NHS
Norfolk and Suffolk
Integrated Care Board

A meeting of the NHS Norfolk and Suffolk Integrated Care Board

Wednesday 20 May 2026 12.30pm

Main Hall, Hellesdon Hospital, Drayton High Road, Norwich, NR6 5BE

Chair: Will Pope

Item	Time	Agenda Item	Purpose	Lead
1.	12.30pm	**Welcome, introductions and apologies**	N/A	Chair
2.	12.35pm	**Notification of Questions from the Public**	N/A	Chair
3.	12.37pm	**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests.	N/A	Chair
4.	12.40pm	**Minutes from previous meeting and matters arising** This section is to approve as a correct record the minutes of the previous NHS Norfolk and Waveney ICB and NHS Suffolk and North East Essex ICB Board meeting in common of 26 March 2026 .	Approval	Chair
5.	12.45pm	**Action Log**	Information	Chair
6.	12.50pm	**Chief Executive Report**	Information	Ed Garratt
7.	1.00pm	**Making the shift to Neighbourhood Working across Norfolk and Waveney**	Information	Mark Burgis
8.	1.30pm	**Norfolk and Suffolk response to 1 April 2026 letter from Sir Jim Mackey.**	Information	Richard Watson
9.	1.40pm	**Suffolk Annual Public Health Report 2025: Youth Social Action**	Information	Stuart Keeble
10.	1.55pm	**Norfolk Annual Public Health Report 2025:**	Information	Lee Watson

11.	2.10pm	**Norfolk and Waveney ICB Research and Innovation team annual report 2025-26**	Information	Dr Clara Yates
12.	2.25pm	**Lampard Inquiry Update**	Information	Lisa Nobes
13.	2.30pm	**Out of Area Mental Health Inpatient Census**	Information	Lisa Nobes
14.	2.45pm	**Integrated Performance Report**	Information	Richard Watson
15.	2.55pm	**ICB Annual Budgets 26/27**	Approval	Howard Martin
16.	3.05pm	**Committee Highlight Reports**	Information	Committee Chairs
17.	3.10pm	**Amendments to the Constitution and Governance Handbook Report**	Approval	Amanda Lyes
18.	3.15pm	**Risk Management and Board Assurance Framework**	Approval	Amanda Lyes
19.	3.25pm	**Questions from the Public**	N/A	Chair
20.	3.30pm	**Any Other Business**	N/A	Chair

Date, time and venue of future Public Board Meetings:

- Wednesday 15 July 2026 – 10.30am Thurston New Green Centre (Main Hall), IP31 3TG
- Wednesday 23 September 2026– 10.00am Great Yarmouth Borough Council, NR30 2QF
- Wednesday 25 November 2026 – 10.00 am Venue tbc Ipswich
- Wednesday 27 January 2027 – 10.00 am Diss Business Hub, Diss, IP22 4GT
- Wednesday 24 March 2027 – 10.00am King's Lynn Town Hall, Saturday Market Place, PE30 5DQ

A meeting of the Board of NHS Norfolk and Waveney ICB and the Board of NHS Suffolk and North East Essex ICB held in common in the Council Chamber, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH on Wednesday, 25 March 2026 at 1.30pm

Attendance

Present:
NHS Suffolk and North East Essex ICB (SNEE) Members of the Board
Prof. William Pope, Chair of the Integrated Care Board
Dr Faisil Sethi, Partner Member – Norfolk and Suffolk NHS Foundation Trust (*deputy member*)
Nicola Cottington, Partner Member – West Suffolk NHS Foundation Trust (*deputy member*)
Dr David Cargill, Partner Member – Primary Care Suffolk Representative
Dr Ed Garratt, ICB Chief Executive
Stuart Keeble, Partner Member – Suffolk County Council (*deputy member*)
Adrian Marr, Partner Member – East Suffolk and North Essex NHS Foundation Trust
Kris Murali, Non-Executive Member – Audit
Howard Martin, ICB Executive Finance and Contracts Director
Phanuel Mutumburi, Non-Executive Member – Patient and Community Engagement
Elaine Noske, Non-Executive Member – Quality and Safety & Chair of the West Suffolk Alliance
Dr Frankie Swords, ICB Executive Medical Director
Karen Watts, Deputy Director of Nursing (*deputy member*)
Janet Wood, Non-Executive Member – Finance

NHS Norfolk and Waveney ICB (NWICB) Members of the Board:
Cathy Armor, Non-Executive Member
Jonathan Barber, Partner Member – NHS Trusts and Foundation Trusts (Acute)
Ed Garratt, Chief Executive Officer, NHS Norfolk and Waveney ICB
David Holt, Non-Executive Member, NHS Norfolk and Waveney ICB
Stuart Keeble, Local Authority Partner Member
Howard Martin, Executive Director of Finance, NHS Norfolk and Waveney ICB
Dr Antonia Moussakou, Partner Member – Primary Medical Services (PMS)
Professor Will Pope, Chair, NHS Norfolk & Waveney ICB
Dr Faisil Sethi, Partner Member – NHS Trusts (Community & Mental Health)
Dr Frankie Swords, Executive Medical Director, NHS Norfolk and Waveney ICB
Cllr Fran Whymark, Chair of the Norfolk Health and Wellbeing Board
Hein van den Wildenberg, Non-Executive Member

