCP
7.4	Regular Trajectory Forecasting takes place to review progress against EHC timeliness targets	From 1/3/24 repeated quarterly	CYP Intelligence Hub - Education Lead, SCC	• Trajectory forecasting informs effective deployment of resources
7.5	Continue to improve the information about support available to families while their children are going through an EHC needs assessment.	On-going	SEND Programme Manager	• Families are supported to access information and wider community support as they need it.
8.0	**Objective:** Annual reviews are held within time and are of good quality including incorporating the views and aspirations of children, young people and families **Impact for children and families:** Timely Annual Reviews will help ensure appropriate on-going support is in place for children and young people with SEND.			

#	Action / Deliverable	Milestones	Owner	Evidence of Impact
	Benchmark Data % Annual Reviews in time/not yet due *Metric ID: SCC High Needs Assurance Dashboard* At 1 September 2022 Suffolk 52% At 1 September 2023 Suffolk 52%January 2024 61% **Target** Initial target of 75% of Annual Reviews are held in time by March 2025 Further targets to be set to progressively to achieve 100%			
8.1	Make permanent the Annual Review Triage Team	In place, on-going	Head of SEND Family Services, SCC	• Annual Reviews can be completed, and parents notified at the first point of contact (maintain or cease), or allocated where needed, so that plans can be amended, and the Annual Review completed.
8.2	Continuation of a third-party contractor. Contract to support Annual Review amendments	In place, on-going	Head of SEND Family Services, SCC	• Improved timeliness of Annual Reviews
8.3	Create a new permanent Annual Review team to address the new Annual Reviews	Immediately following Full Council agreement to the Recovery Ask	Head of SEND Family Services, SCC	• Improved timeliness of Annual Reviews
8.4	Create a Temporary Annual Review Team to address the backlog	Immediately following Full Council agreement to the Recovery Ask	Head of SEND Family Services, SCC	• Improved timeliness of Annual Reviews
8.5	Rigorously track the progress towards timely, good quality Annual Reviews, including through weekly strategy meetings and weekly supervision, making use of the Business Intelligence dashboards designed for this.	In place, on-going	Head of SEND Family Services, SCC	• Improved timeliness of Annual Reviews • Audits evidence Annual Reviews being carried out are of good quality

#	Action / Deliverable	Milestones	Owner	Evidence of Impact
8.6	Ensure Annual Reviews are held as a priority (brought forward as appropriate) for those without an education setting using Inclusion SENDCo resource	Underway, on-going	Head of SEND Family Services, SCC	• Improved timeliness of Annual Reviews
8.7	Regular Trajectory Forecasting takes place to review progress against Annual Reviews held within time	From 03/24 repeated quarterly	CYP Intelligence Hub - Education Lead, SCC	• Timeliness of Annual Reviews continues to improve

Areas for Improvement

#	Action / Deliverable	Milestones	Owner	Evidence of impact
9.0	**Objective:** Leaders across the partnership should use performance data and information effectively to inform their evaluation, sufficiency planning and joint commissioning of SEND services. **Impact for children and families:** Improved sufficiency planning and a data set of outcome, experience and performance indicators helps direct best use of available resources. **This is in part linked to SEND Strategy Priority 2: Right Support, Right Time with other Actions included within Key Strategic Enablers**			
9.1	A co-produced JSNA and Sufficiency Plan is jointly published by the partnership that dynamically informs best use of available resources	12/24 JSNA produced. 3/25 Sufficiency Plan	AD Inclusion, SCC Deputy Director of Transformation SNEE ICB Director N&W	• There is alignment of plans that means joined-up services for families. • Families report fewer gaps in services
9.2	Develop outcome framework and measures to align with the Priority Action Plan and the new SEND Strategy *(Also shown as Action 1.7)*	08/24	AD Inclusion, SCC Deputy Director of Transformation SNEE ICB Director N&W	• Partners have a shared ownership and mutual understanding of the indicators which track outcomes for children and young people rather than just activity. • Leaders work more collaboratively with a collective ambition that focuses on things that are most important to and for children, young people and their families. • Stakeholders, including parents and carers will see, through clear, published performance information, the progress being made by the SEND system in Suffolk.
10.0	**Objective:** The Local Area SEND Partnership engages effectively and widely with children and young people and their families, developing effective communications systems, and acting to address parents' and carers' concerns at an early stage, to reduce dissatisfaction and reduce the need for parents and carers to have to follow formal routes.			

#	Action / Deliverable	Milestones	Owner	Evidence of impact
	Impact for children and families: Concerns are addressed at an early stage, avoiding the need for escalation. The strategic role of Suffolk Parent Carer Forum is strengthened. Arrangements are put in place to engage effectively with other local parent/carer representative groups. Benchmark Data SEND Appeals Rate *Metric ID: 10600, Ministry of Justice, Tribunals statistics* Academic Year 2021-22 Suffolk **1.68%** England 2.4% Next publication June 2024 **This is directly linked to SEND Strategy Priority 1: Communication & Information**			
10.1	Improve telephone and email-based communication arrangements so that families receive a better service; including the publishing of a partnership-wide communications charter, with an agreed response times to phone calls, letters and emails and routinely seek feedback. *'Did we treat you well, Did we help you with your problem/ query?'*	By 1/3/24 8x8 call-handling I place By 1/5/24 more robust staffing model in place By 31/12/24 publish Charter	SEND Programme Manager, SCC	• 10% reduction in complaints on the theme of Communication • Number of new and returning visitors to the Local Offer website pages • Positive feedback about the Local Offer Helpline • Improved response to feedback questions
10.2	Review and improve the summaries for each service on the Local offer website, so that families know what support is on offer and how to access it across the public sector and wider community services	31/8/24 publish initial pages within the Local Offer	SEND Programme Manager	• Specific feedback on webpages
10.3	Further develop the resources on websites, newsletters and social media to make it easier for families to find information	On-going incremental improvements	SEND Programme Manager	• Positive feedback about communications

#	Action / Deliverable	Milestones	Owner	Evidence of impact
10.4	Maintain and develop opportunities for families to share their experiences and use this to inform improvements. Maintain feedback following initial EHC plans. Maintain Time to Listen Sessions for parents/carers to talk to Senior Leads directly. Establish a regular forum for effective engagement of the range of local parent/carer representative groups in the SEND Programme	In place, on-going In place, on-going	Head of SEND Family Services AD Inclusion, SCC SEND Programme Manager	• Feedback shows improvements in: ○ Respondents finding Family Services Coordinators helpful. ○ Respondents feeling that the final EHC Plan largely or fully took account of their views. ○ Feedback informs continuous improvement. • Systemic improvements identified from family experience and feedback are embedded as system changes
10.5	Improve uptake and use of the online Education Health and Care (EHC) portal for families and practitioners so that families are kept informed about their child's assessment and plan	On-going	SEND Programme Manager	• Positive parents/carer feedback about the Liquid Logic Parent Portal especially around communication.
	Actions included further above are also directly relevant in achieving this objective: • Additional, trained resource from the Recovery Ask supporting more effective co-production with families. • LAP evaluation of existing mechanisms for CYP and family feedback			
11.0	**Objective:** Leaders across the local area partnership should ensure that providers of services for children with social and emotional well-being, mental health and neurodiverse conditions work jointly to meet the needs of, and improve outcomes in these areas, for children with SEND. **Impact for children and families:** Children and young people get the right help at the right time in the right way to meet their emotional wellbeing and neurodiverse needs. **This is in directly linked to SEND Strategy Priority 2: Right Support, Right Time**			

#	Action / Deliverable	Milestones	Owner	Evidence of impact
11.1	**Neurodiversity** • Promote the newly developed Autism & ADHD Resource Pack and hold follow up workshops for parents and practitioners	01/24	CYP Transformation Lead, SNEE ICB	• Promotion of resource pack, monitor access and feedback through local offer following publication in January 24 • Increased online workshops available, attendance data and feedback collected to review effectiveness. • Parent & practitioners report increased confidence in supporting neurodivergent children.
11.2	**Neurodiversity** Introduce additional resource to reduce long waits for access to diagnostic assessments for neurodiversity. • Agree business cases detailing approach to reducing waiting times for autism and ADHD assessments. • Agree trajectories with both West Suffolk Foundation Trust (WSFT) and Norfolk and Suffolk Foundation Trust (NSFT) around reduction in waiting times for autism assessments. • Commission additional capacity from the market for autism assessments. • Commence recruitment of additional ADHD staffing within NSFT • Monthly meetings to monitor progress against waiting time trajectories. • Develop long term revised model for ADHD and Autism assessment with	02/24 03/24 05/24 04/24 04/24 04/24	CYP Transformation Lead, SNEE ICB	• Additional capacity in place for Autism and ADHD assessments from June 2024 onwards • Reduction each month in current waiting list for Autism and ADHD assessments from June 2024 onwards • Longer term, improvements in wait times for assessment

#	Action / Deliverable	Milestones	Owner	Evidence of impact
	NSFT and WSFT			
11.3	**Neurodiversity** Review impact of Voluntary, Community and Social Enterprise (VCSE) contracts providing support to CYP and their families waiting for a neurodiversity assessment. Take learning and family feedback to redesign delivery prior to re-procurement. • Review existing service provision. • Develop new co-produced service specifications. • Commence procurement programme. • Award contracts. • New service start	04 – 06/24 06 – 08/24 09/24 04/25 08/25	CYP Transformation Lead, SNEE ICB	• Revised services in place to support children and young people while waiting for NDD assessments by August 2025 • Offer made to all children and young people waiting for a diagnosis for support. • 75% of families who are receiving support whilst waiting report an increase in confidence.
11.4	**Neurodiversity** • Strengthen work across the partnership to further develop whole school approaches to supporting neurodiversity and to further develop support for children not in school. • Formal evaluation to be completed by August 2025	31/12/2024 31/08/2025	CYP Transformation N&W ICB	• Schools feel better able to support children; evidenced by feedback from schools, young people and families including through surveys, direct reporting, comments and complaints. • Improvement in school attendance of neurodiverse children by August 2025

#	Action / Deliverable	Milestones	Owner	Evidence of impact
				• Formal evaluation of pilot informs health and education partners on what support schools need – evidenced in future service plans. • Families and professionals supporting neurodivergent children report positive change and improved outcomes.
11.5	**CYP Mental Health** Strengthening work across the partnership to further develop whole school approaches to supporting emotional wellbeing and mental health: • Delivering system workshops to further establish the iThrive Framework within Suffolk • Recovery plan agreed to manage CAMHS and YAMHS waiting times with a clear trajectory for improvement. • Develop implementation plan for new models of delivery. • Oversee the delivery of the new model of care deliver through the Suffolk Mental Health Collaborative • Psychology in Schools Team (Senior Education Psychologist Mental Health / Whole School Approaches - with a current focus on Emotional Based School Avoidance) further develop approach to support for the Wellbeing	01 – 04/24 04/24 07/24 08/24 onwards 09/24	Deputy Director CYP, SNEE ICB and SCC	• Complete workshops around new iTHRIVE models of delivery by April 24 • Confirmed recovery plan for CAMHS and YAMHS waiting times with demonstrable improvement by March 25 compared to March 24

#	Action / Deliverable	Milestones	Owner	Evidence of impact
	in Education Mental Health Network, training and resources. An example of current joint working across NSFT, Psychology in Schools and the SCC Psychology & Therapeutic Services) • Psychology in schools – review • Embed Mental Health in Schools Teams and utilise learning from programme for future waves	09/24		
11.6	**CYP Mental Health Crisis** • Review and extend the peripatetic offer wrap around support for children and young people in crisis. • Carry out review of the currently commissioned Coordinated Help and Risk Intervention Service (CHRIS) service with any recommendations feeding into the business case to be developed. • Develop a business case/proposal to meet any gaps in the CYP crisis pathway. • Update to the system wide crisis protocol following stocktake. • Commissioning of any gaps identified through the stocktake. • Strengthening support for children and young people attending A+E in crisis by the continuation of acute mental health practitioners post review	05/24 05/24 05/24 06/24 07/24 04/24	CYP Transformation Lead, SNEE ICB	Reduction in CAMHS Tier 4 referrals March 2025 versus March 2024 Increase in number of children and young people supported by CYP crisis support service March 2025 versus March 2024 Evaluate impact on families of CHRIS and peripatetic offer. Families of children with poor mental health report positive change and improved outcomes

#	Action / Deliverable	Milestones	Owner	Evidence of impact
11.7	**CYP Mental Health** • Increase access to support for mental health needs through the Norfolk and Waveney Integrated Front Door (IFD) • Further develop the approach to measuring impact for CYP and families	31/12/2024	CYP Transformation N&W ICB	• Children and young people with poor mental health and their families report positive change and improved outcomes using PROMs data and included in routine measurement of experience. • Reduction of 5% by December 2024 (against December 2023 numbers) in re-referrals – demonstrating needs increasingly met at first contact. • Reduction of 10% in number of CYP rejected by provider following request for support by December 2024 (against December 2023 numbers) • Increase in number of CYP accessing mental health support – meeting or exceeding national trajectory by April 2025 • Increase of 5% in number of self-referrals by December 2024 (against December 2023 numbers) • All requests for support received through IFD by August 2025 • Reduction in waiting list size of at least 10% by August 2025 and trajectory in place to demonstrate continued reduction. • Reduction in recorded absence from school due to a mental health need by July 2025 (against July 2024 numbers).
11.8	**CYP Mental Health**	12/2024	N&W ICB CYPMH	• 50 individuals trained to deliver Single Session Interventions • Implement Single Session Interventions practice.

#	Action / Deliverable	Milestones	Owner	Evidence of impact
	• Introduce Single session interventions for mental health to improve flow through the system			• Greater than 100 CYP effectively supported and discharged following through single session practice by July 2025 • Greater than 50% of CYP supported through single session intervention report needs met. • Fewer than 20% of CYP supported by single session intervention request further support within six months of intervention. • 10% or greater reduction in requests for support tor getting more help and getting risk support.
11.9	**CYP Eating Disorders** • Implementation of the new ARFID pathways following agreed business case • Develop and expand Intensive Day Service as an alternative to admission and admission avoidance to CYP across Norfolk and Suffolk	04/24 onwards 31/12/2024	N&W ICB CYPMH	• Families of children with ARFID report positive change and improved outcomes. • Reduction in CYP admitted for medical stabilisation. • Reduction in number of CYP admitted to an inpatient unit with an eating disorder by December 2024 (against December 2023 numbers) • Reduction in length of stay for CYP admitted to an inpatient unit with an eating disorder by December 2024 (against December 2023 numbers)
11.10	**CYP Mental Health** Key workers / care navigators / Dynamic Support Register (DSR) • Early identification of CYP with escalating / unmet needs to DSR and allocation to key worker / navigator service.	On-going	Quality Lead SNEE	• RAG ratings are dynamic and evidence of change to show reduction of risk. • Monitoring of caseload demonstrates that appropriate CYP are identified on the DSR.

#	Action / Deliverable	Milestones	Owner	Evidence of impact
	• Care Education and Treatment Reviews, reviews and recommendations completed promptly and plans to meet need in place for CYP. • CYP at risk of needing the DSR are identified earlier. • Bimonthly reporting of DSR/CETR policy implementation and action plan to NHSE			• CYP and families report good experience of the support evidenced by routine capture of feedback when CYP are no longer on the DSR. • Risk levels are appropriately assessed with support of CYP and families and reduction of assessed risk is evident within DSR. • Less than 10% of CYP who are 'stepped aside' from support require re-referral DSR evidences 100% completion of CETR's and that recommendations are in place in place. • Achievement of or exceeding national trajectory for CYP in the Transforming Care cohort requiring inpatient admissions by December 2025.
11.11	**CYP Mental Health** • Mobilise a two-year pilot navigator/keyworker scheme for children and young people with poor mental health at risk of admission	04/24	N&W ICB CYPMH	• MH Navigator Team Manager in post and recruitment to five MH Navigator posts complete by August 2024 • Mental health DSR in place by October 2024 and utilised to identify CYP in greatest need of access to more support and risk support. • Reduction in number of CYP presenting in crisis to acute hospitals of 10% or greater by January 2025 (against January 2024 numbers) • All children identified as at risk of admission will have a nominated mental health navigator as evidenced by tracking and on DSR. • Monthly Meetings to review MH DSR in place by August 2024 and all young people on register reviewed. • Report project plan updates to NHSE in place and demonstrating impact of model.

#	Action / Deliverable	Milestones	Owner	Evidence of impact
				• Families of children supported by navigator scheme report positive change and improved outcomes through routine collection of outcome and experience data. • Reduction in numbers of CYP reattending acute hospitals with mental health presentation of 10% or greater by January 2025 (against January 2024 numbers)
11.12	**CYP Mental Health** • Consolidate and expand the Professional Therapeutic Pathway – providing additional MH capacity within Waveney. Particular focus on supporting CYP with neurodiversity through personalised offers of support.	Launched 06/23	N&W ICB CYPMH	• Number of CYP supported through PTP to increase by 20% or more by August 2024 (against August 2023 numbers) • Number of CYP with a SEN supported routinely recorded and represent at least 20% or greater of overall PTP use. • Children and young people with poor mental health and their families report positive change and improved outcomes using PROMs data and included in routine measurement of experience. • Reduction of 5% or greater in re-referrals by January 2025 (against January 2024 numbers) – demonstrating needs met at first contact. • Reduction of 10% or greater in number of CYP rejected by provider following request for support by January 2025 (against January 2024 numbers) • Increase in number of CYP accessing mental health support – meeting or exceeding national trajectory by August 2025 • Increase of 5% or greater in number of self-referrals to IFD by January 2025 (against January 2024 numbers)

#	Action / Deliverable	Milestones	Owner	Evidence of impact
				• Reduction in waiting list size of 10% or greater by August 2025 (against August 2024 numbers) and trajectory in place to demonstrate continued reduction. • Reduction in 10% or greater of recorded absence from school due to a mental health need by July 2025 (against July 2024 numbers).
11.13	Develop and pilot a MH Toolkit to support CYP and their families waiting on the NDD assessment waiting list and identify CYP who may require more specialist mental health support and enable access to this through the Professional Therapeutic Pathway	Launch by 30/09/2024	N&W ICB CYPMH	• CYP and families report feeling supported whilst they are waiting for an assessment. • Fewer CYP present in MH crisis whilst waiting for an NDD assessment (metric to be confirmed)

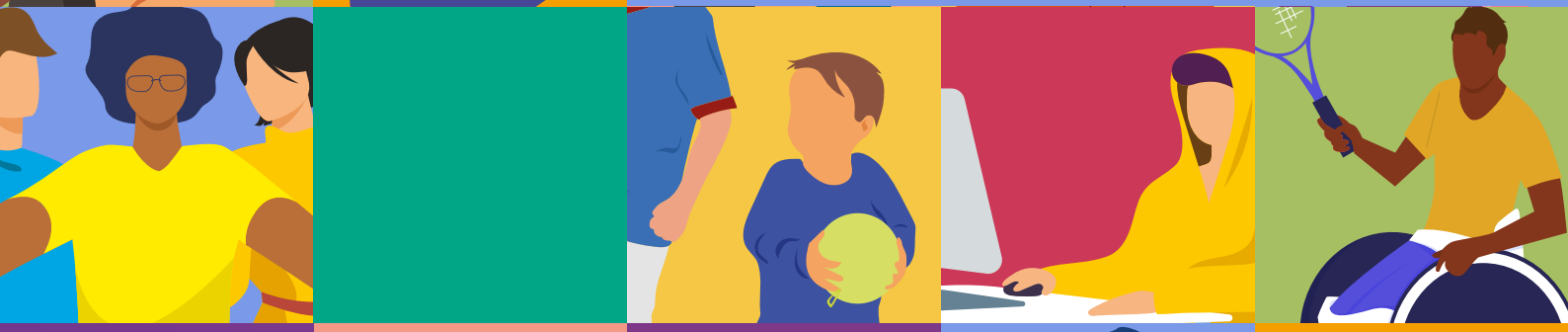
Glossary

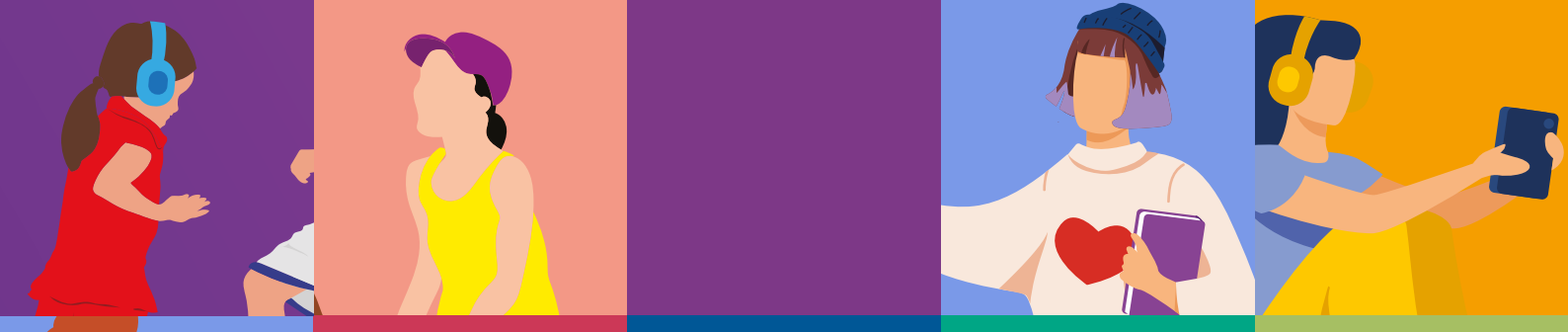
AD – Assistant Director
ADHD – attention deficit hyperactivity disorder
CYP – Children and Young People
DBV – Delivering Better Value
DCO – Designated Clinical Officer
DCS – Director of Children's Services
DfE – Department for Education
DSCO – Designated Social Care Officer
EHCNA – Education, Health and Care needs assessment
EHCP – Education Health and Care Plan
EHE – Electively Home Educated
FTE – Full Time Equivalent
ICB – Integrated Care Board
KS2 – Key Stage 2
KS4 – Key Stage 4
MLD – Moderate Learning Difficulties
N&W – Norfolk & Waveney
NEET – Not in Education, Employment or Training
NSFT – Norfolk and Suffolk Foundation Trust
ONS – Office for National Statistics
QA - Quality Assurance
RWM – Reading, Writing, Maths
SALT – Speech and Language Therapy
SCC - Suffolk County Council
SEND – Special Educational Needs and Disabilities

SENDIASS – Special Educational Needs and Disabilities Information Advice and Support Service
SES - Special Education Services
SLD – Severe Learning Difficulties
SNEE – Suffolk and North East Essex
SPCF – Suffolk Parent Carers Forum
VSEND – Valuing Special Educational Needs and Disabilities

Suffolk's SEND Strategy 2024-2029

This strategy is our plan for how services for children and young people with special educational needs and disabilities in Suffolk will be delivered





NHS Norfolk and Waveney Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board

Suffolk County Council

SPCF Suffolk Parent Carer Forum

Working towards a brighter future for Suffolk's children and young people

Contents

Kathryn Boulton
Chair of the SEND Improvement Board

Foreword

Firstly, I'd like to take the opportunity to thank our Young People's Network and Suffolk Parent Carer Forum, who work tirelessly with us, to provide their honest and valuable feedback. I'd also like to thank our partners across health, education, social care and the voluntary sector for supporting the development of this strategy.

As the new chair of the SEND Improvement Board, I am proud to present the Suffolk Strategy for Children and Young People with Special Educational Needs and Disabilities (SEND).

Drafted by colleagues across the Suffolk Local Area Partnership, this ambitious new strategy sets out how we will work together to build strong relationships, create opportunities and remove barriers to enable our children and young people to feel included, fulfilled and supported to live their best lives.

This updated strategy will drive a significant programme of work co-produced and overseen by the Local Area Partnership, which includes Suffolk County Council and NHS Suffolk and North-East Essex Integrated Care Board and NHS Norfolk and Waveney Integrated Care Board and Suffolk Parent Carer Forum.

Put very simply - SEND is everyone's business. Only by working together will we achieve the change that is needed. And by together, I mean professionals working with children and young people and their families to deliver the services that will best meet everyone's needs. This approach is critical to the success of the SEND strategy. We will also continue to work closely with our schools, colleges, and early years settings to provide children and young people with the best support possible, ensuring that they receive a good quality level of education, whilst also feeling included in their local community.

I recognise that partners haven't always got it right and that not all children and young people, and their families, have received the service they need. Going forward, our actions must speak louder than words with a commitment to ensuring that positive change is felt by everyone and must build on what works well for children, young people and families.

In order to achieve our SEND Strategy, we must do the following:

- **Increase staff resources, particularly within SEND Family Services, to improve communication and co-production with families and meet statutory timescales for the production of EHC plans, Annual Reviews and Phase**
- **Further develop a regular forum for effective engagement of the range of local parent/carer representatives and groups in the SEND Programme.**
- **Further development of the Liquid Logic case management system to support SEND processes and provide direct access by parents/carers to EHCPs and Annual Reviews.**
- **Finalise and publish an Outcomes Framework for children and young people Ensure that this SEND Strategy is not a static document. It must be dynamicso we can adapt and step-up when provision demands it.**

Our services are operating in the context of increasing local need and significant challenge, and a changing national policy environment. We are ready to meet these challenges.

Thank you.

Our Vision

Together we will understand and support children and young people so that they feel included, supported, and fulfilled to live their best lives.

Coproduced with

Young Person's Network

SPCF
Suffolk Parent Carer Forum
Working towards a brighter future for Suffolk's children and young people

Special Educational Needs and Disability Information, Advice & Support Service
sendiass

NHS
Norfolk and Waveney
Integrated Care Board

NHS
Suffolk and North East Essex
Integrated Care Board

Suffolk County Council

What is it like to be a child or young person with additional needs in Suffolk?

"I feel nervous when I go to assemblies, because I am different to everyone else, I don't want to stand out in a crowd or in front of my friends or peers"

Young person

"You can't hide yourself, you have to be yourself"

Young person

"An unknown story"

Young person

"Mental health is still an issue when you have a disability or a SEND need"

SENDIASS CYP 2023 Survey

"…listening to me and giving me the right support is important"

SENDIASS CYP 2023 Survey

"It is a hassle to get some people to talk to you"

Young person

What is important to children and young people in Suffolk?

- Learning to drive and using public transport
- Social clubs/ safe places to socialise and do activities
- Relationships
- Spending time with family and friends and making friends
- Where they live
- More equality and less stigma
- Bringing visibility to invisible disabilities
- Being outside/ exercise
- Getting a job and help with money
- Responsibility
- Taking part in discussions and sharing their views

"Saving money"

"Making my own decisions"

"Going to town"

"My college life"

“Living in Suffolk as a young person with undiagnosed additional needs is extremely hard…My lack of diagnosis, the lack of awareness and support in my community, and my awareness of my needs make me feel like less of an autistic person, because so many people stereotype autistic people, and I don’t fit their stereotype.” Young person

Ebony, Ben, Millie, Archie, Holly, Ben and Emily letting us know what getting it right would feel like to them.

“We need time to process information” Young person, shared with

“I’m scared of going to high school, I’m scared about being bullied” Young person

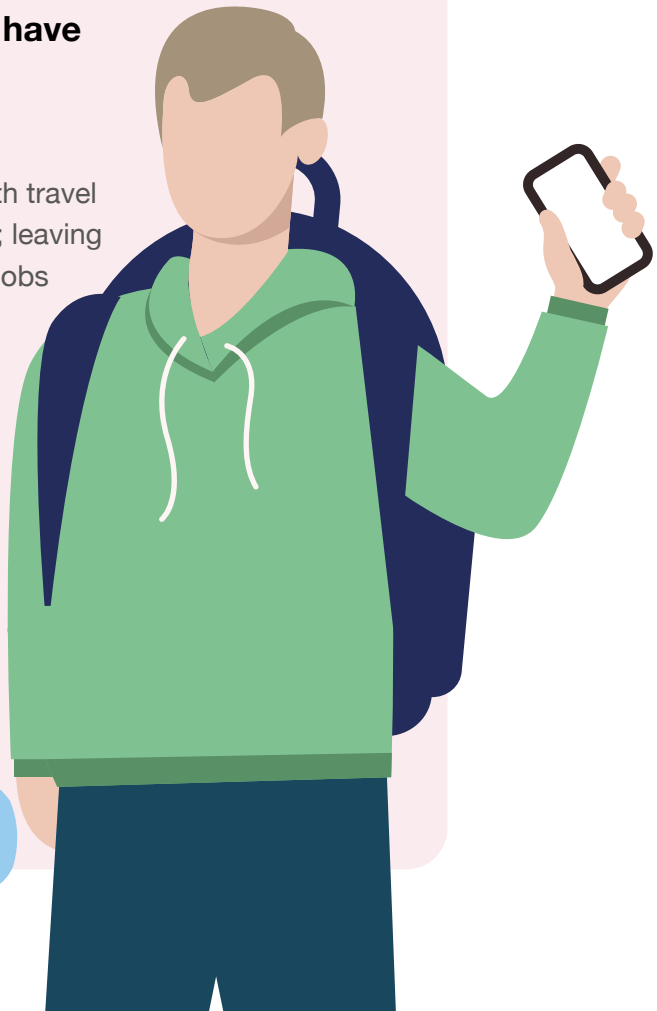
“Unique” Young person

“Ok if you know the right paths to take as you move forward in life” Young person

“There are teachers that will get you (support) if you need extra help” Young person

To achieve their ideal future, young people have told us they need support with:

- Money and budgeting
- Help to get to new places on their own, and help with travel
- More information around what they would like to do; leaving school/ college, volunteering, work experience and jobs
- Mental health, anxiety and self confidence
- Physical health
- Finding information
- Gaining timely diagnoses. When this doesn’t happen, it can cause distress to young people and their families
- Accessibility
- College; learning spaces, flexible choices and student support



“Make neurodivergent people feel as good as everyone else”

“More independence”

What it is like to be Parents and Carers of a child with SEND in Suffolk?

"Being a special educational needs and disability (SEND) family in Suffolk can be like an unplanned journey without a map or a compass. What makes the difference is the people we meet along the way, those that build quality bridges and help us across the difficult streams rather than letting us get swept away in the current.

Being a parent carer can be lonely and isolating. Many have lost friends, relationships, and employment to give their all to their caring responsibilities. Too many parent carers feel judged, trapped, unsupported, gaslit and hopeless. SEND parents are the best friends a parent carer can make. We hold each other's hands through the hard times and celebrate joys that only other SEND parents understand. Joys such as your child eating a new food, being included, wearing a different item of clothing or a successful school run. Things that are everyday occurrences to other parents. The joy of finding a professional who understands and wants to help is like winning the jackpot. These people exist and we need more of them. We desperately hope that their great example is seen by others and those wonderful qualities bring about culture change.

We all want our children to have an education but too many find barriers make it difficult such as lack of support, missed provision, discrimination, no school place, or the wrong school place. We then feel we are labelled as bad parents when our child can't attend. We really worry about our child's education but more than that, we worry about their mental health. Our children and young people should be achieving their best possible outcomes educationally and otherwise.

We worry about our child every day and every night. We are told our child should be more resilient or gets labelled as naughty but what they really need is the right support at the right time so that they can thrive. Accessing mental health services is slow and very often not enough. We sometimes hear of children and young people getting excellent care and we want that too. We are really happy for those parents and carers, but we don't want to have to fight for it, we need that energy for the person we care for. Too often it feels like no one wants to help.

When we reach the point of applying for an education health and care plan for our child after a long period of trying to get support through other means we feel the chances of success will depend on how hard we pursue it. We enter a legal world we have never experienced before. Mediation, appeals, tribunals and more. We find ourselves seeking support from SENDIASS and in some cases, legal advice. When we get an education health and care plan many of us find it's incorrect in some way and find it difficult to get it put right. Getting a school to follow a plan is often the next challenge we face before the annual review comes around and we are met with missed time scales or even completely missed reviews. There should be no missed opportunities and the importance of reviews and transitions should never be underestimated. Some people call education health and care plans a golden ticket. To many they are a necessary evil. It exhausts us. Too often this process leaves us feeling unheard, traumatised, and frustrated. Getting the right school placement for our child can feel like a battle too. There is a lack of special school places and trained staff to meet our child's needs. We long for the good practice we hear about to multiply so that all our children can have the equality of great support.

Many of us live for the weekend. Friday evening can feel as if we are decompressing from the week, but Sunday evening brings tension, fear, tears and worry for the week ahead. We generally don't receive negative news of refusals to assess, support or provide a service on Saturdays and Sundays. Our phones don't trigger us the same at the weekend. Some live for term time because their child is getting the support they need then. This is great but it's so hard when the support is missing out of school. Either way we are tired. Physically and mentally tired.

Waiting is something we find hard. We wait for everything. We wait for referrals, we wait for assessment, we wait for support. Many parents and carers have borrowed money to pay for private assessments because the wait is too long and support is needed now. No one asks for support in advance of needing it. We also wait for communications. Emails, calls, letters but at the same time fear what they might bring. We dread the late afternoon Friday emails and those that arrive encrypted. Not all parents and carers have the technology to open them. Anxiety builds about their content until we can open it or forward it to someone who can open it for us.

Some of us will complain and be vocal about how our child has been let down and failed. It doesn't mean we feel good about it. It weighs heavily on us. These parents and carers are frustrated and exhausted, many have been in this situation a long time and face let down after let down. They feel angry, overlooked, and disempowered. Some of us are quiet. That doesn't mean we don't feel those feelings too. Some of us are new to the world of SEND and are learning. Some of us have our own needs too, physically, or mentally but we find we have to neglect our needs to care for and fight for our children. We can feel like a problem parent for complaining and requesting statutory rights. Sometimes we feel gaslit and silenced by the handling of complaints. If we need to take the complaint to the ombudsman, we know it will be an even longer wait for a remedy.

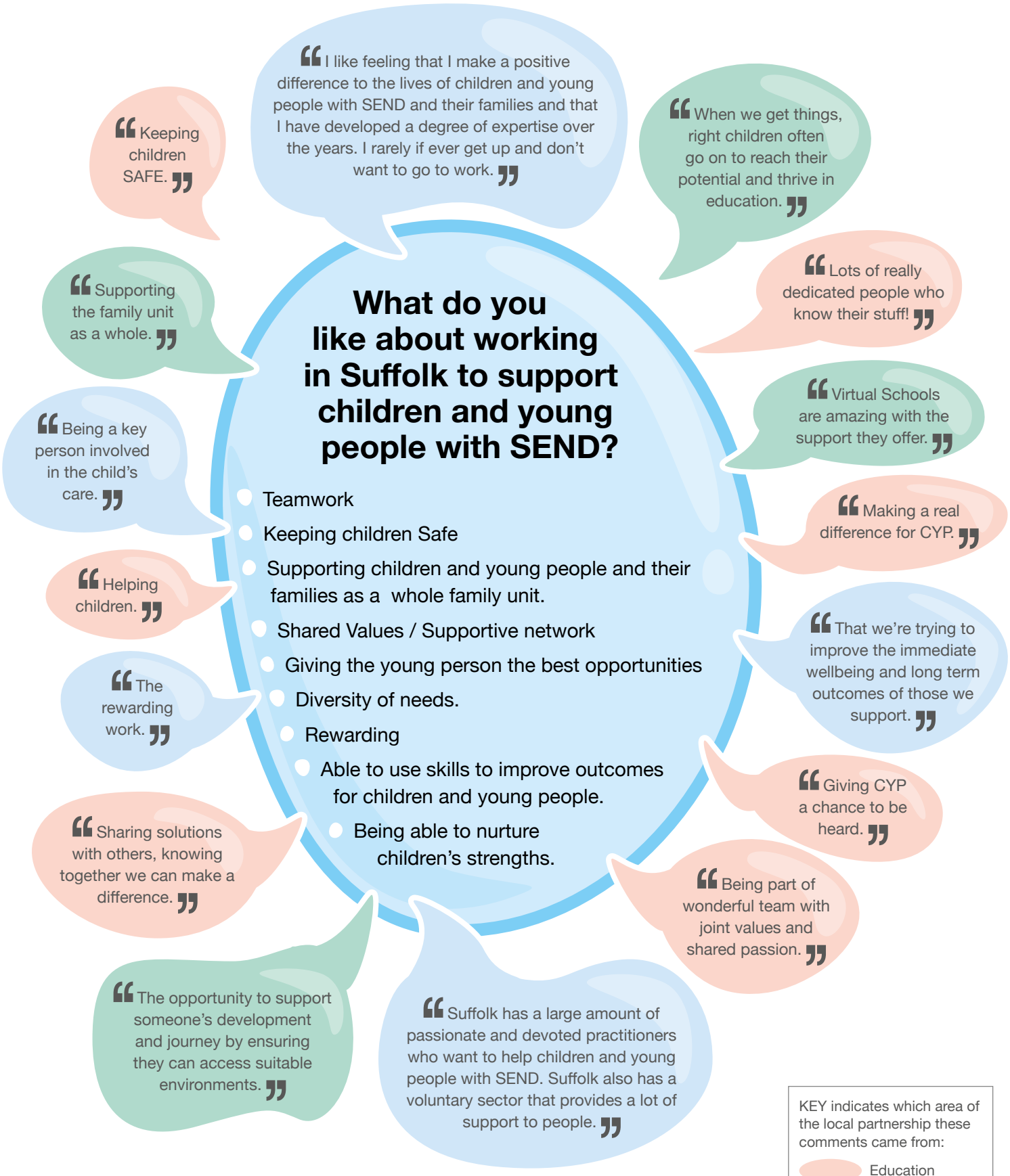
There are many support groups both nationally and locally that make a big difference to parents and carers. There are also many parents and carers who give up their free time to support others, whether it's signposting, advice or a listening ear. Parents and carers are grateful for this support and their value should be recognised.

Every parent and carer is on their own unique journey and at different points in that journey. Some are new, lonely, and taking any bit of learning they can. Some have been on this journey a long time. They are frustrated, but willingly do all they can to support others to have better outcomes. Sadly, some are bereaved. This is the worst possible outcome. Learning must come from these heartbreaking cases, so others don't have to experience that devastation.

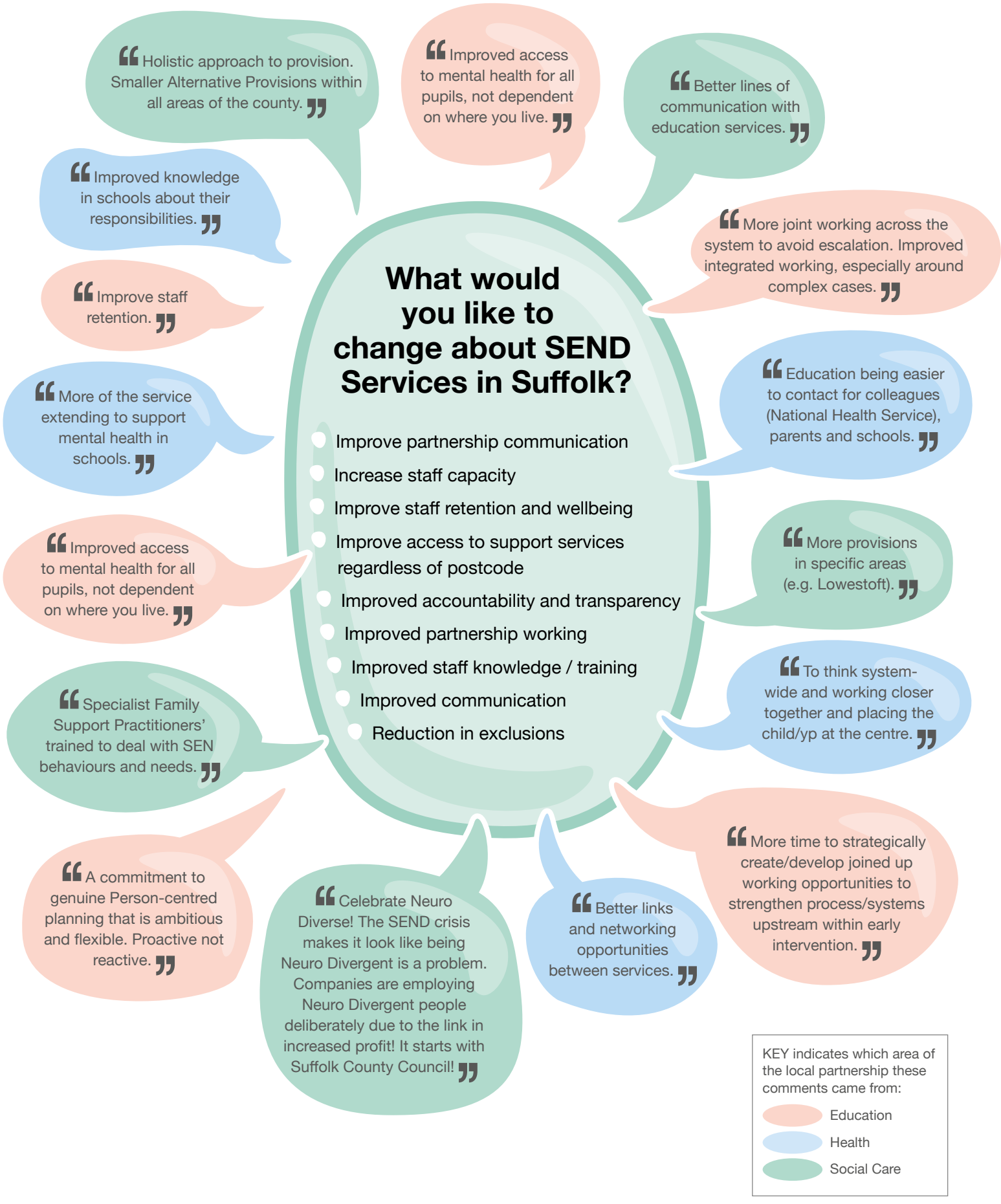
Parents and carers all have different wants and needs but what we all want, and need is change. We need our voices and our children's and young people's voices not just to be heard but listened to and absorbed. We need inclusion, quality, timely support, and statutory rights. We don't want a fight. We want to see our children and young people thrive, feel the best they can, achieve their dreams, be part of the community and for us all to experience improved mental health and a better quality of life. This should not be negotiable. This change cannot wait."

Written by
Suffolk Parent Carer Forum
suffolkpcf.co.uk

What it is like to be a Practioner working with children and young people with SEND in Suffolk


What do you like about working in Suffolk to support children and young people with SEND?
Teamwork
Keeping children Safe
Supporting children and young people and their families as a whole family unit.
Shared Values / Supportive network
Giving the young person the best opportunities
Diversity of needs.
Rewarding
Able to use skills to improve outcomes for children and young people.
Being able to nurture children's strengths.
"I like feeling that I make a positive difference to the lives of children and young people with SEND and their families and that I have developed a degree of expertise over the years. I rarely if ever get up and don't want to go to work."
"When we get things, right children often go on to reach their potential and thrive in education."
"Lots of really dedicated people who know their stuff!"
"Virtual Schools are amazing with the support they offer."
"Making a real difference for CYP."
"That we're trying to improve the immediate wellbeing and long term outcomes of those we support."
"Giving CYP a chance to be heard."
"Being part of wonderful team with joint values and shared passion."
"Suffolk has a large amount of passionate and devoted practitioners who want to help children and young people with SEND. Suffolk also has a voluntary sector that provides a lot of support to people."
"The opportunity to support someone's development and journey by ensuring they can access suitable environments."
"Sharing solutions with others, knowing together we can make a difference."
"The rewarding work."
"Helping children."
"Being a key person involved in the child's care."
"Supporting the family unit as a whole."
"Keeping children SAFE."
KEY indicates which area of the local partnership these comments came from:
Education
Health
Social Care


What is challenging about working to support SEND services in Suffolk?
Time pressure
Communication
Staff capacity / Training / Knowledge
Lack of funding and resources
Lack of specialist places / Lack of suitable provisions.
"Changes to staff groups to maintain working relationships and having good consistent communication and messaging."
"Schools (or academy trusts) are often very quick to exclude children, despite it clearly not being in children's best interests at times."
"Lack of specialist provision spaces for children with the most complex levels of need."
"Severe lack of communication."
"The limited funding for schools and Local Authorities to provide the best for the Children and Young People we support."
"The number of hoops to jump through for parents."
"Lack of coordinated and joined up working/ thinking across services."
"The language used is not always conducive to solutions, lots of blaming others rather than reflecting and admitting when we have got it wrong."
"Not enough input from the young people."
"Limited funding and resource."
"The challenge of supporting schools to meet healthcare needs of children. Fear and a lack of support can create resistance."
"Lack of appropriate education provisions for young people with needs. Particularly in younger age groups."
"Criticism - feels hard to make a positive difference with so much negativity in the system."
"Lack of support for families around choosing education placements."
"Lack of recognition for girls with Neuro Divergent."
"Family Services staff do not meet the child or family face to face anymore, meaning they don't get a full view of the situation and the challenges facing Suffolk young people."
"Communication between different services can be challenging at times and not streamlined."
"Lack of funds available."
"The lack of resources and support services for individuals and their families. Particularly those who are 18+ and out of education. The lack of joint working between services is also a challenge."
KEY indicates which area of the local partnership these comments came from:
Education
Health
Social Care


What would you like to change about SEND Services in Suffolk?
Improve partnership communication
Increase staff capacity
Improve staff retention and wellbeing
Improve access to support services regardless of postcode
Improved accountability and transparency
Improved partnership working
Improved staff knowledge / training
Improved communication
Reduction in exclusions
"Holistic approach to provision. Smaller Alternative Provisions within all areas of the county."
"Improved access to mental health for all pupils, not dependent on where you live."
"Better lines of communication with education services."
"Improved knowledge in schools about their responsibilities."
"More joint working across the system to avoid escalation. Improved integrated working, especially around complex cases."
"Improve staff retention."
"Education being easier to contact for colleagues (National Health Service), parents and schools."
"More of the service extending to support mental health in schools."
"More provisions in specific areas (e.g. Lowestoft)."
"Improved access to mental health for all pupils, not dependent on where you live."
"To think system-wide and working closer together and placing the child/yp at the centre."
"Specialist Family Support Practitioners' trained to deal with SEN behaviours and needs."
"More time to strategically create/develop joined up working opportunities to strengthen process/systems upstream within early intervention."
"A commitment to genuine Person-centred planning that is ambitious and flexible. Proactive not reactive."
"Better links and networking opportunities between services."
"Celebrate Neuro Diverse! The SEND crisis makes it look like being Neuro Divergent is a problem. Companies are employing Neuro Divergent people deliberately due to the link in increased profit! It starts with Suffolk County Council!"
KEY indicates which area of the local partnership these comments came from:
Education
Health
Social Care

Our work so far

The previous Suffolk SEND Strategy covered the period 2021-23.
You can read about the previous SEND strategy here.

The SEND Strategy 2021-23 set out 4 priorities areas in which work was completed; we are committed to continuing to improve within these areas and have taken this into account when developing our SEND Strategy 2024-29.

The Local Area Partnership recognises that under the previous SEND Strategy not enough children, young people and their parent and carers' lived experiences of SEND in Suffolk saw improvement. The SEND Partnership will continue to build on the strengths to improve the impact and better outcomes for children and young people, using the learning from the previous strategy.

It has been recognised that partnership working has improved, with more effective collaborative working and data sharing between services, providers and education settings across the system. Collaboration throughout the partnership has supported discussions about our strengths, and what we need to build on moving forward.

The Local Area Partnership's review of the previous SEND Strategy details what was achieved, and what will continue to be addressed in the SEND Strategy 2024-29. The review can be found within Appendix 1.

Our work moving forward

Coproduction

Co-production is when children, young people, parents and carers and practitioners work equally together to make decision about designing, evaluating, and improving SEND services across education, health and social care.

This strategy has been coproduced following these principles. Further information about coproduction within the SEND partnership can be found in Appendix 2.

Our Commitments: Objectives and Impact

For full details of how we will measure the impact of work towards these objectives please refer the live action plan.

Communication and Information Commitment

This is a priority for us because:

- The voice of children and young people, parents, carers and practitioners are important and valuable to us.
- Children and young people, parents, carers and practitioners report that it is difficult to contact services and this needs to improve.
- Children and young people, parents and carers report that they do not always know what services are available to them.
- Delays in communication lead to less joint working and poorer outcomes for children and young people with SEND.
- The Local Area Partnership wants to support the growth of Suffolk Parent Carer Forum (our strategic coproduction partner) to enable the voice of parents and carers across Suffolk to improve inclusivity of any underrepresented parents and carers.
- Communication between services and partners are not always effective.

Ofsted & CQC Reported

Suffolk Local SEND Inspection found: The local area partnership should engage effectively and widely with children and young people and their Parent and Carers, developing effective communications systems, and acting to address parents' and carers' concerns at an early stage, to reduce dissatisfaction and reduce the need for parents and carers to have to follow formal routes.

	Objectives:	If we do this well:
1	Children and young people with SEND and their parent and carers understand what services and support are available and know how to access them.	• We will have improved communication and reach across Suffolk through community settings such as GPs, libraries, family hubs and digital platforms to ensure children, young people and their parent and carers are aware of services and the support available. • Children, young people and their parents and carers will feedback that they are able to access resources and useful information. • Services will receive appropriate referrals because there is available and accessible information for children, young people, parents and carers and practitioners.
This objective will help children and young people achieve the following outcomes. • **I am in control of my life** • **I feel supported** • **My voice is heard**		
2	We will maintain and develop opportunities to hear the voice of children, young people their parents and carers and practitioners to inform and coproduce improvements across the SEND Partnership.	• We will develop parent carer focus groups, working alongside the Suffolk Parent Carer Forum (SPCF), and supporting the Engagement Hub to extend their reach to children and young people across Suffolk. • Children, young people, parents, and carers will tell us that they are able to share their experiences and have their voice heard. • Children, young people, parents and carers and practitioners will see improvements identified through their experiences and feedback embedded as systems change.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I feel supported**		

Communication and Information Commitment continued

	Objectives:	If we do this well:
3	Effective communication across the SEND Partnership will enable needs to be understood and met in a timely fashion.	• Children, young people, parents, and carers will report that they are informed of progress for assessments via their preferred communication method. • There will be a reduction in complaints on the theme of communication. • Telephone responses will be answered within the agreed time commitments set out in the communication charter.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I feel supported** • **I can learn**		
4	Information about resources and support will be available to children, young people and their parent and carers, and practitioners in a range of formats including written information, digital and through face-to-face meetings and events.	• Children, young people, parents, and carers will find it easier to access resources on websites, social media, and online portals as well as newsletters. • Children, young people, parents, and carers will feedback that they have improved oversight of progress through statutory processes as a result of the education health and care portal as a communication tool. • Information shared will be better promoted and be more accessible to all children, young people, their parents and carers and staff working across the SEND partnership.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I am in control of my life** • **I am happy**		

Preparing for Change Commitment

This is a priority for us because:

- Children, young people, parents and carers report that transition planning (at all stages) is often rushed or inconsistent, and that information is not always shared between settings.
- There are too many young people with SEND who are not in education, employment or training.
- Children and young people are not sufficiently involved in preparing for adulthood in terms of their education, independent living skills, involvement in their communities and having good health.
- Children and young people need to be supported to prepare for changes big and small.

Ofsted & CQC Reported

Ensure consistently good processes supporting transition from Early Years to Primary, Primary to Secondary and Secondary to Further Education

	Objectives:	If we do this well:
1	Develop a multi-agency Suffolk-wide "Preparing for Change Charter", outlining how we will work with children, young people, parents, and carers to prepare young people for times of change to ensure they feel supported and can go on to each new chapter with confidence.	• 'Ideal worker' principles will be applied, ensuring children and young people's voice is clear and informs the help they receive. • Children, young people, parent and carers will feedback that they were informed of and understand the options open to them at each point of change. • The charter will be communicated and used to support children and young people as they progress through phases of change.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I can learn**
- **I am happy**
- **I am safe**
- **I am in control of my life**
- **I am healthy**

2	Children and young people will be supported to successfully navigate times of change including starting education, moving between services or phases of education and preparing for adulthood.	• Phase transfers with named education settings will happen by statutory deadline dates to allow sufficient time for children, young people and their parents and carers to plan for and receive the support they need to enable a good transition. • Children, young people, parents and carers will be better supported at times of transition – including important decisions being made in good time to allow for multi-agency planning and preparation with the child and young person involved.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I can learn**
- **I am happy**
- **I am safe**
- **I am in control of my life**

3	Post 16 providers and system partners will be supported to develop and deliver education and training opportunities so that young people are prepared for employment, independence, inclusion within their communities and to manage their health and wellbeing.	• The number of young people with SEND in post 16 education (including apprenticeships and supported internships) will rise. • The number of young people with SEND not in education, employment or training will drop. • Young people with SEND will be supported to be active within their chosen communities and build meaningful relationships. • Young people will be better prepared to gain independence in adulthood and manage their health and wellbeing. • Services will embed use of the Preparing for Adulthood plan in collaboration with practitioners supporting young people to set and achieve goals.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I can learn**
- **I am happy**
- **I am safe**
- **I am in control of my life**

Timeliness and Quality Commitment

This is a priority for us because:

- Too many children and young people with SEND and parents and carers are not having their assessments completed within the statutory timescales.
- Too many children and young people with SEND do not have their education health and care plans reviewed every year to make sure the provision set out in their plan is meeting their needs.
- Children, young people, parents, and carers report that waiting times across the partnership are too long.
- Our current quality assurance and audit processes are not robust enough in all areas.
- Delays in children and young people accessing the right support can cause frustration and a lack of confidence for children, young people parents, carers and providers.

Ofsted & CQC Reported

The Local Area SEND Inspection found: Local area partnership leaders should cooperate to take urgent action to improve the timeliness and quality of the statutory education heath and care plan processes, education health and care plan needs assessments, and education health and care plans and annual reviews, particularly using annual reviews to amend the quality of existing education health and care plans where required. This should ensure that plans meaningfully capture the views and aspirations of children and young people with SEND and their families, so that they get the right support at the right time.