Regular Attendees
Maddie Baker-Woods, Executive Director of Primary Care and Neighbourhood Health (Suffolk)
Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk and Waveney), NHS Norfolk & Waveney ICB
Susannah Howard, Integrated Care Partnership Director
Amanda Lyes, Executive Director of People, Governance and Corporate Services
Alex Stewart, Chief Executive, Healthwatch Norfolk
Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning

Also Present
Helen Bowles, SNEEICB Integrated Work and Health Lead
Heidi Davey, NWICB Head of Corporate Governance

Phillipa Gregory, NWICB Senior Programme Manager Health Inequalities & VCSE Partnering
Tom McColgan, SNEE ICB Governance and Risk Manager (*minutes*)
Dr Suzanne Meredith, Associate Director of Population Health Management
Simon Morgan, SNEE ICB Associate Director of Communications

1. Welcome and introductions - apologies for absence

1.1. The Chair noted that it was the final meeting of both the Suffolk and North East Essex ICB and Norfolk and Waveney ICB Boards. He thanked those members who were stepping down from the board particularly Hein van den Wildenberg and Cathy Armor NWICB Non-Executive Members and Kris Murali, SNEE ICB Non-Executive Member.

1.2. The Chair thanked Emma Ratzer, NWICB VCSE Representative for her work as part of the Board following Emma's retirement from the Board at the end of February.

1.3. Apologies had been received from Lisa Nobes, Executive Director of Nursing; Ewen Cameron, WSFT Chief Executive and SNEEICB Partner Member; Dr Freda Bhatti, SNEE ICB Essex Primary Care Representative; Moira McGrath, Essex County Council Partner Member; and Kirston Alderson, SNEE ICB VCSFE Representative; and Gareth Everton, Suffolk County Council SNEE Partner Member.

2. **Questions**

2.1. The Chair noted that five public questions had been received in advance of the meeting. He stated that he would take the question from the Save Benjamin Court Campaign under item two and would then take the four remaining questions under the relevant agenda item.

2(i) A question from the Save Benjamin Court Campaign

2.2. The Chair invited Martin Booth to put a question to the Board on behalf of the Save Benjamin Court Campaign.

2.3. Prior to reading out the question Martin relayed some patient experience to the Board which had been sent to the Save Benjamin Court Campaign Group that morning. The Patient had spent five weeks in hospital, across two different hospital sites, and following discharge in a frail state had received no hospital or community based rehabilitation apart from some support from the community dietitian. The Patient had received no support from a physiotherapist or occupational therapist, services which would have once been delivered locally and accessibly from Benjamin Court.

"The post-hospital reablement service at Benjamin Court was closed in July 2023 with no consultation, and the site remains in great condition, albeit empty and 'mothballed'. This unit served the whole of North Norfolk with bed-based care closer to home, freed up ward space in acute hospitals and offered a cost-effective local pathway for a successful return to home.

"There is mounting evidence of the huge cost, both financially and in human terms, of delayed discharges of patients from hospital.

"In one month alone (September 2025), some £2.3 million was spent on keeping patients in hospital who were ready to be discharged, at the three district general hospitals in the Norfolk and Waveney area. This, of course, has a knock-on effect on hospital

admissions; in just one week (ending February 15th 2026) 83 ambulance shifts were lost at Norfolk and Norwich Accident and Emergency, due to delays in transferring patients. In the twelve months from April 2025 to March 2026, delays at N&N resulted in an extraordinary 2328 lost ambulance shifts – by far the worst figures in the whole area covered by the East of England Ambulance service.

"The huge pressure on hospitals nationally, as well as regionally, has prompted the head of NHS Providers to call for the government's much-vaunted policy of neighbourhood health care to be 'turbo-charged' – a call we fully support. Yet Norfolk and Waveney Integrated Care Board – shortly to be merged with their sister organisation in Suffolk – has up to now refused to look at an obvious solution right in their patch – Benjamin Court!

"We understand from our local MP that government ministers are taking an interest in health services in North Norfolk – which has the oldest demographic in the country – and in particular the future of Benjamin Court.

"Accordingly we call on the ICB to follow the lead taken by University Hospitals of Leicester NHS Trust, who have opened a 25-bed post-hospital rehabilitation unit to ease pressure on beds. We would ask that in any review of neighbourhood health services in North Norfolk that you urgently look again at Benjamin Court, and reopen it as an NHS hub to ease the crisis in hospital discharges and provide a vital health facility for the people of North Norfolk. We would also ask that you fully engage in a meaningful way with the local community about the way forward; the Save Benjamin Court campaign stands ready to fully contribute to such discussions."

2.4. Mark Burgis, Executive Director of Neighbourhood and Primary Care for Norfolk thanked all those who had come to the meeting for attending. He stated that he was sorry to hear of the patient experience which had been relayed to the Board and asked if more details could be shared outside of the meeting to allow ICB officers to follow up.

"We are committed as an ICB to work with you and with partners across the system to improve health and wellbeing and care for people across North Norfolk and the whole of the ICB area. We've always been that way and we are absolutely committed to doing that in the future and I'd like to do that with you going forward as well.

"The Question made a point about the Government direction and the focus on communities and neighbourhood and we warmly welcome that. I personally think that is the right direction of travel. With that particular focus on prevent frailty and supporting those who are frail I think there is a lot more that we can do and that is what I would like us to do working with you in the future.

"We are also very supportive of the ambition to shift care out of the acute hospitals and into community to create a neighbourhood service. I think that is very exciting, and will present great opportunities for us all to provide better services and better outcomes. We don't want to do that alone, we want to do that with you.

"We are also very conscious that Benjamin Court has provided very good services in the past and we know its really valued by residents. I'd suggest that there are some excellent facilities right across Cromer and North Norfolk. Given the context of the NHS 10 Year Plan, since we last had detailed discussions on the subject I think the world has moved on a little. I would warmly welcome an opportunity to meet with you and spend some more time looking at some more options because I think there are new options.

"Once again thank you, we are listening as an ICB and do want to work with you."

2.5. Martin Booth responded that he was pleased to hear the response which he felt set a very different tone to previous ICB responses. The Save Benjamin Court Campaign Group would welcome the chance to be involved in discussions about Benjamin Court and a way forward in North Norfolk. He emphasised that the patient feedback provided prior to the question demonstrated this this was an urgent issue and the community could not afford to waste time.

3. Minutes from previous meeting and matters arising

3.1. The Board noted that the draft minutes contained an error in the wording around Mental Health liaison and mental health emergency department and the following wording has been inserted at paragraph 6.1, bullet point one: 'The Board noted that two hospital sites across Norfolk and Suffolk were being considered as part of ongoing system discussions regarding potential mental health emergency department provision, building on models implemented elsewhere. This was distinct from existing psychiatric liaison services within emergency departments. The model, including the exact configuration, co-location or proximity to acute sites, and implementation approach, remained under development and subject to funding and system agreement with the ICB and partners.'

3.2. Howard Martin, Executive Finance and Contracts Director noted that at 11.1 the minutes should read that Norfolk and Waveney was forecasting a breakeven plan of £41m of deficit support funding, not £40m as was stated.

3.3. The Board approved the minutes as amended.

4. Declarations of interest

4.1. No interests were declared.

5. Chair's Action Log

5.1. There were no actions to report.

6. Matters arising from the previous Integrated Care Board meetings and review of outstanding actions

6.1. Elaine Noske, Non-Executive Director confirmed that the Quality Committee would be overseeing the next steps of the Assertive and Intensive Outreach work as discussed at the last meeting of the Board.

6.2. Cllr Fran Whymark, Chair of the Norfolk Health and Wellbeing Board provided an update on the promotion of free flu vaccines by Norfolk County Council to social care staff and social providers. He stated that Norfolk Public Health had funded access to vaccinations to staff not eligible for NHS funded vaccinations. 288 staff had taken up this offer but the Council believed that this was number of significantly underreported as it relied on the cost being claimed back using the right cost code.

6.3. The Board noted the updates on the actions log.

7. Chief Executive's Report

7.1. Ed Garratt, Chief Executive provided a verbal update:

- Ed Garratt thanked Amanda Lyes, Executive Director of People, Governance, and Corporate Services and her staff who had led on the organisational change process and of the creation of Norfolk and Suffolk ICB on 1 April 2026. While it was a stressful process with a lot of staff still going through recruitment the ICB managed to achieve the key milestones and a viable organisation would be launched on 1 April.

- Ed Garratt thanked Susannah Howard, ICP Director who organised a learning and legacy event held in Colchester in early March. The event included participants from Norfolk, Suffolk, and Essex. The event was equal parts looking back and celebrating the work that had been done and looking forward to build on the new geographical footprints.

- The planning round had gone well with good plans that the Board could have confidence in. The plans had been developed with a strong sense of collaboration and alignment across system partners.

- NHS Provider productivity had improved across Norfolk and Suffolk with a 3.1% growth in productivity across providers. The East of England Ambulance Service NHS Trust had increased their productivity by 9%. In General Practice in Norfolk and Waveney 1.5m prescriptions had been issued using Repeat Process Automation.

- The Specialist Obesity Treatment Service won the virtualised care and personalised care awards at the HSJ Awards. The Service was a partnership between ESNEFT, Reset Health, and the ICB. Until recently there had been a two year wait for the service which was not delivered locally. There was now a local service with an eight day waiting time. It was hoped that the ICB would expand the service to cover all patients across Norfolk and Suffolk. At the same awards even the Norfolk County Council, Queen Elizabeth Hospital, Norfolk Community Health and Care Community Interest Company, and the ICB came runner up for their innovative work on the discharge pathway in West Norfolk, the discharge performance in Norfolk and Waveney was now regularly in the top three nationally.

- Dr Richard West and Dr Daniel James from Woolpit Surgery in Suffolk had been recognised by the Royal Collage of GPs for their work supporting mental health in the farming community where there was a particularly high suicide rate. This was an issue across Suffolk and equally in Norfolk.

- The Cardinal Medical Practice in Ipswich had purchased the former site of the Inkerman Pub to expand the provision of GP services in the town centre.

- The National Neighbourhoods Guidance had been published. The ICB had been quite well sighted on what the Guidance would contain and the plans the ICB had put in place aligned well with the Guidance. Developing Neighbourhood working would be a key area of focus and would feature on future Board agendas.

- Dr Frankie Swords reported that the pro-active lung cancer screening programme in Great Yarmouth and Waveney had now diagnosed 100 people with lung cancer. These individuals were asymptomatic but had been identified as being in a high risk group. 66% of those diagnosed had been diagnosed with cancer in its early stages when it was highly treatable the programme was a great example of prevention in action.

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

8. ICB Transition Paper

8.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report. She stated that the ICB had concluded a voluntary redundancy programme and the majority of staff who had applied for voluntary redundancy had now agreed their leaving dates with a few staff still waiting for their pension estimates before a final settlement could be agreed.