	Objectives:	If we do this well:
1	Individuals working with children and young people with SEND will receive appropriate training for their areas of work to be more competent and confident.	• New staff will receive induction training, and existing staff will have the time to undertake continuous professional development. • Staff will tell us they feel more confident. • Feedback from children, young people, parents, and carers will indicate quality is consistently good for education heath and care plans and service delivery. • The voice of children and young people will be evident in education health and care plans.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I am safe**

2	Improve staffing levels and ways of working to strengthen quality, person centred planning and coproducing to increase positive outcomes for children and young people whilst also improving statutory timeliness and service targets.	• Children and young people with SEND and their parents and carers will get quality assessments, plans and reviews on time. • Children and young people with education health and care plans will get the support and provision they need to meet their needs without delay. • The attainment and progress of children and young people with SEND will improve because their educational needs are identified, and provision is adapted to meet more quickly.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I can learn**
- **I am happy**
- **I am safe**
- **I am in control of my life**
- **I am healthy**

Timeliness and Quality Commitment continued

	Objectives:	If we do this well:
3	Create quality educational health care plans and reviews by assuring good practice through robust audit processes and feedback mechanisms.	• The collaborative audit process will be strengthened to regularly sample children's files, incorporating multiagency partners, young people and parents and carers views to improve services. • Audits will evidence the voices and ambition of children and young people and evidence the progress they are making. • The impact of audit outcomes will be strengthened across the partnership, helping to improve the quality of our education health care plans and reviews and identify best practice and areas for improvement. • Staff will be working more efficiently, improving timeliness alongside quality. • Children, young people, parents, and carers will receive education health and care plans of higher quality, promoting better outcomes.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I feel supported** • **I can learn** • **I am safe** • **I am in control of my life**		
4	To have effective processes and practices across the partnership.	• Performance and impact data will be utilised through further developments of audits, learning from complaints and feedback and using internal systems to manage workload. • We will see a reduction in children, young people, parents, and carers unhappy with the quality of their plans or service. • Children and young people with SEND and their parents and carers will experience the delivery of quality services within the set timeframe.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I feel supported** • **I can learn** • **I am happy** • **I am safe** • **I am in control of my life**		

Right Support, Right Time Commitment

This is a priority for us because:

- Early intervention across the partnership is essential to better meet children and young peoples needs.
- Inclusive practice is not always consistent across all settings and areas.
- There is high demand for specialist services, bespoke and alternative provision.
- Children, young people, parents, and carers continue to report delays in accessing services and provision.
- Some schools report not feeling confident or able to meet the needs of all their children and young people.
- The partnership wants to ensure there are good high-quality services within Suffolk that have the capacity to meet need.
- Children, young people, parents, and carers have told us they are not getting support early enough, leading to crises and children's needs escalating.

Ofsted & CQC Reported

Suffolk Local SEND Inspection found: The partnership must agree and embed clear expectations for co-ordinated multi-agency working of children and young people's cases across the Area SEND Partnership.

	Objectives:	If we do this well:
1	Across the partnership systematically plan effective services and use resources to meet children and young people's needs.	• An increase in children, young people and their parents and carers getting earlier help and increase accessible specialist services for those who need additional specialist support. • There will be improved coordination of data and information across the system to better establish and maintain our understanding of the needs of children and young people with SEND as fully and early as possible. • Needs will be met whilst children, young people, parents, and carers are awaiting specialist placements. • Children and young people's individual needs will be understood, and they will be able to access holistic support to meet those needs. • There will be more inclusive schools supported by specialist services to better meet the needs of children and young people through whole school approaches. • Children, young people and their parents and carers will provide positive feedback about the services they receive.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I can learn**
- **I am happy**
- **I am safe**

2	To provide support at the earliest opportunity through the accurate identification of the needs of children and young people with SEND.	• The use of the Suffolk Inclusion Toolkit with schools will be embedded. • Opportunities such as the 2 and a half year health check will be utilised. • Mainstream schools will feel increasingly able to meet the needs of children and young people on their rolls. • Fewer children and young people will be suspended or excluded.

This objective will help children and young people achieve the following outcomes.

- **My voice is heard**
- **I feel supported**
- **I can learn**
- **I am happy**
- **I am safe**
- **I am in control of my life**

3	Training and interventions that are known to be effective will be available to all settings that work with children and young people with SEND.	• The number of settings accessing programmes such as 'Delivering Better Value, Raising Achievements' and the All-Age Autism Strategy will increase. • Education settings will feel confident in the delivery of effective interventions. • Evidence-based interventions will improve the skills and confidence of children and young people with SEND at early age, preventing needs escalating.

This objective will help children and young people achieve the following outcomes.

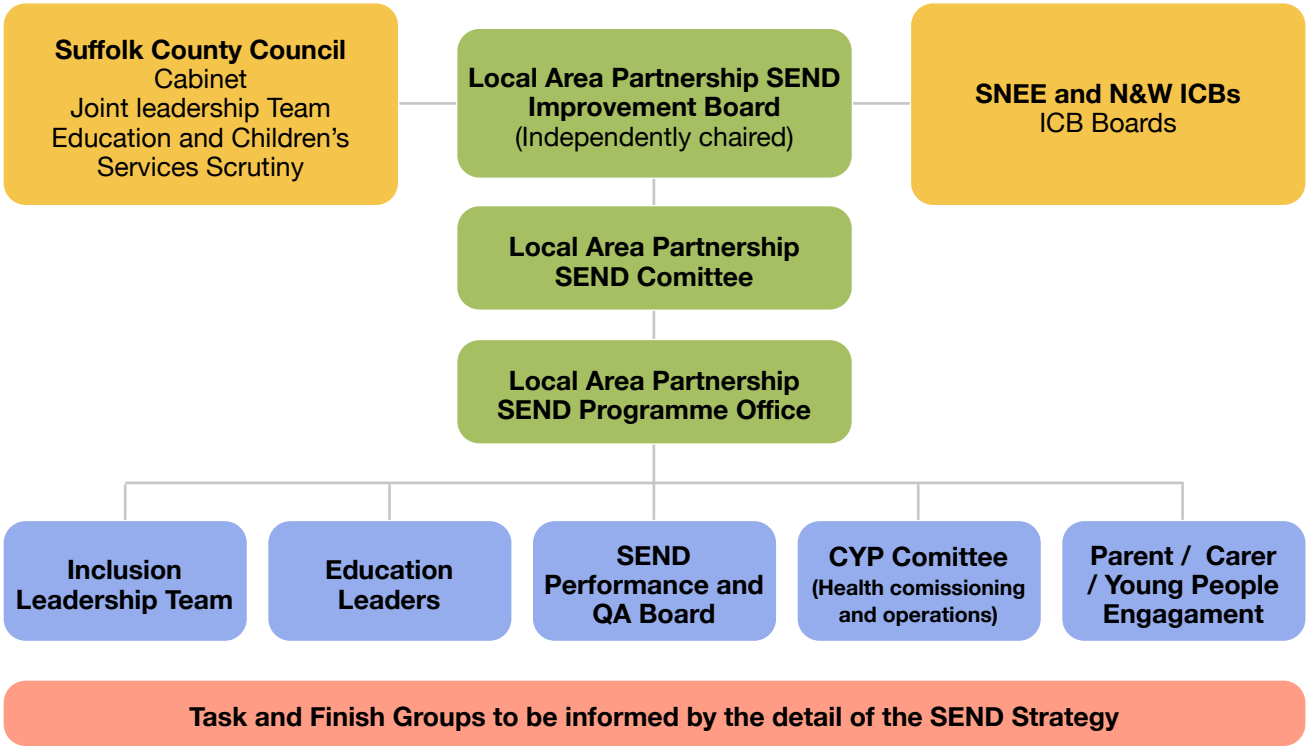
- **I feel supported**
- **I can learn**
- **I am safe**

Right Support, Right Time Commitment continued

	Objectives:	If we do this well:
4	We will create 826 specialist places by September 2026, ensuring that sufficient health and social care provision is also available to support these places.	• Continue with our SEND capital programme to create more specialist places attached to mainstream schools and special school places; to find out more information please see Our Capital Programme - Suffolk SEND Local Offer (suffolklocaloffer.org.uk). • More children and young people will be supported in settings to meet their needs closer to home. • There will be a reduction in waiting times for suitable placements for children and young people that require a specialist placement. • Children and young people will feel included within appropriate settings and have their needs understood and met. • Parent and carers will feel reassured that their children and young person's wellbeing and educational needs are recognised and can be met by their setting.
This objective will help children and young people achieve the following outcomes. • **I feel supported** • **I can learn** • **I am safe**		
5	We will improve support to meet the needs of children and young people who are neurodivergent (both with and without formal diagnosis).	• Children, young people and their parent and carers will receive support whilst waiting for assessments and diagnoses, including through the promotion of the Neuro Developmental Delay resource pack. • Parents and carers and practitioners across the partnership will report and demonstrate increased confidence in supporting neurodivergent children. • Waiting times for diagnoses will be within mandated timescales. • Children and young people, parents and carers will feel supported and valued and are able to access the services they need.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I feel supported** • **I can learn** • **I am happy** • **I am safe** • **I am in control of my life**		
6	We will establish a holistic system wide approach to supporting the emotional wellbeing and mental health of children and young people with SEND and their parents and carers.	• Resources will be available for parent and carers, schools, practitioners, and the voluntary sector, with direct support for children and young people and access to formal mental health pathways as appropriate. • Fewer children, young people, parents, and carers will need crises support. When crises support is still needed, it will be accessible and better meet needs. • The iThrive framework will be adopted and established within the partnership. • Children and young people will feel understood, safe, and secure, and able to access and enjoy the wider aspects of their life. • There will be a reduction in children and young people who are not accessing education, employment, and training due to poor mental health. • Parents and carers of children with poor mental health will report positive change and improved outcomes.
This objective will help children and young people achieve the following outcomes. • **My voice is heard** • **I feel supported** • **I can learn** • **I am happy** • **I am safe**		

How will we ensure we stay on track?

Local Area Partnership SEND Governance



These boards, committees and the independent chair will make sure the partnership stays on track and are doing the things they need to do to make sure the partnership sticks to the commitment so that:

Together we will understand and support children and young people so that they feel included, supported, and fulfilled to live their best lives.

Appendices

Appendix 1: SEND Strategy 21/23 Review

Whilst the SEND Partnership acknowledges that not enough children, young people and their Parent and Carers are receiving or benefiting from the changes and improvements that the SEND Strategy 2021-2023 has made, it is important that we reflect on the previous Strategy and our strengths to understand where we are now and how we move forwards.

The previous SEND Strategy set out four priority areas within which work was completed; we are committed to continuing to improve within these areas and have taken this into account when developing our SEND Strategy 2024-29.

Priority One: Communication

Some of the things that worked well under the previous strategy to address our priority regarding communication were:

- Local Offer website was relaunched, and the Source website was refreshed offering improved accessible content with an enhanced search facility. The feedback to date is that this is a positive step in the right direction.

  "Like the style of it and think it will be easy for families to read and navigate" SENDIASS

  "It looks great and so much better than the current site, well done" practitioner

  "Looks smart, layout is, for the most part, clearer" parent

  "Overall, it is a very good starting point for the new local offer page and can be built upon. As mentioned, we like the 'New to SEND' section as well as what the 'local offer' is about. It is colourful and engaging as the information on some pages can be viewed in small chunks with the drop-down options"

SPCF (Suffolk Parent Carer Forum)

- Co-produced and embedded the ideal worker as part of the recruitment process.
- We continue to work with Young Peoples Network to award more places "Welcoming spaces" status. (Link to "what is welcoming spaces")
- Promoted awareness and understanding of SEND support services amongst practitioners, for example by introducing SEND champions and the SENCo Bulletin.
- Promoted awareness and understanding of SEND support services amongst Parent and Carers, for example by introducing time to listen events.
- More effective collaborative working and data sharing between services, providers and education settings across the system including the successful launch of the community inclusion forums.
- Quality assurance framework now involves more multi agency professionals.

Within the SEND Strategy 2024-29 we will continue to develop communication with Parent and Carers increasing the awareness around support available and progress being made. We will continue to widen the reach of our children and young people's voice through the Engagement Hub, Young Persons Network and Particip8. We will also develop a wider reach of parent carer focus groups alongside Suffolk Parent Carer Forum and embed the time to listen events to capture the voice of Parent and Carers.

Priority Two: The Child and Young Person's Journey

Some of the things that worked well under the previous strategy to address our priority regarding the child and young person's journey were:

- SEND Good Practice Guide now has a SEND area on My SCC for staff.
- System changes and reporting enhancements have also been achieved, including the transition of the Family Services Team to a more robust case management system, alongside the creation of a manual in line with best practice processes.
- Embedded the graduated response, co-produced the Suffolk mainstream inclusion framework, and created the Suffolk inclusion toolkit to support early intervention and whole school inclusive practices.
- Created the EHCNA request team and reviewed the EHCNA panel to support the EHC needs assessment process.
- The Keys to Inclusion Training Programme and Person-Centred Planning Training launched to support a person-centred planning approach across the partnerships.
- Developed a Quality Assurance framework to review the quality of new EHCP's.

- Co-produced SEND Decision Making panels.
- The recruitment and retention of designated clinical officers and designated social care officer to support and strengthen joined up working across the SEND partnership.
- Created a new Tribunal and resolution team.

Within the SEND Strategy 2024-29 we will continue to develop our partnership working arrangements and use of data to inform decision making and strengthen multi agency working and auditing to support the child and young person's journey.

Priority Three: Commissioning and Services

Some of the things that worked well under the previous strategy to address our priority regarding the child and young person's journey were.

- Phase 1 of SEND capital programme created 378 new places.
- Secured funding from cabinet for phase 2 and phase 3 of the SEND capital programme
- Neurodevelopmental pathway was repurposed in 2022, to support Parent and Carers via a number of different means.
- Additional resource of 700k annually for children, young people and their Parent and Carers to access a variety of different voluntary services, this additional investment into Education Health Care Plans Speech and Language Therapy by Local Authority has improved outcomes for children and young people.
- Successful implementation of transforming care navigator teams with dynamic support registers in place resulted in a measured reduction of inpatient stays for children and young people.
- The Launch of the CHRIS and CATAT services to offer enhanced mental health support for children and young people.
- Significant investment in additional mental health services including Mental Health Support Teams in schools.

Within the SEND Strategy 2024-29 we will continue to develop the SEND capital programme to provide additional spaces at specialist settings. We will also continue to work to embed a holistic system wide approach to develop shared outcomes and support the emotional wellbeing and mental health of children young people and their Parent and Carers.

Priority Four: Preparing for Adulthood

Some of the things that worked well under the previous strategy to address our priority regarding the child and young person's journey were.

- Review of the transition guide and co-produced version launched. To view click here: preparing-for-adulthood-transitions-guide (suffolklocaloffer.org.uk)
- Through our Activities Unlimited offer grant funded leisure activities and personal budgets, open to all children and young people with SEND to access high quality, inclusive groups, clubs, and activities.

Within the SEND Strategy 2024-29 we will continue to develop opportunities for supported internships and employment opportunities for young people with SEND as well as opportunities for young people to develop independence, be included within their communities and manage their health and wellbeing.

Find out more about the previous SEND strategy and how we have produced the new Strategy on the Local Offer

Our SEND Strategy - Suffolk SEND Local Offer (suffolklocaloffer.org.uk)

Appendix 2: Co-Production Promise

What does co-production in SEND services look like?

Co-production is when parents, carers and young people work equally with practitioners and decision-makers to design, evaluate, and improve SEND services across education, health and social care.

The co-production stages are described as a series of steps towards co-production. It supports greater understanding of the various stages of access and inclusion before full co-production is achieved. At Suffolk County Council we work with our strategic co-production partner SPCF to achieve this, whilst also recognising that within the partnership different groups will wish to participate at different stages.

How will we achieve co-production in SEND services?

Getting involvement and collaboration* with children, young people and their Parent and Carers right, relies on developing strong relationships with local, building trust and respect. We will do this by co-producing activities with children, young people and their Parent and Carers in ways that work for them, supporting a range of opportunities, and enabling people to work with us in different ways.

- **Collaboration** – working together and creating a partnership that understands children, young people and their parents and carers experiences.
- **Respect** – building trusted relationships between children, young people and their parents and carers and services based on inclusivity, mutual understanding, and accessibility so that everyone feels they belong in the conversation.
- **Listening** – taking every opportunity to hear the children and young person and their parents and carers experience, paying attention and being curious about what it means and acting on what we are told.
- **Equality** – we will ensure that a diverse range of voices are heard.
- **Transparent** – we will be open and honest about our activity, be clear about parameters and decision making.
- **Meaningful** – activity will be relevant and purposeful.
- **Influential** – all activity will seek to have impact and lead to positive change, quality improvement or better decision making.

Appendix 3: Co-production Timeline

Sept 2023

- Co-Production work began on designing the consultation survey.
- Suffolk County Councils Assistant Director of Inclusion released an animated message to ensure consistent messaging during consultation.

Oct 2023

Consultation launched. During consultation the survey was shared across the SEND Partnership.

Oct - Dec 2023

Visited schools and Colleges to work on Children and young people's outcome frameworks. To read more about this, please see appendix 4.

Jan - Feb 2024

- Thematic review of consultation results.
- Co-Production events to produce first draft SEND Strategy.
- Short consultation on draft Summary.

Mar - Apr 2024

- Co-production working groups set up to work on the production of the final SEND Strategy 2024-2029.
- Equality Impact Assessment signed off.

May - Jun 2024

- Quality Assurance Signed off.
- Cabinet and Governance Signed off.

To read more about the feedback received on the consultations please visit the Local Offer website Our SEND Strategy - Suffolk SEND Local Offer (suffolklocaloffer.org.uk)

Appendix 4: Children's Outcome Framework

During the Autumn term of 2023, we also visited 12 schools, two colleges and one home education drop in session to ask young people with SEND what things helped them to feel in control, supported, able to learn, safe, healthy, heard and happy.

The feedback obtained from completing this activity with children and young people has informed our understanding of what getting it right will feel like to Suffolk's children and young people. This will be used to develop the Suffolk Children's Outcome Framework, influencing the measures and indicators for each outcome to determine how effectively we are supporting children and young people.

The above graphic uses a combination of quotes and images to reflect the themes in what the children and young people we spoke to associate with each of the outcome phrases.

Children and young people told us that to them to be healthy is to:

- Get enough sleep
- Eat healthy food
- Think about mental health, mindset and feelings
- Be active, exercise and take part in clubs and hobbies
- Visit the dentist and doctors
- Spend time outside
- Be happy

Children and young people told us that to be safe is to:

- Be in safe space
- Be with, talk to, and listen to trusted people such as family, friends and teachers
- Think about internet safety
- Be sensible and think about surroundings

Children and young people told us that to be happy is to:

- Be proud of achievements and get rewards
- Spend time with friends and pets
- Laugh and hear jokes
- Do hobbies such as play games, listen to music, create art, take part in activities and watch films
- Eat favourite foods

Children and young people told us that to feel supported is to:

- Have people to help you and give advice, such as teachers, friends and family, when you are struggling or are making choices
- Get awards, praise and congratulations from people
- Feel ok to be yourself around others
- Be listened to, and get encouragement from others

Children and young people told us that to be heard is to:

- Share ideas, views and opinions with others
- Talk about things that are important
- Get to make decisions and have a say through school council
- Be listened to and respected

Children and young people told us that to be able to learn is to:

- Be able to learn at their own pace
- Be able to learn through doing, and learn about things that are interesting or new
- Be supported with work, learning and feelings by teachers, teaching assistants and tutors
- Be able to use things that help with learning such as fidgets, games and music

Children and young people told us that to be in control of their lives is to:

- Have help, but make their own choices and decisions about actions, ideas and their future
- Choose to take part in hobbies and activities
- Be their own person, with control and responsibility over thoughts and feelings
- Work towards future goals and dreams, including job choices and learning

Appendix 5: Links to further information

iThrive framework
i-THRIVE | Implementing the THRIVE Framework (implementingthrive.org)

SEND code of practice
SEND code of practice: 0 to 25 years - GOV.UK (www.gov.uk)

All age autism Strategy
Autism - Suffolk County Council

Suicide Prevention strategy Suffolk
Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

The Source
Home - The Source

Suffolk Local Offer
Home - Suffolk SEND Local Offer (suffolklocaloffer.org.uk)

Suffolk Learning

SENDIASS
Home - Suffolk SENDIASS

Suffolk Parent Carer Forum
https://suffolkpcf.co.uk

Suffolk and North East Essex Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 10
Date: 30 July 2024

Title: Finance Report

Lead Director: Howard Martin, ICB Executive Director of Finance.

Author: ICB Finance Team.

Purpose: To note.

Recommendation: That the Board notes the month three Finance Report and Finance Dashboard

Related item on the Board Assurance Framework: Strategic Risk 25 Failure to meet statutory ICB financial targets

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1.1 The month three Finance Report and Finance Dashboard are attached to this paper. Both were considered at the ICB Finance Committee on 18 July 2024.

Appendices:

1) Finance Report
2) Finance Dashboard

NHS
Suffolk and
North East Essex

NHS Suffolk and North East Essex ICB Finance Report

Month 03 2024/25

NHS
Suffolk and
North East Essex

ICB Report

Month 03 2024/25

ICB Key Financial Metrics Month 03 2024/25

NHS
Suffolk and
North East Essex

	Month 03	Forecast	
Surplus / Deficit	A	A	The ICB reported in line with plan at a £2m surplus year to date and £14.8m forecast surplus to offset the WSFT deficit. There was a concerning increase in cost pressures in month which at this point is manageable with mitigating actions identified.
Efficiency Delivery	G	G	The forecast delivery is 97% of the £14.0m target. Year to date delivery is 120%.
Running Costs Limit	G	G	The forecast is an underspend against of £1.9m against the reduced annual limit.
Mental Health Investment Standard	G	G	The forecast is for achievement of the £168.9m target.
Net Risk	G	G	There has been no change to the net risk position from the plan submission at this stage.

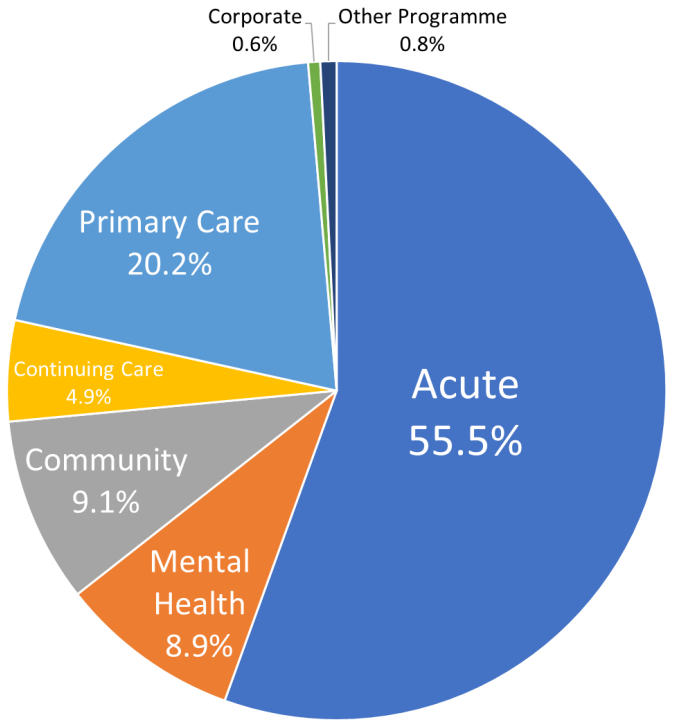
G On plan

A Adverse variance to plan within manageable tolerance

R Adverse variance to plan above manageable tolerance/risk to financial duties

Annual Funding & Expenditure by Category

Funding Type	24/25 M03 £m
Core Programme	1,954.3
Delegated Commissioning	474.0
Running Costs	16.4
Total	**2,444.7**
Plan Surplus/(Deficit)	14.8
Forecast Surplus/(Deficit)	14.8



ICB Summary Position at Month 03 2024/25

NHS
Suffolk and
North East Essex

The ICB reported in line with plan at a £2m surplus year to date and £14.8m forecast surplus to offset the WSFT deficit. There was a concerning increase in cost pressures in month which at this point is manageable with the mitigating actions identified as part of the planning process.

Areas of expenditure to note are:

- **Continuing Care** – The forecast overspend is £4.4m which is highly concerning given the budget increase of 12% for pricing and demand rises. External support has now been engaged to undertake a review of CHC and commissioned services to identify any opportunities.
- **Community** – There is a forecast overspend of £1.7m due to significant increase in patients being recorded at Neurorehabilitation. A patient level review is being undertaken to identify reasons for the increases in packages.
- **Acute** – The overspend is driven by a 50% increase in spend on Insulin Pumps of £1.5m which is under investigation. There is £2.3m of further overperformance on the Independent Sector which is expected to be funded by ERF.
- **Prescribing** – Overall prescribing overspend is forecast at £0.7m, however there is significant variation at Alliance level with West Suffolk forecast to overspend by £1.9m

Category	1 Apr 24 to 30 Jun 24 YTD			Forecast to 31 Mar 25		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Revenue Resource Limit (in year)	626.6	626.6	0.0	2,444.7	2,444.7	0.0
TOTAL REVENUE RESOURCE LIMIT	**626.6**	**626.6**	**0.0**	**2,444.7**	**2,444.7**	**0.0**
Acute	298.9	298.0	0.9	1,162.1	1,163.3	(1.2)
Mental Health	55.5	55.2	0.4	218.7	217.7	0.9
Community Health Services	54.8	54.9	(0.1)	218.5	220.1	(1.6)
Continuing Care	29.2	29.7	(0.5)	116.8	121.2	(4.4)
Primary Care - Prescribing	50.2	52.3	(2.2)	200.6	201.3	(0.7)
Primary Care - Other	6.3	6.1	0.2	25.3	25.3	0.1
Delegated GP	50.4	49.9	0.5	201.5	200.5	1.0
Delegated Pharmacy, Optom, Dental	22.4	19.5	2.9	89.2	79.8	9.3
Delegated Specialised Commissioning	54.3	54.3	0.0	187.0	187.0	0.0
Corporate	3.8	3.2	0.5	15.0	14.5	0.6
Other Programme	5.0	4.6	0.4	19.7	19.5	0.2
Programme Reserve & Contingency	(6.2)	(3.2)	(3.0)	(24.8)	(20.5)	(4.3)
TOTAL EXPENDITURE	**624.6**	**624.6**	(0.0)	**2,429.8**	**2,429.8**	0.0
IN YEAR SURPLUS/ (DEFICIT)	**2.0**	**2.0**	0.0	**14.8**	**14.8**	**0.0**

Commentary Month 03 2024/25

NHS
Suffolk and
North East Essex

Acute
The overspend is driven by a 50% increase in spend on Insulin Pumps of £1.5m which is under investigation. There is £2.3m of forecast overperformance on the Independent Sector which is expected to be funded by ERF, this is being driven by Ophthalmology providers who have opened new facilities in Colchester.

Mental Health
The forecast underspend is mainly driven by a lower number of placements in hospitals at this stage of the year. However, this is very unpredictable as patient numbers can fluctuate throughout the year. There is a £0.5m forecast overspend in Mental Health Shared Care as no change in expenditure yet seen from review work undertaken.

Community
There is a forecast overspend of £1.7m due to significant increase in patients being recorded at Neurorehabilitation. A patient level review is being undertaken to identify reasons for the increases in packages and whether there are opportunities to reduce costs, or if the patients should be recorded under a different category of spend.

Continuing Care
The forecast overspend is £4.4m which is highly concerning given the budget increase of 12% for pricing and demand rises. The overall volume has increased and in particular there has been a steep increase in high cost packages (over £5k per week) which have grown by 71% year on year, this has translated into an additional recurrent cost of £8m per annum. External support has now been engaged to undertake a review of CHC and commissioned services to identify any opportunities.

Prescribing
Overall prescribing overspend is forecast at £0.7m, however there is significant variation at Alliance level with West Suffolk forecast to overspend by £1.9m, North East Essex forecast to overspend by £0.3m partially offset by a forecast underspend in Ipswich & East of £1.6m. The year to date overspend of £2.2m is due to the phasing of the budgets in the plan, this will be amended in month 4. The efficiency programme is on track overall with benefits in CAT M prices offsetting delays in some schemes achieving planned saving targets.

Delegated Pharmacy, Optometry and Dental (POD)
Overall forecast underspend of £9.3m due to contract underperformance. Mobilisation of new primary dental services has proven much slower than anticipated and despite increases in unit prices and other initiatives there is still a material level of under delivery in current contracts. Primary Dental services are subject to a national ring fence so there is a risk of NHS England clawing back any underspend. There is a forecast overspent of £0.3m on Pharmacy which is being offset by a £0.4m underspend on Ophthalmic services.

Delegated GP
The year to date underspend is primarily due to benefit on prior year costs being less than anticipated. Further underspend is forecast for under delivery of quality incentive targets.

Corporate
Overall, the forecast is under budget by £0.6m due to continued vacancies which means the corporate restructure savings target and required Vacancy Factor are on track to deliver. This is encouraging but as vacancies post restructure are recruited to the run rate will need to be under review to ensure the exit position into 25/26 will be within the further reduced running costs limit

Other Programme
Overall budgets remain on plan.

Committee Delegated Budgets Month 03 2024/25

NHS
Suffolk and
North East Essex

At month 03 the overall position of budgets delegated to committees is a forecast underspend of £9m which is driven by dental contract underperformance.

Ipswich & East Suffolk Alliance
Prescribing forecast underspend is currently at £1.6m, however at this stage of the year there is only actual data for April.
This is being partially offset by an overspend on insulin pumps of £0.2m based on the expenditure at month 3.

North East Essex Alliance
Prescribing forecast overspend is at £0.3m however at this stage of the year there is only actual data for April. This is being offset by an overspend on insulin pumps of £0.5m based on the expenditure at month 3.

West Suffolk Alliance
Prescribing forecast overspend is £1.9m, the trend of West Suffolk prescribing spend growing significantly over and above both the system and national average is forecast to continue, however at this stage of the year there is only actual data for April. There is a significant overspend forecast on insulin pumps of £0.8m based on the expenditure at month 3.

Suffolk Mental Health Collaborative
The £0.6m forecast underspend is mainly driven by a lower number of placements in hospitals at this stage of the year. However, this is very unpredictable as patient numbers can fluctuate throughout the year.

Category	1 Apr 23 to 31 Jan 24 YTD			Forecast to 31 Mar 24		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Acute	0.5	0.6	(0.1)	2.0	2.2	(0.2)
Community Health Services	21.0	21.0	0.0	84.0	84.0	(0.0)
Primary Care	20.4	20.8	(0.4)	81.6	79.9	1.7
Delegated GP	19.9	19.6	0.3	79.5	79.1	0.4
Ipswich & East Alliance	**61.8**	**62.0**	(0.2)	**247.2**	**245.3**	**1.9**
Acute	0.3	0.2	0.1	1.1	1.7	(0.5)
Community Health Services	18.8	18.6	0.2	75.1	75.1	0.0
Mental Health	19.8	19.9	(0.1)	79.2	78.9	0.3
Primary Care	20.1	20.8	(0.7)	80.4	80.8	(0.4)
Delegated GP	17.1	16.9	0.2	68.4	68.2	0.2
North East Essex Alliance	**76.1**	**76.4**	**(0.4)**	**304.3**	**304.7**	**(0.4)**
Acute	0.4	0.5	(0.2)	1.5	2.3	(0.8)
Community Health Services	13.3	13.3	0.0	53.2	53.2	(0.0)
Primary Care	14.7	15.6	(0.9)	58.8	60.8	(2.0)
Delegated GP	13.4	13.3	0.1	53.6	53.2	0.4
West Suffolk Alliance	**41.8**	**42.8**	**(1.0)**	**167.1**	**169.5**	**(2.4)**
Delegated Pharmacy, Optom, Dental	22.4	19.5	2.9	89.2	79.8	9.3
Alliance Committees	**22.4**	**19.5**	**2.9**	**89.2**	**79.8**	**9.3**
Mental Health	32.2	31.8	0.4	128.7	128.1	0.6
Suffolk Mental Health Collaborative	**32.2**	**31.8**	**0.4**	**128.7**	**128.1**	**0.6**
Total Delegated	**234.2**	**232.5**	**1.7**	**936.5**	**927.4**	**9.0**

Efficiency Summary Month 03

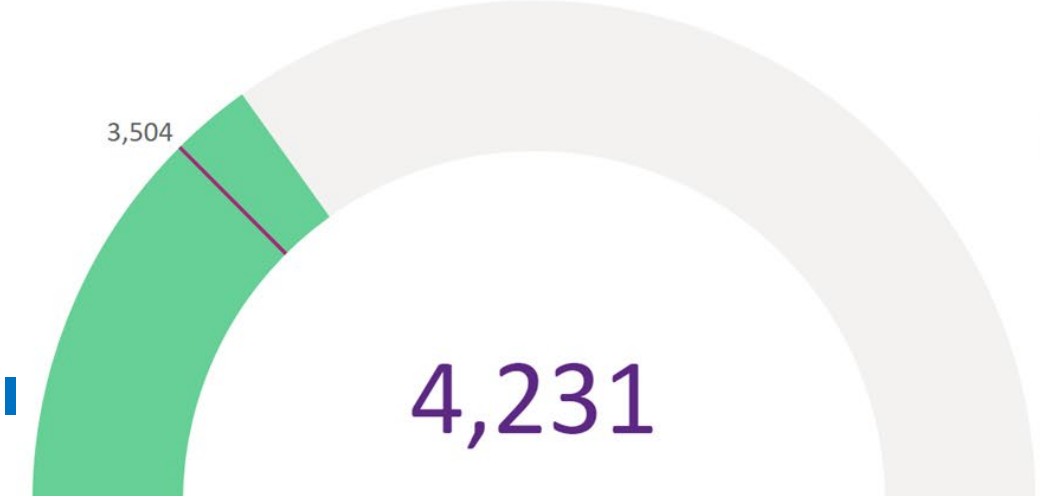
Suffolk and North East Essex

	£,000
Annual Plan	14,000
YTD Plan	3,504
YTD Actual	4,231
YTD Variance	727
Forecast value	13,564
Forecast Variance	(436)

Recurrent / Non-Recurrent	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Annual Plan £,000	Forecast value £,000	Forecast Variance £,000
Non- Recurrent	75	30	(45)	300	255	(45)
Recurrent	3,429	4,201	772	13,700	13,309	(391)
Total	**3,504**	**4,231**	**727**	**14,000**	**13,564**	**(436)**

Directorate	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Annual Plan £,000	Forecast value £,000	Forecast Variance £,000
Alliance Directors	1,782	1,937	155	7,100	7,498	398
All	1,047	1,993	946	4,193	4,863	670
Director of Nursing	282	0	(282)	1,125	0	(1,125)
Director of Finance	258	195	(63)	1,036	779	(257)
West Suffolk Alliance Director	135	106	(29)	546	424	(122)
Contingency	0		(0)	0	0	(0)
Total	**3,504**	**4,231**	**727**	**14,000**	**13,564**	**(436)**

YTD Actual, Annual Plan £,000 and YTD Plan



At month 03 we have reported over delivery of £0.7m year to date and forecast under delivery of £0.4m by the end of the year based on approved schemes. The key drivers are:

- **Continuing Healthcare** - £0.6m forecast under delivery as overall spend forecast is over budget. External support has now been engaged to undertake a review of CHC and commissioned services to identify any opportunities.
- **Mental Health Shared Care** - £0.5m forecast under delivery as no tangible outcomes yet seen from review work undertaken.
- **Running Costs Reduction -** £0.6m forecast over delivery due to the high level of vacancies still within the organisation.
- **Prescribing** - £0.4m forecast over delivery due to larger than anticipated Cat M savings.

NHS
Suffolk and
North East Essex

NHS Suffolk and North East Essex Finance Dashboard

Month 03 2024/25

System Summary Position at Month 03 2024/25

NHS Suffolk and North East Essex

Summary Performance - Key Financial Indicators

Org Name	Financial Performance Metrics															
	Full Year Forecast Surplus / (Deficit)				YTD Surplus / (Deficit)				Expenditure Run Rate vs Forecast £m	Efficiency Variance to Plan		Charge against capital allocation		Capital DEL		Agency Ceiling £m
	Plan £m	Forecast £m	Variance £m	Variance %	Plan £m	YTD £m	Variance £m	Variance %		YTD £m	FOT £m	Forecast Variance vs Plan £m	YTD as % FOT	Forecast Variance £m	YTD as % FOT	
Suffolk And North East Essex ICB	14.8	14.8	0.0	0.0%	2.0	2.0	(0.0)	(0.0%)	(68.4)	(0.2)	(1.1)	-	0.0%			25.4
East Of England Ambulance Service NHS Trust	0.1	0.1	-	0.0%	1.1	1.4	0.3	0.3%	5.4	(1.2)	-	-	14.1%	-	16.3%	(6.0)
East Suffolk And North Essex NHS Foundation Trust	0.3	0.3	-	0.0%	0.3	(0.3)	(0.6)	(0.2%)	(1.5)	(3.3)	-	-	24.5%	1.0	15.9%	(14.5)
West Suffolk NHS Foundation Trust	(15.2)	(15.2)	0.0	0.0%	(6.4)	(9.4)	(3.0)	(3.1%)	(22.5)	(0.1)	-	-	12.4%	-	21.2%	(4.7)
	(0.0)	**0.0**	**0.0**	**0.0%**	**(3.1)**	**(6.3)**	**(3.2)**	**(0.5%)**	**(87.0)**	**(4.8)**	**(1.1)**	**-**	**0.0%**	**1.0**	**0.0%**	**0.2**

At month 3 the system is off plan by £3.2m, being driven primarily by the position at WSFT which is of significant concern at this early stage of the year. Further work is underway to understand the drivers and mitigating actions required to bring delivery back in line with the financial plan including the implementation of system mitigating actions outlined during the planning process.

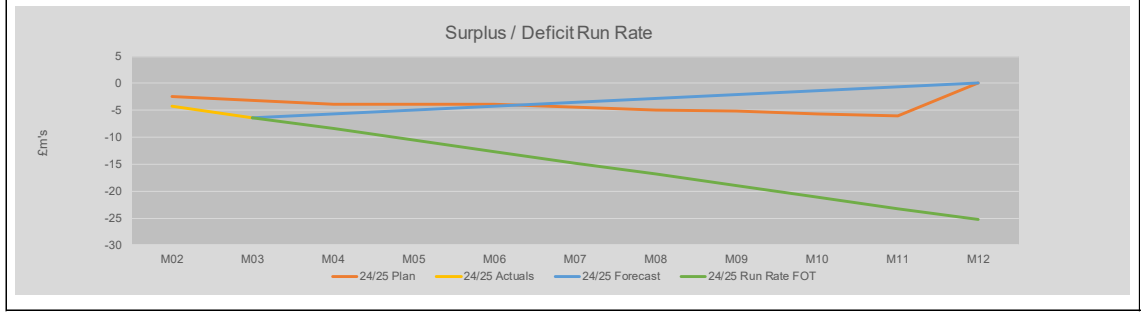
- The year to date variance at WSFT has deteriorated by a further £1.8m in month. There has been a notable increase in the net expenditure run rate of £0.7m per month broadly split equally between income and expenditure. If the current run rate continues the full year variance would be £22m to £27m worse than plan which is significantly in excess of any system wide mitigations identified. The run rate deterioration is a further pressure on the Trust's cash position and ability to pay suppliers. Further detail is included in the Trust Month 3 report submitted to the finance committee.
- The position at ESNEFT has improved in month by £0.2m indicating internal escalations put in place have had an impact in bringing the monthly position back in line with plan.
- EEAST have seen a slight increase in expenditure in month reducing the position variance from month 2.
- The ICB saw increasing pressures compared to month 2. Significant forecast pressures are: Continuing Healthcare - £4.3m due to increasing patient demand and volume of High Costs Packages of Care; Neuro-Rehab - £1.7m due to increase long term packages of care; Non Tariff Devices - £1.5m due to increased ordering of Insulin Pumps and supplies at ESNEFT and WSFT.
- The NHSE crude run rate metric currently indicates a potential ICB overspend, which is being driven by the value of allocations (£63m) not yet received from NHSE, despite expenditure occurring. This will reduce over the course of the year but has an impact on the ICB cash drawdown.

System Dashboard at Month 03 2024/25

NHS
Suffolk and
North East Essex

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit)				Full Year Forecast Surplus / (Deficit)			
	Plan	Actual	Variance		Plan	Forecast	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Suffolk And North East Essex ICB	2.0	2.0	(0.0)	(0.0%)	14.8	14.8	0.0	0.0%
Providers	(5.1)	(8.3)	(3.2)	0.7%	(14.8)	(14.8)	0.0	(0.0%)
ICS Total	(3.1)	(6.3)	(3.2)	(0.5%)	(0.0)	0.0	0.0	0.0%



System I&E Summary

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance YTD %	Plan Year Ending £m	Forecast Year Ending £m	Variance Year Ending £m	Variance Year Ending %
System Revenue Resource Limit	(626.6)				(2,444.7)			
ICB Net Expenditure								
Acute Services	298.9	298.0	0.9	0.3%	1,162.1	1,163.3	(1.2)	(0.1%)
Mental Health Services	55.5	55.2	0.4	0.7%	218.7	217.7	0.9	0.4%
Community Health Services	54.8	54.9	(0.1)	(0.2%)	218.5	220.1	(1.6)	(0.7%)
Continuing Care Services	29.2	29.7	(0.5)	(1.7%)	116.8	121.2	(4.4)	(3.7%)
Primary Care Services	56.4	58.4	(2.0)	(3.6%)	226.0	226.6	(0.6)	(0.3%)
Memo: Prescribing	49.5	51.4	(1.9)	(3.9%)	198.0	205.0	(7.0)	(3.6%)
Other Commissioned Services	3.2	3.2	0.0	1.2%	12.7	12.6	0.1	0.9%
Other Programme Services	1.8	1.4	0.3	19.5%	7.1	6.9	0.1	1.8%
Reserves / Contingencies	(6.2)	(3.2)	(3.0)	48.2%	(24.8)	(20.5)	(4.3)	17.2%
Delegated Specialised Commissioning	54.3	54.3	-	0.0%	187.0	187.0	-	0.0%
Delegated Primary Care Commissioning	72.8	69.4	3.4	4.7%	290.7	280.3	10.4	3.6%
ICB Running Costs	3.8	3.2	0.5	14.2%	15.0	14.5	0.6	3.7%
Total ICB Net Expenditure	624.6	624.6	(0.0)	(0.0%)	2,429.8	2,429.8	0.0	0.0%
ICS Providers I&E - Adjusted Financial Performance								
Income	(479.5)	(483.7)	4.2	(0.9%)	(1,942.6)	(1,942.6)	0.0	(0.0%)
Pay	312.3	318.4	(6.1)	(1.9%)	1,259.4	1,259.4	-	0.0%
Non-Pay	166.9	168.5	(1.5)	(0.9%)	675.9	675.9	0.0	0.0%
Non Operating Items	5.4	5.2	0.1	2.7%	22.2	22.2	(0.0)	(0.0%)
TOTAL Provider Surplus/(Deficit)	(5.1)	(8.3)	(3.2)	0.7%	(14.8)	(14.8)	0.0	(0.0%)
TOTAL ICS Surplus/(Deficit)	(3.1)	(6.3)	(3.2)	0.5%	(0.0)	0.0	0.0	(0.0%)

System Risk

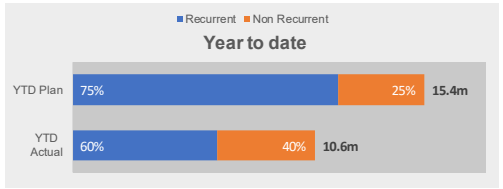
Not reported at month 3

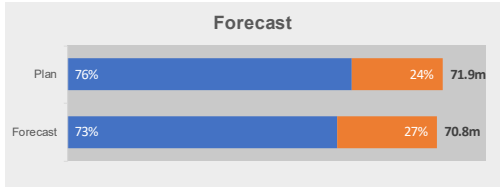
Gross Risk	Net Risk	Net Risk Movement	Movement from Prior Month
-	-	0.0%	-

Mental Health Investment Standard

Target MHIS Spend 2023/24	FOT 2023/24	Excess / Shortfall in 2023/24 MHIS Delivery %	MHIS Achieved in 2023/24?
168.9	168.9	0.00%	Yes

System Efficiencies



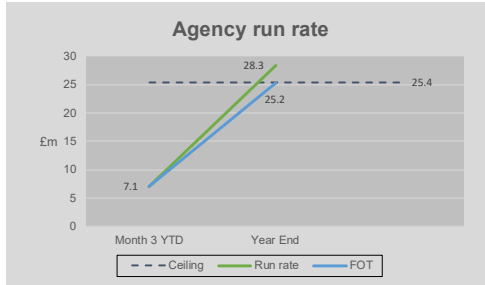


	YTD	Forecast
System efficiency % of allocation	1.7%	2.9%
ICB efficiency % of allocation	0.5%	0.5%
Provider efficiency % of gross operating Expenses	5.2%	9.7%

	ICB	Providers
Unidentified efficiency %	0.0%	5.1%
High risk %	2.8%	8.5%
Medium risk %	75.1%	44.6%
Low risk %	22.1%	19.0%

System Agency Expenditure

Ceiling	YTD spend	YTD % of Cap	Forecast	FOT % of Cap
25.4	7.1	27.9%	25.2	99.3%



System Capital Allocation

	Capital allocation	Variance to allocation	Forecast variance %
Providers	58.3	-	0.0%
ICB	13.5	-	0.0%
System	71.8	58.3	81.2%

Cash

	Prior Year	Year to Date	Forecast
Providers	116.2	43.9	49.3
ICB			
System			

Number of organisations missing BPPC target

		Providers	ICB
Current Month	Non NHS	1	
	NHS	1	
	Total	1	

Prior Month	Non NHS	-	
	NHS	-	
	Total	-	

EEAST Dashboard at Month 03 2024/25

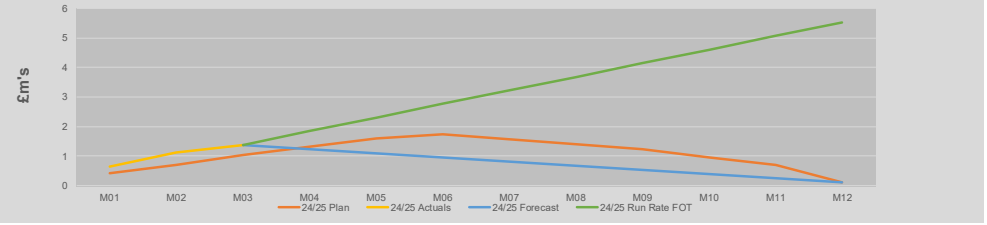
Suffolk and North East Essex

Summary Performance - Key Financial Indicators

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit) Plan £m	Actual £m	Variance £m	Variance %	Full Year Surplus / (Deficit) Plan £m	Forecast £m	Variance £m	Variance %
Income	114.3	114.3	(0.0)	(0.0%)	452.4	452.4	-	0.0%
Pay	(82.5)	(82.7)	(0.2)	0.3%	(330.0)	(330.0)	-	0.0%
Non-Pay	(30.4)	(30.3)	0.1	(0.4%)	(120.2)	(120.2)	-	0.0%
Non Operating Items	(0.4)	0.1	0.5	(111.7%)	(2.1)	(2.1)	-	0.0%
Provider Surplus / (Deficit) - Adjusted Financial Perfor	1.1	1.4	0.3	0.3%	0.1	0.1	-	0.0%

Surplus / Deficit Run Rate



Risk

Not reported at month 3

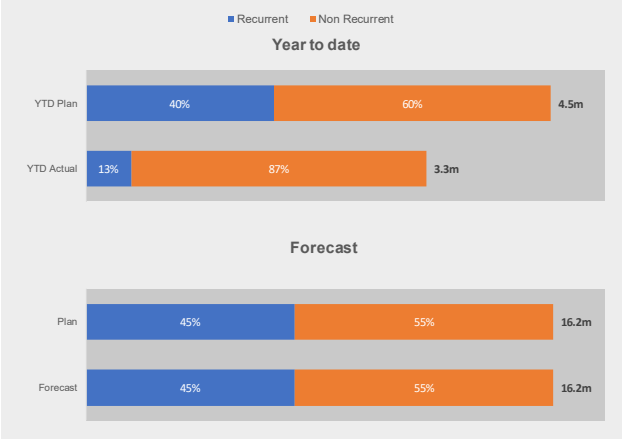
	Gross Risk	Net Risk	Net Risk % of	Movement from
Suffolk And North East Essex ICS	-	-	0.0%	-
East Of England Ambulance Service NHS Trust	-	-	0.0%	-
% share of ICS	0.0%	0.0%		

Agency Expenditure

	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending
All Providers	(6.6)	(7.1)	(0.5)	(25.2)	(25.2)	-
East Of England Ambulance Service NHS Trust	(1.5)	(1.8)	(0.3)	(6.0)	(6.0)	-

	Agency spend as % of total pay bill YTD	Forecast
System Average	2.2%	2.0%
East Of England Ambulance Service NHS Trust	2.2%	1.8%

Efficiencies

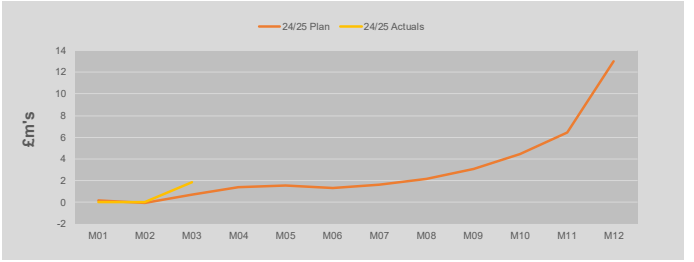


	YTD	Forecast
System efficiency % of allocation	1.7%	2.9%
All Providers efficiency % of gross operating expenses	5.2%	9.7%
East Of England Ambulance Service NHS Trust efficiency % of gross operating expenses	2.9%	3.6%

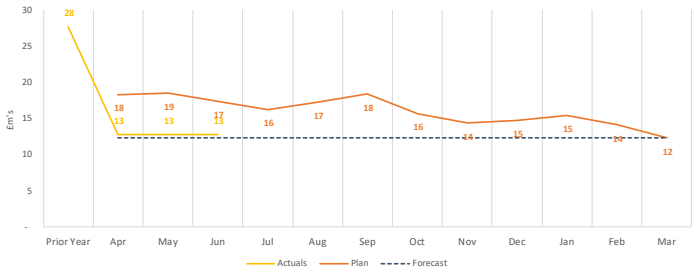
	High risk %	Med risk %	Low risk %
All Providers	8.5%	44.6%	19.0%
East Of England Ambulance Service NHS Trust	0.0%	0.0%	0.0%

	Fully Developed - in delivery	Fully Developed - delivery not yet started	Fully Developed	Plans in Progress	Opportunity	Unidentified
All Providers	2.0%	5.7%	7.7%	47.9%	11.2%	5.1%
East Of England Ambulance Service NHS Trust	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Charge against capital allocation



Cash



BPPC Performance

East Of England Ambulance Service NHS Trust	Non NHS	NHS	Total
Current Month	0.0%	0.0%	0.0%
Prior Month	0.0%	0.0%	0.0%
Movement	0.0%	0.0%	0.0%

System BPPC (Providers only)	Non NHS	NHS	Total
Current Month	90.3%	79.4%	89.4%
Prior Month	0.0%	0.0%	0.0%
Movement	90.3%	79.4%	89.4%

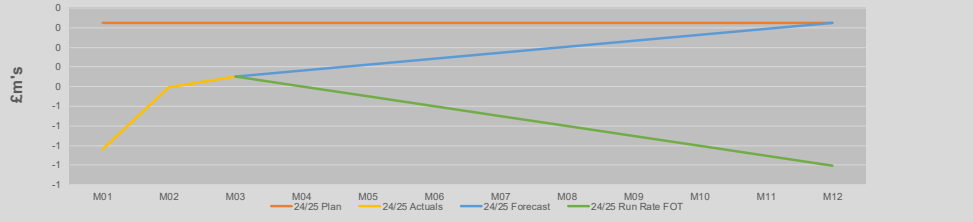
ESNEFT Dashboard at Month 03 2024/25

NHS
Suffolk and
North East Essex

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit) Plan £m	Actual £m	Variance £m	Variance %	Full Year Surplus / (Deficit) Plan £m	Forecast £m	Variance £m	Variance %
Income	268.6	272.4	3.8	1.4%	1,099.1	1,099.1	-	0.0%
Pay	(161.2)	(164.4)	(3.2)	2.0%	(657.0)	(657.0)	-	0.0%
Non-Pay	(103.5)	(104.3)	(0.8)	0.8%	(427.2)	(427.2)	-	0.0%
Non Operating Items	(3.6)	(4.0)	(0.4)	11.9%	(14.8)	(14.8)	-	0.0%
Provider Surplus / (Deficit) - Adjusted Financial Perfor	0.3	(0.3)	(0.6)	(0.2%)	0.3	0.3	-	0.0%

Surplus / Deficit Run Rate



Risk

Not reported at month 3

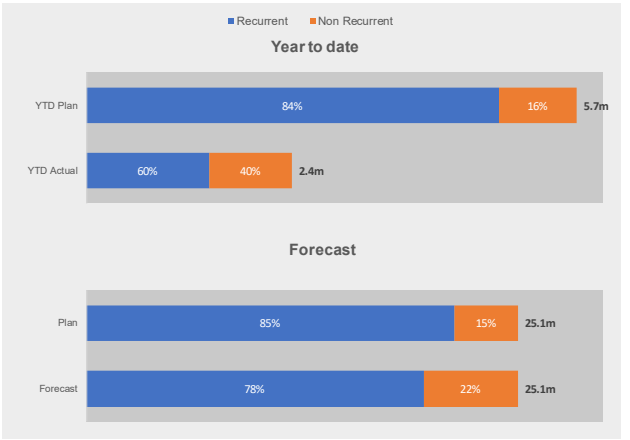
	Gross Risk	Net Risk	Net Risk % of	Movement from
Suffolk And North East Essex ICS	-	-	0.0%	-
East Suffolk And North Essex NHS Foundation Trust	-	-	0.0%	-
% share of ICS	0.0%	0.0%		

Agency Expenditure

	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending
All Providers	(6.6)	(7.1)	(0.5)	(25.2)	(25.2)	-
East Suffolk And North Essex NHS Foundation Trust	(3.6)	(3.8)	(0.2)	(14.5)	(14.5)	-

	Agency spend as % of total pay bill YTD	Forecast
System Average	2.2%	2.0%
East Suffolk And North Essex NHS Foundation Trust	2.3%	2.2%

Efficiencies

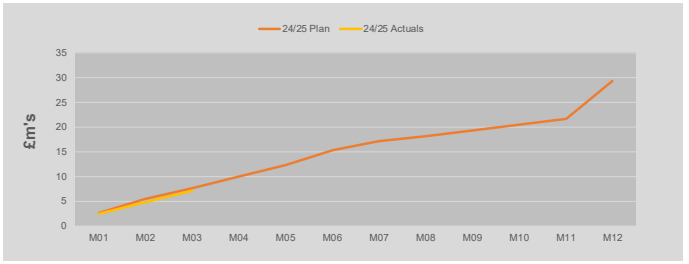


	YTD	Forecast
System efficiency % of allocation	1.7%	2.9%
All Providers efficiency % of gross operating expenses	5.2%	9.7%
East Suffolk And North Essex NHS Foundation Trust efficiency % of gross operating expenses	0.9%	2.3%

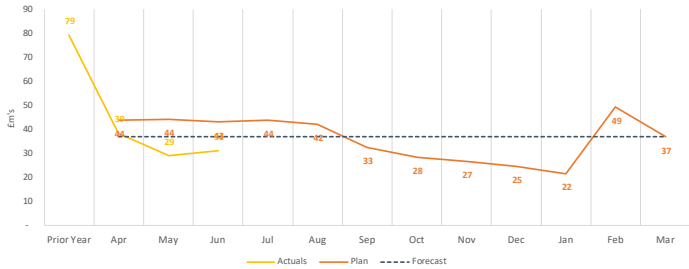
	High risk %	Med risk %	Low risk %
All Providers	8.5%	44.6%	19.0%
East Suffolk And North Essex NHS Foundation Trust	16.7%	66.1%	17.2%

	Fully Developed - in delivery	Fully Developed - delivery not yet started	Fully Developed	Plans in Progress	Opportunity	Unidentified
All Providers	2.0%	5.7%	7.7%	47.9%	11.2%	5.1%
East Suffolk And North Essex NHS Foundation Trust	3.6%	5.9%	9.5%	81.1%	0.0%	9.5%

Charge against capital allocation



Cash



BPPC Performance

East Suffolk And North Essex NHS Foundation Trust	Non NHS	NHS	Total
Current Month	90.3%	79.4%	89.4%
Prior Month	0.0%	0.0%	0.0%
Movement	90.3%	79.4%	89.4%

System BPPC (Providers only)	Non NHS	NHS	Total
Current Month	90.3%	79.4%	89.4%
Prior Month	0.0%	0.0%	0.0%
Movement	90.3%	79.4%	89.4%

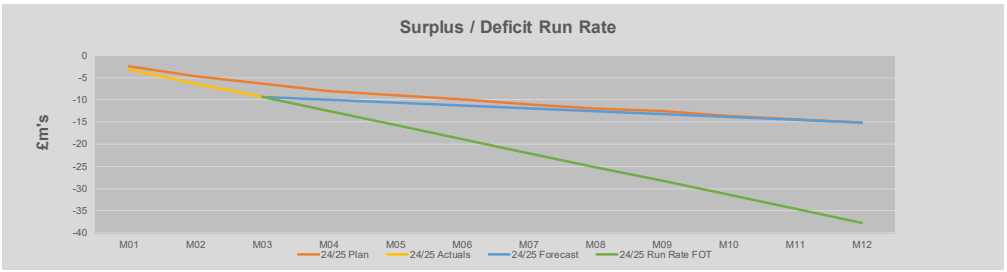
WSFT Dashboard at Month 03 2024/25

Suffolk and North East Essex

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit) Plan £m	Actual £m	Variance £m	Variance %	Full Year Surplus / (Deficit) Plan £m	Forecast £m	Variance £m	Variance %
Income	96.6	97.0	0.4	0.4%	391.1	391.1	0.0	0.0%
Pay	(68.6)	(71.3)	(2.7)	3.9%	(272.5)	(272.5)	-	0.0%
Non-Pay	(33.1)	(33.9)	(0.8)	2.5%	(128.5)	(128.5)	0.0	(0.0%)
Non Operating Items	(1.3)	(1.2)	0.1	(6.7%)	(5.3)	(5.3)	(0.0)	0.0%
Provider Surplus / (Deficit) - Adjusted Financial Perfor	(6.4)	(9.4)	(3.0)	(3.1%)	(15.2)	(15.2)	0.0	0.0%

Surplus / Deficit Run Rate



Risk

Not reported at month 3

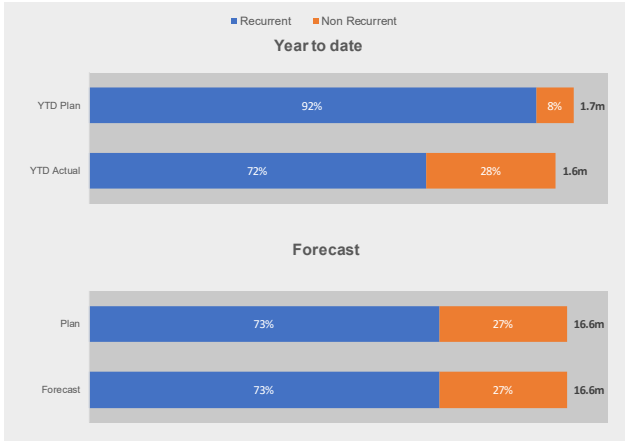
	Gross Risk	Net Risk	Net Risk % of allocation	Movement from prior
Suffolk And North East Essex ICS	-	-	0.0%	-
West Suffolk NHS Foundation Trust	-	-	0.0%	-
% share of ICS	0.0%	0.0%		

Agency Expenditure

	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending
All Providers	(6.6)	(7.1)	(0.5)	(25.2)	(25.2)	-
West Suffolk NHS Foundation Trust	(1.4)	(1.5)	(0.0)	(4.7)	(4.7)	-

	Agency spend as % of total pay bill YTD	Forecast
System Average	2.2%	2.0%
West Suffolk NHS Foundation Trust	2.1%	1.7%

Efficiencies

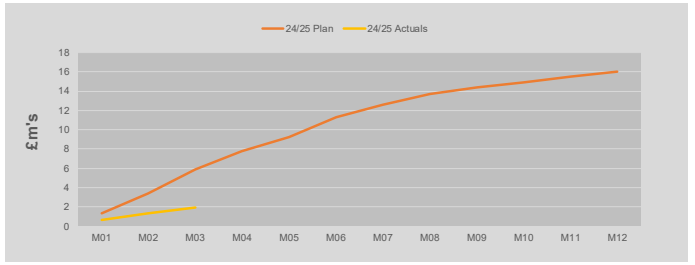


	YTD	Forecast
System efficiency % of allocation	1.7%	2.9%
All Providers efficiency % of gross operating expenses	5.2%	9.7%
West Suffolk NHS Foundation Trust efficiency % of gross operating expenses	1.5%	4.1%

	High risk %	Med risk %	Low risk %
All Providers	8.5%	44.6%	19.0%
West Suffolk NHS Foundation Trust	4.3%	55.6%	40.2%

	Fully Developed - in delivery	Fully Developed - delivery not yet started	Fully Developed	Plans in Progress	Opportunity	Unidentified
All Providers	2.0%	5.7%	7.7%	47.9%	11.2%	5.1%
West Suffolk NHS Foundation Trust	1.6%	10.9%	12.5%	44.7%	39.2%	3.6%

Charge against capital allocation



Cash

Not included in WSFT Working Day 10 submission.