8.2. The ICB was nearing the completion of stage one of the reorganisation programme which was expected to conclude just before Easter which would result in around 60% of posts in the new ICB structure being filled. There had been around 160 appeals from staff relating to the ringfencing of posts all of which were responded to prior to the start of stage one. After Easter all those posts which remained vacant would be filled through stages two and three commencing after Easter.

8.3. The ICB was expecting to receive the formal abolish and establishment order in the next few days which would formally abolish the two existing ICBs and establish NHS Norfolk and Suffolk ICB. The Constitution for the new ICB had been drafted and approved by NHS England and the membership of the new Board had been confirmed.

8.4. The Board recognised the challenge that the transition process had presented and thanked all ICB staff for their work throughout the process.

8.5. The following matters were raised during the Board's consideration of the report:

- The Board noted feedback from staff and partners that the ICB needed to ensure that the restructure process did not disproportionately impact any particular staffing group. The Board welcomed the completion of a full impact assessment and sought further assurance that no issues had been raised through the assessments that the Board needed to act to address. The Board heard that the Remuneration Committee had been receiving regular updates on the impact of the reorganisation. The Staff Networks across both ICBs had been invaluable working with the ICB since the start of the process.

- The Board heard about the work of the Transition Committees which had scrutinised the transition programme in depth including reviewing the operational detail of the programme. The Board heard about the scrutiny of the transition programme undertaken by the Audit Committee.

8.6. The Board **NOTED** the report.

9. Winter Plan Review

9.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning and Mark Burgis, Executive Director of Neighbourhood and Primary Care presented the report. Both ICB's had Winter Plans approved in October 2025. Both ICBs held events to stress test the winter plans which provided learnings around refocusing co-ordination structures, improving pre-hospital data, and strengthen community care emergency response. The ICB was able to invest £0.75m to strengthen community care emergency response. It was a challenging winter particularly around infection prevention and control, ambulance handover times, and staffing challenges. There were 32 incident declarations across Norfolk & Waveney

and Suffolk & North East Essex which were set out in the report. A programme of lessons learnt meetings would be taking place across March and April and the outcome of these meetings would come back to the Board.

9.2. The following matters were raised during the Board's consideration of the report:

- The Board considered the use of pre-hospital data and sought to understand how this would improve the system's response to winter pressure. The Board heard how particularly primary care data could be used to assist the Board in predicting demand which would assist the creation of more robust plans. The ICB's ambition was to improve how its use of data to forecast demand and make better proactive decisions.

- The Board considered how Providers, the ICB, and Public Health could work together to support communities to manage infections in the community as infections spreading outside of hospitals inevitably made it more difficult to control infections within hospitals. The Board noted that the new ICB staffing structure had been amended to include a Head of Infection Control post and two Health Protection Nurses.

- The Board noted the work across the system that was necessary to respond to winter pressures in and out of hospital. The Board welcomed the improvement in system working and the successes around alternatives to conveyance to hospital which had been a target in both system plans.

- The Board suggested that there were opportunities to review the coordination of ambulance deployment and when patient diverts were in place to ensure that best use was made of the system level data available.

- The Board supported the ambition to make proactive decisions to improve the systems ability to respond to winter pressures and to build this into year round decisions as the infrastructure that has been developed around the unscheduled care coordination hub had done.

9.3. The Board **NOTED** the report.

10. Work Well

10.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services was joined by Phillipa Gregory, Senior Programme Manager Health Inequalities & VCSE Partnering and Helen Bowles, Integrated Work and Health Lead to present the paper which provided an overview of the Work Well Programme which was jointly funded by the Department of Work and Pensions and the Department for Health and Social Care.

10.2. The following matters were raised during the Board's consideration of the report:

- The Board welcomed the Work Well Programme and reflected on how the ICB would know if the service had been successful and what outcomes it was expected to deliver. The Board noted that the Department for Work and Pensions had set a number of key performance indicators for the Work Well programme which included the number of people supported by the service and the employment outcomes for those people. There was also a patient satisfaction survey. There would also be a

national evaluation of the programme. The ICB Research Team was also helping to develop a local evaluation model.

- The Board heard that local business, via the Chamber of Commerce, had stated that they struggled with understanding around the implementation of reasonable adjustments. The Board was keen that the ICB explore whether it could help improve knowledge around this area to support the Work Well Programme. The Board recognised the need to provide support and assistance to employers to enable them to take on staff who may need additional support and noted other programmes such as Connect to Work which could provide longer term support to the participant and the employer.

- The Board recognised that local NHS Providers were anchor institutions and large local employers and welcomed the proposal that Work Well Programme linked with the health and social care providers.

- The Board heard that the ICB was seeking to appoint a local provider as its 'lead' provider for the Work Well Programme. This would mean that the provider will start with a good understanding of the local system. The national pilot had shown that most of the participants did not need complex health interventions and most referrals came from GPs who were issuing fit notes which allowed for early intervention to prevent people from falling out of work in the first place.

10.3. The Board **ENDORSED** the report.

11. Strategy & Population Health Improvement Plan

11.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning introduced the reports which had been support by both the Suffolk and Norfolk Health and Wellbeing Boards. NHS England had also reviewed the Strategy. He spoke to the needs of the population of Norfolk and Suffolk, the ICB's priorities, the changing role of the ICB as a strategic commissioner, and how the ICB would assess the impact of the services it commissions.

11.2. The following matters were raised during the Board's consideration of the report:

- The Board welcomed the Strategy and PHIP particularly the focus on health outcomes and communication plan.