BPPC Performance

Not included in WSFT Working Day 10 submission.

West Suffolk NHS Foundation Trust	Non NHS	NHS	Total
Current Month	0.0%	0.0%	0.0%
Prior Month	0.0%	0.0%	0.0%
Movement	0.0%	0.0%	0.0%

System (Suffolk and North East Essex ICB)	Non NHS	NHS	Total
Current Month	90.3%	79.4%	89.4%
Prior Month	0.0%	0.0%	0.0%
Movement	90.3%	79.4%	89.4%

Suffolk and North East Essex Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 11
Date: 30 July 2024

Title: Performance Report

Lead Director: ICB Executive Team.

Purpose: To note.

Recommendation: That the Board notes the performance dashboard for July 2024.

Related item on the Board Assurance Framework: All.

1.1 The July 2024 performance dashboard is attached to this paper. The dashboard includes escalation reports from several ICB sub-committees and the performance measures are also reported to the System Oversight and Assurance Committee.

Appendix 1: July 2024 Performance Dashboard

Suffolk and North East Essex Integrated Care Board Performance report July 2024

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Integrated Care System

System Oversight Assurance Committee 9th July 2024

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

System Oversight and Assurance Committee (SOAC) met on the 9th July 2024 and discussed the following items:

- Terms of reference were discussed and agreed with meeting moving to Bi-Monthly which allow for a greater strategic focus and prevent duplication of work undertaken by existing committees.
- Regional update was provided indicating that there would be a continuous focus on delivery and maintaining key priority areas. Whilst the focus is likely to remain toward acute trusts, the longer-term intention was to shift resources and move toward a greater level of integration. The latter will be linked to new care models and opportunities given through new hospital programme.
- Primary care model was discussed in the context of the national pilot programme which would give an opportunity to understand gaps and explore innovative solutions. Local PCNs have been invited to express an interest.
- Infected Blood inquiry report was discussed with whilst further guidance is expected the next steps and recommendations were considered. The main recommendation being the establishment of a task and finish group which would report to the ICB quality committee and in due course the Board.
- Performance report was discussed with no escalation to the Board but agreed action around infection control and reporting of data which will brough back to SOAC for review.
- Progress on finance were discussed and whilst there continues to be challenges Month 3 is indicating a break even position at year end.
- Potential risk associated GP national contractual dispute were briefly discussed and noted

The committee are not escalating any issues to the Board

Quarterly Performance review 21st June 2024

SNEE ICB attended its quarterly performance review on the 21st June and presented to regional colleagues on the following areas of development:

- PHM and Intelligence Function
- Spotlight on our INTs and Alliance in Ipswich and East Suffolk
- End of Life Care
- Elective Orthopaedic Centre

All the above were well received by regional colleagues who acknowledged the positive work that SNEE ICB is undertaking.

Performance was discussed and whilst we are awaiting formal assessment in terms of segmentation the overarching view expressed was that SNEE ICB was a high performing system.

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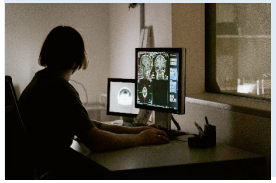
Performance Summary

NHS
Suffolk and North East Essex
Integrated Care Board

	Key Theme	Areas of improvement	Areas requiring further work
	Urgent and emergency care	Community based urgent care response remains consistently above the national standard of 70% with the latest data showing 88.6% of patients seen within 2 hours	12 hour waits in the accident and emergency departments remain high at 9.6% in April, but this remains an improvement on recent months and back to levels from 6 months ago
	Elective (planned) care	81.2% of patients are waiting less than 6 weeks for diagnostic imaging and tests which is a decrease on the last 2 months but still higher than the 23/24 average	Patients waiting 65 weeks or more for elective treatment has flatlined and presents a significant challenge to long term recovery.
	Cancer care	The system just missed the faster diagnosis standard of 28 days from referral in April 74.5% against a target of 75%	Those waiting over 62 days has increased in May to around 380, although this has fallen significantly in early June data
	Primary care	All three alliances have seen significant improvements in the proportion of patients with diabetes completing all eight care processes.	Dental and general practice activity remain stable but below our local plans.
	Mental health	Avoidable out of area placements have fallen over the last few months, but remain well above local plans	Dementia diagnosis rates remain well below the local plan of 65%, at 59.7% in April

Exception Summary

Cancer

Improvement		Common Cause	Concern		Assurance Fail
2		3			2

Concerning Special Cause Variation

Elective Care

Improvement		Common Cause	Concern		Assurance Fail
1	2	5			

Concerning Special Cause Variation

Urgent & Emergency Care

Improvement		Common Cause	Concern		Assurance Fail
	1	5	1		5

Concerning Special Cause Variation

12 hour waits in ED

Maternity

Improvement		Common Cause	Concern		Assurance Fail
	2	7			1

Concerning Special Cause Variation

Mental Health

Improvement		Common Cause	Concern		Assurance Fail
		2			1

Concerning Special Cause Variation

Children & Young People

Improvement		Common Cause	Concern		Assurance Fail
1					

Concerning Special Cause Variation

LD & Autism

Improvement		Common Cause	Concern		Assurance Fail
		2			1

Concerning Special Cause Variation

Quality

Improvement		Common Cause	Concern		Assurance Fail
		2	1		

Concerning Special Cause Variation

Summary Hospital Mortality Index rate - ESNEFT

I&ES Alliance

Improvement		Common Cause	Concern		Assurance Fail
3	1	1	1		1

Concerning Special Cause Variation

Antibiotic Items/STAR-PU

NEE Alliance

Improvement		Common Cause	Concern		Assurance Fail
3	1	1	1		1

Concerning Special Cause Variation

Antibiotic Items/STAR-PU

WS Alliance

Improvement		Common Cause	Concern		Assurance Fail
4	1		1		1

Concerning Special Cause Variation

Antibiotic Items/STAR-PU

Workforce

Improvement		Common Cause	Concern		Assurance Fail

Concerning Special Cause Variation

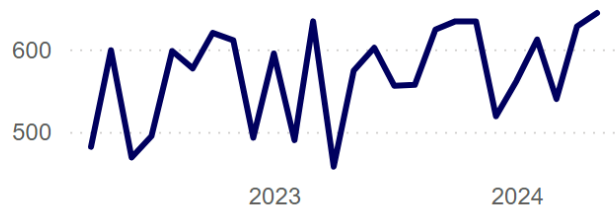
Cancer

NHS
Suffolk and North East Essex
Integrated Care Board

Issues & Root Cause

28 day & 62 day performance is challenged in Skin at WSFT and LGI at ESNEFT due to diagnostic capacity and staffing constraints.

Patients Treated for Cancer



May-24

First cancer treatments are currently **644** for this month

Recovery Actions

Recovery & action plans in place in challenged tumour sites across both Trusts. ESNEFT- Colorectal, Urology & UGI. WSFT – Skin & Colorectal.

Faster Diagnosis Compliance Delivery group meeting monthly to assess action plans and pathway analysis outcomes.

Endoscopy utilisation underway at both Trusts

62+ Day Cancer Waits

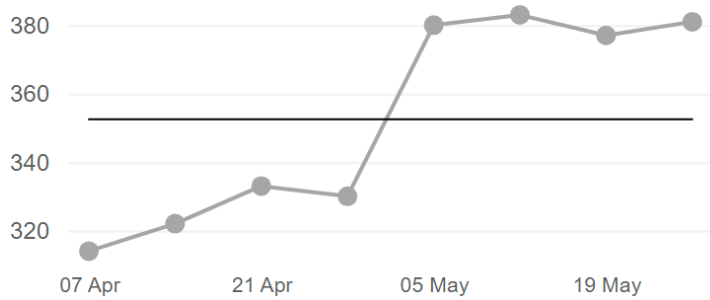
w/e 26-May-24

381 ESNEFT/WSFT patients are currently on the waiting list who have been waiting more than 62 days (urgent suspected)

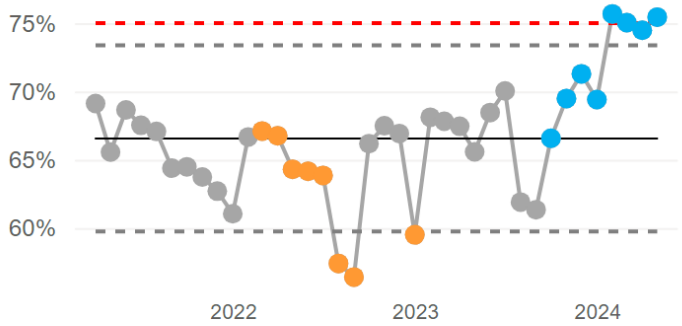
293 at ESNEFT 6.9% of all waiters

88 at WSFT 6.6% of all waiters

62+ day waiting list: Cancer

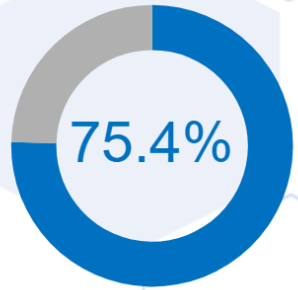


28 Day Faster Cancer Diagnosis



May-24

Proportion of ESNEFT/WSFT patients meeting the faster cancer diagnosis standard



Cancer & Rapid Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
62+ day waiting list (urgent suspected cancer)		Trust Local PTL	Jun-24	●			280		
62+ day waiting list - over 104 days (urgent suspected cancer)		Trust Local PTL	Jun-24	○			71		
Increased first cancer treatments	Reduce shortfall	National CWT	Apr-24	●			628		
28 day faster diagnosis		National CWT	Apr-24	●	75.0%	75.0%	74.5%		
31 day wait diagnosis to treatment	Improve performance	National CWT	Apr-24	○	96.0%		94.9%		
Patients treated within 62 days	Improve performance	National CWT	Apr-24	○	85.0%		74.1%		
Screening uptake - Cervical (25-49)	Maintain and restore cancer screening programmes	NHS Digital	Dec-23	●			72.7%		
Screening uptake - Cervical (50-64)	Maintain and restore cancer screening programmes	NHS Digital	Dec-23	●			77.4%		
Screening uptake - Breast (50-70)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-23	●			70.6%		
Screening uptake - Bowel (60-74)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-23	●			73.0%		
Early stage diagnosis	75% by 2028		Jan-24	●			61.4%		

Key performance issues & root cause summary

28 day & 62 day performance is challenged in Skin at WSFT and LGI at ESNEFT due to diagnostic capacity and staffing constraints.

Key performance recovery actions

Recovery & action plans in place in challenged tumour sites across both Trusts. ESNEFT- Colorectal, Urology & UGI. WSFT – Skin & Colorectal.

Faster Diagnosis Compliance Delivery group meeting monthly to assess action plans and pathway analysis outcomes.

Endoscopy utilisation underway at both Trusts

Cancer & Rapid Diagnostics Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 25/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

* GP direct access is currently being trialled for 3/12 in East Suffolk PCN, with further roll out plan agreed.
* Second FiT pathway in WSFT is being audited following over 100 patients through pathway, learning to be shared across SNEE.
* WSFT Urology audit complete and review of prostate risk stratification tools underway. * ESNEFT Gynae PMB videos in development, to be shared at women's health group.
*Joint working with Community Action Suffolk to start a Cancer network.
* TLHC model & planning revised to reflect fixed CT scanner in WSFT, with bid submitted for ESNEFT Colchester.
* PSA Pilot delivered in East Lynne with outcome evaluation underway.

Key actvities planned for the next 2 months

* Specification written and to be agreed by delivery group for LHC procurement for the TLHC programme.
* Skin Analytics service extension & business case underway.
* Appointment of an Integrating Cancer Journey lead.
* Establish a personalised care network, between all providers including primary and secondary. Network Event to be held 25/09/2024.
*Development of business case for OOH cervical screening provision in NEE and within sexual health setting across SNEE.
*HTAAF PHM capsule sponge pilot to go live by end of Q2.
*Community Partnership to be relaunched in September.
*Showcase of our personalised care work to be undertaken at the Cancer Alliance Summit 18th September.
*SNEE Primary Care Event to be held 28/09/2024.

We have learned this and need to share...

* Despite demonstrating a positive return on investment (ROI) , it has not always been possible for Trusts to prioritise Personalised Care posts.
* Procurement guidelines have changed within the ICB therefore timelines may need to change to account for this.
* Utilising PHM analytics team to support targeted case finding projects.

We need help with..

* Support with innovations, disparity between regional concerns and national agenda's impacting local implementation of innovation.

Key Issues

*Sustainable funding for projects within primary and secondary care, while financially constrained. Some services are now at risk collapse, which will impact patient care. Exit plans are in development.

Key Risks

* IT system in TLHC, the national team are procuring a national IT system, no agreed timelines, impacting on local decision making regarding local solution.

Elective Care & Diagnostics

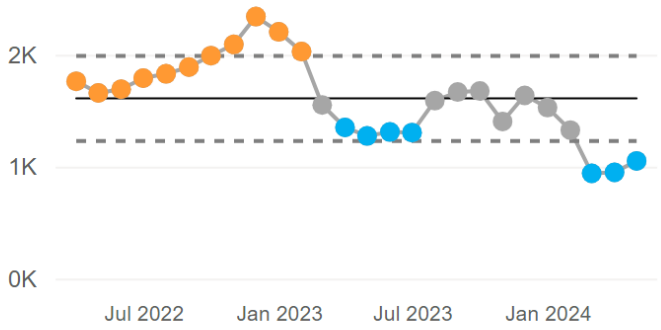
NHS Suffolk and North East Essex Integrated Care Board

Issues & Root Cause

92 patients breached 78 weeks at the end of 2023/24 of which 29 were complex (including corneas and HMP patients) or choice and 34 were from the Urogynaecology sub-specialty which is a regional capacity challenge.

65 weeks: 98.3% of the 55,583 patients who needed to be treated by the 31st March 2024 were treated (all but 813 against our preindustrial action plan of 117). The main areas of 65 week breaches were T&O, Urogynaecology and General. Trajectories for 65wk clearance by the end of Sept-24 are currently being agreed.

RTT - 65 weeks waits



May-24

There are currently **1,052**

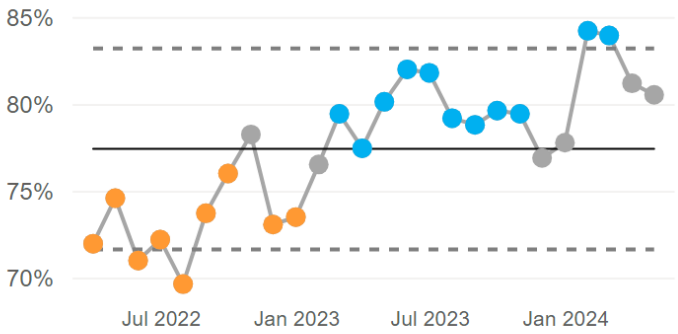
ESNEFT/WSFT patients who have been waiting more than 65 weeks to start treatment

Recovery Actions

With the exception of Urogynaecology where work is in progress, recovery plans are in place for all areas to bring waits down to 65 weeks by September 2024. Theatre utilisation at WSFT in particular has increased in recent weeks. Industrial action remains a key risk to delivery of this going into 2024/25 and there is high reliance on increasing productivity and throughput. The focus on these will continue throughout 2024/25.

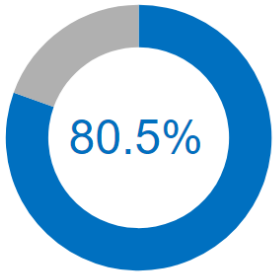
MetricName	Date	Actual	Var.	LPL	Mean	UPL
Elective Day Case	Jun-24	12,594		9,506	11,629	13,751
Elective Ordinary	Jun-24	1,752		1,320	1,646	1,971
First outpatients	Jun-24	31,421		23,073	31,288	39,503
Follow up outpatients	Jun-24	61,612		42,035	55,605	69,175
First outpatients - procedures	Jun-24	6,930		4,462	5,954	7,447
Follow up outpatients - procedures	Jun-24	14,486		8,608	11,086	13,564

Diagnostic Tests within 6 weeks



May-24

Proportion of ESNEFT/WSFT patients waiting less than 6 weeks (target 95%)



Diagnostic Tests

May-24

Diagnostic tests are currently **33,437** for this month

Strategic Programmes, Elective Care and Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
RTT Admitted Pathways		National RTT	Apr-24	○			3,026		
RTT Non-Admitted Pathways		National RTT	Apr-24	○			18,433		
65 weeks wait	0 by September 2024	National RTT	Apr-24	○			950		
52 weeks wait	Reducing by March 2025	National RTT	Apr-24	●			5,484		
Elective Day Case		Faster SUS	May-24	○			13,474		
Elective Ordinary		Faster SUS	May-24	○			1,806		
First outpatients		Faster SUS	May-24	○			46,880		
Follow up outpatients		Faster SUS	May-24	○			111,217		
Diagnostic Tests		DM01	Apr-24	●			30,814		
Diagnostic Tests within 6 weeks	95% by March 2025	DM01	Apr-24	○			81.2%		

Key performance issues & root cause summary

92 patients breached 78 weeks at the end of 2023/24 of which 29 were complex (including corneas and HMP patients) or choice and 34 were from the Urogynaecology sub-specialty which is a regional capacity challenge.

65 weeks: 98.3% of the 55,583 patients who needed to be treated by the 31st March 2024 were treated (all but 813 against our preindustrial action plan of 117). The main areas of 65 week breaches were T&O, Urogynaecology and General. Trajectories for 65wk clearance by the end of Sept-24 are currently being agreed.

Key performance recovery actions

With the exception of Urogynaecology where work is in progress, recovery plans are in place for all areas to bring waits down to 65 weeks by September 2024. Theatre utilisation at WSFT in particular has increased in recent weeks. Industrial action remains a key risk to delivery of this going into 2024/25 and there is high reliance on increasing productivity and throughput. The focus on these will continue throughout 2024/25.

Strategic Programmes, Elective and Diagnostics Committee (1 of 2)

Narrative submitted: 15/07/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

We have continued to monitor and deliver against our agreed recovery trajectories to reduce the number of patients waiting over 65 weeks with the exception of patient choice.
We have managed the impact of the latest Industrial action on our recovery and remain committed to delivering.

We have further developed the outpatient transformation work which will be key to supporting reduction of patients waiting over 52 weeks and have undertaken some analysis to help us decide where to best pace our transformation focus.

We have continued to focus on increasing our productivity to maximise our day case rates and theatre utilisation.

Plans to meet our diagnostic waiting times continue to be delivered with some significant progress being made in some areas.

We have further developed our Power BI reporting to help us maintain our focus on delivering our recovery,

Key actvities planned for the next 2 months

We plan to develop outpatient transformation programme based on analysis undertaken and agree on specific end to end pathway development.

We will continue to monitor and deliver against our agreed trajectories and take remedial actions where required.

We will continue to engage with the GIRFT national programme and pull on good practice going forward.

We continue to develop the opportunities represented by the Colchester Orthopaedic Centre and will ensure patient consultation informs our approach.

We have learned this and need to share...

Both trusts continue to align their work programmes and analysis now showing that whilst a number specialities are recovering towards 18 weeks, there will need to be a focus on certain key specialities where biggest challenge is likely to be.

We need help with..

Going forward workforce will be a limiting factor across some specialities and are actively engaged and triangulating our plans to continue and achieve ongoing recovery.

We continue to engage with our regional colleagues to review opportunities for mutual aid.

Key Issues

We are currently on trajectory to meet out trajectory commitments but going forward need to look and identify plans to reduce the number of patients waiting over 52 weeks with the main challenge being across a small number of specialities.

Key Risks

Our key risks remain workforce and impact of any future industrial actions. We will assess level of risk once we have understood national direction for recovery.

Strategic Programmes, Elective and Diagnostics Committee (2 of 2)

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 25/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

* Diabetes System Review Report (Ian Perrin), presented to diabetes committee, option 3 agreed - (develop common service spec, but commissioned locally). To be taken to SPED and Executive Committee for approval.
* Type 2 Diabetes Remission - ICB Prog Mgr meeting with Counterpoint to establish metrics.
* ME&CFS and Long Covid combined service business case agreed at Executive Committee.
* SiSU CSO sign off now complete, 10 units now out in SNEE.
* Post Stroke 6 month review nurse now in post and undertaking care home reviews in IES
* Emergency cover agreed with GPPC to cover Suffolk, while wider procurment is undertaken.
* Pulmonary rehab and Tobacco dependency treatment national funding proposal presented to respiratory committee for decision.

Key actvities planned for the next 2 months

* Suffolk Spirometry LES has been completed, with LMC to agree
* Design Early Onset (T2DAY) service ongoing * Development of diabetes service specification and review of LES's
* Rollout of remaining SiSU stations and collecting data
* ICANHO service review with SCC to plan long term commissioning ongoing
* Work on hypertension pathway within diabetes has started as well as agreeing a wider Hypertension SNEE strategy, which has been drafted
* Stroke day workshop planned for ICS partners in July
* Level 2 Beds Pathway going through clinical review for sign off
* Hypertension event planned in Claction July 2024 in partnership with ESNEFT
* LTC funding scheme proposals to be presented to SPED committee

We have learned this and need to share...

* Importance of patient voice and co-production in service developments.
* Utilising PHM methodology and PHM analyst team in project development.
* To ensure evalutaion considerations have been considered during the scoping phase of project development.

We need help with..

* Looking at ways to work more collaborative as a system given limited financial constraints.
* Working across strategic and alliance teams to meet common goals, hypertension delivery plan in development to support measuring outcomes to the JFP ambition.

Key Issues

* Impact of conflicting priorities for teams.
* New SNAPP performance process for July - changes to data collection moving to outcomes rather than KPIs and the therapy time for patients will increase, innovative solutions will be required to support implementation.

Key Risks

* Staffing shortages to deliver project deadlines.
* Weight Management Services
* Suffolk Spirometry Service.
* Lack of resource in the Stroke & Neuro rehabilitation spaces in terms of funding opportunities and workforce risks.

Urgent & Emergency Care

NHS Suffolk and North East Essex Integrated Care Board

Issues & Root Cause

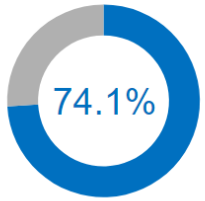
Ambulance response times remain above expected for both C1 & C2 priority categories, however this has remained consistent since improving in Jan-23

The % of ambulance handovers in 30 mins remains well below the target of 95% but has improved since the low of 60% in Jan-24

The % of people waiting 4 hours or less in A&E met the target of 76% in Mar-24. WSFT re-commenced reporting of this metric from Jun-23 so this figure is now ESNEFT/WSFT combined

The number waiting over 12 hours in ED has improved slightly since Jan-24 at 9.7% compared to a target of 2%.

A&E 4 Hour Waits



May-24

Proportion of ESNEFT and WSFT patients waiting in A&E for less than 4 hours

WSFT started reporting in June 2023.

G&A Bed Occupancy

14-Jul-24

94.83% of G&A beds are currently occupied in ESNEFT/WSFT

95.33% at Colchester Hospital

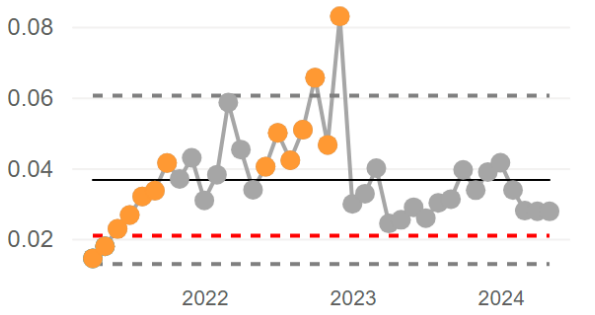
97.04% at Ipswich Hospital

93.02% at West Suffolk Hospital

Recovery Actions

Significant pressure remains across the UEC system. Demand & Capacity work has been undertaken (linked to national funding) with a number of schemes being implemented to support flow. This should improve the ED performance and support improved patient arrival to handover performance.

Ambulance Cat 2 Responses



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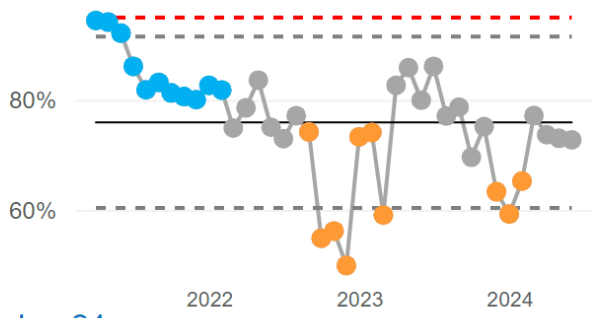
May-24

Mean category 2 ambulance response time (target 30 mins)

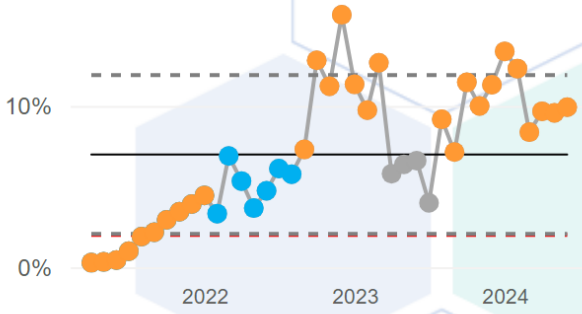
Ambulance Handover Delays



Jun-24

Handovers within 30 mins (target 95%) 72.8%

ED 12 Hour Waits



Jun-24

Reduce towards 0 with no more than 2% 2,232 (9.9%)

Urgent & Emergency Care

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Ambulance response times - C1 Mean	7 mins	EEAST	May-24	●	00:07:00		00:09:46		
Ambulance response times - C1 90th percentile	15 mins	EEAST	May-24	●	00:15:00		00:18:43		
Ambulance response times - C2 Mean	18 mins	EEAST	May-24	●	00:18:00		00:39:57		
Ambulance response times - C2 90th percentile	40 mins	EEAST	May-24	●	00:40:00		01:23:10		
Ambulance handover delays	95% within 30 mins	EEAST	May-24	●			73.0%		
A&E Attendances - Type 1&2		Faster SUS	May-24	○			22,443		
A&E 4 Hour Waits	78% by March 2025	NHS Digital	Apr-24	○			75.6%		
12 hour waits in ED	Reduce towards 0 and no more than 2%	Local Trust Report	May-24	●			2,247 (9.6%)		
NEL Spells		Faster SUS	May-24	○			11,152		

Key performance issues & root cause summary

Ambulance response times remain above expected for both C1 & C2 priority categories, however this has remained consistent since improving in Jan-23

The % of ambulance handovers in 30 mins remains well below the target of 95% but has improved since the low of 60% in Jan-24

The % of people waiting 4 hours or less in A&E met the target of 76% in Mar-24. WSFT re-commenced reporting of this metric from Jun-23 so this figure is now ESNEFT/WSFT combined

The number waiting over 12 hours in ED has improved slightly since Jan-24 at 9.7% compared to a target of 2%.

Key performance recovery actions

Significant pressure remains across the UEC system. Demand & Capacity work has been undertaken (linked to national funding) with a number of schemes being implemented to support flow. This should improve the ED performance and support improved patient arrival to handover performance.

Urgent & Emergency Care Committee

Narrative submitted: 15/07/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

To support delivery of the SNEE JFP (inc. national priorities), the 24/25 UEC Forward Plan has been refreshed and approved at the July UEC Committee. The Plan directly responds to key national and local priorities including the NHS UEC Year 2 Recovery Plan, NHS High Impact Interventions and Alliance priorities. For each project at System and alliance-levels, a problem statement and response has been articulated together with delivery ownership and funding source. In a new partnership, resource has been secured from the NHS EOE UEC Improvement Team to support delivery of specific projects, with personnel having been welcomed into the ICBs central UEC team.

Following its approval in May, refreshed UEC governance has been implemented across the System including strengthened alliance-based governance led by senior locality-based UEC leads.

The July UEC Cttee received a deep dive presentation on the System's virtual ward capacity and agreed actions to be taken to increase referrals from community and primary care providers, in addition to receiving a proposal at their Sept meeting in relation to strengthening evaluation of the services to inform future investment decisions.

Elizabeth Moloney has been appointed as the ICB's Director of Operations.

Key actvities planned for the next 2 months

As part of BAU governance, Quarter 1 performance reviews have been scheduled in early July with Trusts. Delivery that materially varies from agreed planning trajectories will be explored to understand recovery actions, including support requests to system partners.

Application of the GIRFT diagnostic improvement tool Alternatives to ED (A-tED) wis shceulded to conclude in Jul with agreement of response through alliance-based UEC governance ahead of discussion and approval at UEC Cttee.

By September, the UEC Forward Plan will include further information on milestones and forecast impact for each constituent project to enable analysis of return on investment.

The September UEC Cttee will be held in-person at Ipswich Hospital to facilitate a tour of the newly opened Urgent Emergency Care Centre in addition to receiving a mid-year review of delivery against the Forward Plan. Furthermore, evaluation of 23/24 BCF and Discharge funds will be provided together with the output of a system-wide audit in response to NHS England's letter regarding maintaining focus and oversight on quality of care and experience in pressurised services.

We have learned this and need to share...

In April, the SNEE Integrated Care Partnership (ICP) start work to develop the central high level concept of enabling a ‘Future Shift’ in our whole health and care system over the next decade. Building upon this, engagement will shortly commence to explore how the UEC community can become more involved to ensure there is a clear vision for the future of UEC services in the medium and longer term aligned to changing population needs.

We need help with..

There are no matters arising from the UEC Committee to escalate to the ICB Board.

Key Issues

In developing the UEC Forward Plan, issues and management actions have been refreshed. At this time, there are no issues the UEC Committee need to escalate to the Board.

Key Risks

In developing the UEC Forward Plan, risks and mitigation actions have been refreshed. At this time, there are no risks the UEC Committee need to escalate to the Board.

Maternity & Neonatal

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Preterm Births (<37 weeks) 12 month rolling rate	<=6%	RPQOG	Apr-24	○			7.60%	L	F
Preterm Births (<37 weeks) monthly rate	<=6%	RPQOG	Apr-24	○			7.30%		?
3rd & 4th degree tear - singleton vaginal delivery	<=2.5%	RPQOG	Apr-24	○			2.30%		?
3rd & 4th degree tear - instrumental delivery	<=6.3%	RPQOG	Apr-24	○			9.10%		?
Massive Obstetric Haemorrhage = 1500 mls - Vaginal delivery	<=3.3%	RPQOG	Apr-24	○			2.72%		?
Massive Obstetric Haemorrhage = 1500 mls - C-section	<=4.5%	RPQOG	Apr-24	○			3.13%		?
Stillbirth Rate (per 1,000)		Civil Registration of Births	Feb-24	●			0.00		
Neonatal Mortality Rate (per 1,000)		Civil Registration of Deaths	Feb-24	●			0.00		
Smoking at time of delivery	<=6%	RPQOG	Apr-24	○			5.40%	L	?

Key performance issues & root cause summary

Performance metrics currently reported from combined local reports for ESNEFT and WSFT. Known DQ issues with ESNEFT's submission to the national Maternity Services Data Set (MSDS). When rectified, reporting will switch to national flows, and will provide more detail behind some of these metrics.
Variation seen in stillbirth & NND but overall remain static whereas national ambition of 50% reduction before 2025. % of women smoking at time of delivery decreasing due to new smokefree pathway. Preterm births remain higher than national benchmark, however smokefree pathway appears to be assisting to reduce the rates for the first time in over 2 years. New preterm pathway is starting to be implemented across the ICB

Key performance recovery actions

Data Quality - ESNEFT attempting to resolve data quality issues but solution is new EPR.
Stillbirth & NND - ESNEFT review demonstrated vulnerable groups at most risk, VCSE business case aimed at addressing some of issues as well as preterm birth pathway.

**there is a known lag in the completeness of both births and deaths monthly data, so these figures are likely to change on refresh*

Maternity Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 28/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

SBLCB v3: Trajectories reviewed and agreed, SG to sign off early July
MNVP: New model approved by SG, role to advertised imminently, closing down current bank accounts and returning ICB assets
Transformation Programme being implemented at pace.
Development of VCSE offer in West Suffolk area continued
Be Well bus tour with pregnancy focus visits continued, footfall increasing
New safety lead and admin recruited, awaiting start dates.
Coordination of all maternal vaccinations underway inc. whooping cough and new RSV
Suffolk Start Well project groups mobilised
Smokefree pregnancy formal evaluation commenced
Coproduction workplan developed

Key actvities planned for the next 2 months

Preterm birth prevention workstream: lead midwife role still to be banded by ESNEFT
Smokefree pregnancy pathway: NHSE fieldwork commenced to showcase service as addressing health inequalities within maternity, UoS scoping quantitative and ROI evaluation.
ECC pilot for weight management (preconception and pregnancy) scope and funding governance
Scope preconception pilot with Abbeycroft for West Alliance
VCFSE training to deliver enhanced antenatal education for their respective communities
Recruitment of MNVP lead/s
Neonatal deaths review to be published
3rd & 4th degree tears task group to be commence with obstetric involvement due to connection with instrumental births
PHM data extraction/development
Phase two of website
Senior independent advocate to start receiving referrals

We have learned this and need to share...

1. Neonatal death rates: higher than national average, not reducing, not achieving national ambition. LMNS deep dive to report in June 24.
2. Recent increases in tear rates. QI commenced within Trusts, LMNS task group to be formed in June 24
3. Delay to recruitment of Preterm birth midwife due to ESNEFT job matching delays
4. Number of support workers resigned from smokefree teams due to short term nature of their contracts

We need help with..

1. ESNEFT incident reporting to LMNS is considerably delayed, sometimes taking up to a year. One ESNEFT PSII is currently overdue - commenced 20/7/23, draft report not yet complete.
2. Gaining substantive funding for smokefree pregnancy pathway to retain skilled and effective staff members.
3. NHSE reported LMNS funding was recurrent yet retained it as SDF funding. ICB stating it is non-recurrent. Trusts not confident they will be able to recruit obstetricians if non recurrent

Key Issues

1. See above
2. LMNS not meeting national targets for stillbirth, preterm birth, or perinatal death, and inconsistently post partum haemorrhage
3. Competing priorities and reduced LMNS transformation team capacity. Priorities have been agreed for 2024-25, Alliance involvement classed as LOW priority
4. Large number of maternity support workers have left the service due to short length, fixed term contracts. Skills and effective staff members being lost.
5. NHSE reported LMNS funding was recurrent yet retained it as SDF funding therefore Trusts not confident they will be able to recruit obstetricians with the allocated money.

Key Risks

1. Stillbirth and neonatal mortality rates above national rates, ICB not achieving national ambition.
2. CNST Safety Action 7 at risk due to not effective MNVP. Mitigation is to escalate through PQSM and regional team as a risk.
3. Both Trusts rated as "requires improvement" for maternity services. ESNEFT MSSP review and reset meeting held 9/4/24, recognition of improvements but senior team currently under consultation and senior posts/structure requires finalising. Decision to maintain on MSSP. Next review planned Oct '24 where aim will be to set an exit date

Mental Health

NHS Suffolk and North East Essex Integrated Care Board

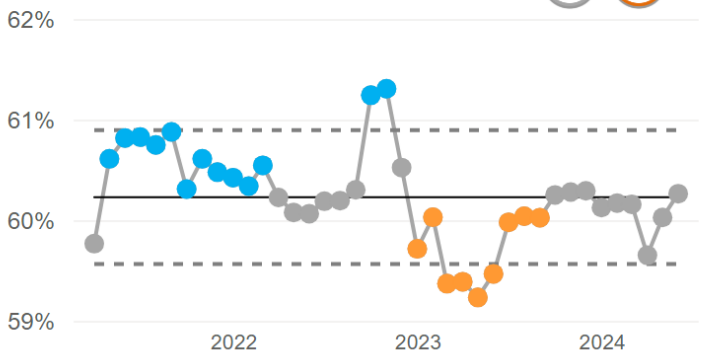
Issues & Root Cause

2/3 of SNEE out of area bed days are reported as being North East Essex. Numbers across the 3 alliances have fallen significantly over the last 2 months

Dementia diagnosis rates appear to show a distinct drop from Dec-22, but this is largely as a result of a change in methodology and corrections in the data published by NHS Digital. The rate is currently at 60.2% against the local target of 65%, which shows an improvement from the last 4 months.

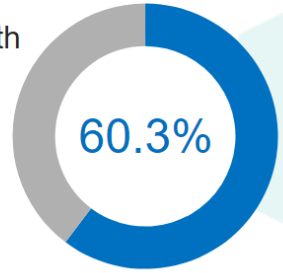
Note: April 2024 data for MHSDS, ECDS, Data Quality, Perinatal, IPS will be delayed by August 2024 due to transitioning to MHSDS v6

Dementia Diagnosis Rate



Jun-24

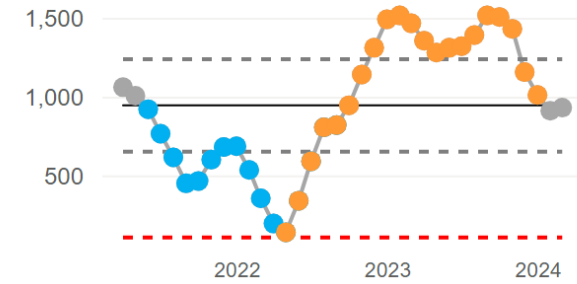
% diagnosed with dementia compared to estimated prevalence (target 66.7%)



MetricName	Date	Actual	Var.	LPL	Mean	UPL
CYP accessing MH services	Mar-24	12,880		11,576	12,012	12,448
NHS Talking Therapies Access	May-24	1,995		1,558	2,149	2,740
Community MH services access (older adults/SMI)	Mar-24	5,640			5,589	
Perinatal Access - YTD	Mar-24	1,350			859	

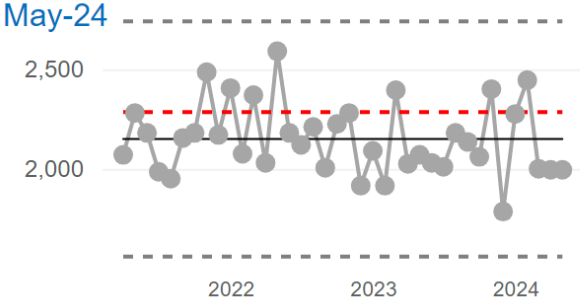
Inappropriate OOA Bed Days

Mar-24



Talking Therapies Access

May-24



Recovery Actions

Access to psychological therapies therapies and 90 day waits between first and second treatments remain challenging particularly challenging within EPUT who continue to explore ways to bolster capacity to increase the number of assessments since the expiry of the Xyla Contract. 24/5 national focus is on reliable improvement and recovery with trajectories being finalised. Nationally, Waiting lists for ADHD assessment within the NHS continue to grow along with increasing requests for assessment under Right to Choose: the ICB is considering potential of the benefits of undertaking a provider accreditation exercise.

Mental Health

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
SMI full annual physical health checks		MH Core Data Pack	Mar-24				5,645		
Community MH services access (older adults/SMI)		MH Core Data Pack	Mar-24		7,778	7,778	5,625		
Dementia diagnosis rate		NHS Digital	Apr-24		66.7%	60.0%	59.7%		
Perinatal Access - YTD		MH Core Data Pack	Mar-24		1,570	1,570	1,350		
EIP - Waiting Times	Treament within 2 weeks of referral	MH Core Data Pack	Mar-24		60.0%		87.0%		

Key performance issues & root cause summary

2/3 of SNEE out of area bed days are reported as being North East Essex. Numbers across the 3 alliances have fallen significantly over the last 2 months

Dementia diagnosis rates appear to show a distinct drop from Dec-22, but this is largely as a result of a change in methodology and corrections in the data published by NHS Digital. The rate is currently at 60.2% against the local target of 65%, which shows an improvement from the last 4 months.

Key performance recovery actions

Access to psychological therapies therapies and 90 day waits between first and second treatments remain challenging particularly challenging within EPUT who continue to explore ways to bolster capacity to increase the number of assessments since the expiry of the Xyla Contract. 24/5 national focus is on reliable improvement and recovery with trajectories being finalised.
Nationally, Waiting lists for ADHD assessment within the NHS continue to grow along with increasing requests for assessment under Right to Choose: the ICB is considering potential of the benefits of undertaking a provider accreditation exercise.

April 2024 data for MHSDS, ECDS, Data Quality (excl. DQMI), Perinatal, IPS will be delayed by August 2024 due to transitioning to MHSDS v6

14th August 2024

- July 2024 data for Dementia.
- June 2024 data for monthly Talking Therapies.
- April 2024 - June 2024 data for MHSDS, ECDS, Data Quality (excl. DQMI), Perinatal, IPS.
- April 2024 - June 2024 data for OAPs.
- Q1 2024/25 data for Talking Therapies.

Mental Health Committees (Suffolk & North East Essex)

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 28/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

The Suffolk system paused the Suffolk MH Collaborative next meeting until Sept '24. Discussions have taken place with NHSE, N&W ICB & NSFT committing to the delivery of one contract with NSFT by 31.03.25. Governance is in the process of being established to deliver this objective. NSFT have established an internal Trust Transformation Group to get a better grip on their work programme.
SNEE ICB continues to support implementation of the Southend, Essex & Thurrock Commissioning strategy through chairing of the County wide Strategy Implementation Group (SIG). Live conversations include development of system wide outcome measures, promotion of co-production & user engagement & establishing better links across system partners taking forward linked MH projects.
NHSE SNEE 24/25 3 Year Inpatient Plan submitted on 28.06.24.

Key actvities planned for the next 2 months

Discussion with NSFT & EPUT on how best to implement the 3-Year Inpatient Plan.
Suffolk Talking Therapies procurement via Most Suitable Provider (MSP) route to be completed.
Continued work by NSFT on their Trust restructure, & deep dives planned for community & urgent care models.
New Suffolk and Norfolk Transformation Board to have its inaugural meeting to oversee the development of a single NSFT contract across both counties and consider areas where more collaboration can take place.
Finalisation of EPUT 24/25 SLA negotiations including management of the Time to Care business case and agreement on the NEE PCN's MH ARRS roles MOU.
Implementation successfully agreed 24/25 Better Care Fund Mental Health schemes in NEE and Suffolk which will aid discharge planning & better patient flow.

We have learned this and need to share...

2024/25 MH financial position will be challenging. A number of known pressures are under review including Suffolk S117 spend & cost of implementing a 'Time to Care' with EPUT.
SMI Annual Physical Health Checks (PHC) Q4 I&E 86.5% WS 83% NEE 71.8%. Best performer in EOE) in all 3 localities.
Agreement with the Suffolk system to ringfence 24/25 'BCF' funding to support MH flow & discharge planning.

We need help with..

Recruitment and retention of workforce challenges.
NSFT and EPUT CQC outcomes. ICB will continue to work with both Trusts to support associated improvement/recovery plans.

Key Issues

Increasing demand for MH services in light of covid pandemic and cost of living crisis.
Recruitment and retention of workforce challenges.
NSFT and EPUT CQC outcomes. ICB will continue to work with both Trusts to support associated improvement/recovery plans.

Key Risks

EPUT Public Inquiry announcement- June 2023.
EPUT CQC report received July 2023- requires improvement rating.
NSFT- release of Norfolk and Suffolk FT report on recording, processing and reporting of mortality data (commissioned by SNEE & N&W ICB's).
System financial challenges could create the conditions for silo working and inhibit organisations from integrated working.

Children & Young People

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
CYP accessing MH services		MH Core Data Pack	Mar-24		14,266		12,690		
CYP Eating Disorders - Routine	Treatment within 4 weeks of referral	MH Core Data Pack	Mar-24		95.0%		77.0%		
CYP Eating Disorders - Urgent	Treatment within 1 week of referral	MH Core Data Pack	Jan-24		95.0%		71.0%		

Key performance issues & root cause summary

Long waiting times for ASD and ADHD assessments were identified within the SEND inspection in Suffolk and will be the same in Essex when the inspection happens there.

Key performance recovery actions

Business cases approved to help clear the backlog for current providers to procure additional support, mobilisation is underway for WSFT and ESNEFT, NSFT procurement process is still underway.

April 2024 data for MHSDS, ECDS, Data Quality (excl. DQMI), Perinatal, IPS will be delayed by August 2024 due to transitioning to MHSDS v6

14th August 2024

- July 2024 data for Dementia.
- June 2024 data for monthly Talking Therapies.
- April 2024 - June 2024 data for MHSDS, ECDS, Data Quality (excl. DQMI), Perinatal, IPS.
- April 2024 - June 2024 data for OAPs.
- Q1 2024/25 data for Talking Therapies.

Children & Young People Committees (Suffolk & North East Essex)

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 26/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

We are working with WSFT, NSFT & ESNEFT to progress reporting on a monthly basis against the recovery trajectories to reduce backlogs for ASD & ADHD Assessments. Evaluation of NDD early support services underway. Contracts due to end in Sept 25, procurement timetable & business case to Executive Board in Sept 24.
MHST (NEE) Wave 12 Training places confirmed by NHSE for Jan 25.
Mental Health redesign in Suffolk, 5 ithrive workshops completed. Crisis work around closing the gaps continues; final workshop arranged for early June with sign off July24.
Suffolk SEND strategy 24-29 signed off by Exec. Asthma work reinvigorated working closely with regional colleagues; 24/25 funding in place. Epilepsy bundle priorities agreed with region.IES asthma priorities now included in overarching plan.

Key actvities planned for the next 2 months

Monthly reporting of ASD and ADHD recovery trajectories to be embedded via contractual meetings.
Project lead appointed & hosted by WSFT starts July to lead on the new clinical pathway for Suffolk.
NDD paper to Execs in Sept - update & lessons learnt.
Implementation of the Balance System & align contracts with ECC SEND Therapies.
Suffolk mental health crisis services new proposal agreed by end July & iTHRIVE developments agreed.
Permanent Transformation Leads appointed for Transformation team.
Q1 NHSE submission relating to CYP LTC . All Asthma, Epilepsy & Diabetes programme plans agreed. Work with community peads to understand gaps for LTC. Agreeing funding for Asthma nurses within the alliance space for SNEE.

We have learned this and need to share...

CYP work being further embedded in alliances frameworks is supporting join up & preventing duplication.
Following the SEND review, focus on impact measures for CYP and families.
Lessons learnt paper re Suffolk NDD pathway.
Need to develop stronger relationships with Acute clinical leads in relation to LTC around support with delivery of change & improvement.

We need help with..

Continued support from system partner for SNEE NDD pathway to address backlog.
Working with educational partners to ensure an equitable mental health offer within our schools.
Continued system working to ensure CYP and families are supported whilst waiting for assessment & treatment.

Key Issues

Residual waiting lists for autism diagnostic services procurement about to mobilise to help clear the backlogs.
Redesign of referral forms in NEE.
Staff recruitment is ongoing system challenge.
Continuing high level of demand for emotional health & wellbeing services.
Continuing high level of demand for ASD and ADHD CYP Assessments.

Key Risks

Lack of financial support for non-mental health investment.
Staffing resource to support CYP Transformation.
Identification of resource to support current demands on service.
CYP not able to access support quickly causing escalation in some cases to crisis or more complex needs.
Significant demand for ASD/ADHD assessments and backlog of referrals.

Learning Disabilities & Autism

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
LD health checks		NHS Digital	Apr-24		85.0%	7.1%	4.5%		
ICB Adult Inpatients - Suffolk TCP		NHS England	Apr-24		7		5		
PC Adult Inpatients - Suffolk TCP		NHS England	Apr-24		7		9		
U18s Inpatients - Suffolk TCP		NHS England	Apr-24		2		3		
ICB Adult Inpatients - Essex TCP		NHS England	Apr-24				24		
PC Adult Inpatients - Essex TCP		NHS England	Apr-24				16		
U18s Inpatients - Essex TCP		NHS England	Apr-24				11		
Flu Vaccination Uptake		CQRS	Mar-24				91.0%		
LeDeR - Reviews completed within 6 months of notification		NHS England	May-24		100.0%		70.5%		
LeDeR - Completed reviews that were focussed		NHS England	May-24		35.0%		54.3%		

Key performance issues & root cause summary

Annual Healthchecks – April data is showing that SNEE have achieved 4.5% completed annual health checks in 24/25 compared with 3.9% in 23/24. Health Action Plans 79.3%
IES have completed 5.2% in 24/25 compared with 4.3% in 23/24. Health Action Plans 82.5%
WS completed 5% in 24/25 compared with 5.5% in 23/24. Health Action Plans 78.8%
NEE completed 3.7% compared to 2.7% in 23/24. Health Action Plans 75.6%
Adult inpatients: 2 at walker close. 1 is medically fit for discharge the other is still in assessment. 2 at the woodlands 1 is medically fit for discharge,2nd one receiving treatment. Provider Collaborative: 7 inpatients with 3 of these clinically ready for discharge
LeDeR reviews to be completed within 6 months of notification – May data shows IES 79%, WS 71% and NEE 65%

Key performance recovery actions

A fourth LeDeR bank reviewer is due to start on the 27th June and will be undertaking LeDeR reviews for Suffolk. This will help towards managing the number of LeDeR reviews.

Learning Disabilities & Autism Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 28/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

LD Friendly GP Practice pilot – Stow Health and Unity Healthcare have been awarded the first Learning Disability Friendly Kitemark award in Suffolk and North East Essex. Communications has been sent out to highlight this work and encourage GP practices in SNEE to come forward to work towards becoming a LD friendly practice. 2 GP practices have already emailed the ICB to enquire for more information.
The SNEE LD annual health check patient experience questionnaire and carers questionnaire has now been launched. This is available on the Lets Talk SNEE platform and GP practices have been asked to send out to people after they have had an annual health check. The questionnaire will be available throughout 24/25 in order to gather as much information as possible. Traditionally, more annual health checks take place in Q3 and Q4 of the year.
A SNEE ReSPECT LD&A working group took place with key partners involved to discuss how we rollout ReSPECT to the LD&A community. This group will now put an action plan into place and are aiming for an Autumn 2024 rollout.
Inpatient training on CETRs for mental health inpatient staff.
SNEE LeDeR annual report for 2023/24 to be developed.
The LD Register Deep Dive evaluation report was presented to the LD&A Integrated Board and ICB internal governance meetings. Action plan to be developed to describe the work that needs to happen and who will lead on the various workstreams.
Step up step down service (Lavenham Place) – The ICB are working with SCC, NSFT and Ocala together to ensure CQC requirements are met in order for CQC registration to be awarded to Ocala to support people through the admission avoidance service.
The Oliver McGowan Mandatory Training Trainer has now been recruited to and will start in their role in July. The postholder will support the rollout of the OMT training collaborative pilot across SNEE.
The SNEE LD Annual health check steering group will now morph into the SNEE LD&A Health Inequalities Steering Group in order to discuss the whole of the LD&A quality improvement programme.

Key actvities planned for the next 2 months

Step up step down service (Lavenham Place) – The ICB are working with SCC, NSFT and Ocala together to ensure CQC requirements are met in order for CQC registration to be awarded to Ocala to support people through the admission avoidance service.
Interviews for the Oliver McGowan Mandatory Training Trainer to take place
Inpatient training on CETRs for mental health inpatient staff.
Launch of the NSFT Recovery College offer for those waiting on the Suffolk adults ASD/ADHD assessment waiting lists
Oliver McGowan Mandatory Training Tier 1, 1 hour online training continuing with staff from ESNEFT in attendance. ICB OMT Trainer will start in role.
SNEE LeDeR annual report for 2023/24 to be finalised and presented at ICB governance meetings.
Work will continue on the rollout of ReSPECT to the LD&A community
First meeting of the SNEE LD&A Health Inequalities Steering Group which will discuss the SNEE LD&A quality improvement programme

We have learned this and need to share...

9,759 (75.98%) staff in ESNEFT have completed the Oliver McGowan Mandatory Training 90 minute e-learning and 314 staff have completed the Tier 1, 1 hour online training.

We need help with..

Practices to be encouraged to undertake and complete the Learning Disability Annual Health checks and Health Action Plans and continuing to focus on making contact with individuals who have not had an AHC in the previous year.

Key Issues

Rising demand for adult ASD assessments. People now waiting up to 3 years.

Key Risks

ASD waiting lists are long and demand is not being met.

Quality

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Summary Hospital Mortality Index rate - ESNEFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Jan-24				1.1101 (2)		
Summary Hospital Mortality Index rate - WSFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Jan-24				0.9044 (2)		
CQC rating - ESNEFT		CQC	Jan-20				Requires improvement		
CQC rating - WSFT		CQC	Jan-20				Requires improvement		
CQC rating - NSFT		CQC	Feb-23				Requires improvement		
Safety culture in NHS - raise concerns (ESNEFT)		NHS Staff Survey	Mar-23				67.3%		
Safety culture in NHS - raise concerns (WSFT)		NHS Staff Survey	Mar-23				69.7%		
MRSA rate (current month)		GOV.UK	Apr-24				1		
C Diff rate (current year - cummulative)		GOV.UK	Apr-24				13		
E-coli rate (current year - cummulative)		GOV.UK	Apr-24				20		

Key performance issues & root cause summary

The mortality index for ESNEFT remains as expected in the rolling 12 months up to Dec-23 but remains well above the upper SPC range. The rate for WSFT has fallen significantly and is now below the lower SPC range. Both remain as expected however (SHMI Banding 2)

Both Trusts were rated as overall requiring improvement in Jan-20. ESNEFT required improvement in the responsive and safe domains, but was rated good for being caring, effective and well-led. WSFT were rated good for being caring and effective, but required improvement in all other domains

There were no MRSA breaches in Mar-24. C. diff and E. coli are monitored against an annual cumulative threshold based on infection rates for the 12 months up to Nov-21. Both have exceeded the target for 23/24

Key performance recovery actions

NSFT CQC rating: ICB executives fully engaged in improvement work within NSFT, as well as triangulating at regional level with colleagues from N&W ICB. Evidence groups underway with ICB commitment. Re-inspection expected September 2022.
MRSA: All MRSA cases investigated at provider level with oversight from ICB IPC team. PIRs underway, performance on timely completion improving, and resulting actions are followed through. IPC inspections have identified further areas for improvement (cleaning) and are working with providers to implement them.

NHS
Suffolk and North East Essex
Integrated Care Board

Executive Summary

Following identification of an incident within the Colposcopy service at ESNEFT, assurance was provided regarding immediate actions taken by the trust to ensure oversight and patient recall. The need for a SNEE wide ACP Framework to provide oversight and consistency of supervision of ACP's within all disciplines was shared and will be taken to the Advancing Roles oversight group for further discussion.

The report from SNEE Integrated Medicines Optimisation Committee (IMOC) was received. IMOC is required to report through the quality route as well as to alliances for which it is a community in common. The report provided at three-month overview of IMOC Integrating Medicines Optimization Committee work.

There have been three incidents raised by ESNEFT and West Suffolk relating to Marie Stopes International, the charity that provides our medical abortion services that is colloquially known as pills by post. Concern regarding patient safety and governance of the service remain a focus locally and regionally with investigative work ongoing.

Shared definition of Quality

- **Safety** - No immediate safety concerns were noted by ICB or Provider Partners.
- **Experience - WHAT AM I PROUD OF, OR GRATEFUL FOR TODAY** International nurses' day across the system and the economic power of nurses was recognised.
- **Effectiveness** - The Committee was in receipt of the current quality dashboard with key issues highlighted as being: The information shared on the dashboard is out of date. Further discussions with the SNEE ICB Business Intelligence team to work out a more effective way to view current data. Public viewing – the information presented would not interest the public e.g. Dr appt or dentist.
- **Well Led –** All key providers currently rated as 'Requires Improvement' Care Quality Commission ratings. The aspiration is to have all acute hospitals in the system to have a CQC rating of "Safe" by 2028. The Committee were asked what oversight of CQC ratings would be preferable going forwards?
- **Use of Resources** – Estates, Digital and Financial planning have not been considered by the Quality Committee, but assurance is provided in separate reporting.

Quality snapshot

SNEE Business Intelligence

NHS

Friends and family test - Inpatients

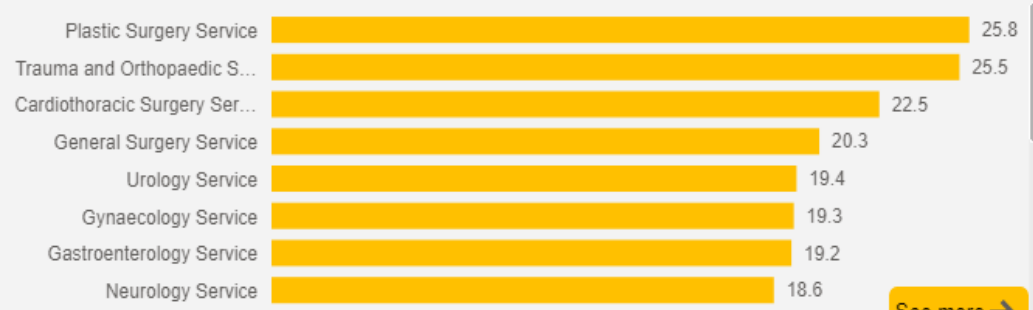
92.3% ESNEFT

96.5% WSFT

had a positive experience

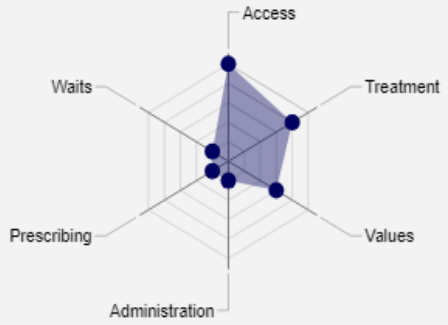
See more

Average wait (weeks) by Specialty



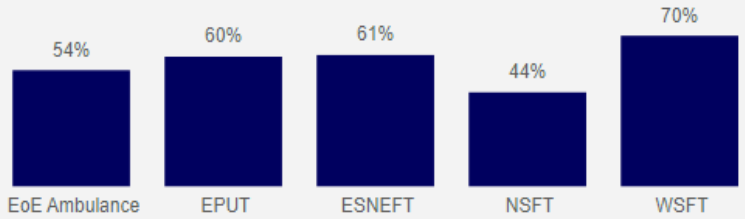
See more

Complaints by theme



See more

Staff survey - "If a friend of relative needed treatment I would be happy with the standard of care provided by this organisation"



See more

Emergency readmissions

Data currently under review

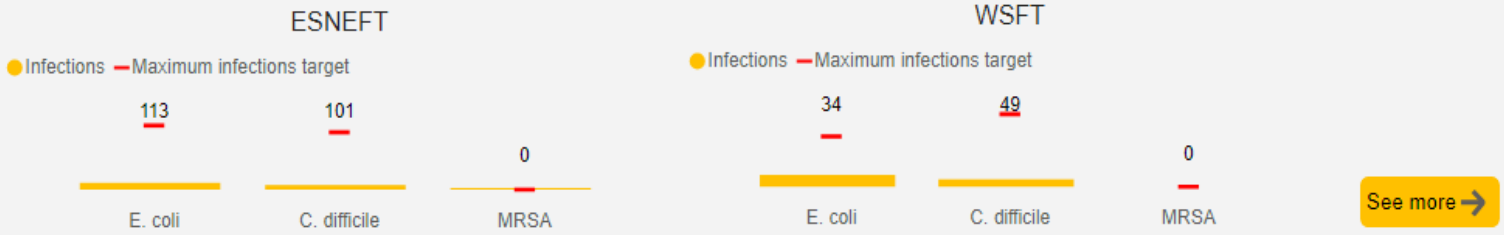
See more

CQC overall rating

East of England Ambulance Service NHS Trust	Requires improvement
East Suffolk and North Essex NHS Foundation Trust	Requires improvement
Essex Partnership University NHS Foundation Trust	Requires improvement
Norfolk and Suffolk NHS Foundation Trust	Requires improvement
West Suffolk NHS Foundation Trust	Requires improvement

See more

Hospital acquired infections



See more

Ambulance

Mean call answer time

11 seconds

C1 mean response time (SNEE)

00:09:46

See more

NHS
Suffolk and
North East Essex
Integrated Care Board

Quality Snapshot

CQC: ratings for all providers within SNEE remain as Requires Improvement, each Trust are working towards their action plans, with EEAST reporting favourably following a review of sanctions that have recently been lifted.

Complaints: top two themes remain access and treatment which is reflected in the average waiting times section. A new theme to note is that of values which appears to have steadily increased since January. Further exploration is required to understand why this has increased and the types of complaints that have been received in relation to values.

Average waits for treatment : Longest waits remain in Plastic Surgery and Trauma Orthopaedics respectively, Cardio Thoracic Surgery currently sits third in SNEE longest waits at 22.5 weeks, an increase on previous months. Urology waits remain static at 19 weeks, whilst General Surgery has increased slightly from 19 to 20 week waits.

Escalations from Quality Committee

NHS
Suffolk and North East Essex
Integrated Care Board

Escalation QC - 1

ACP Supervision/Colposcopy Incident:

Following the Colposcopy Incident that had been identified by at ESNEFT.

To date, a number of woman have been recalled and follow up letters sent out which have been agreed by screening services. It was confirmed the Nurse Practitioner may have worked outside of their professional remit and following a referral to the NMC the practitioner is being supported. Bi-weekly meetings held with Chief Medical Officer of ESNEFT.

The need for a framework for ACP supervision across SNEE was discussed to ensure appropriate monitoring and supervision is in place.

Escalation QC - 2

Integrated medicines optimisation committee

The report provided a three-month overview of IMOC Integrating Medicines Optimization Committee work .

For noting, the report focused on safety alerts and medication shortages and how these have been managed within SNEE. Current medication shortages to note are GLP 1 antagonists and ADHD medications, both of which have been managed extremely well through collaboration between local partners, community pharmacy and primary care. Other medication shortages are monitored within the group.

Escalation QC - 3

Marie Stopes International

There have been three incidents raised by ESNEFT and West Suffolk relating to Marie Stopes International, the charity that provides our medical abortion services.

Three women utilised the pills in post service who had believed that they were at gestation of under 12 weeks, but sadly delivered between 28- and 36-week foetuses. These incidents have been reported regionally to the regional quality group, with investigative work ongoing.

Alliance - Ipswich & East Suffolk

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	May-24				79.3%		
Hospital discharge to usual place of residence		SUS	May-24				97.0%		
GP appointments per 10k weighted pop		NHS Digital	Apr-24				5,837		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-23				62.3%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Mar-24				0.995		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Mar-24				8.01%		
All 8 diabetes care processes		Eclipse	Jun-24				57.13%		
Supported through NHS diabetes prevention programme		Eclipse	May-24				5,205		
Seasonal flu vaccination (over 65s)		CQRS	Mar-24				92.4%		
MMR 2 doses (5 year olds)		GOV.UK	Dec-23				90.56%		

Key performance issues & root cause summary

The reported UCR % is well above the target of 70% in November.

Those who had a good experience of making a GP appointment is considerably higher than the 56% reported nationally and the highest in SNEE

In regards to reducing antibiotic usage, the number of items per STAR-PU remains above the target of 0.871 and the prescribing of broad spectrum antibiotics are well below the 10% Target

Key performance recovery actions

Work is underway to review and update guidance on the use of prophylactic antibiotics for recurrent UTI in primary care. We will be seeking input from urology and microbiology teams from each of the acute trusts. The aim will be producing guidance to support GP practices in ensuring patients with recurrent UTIs are managed through the use of national patient facing materials, lifestyle advice and appropriate use of antibiotics. It will also aim to encourage reviews to ensure patients are continuing to derive benefit from long term antibiotics.

Further work is being undertaken to update an antibiotic resource pack which aims to provide GP practice with a range of resources such as:
- Audit tools to analyse prescribing trends
- Tools to encourage discussions of findings
- Patient facing resources which can be used by the practices e.g. posters for TV screens
- Guidance on the utilisation of clinical system to issue patient facing material e.g. TARGET leaflets
- Links to useful local antimicrobial resources

Ipswich & East Suffolk Alliance Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 27/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

• IES Alliance Annual Report 2023/24 finalised and IES Alliance Delivery Plan developed.
• Primary care - Launched Primary Medical Care Strategy and Action Plan; Supported PCNs in delivery of additional roles reimbursement scheme (ARRS) workforce and recruitment plans for 2024/25.
• Medicines Optimisation - Blood glucose testing meter formulary approved at ESNEFT and Integrated Medicines Optimisation Committee; Practices informed of 2024/25 budgets and incentive scheme details.
• Personalised Care - Hypertension workshops delivered; SiSU machines installed at the Unity Centre and on the Be Well Bus (174 health checks completed on the Be Well Bus between May-June); Respiratory specialist Social Prescribing Link Worker recruited.
• Transformation - Macmillian Social Finance work presented to the Financial Investment Group; Care Homes Engagement and Support Service (CHESS) review and redesign work in progress.

Key actvities planned for the next 2 months

• Primary Care - Planning for SNEE Primary Care Commissioning Annual Audit; Planning for Industrial Action and potential mitigation; Support and implement the PCN pilot with the selected PCN.
• Medicines Optimisation - Development and launch of SNEE incentive schemes dashboard; Workshops for high dose opioids and Dependence Forming Medicines (DFM) workstream in July/September.
• Personalised Care - Launch event for the SiSU health check machine at the Unity Centre; Delivery of the Connect Prevention Partnership group meetings; Social prescribing reprocurement activities.
• Transformation - Deep dive into a delayed transfer of care for an end of life patient from an INT perspective.

We have learned this and need to share...

• PCN Pilot launch 19th June – working with 2/3 PCNs in the SNEE area to review all demand, capacity and identifying the gap
• Oral Health - Recruitment of dental staff to fixed term roles for mobile dental unit remains a challenge

We need help with..

• Managing patient expectations, increasingly challenging and aggressive patients being experienced across Practices with unrealistic expectations of service availability from Primary Care.
• Promoting to practices that they need to be signed up to PowerBI to access all prescribing data in 2024/25.
• Oral Health - Identification of VCFSE and other referral partners to ensure children most in need are able to access mobile assessment and treatment service
• Oral Health - Identification of parking locations for mobile dental unit in areas of greatest need (with access to toilet facilities for staff)

Key Issues

• Practice resilience and sustainability – Demand continues to be high, challenged by available capacity (workforce) compounded by lack of enabler required funding to respond to needs identified particularly estates and IT
• Team resource to complete and implement work – vacancies across all three Medicines Optimisation teams
• Significant wait time for social prescribing in Ipswich

Key Risks

• Operational delivery – Potential Industrial Action in response to new GP Contract 2024/25
• Oral Health - Monitoring referrals and balancing capacity of service to ensure targeted groups gain access
• There is a risk that the usage of Advice and Guidance by Primary Care will reduce following a recent letter from the British Medical Association (BMA). This may result in an increase in referrals to secondary care

Alliance - North East Essex

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	May-24				92.0%		
Hospital discharge to usual place of residence		SUS	May-24				97.0%		
GP appointments per 10k weighted pop		NHS Digital	Apr-24				4,859		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-23				55.5%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Mar-24				1.056		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Mar-24				8.12%		
All 8 diabetes care processes		Eclipse	Jun-24				75.93%		
Supported through NHS diabetes prevention programme		Eclipse	May-24				4,374		
Seasonal flu vaccination (over 65s)		CQRS	Mar-24				87.7%		
MMR 2 doses (5 year olds)		GOV.UK	Dec-23				89.43%		

Key performance issues & root cause summary

ESNEFT has reported data quality issues on CSDS, which may be affecting performance figures. This is being actively looked at. Prior to CSDS the response was generally around the 80% mark but since the introduction of CSDS performance has dropped to be constantly in the 50 – 60% bracket for 2 hour response.

Other issues impacting performance include referrals coming into the service that do not need a 2 hour response but still need an urgent response (within 4 hours) and referrals coming in from the discharge pathway that are delayed with transport to get the patient home.

Key performance recovery actions

The team are looking at resolving data quality issues in CSDS submissions and reporting, which has been affecting UCRS performance figures.

Further information may need to be shared with referrers to ensure only referrals requiring a 2 hour response are sent to UCRS and to ensure patients not suitable for UCRS are signposted to more appropriate services.

Transport delays are being discussed with the NEE transport provider to improve timeliness of discharge.

North East Essex Alliance Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 25/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

"The NEE Crisis Alternatives Procurement Award was Ratified by Committee members.

JFP Refresh was discussed with positive feedback received from Committee members.

Quality reports were discussed and it was agreed that Primary Care colleagues will be invited to future meetings.

Mental Health Transformation Closure Reports were also shared with Committee members and discussed.

A roundtable discussion also took place amongst Committee members. "

Key actvities planned for the next 2 months

"AEG, AOG, Finance, AQG (bi-monthly) and NEE BCF Highlight Report

Work continues from the ICB in supporting the options around the Heart of Greenstead project.

Place Plans to be shared with system partners by September 24.

The forward plan for the APG continues including planning for the next discussions on skills and employment, health and planning and housing.

SET Keyworker service contract and it was also agreed at the Alliance Committee Workshop on 20th June, that every other Alliance Committee will be a workshop so there are likely to be less agenda items going forward. "

We have learned this and need to share...

"Feedback from partners is that the governance is supported and direction is clearer

Sequencing has been raised with the balance of short term deliverables against the longer term ambition. Partners support the need for longer term plans at place to achieve this

Partners are keen to ensure we avoid duplication and learn from others.

There is a need to revisit data sharing and barriers to this"

We need help with..

"Data sharing and overcoming the barriers to this which remain

Further requests for help may arise following on from the workshops and/or task and finish groups that have agreed to be held."

Key Issues

Nothing to escalate at this time other than those already known to ICB.

Key Risks

Nothing to escalate at this time other than those already known to ICB.

Alliance - West Suffolk

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	May-24				90.2%		
Hospital discharge to usual place of residence		SUS	May-24				96.3%		
GP appointments per 10k weighted pop		NHS Digital	Apr-24				5,477		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-23				58.2%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Mar-24				1.088		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Mar-24				8.83%		
All 8 diabetes care processes		Eclipse	Jun-24				54.51%		
Supported through NHS diabetes prevention programme		Eclipse	May-24				2,579		
Seasonal flu vaccination (over 65s)		CQRS	Mar-24				90.6%		
MMR 2 doses (5 year olds)		GOV.UK	Dec-23				90.33%		

Key performance issues & root cause summary

Antibiotics/prescribing and dementia diagnosis rate

Key performance recovery actions

Dementia diagnosis rate actions would include support for the new dementia support service and strategy with teams linked in through age well to determine action after a workshop due to take place

West Suffolk Alliance Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 20/06/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Update from N/market locality outlining progress and a snapshot of local data showing of the 21,000 residents almost 40% deprived. An asset mapping exercise undertaken had identified 3 buildings that could be used to create a hub for a range of services. A collaboration between statutory and voluntary organisations is hoped to lead to more effective working. Joint working with Suffolk Libraries discussed and contacts made across localities and partner organisations to support healthcare. Suffolk Community Foundation key development opportunities for the VCSFE sector brought to the meeting with intent for a better referral mechanism to capture data . Social prescribers now in post. The Health Inequalities Committee requested more information prior to providing funding.

Key actvities planned for the next 2 months

Committee 9 July - new Chair in post (NED) to include deep dive from Stay well around diabetes work in West. Care Market update to come to meeting.
No Committee meeting in August due to amount of A/L with Haverhill Locality attending the September meeting. Increased interface with Primary Care and Trust - meeting taking place 20/06/24.
HI proposal to be completed with aim of sign off from relevant board.
Haverhill severe Frailty Project to go live with partners, focusing on frailty framework being used to develop interventions for the population.
Recruitment to vacant posts already commenced and hope to have people in place asap.
Alliance Operational Group to go live to support Stay Well domain function and bring system partners into UEC sphere.

We have learned this and need to share...

Working with Suffolk Community Foundation across localities would enable funding availability from charities and private organisations. Suffolk Libraries offer unique services to meet needs of their communities including; menopause and meat program, physical activity program, peer support groups, and support for alcohol cessation.

We need help with..

A Committee to flag up successful projects that should move to mainstream funding once through referrals for small organisations linking with Suffolk Community foundation - discussions underway

Key Issues

Lack of capacity following the restructure is still awaiting resolve in some areas.
Cost of living
SNE/MH support - ongoing
Impending industrial action
Financial situation of partners in the locality that is impacting change projects to commence and meet national / local targets.

Key Risks

Workload of staff with current reduced resource
vacancy panel rejected extensions to seconded staff which is large risk to workstreams underway
Lack of finance to action and deliver change

Workforce

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Leadership culture - staff survey (ESNEFT)	Score out of 10	NHS Staff Survey	Mar-23				7.01		
Leadership culture - staff survey (WSFT)	Score out of 10	NHS Staff Survey	Mar-23				6.88		
CQC well-led rating - ESNEFT		CQC	Jan-20				Good		
CQC well-led rating - WSFT		CQC	Jan-20				Requires improvement		
Engagement - staff survey (ESNEFT)	Score out of 10	NHS Staff Survey	Mar-23				6.85		
Engagement - staff survey (WSFT)	Score out of 10	NHS Staff Survey	Mar-23				6.97		
Bullying and harrassment (never experienced) - staff survey (ESNEFT)		NHS Staff Survey	Mar-23				80.8%		
Bullying and harrassment (never experienced) - staff survey (WSFT)		NHS Staff Survey	Mar-23				81.8%		
FTE GPs per 10k weighted pts		NHS Digital	Apr-24				5.4		
Direct pt care staff per 10k weighted pts		NHS Digital	Apr-24				5.6		

Key performance issues & root cause summary

The latest results from the NHS staff survey show that in regards to compassionate leadership both ESNEFT and WSFT staff responses were broadly in line with the national average, with WSFT matching the 6.8 (out of 10) sub-score and ESNEFT only just below

In relation to staff engagement, both Trusts reported similarly to the national average of 6.8 (out of 10), with WSFT above the average and ESNEFT just below

There are 3 survey questions in relation to bullying and harrassment, from patients, from managers and from colleagues. The metric score shown is the average of these 3 percentages

Key performance recovery actions

On going engagement with system partners
Linking with East of England Leadership Academy/ Looking at the system leadership programme
Utilising national staff survey engagement schemes
Developing Health and Wellbeing strategy and action plan
Continuing to develop the Training hub recruitment and retention programmes

Workforce Committee

CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Narrative submitted: 26/01/2024

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

- The process continues with providers for the Operational Planning 24/25. Initial meeting with system colleagues which included finance, activity and workforce to ensure the final submission in March is triangulated between those three elements

- The inaugural System Strategic Clinical Education Group met to identify the education and training strategy and transformation required to support new and current learners. An Operational Group will now take forward and develop the plans to then feedback to the Strategy Group in 2 months

- The inaugural Health Care Science Workforce Community of Practice was successful with the second being planned

- The inaugural System Apprenticeship Group was held to identify areas of focus. The report was sent to delegates and a further workshop is being planned to develop and progress the plan

- A Workforce workshop for INTs Leads/Managers was held with the suggested action plan and follow up workshop out for comments by the INTs Managers

- A further round of Introduction to Workforce Planning courses in conjunction with the ICA were held with the final courses for this financial year taking place at end of February. Over 100 delegates will have been on the courses by that point

-Follow-up meetings with Maternity, EoL, Frailty to agree next steps with the action plan have been held and actions being taken forward

Key actvities planned for the next 2 months

- The Operational Planning process 24/25 will increase substantially over the next two months with deadlines and milestones to reach with providers. This along with the refresh of the JFP and Q4 activities will be the main focus for the next 2 months. However, work will continue to progress with:

- INTs Leads/Managers to agree focus
- Cancer and Diagnostic leads to agree focus incl. a workshop in February
- Deliver the Introduction to Workforce Planning courses
- Finalise the the Maternity, EoL, Frailty action plans
- Agree focus for the Alliance workforce groups and plans incl. capacity to support

The focus for 24/25 will be on productivity and efficiencies so plans are being developed around solutions for these ready to implement from April '24

We have learned this and need to share...

The continuation of of co-production and collaboration on programmes from start to finish

We need help with..

Engagement with alliance partners with alliance workforce plans and establishing groups

Key Issues

Workforce challenges such as attraction, and shortages continue. The proposed financial pressures for 24/24

Key Risks

Industrial action and on-going demand are placing further pressure on already stretched and burnt out staff. The impact of reduced resources for 24/25.

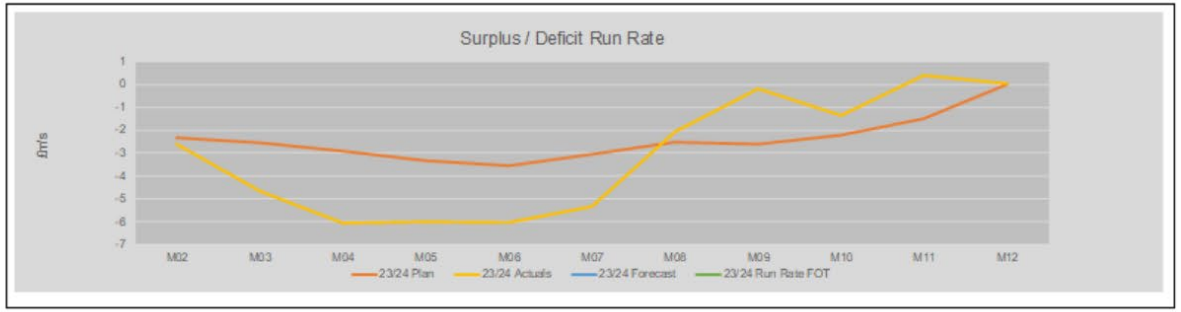
SNEE Business Intelligence

NHS

Finance - SNEE ICS System Dashboard (Month 12)

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit)				Full Year Surplus / (Deficit)			
	Plan	Actual	Variance		Plan	Outturn	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Suffolk And North East Essex ICB	2.6	4.5	1.8	0.1%	2.6	4.5	1.8	0.1%
Providers	(2.6)	(4.4)	(1.8)	0.1%	(2.6)	(4.4)	(1.8)	0.1%
ICS Total	-	0.0	0.0	0.0%	-	0.0	0.0	0.0%



System I&E Summary

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance YTD %	Plan Year Ending £m	Outturn Year Ending £m	Variance Year Ending £m	Variance Year Ending %
System Revenue Resource Limit	(2,203.5)				(2,203.5)			
ICB Net Expenditure								
Acute Services	1,139.0	1,140.2	(1.2)	(0.1%)	1,139.0	1,140.2	(1.2)	(0.1%)
Mental Health Services	208.6	209.2	(0.5)	(0.2%)	208.6	209.2	(0.5)	(0.2%)
Community Health Services	211.1	216.0	(4.8)	(2.3%)	211.1	216.0	(4.8)	(2.3%)
Continuing Care Services	98.2	105.9	(7.7)	(7.9%)	98.2	105.9	(7.7)	(7.9%)
Primary Care Services	222.1	227.4	(5.3)	(2.4%)	222.1	227.4	(5.3)	(2.4%)
Memo: Prescribing	190.0	198.3	(8.3)	(4.4%)	190.0	198.3	(8.3)	(4.4%)
Other Commissioned Services	15.6	16.5	(1.0)	(6.2%)	15.6	16.5	(1.0)	(6.2%)
Other Programme Services	4.2	3.6	0.6	15.3%	4.2	3.6	0.6	15.3%
Reserves / Contingencies	(7.2)	(13.4)	6.2	(85.9%)	(7.2)	(13.4)	6.2	(85.9%)
Delegated Primary Care Commissioning	289.8	274.8	15.0	5.2%	289.8	274.8	15.0	5.2%
ICB Running Costs	19.4	18.9	0.5	2.6%	19.4	18.9	0.5	2.6%
Total ICB Net Expenditure	2,200.9	2,199.0	1.8	0.1%	2,200.9	2,199.0	1.8	0.1%
ICS Providers I&E - Adjusted Financial Performance								
Income	(1,798.3)	(1,906.4)	108.1	(6.0%)	(1,798.3)	(1,906.4)	108.1	(6.0%)
Pay	1,178.9	1,251.7	(72.8)	(6.2%)	1,178.9	1,251.7	(72.8)	(6.2%)
Non-Pay	598.2	644.6	(46.4)	(7.8%)	598.2	644.6	(46.4)	(7.8%)
Non Operating Items	23.9	14.6	9.3	38.9%	23.9	14.6	9.3	38.9%
TOTAL Provider Surplus/(Deficit)	(2.6)	(4.4)	(1.8)	0.1%	(2.6)	(4.4)	(1.8)	0.1%
TOTAL ICS Surplus/(Deficit)	-	0.0	0.0	(0.0%)	-	0.0	0.0	(0.0%)

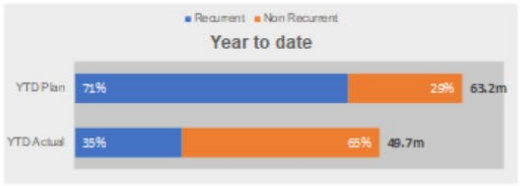
System Risk

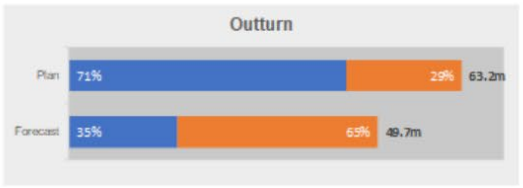
Gross Risk	Net Risk	Net Risk % allocation	Movement from prior month
N/a	N/a	N/a	N/a

Mental Health Investment Standard

Target MHIS Spend 2023/24	Outturn 2023/24	Excess / Shortfall in 2023/24 MHIS Delivery %	MHIS Achieved in 2023/24?
161.6	161.8	0.09%	Y

System Efficiencies





	YTD	Outturn
System efficiency % of allocation	2.3%	2.3%
ICB efficiency % of allocation	0.5%	0.5%
Provider efficiency % of gross operating Expenses	6.3%	6.3%

	ICB	Providers
Unidentified efficiency %	N/a	N/a
High risk %	N/a	N/a
Medium risk %	N/a	N/a
Low risk %	N/a	N/a

System Agency Expenditure

Ceiling	YTD spend	YTD % of Cap	Outturn	FOT % of Cap
34.0	27.8	81.9%	27.8	81.9%

System Capital Allocation

	Capital allocation	Variance to allocation	Outturn variance %
Providers	89.3	(0.3)	(0.4%)
ICB	2.1	(0.7)	(34.0%)
System	91.3	(1.0)	(1.1%)

Cash

	Prior Year	Year to Date	Outturn
Providers	112.7	116.2	116.2
ICB			
System			

Number of organisations missing BPPC target

		Providers	ICB
Current Month	Non NHS	3	
	NHS	3	
	Total	3	
Prior Month	Non NHS	3	
	NHS	3	
	Total	3	

System Financial Position: Narrative Month 12

- The system achieved its target revenue position in 2024/25. The system recorded an overall surplus of £0.034m, comprising surpluses at the ICB (£4.478m), ESNEFT (£1.339m), EEAST (£0.487m) offsetting a deficit of £6.270m at WSFT.
- The above figures represent favourable variances of between £0.000 and £0.021m at organisational level from the plans (re)submitted in November 2023.
- County council year end positions are not available for sharing. Both are likely to show overspends as has been forecast throughout out the past year, with the impact being addressed by an 'affordable' transfer from reserves
- 2024/25 financial plans are in the late stages of being prepared. It is considered likely that a plan balanced at system level will be submitted on 2nd May 2024. While WSFT remains in deficit, significant steps have been made to reducing the underlying deficit in that organisation.
- Risks and mitigations are not collected in month 12, on the assumption that both have crystallised at 31st March 2024. In reality audit risk remains, ie the risk of material error being identified during the audit process, but that is considered both highly unlikely, and unquantifiable.
- The system exceeded its capital spend allocation by £0.313m, primarily as a result of increases in expenditure not forecast in month 11. It is likely that this overspend will be covered by underspends at Regional or National level, with no adverse implications for the system. Confirmation of this assumption is awaited.
- The ICS delivered against the the mental health investment standard target. Mental health expenditure of £161.776m was incurred, against a minimum target of £161.631m.
- System cash balances totalled £117.7m at the year-end, down from £152.6m at month 11 following a month of high levels of capital expenditure, and ICB cash management. The cash position at WSFT remains challenging at £9.3m, and will require continued DHSC support in 2024/25.

Icon Descriptions

Variation	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
(blank)	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is capable and will consistently **PASS** the target if nothing changes.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Common cause variation, **NO SIGNIFICANT CHANGE**. This process is not capable and will **FAIL** the target without process redesign.	Common cause variation, **NO SIGNIFICANT CHANGE**. Assurance cannot be given as there is no target.
H	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**. Assurance cannot be given as there is no target.
L	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target if nothing changes.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target as the target lies between process limits.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. This process is not capable and will **FAIL** the target without process redesign.	Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**. Assurance cannot be given as there is no target.
↗				Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
↘				Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning, Assurance cannot be given as there is no target.
(blank)				There is insufficient data to determine either special cause or common cause variation. Assurance cannot be given as there is no target.

NHS
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NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 12
Date: 30 July 2024

Title: SNEE ICB Board Assurance Framework – July 2024

Lead Director: Amanda Lyes, Executive Director for People and Workforce

Author: Tom McColgan, Governance and Compliance Manager and Tony Buckle, Risk Manager.

Purpose: Approve

Recommendation: That the Board approves the Board Assurance Framework for 30 July 204.

Related item on the Board Assurance Framework: not applicable.

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1. Background

1.1 The Boad Assurance Framework (BAF) is a key document presented at every meeting which maps the sources of assurance for the controls applied to our strategic risks. By mapping the sources of assurance, we can answer the question 'do we really know what we think we know?' i.e. do we have access to the right information to be able to understand if our controls are modifying risks in the way we expected them to.

1.2 The BAF is not a risk register in itself but is supported by directorate risk registers held by each directorate. The BAF focuses on risks that if realised would prevent us from achieving our strategic objectives as set out in the Joint Forward Plan. Risk to the day to day operation of the ICB are included on the BAF by exception.

2. Key Issues

2.1. There are currently 13 risks on the BAF. No new risks have been added and no risks have removed since the BAF was last reported to Board in March 2024.

2.2. WSFT provided a positive update on their work to secure their hospital structure following the identification of RAAC; strategic risk 31 on the BAF. WSFT have reported that the works on the building structure have significantly reduced the likelihood of serious structural failure and they have reduced their risk rating for the first time since the risk was identified.

2.3. Strategic Risk 8 Adult Mental Health Services has been updated to reflect assurances that NSFT had given to both the ICB Quality Committee meeting in May 2024 and the Eating Disorder Recovery Group about the improvements in the adult eating disorder service.

2.4. Strategic Risk 10 Access to Primary Care highlights the increased risk of disruption to primary care services resulting from the ongoing dispute between GPs and Government around the new GP contract.

3. Patient and Public Engagement

3.1. None.

4. Committees and Groups

4.1. The Audit Committee has responsibility for reviewing our overall risk management process and each item on the BAF is also reported to the relevant Board Sub-Committee. The Executive Committee also receives the BAF in advance of it coming to the Board.

NHS
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Integrated Care Board

Board Assurance Framework

BAF SUMMARY DASHBOARD	Current Aggregated Assurance Rating	Current RAG Rating
Strategic Risk 1: System Accident & Emergency Services - The ICB continues to be under significant pressure whilst benchmarks well against other regional systems it continues to fail several well-established standards.	LIMITED	SEVERE
Strategic Risk 3: System Referral to Treatment (RTT) - System is not meeting Constitutional Referral to treatment Target of 18 weeks. Patients are therefore not receiving care within expected standards.	LIMITED	SEVERE
Strategic Risk 8: System Mental Health Services - The inability to demonstrate appropriate safety and mortality standards throughout mental health services. These present significant patient safety risks to the population of Suffolk and North-East Essex.	LIMITED	SEVERE
Strategic Risk 10: Access to Primary Care - Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).	ADEQUATE	SEVERE
Strategic Risk 11: Cyber Security - Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc.	ADEQUATE	SEVERE
Strategic Risk 12: Workforce challenges across the system - Workforce challenges across the system.	ADEQUATE	SEVERE
Strategic Risk 16: EEAST Performance & Quality - EEAST is not achieving national performance targets.	LIMITED	SEVERE

Strategic Risk 19: System Cancer Standards - System not meeting the cancer related standards within the NHS constitution leading to worsening patient outcomes and quality of services.	LIMITED	SEVERE
Strategic Risk 25: Failure to meet statutory ICB financial targets to: At least break-even/ Ensure both capital and revenue resources do not exceed the limit set by NHSE/ Ensure expenditure on running costs does not exceed the limit set by NHSE.	ADEQUATE	SEVERE
Strategic Risk 29: Consequences of Climate Change - Risk to health and social care service delivery.	ADEQUATE	SEVERE
Strategic Risk 30: Risk of Failing to Ensure Comprehensive FTSU arrangements – Recent Lucy Letby trial & conviction demonstrates the risk of not having robust FTSU arrangements in place within a listening organisation.	SUBSTANTIAL	MODERATE
Strategic Risk 31: Infrastructure – West Suffolk Hospital NHS Foundation Trust – RAAC – WSFT have identified and alerted the previous CCGs to risks associated with the Trusts Reinforced Autoclaved Aerated Concrete (RAAC) infrastructure.	ADEQUATE	MODERATE
Strategic Risk 32: System Children and Young People services (inc. SEND) Children and Young People cannot access the appropriate health services in a timely way, including those children whose special educational needs are not being met sufficiently across Suffolk and North East Essex.	LIMITED	SEVERE

Strategic Risk Number: 1	**Description: System Accident and Emergency:** Failure to meet established standards.

Risk due to:	**Impact(s) arising from the risk:**
1. Overall demand on system A&E Departments **2.** Insufficient flow through A&E Departments **3.** increased length of stay **4.**Workforce challenges across providers **5.**Competing recovery priorities **6.** Industrial Action	**1.** Poor patient experience **2.** Patient safety risks **3.** Risk of not meeting recovery plan trajectories **4.** **5.**

		
Original Risk Rating **4 x 4 = 16**	**Current Risk Rating** **4 x 4 = 16**	**Target Risk Rating** **4 x 3 = 12**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024

Responsible Executive Director:	Paul Gibara – Director of Performance & Improvement
Responsible Committee:	Urgent & Emergency Care Committee (UECC)
Relevant Directorate Risk Register entries:	The risk associated with urgent care is a system risk affecting and including the majority of ICB Directorates.
Relevant System Partner Aligned Risks:	Risk surrounding urgent care has been identified by the majority of system partners with biggest risk associated with Acute, Ambulance services and Mental health Trusts.

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. System Coordination Centre (SCC) managing daily operational issues. **2.** SCC forward view to support expected pressure points. **3.** Admission avoidance schemes **4.** Improvement trajectories aligned to 'Forward Plan' **5.** Seasonal planning **6.** Alliance Governance and oversight – including BCF and Discharge funds process. **7.** System senior Clinical Huddles **8.** Vaccination programmes **9.** Established Governance oversight structure both at system and Place. **10.** On call support	A Number of schemes are work in progress: • Same Day Emergency Care. • Respiratory services. • Unscheduled Care Coordination Hub • Care closer to home schemes	**1.** Performance dashboard with live data feed to monitor system pressures **2.** Tactical reviews of system performance at ODG. **3.** UECC oversight of performance **4.** SOAC oversight of performance **5.** Regional oversight of performance **6.** Tiering Process	1. Infection outbreaks not predictable.

Current Aggregated Assurance Rating:	LIMITED

Assurance Rating	Details
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided

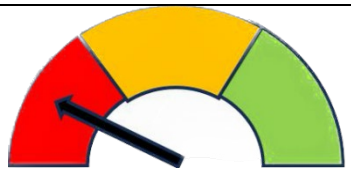
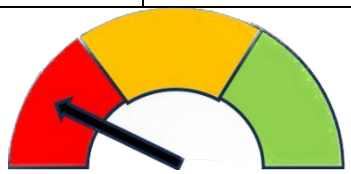
Actions Being Taken to Improve Assurances:	Implementation Dates:
See – Integrated performance report	Ongoing
Review and planning in respect of seasonal variation.	Ongoing – initial plan summary ahead of October
Planning for Industrial action.	Ongoing / as required
Link to ICS System Assurance Framework	**ICS Aim 2** 2.5: NHS Performance (access)
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date

May 2024 update: Key UEC targets for 24/25 are ED 4 hour performance to be at 78% by March 25, Improved C2 ambulance response at 30mins which links to reducing ambulance handover delays. For ED performance we have seen a reduction in both Trusts from the March 24 position with ESNEFT just under 75% and WSFT 67% for the end of May. There is significant focus on C2 delivery, with SNEE at 40mins with patient handover challenges on both ESNEFT sites.

Strategic Risk Number: 3	**Description: Waiting lists are not meeting constitutional target of 18 weeks:** The operational guidance clearly set out priorities as detailed with operational delivery which are achieving a maximum wait of 65 weeks by the end of September 2024.

Risk due to:	**Impact(s) arising from the risk:**
1. Post Covid-19 backlog **2.** Capacity constraints 3. Workforce availability 4. Industrial action	**1.** Poor patient experience **2.** Patient safety risks **3.** Reputational damage **4.**

		
Original Risk Rating **4 x 4 = 16**	**Current Risk Rating** **4 x 4 = 16**	**Target Risk Rating** **4 x 3 = 12**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024

Responsible Executive Director:	Paul Gibara – Director of Performance & Improvement
Responsible Committee:	Strategic Programmes, Elective & Diagnostics Committee (SPED)
Relevant Directorate Risk Register entries:	The risk identified goes across all ICB directorates
Relevant System Partner Aligned Risks:	Risk of delivery has been identified by all relevant partners who are brought together under the umbrella of Strategic Programmes, Elective and Diagnostics Committee supported by an acute trust led elective care programme board jointly chaired by ESNEFT and WSFT.

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. Established productivity programme. 2. Digital support programme. 3. Detailed delivery plans. 4. Detailed Industrial action plans and oversight. 5. Speciality level review plans. 6. Mutual Aid arrangements. 7. Use of Independent sector. 8. Waiting well programmes. 9. Outpatient transformation group.	• Workforce capacity remains a limiting factor. • Ongoing Industrial action will ultimately impact on recovery. • Development of end-to-end pathways linked to managing demand differently will evolve over time.	1. Oversight by SPED. 2. Joint Elective Care Programme Board chaired by ESNEFT & WSFT. 3. Weekly system performance reviews. 4. Tiering oversight process. 5. System Oversight and Assurance Committee. 6. Board oversight. 7. Regional Acute planned care task force 8. Regional sitrep returns and national oversight.	• Workforce challenges remain one of the main limiting factors. • Ring-fenced bed capacity is not available for some specialties (especially orthopaedics) – this will be partially resolved in Summer 2024 with the opening of the Elective Orthopaedic Centre (The Dame Clare Marx building).

Current Aggregated Assurance Rating:	**LIMITED**
Assurance Rating	**Details**

SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
Weekly review of performance and delivery. Once a month NHSE join this meeting.	Ongoing
GIRFT national team review and visit combined with region. New best practice workbooks being worked through by the trusts. Tier 2 review meetings.	Ongoing Both trusts exited national and regional tiering in Autumn 2023 due to relatively good performance.
Link to ICS System Assurance Framework	**ICS Aims 2 & 3** 2.5: NHS Performance (access) 3.1: NHS Performance (activity)
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date

April 2024 update:
The system aimed to clear all but 297 65 week waits for referral to treatment, owing to capacity issues by the end of financial year. Due to the impact of industrial action and a forecast slowdown in elective activity over winter, there is considerable risk in achieving the plan.
There are some indications that waiting list growth and growth in patients waiting more than a year may have slowed or stabilised in the last few months.
Patients waiting long periods of time are monitored so as to mitigate risk associated with long waits.
Focus continues to be on patients waiting over 65 weeks and patients requiring urgent care.

Strategic Risk Number: 8	**System Adult Mental Health (excluding dementia)** Our Joint Forward Plan sets out our commitment to support people with mental health needs as part of the feel well domain. If the current issues relating to our two major mental health providers persist (NSFT/EPUT), we will not improve outcomes for our population by 2028.

Risk due to:

Both of the acute mental health providers in SNEE (NSFT/EPUT) currently have overall ratings of 'requires improvement' from the CQC.

Risk at NSFT arising from:

- Evidence assurance processes are in place but their sustainability is still uncertain. Particular concerns around mortality data.
- Significant organisational change
- CQC concerns – Safe, Effective, Responsive, Well-led all require improvement. The following specific services also require improvement:
  - Specialist community mental health services for children and young people
  - Mental health crisis services and health-based places of safety
  - Acute wards for adults of working age and psychiatric intensive care units
  - Community-based mental health services for adults of working age
- Adult eating disorders services which are currently running in business continuity mode.

Risk at EPUT arising from:

- Evidence assurance process continues to embed
- CQC Concerns - Safe, Effective, Responsive, Well-led all require improvement. The following specific services also require improvement:
  -Child and adolescent mental health wards
  -Wards for people with a learning disability or autism
  -Wards for older people with mental health problems
  -Community-based mental health services for adults of working age
  -Acute wards for adults of working age and psychiatric intensive care units were deemed inadequate by the CQC

There are also concerns about system wide demand pressures and capacity particularly related to:

- Section 117 implementation and governance.

Impact(s) arising from the risk:

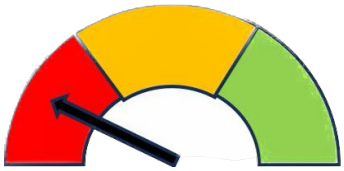
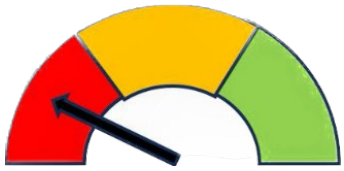
We will not achieve the outcome set out for Feel Well in the Joint Forward Plan and our outcomes as set out below.

Outcome: Supporting the mental wellbeing of our population

Five Year Commitment: We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to stay mentally well and to get support in the community to live and thrive when they need it

Key Performance Indicators:

1. Achieve a 5% year-on-year increase in the number of adults supported by community mental health services.
2. Achieve a year-on-year reduction in hospital admission rate for mental health conditions.
3. Identify and reduce health inequalities amongst people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028.
4. By 2028, no child or young person waits more than 12 weeks for child and adolescent mental health services (CAMHS) or 18 weeks for neurodevelopmental diagnostic (NDD) services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas.

• Workforce planning. • Demand for Autism and ADHD services.			
 **Original Risk Rating** **Impact x Likelihood = 20(5x4)**	 **Current Risk Rating** **Impact x Likelihood = 16 (4x4)**	 **Target Risk Rating** **Impact x Likelihood =9 (3x3)**	
Risk Appetite:	**Risk Appetite: High**	**Action: Treat**	
Last Review Dates:	**Executive Committee:** 1 July 2024	**Board:** 30 July 2024	
Responsible Executive Director:	Lisa Nobes, Director of Nursing Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation		
Responsible Committee:	Quality Committee		
Relevant Directorate Risk Register entries:	Finance, Nursing and Strategy and Transformation		
Relevant System Partner Aligned Risks:	ECC - TBC SCC- TBC Alliance – Feel Well Domains NSFT – Board Assurance Framework July 2023 EPUT – Board Assurance Framework September 2023		
Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
Overall • SNEE Quality Committee • SNEE SOAC (Performance Cttee) **Suffolk - Governance:** • Suffolk Mental Health Collaborative (reporting directly to the ICB Board) with accountability for Suffolk MH services (commissioning and delivery) (bi-monthly) • NSFT OAG (bi-monthly) • NSFT Improvement Board (monthly) • NSFT/ICB Exec to Exec (bi-monthly) • NSFT/ICB QCPM meetings (monthly) • Suffolk 117 Steering Group • Norfolk and Suffolk Internal Quality Forum **Programmes:** • NSFT Improvement Action Plan • NSFT Strategy and Programme • Suffolk MH Collaborative Programme (Charter) **North East Essex - Governance:** • North East Essex Mental Health Group (reporting to NEE Alliance Committee) (bi monthly)	Despite our governance and programmes of work the following areas remain gaps: **Suffolk** • Eating disorders service remains in business continuity mode. • Robust plan for ADHD and autism children and young people and adults demand and capacity challenges with significant waiting times. Regional and national issue. • Continued focus on the urgent and emergency care pathway and out of area placements. **North East Essex:** • Out of Area Placements remain high and require further work to have a robust plan.	**Overall** • Regular focus on mental health through our SOAC and Quality Committees **Suffolk** • NSFT monitoring by NHSE as part of the NOF 4 process. • NSFT – Evidence Assurance Group focus on CQC Must Dos, commissioners attend. **North East Essex** • EPUT Quality Together Meeting.	NSFT Evidence Assurance Group (EAG) has improved assurance, but further work needed to evidence sustained improvement.

• EPUT Quality Together Committee (monthly) • Essex quality collaborative/single contract • EPUT/ICB Exec to Exec (bi monthly) • ICB MH Quality Issues meeting • Pan Essex Internal Assurance Group • SOAG **Programmes:** • EPUT Improvement Action Plan • EPUT Strategy and Programme • Strategy Implementation Group	• EPUT LDOG not consistently noticing trends.		