- The Board stated that it would welcome a development session or sessions to build the Board's skill around health economics to support the ambitions in the Strategy. The Board noted that there would be a national programme of development sessions for ICBs but that this would take sometime to role out to all 26 ICBs.

- The Board noted that the local government reorganisation would necessitate a review of some aspect of the Strategy particularly around alignment of 'Places'.

- The Board reflected on the need for the plan to be able to adapt to changing circumstances both locally, nationally and internationally. The Board noted that the Plan and Strategy would be refreshed annually.

11.3. The Board **APPROVED** the Strategy and Population Health Improvement Plan.

12. Population Health Management Annual Report

12.1. Dr Frankie Swords, Executive Medical Director presented the reports which provided an overview of the work of the Population Health teams in Suffolk and North East Essex and Norfolk and Waveney. She highlighted how population health management had been embedded across the ICBs and in business as usual. Dr Suzanne Meredith, Associate Director of Population Health Management highlighted a number of case studies from across Norfolk and Waveney including the digital weight management programme which had taken NWICB from the worst referring ICB area to the best for digital weight management support and inequalities in post-natal outcomes which connected mothers who lived in the most deprived areas with support around mental health, housing, and finances.

12.2. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning spoke to the Suffolk and North East Essex report. He highlighted the rapid development of the Population Health Management service and the national recognition the service model had received. Suffolk and Norfolk both benefited from significant support from general practice with all GPs agreeing to share data with the ICBs, this was not common across the county. The ICB has also trained a large number of staff in how to use the population health data sets to ensure that making use of data was embedded across the organisation and that the ICB was not relying on a single, small team.

12.3. The following matters were raised during the Board's consideration of the report:

- The Board welcomed the reports particularly the focus on outcomes.
- The Board considered the need to adapt the population health management plans to changing circumstances and noted that Norfolk and Suffolk ICB would review the two existing plans to ensure that the focus remained on where the ICB could make the biggest impact to the wider determinant of health.
- The Board encouraged the ICB to be ambitious in its use of the population health data to achieve the allocative efficiency that had been referenced earlier in the meeting and drive improved outcomes across the ICB area. The Board welcomed the ongoing conversations between the ICB and the two Public Health Teams about how to develop and scale up the population health work.

12.4. The Board **NOTED** the reports.

13. Progress against Suffolk Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) priorities 2025-2026

13.1. Karen Watts, Deputy Director of Nursing presented the report which set out the progress against the priorities agreed by Board earlier in the year. She highlighted the improvements in the completion of annual health checks and actions plans. There had also been positive work around education and workforce development with education sessions delivered in primary care. She also highlighted the three areas where there had been delays in progress: the learning disability friendly GP kitemarks due to staff shortages, a slow uptake in Oliver McGowan training with a paid delivery model was being introduced to improve take up, and NSFT was developing a 'one team' model to take forward the priority around continuity of care.

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

14. Neighbourhood Health, Care and Wellbeing in Suffolk including the Care Management Service

14.1. Maddie Baker-Woods, Executive Director of Neighbourhoods and Primary Care for Suffolk and Nicola Cottington, Chief Operating Officer, WSFT and SNEE ICB Partner Member presented the report. They spoke to the establishment and development of the Integrated Neighbourhood Teams across Suffolk. They highlighted the ways that the Neighbourhood Teams were able to respond planned care needs and to react to support unplanned care. They set out how population health management to develop more proactive work. The Care Management Service was a multidisciplinary approach which had developed out of the Sustainability Review carried out by McKinzie in SNEE and was supported by national policy. The Care Management Service would use population health data to target support at the cohort who were most likely to be admitted into hospital. The Service would develop a bespoke personalised care plan for every individual. An evaluation of a pilot running in a Primary Care Network in West Suffolk was expected to be available in the coming weeks.

14.2. The following matters were raised during the Board's consideration of the report:

- The Board welcomed the presentation and the proposed approach to developing neighbourhood health and the Care Management Service.

- The Board heard about the progress on developing Integrated Neighbourhood Teams across Norfolk and Waveney. The Board welcomed the work that was underway to share learning across Norfolk and Suffolk to ensure that development of neighbourhood work was able to progress well under the new ICB area.

- The Board heard about the discussion of the paper and support of the proposed model at the Alliance Committees and the Integrated Care Partnership Committee.

- The Board welcomed the suggestion that the cohort of patients that would be under the care of the Care Management Service would be identified using predictive modelling rather than retrospectively to proactively prevent patients needing hospital care.

14.3. The Board **NOTED** the report.

15. Financial Report for Month 11 2025/26

15.1. Howard Martin, Executive Finance and Contracts Director presented the report. At month 11, Norfolk and Waveney was ahead of plan following mitigation actions at the Norfolk and Waveney University Hospital Group and the NWICB. The Norfolk and Waveney System was expected to achieve its financial plan for 2025/26 both in aggregate and by organisation. At month 11, within Suffolk and North East Essex East Suffolk and North Essex Foundation Trust had revised their financial plan to deliver a £4.9m deficit, all other system partners were on track to deliver plans. There was still a risk to the overall delivery of the SNEE financial plan if ESNEFT were not able to deliver their revised plan.

15.2. NHS England has approved the distribution of unearned deficit support money worth £6.6m to SNEE providers and £11.5 to NW providers. The monies were distributed provided that organisations had met their in year plans and set balanced plans for the coming financial year. The funding provided a cash benefit to trust but NHS England anticipated that systems would exceed their plans by an amount equal to the additional funding provided.