Current Aggregated Assurance Rating:	**LIMITED**

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Controls:	**Implementation Dates:**
Suffolk ADHD pathway design/demand & capacity programme: Adult ASD/ADHD Oversight Group formed to facilitate planning and transformation of current pathways, commissioning of waiting list capacity and dedicated support for people pre/during/post assessment and/or diagnosis. NSFT Recovery College have developed a bespoke support offer for everyone on ASD/ADHD waiting list, consisting of a range of webinars and courses.	Ongoing.
Suffolk Eating Disorders working group established: Culture change work to be arranged by SRO. Senior leadership has been effective in improving morale and reducing sickness. Specialist team workforce position is improving with some key positions filled substantially, including posts which engage in medical monitoring. Urgent business case requested from NSFT to identify reconfiguration proposals and remaining gaps, including psychological provision. Steering group continues to lead and oversee progress with better integration with the wider system including acute hospitals. The service remains in business continuity mode however the plan with to move from BC to BAU by September.	Ongoing.
Suffolk Section 117 Steering group is now established and meeting. NHSE 117 Maturity Matrix benchmarking exercise completed jointly by NSFT, ICB and SCC – outcome is that the system is largely underdeveloped. Maturity matrix to be used as vehicle for improvement. To report into Suffolk MH Collaborative.	Likely 3 year workplan

EPUT Evidence Assurance Group -implemented – chaired by MSE CNO (lead commissioner).	Ongoing
MH Commissioning Framework –Recruitment to hosted 8C roles successful. Steering Group established. Transformation Team lead dedicated SNEE plan.	
Link to ICS System Assurance Framework	TBC
Reference to Board Opportunities Framework (BOF)	TBC
Executive Director Update on Actions to Date	
• MONTH YEAR update: Eating Disorders – Culture change work to be arranged by SRO which addresses system relationships. • ADHD - see action above. • Mental Health MDT are developing a risks and issues log which will inform BAF as appropriate (May development day in calendar). DELAYED PENDING RISK AND RESILIENCE GROUP	

Strategic Risk Number: 10	**Description: Access to Primary Care** Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).

Risk due to:	**Impact(s) arising from the risk:**
1. Recruitment - inability to recruit & retain GPs + reduction in number of trainees. **2.** Reduction in partners willing to take on practice estates liability. **3.** Stress leading to high turnover. **4.** Reduction in clinical sessions to protect from burnout. **5.** IT Pressures including availability of hardware and changing systems. **6.** Lack of system alignment. **7.** Financial - partner liabilities (estates, employment and single partners), wage growth and inflation including energy prices **8.** System pressure including movement of unfunded workload. **9.** Reduction in number of carers. **10.** Lack of dental and mental health capacity. 11. Imposition of new GP contract 24/25.	**1.** Potential quality of outcomes for patients. **2.** Decline in continuity of care. **3.** Decline in clinical workforce capacity. **4.** Increased waiting times resulting in deterioration (delay in accessing appointments (first and follow up). **5.** Increased referral to acute diagnostic and/or planned care services. **6.** Increased attendances at A&E. **7.** Increased pressure on 111 and Pharmacy services. **8.** Potential GP industrial action because of new GP contract. Could include reduction of appointments or services provided by primary medical care. **9.** GP and staff retention

		
Original Risk Rating **4 x 4 = 16**	**Current Risk Rating** **4 x 4 = 16**	**Target Risk Rating** **4 x 2 = 8**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024
Responsible Executive Director:	Alliance Directors	
Responsible Committee:	Alliance Committees (supported through Primary Care Commissioning Groups)	
Relevant Alliance Risk Register entries:	1. Alliance risk logs 2. Workforce 3. Estates	
Relevant System Partner Aligned Risks:	1. Urgent and Emergency Care 2. Performance of mental health services - access and outcomes 3. Physical and psychological support to dementia patients	

Current Controls (what do we have in place to mitigate the risk)	Gaps in Controls (which of the controls are not effectively mitigating the risk or are not operating effectively)	Current Assurances (how do we know the controls are working)	Gaps in Assurances (which of the controls are not able to provide us with assurance)
1. Development of Primary Medical Care forward strategy and plan towards new models of care including safe working levels. 2. Recruitment and retention programmes (clinical and non-clinical) including ARRS roles. 3. Workload management models. 4. Development of PCN estates plan and delivery of new digital support. 5. Delivery Plan for Recovering Access to Primary Care released. 6. CBT and online consultation tools to increase access. 7. SNEE General Practice Assurance Framework. 8. ICB working with LMC to understand what format IA likely to take and how the system will be able to mitigate.	1. Forward strategy is in development and not yet complete (Target August). 2, GP recruitment and retention programmes do not yet meet full demand. 3. Workload management models require OD support not yet funded or fully in place. 4. National estates planning tools have not fully reflected local need and goals – local supplementary work in place. 5. Details of new contract now published and begin worked through to understand implications. 6. Digital strategy to address telephony and consultations tools underway but shortfall in funding. 7. National GPIP transformation programme has low uptake in SNEE	**1.** Primary Care Commissioning Groups. **2.** Training Hub (THOG) **3.** Operational Support: (PM meetings / PCN CD and PCN Business Manage Meetings. **4. I**CB wide GP Executive. **5**. Monthly ICB and LMC meeting. **6.** Weekly SNEE PMC MDT	1.Further work is required to align the given controls to provide collective and comprehensive assurance.
Current Aggregated Assurance Rating:		**ADEQUATE**	

Assurance Rating	Details
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	Implementation Dates:
1. Primary Care Forward Strategy and Plan complete	August 2024

2. Primary Care Access Recovery Plan	Regional Submission – End September 2024
3. Progression of PCCG in common governance and management	On-going
Link to ICS System Assurance Framework	**ICS Aim 2** 2.5: NHS Performance (access)
Reference to Board Opportunities Framework (BOF)	TBC
Executive Director Update on Actions to Date	
June 2024 There is a co-ordinated and collective (all three Alliance/ICB) approach to the management and governance of the actions set out – strategy, recovery plan, workforce and estates programmes, which respect local differences and the benefits of collective and aligned actions. Implications of IA and PCN pilot still TBD	

Strategic Risk Number: 11	**Description: Cyber Security** Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc

Risk due to:	**Impact(s) arising from the risk:**
1. Potential system cyber security attack **2.** Increase in national requirements regarding the need to achieve cyber essentials + accreditation **3.** Sporadic national funding for cyber security to assist in mitigating risk	**1.** Wide scale IT system outages **2.** No access to patient records **3.** Disruption to all IT based services **4.** Complex restoration of IT services **5.** Potential lack of access to relevant IT skills for system restoration

	Original Risk Rating 4 x 5 = 20	Current Risk Rating 3 x 5 = 15	Target Risk Rating 4 x 3 = 12
Risk Appetite: (see matrix)		**HIGH**	**TREAT**
Last Review Dates:		**Executive Committee:** 8 January 2024	**Board:** 30 January 2024
Responsible Executive Director:		Peter Wightman – Lead ICB Director for IT	
Responsible Committee:		Strategic DDaT Delivery Committee	
Relevant Directorate Risk Register entries:		Held on SNEE Wide risk register (Datix)	
Relevant System Partner Aligned Risks:		Not applicable	

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. Microsoft MFA. 2. Ensuring backup restore mechanisms are in place. 3. Business continuity & disaster recovery procedures. 4. Firewalls 5. NAC	**1.** Lack of visibility of ICS system partner controls **2.** Lack of visibility on DR/BCP testing 3. Not all organisations have same level, method and rigor of testing	**1.** External & internal audits. **2.** Monthly SLA provider meetings. **3.** CE+ certification in some ICS organisations **4.** The annual DSPT **5.** Monthly MDE scores	1. No holistic view 2. No central oversight
Current Aggregated Assurance Rating:		**LIMITED**	**ADEQUATE**

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.

ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided

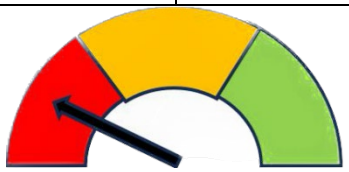
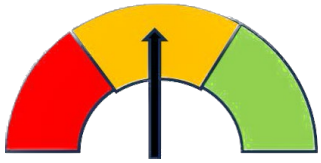
Actions Being Taken to Improve Assurances:	**Implementation Dates:**
1. Gather partner organisations cyber data	31/05/2024
2. Set up process for ongoing monitoring	31/07/2024
3. Agree a baseline cyber position	30/09/2024
4. Target funding to ensure baseline is achieved	2024/25
Link to ICS System Assurance Framework	**ICS Aim 3** 3.5: Digital
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date

April 2024 update:

- Agree Scope, which organisations are included?
- Agree Approach
- Agree Criteria (Could use CE)

Risk due to: **1.** Workforce Growth: attraction and supply of staff across a range of disciplines & professions to meet demand and capacity. **2.** Sustainability – Retention of experienced staff and newly qualified with a focus on work-life balance.	**Impact(s) arising from the risk:** **1.** Inability to meet patient demand and capacity targets. **2.** Concerns for patient safety. **3.** Ability to sustain current & future workforce. **4.** Cost pressures due to skill mix.

		
Original Risk Rating **4 x 5 = 20**	**Risk Rating This Month** **4 x 5 = 20**	**Target Risk Rating** **12 or below**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024

Responsible Executive Director:	Amanda Lyes – Director of Workforce & People
Responsible Committee:	ICB People Committee
Relevant Directorate Risk Register entries:	Workforce Risk register – work currently in progress
System Partner Aligned Risks:	ESNEFT, WSFT, NSFT, EPUFT, Primary Care, EEAST, Suffolk County Council & Essex County Council (Adult and CYP Social care), Alliances incl. partners.

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Assurance Methods** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. SNEE People Plan & associated activities. **2.** Alliance local Workforce Transformation activities. **3.** Programmes to address specific challenges. **4.** Workforce planning and transformation – workshops for challenging pathways.	**1.** SNEE People plan needs to be refreshed and updated (currently in development) to include recently published NHS Long Term People Plan. **2.** West Suffolk Alliance plans are underway. Scoping with NEE and IES Alliance workforce challenges and plans to address.	**1.** Reports to SNEE People Committee. **2.** ICS Anchor Summary data. **3.** Sharing of data & intelligence with partner organisations. **4.** Creating KPI's and a Workforce Dashboard to become part of SOAC reporting.	**1.** The underlying problem of staff supply across both the system & more widely across the national health and social care remains.

Current Aggregated Assurance Rating:	**ADEQUATE**

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
1. Re-energise the workforce through improved wellbeing, work-life balance, flexibility, availability of tools to do jobs, functionality & improved estates.	Ongoing
2. People Committee sub-groups being reviewed and ongoing conversations with stakeholders.	31/03/2024
3. Assurance dashboard being created & aligned with performance improvement.	31/03/2024
4. Pathway workforce strategies & plans created for future models.	31/03/2024
Link to ICS System Assurance Framework	**ICS Aim 4** 4.1:Workforce

Reference to Board Opportunities Framework (BOF)	Addressing workforce supply means that we need to address skill mix and transformation opportunities within pathways that could lead to better efficiency and productivity.

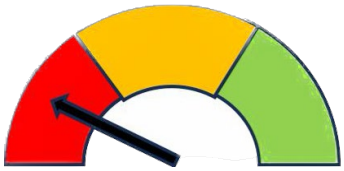
Executive Director Update on Actions to Date

March 2024 update:

- The Frailty/EoL/Maternity/INTs and Cancer and Diagnostic Workforce draft plans have been presented at the relevant meetings/groups. After the period of review, these will be finalised and taken forward as actions plans. Follow up workshops are being planned to agree actions and action owners.
- At the first Strategic Clinical Education Group (SCEG) it was agreed that an Operational Group will develop a plan and present to the SCEG for review in 2 months.
- The process for the Operational Planning 24/25 is underway with the first system meeting between providers and the ICB to agree triangulation between finance, activity/performance and workforce being discussed. A system workshop was hosted in February to outline process and timelines once further guidance from NHSE is distributed. This will allow for an improvement in how the system triangulates the plans and submitted to NHSE in March ’24.
- Inaugural meeting of the system Apprenticeships Group established with a further workshop planned for February ’24.
- The final round of Introduction Courses to Workforce Planning will be held in February ‘24, by which time over 100 people from across health, care, local government and the VCSE sector would have attended. Further masterclasses are being planned to focus on productivity and efficiencies.

Strategic Risk Number: 16	**Description: EEAST Performance & Quality** EEAST is not achieving national performance targets particularly C2 target of <30min mean for 23/24 as a whole.

Risk due to:	**Impact(s) arising from the risk:**
1. Capacity constraints. **2.** Productivity issues regarding abstraction rates & hospital handover delays. **3.** The level of PFSH available to deploy on the road is unable to meet capacity and is below 2019/2020 ISR plan. **4.** Relatively high sickness/absence & vacancy rates. **5.** Being able to maintain pace of recruitment.	**1.** Increase in SIs arising from response delays. **2.** Pressure on staff in patient facing positions. **3.** A&E handover delays affecting capacity. **4.** Response delays causing patient safety risks particularly in Category 1 & 2 calls.

		
Original Risk Rating **5 x 5 = 25**	**Current Risk Rating** **5 x 4 = 20**	**Target Risk Rating** **4 x 2 = 8**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024

Responsible Executive Director:	Ed Garratt – Chief Executive
Responsible Committee:	Executive Committee
Relevant Directorate Risk Register entries:	On BAF - no directorate risk register entries
Relevant System Partner Aligned Risks:	Primary Care, Acute care providers particularly with A+E department, Mental Health Providers.

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. Monthly oversight & assurance meeting – Regulator & Lead Commissioner at Chief Executive level. **2.** Monthly deep dive on specific areas for assurance on improvements – Regulator, Lead Commissioner & Provider. **3.** Local monthly quality & performance meetings at ICS level. **4.** ICS/Alliance UEC system meetings. **5.** Weekly SI reports. **6.** ICBs agreed system hand over hours target of	**1.** Agreed system hand over hours target for each ICB not agreed.	**1.** Oversight of EEAST Operational Improvement & Workforce Plan. **2.** Updates and oversight at OSM. **3.** Clinical review of serious incidents through SI Panel. **4.** Oversight of local EEAST improvement plans. **5.** Escalation where necessary to Executive Quality & Safeguarding QSAF, Quality and Scrutiny Committees. 6. EEAST submitted operational performance plan for	**1.** Workforce plan is 'low road' plan for front line staff as EEAST have confirmed this is to align with cost envelope. 24/25 Workforce plan yet to have assurance from commissioners as maintaining focus in key areas for C2 performance. **2.** ICB system handover plans have yet to be agreed to achieve <2000 hr handover delay target. NHSE are working on targets on fair share basis. **3.** EEAST operational plan not fully signed off by

<2000 hours regionally >15min. **7.** Vehicle off road and fleet trajectory and action plan shared by EEAST. **8.** Operational Improvement plan agreed by NHSE and Commissioners for 2024/25 areas of focus.		24/25 is compliant against <30min target.	their board expected 1st week of May.

Current Aggregated Assurance Rating:	**LIMITED**

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
1. EEAST, Commissioner and Regulator agreed to receive monthly update on vehicle off road action plan update to review as part of pre OSM forum. 2. Workforce conversation and frontline recruitment queries escalated to OSM.	28th May 2024 2nd May 2024
Link to ICS System Assurance Framework	**ICS Aims 2 & 3** 2.5: NHS Performance (access) 3.1: NHS Performance (activity)
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date

April 2024 update:

Compliant <30min mean Cat2 performance plan has been submitted. The plan is only just under the <30min target for 24/25 and there is risk of slippage as improvement plan and handover target needs to be achieved.

Handover delays have been close to the <2000 hours recently as a region although only 1 week actually under the threshold.

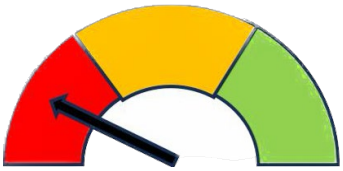
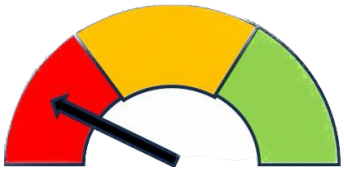
C2 performance in early weeks of ear is closer to C2 performance requirement but still not yet achieving.

Expected further workforce plan discussions following OSM conversation on 2nd May including ability to re-align Provider underspend to frontline resources.

Contract discussions continue with finance elements from 3 ICBs being queried by individual ICBs.

Strategic Risk Number: 19	**Description: System Cancer Standards** System not meeting the cancer related standards within the NHS constitution leading to worsening patient outcomes and quality of services.

Risk due to:	**Impact(s) arising from the risk:**
1. Capacity insufficient to meet significant increases in demand, staff recruitment difficulties e.g. oncology, radiology and diagnostics. **2.** Key staff sickness. **3.** Diagnostic capacity and reporting in particular for the Faster Diagnosis 28-day standard. **4.** Industrial Action.	1. Poor patient experience. **2.** Clinical risk of patients not seen within appropriate timescales. **3.** Deteriorating patient outcomes. **4.** Breach of constitutional obligations.

			
	Original Risk Rating **4 x 4 = 16**	**Current Risk Rating** **4 x 4 = 16**	**Target Risk Rating** **4 x 2 = 8**
Risk Appetite: (see matrix)		**HIGH**	**TREAT**
Last Review Dates:		**Executive Committee:** 7 May 2024	**Board:** 28 May 2024
Responsible Executive Director:	Richard Watson – Director of Strategy & Transformation		
Responsible Committee:	ICB Cancer Programme Delivery Committee		
Relevant Directorate Risk Register entries:	ICB Strategy and Transformation		
Relevant System Partner Aligned Risks:	ESNEFT WSFT East of England (NHSE) Cancer Alliance (North)		

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. Annual Cancer Plan 24-25 and wider five-year Cancer Strategic Plan. **2.** Recovery Plans in place for both our major cancer providers (WSFT and ESNEFT). **3.** Investment Plan to support improvement. in quality and performance. **4.** Development of different roles and	1. It is not the case that the controls are not working however there are a combination of the following factors impacting on performance: a. Demand b. Industrial Action c. Workforce Gaps d. Recruitment delays	1. Performance overview by monthly SNEE Cancer Ops Group. 2. Weekly cancer focused reporting with ESNEFT & WSFT PTLs in place. 3. Monthly joint quality/performance meetings with ESNEFT & WSFT. 4. Bi-monthly SNEE ICS Cancer Committee.	The assurances are appropriate but the risk is not being completely mitigated due to the reasons set out in the 'gaps in control' section.

providers to augment core provision.			

Current Aggregated Assurance Rating:	LIMITED

Assurance Rating	Details
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	Implementation Dates:
1. Recovery & action plans in place in challenged tumour sites across both Trusts. ESNEFT- Colorectal, Urology & UGI. WSFT – Skin & Colorectal. 2. Faster Diagnosis Compliance Delivery group meeting monthly to assess action plans 3. Endoscopy utilisation underway at both Trusts	Partially complete, progress ongoing.
4. EoE Cancer Alliance Team working with Regional CEs and have identified FDS recovery as one of their top three priorities. RCAT Phase 1 is complete with actions being delivered in Gynae, LGI & Skin. RCAT phase 2 project launch underway in Urology, UGI & Lung. Phase 2 task & finish groups to commence in Q2.	Quarter 2
Link to ICS System Assurance Framework	**ICS Aims 2 &3** 2.5: NHS Performance (access) 3.1: NHS Performance (activity)
Reference to Board Opportunities Framework (BOF)	TBA

Executive Director Update on Actions to Date

June 2024 update:

- 28 day FDS performance trajectory was achieved in SNEE in March 2024 at 75%. This positive performance has been sustained at ESNEFT in April but a slight decrease seen at WSFT to 71%, largely due to endoscopy capacity and Skin pathway work force challenges.
- The 62-day performance 70% standard was exceeded in March 2024 at both Trusts with WSFT at 85% and ESNEFT at 75%. Performance has dropped in April to 67% at ESNEFT and 76% at WSFT. Pathway analysis and MDT streamlining is underway for challenged tumour sites including Colorectal, Urology, Skin, UGI and Gynae.
- ESNEFT colorectal performance has noted a gradual improved position at Colchester but the new colorectal pathway at Ipswich continues to be challenged due to endoscopy capacity,

nursing posts are still being recruited to while clinical review times are much improved. 62 day performance in April 24 was 43%, a sustained position but LGI remains the most challenged tumour site, but a recovery action plan is in development with the clinical and operational teams.

- Skin performance at WSFT continues to fluctuate, with staffing challenges and clinic capacity impacting their ability to treat in a timely way. Insourcing within Dermatology for face to face and some excisional work continues. Performance had improved in February/March to 65% with 58% performance reported in April 24. Work is underway to build resilience in the pathway with the recruitment of an additional photographer and with clinical leads reviewing the pinch points in the pathway.

Strategic Risk Number: 25	**Description: Failure to meet statutory ICB financial targets to:** • At least break even. • Ensure both capital and revenue resources do not exceed the limit set by NHSE. • Ensure expenditure on running costs does not exceed the limit set by NHSE.

Risk due to: **1.** Insufficient funding **2.** Ineffective controls **3.** Ineffective cost improvement to meet statutory targets **4.** Impact of Industrial Action **4.** Prescribing price inflation **5.** Additional cost of urgent & emergency care **6.** 30% Running Cost Reduction Programme **7.** System risk associated with WSFT presenting a year to date deficit position against plan.	**Impact(s) arising from the risk:** **1.** Failure to deliver financial planning targets **2.** Failure to deliver statutory duties **3.** Loss of system autonomy & credibility **4.** Potential investment restrictions **5.** Potential challenging disinvestment decisions

 **Original Risk Rating** **3 x 5 = 15**	 **Current Risk Rating** **3 x 5 = 15**	 **Target Risk Rating** **3 x 4 = 12**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Finance Committee:** 14th May, 2025	**Board:** 28th May, 2023
Responsible Executive Director:	Howard Martin – Director of Finance	
Responsible Committee:	ICB Finance Committee	
Relevant Directorate Risk Register entries:	N/A	
Relevant System Partner Aligned Risks:	ESNEFT / WSFT / EEAST	

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. Internal expenditure controls, including Vacancy Approval Panel. **2.** Contingency reserve **3.** Depreciation Allocation (contingency)	System finance risk associated with WSFT not yet presenting a plan to deliver the target £15.2m deficit. Projected financial risk associated with the EEAST underlying financial	1. Internal Audit of key financial controls 2. Internal Audit against HfMA Financial Sustainability Checklist **3.** Oversight by ICB Finance Committee & Financial Recovery & Sustainability Group	1. Not currently sighted on the WSFT delivery plan.

4. Projected underspends in Dental and Specialist Commissioning. **5.** Detailed Cost Improvement Plans **6.** Double Lock Arrangements for WSFT **7.** Production of the WSFT FRP and detailed review **8.** Escalation and De-Escalation process established.	position. This risk increases most significantly from 2025/26.	**4.** Monthly Director budget scrutiny meetings **5.** Alliance Committee scrutiny of delegated budgets **6.** Vacancy Approval Process to remain in place. **7.** WSFT Recovery Plan for 2024/25	

Current Aggregated Assurance Rating:	**ADEQUATE**

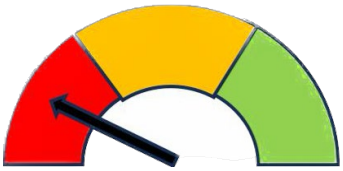
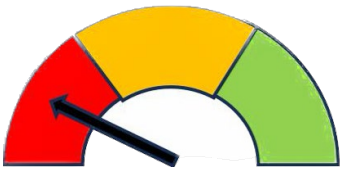
Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
1. Monitoring of progress and delivery of mitigations	Ongoing through Finance Committee
2. Presentation of WSFT Recovery Plan	May, 2024
3. EEAST Diagnostic Review	May/June, 2024
Link to ICS System Assurance Framework (see attached where available):	3.2: Finance
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date
A range of mitigations have been presented to the Board in April prior to the 2nd of May planning submission. The key mitigation not yet completed is sight and scrutiny of the WSFT recovery plan to deliver a £15.2m deficit in 2024/25.

Strategic Risk Number: 29	**Description: Consequences of Climate Change** Consequences of climate change on health and healthcare services for the SNEE population.

Risk due to:	**Impact(s) arising from the risk:**
1. Increases in adverse weather events **2.** Rising temperatures **3.** Increase exotic disease & pathogens vectors **4.**	**1.** Health & social care delivery **2.** Patients & staff suffering increased ill health **3.** Potentially unusable healthcare premises **4.** Poor air quality

		
Original Risk Rating **4 x 4 = 16**	**Current Risk Rating** **4 x 4 = 16**	**Target Risk Rating** **4 x 3 = 12**
Risk Appetite: (see matrix)	**SIGNIFICANT**	**TOLERATE**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024
Responsible Executive Director:	Amanda Lyes – Director of Workforce & People	
Responsible Committee:	Estates Committee	
Relevant Directorate Risk Register entries:	Workforce & People Directorate	
Relevant System Partner Aligned Risks:	All system partners should have climate change on their risk registers.	

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. ICB Green Plan. **2.** Multi-agency planning by LRFs. **3.** Trust annual report returns received.	**1.** Unaware of current position within primary care as to their climate adaptation & resilience planning.	**1.** ICS Board oversight & approval. **2.** LRF Executive Boards. **3.** Debriefs held after incidents. **4.** ICB Sustainability Steering Group meetings underway.	**1.** Trust returns have identified where additional work is necessary, adaptation of premises to reduce risks associated with climate change and severe weather.
Current Aggregated Assurance Rating:		**LIMITED**	

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.

LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
1. The NHS Estates Net Zero Carbon Delivery Plan sets out the actions that the various organisations within the NHS should be delivering over the next five years. These are included in Appendix J. These actions have been shared with all organisations in SNEE and form the basis of the SNEE action plan.	01/12/2028
2. Further review the risk following LRF Community Risk Register updates following the update to the National Strategic Risk Assessment (NSRA).	31/01/2024
3. Limited assurance due to lack of oversight within primary care climate risk planning, climate resilience instructed to be in PCN strategies. NHS Trust returns received. Action plan being developed.	31/01/2024
Link to ICS System Assurance Framework	**ICS Aims 3 & 4** 4.1 Environment 3.3 Estates
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date

January 2024 update:

- Feedback being collated final draft for hard launch in Q4. This is now included in the Business Case template.

Strategic Risk Number: 30	**Description: Risk of Failing to Ensure Comprehensive Freedom to Speak Up Arrangements:** The recent Lucy Letby trial & conviction demonstrates the risk of not having robust FTSU arrangements in place within a listening organisation.

Risk due to:	**Impact(s) arising from the risk:**
1. Inadequate FTSU arrangements. **2.** Action not taken in relevant FTSU cases. **3.** Lack of full Fit & Proper Person testing for senior staff. **4.** Lack of full pre-employment screening for all staff.	**1.** Potential adverse organisational consequences for the public/patients & staff **2.** Organisational reputation. **3.** Lack of confidence by staff & the public that their concerns will be addressed. **4.** Failure to meet CQC 'Well Led' quality statement.

 **Original Risk Rating** **5 x 3 = 15**	 **Current Risk Rating** **4 x 2 = 8**	 **Target Risk Rating** **4 x 2 = 8**
Risk Appetite: (see matrix)	**HIGH**	**TREAT**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024

Responsible Executive Director:	Amanda Lyes – Director of Workforce & People.
Responsible Committee:	Remuneration & Human Resources Committee.
Relevant Directorate Risk Register entries:	Workforce Risk Register – work currently in progress.
Relevant System Partner Aligned Risks:	This risk applies to all system partners & to health & care providers in particular.

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. FTSU policy. **2.** FTSU Guardian in place. **3.** FPPT policy & procedure.	**1.** FTSU policy not yet in place. **2.** FTSU Guardian not yet in place. **3.** Staff awareness training for FTSU yet to be arranged.	**1.** FPPT policy in place as required by 30/09/23 + Director & HR Staff training completed. **2.** Existing Whistleblowing policy remains in place until new FTSU policy established by 30/11/23.	**1.** Assurance 2. pending introduction of all new arrangements.
Current Aggregated Assurance Rating:		**SUBSTANTIAL**	

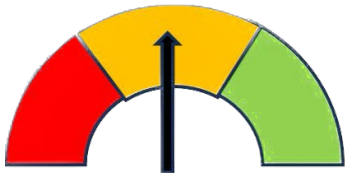
Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.

ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
3 Following discussion at the ICB Board meeting in November, the FTSU processes across the system are to be explored in order to be assured of system wide cover.	**31/01/2024**
Link to ICS System Assurance Framework	**ICS Aim 3** 3.6: Workforce
Reference to Board Opportunities Framework (BOF)	N/A
Executive Director Update on Actions to Date	
January 2024 update. The aggregated assurance rating has been changed substantial meaning that the risk it can be removed from the BAF. It will however remain on the People & Workforce risk register.	

Strategic Risk Number: 31	**Description: Impact of RAAC on the Suffolk and North East Essex ICS** WSFT have identified and alerted the previous CCGs to risks associated with the Trusts Reinforced Autoclaved Aerated Concrete (RAAC) infrastructure

Risk due to:	**Impact(s) arising from the risk:**
1. Lack of structural integrity of RAAC planks within the West Suffolk Hospital. 2. Unassessed Primary care properties that may contain RAAC. 3. Increased media interest in RAAC in the public sector estate following closures of schools.	1. Loss of part or all of WSH due to structural damage. 2. Fatalities or injuries to staff or public 3. Dust contamination that may include asbestos. 4. Reputational and loss of trust and confidence in the NHS. 5. Loss of primary care facilities.

			
	Original Risk Rating **3 x 5 = 15**	**Current Risk Rating** **3 x 4 = 12**	**Target Risk Rating** **2x 3 =6**
Risk Appetite: (see matrix)		**HIGH**	**TREAT/TOLERATE**
Last Review Dates:		**Executive Committee:** 7 May 2024	**Board:** 28 May 2024
Responsible Executive Director:		Paul Gibara Director of Performance Improvement	
Responsible Committee:		Estate Committee	
Relevant Directorate Risk Register entries:		This Risk crosses over all Directorates	
Relevant System Partner Aligned Risks:		• West Suffolk Foundation Trust • Integrated Care Board • Wider Primary Care service providers	

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. Local and Regional plans in place and aligned with regional oversight group established. **2.** ICB is required to ensure WSFT who are legal owners of estate and provider of services give assurance as to the safety of services. **3.** WSFT have significant surveyance program /remedial plan to ensure safety of patients, visitors and staff. **4.** Governance Structure in place to monitor level of	**1.** Some Primary Care site returns outstanding.	**1.** Risk and assurance is reviewed through risk committee. **2.** Exercise Vesta held to review the SNEE and wider LRF response to an incident at WSFT. **3.** Regional exercises (Walker and Fox) held to develop region evacuation /shelter planning. **4.** On going assurance provided to ICB risk manager by attending WSFT risk meetings.	

assurance together with measures to assess and give the ability to respond to any adverse changes and consequence of the risks identified. 5. WSFT internal expert leadership team. 6. ICB currently supporting the review of Primary Care premise for RAAC.		5. EPRR Forum in place within the system which has reviewed SNEE RAAC Framework in 2023. 6. Incidents or Events are routinely monitored through EPRR Team.	
Current Aggregated Assurance Rating:		**ADEQUATE**	

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
1. Work with social care providers to investigate how to ensure patient safety in a mass casualty/evacuation of a hospital site.	Ongoing
2. Ongoing remedial engineering work led by WSFT.	Ongoing
Link to ICS System Assurance Framework	**ICS Aim 3** 3.3: Estates
Reference to Board Opportunities Framework (BOF)	WSFT - New hospital build

Executive Director Update on Actions to Date

April 2024 no further update:
This is an update of the original RAAC BAF entry focusing on WSFT and has now been broadened to include the wider system including primary care. The ICB is seeking to assure itself and the system that the right processes are being followed to mitigate the impact of RAAC on patients, staff and public that use our buildings.
The ICB EPRR Team is developing a process to understand how we would work with social care in the event of an incident with WSFT to enable us to discharge patients at pace.
Further review of RAAC processes within the ICS underway following announcement of schools nationally being closed to ensure our processes are robust and fit for purpose within SNEE.

Strategic Risk Number: 032	**Description: SYSTEM CYP SERVICES including SEND.** CYP cannot access the appropriate health services in a timely way, including those children whose special educational needs are not being met sufficiently across Suffolk and North East Essex.

Risk due to:

1.Suffolk's recent OFSTED/CQC Inspection of SEND services with poor outcome. Inspection highlighted "Leaders across the local area partnership should ensure that providers of services for children with social and emotional well-being, mental health and neurodiverse conditions work jointly to meet the needs of and improve outcomes in these areas for children with SEND".

2.North East Essex's previous inspection in 2019 found areas of weakness with a subsequent revisit 2022 highlighting sufficient progress for the following areas but not exclusively; joint commissioning and variation between ICB's leading to wait times/inconsistency and EHC plans not of sufficient quality, with right professional advice or fit for purpose. In addition, they found "too much variation between the CCGs lead to inequality, inconsistency and unacceptably long waiting times for services".

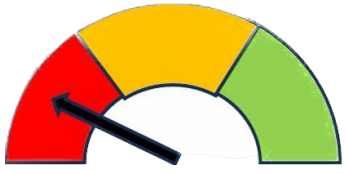
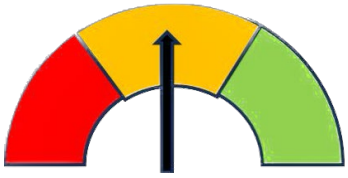
3.CYP in Suffolk are unable to access MH therapy and treatment in a timely way.

4.Within the Suffolk SEND/CQC inspection waits for neurodevelopmental services were highlighted within the report "there are very long waiting times to access some neurodevelopmental assessments". In addition, there are a significant number of CYP currently who are or will shortly be added to caseloads for NSFT and WSFT from Barnardo's.

5.In North East Essex there are similar challenges. Within the Joint Area SEND Revisit in 2022 it was highlighted "waiting times for diagnostic pathways for autism spectrum disorder and attention deficit and hyperactivity disorder remain variable".

Impact(s) arising from the risk:

1. Suffolk and NEE children may not have an appropriate statement of their SEN including their health needs in accordance with statutory duties.
2. Children are waiting to access health services, specifically NDD and MH. This will in turn potentially affect a young person's wellbeing, access to the appropriate support and a potential to escalate through to other services.
3. Reputational risk and high levels of dissatisfaction from parents and carers.
4. Young people are being admitted into physical acute paediatric wards across the ICS creating a risk to staff, patients and families on these wards.
5. Long waiting and delays in treatment meaning young people's wellbeing and mental health deteriorating. This could result in harm to CYP.

		
Original Risk Rating **Impact x Likelihood = 25**	**Current Risk Rating** **Impact x Likelihood = 20**	**Target Risk Rating** **Impact x Likelihood = 12**
Risk Appetite: (see matrix)	**High**	**treat**
Last Review Dates:	**Executive Committee:** 7 May 2024	**Board:** 28 May 2024

Responsible Executive Director:	Richard Watson/Lisa Nobes
Responsible Committee:	Quality Committee Suffolk CYP Committee North East Essex Alliance Committee
Relevant Directorate Risk Register entries:	MH granular risks on CNO register. NDD and Mental health granular risk to be added on to the Transformation register.
Relevant System Partner Aligned Risks:	SEND risks on Partnership Board and Programme Board risk register. These need to be reviewed.

Current Controls (what do we have in place to mitigate the risk)	**Gaps in Controls** (which of the controls are not effectively mitigating the risk or are not operating effectively)	**Current Assurances** (how do we know the controls are working)	**Gaps in Assurances** (which of the controls are not able to provide us with assurance)
1. CYP - ICB Escalation and flow management in acute hospitals. **2.** Regular system calls for CYP with involvement of all partners and ICB to manage clinical risk, share information and plan delivery of care. **3.** NDD controls – monthly meeting with providers and the ICB and weekly recovery meeting in Suffolk with system colleagues to review recovery plans and any key challenges. **4.** NDD SNEE – recovery plans and additional investment from ICB agreed and accelerated plan to access assessment agreed. **5.** NEE North East Essex – feeding into the wider Essex SEND Joint Commissioning Group. **6.** MH controls with NSFT for CYP waiting - SUTL and waiting list management protocols of clinical harm processes. CAMHS/YAMHS	• Suffolk SEND Priority Action Plan and strategy currently being formulated by LAP in response to Inspection findings. • Credible recovery plan for CAMHS/YAMHS at NSFT not yet in place and NSFT reporting for CYP MH waiting times for MH treatment in NSFT not improving. Data quality cited as a factor but needs to be better understood. • Final trajectories for NDD recovery. not in place yet for SNEE.	1. Local protocol and processes and additional MH staffing in A and E for managing escalating need. 2. Weekly recovery calls with system partners. Update and agreement for decisions provided to Suffolk CYP Committee, Suffolk SEND Programme Board and Suffolk SEND Partnership Board and in NEE the NEE Alliance Cttee as needed and the Essex SEND JCG and Partnership Boards. 3. Monthly meetings to review / challenge quality performance with providers. 4. MH - NSFT monthly meetings between ICB and NSFT on CAMHS/YAMHS recovery. 5. Regular reporting and escalation of issues through QC/ ICB CYP MDT/MH Steering group/CYP Board. 6. ICB Health and LAP quality audits of plans across SNEE.	• Gap in information provided re over 11's autism performance recording. • NEE SEND LAP have identified a review of Partnership Board governance and risks required. • Waiting times for MH treatment in NSFT not improving. Data quality cited one possible factor but needs to be better understood.

recovery plan in development with regular meetings between NSFT and the ICB. **7.** MH Delivery Group in place across Suffolk with focus on improvements to the model and timely delivery of services. **8.** Health providers across SNEE have SEND processes and monitoring in place for input to statutory processes.			

Current Aggregated Assurance Rating:	**LIMITED**

Assurance Rating	**Details**
SUBSTANTIAL	The scope of Assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk.
ADEQUATE	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
LIMITED	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk and action is required to address and / or there are gaps in assurance.
NONE	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address to improve Controls and Assurance provided.

Actions Being Taken to Improve Assurances:	**Implementation Dates:**
NDD Introduce additional resource to reduce long waits for access to diagnostic assessments for neurodiversity.	
• Agree business cases detailing approach to reducing waiting times for autism and ADHD assessments.	Feb 24
• Agree trajectories with both West Suffolk Foundation Trust (WSFT) and Norfolk and Suffolk Foundation Trust (NSFT) around reduction in waiting times for autism assessments.	Mar 24
• Commission additional capacity from the market for autism assessments.	May 24
• Commence recruitment of additional ADHD staffing within NSFT, this has been delayed and will now go to market following the General Election based on advice NSFT have received.	~~April 24~~ July 24

• Monthly meetings to monitor progress against waiting time trajectories. • Develop long term revised model for ADHD / Autism assessment with NSFT and WSFT, new project manager starts 1st July to lead this piece of work.	April 24 July 24
NDD Review impact of Voluntary, Community and Social Enterprise (VCSE) contracts providing support to CYP and their families waiting for a neurodiversity assessment. Take learning and family feedback to redesign delivery prior to re-procurement. • Review existing service provision. • Develop new co-produced service specifications. • Approval from Execs • Commence procurement programme once approval granted • Award contracts. • New service start	 April - Jun 24 June - August 24 23rd September 2024 September 24 April 25 August 25
CYP Mental Health Strengthening work across the partnership to further develop whole school approaches to supporting emotional wellbeing/mental health: Delivering system workshops to further establish the iThrive Framework within Suffolk. Recovery plan agreed to manage CAMHS and YAMHS waiting times with a clear trajectory for improvement. Develop implementation plan for new models of delivery. Oversee the delivery of the new model of care deliver through the Suffolk Mental Health Collaborative. Psychology in schools – review. Embed Mental Health in Schools Teams and utilise learning from programme for future waves.	 Jan - June 24 April 24 July 24 to September 24 ~~August 24 onwards~~ September 24 onwards September 24 onwards September 24
CYP Mental Health Crisis Review and extend the peripatetic offer wrap around support for children and young people in crisis. Carry out review of the currently commissioned Coordinated Help and Risk Intervention Service (CHRIS) service with any recommendations feeding into the business case to be developed. Develop a business case/proposal to meet any gaps in the CYP crisis pathway. Update to the system wide crisis protocol following stocktake.	 March 24 June 2024 ~~June 24~~ September 24

Commissioning of any gaps identified through the stocktake. Strengthening support for children and young people attending A+E in crisis by the continuation of acute mental health practitioners post review.	June 24 ~~July 24~~ September 24 April 24
NSFT quality and safety reviews jointly with ICB and NHSE.	March 2024
NEE SEND Health Inspection preparation workshops with senior leaders and partners, led by NHSE SEND Manager. Will identify gaps, challenges, and plan actions for joined up Health approach. Will also review Health SEND forum effectiveness. Started 27th Feb 2024.	27th February 2024
NEE SEND Inspection preparation and planning for Self-Evaluation Framework by LAP.	March 2024
SEND Health refreshed work to draw together data available to understand health services performance across Essex led by MSE.	February 2024
Suffolk SEND Priority Action plan by LAP to be submitted to OFSTED/CQC by 1st March.	March 2024
Link to ICS System Assurance Framework	**XXXX**
Reference to Board Opportunities Framework (BOF)	TBC

Executive Director Update on Actions to Date

NDD:

- Business cases agreed for additional investment into NDD services across SNEE.
- Recovery trajectories in draft form with each provider.
- April update: working with providers to agree trajectories, WSFT have completed procurement, NSFT about to start procurement.

CAMHS

- Review and extend the peripatetic offer wrap around support for children and young people in crisis. April update: peripatetic offer continuing however with altered criteria/funding as per review. Further conversations with Acute Trusts regarding pooled funds to take place as part of crisis review work expected June.
- NSFT quality and safety reviews jointly with ICB and NHSE – April update: NSFT have advised QSR's suspended until further notice whilst Trust focuses on Mortality Review project. Further discussion on risk between LN and AD (NSFT) to take place
- Suffolk CAMHS/YAMHS Recovery Plan and trajectories in development and due to conclude end of March 24. April update: trajectories now drafted and being agreed.
- Suffolk CYP Crisis Stocktake concluded and due for consideration and agreement end of March 24. April update: task and finish group now established, expected model by end of May 2024
- Suffolk CYP MH workshops commenced to reboot the CYP MH transformation programme with recommitment of NSFT/SCC/ICB to move ahead. April update: final workshop on 30th April, combined workshop planned for 14th June.

Suffolk SEND

- Suffolk SEND Action Plan developed and submitted to Ofsted and CQC. April update: Priority action plan agreed by DfE, new SEND strategy to be signed off by mid-May.

NEE SEND

- Workshop held to commence development of self-evaluation for Essex SEND services.
- Health prep: April update final workshop being held May including refresh of health forum aims and objectives. Linking with MSE as leads re dashboard timeframe for delivery to be clarified.

NHS
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Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 14
Date: 30 July 2024

Title: Integrated Care Board Governance Self-Assessment

Lead Director: Amanda Lyes, ICB Execuitve Director of People and Workforce

Author: Tom McColgan, ICB Governance and Compliance Manager and Colin Boakes, Governance Advisor

Purpose: To note the response the self-assessment

Recommendation: That the Board notes the responses to the self assessment and considers the areas for further development suggested by Members.

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1. Background

1.1 In 2023 NHS England set out a requirement for ICBs to conduct periodic self-assessment of their governance arrangements to help identify opportunities to strengthen relationships and collaboration and optimise decision-making and implementation within the context of partnership.

1.2 The self-assessments are intended to inform the work of the ICB to ensure decision-making arrangements remain effective as the ICS evolves and that they are best enabling integrated, system-based working and in turn, improvements in care and outcomes for the local population.

1.3 It is considered particularly relevant for ICBs to review their partnership governance arrangements following a period of establishment and transition, the development of the first Joint Forward Plan and further delegation of functions from NHS England. As such, it was expected that the ICB self-assessment process would commence in **Q3 2023-24** although dates were flexible in order to meet the needs of individual organisations.

2. **Key Issues**

2.1 ICB Chairs are responsible for the governance and partnership arrangements of their respective ICBs and have ownership, working with the Chief Executive, of any process for reviewing these.

2.2 NHS England provided supporting resource materials for ICBs which took into account learning from ICBs that had already started to review their governance and partnership arrangements. They were designed to be used flexibly to support ICBs undertaking their self-assessments although they are also at liberty to draw on other relevant resources.

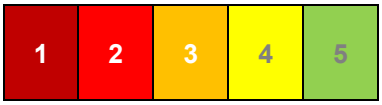
2.4 Further to local discussion, four areas were considered appropriate to include within the assessment, these also reflecting the focus areas suggested by NHS England.

2.5 Four questionnaires were subsequently produced covering the key topics of:

- **Questionnaire One**: Role and Functioning of the ICB Board
- **Questionnaire Two**: Decision Making by the ICB and its Partner Trusts
- **Questionnaire Three**: Commissioning Decision Making
- **Questionnaire Four**: Assignment of Decisions to System, Place and Providers

2.6 It was suggested that for analysis, a sliding scale scoring should be used for responses to the individual questions, supported by free text comments.

2.7 By way of a reminder, the sliding scale scoring was a simple 1 to 5 where respondents:



1. Strongly Disagreed
2. Disagreed
3. Neutral – Neither Agreed or Disagreed
4. Agreed
5. Strongly Agreed

2.8 When scoring at 1 or 2 respondents were asked to provide a brief explanation for that score in the comments section in order that the ICB could learn more about their specific reasons for making such scores and possible actions that could be taken to address the issue(s).

2.9 The content of the questionnaires was discussed and agreed by the Executive Committee and also shared with Partner Members for their input.

2.10 The questionnaires were sent out to Board Members on 22 November 2023.

3. Conclusions

3.1 A total of 17 responses were received from board members and regular attendees. The full scores and summary of the comments are included at appendix 1. The following themes emerged from the responses.

3.2 The average score for every question across all domains was between **3-4**.

3.3 The three lowest average scores (so the area where respondents feel there is the most room to improve) were in response to the questions:

- Do you agree that current processes for understanding and making decisions related to health inequalities, including identifying populations at risk of health inequalities and our efforts to address the known drivers, including allocation of resource, are acceptable/robust enough? **Average Score 3**

- Do you agree that the ICB's current ask of providers/provider collaboratives, for example supporting wider service resilience, improvement and efficiency is appropriate and is delivering? **Average Score 3.1**

- Do you agree that the ICB is ready to delegate further responsibilities to place & wider system partners? **Average Score 3.1**

3.4 The three highest scores (so the areas where respondents feel that the ICB is performing well) were in responses to the questions:

- Do you agree that the ICB is appropriately managing conflicts of interest in view of the increased risk of conflicts arising given the Board composition? **Average Score 3.9**

- Do you agree that the ICB's and partner Trusts' current decision-making arrangements in relation to NHS system financial planning and NHS capital investment planning, together with processes for collectively monitoring and managing financial balance during the ICBs first year have been robust ? **Average Score 3.7**

- Do you feel that the ICB has effective arrangements in place to ensure engagement with other system partners, including local government and VCSE, in decision-making around fulfilling NHS system management priorities? **Average Score 3.7**

3.5 For the three highest rated questions at least one respondent disagreed with the statement scoring it as a '2' or '1'. For the three lowest rates questions at least one respondent strongly agreed with the statement scoring it as a '4' or '5'. For all questions there was a wide variation in responses reflecting a difference in opinion about how the Board is performing.

3.6 There are several themes that can been seen in the comments which the Board may wish to take forward:

- Developing an approach to meetings which enabled constructive and robust debates.
- Developing an approach to allow a wider diversity of opinions to be aired at meetings from different sectors of the health and care system and from our citizens and patients.
- Explore how the Board can support the development of provider collaboratives.
- Ensure that the data available to the Board was being use to inform commissioning decisions.
- How can the Board be more forward looking when seeking to identify risk, particularly financial risk.

Appendix A – full results

Role and Functioning of the ICB Board

1. Do you feel that the Board is thus far achieving its principal purpose of assurance and strategic decision making? Average rating: **3.4,** Highest rating: **5,** Lowest rating: **2**, most common rating: **3.**

2. Given that this self-assessment is being undertaken after just one year of the ICBs establishment, do you feel that the Board has so far matured? Average rating: **3.5,** Highest rating: **4,** Lowest rating: **2,** most common rating:4**.**

3. It might be said that Board meetings are rightly very functional, but do you think that there is equality and diversity of discussion and thinking at meetings? Average rating: **3.2,** Highest rating: **4,** Lowest rating: **2,** most common rating:**3.**

4. Do you think that the Board is effectively aligned within the wider ICS partnership arrangements? Average rating: **3.6,** Highest rating: **5,** Lowest rating: **2,** most common rating:**4.**

5. Do you think that the Board demonstrates its use of people's perspectives when making decisions, including those of key communities in the ICS area? Average rating: **3.2,** Highest rating: **4,** Lowest rating: **2,** most common rating:**3.**

6. Any specific comments about the role and functioning of the ICB Board that you would like to make? 9 further comments were made and are summarised below:

- Most comments noted that the Board had matured over the first 18 months of the ICB and were positive about the direction of travel. However, several respondents felt the development of the Board had been impeded by a relatively high turnover of members.
- Several respondents felt there was a need to develop an approach to debate and decision making that allowed for more robust discussion and for the diversity of opinion on the Board to be fully expressed. It was felt that this would enable the Board to better tackle the major strategic decisions need to support the ambitions of the JFP.

NHS System Management – Decision Making by the ICB and its Partner Trusts

7. Do you agree that the ICB's and partner Trusts' current decision-making arrangements in relation to NHS system financial planning and NHS capital investment planning, together with processes for collectively monitoring and managing financial balance during the ICBs first year have been robust ? Average rating: **3.7,** Highest rating: **4,** Lowest rating: **2,** most common rating:**4.**

8. Are you satisfied with the ICB's current decision-making arrangements in relation to engagement with primary care and other providers in the joint decision-making process? Average rating: **3.2,** Highest rating: **4,** Lowest rating: **1,** most common rating:**3**.

9. Do you feel that the ICB has effective arrangements in place to ensure engagement with other system partners, including local government and VCSE, in decision-making around fulfilling NHS system management priorities? Average rating: **3.7,** Highest rating: **5,** Lowest rating: **1** most common rating:**4.**

10. The Board Assurance Framework (BAF) has rightly been a key area for discussion over the past year. Do you believe that the ICB is now managing risk appropriately? Average rating: **3.4,** Highest rating: **5,** Lowest rating: **1,** most common rating:**4.**

11. Any specific comments about decision making by the ICB and its Partner Trusts that you would like to make? 7 Additional comments were made and are summarised below:

    - Several respondents focused on system financial governance and controls. Commenting that the financial pressures in the system during 2023/24 had positively driven the development of system financial governance arrangements.

However, there was a recognition that the financial challenges would persist, and the Board would need to continue to develop to become more adept as identifying risk earlier.

- While most respondents felt that representation on the Board (and Board sub-committees) was good there was a recognition that it could be expanded to include wider primary care and VCSE representation.
- Echoing comments in the first section some respondents felt that the Board was too focused on consensus and was not yet able to facilitate robust discussion and debate.

Commissioning Decision-Making

12. Do you agree that current processes for understanding and making decisions related to health inequalities, including identifying populations at risk of health inequalities and our efforts to address the known drivers, including allocation of resource, are acceptable/robust enough? Average rating: **3,** Highest rating: **3,** Lowest rating: **2** most common rating:**3.**

13. Do you agree that the current scope and decision-making arrangements for co-commissioning (for example Section 75) including the extent to which there is cultural alignment between the approaches of the ICB and its partner local authorities has been achieved? Average rating: **3.2,** Highest rating: **5,** Lowest rating: **1,** most common rating:**3.**

14. Do you agree that the ICB is currently supporting VCSE organisations, including grant giving and wider support and could this be improved? Average rating: **3.6,** Highest rating: **5,** Lowest rating: **1,** most common rating:**4.**

15. Do you agree that the ICB is appropriately supporting primary care commissioning through engagement at the Board and could this be improved? Average rating: **3.4,** Highest rating: **4,** Lowest rating: **1,** most common rating:**4**.

16. Do you agree that the ICB is appropriately managing conflicts of interest in view of the increased risk of conflicts arising given the Board composition? Average rating: **3.9,** Highest rating: **5,** Lowest rating: **2,** most common rating:**4.**

17. Any other specific comments about the ICBs commissioning decision making that you would like to add? 7 Additional comments were made and are summarised below:
    - Respondents felt that delegated commissioning arrangements were working well (i.e. primary care in alliances) but there was a need to improve the flow of information from sub-committees to the Board.
    - The ICB had made good progress in developing its local intelligence functions but there was still work to be done to ensure that commissioning decisions were being fully informed by the available data. Health inequalities was an area were respondents felt that data could be better deployed to guide commissioning.
    - Some comments noted the differences in culture and approach between NHS organisations and local authorities, and Suffolk and Essex. They felt that these differences needed to be discussed and explored and not ignored.
    - Some respondents felt that the Board took an overly cautious approach to managing conflicts of interest which risks hampering collaboration and partnership working.

Assignment of Decisions to System, Place and Providers

18. Do you agree that the ICB's current ask of providers/provider collaboratives, for example supporting wider service resilience, improvement and efficiency is appropriate and is delivering? Average rating: **3.1,** Highest rating: **5,** Lowest rating: **2,** most common rating:**3.**

19. Do you agree that the current alignment between ICB decision making at system level, at place level and with providers discharging wider responsibilities is functioning appropriately? Average rating: **3.4,** Highest rating: **5,** Lowest rating: **1,** most common rating:**4.**

20. Do you agree that the ICB is ready to delegate further responsibilities to place & wider system partners? If yes, please suggest what these should be in the comments section below. Average rating: **3.1,** Highest rating: **5,** Lowest rating: **2,** most common rating:**3.**

21. Do you agree that committees of the ICB ensure that peoples and communities are involved at all the relevant levels and stages of the decision-making process? Average rating: **3.4,** Highest rating: **5,** Lowest rating: **2,** most common rating:**3.**

22. Do you agree that the ICBs governance arrangements fully include system partners in the development of service change proposals, clearly connecting to the system's priorities? Average rating: **3.4,** Highest rating: **5,** Lowest rating: **1,** most common rating:**4.**

23. Any other specific comments about assignment of decisions to system, place and partners that you would like to make? 8 Additional comments were made and are summarised below:
    - The two clear themes running through almost all comments: 1) to ensure that patient/ community engagement was consistent across the organisation and where feedback was sought it was considered and responded to, and 2) there was a desire to further explore provider collaboratives which was an area where the SNEE ICS was relatively immature.
    - Several comments stated that the ICB's existing governance arrangements where difficult to understand particularly to those outside of the organisation.

NHS
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NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item Number: 15
Date: 30 July 2024

Title:	Leadership Competency Framework for Board Members
Lead Director:	Amanda Lyes – Execuitve Director of Workforce and People
Author:	Colin Boakes – Independent Governance Advisor
Purpose:	To Note
Recommendation:	To note the implementation of the new Leadership Development Competency Framework for Board Members being inntroduced as part of the NHS England Fit and Proper Person Framework

1. INTRODUCTION

NHS England has published a Leadership Competency Framework (LCF) designed to support Chairs, Chief Executives, and Board Members to self-assess against six competency domains and identify development needs. The framework is for all Board Members of NHS providers, ICBs and for NHS England.

2. BACKGROUND

The LCF has been developed in response to the recommendation from Tom Kark KC's review of the Fit and Proper Persons Test in 2019 and following the publication of NHS England's Fit and Proper Person Test framework for Board Members in August 2023. The Kark review included a recommendation for the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed.

3. PURPOSE

Being an NHS Board Member means holding an extremely demanding leadership responsibility. They have both an individual and collective role in shaping the vision, strategy and culture of a system or organisation, and supporting high-quality, personalised and equitable care for all now and into the future.

This framework is designed to:

- Support the appointment of diverse, skilled and proficient leaders
- Support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- Help organisations to develop and appraise all Board Members
- Support individual Board Members to self-assess against the six competency domains and identify development needs

It is recognised that people taking on first-time director roles, in particular, are unlikely to be able to demonstrate all the competency examples. However, the framework provides a guide by which, over time, directors can measure themselves and develop proficiency in all areas. Where development areas are identified, commitment to working on these is necessary.

As Non-Executive Members of the Board have different roles and responsibilities to those of Executive Directors, and there are also differences between Executive Director roles, the framework supports the assessment of members in their individual roles as part of a unitary Board. All six competency domains are therefore applicable to all Board Members, taking account of any specific role related responsibilities and differences.

The individual competencies are expressed as 'I' statements. This is to indicate personal actions and behaviours that Board Members will demonstrate in undertaking their roles. However, it is recognised that, including in the context of a unitary board, high performance and delivery against objectives is also achieved through effective team working and collaboration.

4. THE COMPETENCIES

The six LCF competencies are:

Driving high-quality and sustainable outcomes

The skills, knowledge and behaviours needed to deliver and bring about high quality and safe care and lasting change and improvement – from ensuring all staff are trained and well led, to fostering improvement and innovation which leads to better health and care outcomes.

Setting strategy and delivering long-term transformation

The skills that need to be employed in strategy development and planning, and ensuring a system wide view, along with using intelligence from quality, performance, finance and workforce measures to feed into strategy development.

Promoting equality and inclusion, and reducing health and workforce inequalities

The importance of continually reviewing plans and strategies to ensure their delivery leads to improved services and outcomes for all communities, narrows health and workforce inequalities, and promotes inclusion.

Providing robust governance and assurance

The system of leadership accountability and the behaviours, values and standards that underpin our work as leaders. This domain also covers the principles of evaluation, the significance of evidence and assurance in decision making and ensuring patient safety, and the vital importance of collaboration on the board to drive delivery and improvement.

Creating a compassionate, just and positive culture

The skills and behaviours needed to develop great team and organisation cultures. This includes ensuring all staff and service users are listened to and heard, being respectful and challenging inappropriate behaviours.

Building a trusted relationship with partners and communities

The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment.

5. USING THE FRAMEWORK

Recruitment

From 1 April 2024 it is a requirement that the competency domains are incorporated into all NHS Board Member* job/role descriptions and recruitment processes. They will therefore be used to help evaluate applications and design questions to explore skills and behaviours in interviews, presentations and other aspects of the recruitment and assessment process.

Appraisal and Personal Development Plans (PDP)

The competency domains will form a core part of Board Member appraisals and the ongoing development of individuals and the Board as a whole.

6. IMPLEMENTATION

The Board Member Appraisal Framework (BMAF) will be published by autumn 2024. It will reflect the competency domains, as well as other performance objectives. It will also provide guidance on how to assess performance against the 6 competency domains, including for experienced Board Members and those who have been in post less than 12 months.

For appraisals/PDPs undertaken in advance of publication of the BMAF, it is recommended that the six domains be included to supplement to the existing documentation and be used to assess performance and development needs. The LCF self-assessment form (copy attached) will therefore be used alongside the current PDP paperwork.

For Chairs, a new framework for conducting annual appraisals has already been published and establishes a more standardised approach, including ICB, NHS Trust and Foundation Trust Chairs. The framework establishes a consistent process, consisting of four key stages:

- Preparation

- Multisource Assessment
- Evaluation
- Appraisal Output

The preparation for and conduct of the appraisal discussion should be facilitated by the Senior Independent Director (SID) or Deputy Chair. Pending the SID's appointment in ICBs where this role does not currently exist, an experienced Non-Executive Member must be nominated via the Remuneration and Human Resources Committee. The SID or nominated Non-Executive Member (ie the 'appraisal facilitator') will be responsible for receiving the Chair's self-evaluation and collating all assessment feedback from the participant stakeholders. Where this is not immediately possible locally, the Regional Directors office will retain responsibility for overall Chair appraisal.

7. TIMELINE

The NHSE timeline for compliance is:

From 1 April 2024

- All ICBs to use the LCF for the recruitment of new Directors with the competency domains incorporated into all NHS Board Member job/role descriptions
- For Chairs, LCF competency domains included in new annual appraisal framework
- For other Board Members, the LCF competency domains to be considered as part of the 2023-24 appraisals round and to be included for 2024-25 objective setting

By 30 June 2024

- Chair appraisal process to be completed and report template submitted to England.chairsappraisa@nhs.net
- 2023-24 FPPT assessment annual return to be submitted to Regional Director – deadline extended from 31 March

By 30 September 2024

- All other Board Member 2023-24 appraisals to be completed and submitted to England.chairsappraisal@nhs.net
- Preparation for use of new LCF template for Board Member appraisal in 2024-25 onwards

8. APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR AND DEPUTY CHAIR

A key element of future Chair appraisal and overall Board governance is the appointment of a Deputy Chair and Senior Independent Director (SID) being proposed by NHS England. These would not be new positions but drawn from the existing NEM establishment.

However, this requirement has not yet been formally signed off by NHSE and as such, amendments to the ICB Constitution to reflect these appointments is not yet possible. Once confirmation is received, a separate paper setting out next steps will be presented.

9. CONCLUSION AND RECOMMENDATION

The Board is recommended to note the foregoing report in regard to:

- Implementation of the LCF
- The new Chair & Board Member appraisal requirements
- Timeline for submission of completed appraisals to NHSE
- Future requirement to appoint a SID and Deputy Chair

Scoring guide for individual self-assessment against the competencies

Domain 1: Driving high quality, sustainable outcomes						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to ensure that my organisation delivers the best possible care for patients					
1b	to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation					
2	**I assess and understand:**					
2a	the performance of my organisation and ensure that, where required, actions are taken to improve					
2b	the importance of efficient use of limited resources and seek to maximise: i. productivity and value for money **ii.** delivery of high quality and safe services at population level					
2c	the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements					
3	**I recognise and champion the importance of:**					
3a	attracting, developing and retaining an excellent and motivated workforce					
3b	building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles					
3c	retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate					
4	**I personally:**					
4a	seek out and act on performance feedback and review, and continually build my own skills and capability					
4b	model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training					

Domain 2: Setting strategy and delivering long term transformation						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities					
1b	ensure there is a long-term strategic focus while delivering short-term objectives					
1c	ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates					
1d	ensure effective prioritisation within the resources available when setting strategy and help others to do the same					
2	**I assess and understand:**					
2a	the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments					
2b	the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy					
2c	clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans					
3	**I recognise and champion the importance of long-term transformation that:**					
3a	benefits the whole system					
3b	promotes workforce reform					
3c	incorporates the adoption of proven improvement and safety approaches					
3d	takes data and digital innovation and other technology developments into account					
4	**I personally:**					
4a	listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same					

4b	seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies					

Domain 3: Promoting equality and inclusion, and reducing health inequalities						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care					
1b	ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes					
1c	reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups					
2	**I assess and understand:**					
2a	the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)					
3	**I recognise and champion:**					
3a	the need for the board to consider population health risks as well as organisational and system risks					
4	**I personally:**					
4a	demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds					
4b	encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities					

Domain 4: Providing robust governance and assurance						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader by:**					
1a	working collaboratively on the implementation of agreed strategies					
1b	participating in robust and respectful debate and constructive challenge to other board members					
1c	being bound by collective decisions based on objective evaluation of research, evidence, risks and options					
1d	contributing to effective governance and risk management arrangements					
1e	contributing to evaluation and development of board effectiveness					
2	**I understand board member responsibilities and my individual contribution in relation to:**					
2a	financial performance					
2b	establishing and maintaining arrangements to meet statutory duties, national and local system priorities					
2c	delivery of high quality and safe care					
2d	continuous, measurable improvement					
3	**I assess and understand:**					
3a	the level and quality of assurance from the board's committees and other sources					
3b	where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making					
3c	how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements					
3d	the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks					

4	**I recognise and champion:**					
4a	the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders					
4b	working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement					
5	**I personally:**					
5a	understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same					

Domain 5: Creating a compassionate, just and positive culture						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues					
1b	to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement					
1c	to improve staff engagement, experience and wellbeing in line with our NHS People Promise					
1d	to ensure there is a safe culture of speaking up for our workforce					
2	**I assess and understand:**					
2a	my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture					
3	**I recognise and champion:**					

3a	being respectful and I promote diversity and inclusion in my work					
3b	the ability to respond effectively in times of crisis or uncertainty					
4	**I personally:**					
4a	demonstrate visible, compassionate and inclusive leadership					
4b	speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice					
4c	challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe; or staff or people being excluded in any way or treated unfairly					
4d	promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention					

Domain 6: Building trusted relationships with partners and communities						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader by:**					
1a	fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners					
1b	identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest					
2	**I assess and understand:**					
2a	the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems					
2b	the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners					
3	**I recognise and champion:**					
3a	management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues					

3b	open and constructive communication with all system partners to share a common purpose, vision and strategy					

NHS
Suffolk and
North East Essex
Integrated Care Board

NHS Suffolk and North-East Essex Integrated Care Board Meeting

Agenda Item number: 16.
Date: 30 July 2024.

Title: Committee Minutes and Highlight Reports.
Lead Director: Amanda Lyes, Executive Director of People and Workforce.
Purpose: To receive minutes and highlight reports from Sub-Committees of the Integrated Care Board that were available at the time of publication.

a) Ipswich and East Suffolk Alliance Committee
Minutes of hybrid meeting held on 16 April 2024.

b) West Suffolk Alliance Committee
Highlight report and annual delivery plan extract for May 2024 and Highlight report for July 2024.

c) ICB People Committee
Draft minutes of the People Committee meeting held on 17 April 2024.

d) ICB Audit Committee
Draft minutes of the Audit Committee meeting held on 4 April 2024.

e) ICB Estates Committee
Minutes of the Estates Committee meeting held on 19 March 2024.

f) ICB Finance Committee
Minutes of the Finance Committee meeting held on 13 February, 12 March, 9 April, 25 April 2024, 14 May 2024, 17 May 2024, and 20 June 2024.

g) ICS DDaT update
The may bulletin from the SNEE ICS DDaT team including an update on the work of the Strategic Digital Investment and Assurance Committee.

h) North East Essex Alliance
Minutes for the alliance committee meeting on 23 May 2024.

Recommendation: To note.

Ipswich and East Suffolk Alliance Committee
Minutes of hybrid meeting held on 16 April 2024, 1030-1230
Deben Conference Room, East Suffolk House, RIduna Park, Station Road, Melton, IP12 1RT and on Microsoft TEAMs

PRESENT:		
Edward Creasy	Chair	In-person
Maddie Baker-Woods	Director of IES Alliance	In-person
Paul Little	Suffolk County Council	In-person
Clare Banyard	Deputy Director of Transformation	In-person
Dr Ruth Bushaway	Alliance Clinical Lead	In-person
Judi Newman	St Elizabeth Hospice	In-person
Kirsten Alderson	Suffolk Family Carers	In-person
Angela Ashton	Head of Alliance Programme Management & Operations	In-person
Maddie Sawyer	Alliance Operations Manager	In-person
Lindsey Crockett	Primary Care	In-person
Phanuel Mutumburi	Chair of the IES Executive Delivery Group	In-person
Martin Seymour	Public Health Suffolk	In-person
Mark Shenton	Integrated Care Academy	In-person
Nick Khan	East Suffolk Council	In-person
Lizzie Herbert	NSFT	In-person
Sarra Bargent	Deputy Director of Nursing	In-person
Kathy Nixon	Babergh and Mid Suffolk Councils	Online
Greg Brown	Head of Dental Contracts & Performance	In attendance
Tony Bush	Active Suffolk	In attendance
Gareth Davies	Active Suffolk	In attendance
Susannah Howard	ICP Director	In attendance
Tom McColgan	Governance & Compliance Manager	In attendance
Alex Royan	Deputy Director for Strategic Analytics	In attendance

1.	**Arrival**	
2.	**Welcome, Apologies, Declarations of Conflicts of Interest and review minutes and action log from 19th March**	**Action**
	The Chair welcomed everyone to the meeting and apologies for absence were received from: Dr Shane Gordon Kate Price David Pannell Andy Yacoub Louise Hardwick Stephen Skeet Jason Joseph No declarations of interest were raised by Alliance Committee members. The Alliance Committee signed off the minutes of the previous meeting as an accurate representation.	

	Assurance	
3.	**Escalations from Executive Delivery Group – Summary slide** **Headline Director's Report including ICB Restructure Update**	
	Escalations from the Executive Delivery Group were as follows: • Ratification of the ID Medical Service Review • Note the Suffolk Wide Non-Injury Falls Service Business Case • Note the evolution of the Non-Housebound Interventions • Note the End of Life Proposed Programme of Work • Celebration of the HSJ Awards – WHAT Clinic • Thoughts on building a sustainable funding model Some good news stories were shared in terms of the Integrated Health and Care Funding encouraging continuation of funding for successful schemes. **It was confirmed that the Ipswich and East Suffolk Alliance Committee ratified the ID Medical Service Review.** <u>Directors Report</u> Further praise was voiced around the Woodbridge Holistic Assessment Team Clinic and their HSJ award, acknowledging it as a truly integrated and collaborative project. An update was provided on the Be Well Bus and its benefits, it was stated that the impact of the bus is being monitored. Furthermore, a brief overview of the Suffolk and North East Essex Integrated Care Board restructure was given to the Committee members, highlighting risks to the Be Well domain. The clinical leadership structure was explained to the Committee, stating that the professional roles will be matrix working across domains and place. It was taken as an action to share the link for the East Suffolk Well Minds leaflet.	**77**
	Approval	
4.	**Stay Well Terms of Reference**	
	An update on the state of play of the Stay Well Domain, stating how the membership will alter depending on priorities. Discussions included: • Influence of strategic programmes – it was explained that Stay Well is looking at what more can be done locally using PHM data. • PHM insights. • Lived experience – health inequalities. • Urgent and Emergency Care portfolio needs addressing. • Inclusion of quality metrics and patient voice. **The Stay Well terms of reference were approved with the above points to be discussed with the Stay Well Senior Responsible Officer for consideration and inclusion.**	
5.	**Dental Commissioning Group Terms of Reference**	
	The reasoning behind the creation of a Dental Commissioning Group across the Integrated Care Board was explained, highlighting the high volume of provider requests needing to be responded quickly and efficiently. Current membership was outlined, and potential gaps were highlighted to the Committee.	

	Discussions included; • Alliance Director quoracy to be updated to reflect dedicated role. • Crossover between medical/dental/domains – medical input to be included. • Clinical/professional lead to be linked into the matrix. • How is the Ipswich and East Suffolk Alliance assured that the needs of Ipswich and East Suffolk are accounted for within the group – Dental lead for Ipswich and East Suffolk is within the membership, however the Committee decided it would be appropriate for an IES representative to be established. **The Dental Commissioning Group Terms of Reference were approved as long as the requests from the Committee are incorporated to ensure the group is more place-focused, has more links with the domains and a more frequent governance line.**	**78**
	Strategy and Finance	
6.	**Joint Forward Plan Annual Review**	
	An update was provided on the status of the Joint Forward Plan highlighting that this is still opportunities for updates to reflect the requirements of the Committee and the Ipswich and East Suffolk population. Context around the Joint Forward Plan was outlined, stating that it is a legal requirement for the Integrated Care Board to update the plan annually making it a five-year rolling plan. It was explained that the deadline for the refresh has been extended due to the publication of the planning guidance and the need to reflect this within the plan. Emphasis was placed on the target indicators and the changes that had been made to these since the 2023-2028 plan. Furthermore, next steps were stated as a summary of the first-year performance of the Joint Forward plan being included in an Annual Report which will be submitted to NHS England in June and published on the ICB website in September and SOAC quarterly reporting reviewing the progress of the key indicators. Discussions included: • Die Well risk of achievement of identification of End of Life due to lack of digital EPACCs. • UCRS services increase unachievable due to lack of capacity. • The Joint Forward plan doesn't reflect the concept of the 'Future Shift', if this is the strategic direction of the ICB success measures need to focus on community/prevention. • CORE20 prioritisation. • Preventative admissions being looked at at an Integrated Neighbourhood Team Level. • Relationships and interdependencies – shared priorities. • Prevention targets first above acute care to win hearts and minds. • Dementia Diagnosis Rates for Ipswich and East Suffolk. • SOAC reporting clarification. • Joint Forward Plan and ICS Strategy working together cohesively. • Opportunity to refresh the Joint Forward Plan provides the opportunity to further evolve and mature the plan. It was concluded that it would be beneficial to have sight of the Joint Forward Plan before the submission deadline of the 30th June 2024, also the Alliance will need to demonstrate how we are contributing to the Joint Forward Plan which will also be presented to the Committee in June.	**79**

7.	**CQC Inspection**	
	Context behind the CQC Inspection was provided to the Committee, highlighting that it is an inspection of the ICS. It was stated that in addition to undertaking period assessment of the ICS the CQC would also like to have a regular more routine relationship with our ICS through a programme of engagement. Furthermore, it was explained that the effectiveness of place-based working will be central to the assessment of an ICS, hence Alliances will be front and centre. It was emphasised that the CQC is yet to issue more detailed guidance following two pilot inspections. The ICP preparations for the assessment were explained to the Committee. The role of the coordination group was explained highlighting that learning from the system is being discussed in this forum. It was stated that a mock assessment of the ICS will be completed in Summer 2024. The case tracking process was explained, stating the added value of the approach when look at patient experience was stated as an efficient way to prepare for the CQC inspection. It was stated that this methodology should be brought to a future meeting. Die Well was provided as an area of best practice for case tracking. An overview of how the Integrated Care Board is contributing to the preparations for the assessment. The Integrated Care Board has established a CQC Steering Group which is working to build an evidence base. **It was concluded that the Committee are ready to engage in the process in terms of showcasing and learning, it was taken as an action that colleagues should come back to the Committee once the guidance has been published.**	**80** **81**
8.	**Active Suffolk**	
	A presentation was given on the Sport England place-based expansion opportunity. It was clarified that there is no guarantee of investment, but there is an opportunity to work collaboratively as system partners. It was stated that system alignment is a key indicator to secure investment. The areas of focus were highlighted to the Committee as Whitton, Gainsborough and Belstead Hills. The key impact areas Sport England are looking for were outlined as increasing physical activity, decreasing inactivity, tackling inequality and positive experiences for children and young people. Potential funding areas included capacity, workforce development, delivery, evaluation, learning and capital. Emerging themes were outlined as: - Focus on children and young people, healthy weight and inactivity levels. - Older adults and long-term health conditions/disability and high inactivity levels. - Economic inactivity and physical inactivity / good health at work – mental health and wellbeing. - Working with local communities to understand need, barriers, and experiences in relation to physical activity. The ask of the Committee was to support Active Suffolk in their next steps of developing insight, evaluation and leaning framework, engagement with stakeholders and developing the offer collaboratively. Discussions included: • Ipswich centric nature of the areas of focus – other areas in need. • Alignment/opportunity with the Town Deal Investments. • University of Suffolk development. • Engagement with the Integrated Neighbourhood Teams. • Future rollout into other areas once the top 10% has been invested in – timescales unclear for this expansion. • Public engagement.	

	• Social mobility. **The Committee endorsed the project and showed their support for collaborative working to ensure the success of the project.**	
	Deep Dive	
9.	**Mental Health Deep Dive (Feel Well)**	
	Due to apologies a presentation was not possible however the Committee members provided feedback on the papers included within the meeting pack, this feedback included: • Urgent and emergency care crossover – clinical and professionals • Strategic basis - what does it mean at a local level, what can we build upon, what is missing and what can be joined up – bottom-up approach. • Are the deliverables achievable – more focus of priorities and timelines. • Potential for the Mental Health PHD student. • Mental health touchpoints within the Integrated Neighbourhood Teams. • Suffolk Mental Health Strategy missing. **It was taken as an action that the Alliance Director would feedback the thoughts of the Committee to Mental Health colleagues and that the item should be deferred for a further discussion at a future meeting, and it should take a more holistic approach.**	**82**
	Date of Next meeting	
	18 June 2024 – Kesgrave War Memorial Community Centre	
	CLOSE	

West Suffolk Alliance Update including Committee meetings of 17 April and 15 May.

1. Transport collaboration Suffolk County Council

- Suffolk County Council Local Transport Authority attended the committee and described their statutory role including supporting 40 routes across Suffolk through 26 contracts.
- BS/P2 Funding has been granted at £1.8m/year for 23/24 and 24/25 with requests to parishes, operators for ideas on services. Variation has been funded which adds WSFT to three routes in addition to evening and Sunday services to Sudbury and Haverhill. NHS developed scheme not funded but is being taken forward as a separate project and presented to the Department for Transport (DfT).

Next steps:

- WSFT to promote bus routes to patients and staff attending WSFT routinely (e.g. outpatient letters)
- Conversations in Localities on key issues

2. Health Inequalities

The Committee agreed a proposal for use of SNEE ICB Health inequality funds in West Suffolk including:

- Support for people with hypertension and AF to optimise their health outcomes
- Work with Cancer programmes to support targeting work on screening and early diagnosis
- Targeting populations where data shows greatest opportunity, including the 15 local populations showing higher relative social challenges

3. Physical health commissioning (April)

Committee agreed a Strategic Partnership approach to review all partner funding and current pathway design for physical activity to optimise plans and use. To include and develop a standard approach to evaluation linking to the healthy behaviours offer. This includes opportunities for working with Sport England.

4. Approach to partnership at locality level

Committee agreed its strategic approach to working in partnership at locality level: Haverhill, Newmarket, Mildenhall & Brandon, Bury St Edmunds, Bury Rural and Sudbury. Committee noted locality working is progressing well in Haverhill.

5. Primary Care Medical Strategy 2024-29

The Committee discussed and supported the SNEE ICB primary care strategy which has been co-produced with local professionals and patient groups. It describes the challenges and goals for 8 aspects of primary care.

The Alliance can play a key role including joint approaches with regards to estates, workforce, using digital technology and working better together at the interface of primary care and other services.

1) Workforce
2) Estates
3) Access with Capacity
4) Resilience
5) Working Better Together
6) Clinical Safety and Safe Working Practices
7) Contracts and Investment
8) Using Digital Technology

6. Planning for 2024/25

Partner views

Partners discussed their priorities and ambitions for 2024/25. The discussion noted the serious pressures being faced in terms of demand, capacity, and finance. The discussion noted the importance of being open and realistic in this context as well as the aspirations for improvement through partnership.

SNEE Joint Forward Plan (JFP)

ICB analysts identified the key areas where data on West Suffolk population shows improvement or concern with regards to JFP targets. The Committee noted the Alliance Delivery Plan covers the majority of these areas but notes the need for more work to clarify plans for children's asthma admissions and children's obesity levels at year six.

Alliance Delivery Plan 2024/25

The group received and approved the Alliance Delivery plan which has been developed in co-consultation and agreed – for review in November 2024

7. Diabetes Review

An ICS-wide review has been completed for diabetes. It identifies the strengths and key challenges being faced and considers options for the future. It recommends option (3) - a *common ICS service specification focused on outcomes but commissioned locally for each Alliance.*

The Committee supported the review and this option and noted the importance of funded dedicated time for specialist clinical leaders to achieve the integrated model envisaged.

The strategy is due to be decided formally at the SNEE ICB Board in July.

8. Other Alliance Business

- **Minor surgery contract extension** – 2-year extension agreed to existing contract with Swan Surgery
- **Sustainability Impact Assessment** received and supported
- **Feel Good Suffolk -** performance report received

Appendix – extract of West Suffolk Alliance Delivery Plan 2024-25

West Suffolk Alliance Delivery Plan 24/25

Improving Health & Care Through Partnership

April 2024

Context

West Suffolk Alliance

What is the Alliance?

A "place based" system of care defined by the local footprint of health and care partners, as well as natural geography. The partners work together for a common purpose to provide the focus for planning and delivering integrated care for the population.

What does the Alliance do?

- Work with people and partners to understand the wellbeing, social and healthcare needs of the local population and develop outcomes and solutions together
- Work collectively to identify improvements to individual services
- Deliver joined up (integrated) health and care
- Ensure continuous improvement and innovation in the quality and delivery of services
- A monthly Alliance Committee is held to provide the governance and all alliance partners are invited to be the voice of the respective organisations and partners.

Who is in the Alliance

NHS & Council Statutory Bodies

- Suffolk and Northeast Essex ICB
- West Suffolk NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Suffolk County Council
- West Suffolk District Council
- Babergh and Mid Suffolk District Councils

Service Providers

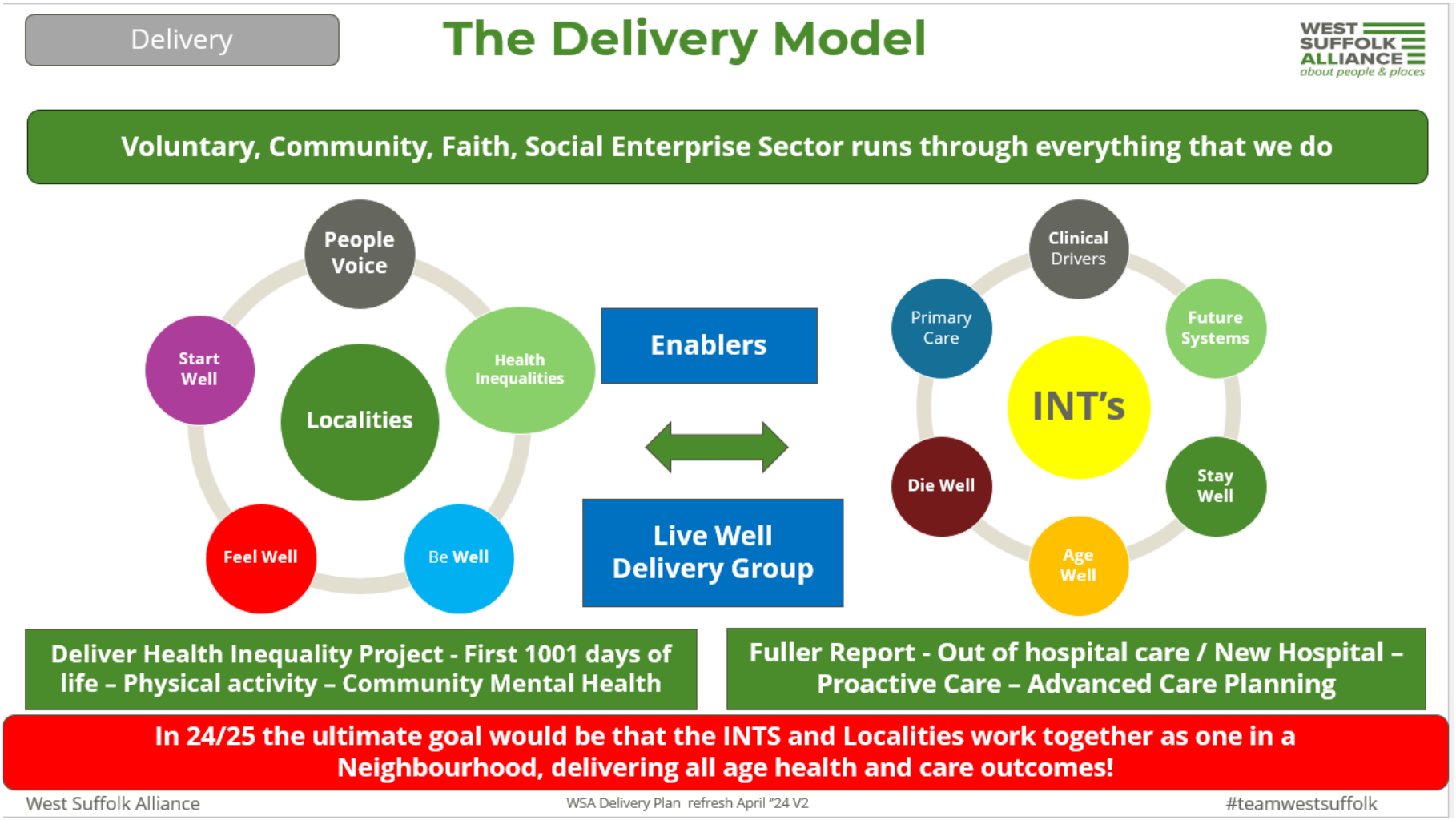
- GP teams and Primary Care Networks
- Dentists, pharmacists & optometrists
- Department for Work & Pensions
- St. Nicholas Hospice Care
- Care Market
- Allied Health Professionals CIC
- West Suffolk College
- Abbeycroft Leisure

Voluntary Community Faith and Social Enterprise

- Community Action Suffolk
- Healthwatch Suffolk
- Active Suffolk
- Suffolk Libraries
- Multiple local & national VCFSE Partners
- Home Start
- Reach Haverhill

Delivery

The Delivery Model



INT – integrated neighbourhood team

Delivery

West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider system Focus	Alliance Priority	By When	Leadership
Start Well	• **Increase the number of pregnant women supported by Midwifery Continuity of Carer within targeted communities** • **No child or young person waits more than 12 weeks for CAMHS or 18 weeks for neurodevelopmental diagnostic services** • **Reduce hospital admission rate due to asthma**	1. Preconception, Maternity and Neonatal Care 2. Children and Young People including CAMHS, Neuro Developmental, SEND, 3. Community 4. Long Term Conditions	**First 1001 days of life:** 1. To pilot a collaborative approach to a targeted preconception, offer for people who may suffer with obesity, smoke, and/or have high levels of alcohol, and associated poor outcomes. 2. To provide a multi-agency support programme for parents at risk of babies becoming LAC at birth, to reduce the likelihood of recurrent pregnancies and removals and associated poor outcomes. 3. To map the support offer to new parents and establish how further work with VCFSE can be embedded to reduce isolation, postnatal mental health difficulties and promote healthy attachments with children.	• Commence service 01/10/24 • Scoping underway • Scoping underway	**Strategic** **Nic Smith-Howell** Associate Director of Integrated Community Paediatric Services **Change Coordinator** **Helen Bowles** Maternity & Neonatal Programme Manager SNEE ICB
Feel Well	• **Achieve 5% year on year increase in adults supported by community MH** • **Year on year reduction in hospital admission rates** • **90% SMI Health Checks by 2028** • **85% of people on the learning disability register to have an annual health check**	1. Mental Health and Wellbeing 2. Suicide Prevention 3. Addictions 4. Trauma and Abuse	• **Haverhill Community Integration –** Integrated Community Model including PCN MH Practitioners, new MH Recovery Teams, Integrated Neighbourhood Teams & NEE Neighbourhood Teams • Increase access to **SMI physical health checks**, meaning that by 2028/29 over 90% of people with an SMI have received an annual check • Deliver dementia action plan and **achieve Dementia diagnosis target of 67%** • Provide dedicated support to people waiting for an **ASD/ADHD assessment and diagnosis**	• March 2025	**Peter Henson** Service Director Suffolk Care Group, NSFT **Hannah May** Transformation Lead
Be Well	• **Halt increase in overweight and obese children** • **Reduce number of smokers to 5%** • **Year on year increase of NHS dental activity delivered**	1. Healthy Behaviours 2. Personalised Care 3. Women's Health 4. Dental / Oral Health 5. Eye Health	**Physical Activity:** • Establish a universal offer for physical activity and secure good and equitable **uptake** • **Increase the impact of the WSFT exercise referral pathways with Abbeycroft Leisure by 25%** • **Establish a strategic partnership approach to funding for physical activity providers to improve value for money and evaluation** **Overarching measure:** • **Percentage of physically inactive adults reduces from 19% to 17%**	• March 2025	**Ian Gallin** Chief Executive West Suffolk Council **Kathy Nixon** Deputy Chief Executive Babergh and Mid Suffolk District Councils

Delivery

West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider System Focus	Alliance Priority	By When	Leadership
Age Well 	• **Reduce rate of emergency hospital admission due to falls** • **Achieve 66.7% dementia diagnosis rate**	• **Healthier life for longer in preferred place of residence** • **Avoid unnecessary hospital admissions** • **An active ageing population** • **Joined up mental and physical health** • **More carers identified**	**Proactive Care** • Training of INT / Locality teams to recognise Frailty at an earlier stage • Frailty Toolkit being delivered across the system to inform where the person should be signposted to • Social Prescribers actively working with and recording outcomes of people to prevent deterioration and reduce risk of admission. **Falls Service** • Implementation of Suffolk wide Level 1 Falls service – linked to onward referral to INTs/EIT and preventative services.	**March 2025**	**Clement Mawoyo** Director of Integrated Adult Health and Social Care **Michelle Glass / Lucy Webb** Senior Transformation Lead
Stay Well 	• **Increase GP teams to meet demand** • **No one to wait more than 15 months for elective care** • **Increase UCR delivery by 10% each year** • **78% 4 hour wait in A & E** • **Reduce hospital bed days without criteria to reside** • **Increase cancer diagnosed at stage ½** • **80% of people with high blood pressure identified and treated** • **85% AF identified and 90% of high stroke risk treated**	• **Elective care and diagnostics** • **Urgent and emergency care including community** • **Cancer** • **Respiratory** • **Cardiovascular disease** • **Stroke services** • **ME and CFS** • **Neurological rehabilitation** • **Learning disabilities & Autism** • **Diabetes** • **Virtual Ward 80% bed occupancy**	**Future System Transformation Programme** • Programme/implementation of Clinical Care Strategy: • Virtual Ward – supporting the reduction of acute beds, moving to Virtual beds as supported early discharge or step up from community. 24/25 Focus on roll out of further pathways and community step up. • Outpatients – maximise virtual clinical appointments and increase provision at peripheral clinics. • UEC – Target Operating Model for 'Emergency Village'. Develop implementation plan for Emergency Village Model of Care. • UCR – Development of Hub and Spoke model for UCR service, to reduce unnecessary admission and promote population health.	**March 2025**	**Nicola Cottington** Chief Operating Officer West Suffolk NHS Foundation Trust **Renu Mandal / Lucy Webb** Senior Transformation Lead
Die Well 	• **Increase % of people being identified as being at End of Life**	• **Co-ordinated 24/7 care** • **Personalised Plans** • **Compassionate Communities**	**Advanced care planning** • Increased number of residents in care homes having advanced care plan discussions being offered and documented. • Social Finance implementation to increase people being identified • Training for advance care planning, particularly for care home staff		**Susan Wilkinson** Chief Nurse West Suffolk NHS Foundation Trust **Michelle Glass** Senior Transformation Lead

Delivery

West Suffolk Alliance Delivery Plan Summary - Enablers

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider System Focus	Alliance Priority	By When	Sponsor
Workforce 	• **Work with the Integrated Care Academy to lead new ways of working** • **Enable collaboration with VCFSE** • **New models of delivering care** • **Embed a culture of training and progressive development in roles** • **Develop and deliver a system orientated career and leadership pathway** • **Increase use of apprenticeships** • **Work with education to develop training and placement opportunities to address gaps**	**Support organisations to build workforces that enable them to effectively serve populations by taking a system approach to** • Implement an Education and Training Digital Passport • Improve Equity to International Recruitment Opportunities for Alliance Stakeholders	**Focus on supply/recruitment in 24/25** • Develop a young people's network to support engagement with the future workforce • Determine how to proceed with future recruitment processes for young people that meets their needs	• March 2025	**Ewen Cameron** Chief Executive West Suffolk Foundation Trust
Digital & data 	• **Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put people at the centre of their care** • **Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation and health inequalities and drive continuous improvement in performance and outcomes**	**1. implement a Strategic Delivery Plan** 2. **implement systemwide delivery models,** e.g. shared care records and personalised care planning 3. **build our multi-disciplinary approach** to safe practice 4. by embracing a culture of **continuous learning** 5. develop a common **digital front door** for our people 6. enable an approach to **digital care technologies and remote care** 7. enable a **linked data set platform** that will provide data insights for a range of purposes 8. form and operationalise **provider collaboratives, and integrated care**	**Integrated digital systems within the INT / Locality space** Investigate the options to improve the co-ordination of care between teams within the Integrated Neighbourhood Teams (INTs) using digital solutions. Investigate the opportunity to improve communication across partners and provide a shared service directory and referral platform. **Supporting key themes:** • A reduction in health inequalities • Decreased digital exclusion • An increased ability to promote healthy behaviours. • Empowering people to engage with community/home-based care models.	• March 2025	**Craig Black** Executive Director of Resources West Suffolk Foundation Trust **Nicola Chalk** Change Coordinator
Estates 	• **Optimise estates for integration with partners** • **Rationalised and prioritised capital pipeline** • **A single system delivery plan** • **Wider sharing of estate across the system** • **Reduce backlog maintenance** • **Improved efficiency and effectiveness of estates to support clinical delivery** • **Services in the right place to meet demand** • **Disposal of redundant estate**	**Create and manage one public estate that is driven by service needs; run and planned as one system** • Optimise use of existing estate • New Hospital Programme • Plan for population growth	**Multidisciplinary approach to optimisation of building assets.** • Agree re-occupation of Haverhill HC • Agree multi-partner occupation agreement • Understand current usage of Sudbury Health Centre across all partners • Co-locate and integrate services: Taking on board learning from re-occupation of Haverhill Health Centre, consolidate and optimise service locations within the health centre implementing co-location opportunities wherever possible and appropriate to support integration.	• March 2025	**Peter Wightman** West Suffolk Alliance Director

Delivery

West Suffolk Alliance Delivery Plan Summary - Enablers

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider System Focus	Alliance Priority	By When	Sponsor

Localities 	• **Ensure communities have an active role in decision making and governance**
	• **Understand the communities needs**
	• **Build relationships based on trust**
	• **Work with system VCFSE partners**
	• **Provide clear public information**
	• **Use community centred approaches that empower people**
	• **Use co-production to tackle priorities**
	• **Learn from what works and build on community assets**
		Enable coordination at a locality level
		• Empower localities to have a locally owned shared purpose and plan to live healthy, connected lives
			• **To improve communication, relationships and trust across staff within West Suffolk Alliance to facilitate successful community connections and healthy living**
			  • We will work with our localities to evolve the distributed leadership partnership to include key stakeholders and sectors around the table either within the knitters, champions and voice
			  • We will develop individuals within asset-based community development/One Team training to empower them to be accountable for the local priorities collectively identified
			  • We will align language and branding to develop a system wide understanding
				• Novembe r 2023	**Mark Shorter** Head of Alliance Development
					
					Sarah Hedges Integrated Transformation Lead

INT's 	• **Fewer people need unplanned care and support in crisis**
	• **Greater numbers have access to care and supported by activity outside of statutory services**
	• **Resources in the delivery of community-based health and care are used more efficiently**
	• **Ongoing costs of supporting people reduce as people's independence is increased**
		• **Focus on personalisation**
		• **Increase co-production**
		• **Digital tools to increase independence**
		• **Embedding equality, diversity and inclusion throughout the system**
		• **Improved support for more vulnerable and complex people**
		• **Prevention via integrated services**
		• **Measuring and communicating quality outcomes**
		• **Work at a locality level supported by PHM**
		• **Continue learning disabilities, Autism and Mental health transformation through partnership and collaboratives**
			• **Haverhill – Severely Frail Project**
			  • To explore the art of the possible with integrated system partners working in the Haverhill area to improve the outcomes of the severely frail
			  • To deep dive with Population Health Management Data to understand the needs of the patients
			  • To understand the current offer available to the population across the teams in the system
			  • To deliver an intervention that is sustainable and interoperable that can be widened into other localities
				• March 2025	**Clement Mawoyo**
					
					Kevin McGinness

Delivery

Primary Care Priorities in West Suffolk

Priority	Actions	Milestones
Finalise Primary Care Strategy	Develop action plan	1.4.24
Primary Care Primary Care Networks	Enhanced Access – ensure 100% of required slots are provided and utilised Additional roles reimbursement – ensure full utilisation of budget to support population need and work with Training Hub to maximise development and training opportunities Monitor capacity and access to ensure improvement, particularly around patient experience	Monthly returns from PCNs. Monthly validation and sign-off Quarterly F2F monitoring meetings
Further join-up PCN and INT Teams	Work with Clinical Directors and wider practice teams to develop INT relationships Utilisation of clinical shutdown to progress relationships Map inequalities utilising PHM to existing service provision/PC activity and review resources to meet those needs	Ongoing 2024 shutdown schedule Ongoing
Modernise General Practice	Support all Practices to move to digital telephony Introduction of online consultations; particularly where access and patient experience is below national average Consistent approach to care navigation, including signposting to Pharmacy First	10 Practices in Phase 1 7/25 Practices have a fully digital model Development of a local offer
Quality and Resilience	Continue to support practices with CQC to remain in a 'good' status Deep dive into minor surgery at practice level (currently delivered under a DES) to ensure SOP etc. in place Primary Care Assurance Framework and supporting data – includes many ICB functions to ascertain risks at practice level	One Practice currently in RI Estimated start date 1.4.24 Bi-monthly meetings
Implement national Improving Access Plan	Reduce time spent liaising with hospital, improving PC interface. National target implementation of electronic fit notes, in testing phase at WSFT Support Level Frameworks completed for each practice and encourage uptake of the General Practice Improvement Programme Empowering patients by increasing self-referral pathways, looking specifically at vasectomy pathway in west Suffolk Enable over 90% of practices to see their records and practice messages, book appts and order repeat prescriptions. Ongoing T&F group working with Alliance Partners to increase uptake. Facilitate better uptake of Pharmacy First: ICB-funded initiative to improve relationships between practices and their local community pharmacists.	20.6.24 collaboration forum 12/25 enrolled or completed GPIP 4/7 National PWs up and running 100% practice compliance and 53% of patient's utilisation Ongoing

West Suffolk Alliance Update including Committee meetings of 11 June and 9 July

June 11 meeting:

1. Health Inequity update

1.1. Work continues in the Howard estate. Data relating to other target ward areas is being undertaken to guide the focus of the next stages of the work. A final paper is to return to Committee in September 2024.

2. Newmarket Locality update

2.1. A comprehensive snapshot of local data for 23/24 was provided and highlighted how the partnership was forming. Concerns had been raised around the number of MASH referrals made from the VCSFE which has led to MASH attending the Locality meeting to support the group. Further details attached **Appendix 1**

3. Suffolk Community Foundation

3.1. Opportunities to access grants awarded by the Suffolk Community Foundation were discussed. This included a new grant programme – The Smoke Free Generation Fund – focusing on Suffolk. The Alliance agreed to work with Suffolk Community Foundation to optimise access to grant funding opportunities across all 6 INTs and plan next steps for schemes when grant funding ends.

4. Suffolk Libraries

4.1. Suffolk Libraries provided information as to the level of support that can be available to WSA to build capacity and meet Wellbeing needs of the Suffolk population including menopause and Children and Teens support. Support for the loan of equipment i.e. Blood pressure cuffs/machines to assist PCN's is also available.

4.2. Following this presentation, the Alliance have met with Suffolk Libraries to consider how we can activate the hyperlocal approach against our priorities to support delivery across our system.

5. Decaffeination project

5.1. A research study based on a joint investigation by Care England and Stow Healthcare, in partnership with University Hospitals of Leicester NHS Trust in April 2024 was presented which demonstrated a reduction in falls and improvements in bladder health by the replacement of decaffeinated coffee provided in Care homes. A request to Committee members was made to join a working group to develop the project across the system. A working group has now been formed to mobilise a project with providers across the SNEE system that can be actively evaluated and monitored.

6. Quality update

6.1. One GP practice had been rated as requires improvement now showing as good following sustained improvement through their action plan. A further CQC visit is awaited.

6.2. Medicines Optimisation issues: lack of retinal screening for hydroxychloroquine; however, a service variation is being put in place to commence this pathway in September 2024. Ongoing national shortage of medications is due to return to Committee in September.

July 9 WSA Committee meeting

1. Adult Social Care-Market Strategy

1.1. SCC are developing a strategy for the Suffolk Adult Care-Market. Committee members provided comments and support for next steps. For return to Committee in November for update with final return for agreement in March 2025. Agreed to understand feedback from INT's regarding the top 3 challenges and strengths for each area. Alignment around different services to be considered and include the localised Voluntary sector. A dedicated workshop with Alliance members is proposed for 4 November (tbc).

2. Community Referral and Communication Software

2.1. A presentation was provided which identified the opportunities to better connect partners with regards to a shared service directory and referral platform to improve communication, relationships, and trust across staff within West Suffolk Alliance and thereby facilitate successful community connections and healthy living. Other areas of good practice were identified. Committee agreed to pause and review options to agree the best way forward.

3. Diabetes

3.1. A comprehensive appraisal of the current work underway in Diabetes was provided. Good progress has been made at practice level with regards to 8 care processes and treatment targets. Lead clinician is working with other practices showing variation.

3.2. Specialist nursing capacity issues remain and a core problem is increasing demand and the need for improved work across primary care and community team interface. A new model for primary and secondary care joint-work is being developed based on the "Super 6 model" to define roles and commission General practice and WSFT in line with this.

4. Start Well – Children Young People and First 1001 days

4.1. Project updates were given. Committee members offered support to help increase Education involvement including Head teachers and pastoral leads for CYP mental health provision. Discussions possible to consider a front-door team in each locality to reduce the number of referrals and thereby improve early intervention and reduction of demand on secondary services.

4.2. Progress on the work in the First 1001 days was provided to consider a more local multi-agency approach in WSA with the possibility to focus the Committee meeting in October around 2 specific areas. (TBC)

5. ICS Strategic programmes update with a focus on WSA

5.1. Further work to consider how to align and interface was discussed. The ICS is best in region for Hypertension and CVD work.

5.2. Noted that spirometry services are currently a concern, following cessation of the GP Federation service. An alternative is being mobilised.

6. Director update

6.1. **Primary Care Network Pilot:** A national pilot involving primary care networks aimed at fostering innovation and creative thinking in general practice over a two-year period will commence in the Autumn. Current stage is to select 1-3 PCNs across the ICB following expressions of interest.

6.2. **Dental Care Priority Access:** A priority access service for dental care has started across the ICB. There are four practices in West Suffolk offering the service which includes urgent services and services for specific vulnerable patient groups.

6.3. **Interface Pharmacist Role:** The recruitment of an interface pharmacist was noted as a step towards enhancing the collaboration between primary care and the West Suffolk Trust, focusing on safety and cost-effective prescribing

7. **PCN – INT Integration Project**

7.1. Work has been progressing with Haverhill PCN and the Integrated Neighbourhood Team to focus on a single common issue that can support an MDT approach to improvement. Population Health Management Data has given us the steer to deliver change with the severely frail population in the Haverhill area. The integrated approach is now designing its next steps and interventions to be delivered to inform change. This has resulted in all PCN's across the 6 Localities agreeing to an invitation to follow suit and enable an integrated approach to change in the West Suffolk Alliance.

8. Review of Committee T'sOR

8.1 Review taking place September meeting

Appendix 1 : Newmarket focus

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Minutes of a meeting of the People Committee on 17 April 2024 held on Microsoft Teams.

Present

Committee members

Kate Read, ESNEFT Director of People and Organisational Development (*Chair, items 1-5*).

Amanda Lyes, ICB Executive Director of People and Workforce (*Chair, items 6-8*)

Elaine Noske, ICB Non-Execuitve Member – People and Quality

Jeremy Over, WSFT Executive Director of Workforce And Communications

Hein Scheffer, EEAST Director of Strategy, Culture and Education

Susannah Howard, ICP Director

Jessica Douglas, Colchester City Council Head of People

Graham Seward, ICB Head of Workforce Transformation

Others Present

Dr Amina Chitembo, NHSE System Culture Transformation Lead (Regional EDI Education and Training Pillar and SNEE)

Alice Robinson, WSFT Corporate Lead Advanced Practitioner

Ganesh Baliah, Chief AHP & System AHP Programme Director

Giles Turner, Head of Workforce Intelligence and Planning

Rachel Jennings, ICP Communities Lead

Tom McColgan, ICB Governance and Compliance Manager (Minutes)

1. Welcome

1.1. The Chair welcomed all in attendance and noted that Elaine Noske, ICB Non-Execuitve Member was joining the Committee for the first time and would be taking over as Chair of the Committee for future meetings.

1.2. Apologies for lateness were noted from Amanda Lyes, ICB Director of People & Workforce.

2. Declarations of interest

2.1. There were no declarations of interest on any item on the agenda.

3. Action Log

3.1. The Committee heard updates on the development of the Operational Plan and on two Allied Health Professional Leadership actions.

3.2. The Committee noted the updated action log.

4. Working Differently and productively

4.1. Susannah Howard, Integrated Care Partnership Director spoke to a presentation on the future shift strategy that the Integrated Care Partnership was developing to supersede the left shift strategy. She also spoke to the CQC's assessment of integrated care systems for which SNEE was part of an engagement pilot.

4.2. The Committee discussed the presentation on future shift and agreed that it would be useful to hold a workshop for the Committee and other partners to discuss what a future shift for SNEE's workforce looked like. Recognising that the future shift strategy would require a significant change in the ICS's workforce to deliver it.

4.3. **Action -** Susannah Howard, Integrated Care Partnership Director to arrange a workshop on creating future shift in SNEE's workforce.

4.4. The Committee noted the presentations and updates.

5. In a compassionate and inclusive culture

5.1. Dr Amina Chitembo, NHSE System Culture Transformation Lead spoke to the progress on the EDI Culture Transformation Workplan and the East of England EDI Maturity Matrix. She highlighted the need to improve representation from partners at the EDI Review and Oversight Group and the drive to bring EDI work together in a more centralised and cohesive way.

5.2. The Committee welcomed the update and work so far. Members of the Committee were keen to ensure that the work was carried forward and that EDI was seen as a golden thread running through all activity. Members also discussed the need to set appropriate measurable indicators for EDI.

5.3. Ganesh Baliah, ICB Chief AHP & System AHP Programme Director spoke to a report on the Cultural Safety Workshop. The workshop materials would be published on the SNEE ICP website to enable it to be delivered across the system supported by 'train the trainer' sessions.

5.4. The Committee noted the presentations and updates.

6. Growing the workforce

Amanda Lyes chaired the meeting for the remaining agenda items.

6.1. Giles Turner, ICB Head of Workforce Intelligence and Planning provided an update on the workforce Board Assurance Framework entry which would be reviewed by a group of Committee members and revised entry would be brought to the next meeting.

6.2. Alice Robinson, WSFT Corporate Lead for Advanced Practice (AP) spoke to the aims for the AP workforce as set out in the NHS Long-term Workforce Plan and the KPIs that had been set for each integrated care system. She

also discussed the need to increase the visibility of AP across the system. A Regional Capability Framework had been developed and adapted for SNEE but further work was needed to identify the right platform to launch this on and how to get buy in from stakeholders.

6.3. The Committee discussed the development of the Workforce Operation Plan and requested that officers circulate the Plan to Members of the Committee.

6.4. **ACTION** - Giles Turner, ICB Head of Workforce Intelligence and Planning to circulate the workforce operation plan to the Committee.

6.5. The Committee noted the presentations and updates.

7. Workforce transformation programmes

7.1. Amanda Lyes, ICB Execuitve Director of People and Workforce and Rachel Jennings, ICP Communities Lead spoke to the recently completed anchors dashboard and the examples of workforce transformation highlighted on the dashboard.

7.2. The Committee noted the presentations and updates.

8. AoB

8.1. None.

Minutes of a meeting of the SNEE ICB Audit Committee held on 4 April 2024 in Endeavour House, Ipswich at 10am.

Present:

Janet Wood, ICB Non-Execuitve Member (Chair)
Phanuel Mutumburi, ICB Non-Executive Member

Attendees

Amanda Lyes, Execuitve Director of People and Workforce
Howard Martin, Execuitve Director of Finance
Chris Armitt, Director of Finance

Also Present

Will Pope, Chair of the Integrated Care Board
Debbie Hanson, Ernst & Young – ICB External Auditors
Liz Wright, RSM – ICB Head of Internal Audit
Nick Fanning, RSM
Mark Kidd, RSM Local Counter Fraud Specialist
Paul Cook, ICB Head of Information Governance
James Thompson, Senior Financial Accountant
Tom McColgan, Governance and Compliance Manager (Minutes)

1. **Apologies for absence.**

1.1. None.

2. **Declarations of interest.**

2.1. None.

3. **Minutes**

3.1. The Minutes of the previous meeting were agreed as a correct record with an amendment to the attendance to include Howard Martin, ICB Director of Finance.

4. **Action log**

4.1. The Committee noted that all outstanding actions had now be closed.

5. **Audit Committee Briefing**

5.1. Howard Martin, ICB Execuitve Director of Finance stated that the ICB had completed the consultation on a revised staffing structure and was working towards implementation. The Finance Team were focusing on the planning round for 2024/25 which started late due to a delay in guidance being issued. SNEE ICS had a projected deficit of £33m for 2024/25 which was expected to reduce to £18m before the financial plan was set. A clear expectation of zero workforce growth for the NHS had been set by Government and productivity was a focus for SNEE. The ICB would also be looking at how it approached commissioning and the commissioning cycle.

5.2. Howard Martin also provided a summary of the Financial Governance Diagnostic Report carried out in WSFT and noted that commissioning responsibility for 59 specialised services had been delegated to the ICB from NHSE.

5.3. Amanda Lyes, ICB Execuitve Director of People and Workforce stated that as the revised staffing structure was implemented the HR Team would be focusing on supporting the 20 staff who were as risk of compulsory redundancy to find alternative roles. The ICB's Workforce Team were working with providers to address workforce growth and to develop a workforce productivity tool.

5.4. The Committee discussed their role in monitoring the financial and productivity challenges in the system and the need to gain assurance that the Finance and People Committees had adequate oversight. The Committee noted that the ICB was working with the NHSE Regional Team and the consultancy firm McKinsey to coordinate activity around workforce productivity. The Committee also heard about a workforce planning tool that ESNEFT had developed that could potentially be rolled out in other partner organisations.