15.3. Howard Martin also provided an overview of financial planning for 2026/27 which covered a three year period and included the establishment of an investment fund to support investments in services to drive the three shifts set out in the NHS Ten Year Plan.

15.4. The Board **NOTED** the report.

16. Integrated Performance Report (IPR)

16.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning presented the report. Norfolk and Waveney had seen improvement in performance around cancer faster diagnosis, outpatient waits, and the sprint drive elective recovery. This was balanced with pressures in diagnostics, urgent and emergency care, and some of the cancer pathways. Suffolk and North East Essex had seen improvements across cancer pathways, urgent and emergency care, and planned care with real improvement in both Trusts in referral to treatment and diagnostic performance. There were pressures around certain cancer pathways and ambulance handover delays. The report also provided an update on the recommendations from the sustainability review which were being led by the Suffolk and North East Essex Trusts.

16.2. The Board **NOTED** the report.

17. Integrated Care Partnership Update – verbal

17.1. Susannah Howard, Integrated Care Partnership Director provided a verbal update. She highlighted that the final meeting of the Suffolk and North East Essex Integrated Care Partnership Committee took place at the beginning of March, and the Committee received a report on the learning and legacy exercise that had been undertaken involving all system partners. The report pulled together reflections from around 200 stakeholders on what was most important about how partners worked together as a whole health and care system. The report highlighted the importance to ‘softwire’ the integrated health system, that is proactively seeking to build a shared purpose and relationships, actively redistributing power, and focusing on culture and leadership. National organisations had also contributed reflections on the partnership approach to Suffolk and North East Essex.

17.2. The first Norfolk and Suffolk event, hosted by the ICB, Norfolk County Council, and Suffolk County Counsil, would be announced in the coming weeks and would be a Health and Care Expo and a Health and Care Awards event held on 3 July 2026.

18. Board Assurance Framework

18.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report. She highlighted the updates and amendments to the BAF entries, six entries had been positively reviewed.

18.2. The Board **APPROVED** the report.

19. Committee Reports

19.1. The Board **noted** the committee highlight reports.

20. Equality Delivery System 2

20.1. The Board **noted** the report.

21. Questions from the Public

21.1. The Chair noted that four questions had been received in advance of the meeting and asked the Associate Director of Communications to read each question in turn to be responded to by the relevant Board Member.

Question from Anthony Dooley

"Does the ICB consider that the government's intent to increase the time overseas workers will have to wait to apply for indefinite leave to remain in the UK from 5 to 10 years, that includes Health Workers, is compatible with your claim to be committed to Equality, Diversity and Inclusion? And what do you regard as the impact this is likely to have should this proposal is implemented will be on staff morale and workforce planning?"

Amanda Lyes, Executive Director of People, Governance, and Corporate Services responded:

"Our ICB is committed to creating an inclusive environment for our workforce and community. We have established frameworks and initiatives to promote equality, diversity and inclusion such as the Workforce Race Equality Standard and the Workforce Disability Equality Standard. These efforts reflect a collective commitment to fostering an inclusive workplace and community.

"NHS Employers, the body which represents NHS organisations, has said staff already on a pathway to settlement under existing rules should not be disadvantaged by these changes. They have also said there is a risk to workforce retention. We will ensure any risk to workforce retention is minimised as much as possible."

Question from Anthony Dooley

"Will the newly formed Norfolk and Suffolk ICB as Commissioners ensure that the disgraceful treatment of counsellors over the past 2 years with the decision of NSFT to outsource a service to MIND in Norfolk and Waveney that has failed to pay those Counsellors the NHS rate for the job will end, and those counsellors affected will be paid the NHS rate for the job, including back pay entitlement? If so, will the new ICB make explicit that it will insist that future contracts to the likes of NSFT shall not be outsourced, in line with the Government's promise before the General Election to reverse outsourcing in the Health Service."

Dr Faisil Sethi, ICB Partner Member and NSFT Medical Director responded:

"Norfolk and Suffolk NHS Foundation Trust (NSFT) is aware of the ongoing pay issue involving counsellors at Norfolk and Waveney Mind working in Talking Therapies services. We have met with Norfolk and Waveney Mind and Unison to discuss the issues that have been raised.

"We absolutely understand and respect the concerns raised by the workers and their representatives. As a healthcare provider, we are committed to ensuring that everyone involved in delivering high-quality care is treated fairly and with respect.

"The counsellors are not NHS employees and Norfolk and Waveney Mind as the employer is responsible for employment terms, including pay and working conditions. Having said that, NSFT will continue to liaise closely with everyone involved and do everything we can reasonably do to support and facilitate a resolution in this matter.

"Our priority is to ensure that service users continue to access safe and effective Talking Therapies services to support improved wellbeing and quality of life."

Question 3 from Tony Bence

Mr Bence provided a paper regarding the sustainability of our primary care prescribing budget as part of the Prostate Cancer Pathway.

"This submission highlights the catastrophic financial impact of late-stage prostate cancer diagnosis on Primary Care budgets and also advocating for a shift toward a more open approach such as that being adopted by the Australian "Wider Invitation" Model. As a local constituent and 5.5-year survivor of asymptomatic Gleason 4+3 (GG3), I am living proof that early detection prevents the transition to high-cost metastatic management. There is a growing movement toward an "Optimal" diagnosis but there are less obvious concerns being expressed over the longer-term financial burden on Primary Care.