5.5. The Committee **NOTED** the verbal update.

6. **External Audit Briefing**

6.1. Debbie Hanson, Ernst & Young (EY) stated that EY had taken over as the ICB's external Auditors in the previous week after a handover from BDO. Due to a delayed handover period the audit was significantly behind where it would usually be. There was a risk that EY's year one audit would not be delivered on time, this risk had been flagged to NHSE. EY would bring an Audit Plan to the next meeting of the Committee.

6.2. The Committee **NOTED** the verbal update.

7. **Internal Audit Update.**

7.1. Liz Wright, RSM - ICB Head of Internal Audit presented the Draft Head of Internal Audit Opinion. The report assessed the ICB as having adequate controls in place but with room for enhancements. She stated that it was very rare for an organisation to have no room for enhancements, it was also very rare for an organisation to be found to have completely inadequate internal controls.

7.2. The Committee **NOTED** the draft Head of Internal Audit Opinion.

Revised internal audit plan.

7.3. Liz Wright presented the revised audit plan which had been through RSM's internal approval processes. The commissioning and contracting, and safeguarding audits had been deferred to the next year and an audit on the implementation of the Provider Selection Regime and compliance with Section 117 of the Mental Health Act had been included.

7.4. Howard Martin, ICB Execuitve Director of Finance stated that he was keen to check with the Execuitve Director of Nursing about the s117 and safeguarding audits. He stated that he was minded to recommend that the s117 audit be removed from the schedule and safeguarding be included as he was not sure that an audit carried out by RSM would provide the assurances that the Execuitve Director of Nursing was seeking.

7.5. The Committee **AGREED** the revised internal audit plan subject to a potential further amendment to replace s117 with safeguarding.

Briefing papers.

7.6. Liz Wright spoke to the briefing papers which were presented to the Committee for information.

Progress report and completed audits.

7.7. Liz Wirght presented the internal audit progress report. The Patient Engagement audit had concluded with partial assurance due to issues with data quality and recording. An audit of the ICB's management of conflicts of interest had concluded with reasonable assurance identifying some gaps in controls around consistency of data between different registers of interest and in declarations of hospitality and gifts.

7.8. The Committee noted the outstanding actions in the progress report and agreed that where actions were not being completed it would be helpful for responsible officers to be asked to attend committee to speak to their actions.

7.9. The Committee **NOTED** the progress report and completed audits.

8. **Local Counter Fraud Work Plan 2024/25**

8.1. Mark Kidd, Local Counter Fraud Specialist presented the plan for the coming year which aimed to help the ICB confirm to counter fraud standards and mitigate against risk in areas where that risk my be elevated. A further discussion with the Chair of Audit Committee, ICB Execuitve Director of Finance, and the Local Counter Fraud Specialist would be scheduled to consider the Functional Counter Fraud Return.

8.2. The Committee **APPROVED** the Local Counter Fraud Work Plan 2024/25.

9. **Care Home Restructuring – VAT**

9.1. James Thompson, ICB Senior Financial Accountant introduced the report which related to care homes forming specialised contracting companies for the purposes of their contractual relationship with the ICB. This arrangement allowed care homes to become more tax efficient but carried additional cost and risk for the ICB. Invoices from a specialised contracting company attracted VAT at a standard rate which NHSE have indicated may not be recoverable in the future. There were also concerns around the accountability as the specialised contracting company would be a third party sitting between the ICB and the care homes which were undertaking regulated activity on behalf of the ICB. The ICB was following the lead of Norfolk and Waveney ICB and the County Councils who had already sought legal advice.

9.2. Howard Martin, ICB Execuitve Director of Finance stated that the ICB would need to maintain a watching brief on the situation. The Committee requested the officers keep them appraised of any developments.

9.3. The Committee **NOTED** the report.

10. **Information Governance Update**

10.1. Paul Cook, ICB Head of Information Governance presented the report highlighting that the ICB had achieved secure email accreditation for the snee.nhs.uk email domain, the ICB was awaiting the outcome of the Data Security and Protection Toolkit, the ICB was developing communication materials to inform patients about how their data was being used to support risk stratification, and the IG Team was seeking to strengthen assurances around IT infrastructure.

10.2. The Committee noted the positive attitude expressed by patients to their data being used for risk stratification as seen in the survey results reported in the paper.

10.3. The Committee **NOTED** the report.

11. **Risk Management Update including the Board Assurance Framework**

11.1. Amanda Lyes, ICB Execuitve Director of People and Workforce presented the report highlighting the work that had been undertaken to review the ICB's risk management guidance in light of the recommendations made by Internal Audit and the terms of reference for a new Risk and Resilience Group to oversee operational risk management. She also spoke to the Board Assurance Framework which had been presented to the ICB Board in March 2024.

11.2. The Committee:

i. **ENDORSED** the risk management guidance.

ii. **AGREED** the terms of reference for the Risk and Resilience Group.

iii. **NOTED** the Board Assurance Framework.

12. **Launch of New Finance System for SNEE - ISFE 2**

12.1. James Thompson, ICB Senior Financial Accountant presented the report stating that there was still no confirmed date for the system to be launched but the NHSE central team was reviewing the timetable. The ICB had carried out a self-assessment of its readiness to move to ISFE 2 and was confident in its readiness. Chris Armitt, ICB Director of Finance spoke to the use of purchase orders which was required under ISFE 2. Purchase orders would not provide any significant benefit as the majority of expenditure was through contracts. There was a risk that staff would see purchase orders as an alternative to issuing a contract for low value awards.

12.2. In response to the Committee, Both External and Internal Audit confirmed that when ISFE 2 was introduced it would be a consideration for audit work.

12.3. Howard Martin, ICB Execuitve Director of Finance stated that officers would bring a further report to provide assurance to the Committee that the ICB was fully prepared for the go live of ISFE 2.

12.4. The Committee **NOTED** the report.

13. **Non-Emergency Patient Transport Service Procurement.**

13.1. Howard Martin, ICB Execuitve Director of Finance stated that he would work with officers to consider how best to keep the Committee appraised of commissioning activity and escalations, potentially through a regular commissioning highlight report.

13.2. The Committee noted the report.

14. **Integrated urgent care service procurement**

14.1. The Committee noted the report.

15. **Policies for Approval**

15.1. James Thompson, ICB Senior Financial Accountant introduced the Off-Payroll Worker Policy and Procedure (IR35) highlighting that the only change was to reduce the day rate limit for contractors from £600 to £500 in line with a change in NHSE policy. This change did not affect any one at the ICB.

15.2. The Committee **APPROVED** the Off-Payroll Worker Policy and Procedure (IR35)

16. **Governance Logs**

16.1. The Committee **NOTED** the governance logs.

17. **Any Other Business**

17.1. The Chair provided an update on a meeting of Chairs of Audit Committees from across the ICS to begin to develop a system approach to risk management which was an ambition set by the Integrated Care Partnership Committee.

The meeting ended at 11:45am

Meeting of the ICB Estates Committee held online on 19 March 2024 at 10am

Present:
Geoff Dobson (Chair), SNEE ICB Non-Executive Member
Christopher Philbedge, NHS England
Christopher Todd, West Suffolk Foundation Trust
Rachel Jennings, SNEE Integrated Care Partnership
Jodi Thompson, Essex Housing Partnership
Amanda Lyes, SNEE ICB Director of People and Workforce
Dr John Lynch, Primary Care Representative, Suffolk
Howard Martin, SNEE ICB Director of Finance
Martin Mizen, EPUT
David Osborne, West Suffolk District Council
Nick Sammons, ESNEFT
Daniel Turner, ICB Senior Estates Development Manager
Andrew Urquhart, ICB Sustainability Lead
Zoe May, EEAST

Also in attendance:
Simon Waters, Community Health Partnerships
Gareth Cumberland, SNEE ICB
Tom McColgan, SNEE ICB (Minutes)

1. **Apologies for Absence**

1.1. Apologies for absence had been received from Quentin Cass, Andrew Kelso, and Richard Chilcott.

2. **Declarations of Interest**

2.1. There were no declaration of interest.

3. **Minutes of the previous meeting**

3.1. Howard Martin noted that the Estates Infrastructure Strategy considered at the last meeting had now been approved by the ICB Executive Committee and would be going to the ICB Board for approval on 26 March 2024.

3.2. The Committee confirmed the minutes of the previous meeting as a true and accurate record.

4. **Matters Arising and Review of the Action Log**

4.1. There were no matters arising not included on the action log. The following updates to the action log were given:

4.2. On the action relating to RAAC identification within the primary care estate Dan Turner stated that John Lynch was chasing up the remaining eight practices who had not responded on RAAC. For POD, Paul Gibara had reached out to his counterparts across the other five EoE ICBs to discuss the region's proposed approach to POD and form a the collective view.

4.3. On the action relating to Sustainability Update Andrew Urquhart confirmed that his update would cover the action and that it could be closed.

4.4. Zoe May confirmed that the action relating to the Estates Infrastructure Strategy had been actioned and could be closed.

5. **Update from Strategic Estates Advisor**

5.1. There was no update available.

6. **Sustainability Update**

6.1. Andrew Urquart spoke to a presentation highlighting that a task and finish group had been established to take forward the Electric Vehicle Infrastructure Work and the good work being done by leads across partner organisations.

6.2. The Committee noted that West Suffolk Council were seeking to develop a district heat network and that there may be the possibility for the new West Suffolk Hospital to link in to that work.

6.3. The Committee noted that a group of East Anglia MPs were asking local hospitals to sign up to a letter about offshore windfarms. The Committee requested that Andrew Urquart investigate and help the system form a collective view and approach.

6.4. The Committee **NOTED** the update.

7. **One Public Estate**

7.1. Jodi Thompson provided an update on One Public Estate Essex. She spoke to recent presentations that Essex County Council had received on prisoners building homes which was a programme being piloted by Devon and Cornwall Police and on bio-diversity net gain. She also spoke to the applications made to release brownfield sites and confirmed that there was no update on including NHS organisations in brownfield site applications.

7.2. There was no update from Ipswich Central or West Suffolk.

7.3. The Committee **NOTED** the update.

8. **Highlight Reporting Updates**

8.1. **ESNEFT** – Nick Sammon provided a verbal update. He spoke to progress being made at Ipswich hospital on ‘going green in our theatres’ and provided an update on the major works at the site which were on track. Two new RHS funded gardens had been agreed to be constructed over the next 10 weeks at Colchester hospital. The new endoscopy building was being constructed using modular construction methods and was due to be completed in 2024/25. Construction of the Dame Clare Marx Building was progressing although the contractual completion date was at risk and ESNEFT were working through options to protect the planned August 2024 opening date.

8.2. **EEAST** – Zoe May provided a verbal update. She stated that the new Bury St. Edmunds Ambulance Hub was expected to be ready to open by mid-September 2024 and EEAST were exploring whether the electricity supplied to the site would allow for electric vehicle charging to be provided for both ambulances and staff vehicles. EEAST were also exploring the development of a new site in Ipswich although that was contingent on the availability of capital funding.

8.3. **WSFT** – Christopher Todd spoke to the written report that had been circulated. He highlighted that the work at Walden Abbey had been completed and that WSFT were exploring how to extend the life of RAAC. Tree planting had begun at the new hospital site and WSFT were seeking to secure a 100% renewable electricity source for the new hospital to make it a net 0 site. The construction of the Newmarket Community Diagnostic Centre was on target.

8.4. The Committee discussed how to approach review of the business case for the new hospital and how to best review this between Estates and Finance Committees among other forums. The Committee requested that a report come back to a future meeting setting out the governance steps for the new hospital programme and identifying what would come to the Estates Committee and when. The Committee recognised that they would need to focus on the parts of the business case relevant to their terms of reference and ensure that the proposed new hospital aligned to the System Estates Strategy.

8.5. **EPUT** – Martin Mizen provided a verbal update stating that EPUT were formulating plans around estates optimisations, particularly the corporate estate, and creating closer links with acute partners. This was part of the Trust's overarching estate strategy and its ambition to link in with communities.

8.6. **NSFT** – There was no update from NSFT.

8.7. **Alliance Update** – Daniel Turner provided a verbal update highlighted that two members of the ICB Estates Team were leaving and that there would be reduced capacity while the new structure was brought in. He highlighted work across the three alliance areas:

- Work on Clacton surgery was progressing well
- There was a need for longer leases across the primary care estate
- The Estates Domain Group which had been established in West Suffolk and looked at strategic work would be replicated in Ipswich and East Suffolk.
- Haverhill surgery was back up and running with some additional work to make the building more integrated and useful.

- Utilisation work on Sudbury Health Centre was starting to explore whether the existing space could be improved or if a new space was needed.
- The expected significant increase in demand for services in Felixstowe meant that facilities would need to be reviewed and there was the potential for health to gain some space in the new leisure centre being developed.
- There was a need to make better use of space available in Gainsborough to avoid the current void issues.
- There was a forthcoming decision required about provision in Tendering and Colchester to provide for the growing demand over the next 40 years. Facilities would need to be flexible.

9. **Any Other Business**

9.1. The Committee agreed that a standard reporting format and report template for Highlight Reporting Updates should be developed.

9.2. The Committee considered how apprenticeships could be provided within Estates Teams and that highlighted the availability of apprenticeship levy funding.

9.3. The Committee thanked Geoff Dobson for his work as interim chair.

The meeting finished at 10:50am.

NHS
Suffolk and North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1A - System Finances held on 13 February 2024

PRESENT:

Geoff Dobson	GD	ICB Non-Executive, Finance (Interim) (Chair)
Craig Black	CB	WSFT Representative
Antoinette Jackson	AJ	Provider Non-Executive
Adrian Marr	AM	ESNEFT Representative
Howard Martin	HM	ICB Director of Finance
Kevin Smith	KS	EEAST Representative
Janet Wood	JW	ICB Non-Executive, Audit
Chris Armitt	CA	ICB Deputy Director of Finance
Andy Plummer	AP	Suffolk County Council
Trevor Smith	TS	EPUT Representative
Kathryn Walsh	KW	NSFT Representative

IN ATTENDANCE:

Kris Murali	KM	New Non-Executive Member
James Rowe	JR	ESNEFT
Kate Read	KR	Head of HR, ESNEFT
Graham Seward	GS	ICB Head of Workforce Transformation
Giles Turner	GT	ICB Head of Workforce Intelligence
Jo Mael	JM	ICB Corporate Governance Manager (Minutes)

24/001 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting. Apologies for absence were received from.

Louise Aynsley, Suffolk County Council
Paul Gibara, ICB Director of Performance Improvement
Jason Hollidge, NSFT Representative
Mark Millar, Provider Non-Executive
Dr Nick Rayner, ICB Board Primary Care Representative

24/002 DECLARATIONS OF INTEREST

No declarations of interest were received.

24/003 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Finance Committee held on 12 December 2023 **were approved** as a correct record, **subject to** the revision of last sentence of the second paragraph of comments on page three being amended to read ‘inevitable’ and not ‘evitable’ as written.

24/004 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

24/005 SYSTEM FINANCES

System Finance Dashboard Month 09

The Committee was in receipt of the System finance dashboard for Month 09, key points highlighted included:

- The System was reporting a YTD deficit of £0.177m, which represented a favourable variance of £2.431m on a planned deficit of £2.607m.
- The forecast was that the System was on plan to achieve a balanced plan position at the year-end.
- The updated position was that of a planned deficit of £2.2m, actual deficit of £1.35m equating to being ahead of plan by £860k.

At Month 9 the ICS was the only one across the country that was assuring a breakeven position at outturn, accepting the receipt of industrial action funding. There was expectation that any industrial action funding would be allocated via a fair shares position.

The Committee was informed that industrial action costs relating to December 2023 and January 2024 had been included in WSFT's reported £1.2m of costs, although it should be noted that additional industrial action was planned next week.

ESNEFT had also played industrial action numbers into its position and the announcement last week with regard to additional funding should assist the year-end position.

ICB Finance Report Month 09

- The ICB reported in line with the revised system forecast for month 09 with a £2m surplus year to date and £4.5m forecast surplus to help finance the deficit at WSFT. Overall cost pressures remained stable.
- The forecast delivery of CIP had improved to 88% of the £13.5m target. Year to date delivery had also improved to 73%.
- The forecast is an underspend on Running Costs of £2.5m against the annual limit.
- The forecast was for achievement of the £161.4m target for the Mental Health Investment Standard
- There had been no change to the net risk position as risks had now moved into the forecast.

Areas of expenditure to note continued to be prescribing, continuing healthcare, mental health and acute.

The ICB had been over its cash utilisation limit for most of the year with a key issue being the mistiming of payments between financial years. The situation was being monitored closely with regard to any effect on drawdowns in March 2024.

It was reported that contingency for not being able to draw down included pushing out payment terms the effect of which was currently being explored.

Salary overpayments was raised as an area of concern, and it was explained they were an ongoing issue with the ICB's payroll provider SBS and being monitored closely.

ESNEFT reported that it was currently looking at options to bring their payroll function in house.

Having noted the movement on variants with regard to prescribing and CHC, it was queried what the percentage movement was in year-end forecast. The Committee was informed that prescribing movement was 1.5% and CHC 2.4%. Prescribing movement was due to price and CHC due to demand.

The ICB's Director of Finance reported that from an ICB perspective key areas of concern were prescribing volatility and delivery of the CIP. With regard to prescribing there had been progress in relation to internal control and the same approach was being taken with CHC. A new cost pressure of £2m had materialised with regard to S117 placements in Suffolk and work was underway to seek to address that issue.

Having queried where car parking information was reported within Provider statements of income, **the Committee requested** that a breakdown by organisation be provided to the Chair prior to the next meeting.

WSFT's cash position looked healthy which was due to ICB payback etc. Discussions were taking place with the national cash team with regard to a possible £10m cash advance next month. The Trust had an underlying cash balance of £1m.

<u>Impact of changes to System capital targets.</u>

The Committee was in receipt of a briefing note outlining the impact of changes to System capital targets to incorporate the impact of operating leases, following notification on 29 November 2023.

The impact of the implementation of the target effected most systems. However, systems that hosted ambulance organisations on behalf of their regions were likely to be disproportionately impacted, as a result of decisions taken many years ago by most ambulance providers to lease their fleet (both double staffed and rapid response vehicles) using operating leases with a primary period of five years.

The report went on to provide background information and detail.

In conclusion there was no prospect of delivery of the target in 2023/24 or any other year in which substantial fleet replacement was scheduled. The current proposals effectively restricted the ambulance trust from replacement of all but a handful of vehicles each year. It was assumed that was not the intention of the target.

Special case status for National support was therefore required:

1. To help resolve the EEAST issue in the current and future years.
2. To help confirm NHSPS accounting treatment of intra DHSC leases.

The Committee was informed that there was ongoing debate with regard to the target and current advice was not to avoid critical or significant capital expenditure in 2023/24. The situation continued to be reviewed and monitored.

Correspondence had been sent and whilst there was support from a regional perspective there was no national resolution as yet.

Having queried what the penalty for not achieving the target might be, it was explained that the national team had indicated there was a need to reflect the situation within governance statements. There was good engagement with external auditors on the issue.

There was a need for special case status for national support as the circumstances were exceptional. It was frustrating as statements regarding the commitment had been submitted and 140-160 vehicles were coming to the end of their five year leases over the next year.

There was a need for rebalance via a new policy and a different method for allocation of resource.

The East of England commitment for fleet replacement was 2.5 times the entire system allocation.

The Committee noted the report, **was disappointed** that there was no current satisfactory resolution or response to the ICB's correspondence **and requested** a further update with recommendations on actions at the next meeting.

24/006 WSFT FINANCIAL RECOVERY UPDATE

a) Progress Update from Trust

The Committee was in receipt of a progress update on WSFT's financial recovery plan.

The Trust was on track to deliver its revised year-end forecast with key drivers of deterioration being a shortfall on inflation and delay in starting CIP, together with the costs of industrial action. Those risks were being managed and there had been significant improvement in the achievement of CIP with the Trust now broadly expected to breakeven in the final quarter. Industrial action was a significant concern although the costs could be managed it would limit flexibility into next year. With six weeks of this financial year left the Trust was halfway to identifying CIP for 2024/25. There was expectation that 100% would be identified before the end of the financial year. There was guaranteed delivery of £12.3m of CIP and the Trust delivered 75% of its CIP this year with non-recurrent CIP being added to next year.

Having noted that the process of looking at setting 2024/25 budgets had commenced, and the Trust was indicating it would be in a deficit, it was queried if the Trust had identified what was an acceptable deficit and whether that had been discussed across the System. The Committee was informed that information on the Trust's position had been shared and it made clear that there was an expectation that the position would improve.

Having questioned if there was a risk associated to ERF within the forecast, it was reported that, at present, the assessment had included costs associated to industrial action, drop off of ERF funding and costs associated to additional pay. There was an assumption of receipt of £1.1m of ERF income which although might be overly prudent would be worked through in the next few weeks.

In response to questioning as to how far through the organisation the CIP was being developed and owned, it was explained that there was a programme of communicating financial issues across the organisation in order to seek engagement in the process. It was felt that the significant number of schemes reflected dispersal of engagement. The issue was a key priority alongside that of urgent and emergency care. The Trust's Finance and Operations Committee met monthly to scrutinise CIP progress and report on to the Trust Board. The situation was reflected within the context of NED visits within the Trust.

Whist, as a System, there had been delivery of the set of plans expected, it was important to maintain momentum into 2024/25. The next stage would be lessons learnt and addressing actions from the PA consulting review.

There was a template submission in respect of activity and workforce required by 29 February 2024 with a further round of planning submissions expected on 2 May 2024.

The need to look at productivity and workforce as well as CIP was emphasized.

b) Comparative Review ESNEFT/WSFT

The Committee was in receipt of the outcome of the comparative review of WSFT and ESNEFT's approach to business planning. Comments included:

Having queried whether the identified areas of difference were being taken forward, the Committee was assured that they were, and the work was being carried out in a collaborative way. There was confirmation that all actions had been agreed and that more work was required with regard to ongoing monitoring of progress.

It was noted that ESNEFT included divisional governance within its internal audit plan, and **it was agreed** that internal audit information be shared with WSFT outside of the meeting.

The Trust's Insight committee would monitor progress against action plans going forward.

It was agreed that a combined action log would be developed that included this work and the recommendations from the PA Consulting diagnostic. Progress against which would also be monitored in the ICB Finance Committee.

c) PA Consulting Update

The ICB's Director of Finance reported that slides contained within the agenda pack provided an update on progress with regard to actions agreed as a System in response to WSFT going off plan. There had been good collaboration with WSFT, and PA Consulting was due to complete its review by the end of February 2024. The early outcomes were due to presented to CEOs and DOFs on the 16 February 2024 with opportunity for them to comment prior to completion of the final report. The final report would be presented to the Finance Committee in March 2024 prior to presentation to the ICB P2 Board in March 2024.

The Committee noted the update **and welcomed** receipt of the report in March 2024.

24/007 2024/25 FINANCIAL PLANNING

a) System CIP progress updates

The Committee was in receipt of cost improvement plan updates from the ICB and ESNEFT.

ICB - current position was a target of £14m. To date 90% had been identified.

ESNEFT – business planning process underway. A cost pressure review was underway, and the Trust was meeting with its divisions to run through its current position and check cost improvement and value. CIP targets rolled forward and the Trust was keen to run a productivity programme. The Trust's 'Making Time Matter' agenda linked to productivity. Next steps included the continuation of discussion and validation of schemes.

b) Workforce Update

The Committee received a presentation on workforce planning and the requirement for 2024/25 to submit workforce planning information via the Strategic Data Collection Service (SDCS) portal. The presentation set out the timetable and process, and included information on recruitment, retention and reform of the workforce.

A Workforce Cell had been established that met on a fortnightly basis. Workforce planning information was expected to be submitted to NHSE on 29 February 2024, with further submission dates being 21 March and 2 May 2024.

It would be important to add narrative in respect of some questions, and particularly those regarding finance and productivity.

A meeting was planned for 1 March 2024 to look at triangulation and pull together workforce, activity and finance information.

It was highlighted that Appendix 1 of the report was currently a non-functioning spreadsheet. In light of the expected timescales the issue had been raised at a national level for addressing.

Data collection was not different to previous years but there was a need, this time, to ensure there had been a attempt to triangulate at provider and System level. It was anticipated there might be a requirement for no growth in establishment.

Comments included:

It was highlighted that workforce was a key aspect of ESNEFT's agreed capital schemes and that no growth in the workforce was not viable. It would be important to use the narrative to highlight such issues.

The need for the work to be a rolling programme of triangulation was highlighted and it was felt that continued effort into joint finance/workforce meetings would be beneficial. There was confusion with regard to no growth in comparison to looking at recruitment and retention rates and clarity was required. A lot of work regarding workforce planning was aligned to productivity and a single approach across providers would be helpful going forward.

There was a need for workforce plans to be consistent with financial plans and it was important that where there was growth in workforce the cause was identified and that it linked to productivity. It was felt there should be enough information available to assist development of a dashboard and work was already underway to produce information for the ICB's People Committee.

There was a need to be cautious when using the term 'productivity' as often NHSE used that for performance. It was important to clearly identify what was being measured.

The Committee noted the update **and requested** a further update to its March 2024 meeting.

24/008 PERFORMANCE UPDATE

As the ICB's Director of Performance Improvement was not present, no update was received.

24/009 BOARD ASSURANCE FRAMEWORK

The ICB's Director of Finance agreed to circulate the latest entry in the ICB's Board Assurance Framework to Members outside of the meeting.

24/010 ISSUES TO BE HIGHLIGHTED TO THE ICB BOARD

The Chair advised of the following issues for highlight to the ICB Board:

- That System finances were on track.
- That there was concern with regard to operating leases which is being taken up nationally with NHSE
- That the Committee had been reassured that the WSFT Recovery plan was on track.
- That there had been discussion with regard to CIP for 2024/25 which was well developed.
- That actions from the ESNEFT/WSFT comparative review had been agreed.

- That PA consulting work was in progress and the report would be presented to the next meeting.
- That the Committee had received a workforce update outlining the requirement for workforce planning information to be submitted to NHSE by May 2024.

24/011 DATE OF NEXT MEETING

The next scheduled meeting was 12 March 2024.

NHS
Suffolk and North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1A - System Finances held on 12 March 2024

PRESENT:

Geoff Dobson	GD	ICB Non-Executive, Finance (Interim) (Chair)
Craig Black	CB	WSFT Representative (Part)
Paul Gibara	PG	ICB Director of Performance Improvement
Antoinette Jackson	AJ	Provider Non-Executive
Adrian Marr	AM	ESNEFT Representative
Howard Martin	HM	ICB Director of Finance
Mark Millar	MM	Provider Non-Executive
Kevin Smith	KS	EEAST Representative
Janet Wood	JW	ICB Non-Executive, Audit
Chris Armitt	CA	ICB Director of Operational Finance
Louise Aynsley	LA	Suffolk County Council
Jason Hollidge	JH	NSFT Representative

IN ATTENDANCE:

Kris Murali	KM	New Non-Executive Member
Giles Turner	GT	ICB Head of Workforce Intelligence
Charlotte Vitty	CV	PA Consulting Group
Gareth Fitzgerald	GF	PA Consulting Group
Keith Wood	KW	ICB/ESNEFT
Jo Mael	JM	ICB Corporate Governance Manager (Minutes)

24/012 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting. Apologies for absence were received from.

Dr Nick Rayner	NR	SNEE ICB Board – Primary Care Representative
Trevor Smith	TS	EPUT Representative
Zoe Pietrzak		NHSE Regional Director of Finance

24/013 DECLARATIONS OF INTEREST

No declarations of interest were received.

(The Chair advised that agenda items would be taken in the following order)

24/014 WSFT DIAGNOSTIC REVIEW CONCLUSION

The Committee was in receipt of the report from the financial diagnostic review undertaken at WSFT. The review had been commissioned by the Integrated Care Board (ICB), on behalf of the ICS to understand the drivers and causes of WSFT's financial position; develop a forward look including review of the Trust's 2024/25 cost improvement programme (CIP); and develop

a clear set of recommendations to ensure the Trust was set up for success to achieve best value for money going forwards.

The review had identified 30 recommendations as detailed in Section 8 of the report.

WSFT and the ICB were thanked for their support during the carrying out of the work.

Comments included:

The Committee was informed that WSFT Board had not yet seen the report and it would be presented at its formal Board on the 22 March 2024.

The work had been complex and provided a better understanding of the Trust's financial position. There was concern that the report did not provide a route to recovery but aspiration to recovery and it was questioned how it might affect affordability of the new hospital. There was a need to move past fair shares and think about need. There was no overall picture with regard to the delivery of clinical services.

Whilst the diagnostic was helpful a key factor was what would happen next within the context of the new hospital, efficiencies and productivities. There was a need to know the view of the WSFT Board and whether the recommendations from the report would be adopted.

WSFT's Provider Non-Executive reported that from a personal viewpoint there was no reason why the Trust Board would not accept the recommendations of the report. The process had been open and transparent, and the Board would need to look at a detailed recovery trajectory.

The Committee was advised that the Trust's Finance Dept already had an action plan which could be incorporated into the comprehensive response to the report.

Workforce growth was a key aspect, and it was important to consider how the System might work together to move people into funded posts. Whilst there was desire for WSFT to get back into balance there was a need to consider how that might affect performance and to be open minded in that respect. Some comments within the report on the qualitive side were of concern and it was queried how they linked with the Well Led report. Organisational design was a key aspect.

Timelines and the response from the Trust would be key as there was opportunity to get to a better place. The report was to be presented to WSFT Board on 22 March and the ICB Board on 26 March 2024.

The Committee was informed that with regard to workforce the Trust was currently focussed on agency spend. No growth was planned for next year. It was felt there could be more strategic workforce planning if colleagues across the System worked together.

It was noted that the WSFT Trust Board had overall accountability and that information presented to the Trust Board would be shared with the ICB.

The Trust's CIP had significantly improved its position and it showed a breath of areas on which to focus CIP delivery.

There was concern that the improvement in financial position was not due entirely to management action and a significant part was the use of non-recurrent funding. There was nothing within the report that provided comfort that there would be recurrent recovery by 2027/28.

The Trust expected to receive scrutiny of its performance. The development of any action plan needed to be carried out at pace and with intent.

The Committee noted the report and thanked PA Consulting. It **recommended** that the Trust respond at pace, develop its delivery plan, and its trajectory for sustainability. The Finance Committee also **recommended** that future monitoring of delivery of that action plan for the system would be through this Finance Committee.

24/015 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Finance Committee held on 13 February 2024 **were approved** as a correct record **subject to** Page 4 being amended to read 'NED visits within the Trusts' rather than NEM as written.

24/016 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

24/017 SYSTEM FINANCES

System Finance Dashboard Month 10

The Committee was in receipt of the System finance dashboard for Month 10, key points highlighted included:

- Month 11 – there was a year-to-date surplus of £97k which was £1.6m ahead of plan. The System capital overspend had decreased by £250k and related to EEAST fleet replacements.
- The System was on target for year-end revenue positions.

The Committee was informed that ESNEFT had received confirmation in respect of its accounting treatment of EPR licences which would enable a smooth capital year end. Audit had confirmed the Trust's accounting policy.

ICB Finance Report Month 10

- The ICB reported in line with the revised system forecast for month 10 with a £2m surplus year to date and £4.5m forecast surplus to offset the deficit at WSFT. Overall cost pressures remained stable.
- The forecast efficiency delivery was 89% of the £13.5m target. Year to date delivery had improved to 76%.
- The Corporate Costs forecast was an underspend of £0.6m and £2.5m below the Running Costs Allowance.
- The forecast was for achievement of the Mental Health Investment Standard of £161.4m.
- There had been no change to the net risk position as risks had now moved into the forecast.

Key areas of expenditure continued to be continuing healthcare, prescribing, mental health and acute. The 7.5% uplift in Funded Nursing Care was of concern going forward and the ICB was pushing for funding to address the situation. Delegated budgets were now within plan but there was higher overspend in West Suffolk due to prescribing. Delivery of £11.9m efficiencies was on track. There was over utilisation of cash which was a risk with regard to draw down although the drawdown request had been approved so was no longer an issue.

The ICB recognised that it had an underlying deficit and had invested in getting support for to improve its prescribing cost improvement programme. The ICB was looking to do an independent review of continuing healthcare review to ensure best practice.

Having noted the increase in CHC cases from the local authority, it was highlighted that they tended to be high cost and prevention would be a key aspect going forward. There was an increase to mental health shared packages of care costs and a lot of work was required to ensure correct governance.

IFRS16 Impact on System Capital: Update

The report provided an update on the continuing issue of the impact of IFRS16 treatment of operating leases on the delivery of system capital targets.

The ICB Finance Committee had previously received a briefing which confirmed that the system would not be able to deliver the system capital allocation. On 29 November 2023 NHSE confirmed an additional allocation of system capital of £8.7m. A combination of incurred expenditure and contractual commitments for the replacement of fleet at EEAST suggested a forecast £29.6m overspend of the allocation. Whilst slippage of fleet replacement had reduced the expected overspend to £22.1m by month 10, the system had no means of covering the issue. At last month's ICB Finance Committee it was reported that NHSE was working on a national solution, and that in the interim organisations did not need to seek local solutions that would result in contractual commitments being broken, or high priority investments delayed.

The ICB had now received confirmation of a national solution to the need for CDEL cover for the IFRS16 accounting treatment. In summary, in month 12 organisations would be provided additional CDEL cover for 2024/25 based on the lower of the forecast lease capital expenditures in the month 10 and 11 financial returns (PFRs).

The solution provided would resolve the IFRS16 issue for accounting year 2023/24. However, it was notable that it did nothing to resolve the problem in 2024/25. Planning submissions due on 21 March 2024 would confirm the figures included in monthly returns throughout 2023/24 that the proposed provision for CDEL cover for 2024/25 was inadequate, once again primarily due to the hosting arrangement for EEAST and their on-going fleet replacement programme.

NHSE remained briefed on the issue. The submission of 'non-compliant' capital plans on 21 March 2024 might trigger further action from NHSE, although it was likely that in the short term the focus would remain on other systems and the revenue position.

The Committee was informed that there would be an additional allocation in M12 which could be in the region of £21.4m. There was concern that it would not provide a solution for 2024/25 and that the allocation for that year was inadequate.

Action: Having queried what further steps could be taken it was felt the first step should be to formally write back to the Region asking what the solution might be.

The Committee noted the reports and updates.

24/018 2024/25 FINANCIAL PLANNING UPDATE

The Committee received an update on the 2024/25 financial planning process which included information on the timetable, System and ICB headlines and the key metrics submission.

Comments included:

The ICB's Director of Finance reported that there was a call scheduled with the NHSE region on the 13th March. This was likely to be a challenging meeting with expected pressure to

demonstrate balanced financial plans. Financial plans that were not balanced would not be expected to have workforce growth in 2024/25 as a minimum.

There was concern that no planning guidance had, as yet been issued. ESNEFT was holding internal meetings to review cost pressures with the conclusion to be reported to its Board. The Trust was working towards a break even position (improvement of £10m).

WSFT had already committed to its position not getting worse, but it would be challenging. The Trust was committed to working towards an improved position.

The implications of the IFRIC12 new accounting standard were queried.

It was thought that Trust Boards would be asked to approve budgets in March and agree plans subject to their change once guidance was received.

The ICB would likely convene an Extraordinary Board in April to sign off system and ICB financial plans.

The Committee noted the update.

24/019 SPECIALISED COMMISSIONING

On 7 December 2023, the NHS England Board approved plans to:

- Fully delegate the commissioning of appropriate specialised services to Integrated Care Boards (ICBs) in the East of England, Midlands and the Northwest regions of England from April 2024.

- Continue to jointly commission appropriate specialised services with ICBs in the Southwest, Southeast, London and the Northeast and Yorkshire regions of England for a further year to help support a smooth transition of commissioning responsibility by April 25.

Moving to ICB-led commissioning supported a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities and ensuring best value.

The six ICBs in the East of England proposed a collaborative approach to:

- Commission specialised services through a multi-ICB Committee.
- Manage the portfolio through a shared specialised commissioning team.

The report went on to provide information on benefits of an integrated approach, safeguards and funding.

From April 2024, BLMK ICB would host the specialised commissioning function in the East of England on behalf of all EoE ICBs. The existing Specialised Commissioning team would continue to manage the commissioning of services and in April 2025, the team would transfer to BLMK. Service providers and clinicians would continue to play their part in the design and development of services. There would be a move from legacy allocation to a needs-based formula from 2024/25.

It was highlighted that it had been known for a long time that there was under-provision of services within SNEE. There was a need to ensure quick development of a Strategy to address that situation for local residents and identify what services were planned to be moved and increased locally. It was queried what the clinical strategy might be as how providers reacted to it would be key.

The Committee was informed that there had been a regional call earlier in the week where the same question had been raised. There was need for the strategy developed to look initially at population health management.

The Committee noted the update.

24/020 WORKFORCE UPDATE

The Committee was informed that a meeting had been scheduled to take place on 13 March 2024 to discuss workforce triangulation.

- Current focus was on why workforce growth within the Region was currently at 3.6% in comparison to 0.5% nationally.
- Workforce growth figures from providers were being collated with new figures from EEAST expected next week. WSFT had sent across revised figures which showed increased growth due to the new diagnostic Centre at Newmarket.
- There was also growth at ESNEFT due to approved initiatives such as the Clare Marx Centre. It was noted that the cost pressures business case would change the workforce figures for ESNEFT. There would be a lot of scrutiny on workforce over the next few weeks and it would be important to ensure growth was clearly evidenced.

The Committee noted the update.

(Craig Black and Antoinette Jackson left the meeting)

24/021 PERFORMANCE UPDATE

The ICB's Director of Performance Improvement reported:

Urgent care

Cancer performance had improved, and mental health performance was recovering. There was concern that planning guidance lacked ambition and, as such, it was expected that things would change going forward.

During February 80% of urgent care activity had been walk-ins with 20% being ambulance arrivals. Handover performance was reasonable. There continued to be high bed occupancy and there was room for improvement regarding long stays. The bed occupancy target was 76% which had been achieved recently for the first time, although it was currently running at 77%. Colchester had reached up to 90%. Category 2 performance was reasonable with response times currently being 40 minutes. There was a need to sustain targets going into next year. WSFT was committed to review minors and there was a need to invest further in community services to address the bed occupancy issue. There was focus on discharge funding and both Trusts were reviewing the impact of capacity funding. There was capital funding of £150m available to hospitals that achieved 85% performance and NHSE national team was considering giving a proportion to Systems although the criteria was yet to be determined.

Elective

A System dashboard had been developed. There was pressure nationally and the SNEE planning submission had indicated the System was on target to hit 78 weeks and 65 weeks by the end of September 2024 with the exception of one specialty. 52 weeks would pose significant challenge going forward.

Key focus areas for next year were diagnostics and demand and capacity.

ESNEFT reported that non-elective spend on urgent care was increasing in an attempt to improve patient experience. The Trust was hopeful that when allocations of capital funding were made it might be apportioned on achievement.

The Committee noted the update **and requested** that the slides be circulated to Members outside of the meeting.

24/022 BOARD ASSURANCE FRAMEWORK

The ICB's Director of Finance reported that there was no change from what had been circulated following the previous meeting.

24/023 ISSUES TO BE HIGHLIGHTED TO THE ICB BOARD

The Chair advised of the following issues for highlight to the ICB Board:

- Receipt of the PA consulting report, its consideration by the WSFT Board (22 March) and development of an action plan.
- Systems were in balance with a key challenge going forward being continuing healthcare.
- Financial planning guidance had not yet been received.
- The Committee had received papers on specialised commissioning and IRFS16

24/024 DATE OF NEXT MEETING

The next scheduled meeting was 9 April 2024.

The Committee was informed that today was the Geoff Dobson's last meeting and he was thanked for his contribution as Committee Chair and wished well for the future.

Meeting of the SNEE ICB Finance Committee Part 1a and Part 1b held on 9th April 2024 at 2pm in Constantine House

PRESENT:

Kris Murali (Chair)	ICB Non-Executive Member, Finance
Janet Wood	ICB Non-Executive Member, Audit
Howard Martin	ICB Director of Finance
Craig Black	WSFT Representative
Antoinette Jackson	Provider Non-Executive
Adrian Marr	ESNEFT Representative
Mark Miller	Provider Non-Executive
Kevin Smith	EEAST Representative
Louise Aynsley	Suffolk County Council

IN ATTENDANCE:

Chris Armitt	ICB Director of Operational Finance
Keith Wood	ICB/ICS Senior Finance Manager
Jarrad Murray	ICB Information & Modelling Manager

24/025 APOLOGIES FOR ABSENCE

1.1 The Chair welcomed everyone to the meeting and introduced himself as the new chair of the ICB Finance Committee.
Apologies for absence were received from:
Paul Gibara, ICB Director of Performance Improvement
Jason Hollidge, NSFT Chief Finance Officer

24/026 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

24/026 MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the meeting held on 12th March 2024 were approved.

24/027 MATTERS ARISING AND REVIEW OF ACTION LOG

4.1 The Action Log was reviewed and updated.

4.2 Mark Miller raised a matter stating, that it had been expected that the PA Diagnostic Review report that had been presented at the previous meeting would be included on the agenda for this meeting as it has now been through WSFT and ICB Board. Craig Black reported that an Action Plan has been produced that is going to WSFT Executive Committee and then Insight Committee on 17th April and following this he will share the plan, Howard Martin advised that the ICB are working closely with WSFT on the trajectories and there is an expectation that a report will be brought to the ICB Board on 30th April.

The Committee noted the matter arising **and requested** that an extraordinary ICB Finance Committee before the Board meeting to review the WSFT Action Plan.

24/028 SYSTEM FINANCES

5.1 Keith Wood reported that Revenue at Month 11 had moved into a surplus position, it being year-end. Working day seven return is due tomorrow which is the first formal reporting to NHSE, an email to colleagues had requested information on any significant issues that had been reported in the first six days of the working year that could cause any problems and none have been received.

5.2 Capital, there will be an additional allocation in month 12 which will address the IFRS 16 issue that was reported previously, however the long-term problem remains unresolved and this is being escalated with NHSE and will remain a focus as it is a risk to the 24/25 plan.

5.3 Expecting a small underspend against the system owned capital allocation for 23/24.

The Committee noted the report

24/029 2024/25 FINANCIAL PLANNING UPDATE

6.1 EEAST reported on the issue with access deprecation but is currently working to ensure they maintain a good system partners role and managing the risks. It was acknowledged that we have a challenging year ahead, with new investment brings expectation and have set a challenging cost improvement target, trying to return to pre-covid position.

6.2 ESNEFT reported that revenue position was good, capital has quite an overspend but this is currently being analysed. WSFT reported a similar position. No spare capital within the region and it was agreed this has been an unusual and challenging year. The group discussed the challenges of balancing the plan and the need to be consistent, particularly as 24/25 is going to be even more challenging that 23/24.

6.3 The group discussed getting transparency to the ICB Board in an appropriate way and presenting a plan that is achievable and can be believed in.

6.4 Lobbying NHSE more effectively around incentives and disincentives on buying was very crucial.

6.5 SNEE ICB reported a balanced position, with a risk due to the late planning and carrying a risk as still to start provider negotiations. No discretionary growth and no investments until systems are balanced, quite an unusual start to the year. It was agreed that this is difficult but better than some systems.

6.6 Discussion around system collaboration, pathways, and commissioning intentions, ICB needs to be driving this but with collaboration from the trusts, Primary and Secondary care should be the focus.

The Committee noted the report.

24/030 SPECIALISED COMMISSIONING

7.1 The Committee received an update on Specialised Commissioning funding envelope and the changes in spending position, the commissioning team are working to understand what is a truly justifiable growth in contracts. The regional team is now involved in the decision-making.

7.2 There will be changes in services and the need for a plan by the end of September, market forces and pathways were discussed and the need to bring back services locally.

In recognition of the discussion **The Committee requested** an **Action** to invite Nerinda Evans to join the meeting in June to provide an update on Specialised Commissioning.

24/031 PLANNING SUBMISSION UPDATE

8.1 Jarrad Murray joined the meeting and provided an update on the planning round that has just taken place.

8.2 Looking to meet most of the targets but one area of concern is bed occupancy as we are sitting quite high, more within paediatric and children's beds although we are meeting the regional targets so more of an internal review.

8.3 Region have acknowledged that we are doing well as a system concerns are within other trusts.

8.4 Second submission due on 2nd May and we are in a good position.

The Committee noted the update **and requested** that the performance report provided to the last meeting be refreshed each month and circulated with the agenda for future meetings.

24/032 ISSUES TO BE HIGHLIGHTED TO THE ICB BOARD

The Chair advised of the following issues for highlight to the ICB Board:

- £18 million deficit and the dental deadline.
- An extraordinary ICB Finance Committee will be held before the next ICB Board to discuss the WSFT Action Plan following the PA Diagnostic Report.
- Balanced budget and capital gap.
- Explore system wide opportunities.

The ICB's Director of Finance reported that he is hoping that next year we do more to triangulate workforce , performance and financial delivery and bring more to the fore and this will become the purpose of the ICB Finance Committee as it evolves.

The Committee requested that Finance Risk would be included on the agenda for the next meeting.

DATE OF NEXT MEETING

The next scheduled meeting was 14th May 2024

Meeting of the SNEE ICB Finance Committee Part 1a and Part 1b held on 25th April 2024 at 1030 via MS Teams

PRESENT:

Kris Murali (Chair)	ICB Non-Executive Member, Finance
Janet Wood	ICB Non-Executive Member, Audit
Howard Martin	ICB Director of Finance
Paul Gibara	ICB Director of Performance Improvement
Craig Black	WSFT Representative
Antoinette Jackson	Provider Non-Executive
Adrian Marr	ESNEFT Representative
Mark Millar	Provider Non-Executive
Kevin Smith	EEAST Representative

IN ATTENDANCE:

Chris Armitt	ICB Director of Operational Finance
Keith Wood	ICB/ICS Senior Finance Manager
Ameeta Bhagwat	ICB Head of Financial Management

ITEM 1 APOLOGIES FOR ABSENCE

1.1 The Chair welcomed everyone to the meeting.

1.2 Apologies for absence were received from:
Louise Aynsley, Suffolk County Council
Trevor Smith, EPUT Representative

ITEM 2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

ITEM 3 MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the meeting held on 9th April 2024 were approved.

ITEM 4 MATTERS ARISING AND REVIEW OF ACTION LOG

4.1 The Action Log was reviewed and updated.

ITEM 5 2024/25 FINANCIAL PLANNING UPDATE

5.1 Howard Martin presented the financial planning update setting out a viable route to a system break-even position with £5m of headroom, which required three key issues to fall into place.

5.2 The first of which was the Provision of £6.8m of support from NHSE, this has now been confirmed as a £6.8m allocation, not to be confused with the £7m of legacy CCG surpluses lodged with NHSE which is still in place.

5.3 In addition the ICB had been notified late on the previous day of a £7.7m windfall allocation for depreciation. This funding was to be used to improve system financial positions. Agreement would be sought over the next day on how this funding would be presented and distributed. However the ESNEFT position was clear that for the 2nd of May submission it should not fall into organisations bottom lines.

5.4 The second of which was an improved position from WSFT in line with the 4% CIP requirement set out in the diagnostic, at this point the WSFT position is still at an £18m deficit.

5.5 The third of which projected underspend in dental and specialist commissioning equalling £10m. This had been previously highlighted as a risk given the ringfenced nature of dental allocations. In the event that NHSE decide they will withdraw this allocation the paper sets out some £8m of additional mitigations as well as, as yet, uncosted mitigations including income recovery from ERF.

5.6 The committee discussed the overall system risks including those associated with holding back funding, the overall level of unmitigated risk associated with CIP delivery, non pay inflation, and the risk of delivering a increased level of CIP at WSFT.

5.7 With the unexpected additional depreciation allocation the financial headroom has increased from £5m to £12.7m, at this point the clear recommendation was to support the break even plan.

5.8 It was agreed that a watching brief and review point at month 6 reporting would be put in place to determine at what point held funding (including those set out in table 4 of the paper) could be released as determined by best estimates at that time.

The Committee agreed that the additional £7.7m of funding was to mitigate system risk the distribution of which would be agreed by system Directors of Finance.

The Committee approved the break even financial plan for 2024/25,

ITEM 6 WSFT FINANCIAL PLAN AND DIAGNOSTIC

6.1 Craig Black presented the WSFT response to the PA Consulting Diagnostic Review. The paper circulated describes the position over the next three years and the PA Consulting recommendations are contained within it.

6.2 The majority of the PA Consulting recommendations are dealt with in the early stages of the plan so can be implemented quickly.

6.3 Submitted a zero-staffing growth and a cautious approach to growth in elective activity and not assumed any notable increases in ERF. Acknowledged work that needs to happen around culture within the organisation and also governance processes.

6.4 PA Consulting will be attending the WSFT Board tomorrow when the plan will be presented.

Comments included:

6.5 A request for an understanding of the work that will happen at the Trust to allow for the delivery of the 4% CIP which means movement from the £18m to a £15.2m deficit and a clear idea of the timing. The response explained that following the Board meeting tomorrow an informal update will be provided with a formal response submitted on Monday.

6.6 A request for a clear idea of the plans that will sit underneath to ensure delivery, this cannot just be numbers on a spreadsheet, and we need to see deliverable plans, however recognise that the intent needs to be agreed first.

6.7 A question was asked about the speed of the plan and if it is aggressive enough, the degree of pace is important. There is a need to explore collaborative opportunities and a response provided suggestions for reducing temporary staffing but in reality, it will be permanent posts that are affected. They also identified four areas of Covid funding where the expenditure has continued, and income disappeared, and this will be discussed at the Board meeting.

6.8 Workforce planning was discussed and a suggestion that it would be useful to analyse the growth in workforce, introducing a strategy whereby posts are funded recurrently. It would be useful to compare workforce statistics to identify where reductions could occur and to work collaboratively to identify these and to minimise staffing disruption.

6.9 It was noted that discussions are taking place across HR departments to explore opportunities to harmonise workforce plans, share posts and reduce staffing disruption across organisations, particularly across corporate services.

6.10 A question on how the plan links with the recommendations in the PA Consulting report and have we received feedback from PA on the proposals. A suggestion was made to request feedback from PA Consulting on the Boards response and the adequacy of the WSFT plan.

6.11 It was agreed that for WSFT to achieve the 4% CIP a major change would have to happen within the organisation because this degree of saving has not been made before, it will need to be a significant change of mindset, it is not just financial but must be embedded within the entire root and branch of the organisation. The option of bringing in a turnaround Director to assist with this change was discussed.

The Committee noted the report and looked forward to the WSFT response to the ICB letter following the Board meeting tomorrow.

ITEM 9 ISSUES TO BE HIGHLIGHTED TO THE ICB BOARD

The Chair advised of the following issues for highlight to the ICB Board:

- It was agreed to support the submission of a balanced finance plan to the ICB Board on the 30th April.
- Accepted that the £7.7m depreciation allocation will be factored in to the plans financial mitigations, agreement on how this will be presented will be decided by system Directors of Finance.
- WSFT will provide a formal response from their Board on the recovery plan so this can be factored in to the submission, this will be circulated to this committee and taken to the ICB Board next week.

DATE OF NEXT MEETING

The next scheduled meeting was 14th May 2024

Meeting of the SNEE ICB Finance Committee Part 1a and Part 1b held on 14 May 2024 at 1030 at Quince House, WSFT and via MS Teams

PRESENT:

Kris Murali (Chair	ICB Non-Executive Member, Finance
Howard Martin	ICB Director of Finance
Paul Gibara	ICB Director of Performance Improvement
Antoinette Jackson	Provider Non-Executive
Adrian Marr	ESNEFT Representative
Mark Millar	Provider Non-Executive
Kevin Smith	EEAST Representative

IN ATTENDANCE:

Keith Wood	ICB/ICS Senior Finance Manager
Jarrad Murray	ICB Information & Modelling Manager
Kathy Wilton	ICB Executive Assistant (Minutes)

Item 1 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE
The Chair welcomed everyone to the meeting.

Apologies for absence were received from:
Chris Armitt, ICB Director of Operational Finance
Craig Black, WSFT Representative
Janet Wood, ICB Non-Executive Member, Audit
Louise Aynsley, Suffolk County Council (joined for 10 mins but bad sound quality)
Trevor Smith, EPUT Representative

24/032 DECLARATIONS OF INTEREST

There were no declarations of interest.

24/033 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 9th April 2024 **were approved** as a correct record

24/034 MATTERS ARISING AND REVIEW OF ACTION LOG

The Action Log was reviewed and updated.

24/035 SYSTEM FINANCES

The Committee was in receipt of the System Finances Dashboard month 12 key points highlighted included:

The system achieved its target revenue position in 2024/25. The system recorded an overall surplus of £0.034m, comprising surpluses at the ICB (£4.478m), ESNEFT (£1.339m), EEAST (£0.487m) offsetting a deficit of £6.270m at WSFT.

The complete financial position narrative was provided in Slide 3.

The Committee **noted** the report.

24/036 2024/25 PLANNING

6.1 The Committee was in receipt of the 2024/25 System Financial Plan:

The Committee was informed that following lengthy discussion at the private Finance Committee in April the Plan presented here sets out the positions that were agreed along with the high level external funds that support the plan. This version will be going to the public ICB Board in May.

The plan includes the high level capital plan as well as a summary of the workforce growth assumptions that help underpin the finances.

Work has commenced with workforce colleagues to ensure that by June we will be including workforce trajectories.

The Committee **noted** the plan and **recommended** it for onward approval to the ICB Board.

6.2 The Committee was in receipt of the Joint Capital Resource Plan, along with Guidance on developing joint capital resource plans 2024/25.

ICB's are statutorily required by the Health and Care Act 2022 to publish a joint capital resource plan each year and the Committee was asked to review the plan and were advised that following Board approval it will be published on the ICB website.

The report went on to provide more detailed information on the plan.

The Committee **approved** the plan.

6.3 The Committee were in receipt of the EEAST CIP discussions report key points highlighted:

The ICB/ICS Senior Finance Manager undertook a mini-review of EEAST CIP to provide a level of assurance that EEAST has the capacity to deliver improved efficiency.

The report was based on a 2.5 hour interview with EAST Head of QCIP and full details are provided within the report.

EEAST consider the report fair and balanced and highlighted the main areas of focus. The report will assist with the ToR for an external review that is planned. It was recognised that the key focus should be on getting efficiency and productivity within operations and at a time when receiving investment to grow the workforce and capacity this becomes a challenge.

The key messages from the report highlighted:

Hubs: EEAST is slowly transitioning from a traditional ambulance station model, to a central hub with serviced response spokes. The importance of this transition cannot be overstated. However, the move towards this (18 hub) model does need to be accelerated, and its purpose needs to be clear:

Career Planning: The issue is raised here to draw attention to the role that the wider system may have in helping EEAST to reduce its long-term sick rates.