"I request that this briefing be included in the papers for the March 25th meeting, specifically addressing the Board's duty to meet the National Cancer Plan's 75% early-diagnosis target while managing pharmacological liabilities."

Dr Frankie Swords, Executive Medical Director responded:

"Thank you, Mr Bence, for taking the time to submit your paper and we are very pleased that you're continuing well on your recovery journey. We will ensure our cancer board receives your paper and considers its contents.

"Cancer screening policies are very carefully weighted and decided nationally. As you have highlighted in your report, for many cancers treatments are easier, cheaper and more effective when cancers are caught at an early stage. This is why the NHS screening programmes try to detect various cancers before they have started to cause symptoms. Although we have engaged in the recent call for input to review this, the national position remains that mass screening for prostate cancer is not recommended.

"In line with your paper however, we do continue to encourage targeted screening of high risk individuals - in particular people over 50, from a black ethnic background and those with

a family history of prostate cancer. We also strongly recommend that anyone with symptoms of prostate cancer should contact their GP team for testing."

Question 4 from Nick Sharpe, Ambulance Care Assistant, EEAST

"*My name is Nick Sharpe, and I work for the East of England Ambulance Service (EEAST) as an Ambulance Care Assistant for North East Essex (NEE) Patient Transport Services (PTS). As you will be aware, after the tender process was completed for the SNEE PTS Contract, from the 1st April 2026 the Private Ambulance Service company HTG will be responsible for PTS in this area. I am, along with many of my colleagues, currently going through the TUPE process so that I can remain employed in my PTS role.*

"The reason I am submitting this question/topic for your attention is that I have major concerns regarding the current state of the TUPE from EEAST to HTG. The whole process has been stressful with very little information being provided by the new provider, not until recently, just weeks before the TUPE is set to complete. After 1-to-1 engagement sessions between staff wishing to TUPE and the new provider, we were advised that HTG would be honouring our existing working patterns and shift times (for at least six months). This was a major relief to staff who had been concerned that this would not be the case. In addition, many staff were also advised which of the new Essex bases they would be working out of.

"However, since then, we (the staff wishing to TUPE to HTG) have been advised that we must adopt a brand new 16 week working rota pattern effective immediately from April 1st. Many staff have also been advised that they are to work out of a different base station to that they had agreed with HTG during their 1-to-1 meeting. In some instances, this means staff are to travel an hour or more just to get to work.

"As you can imagine the whole TUPE process has been of massive concern to staff and these new revelations that despite verbal agreement with the new provider, new working patterns are being forcibly placed upon us, is majorly concerning. Staff are anxious and worried about working for a new provider and are extremely concerned for SNEE patients who will be affected by this change in provider.

"Concerns are that unless the TUPE process can be managed in such a way that it allows for staff to have their current terms of employment honoured, then there are going to be massive service level issues for the ICB to have to deal with come April 1st. I imagine the last thing that the ICB wants to have to do is have to spend more money on another PAS whilst HGT manage to get their feet on the ground.

"Ideally, we would like to request the ICBs involvement in the final days of the TUPE process in order to ensure a smooth transition of service. HGT have a ready made, ready trained team available to TUPE over to them, should they only ensure that they agree to meet the needs and requirements of the staff. This entails honouring agreements made to keep staff on existing working patterns and at agreed working locations.

"I hope that this request for the ICB to help conclude the TUPE process can be accommodated."

Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning responded:

“Thank you for raising that and I’m sorry for the experience you’re raising on behalf of your colleagues.

“Just for some context we are the commissioner for the service for Suffolk and North East Essex and we have a clear role and responsibility to facilitate the information exchange between the outgoing and incoming provider as part of the process and out Team has met regularly with both of those providers to ensure that they are discharging their primary legal duties to inform and consult with staff on the TUPE arrangements to ensure that there is continuity of service which is so important for our patients. We are not able to get directly involved in the transfer process as staff are not employed by the ICB. However, we have as part of our oversight arrangement in terms of moving from one provider to another been contact their senior team particularly their Chief Operating Officer to ensure they are addressing the issues raised as part of the TUPE process. Particularly the risk that has been highlighted of any gaps in rotas on the go live date and how that is going to be mitigated.

“The ICB understands that HTG are working with EEAST employees on an individual basis to address individual concerns but we are picking up further with the team there.”

22. Any other business

22.1. No other business was raised.

The meeting finished at 4.10pm

The inaugural meeting of the Norfolk and Suffolk Integrated Care Board held online on Wednesday, 1 April 2026 at 10am.

Present

Members of the Board

Will Pope, Chair of the ICB
Kirsten Alderson, VCSE Member – Chair of the Suffolk VCFSE Assembly
Jonathan Barber, NHS Foundation Trust Partner Member – Director of Strategy & Transformation James Paget University Hospitals NHS Foundation Trust (*deputy member*)
Ewen Cameron, NHS Foundation Trust Partner Member – Chief Executive, West Suffolk NHS Foundation Trust
Tim Gardiner, VCSE Member – Chair of the Norfolk and Waveney VCSE Assembly
Ed Garratt, Chief Executive
David Holt, Non-Executive Member
Amanda Lyes, Accountable Emergency Officer and Executive Director of People, Governance, and Corporate Services
Adrian Marr, NHS Foundation Trust Partner Member - Chief Executive, East Suffolk and North Essex NHS Foundation Trust
Howard Martin, Executive Finance and Contracts Director
Phanuel Mutumburi, Non-Executive Member
Lisa Nobes, Executive Director of Nursing
Elaine Noske, Non-Executive Member
Dr Faisil Sethi, NHS Foundation Trust Partner Member – Chief Medical Director, Norfolk and Suffolk NHS Foundation Trust (*deputy member)*
Dr Frankie Swords, Executive Medical Director
Janet Wood, Non-Executive Director