Benchmarking: Many aspects of the service could benefit from benchmarking in areas such as Conveyance rates, management costs and others.

Personal Performance Data (Operational Clinical): There is an abundance of data available within the service and recommendations for how this could be utilised are provided.

Comments included:

This report was produced as a result of a desire to become more proactive and address the underlying pressures within the ambulance service that have been voiced for some time. Using the ICB/ICS Senior Finance Managers understanding and experience of the CIP to assist with developing the way forward.

It has been agreed that someone from the ICB will join the EEAST budget review group.

Currently in discussion with PA Consulting to undertake a review, similar to that done in WSFT, however this maybe challenging due to the lack of comparative data and geographical differences between services. Need care in specifying this work and the required outcomes.

The integrated planning tool that will go live on Thursday is an existing development which has huge potential in reducing staff extractions, rates and downtime.

The current Financial Plan was discussed and It was acknowledged that the risk is lower for the 24/25 plan but the intention is to look at the longer term and get ahead of what looks to be a more challenging year from 25/26.

The Committee **noted** the report and thanked Keith Wood for his insight and looked forward to receiving the outcome of discussions with PA Consulting.

6.4 The Committee were in receipt of the WSFT Response to the SNEE ICB letter – revised financial plan. Key points highlighted:

This report is in response to the ICB request that the trust increase its CIP requirement to 4% of its expenditure, resulting in a revised target of £16.5m an increase of £2.8m. It was advised that based on the 70% assumption, the reality is that £4m will need to be identified to achieve a CIP of £2.8m.

Four key areas have been identified, where the position could be improved:
- Legacy Covid response expenditure
- Unassessed Pipeline schemes on the Tracker
- Staffing and holding posts.
- Elective activity and scope in the ERF

Acknowledged that this is challenging.

Comments included:

A question was asked around the risks and what is going to change operationally and when are we going to see a plan to support the delivery of this. It is a difficult challenge not just for this year but for the next two to three years.

A response advised that there had been a robust discussion at Board and it was recognised that it does need to be operationalised and also that we are already in May and the focus needs to be maintained. A new Director of Transformation commencing in June will provide additional strategic focus.

A question was raised around workforce and the report focusing on reducing 600 FTE just within the corporate and clerical staff groups over the next few years, it was difficult to see how this would be possible. A consideration should be made to look further than non-clinical staff and be looking at services in terms of clinical input and

how we utilise workforce across the system. A request was made for a trajectory to be provided that detailed how this strategy was to be achieved.

Concern was reported that this seems very top down and a request for more detail on where they are on the journey and how they are making the necessary changes. The response advised that this is not top down and much work is being clinically divisionally led. The Committee were reminded that this report just deals with the £2.8m and was requested within a short time frame.

The group were reminded that PA Consulting had been in the Trust since February, so a long time, and PA Consulting outcome clearly indicated that a 4% CIP was achievable and that should have been worked through earlier by the Trust.

It is recognised that this is a good report, but it is still missing a trajectory linked to a sustainable position and what is going to look differently in the organisation to support the delivery of it, for example additional resource of help such as a turnaround director who would be able to make the dynamic changes that are required.

It was noted that a report detailing the three year trajectory as to how they will get to a break even position in 26/27 was going through internal governance at the moment.

The Committee **noted** the report and **recommended** that this is still recorded as a high risk and **looked forward** to receiving the three-year trajectory plan following its discussion at Insight Committee tomorrow and Board next week.

The Committee **requested** an update at the next Finance Committee in June.

24/037 PLANNING SUBMISSION

The Committee received an update on the Planning Submission that has been accepted and waiting final outcome from NHSE. highlighting:

The NHS Oversight Framework will be published in June and performance reporting going forward will be aligned to the planning. A dashboard has been created which tracks the operational planning guidance and it is suggested that this committee receives a copy of the dashboard.

Four key areas of focus: urgent care, 12 hours and flow, elective recovery, diagnostics and mental health.

Aiming to meet the majority of targets but a few areas of concern:

- Diagnostics and the requirement to make a 95% achievement causing a problem for WSFT.
- Ambulance C2 performance, expected to meet required target but this heavily reliant on a number of criteria so a risk it may not be met.
- 52 week waits are not being reported consistently by providers and some are overestimating their ability to reduce wait times, this is currently being investigated by NHSE.
- Outpatient patient initiated follow-ups overall sitting at 4.7% of the required 5% target with ESNEFT at 4.5% so they will not achieve the target.

The Committee **noted** the report and **requested** that a Monthly Performance Update Report is added as a standing item to the agenda.

24/038 BAF

The Committee was in receipt of the Board Assurance Framework 2024-2025, May 2024 report which was circulated for information following being updated for the planning submission. It will now be going to Board for approval.

The Committee **noted** the report.

24/039 AOB

The Committee **agreed** that the next Finance Committee will be extended to feature an item on Workforce to enable discussion on the plans submitted, productivity and how these will be monitored. The ICB Director of Workforce will be invited to lead the session.

The Committee **noted** that this was Keith Wood's last meeting as he is retiring after many years working for the NHS and he was thanked for his significant contribution over the years.

24/040 ISSUES TO BE HIGHLIGHTED TO THE ICB BOARD

The Chair advised of the following issues for highlight to the ICB Board:

- Noted the progress of the system finance plan
- Noted the progress of the Joint Capital Reserve Plan
- Recommend the actions from the EAST CIP discussions report and noted the need for a more holistic and regional approach.
- Received the WSFT Response to the SNEE ICB letter and noted the plan and await the three-year delivery plan which will outline how the £2.8m reduction will be achieved.

DATE OF NEXT MEETING

The next scheduled meeting was 11 June 2024

NHS
Suffolk and North East Essex
Integrated Care Board

Meeting of the SNEE ICB Finance Committee Part 1B - ICB Finances held on 17 May 2024

(The meeting was inquorate)

PRESENT:

Kris Murali	KM	ICB Non-Executive, Finance
Janet Woods	GD	ICB Non-Executive, Audit
Howard Martin	HM	ICB Director of Finance (Part)

IN ATTENDANCE:

Kathy Wilton	JM	ICB Executive Assistant (Minutes)
Ameeta Bhagwat	AB	ICB Head of Financial Management

24/040 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting.
Apologies for absence were received from:
Chris Armitt. ICB Director of Operational Finance

This meeting was convened for ICB members only to provide an update on the Financial Plan and ICB Budgets 2024/25.
However less than 50% of the Internal ICB Finances members attended so the meeting was determined as inquorate, for clarification the membership details:

Part 1b – Internal ICB Finances

- Independent Chair - The chair will be selected to ensure that the Audit Committee and the Finance Committee are chaired by different members
- Non-Executive Member (ICB Finance and Audit)
- Primary Care ICB Board representative
- Suffolk and North-East Essex ICB Director of Finance
- Suffolk and North-East Essex ICB Director of Performance Improvement
- Suffolk and North-East Essex ICB Deputy Director of Finance (non-voting member unless deputising for the Director of Finance)
- ICB Alliance Directors

24/041 DECLARATIONS OF INTEREST

No declarations of interest were received.

24/042 MINUTES OF THE PREVIOUS MEETING

As the meeting was inquorate approval of the minutes of the ICB Finance Committee Part 1b held on 14 May 2024 was postponed until the June meeting.

24/043 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was complete.

24/044 SNEE FINANCIAL PLAN AND ICB BUDGETS 2024/25

The Committee was in receipt of the SNEE Financial Plan and ICB Budgets 2024/25.

The Committee were informed that these papers had been shared and discussed previously and a couple of minor changes have been made and this is the version presented today. The meeting today is to provide an opportunity to raise any comments and ask any questions before the paper is presented to Board on 28 May 2024.

Key points within the plan include:

- Key Statutory Duties are:
    - The ICB has a duty to at least break even individually and collectively with partner trusts.
    - The ICB and its partner trusts must ensure both capital and revenue resources do not exceed the limit set by NHSE.
    - The ICB has a duty to ensure expenditure on running costs does not exceed the limit set by NHSE.
    - The ICB is required to achieve the MHIS, requiring investment in mental health services to increase at a higher percentage than the overall rise in allocation from NHSE each year.

The Committee agreed to add an additional line on slide 12 that says this plan is compliant with these statutory duties.

Key System headlines

- The ICB submitted a plan with a surplus of £14.8m to offset the deficit at WSFT and ensure submission of a balanced system financial plan to NHSE on 2nd May 2024
- The underpinning plan:
    - Meets the stand-alone statutory duties and the system duties.
    - Is compliant with the Mental Health Investment Standard growth target of 4.37%.
    - Meets the requirement to stay within the reduced running costs limit for 24/25.
    - Maintains the ring fence on Primary Dental Services but assumes any underspend will be retained in the system.
    - Requires £14m of efficiency delivery (3% of influenceable expenditure).
    - Is supported by £6.8m of additional funding from NHS England in addition to assumed underspends for delegated Specialised Commissioning and Dental.

ICB Plan Bridge

- The Committee were informed that this slide details where we ended up in 23/24 to the budget being set in 24/25. It includes non-recurring adjustments, inflation, efficiency etc.
- We have gone through a rigorous process in terms of building up the model and this is a very high-level summary.
    - Acute reduction driven by redistribution of EEAST capacity funding (£25m), Industrial Action funding in 23/24 (£15m), Elective Recovery Funding Overperformance in 23/24 (£12m)
    - Primary care (other) reduction is due to Non-Recurrent national funding for Cloud Based Telephony not planned for 24/25 and IT efficiency savings.
    - Corporate reduction due to restructure in response to reduction in limit.
    - Other Programme reductions due to negative adjustments to account for assumptions on underspends for Specialised Commissioning, Dental and confirmed funding from NHS England to support system breakeven not yet reflected in allocations.

Allocations

- The Committee were informed that this slide details the allocation of the 2.2 billion, split into core allocations and additional allocations.
    - The total ICB allocation included in the plan is £2.28bn.
    - Of which £2.14bn is in recurrent core allocations and £138.7m is additional to this.
    - £79.1m of the funding is indicative at this stage as the actual funding will be based on:
        - Value of activity delivered (Elective Recovery Funding and Service Development Funding for Community Diagnostic Centres)
        - Actual Expenditure (Depreciation funding)
    - SNEE no longer hosts the Cancer Alliance so an allocation for Cancer Service Development Funding will be transferred from the new host during the financial year.
- The increase in the core programme allocation is about 4.37% which is additional investment in mental health, the increase in primary care medical is about 2.9% and reduction in running costs have reduced from about £18m to £16m. 2% increase in salary budgets is built in as requested by NHSE.

ICB Cost Pressures and Investments

- The Committee were informed that the breakdown of the £153.8m shown in cost pressures and investments were shown in the table.
    - Most of the additional allocation expenditure is a continuation of existing investments rather than new investments for 24/25.
    - The value of cost pressures included, particularly prescribing is a best estimate based on 23/24 but this will fluctuate during the year.
    - Prescribing (£10.1m) and Continuing Healthcare (£7m) are the most significant cost pressures.
    - The £3.5m investment reserve is non-recurrent. An extensive process to pioritise investment requests for the funding has now concluded and the funding is fully committed.

ICB Efficiency Plans

- The Committee were informed that the efficiency plan is about £14m and the split of that is the main efficiencies against prescribing and then corporate savings of £4.2m and that how we have achieved the running cost allowance in 24/24.
    - The ICB Efficiency target is £14m.
    - After adjusting for mandated contracts and spend (NHS blocks, MHIS, GP contract) the Efficiency Target of £14m is 3% of influenceable spend.
    - Schemes to the full value of the target are identified with a high proportion of the target to be delivered recurrently.
    - Development of further schemes to increase the level of headroom is overseen by the ICB Financial Recovery & Sustainability Group.

Risks and Mitigations

- The Committee were informed that the mitigations include a significant amount of non-recurrent solutions within the budgets and if this is not sufficient, we would expect system partners to work to a solution. This is linked to the paper that went to Board which agreed the use of the £7.7m allocation that we received for depreciation.
- The table detailed the high level ICB risks and mitigations included within the plan, showing a balanced position.
- Continual scrutiny and updated progress will be made on risks and mitigations via the Financial Recovery and Sustainability Group.

Mental Health Investment Standard (MHIS)

- The Committee were informed that as part of the planning submission we have to have proved that we have achieved the MHIS and have invested 4.37% more than last years mental health investment.
    - The Investment Standard target in the plan is to increase 23/24 baseline spend by 4.37% to £168.7m.
    - The plan meets the standard with spend of £168.7m as shown in the table to the left.
    - Delivery of the standard is closely monitored through the year with particular focus on ensuring any investment slippage is repurposed for mental health services in year.
    - The table showed other baseline spend which does not count towards the standard.
    - In addition, Service Development Funding is over and above this with a further £16.1m for Mental Health and £2.4m for LD & Autism as shown in the allocations slide.

Detailed ICB Budgets

- The Committee were informed that the remaining slides detailed the summary budgets by Director.
    - These budgets are net of CIP which was approved by the FRSG
    - As default all budgets previously held by Director of Performance Improvement have been transferred to Director of Finance. These and all other budgets will be subject to further review during the year and transferred to the most appropriate Director.
    - Specialised Commissioning budgets have been formally delegated to the ICB from 1 April 2024. These budgets were not included in the ICB planning submissions as these were separately submitted by NHSE. The budget of £184.76m includes a reserve of £2 but excludes a proposed national holdback of £5.7m. This constitutes an added risk to financial plans, as specialised commissioning slippage of at least £2m had been assumed. These figures are still draft and subject to national negotiation. The budget will be held by the Director of Finance.
- The formal delegations to budgets by Director and by Committee have all been through Executive Committee and will be going to Board on 28 May 2024 for their formal delegation.

The Committee were informed that the final plan and associated budgets will be submitted for formal approval at the Board on 28 May 2024.

Those present supported:

- The balanced System Financial plan
- The surplus ICB Financial plan and associated budgets by Director and Committee.
- The unmitigated risk in the system plan.

It was agreed that those present would meet monthly or bi-monthly following the formal Finance Committee meeting to enable more of a focus on ICB Budgets and delivery of CIP rather than system finances which take precedent at those meetings.

DATE OF NEXT MEETING

11 June 2024

Meeting of the SNEE ICB Finance Committee Part 1a and Part 1b held on 20 June 2024 at 1030 at Endeavour House, Ipswich and via MS Teams

PRESENT:

Antoinette Jackson (Chair)	Provider non-executive
Howard Martin	ICB Director of Finance
Adrian Marr	ESNEFT Representative
Kevin Smith	EEAST Representative
Janet Wood	ICB Non-Executive Member, Audit
Freda Bhatti	GP Representative
Trevor Smith	EPUT Representative
Nick Macdonald	WSFT Representative

IN ATTENDANCE:

Amanda Lyes	ICB
Jeremy Over	WSFT
Andrew McMenemy	EPUT Executive Chief People Officer
Deborah O'Hara	ESNEFT
Elaine Noske	ICB Non-Executive Member, HR
Kathy Wilton	ICB Executive Assistant (Minutes)

Item 1 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The ICB Director of Finance welcomed everyone to the meeting. In the Chair's absence it was necessary to approve a temporary Chair. Antoinette Jackson was nominated and **approved** as Chair for this meeting.

Apologies for absence were received from:
Kris Murali, ICB Non-Executive
Paul Gibara ICB Director of Performance Improvement
Mark Miller, Provider Non-Executive
Craig Black, WSFT Representative
Louise Aynsley, Suffolk County Council
Marika Stevenson, EASTamb
Laura Taylor Green, ICB
Jason Hollidge NSFT Representative
Kate Read, ESNEFT Director of People & Organisational Development

24/041 DECLARATIONS OF INTEREST

There were no declarations of interest.

24/042 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 14 May 2024 **were approved** as a correct record

24/043 MATTERS ARISING AND REVIEW OF ACTION LOG

The Action Log was reviewed and updated.

24/044 MONTH 2 FINANCIAL POSITION

The Committee were in receipt of the latest Financial Plan and key points highlighted:

- The system submitted a balanced financial plan to NHS England on 2 May 2024.
- However, across England a significant level of deficit remained which triggered a review of every system by the NHS England Chief Executive and Chief Finance Officer.

- Following this, all organisations were notified on 30 May 2024 that they were required to submit revised set of plans (finance, workforce and performance/activity) by 12 June 2024 to reflect:
    - Delivery of revised financial control totals as determined by NHS England
    - An update to the financial framework designed to incentivise systems to deliver a break-even position (further detail included in appendices)
    - Contract signature status to trigger dispute resolution processes.
- The control total for SNEE remained unchanged at break even and there were no changes to individual organisation's surplus/deficit positions.
- The updated SNEE plans were submitted to NHS England by the 12 June deadline.
-

Comments included:
The plan is to pull together an options paper which will be shared with the finance community in the next week to receive views for what we will do for this year and next year.

It appears that NHSE have held back 20%

The challenges faced by ESNEFT around non-pay inflation funding were discussed and an example of the blood authority increasing its prices by 15% and property services by 6%.

The Committee was in receipt of the System Finances Dashboard month 2 key points highlighted included:
- The System summary position at month 2 detailed that the system is off plan by £1.6m which is of concern at this early stage of the year so further work will be required to understand the drivers and mitigating actions required to bring delivery back in line with the financial plan.

The ICB summary position narrative was provided in Slide 3.

Comments included:
Clarity was requested as to why some areas are already off track when it is only month 2, the response from ESNEFT stated that for clarity there is no additional money coming to ESNEFT from the ICB but there is to WSFT. It is the non-pay inflation that is causing the real challenge, plus they have been slower that wanted on CIP and escalation meetings are planned to address this. They have also made changes to divisional management which will have a positive effect. Have set spending limits in non-clinical areas and can confirm this is being taken seriously and recognise this is going to be a very tough year for everyone.

WSFT noted very similar challenges and they have a plan in place but there are lots of risk associated with it and they are working to put measures in place.

A request was made to see where ESNEFT is against the trajectory, and this was explained and the realisation that this year was always going to be difficult and recognise the need to move quickly.

EEAST stated that there are no major concerns to flag at the moment, the position is about 200k better each month although there are variances within the organisation. For example, private ambulances are always going to be a volatile market. It is looking likely that they will receive about £900k additional funding from NHSE nationally to put on some overtime incentives through June and into July in order to improve the C2 position.
The Committee **noted** the report.

24/045 WSFT FRP UPDATE

The Committee was in receipt of the WSFT Financial Plan for ICB and insight and key points highlighted included:

- This paper is partly a response to the PA review and provides progress against the 30 activations that are in place to provide break even by 26/27.
- The three charts on page 2 detail the bridge analysis for each of the three years moving from the current financial plan for 24/25 to a break-even position at the end of 26/27, including delivery of a CIP of 4% each year.

The Committee welcomed that more details are provided in this report but requested that time was included and more detail on key areas as this would assist this committee but also the turnaround director when they start.

Comments included:

A request to understand more detail on changes to the culture and what additional capacity is being introduced to influence that change. It was advised that the Director of Strategy Transformation starts on Monday, and this will be a key focus, however the Trust were reminded that there needs to be a plan and it needs to be delivered quickly.

It was noted that in the report were a couple of investment items included such as Abbeycroft but there is no record that this went through the double lock process last year. WSFT clarified that this was an existing contract commitment and not a new investment. A request was made that when Chris Armitt is undertaking his review that the double lock arrangements are included.

It was noted that there is obviously concern around year one position and delivery, and that this year has to be around what is different.

The Committee **noted** the report, **agreed** for the ICB to carry out a check and challenge of the report for the July committee, and **recommended** that this is still recorded as a high risk and **requested** that traction on delivery is escalated within the Trust.
The Committee **requested** an update at the next Finance Committee in July.

24/046 EEAST DIAGNOSTIC

The Committee were in receipt of a letter that detailed the specification of a Financial Diagnostic for East of England Ambulance Service NHS Trust by PA Consulting, this is similar in nature to a previous review for WSFT.

This has been brought for noting and it has been approved by both Executive Committees and currently awaiting NHSE financial approval to spend the £50k, but we have received indication this will be granted.
Comments included:

A question as to whether other consultants were considered, and the response advised that it had not been necessary as it is only recently that we had used PA Consulting and were very happy with the work and when that work was commissioned it had been benchmarked through a competitive tender process.

The Committee **noted** the report and looked forward to receiving updates on progress and the final report in September.

24/047 ESEOC

The Committee are in receipt of an update on the opening of the Essex and Suffolk Orthopaedic Centre (ESEOC) highlighting:

- The Essex and Suffolk Elective Orthopaedic Centre (ESEOC) was originally due to open in August 2024. Various construction issues, most notably linked to power supply and the connection of the new centre to the main Colchester hospital electricity network, means that the opening will now be delayed. The latest planning envisages the facility becoming operational in October 2024.
- As part of its financial planning for 24/25, the Trust had assumed that the facility would essentially achieve revenue 'breakeven' with income and expenditure for the scheme matching.
- The later opening date now puts pressure on this assumption of revenue neutrality. There is the loss of an estimated two month's activity and associated income that had previously been assumed, whereas some of the costs for the centre are fixed or semi-fixed in nature and cannot be avoided. This means that the Trust is now modelling a deficit for the ESEOC in 24/25.
- Work is ongoing to mitigate the deficit as much as is reasonably possible. This includes a review of the recruitment plans, and where possible, delaying or repurposing staffing appointments.
- The Trust recognises that it needs to manage and deal with the financial consequences of the delay and is not seeking any support from the wider system in relation to this.

Comments included:

Reassurance was requested that there will not be any further delays and assurance was provided that it will be in October, but the exact date has to be determined.

The Trust also confirmed it had sufficient reserves to cover further delays, but it was confident that the October date would be delivered.

A discussion took place between ESNEFT and WSFT around the proposed partnership working between the two trusts. ~~,~~ WSFT expressed concern that the funding mechanism caused a financial disadvantage for WSFT and that as a system the business case should make sense for all parties. ESNEFT saw this as an WSFT to resolve. It ~~and it~~ was agreed to take the conversation offline and find a way to resolve the difference and bring back to the July meeting.

The Committee **noted** the update.

24/048 WORKFORCE AND PRODUCTIVITY SESSION

The Committee were joined by Amanda Lyes, Jeremy Over, Andrew McMenemy and Deborah O'Hara for a discussion on how they will monitor workforce and finance during 2024/25. A number of questions were proposed:

a) How will we monitor workforce productivity during 2024/25?
b) What collaboration opportunities do we want to progress?
c) Reflections on the meeting, how do we want to take this agenda forward?

The aim of the discussion was to bring together the HR and Finance community based on the planning submission recently submitted to region and to decide how they will monitor the submission throughout the year.

The committee were in receipt of the SNEE ICB Assurance dashboard 24/25 outlining the NHS Operating Plan 2024/25 and the key objectives and targets that healthcare systems across the country are expected to meet.

The SNEE Workforce Assurance Dashboard provides the SNEE System Workforce Summary showing staff in post, bank and agency FTE against the operation plan. The workforce highlights show a summary by trust and the detailed analysis allows the user to drill down into each trust to explain any variances in workforce performance.

Comments included:
It is important to understand the trajectory and trend analysis of the data together with quality and safety needs. Need to understand productivity and trends, it is not just about numbers.

The system needs to be easily accessed by everyone and a suggestion that people from each of the different organisations are involved to develop the system.

Important to analyse local data sources to understand workforce productivity by speciality between WSFT and ESNEFT, this would be more valuable than relying on national data.

A question asked if the FTE numbers align with financial tracking, it was confirmed that the number are recognisable but there are different data sets.

Productivity improvements were discussed, and it was recommended that they find a universal position across all providers. Should consider learning from other systems and also exploring community provision and it was acknowledged that productivity is affected by every single provider in the system including primary care.

A timeline for the next few months was agreed in order to manage expectations and frequency of meeting and invitees was discussed.

Following the discussion the Committee **supported** the intent that there is an improved alignment of finances, workforce, and activity and to build on the working model that was presented at the meeting that will also include productivity and efficiencies and would meet quarterly.

It was **agreed** that the workforce dashboard will be updated with the feedback from this meeting and to ensure it includes trend analysis and productivity measures, this will be circulated, and feedback brought to this committee in August.

The Committee **agreed** an action to establish a working group to develop this working model and the group were asked to provide nominations from their organisations to this working group. Graham Seward and Giles Turner will establish the first meeting in July (date TBC) with a draft model to be presented at the September Finance Committee.

24/040 ISSUES TO BE HIGHLIGHTED TO THE ICB BOARD

The Chair advised of the following issues for highlight to the ICB Board:

- The System summary position at month 2 detailed that the system is off plan by £1.6m which is of concern at this early stage of the year so further work will be required to understand the drivers and mitigating actions required to bring delivery back in line with the financial plan.
- The Committee noted the updated WSFT FRP and recommended that this is still recorded as a high risk and requested that traction is escalated as 3 months have already passed and they really need to see delivery on this now.

- An updated on ESEOC was provided and noted that there will not be any further delays but the exact date of opening in October has to be determined. It was noted there was a disconnect in conversations between WSFT and ESNEFT and this needs to be resolved and an update will be provided at the 18 July meeting.
- A very productive discussion on Workforce productivity and how data will be monitored through 2024/25 took place and updates will be brought back to future meetings.

DATE OF NEXT MEETING

The next scheduled meeting was 18 July 2024

Venue Endeavour House, Ground Floor, Millicent Fawcett Room with MS team's option

SNEE DDaT Strategy & Assurance Team

SNEE ICS DDaT Monthly Bulletin

May 2024

Updated 21st May 2024

sneeics.org.uk

SNEE ICS DDaT Strategy 2024 - 2026

DDaT Vision & Mission

Our ICS DDaT Vision:
Equitably and effectively co-ordinate the design and delivery of digital, data and technology through collaborative working that puts the person at the centre to support and improve all user experiences.

Our ICS DDaT Mission:
Deliver fundamental digital change in the delivery of health and care services that creates the right environment to improve health and care outcomes for all our people.

Agreed priorities and focus areas

- **Cyber** – Develop and embed an ICS systemwide strategy across the whole of the ICS which includes the use of a centralised dashboard and develop a system-wide list of contacts with an agreed 'system-response' procedure owned by all
- **Workforce** – Have a pool of staff who can work seamlessly across organisations to share knowledge and have standardised pay grades with clearer career paths. Create an inventory of skills and training resources that can be utilised by all
- **EPaCCS** – Have one EPaCCS system across the whole of SNEE so any care provider can contribute to it and it can be updated at the point of care; initially through the development of a short term solution but in tandem with the development of a long-term solution.
- **Enabling Unified Digital Care**
  - **Virtual Wards** – Develop a single *approach and methodology* on how virtual wards will be provided in SNEE which will offer a single patient-facing solution and be able to integrate to have one virtual ward across the EoE
  - **PEPs** – All PEPs to be integrated with the NHS App for a core data set and level up functionality across the ICS so residents have a seamless and consistent experience.
- **DiSC** - All Care providers to have a digital social care record and connection to the Social Care Integration Platform to be interoperable with the ShCR
- **EPR** - Get behind ESNEFT's EPR programme so it delivers what is set out in business case and the strategies and priorities of other partners are aligned to it.
- **ShCR** - Continue with Cerner HIE as the ShCR and ensure all partners commit to it with access through the NCRS (National Locator Records Service) and develop a long-term strategy for the ICS as well as linking across ICSs in the region.

Governance

The SNEE ICS DDaT governance is shown on the following two slides.

Terms of Reference and membership for the DDF, SDDC and SDIAC forums are currently under review and a questionnaire has been issued to solicit opinion and feedback

Our ICS DDaT operating framework

Partners

–DDaT Strategy & Assurance Team
–ICB Digital Primary Care Team
–ICB Data Team
–EEAST
–Acute Trusts
–Mental Health Trusts
–Local Authorities
–Allied Health Professionals
–ICB Alliances

Key Principles

- Collaborate, align and co-ordinate by default
- Work to common standards and governance *(where appropriate)*
- Align our knowledge and resources
- Align our approachess and work in partnership
- Make data available and accessible
- Embed digital and data literacy skills

Inputs & Dependencies

1. Funding
2. National direction and policy
3. Communications and engagement across partners – especially public facing.
4. Senior leadership and acknowledgment (Board Level)
5. Shared learning & knowledge for the wider communities and partners

Out of Scope – to be managed at an organisational level

-Digital inclusion
-Provider collaboratives
-Falls and sensor tech
-Community levelling up
-Other things that sit automatically with other digital teams in the ICB. (e.g. SDE, FDP, Primary Care, PHM and Data.

Further development – currently 'parked'

- Integrated neighbourhood teams
- Develop our ICS position and approach to how we will develop and deploy AI and Automation
- Appropriate system architecture and standards
- Minimum digital maturity standards
- Common digital policies across clinical health and care pathways
- Vision of our ICS-wide platform.

Review date: 30/09/24

Key SNEE Programmes - Latest News

Jo Lennox, Digital Programme Director

Shared Care Record
Stewart Taylor

SNEE ShCR is now consuming data from OneLondon.

ShCR Clinical Reference Group has kicked off.

Electronic Patient Record
ESNEFT Update

ESNEFT have awarded Epic as their EPR
The choice of supplier and the full business case (FBC) was approved by the Trust Board on 2 November 2023.
The contract was signed with Epic on 7th March 2024.
Epic Training from March until June 2024.
Orientation Event with Epic – 19th June

Cyber Security
John Lamont

SNEE ICS Cyber Security Strategy & Plan in draft. Key stakeholder interviews progressing
SNEE ICB CE+ Assessment nearing completion.
VMMA (Vulnerability Management Maturity Assessment - ESNEFT & WSFT)
Cyber Security Instant Response Exercise - 2nd October 2024

WSFT Future Systems (Digital Workstream)
Sarah Judge

Digital design briefs with technical teams
Benefits planning
NHP's 'intelligent hospital capabilities' review
Trust-wide digital capabilities review complete
Smart buildings strategies

Digitising Social Care
Julie Irving

Year 3 Plan agreed
Only ICS Regionally to support two different care technology scaling up projects
Digital Social Care Record applications exceeding plan

Enabling Unified Digital Care
Glenn Tooke

Market engagement activities in progress to access options for future virtual ward digital solution.

Exploring options to provide a system wide digital EPaCCs.

Workforce
Jo Lennox

In the process of establishing the DDaT Workforce Collaboration group that will report into the People Committee. Risks and challenges in this area are funding, maintaining workforce alignment, the impact of digital transformation on our workforce skills and the avoidance of duplication.

Any Other News

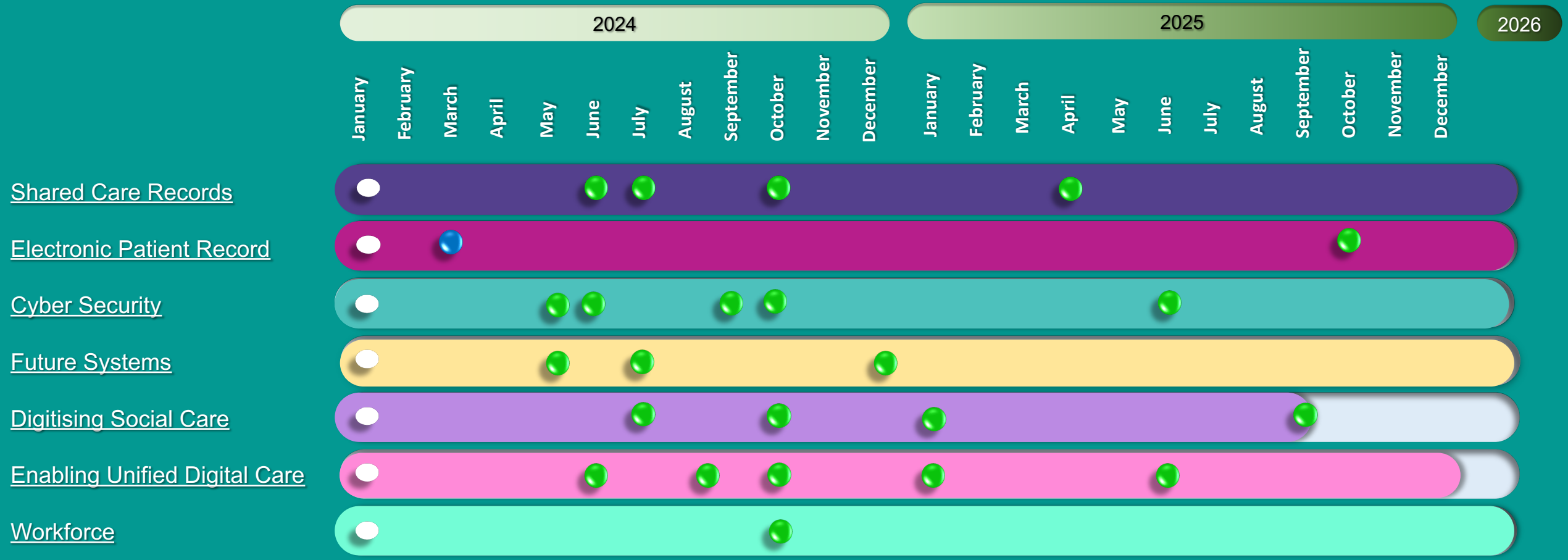
SNEE ICS Digital Maturity Assessment Submitted.
DMA Peer Review – June 24

Regional focus is starting to emerge on how ICSs can interconnect their independent Shared Care Records.

Programme Timelines

= Key milestones

CAN DO HEALTH & CARE

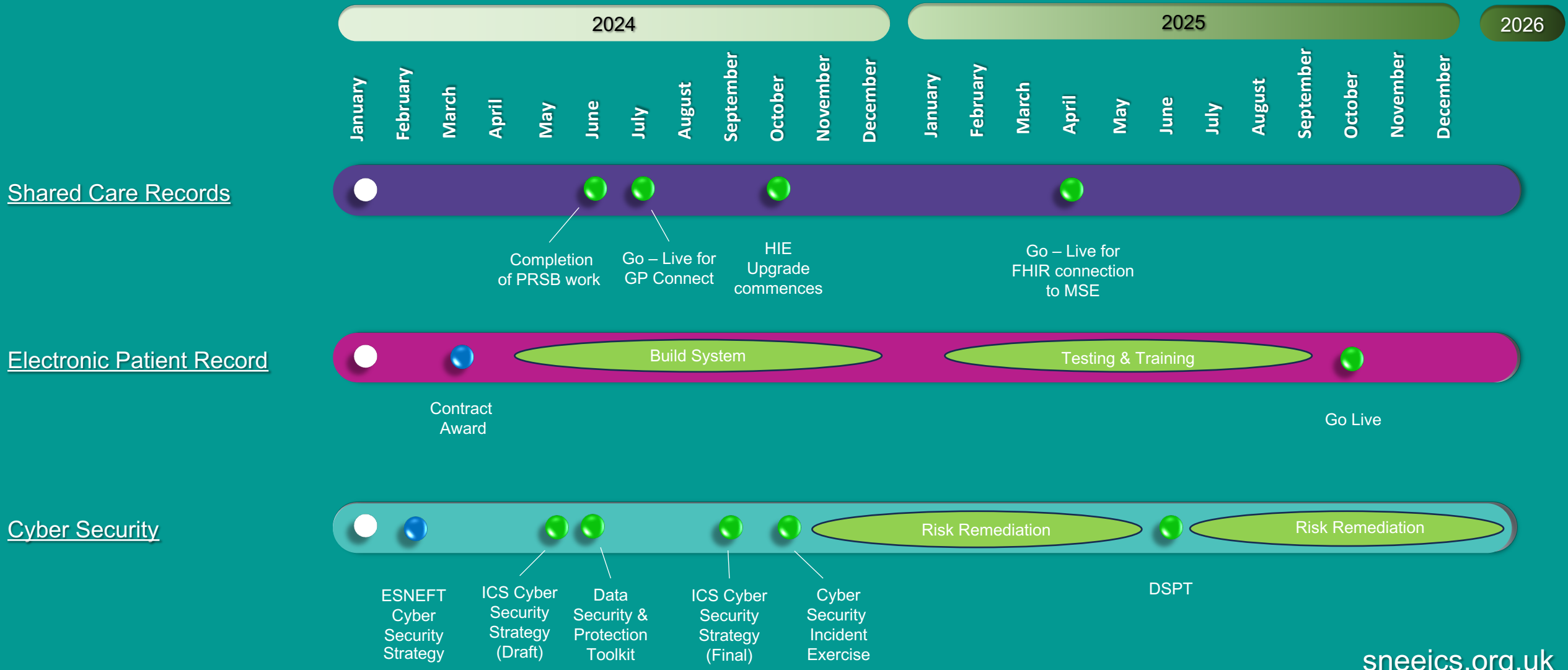


Please see next slides for details of milestones

Programme Timelines

= Key milestones

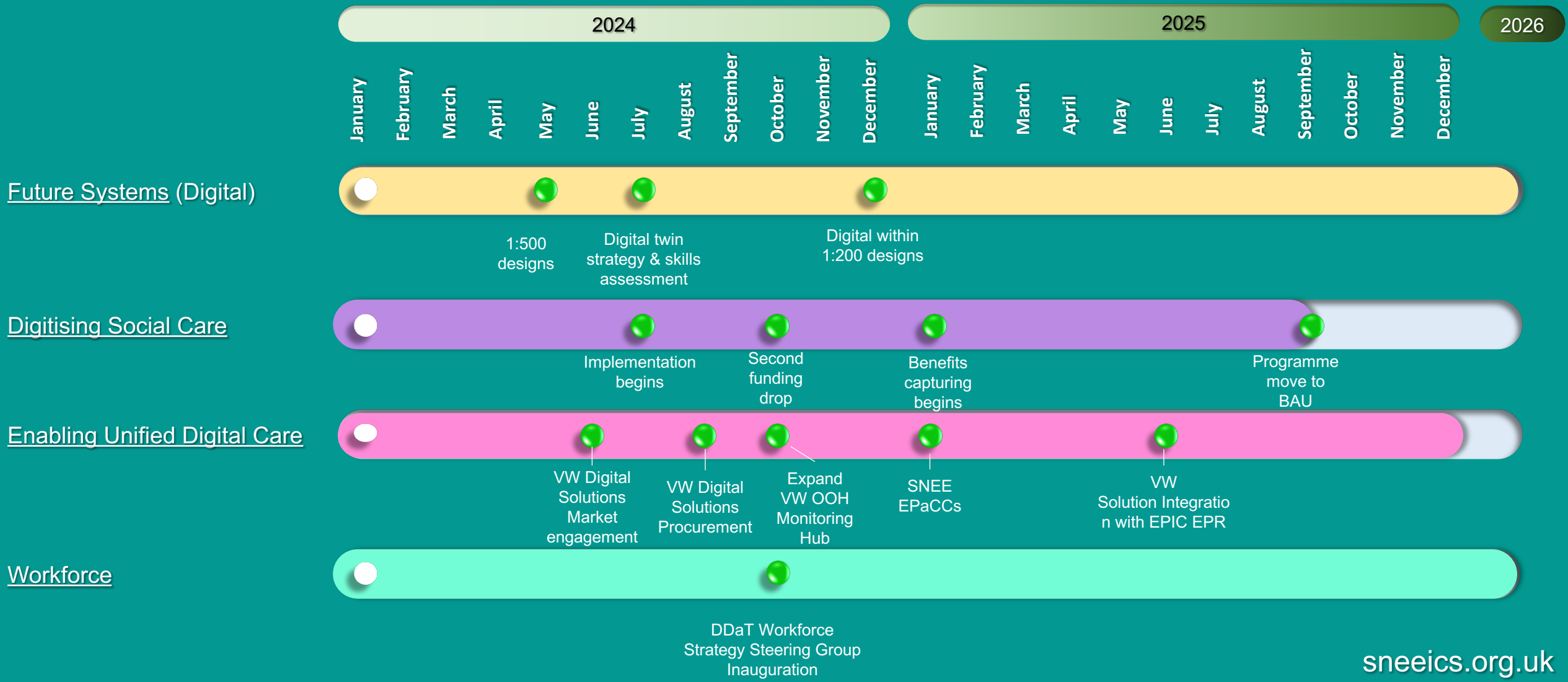
CAN DO HEALTH & CARE



Programme Timelines

= Key milestones

CAN DO HEALTH & CARE



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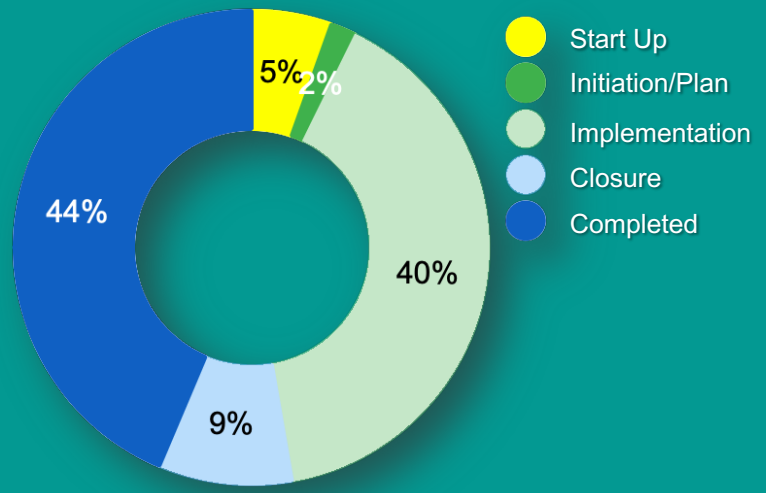
DDaT Programme Dashboard

Total Active Projects
33

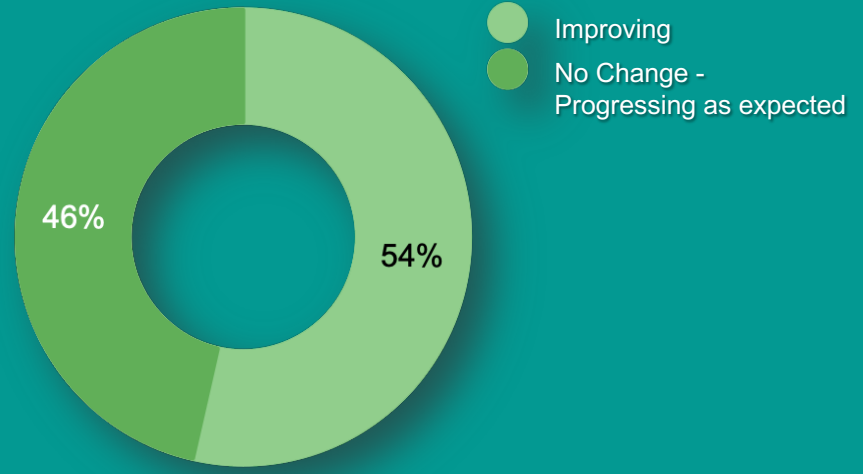
Totals - RAG Status (active)	Total - Project Stage	Totals - Project Status (active)
33 - GREEN	4 - Start Up / Initiation	17 - Improving
0 - AMBER	22 - Implementation / Planning	16 - No Change - Progressing as expected
0 - RED	5 - Closure	0 - Deteriorating
	---	
	24 - Completed	

Overall RAG Status % (Active)

All Project Project Stages %



All Active (PM Led) Project Status %



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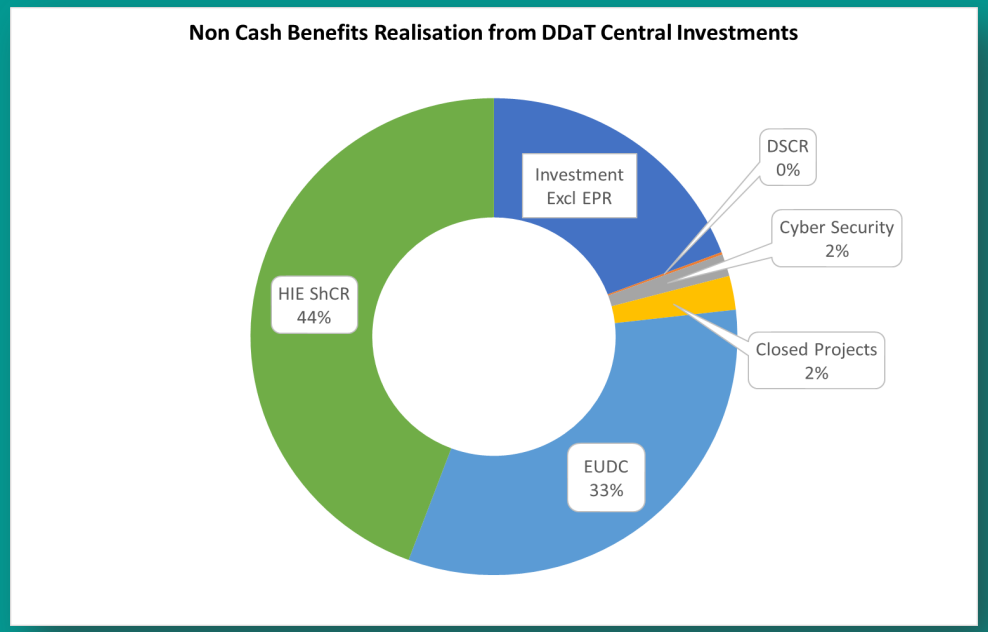
Benefits Realisation Summary



Graph Data Source

Programme	Non Cash Benefits £m	DDaT Investment £m Excluding EPR	Net Benefit £m / RoI %
Shared Care Records	£177		
Enabling Unified Digital Care (ie. Virtual Care)	£130		
Cyber Security	£9		
Digitising Social Care	£1		
Closed Projects	£15		
Central Funding		-£77	
Total	**£332**	**-£77**	**£255 / 331%**

Non-Cash Benefits contributed towards:

Increasing efficiency
e.g. Shared Care Records reduces the time taken to view patient records for non-planned contact

Increasing productivity
e.g. Virtual Care releases time to care for more patients and Digital Care saves workforce time

Robust prevention
e.g. Cyber Security enables cost avoidance – reduced risk of cyber attacks due to preventative measures

NEE Alliance Committee
Thursday 23rd May 2024
Meeting held via Microsoft Teams

MINUTES

PRESENT

Mark Cory	**MC**	**NEE Alliance Chair, Colchester City Council**
Freda Bhatti	FB	NEE Deputy Alliance Chair, Great Bentley Surgery
Gina Placey	GP	Portfolio Holder for Partnerships, Tendring District Council
Laura Taylor-Green	LT-G	Executive Director for Place - North East Essex Alliance & Executive Director for Health Inequalities, SNEE ICB
Rory Doyle	RD	Associate Director - Integrated Strategic Partnerships North East Essex Health & Wellbeing Alliance, Colchester City Council
Joanne Sunderland	JS	Chief Executive Officer, GP Primary Choice
Praveen Tatavarthi	PT	St James Surgery
Udupi Alam	UA	East Lynne Medical Centre
Lynn Stimson	LS	Associate Director of Integration and Operations for NEE Alliance, SNEE ICB
Alison Armstrong	AA	Director of Health and Care Partnerships for NEE Alliance, SNEE ICB
Emma Strivens	ES	EPUT
Elizabeth Kingsford	EK	Head of Services North Essex, HCRC Care Group
Sharon Alexander	SA	Chief Officer, CVST
Anastasia Simpson	AS	Tendring District Council
Joanne Sunderland	JS	Chief Executive, GPPC
Sharon Alexander	SA	Tendring District Council
Mark Jarman-Howe	MJ-H	Chief Executive, St Helena
Ben Hughes	BH	Head of Wellbeing and Public Health, Essex County Council
Shume Begum (In place of Alison Stace)	SB	Deputy Director of Operations & Associate Director of Operations Medicine, ESNEFT
Temi Ogunjimi	TO	Essex County Council
Will Herbert	WH	Essex County Council
Peter Devlin	PD	Director of Adult Social Care, North Essex & Mental Health, Essex County Council
Tamsyn Nunn (Minutes)	TN	Business Manager, SNEE ICB

Presented via MS Teams

Maisey Dear	MD	Clinical Quality Lead, SNEE ICB
Maddie Baker-Woods	MB-W	Chief Operating Officer, Ipswich and East Suffolk CCG, SNEE ICB

		Action
1.	**Introduction & Apologies** MC welcomed all to the meeting. **Apologies were received from**: Nicky O'Shaughnessy, Ian Adams, Charlotte Mackenzie, Janine Dawson, Alison Stace, Shane Gordon, Angela Tillett, Ameeta Bhagwat, Leighton Hammett, Simon Morgan, Jason Baker, Andy Yacoub. The meeting was confirmed quorate.	
1.1	**Declarations of interest** No declarations of interest were declared. **Action log** It was agreed that there were no open actions on the action log.	
2.	**Committee Check-in** We are reviewing the structure of these meetings; this is an opportunity to get some feedback from the committee. We have delegated a lot more work to ensure that conversations are happening within the group meetings, this gives us the opportunity for groups to choose the work that they are doing. We are looking at how we engage with the Tendring Health and Wellbeing Board and the Strategic ONE Colchester Board. Memberships to formal meetings are constantly being reviewed to ensure we have the right representatives, but it is an evolving piece due to the complexity and nature of work. We are reviewing where reports/projects have been in terms of meetings to ensure they follow the appropriate governance pathway, and we have TN who has recently taken over from Lillie Stone to take minutes. Committee are in favour of the changes, no feedback to note.	
3.	**Alliance Operational Group (AOG) Highlight Report** There is a lot of work being done in terms of targets, we are trying to switch our focus to mental health but there is nothing specific to highlight.	
4.	**Place Highlight Report** We had an exciting workshop which took place in Jaywick; there was a really good level of engagement and attendance, we have another one planned in a couple of weeks which is starting to gather pace. We need to look at how we involve the PCN's and the training hub going forward. The workshop is about who wants to attend or shares an interest in attending rather than encouraging everyone to attend.	
5.	**Better Care Fund (BCF) Highlight Report** Looking at end of year reports we are on track for falls and unplanned admissions. Despite being off track in other areas, we are still one of the best performing ICB's regarding residential care admissions. Although overall are reporting as off track for the year, we should see this improve. A lot should remain the same in terms of 24/25 plans but with a few additions. The Dementia service has been a successful scheme. No paper was provided to support the update, however, WH will provide a summary paper for future meetings.	

6.	**Primary Medical Care Strategy** Primary Care is under a lot of pressure on a day-to-day basis, we have created a Primary Care Strategy to provide support over the next 5 years. A lot of Primary Care colleagues feel quite isolated and feel like issues raised are not being addressed or heard. We have agreed that any matters raised to the ICB will be addressed. The strategy started as an engagement exercise with GP's and those working in Primary Care. Over 1000 people contributed to the strategy which was then extended to wider teams on a national basis. We have taken a community-based approach to ensure we capture everybody and are looking at how we can work better together. We have also been looking at clinical safety and how we can improve the environment we work in. We have also looked at ways of working better together across SNEE and providing relevant training where needed. In addition, we are utilising our partnerships and local authorities to see how we can make improvements on a wider basis. There are some practices involved in the project and we have taken on board their feedback and implemented adjustments accordingly. It is very important that we get approval from the committee. We have looked at demand and capacity and intend to further our assessments for each area so that we can understand the work required as things evolve. We will ensure that we then continue to evolve in line with demand. We are almost ready to launch the strategy and are making the most of every opportunity. The strategy does have capacity to flex should there be changes in government, i.e. Labour being elected. Positive feedback was received from the committee to compliment the strategy and the work that has been done. The committee agreed that the strategy is easy to understand. Primary Medical Care Strategy was **APPROVED** by the committee.	
7.	**AOB** Our next Alliance Committee meeting will be F2F and will include our leadership workshop. Hopefully everyone can attend; we will confirm timings and location in due course. Local authorities are now subject to CQC assurance so Essex County Council will be involved, therefore some of you may be contacted in the next 6 months. The 'pre-election period' commences on 30th May.	
	Date of Next Meeting 20th June 2024	

NHS
Suffolk and
North East Essex
Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board Meeting

Agenda Item number: 20
Date: 28 May 2024
Title: Attendance at Board meetings from April 2024 – March 2025

Members of the Board:

Role	Name	30 April 2024 – Part 2 only	28 May 2024 – Part 2 only	24 June 2024 – part 2 special meeting
Chair	Will Pope	Present	Present	Present
ICB Chief Executive	Ed Garratt	Present	Present	Substitute (Richard Watson)
Partner Member – ESNEFT	Nick Hulme	Substitute (Shane Gordon)	Present	Present
Partner Member – NSFT	Caroline Donovan	Sent apologies	Sent apologies	Sent apologies
Partner Member - WSFT	Ewen Cameron	Present	Present	Present
Partner Member- Primary Care Essex	Freda Bhatti	Present	Present	Present
Partner Member – Primary Care Suffolk	David Cargill	Present	Present	Sent apologies
Local Authority Partner member – Essex County Council	Moira McGrath	Present	Present	Present
Local Authority Partner member – Suffolk County Council	Georgia Chimbani	Present	Substitute (Paul Little)	Sent apologies
Non-Executive Member – Audit	Janet Wood	Present	Present	Present
Non-Executive Member – Finance	Kris Murali	Sent apologies	Present	Present
Non-Executive Member – People and Communities	Phanuel Mutumburi	Present	Present	Present

Non-Executive Member – Quality	Elaine Noske	Present	Present	Present
ICB Executive Director of Finance	Howard Martin	Present	Present	Present
ICB Medical Director	Andrew Kelso	Present	Present	Sent apologies
ICB Executive Director of Nursing	Lisa Nobes	Present	Present	Present
Member for the VCSE Sector	Kirsten Alderson	Present	Present	Present

Regular Participants of the Board:

Role	**Name**	**30 April 2024 – Part 2 only**	**28 May 2024 – Part 2 only**	**24 June 2024 – part 2 special meeting**
Executive Director: North East Essex Alliance	Laura Taylor-Green	Sent apologies	Apologies	Apologies
Executive Director: Ipswich and East Suffolk Alliance	Maddie Baker-Woods	Present	Present	Present
Executive Director: West Suffolk Alliance	Peter Wightman	Present	Present	Present
Executive Director of People and Workforce	Amanda Lyes	Present	Present	Present
Executive Director of Strategy and Transformation	Richard Watson	Present	Present	Present (deputising for CEO)
Executive Director of Performance and Improvement	Paul Gibara	Sent apologies	Present	Present
Integrated Care Partnership Co-Chairs	Will Pope/ Cllr Spence/ Cllr Rivett	Present	Present	Present
Integrated Care Partnership Director	Susannah Howard	Present	Present	Present