Regular Attendees
Maddie Baker-Woods, Executive Director of Primary Care and Neighbourhood Health (Suffolk)
Mark Burgiss, Executive Director of Primary Care and Neighbourhood Health (Norfolk)
Richard Watson, Executive Director of Strategy, Digital, and Commissioning

Also in attendance
Tom McColgan, Corporate Governance Manager (*minutes*)

1. **Welcome, introductions and apologies**

1.1. The Chair welcomed all those present to the first meeting of the newly established NHS Norfolk and Suffolk Integrated Care Board.

1.2. The Chair noted that apologies had been received from Dr Frankie Swords, Executive Medical Director; David Holt, Non-Executive Member; Stuart Keeble, Local Authority Partner Member; Ian Wake, Local Authority Partner Member; Cllr Fran Whymark, Chair of the Norfolk Health and Wellbeing Board; and Caroline Donovan, NHS Foundation Trust Partner Member.

2. **Declarations of interest**

2.1. There were no declarations of interest.

3. **Approval of key documents**

3.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the key documents for approval including the adoption of the ICB Constitution and Governance Handbook.

3.2. In response to a question from the Board, Officers clarified that commissioning of primary care services had been delegated to the Norfolk and Waveney Primary Care and Neighbourhood Committee and Suffolk Primary Care and Neighbourhood Committee. The two committees had in turn jointly established a Primary Care Commissioning Group which had delegated authority to take financial decisions relating to primary care commissioning.

3.3. The Board resolved to:

(1) **Adopt** the NHS Norfolk and Suffolk Integrated Care Board Constitution as approved by NHS England.

(2) **Approve** an amendment to the Constitution to update the name of the Norfolk Community Health and Care NHS Trust to East of England Community Health and Care NHS Trust, and amend 3.13.2 a) to read 'hold a suitably senior role at one of the VCSE organisations' within the ICB area.

(3) **Approve** the Governance Handbook comprising the following elements as required by the Constitution:

a Functions and Decisions Map
b Scheme of Reservations and Delegations
c Standing Financial Instructions
d Terms of Reference for all Committees of the Board that exercise ICB functions.
e an up-to-date list of eligible providers of primary medical services.
f standards of business conduct policy
g conflicts of interest policy and procedures
h policy for public involvement and engagement

(4) **Note** that the ICB is not seeking to establish any joint committees or delegate any ICB functions in accordance with section 65Z5 of the NHS Act 2006.

(5) **Approve** the following Chair appointments for the Committees of the Board:

a Integrated Care Partnership Committee: Will Pope, Cllr Steve Wiles, Cllr Fran Whymark
b Executive Committee: Ed Garratt
c Strategic Commissioning Committee: Phanuel Mutumburi
d Quality Committee: Elaine Noske
e Finance, Performance, and Workforce Committee: Janet Wood
f Audit and Risk Committee: David Holt
g Remuneration and HR Committee: Janet Wood
h Primary Care Commissioning Group: Phanuel Mutumburi

(6) **Delegate** to the Chair responsibility for appointing a Chair to the Norfolk and Waveney Neighbourhood and Primary Care Committee & the Suffolk Neighbourhood and Primary Care Committee.

(7) **Approve** the following policies for adoption by NHS Norfolk and Suffolk ICB:

a The Individual Funding Requests Policy and Experimental and Unproven Treatments Policy.

b The Complaints Policy.

c The Emergency Preparedness and Resilience Policy

d The Freedom of Information Policy

(8) **Approve** the transfer of all other existing NHS Norfolk and Waveney ICB and NHS Suffolk and North-East Essex ICB policies to NHS Norfolk and Suffolk ICB noting that these are expected to be reviewed, consolidated and approved by the relevant Committee within 3 months.

4. **Any Other Business**

4.1. No other matters were raised.

The meeting finished at 10.10am

NHS Norfolk and Suffolk ICB
Action log for March 2026

Actions arising

Agenda Item	Action	Lead	Update	Target Date
Lampard Inquiry	To bring a further update to the Board on progress of the Lampard Inquiry and the ICB's involvement.	Lisa Nobes	Complete. On agenda.	May 2026
Deep Dive Reports: SEND Suffolk.	To bring a further report detailing the progress on the actions adopted by the ICB following the NHSE/DfE led deep dives.	Lisa Nobes	Suffolk SEND monitoring Inspection outcome to come to July Board meeting, subject to its publication.	July 2026
SNEE Integrated Care Board Performance report for March 2025.	Board Members stated that they would welcome a future development session focused on ambulance call out time times particularly focusing on category one and two call performance.	Richard Watson	Neill Maloney CEO EEAST will attend the Board's July meeting.	July 2026
Norfolk & Waveney Green Plan	To consider a future development session to provide input into the Green Plan and ensure momentum is maintained on this essential work.	Amanda Lyes	Adoption of a Norfolk and Suffolk Green Plan is on the Board forward plan	July 2026
Performance Report for January 2026.	To arrange for a board development session on the use of AI tools in primary care triage	Maddie Baker-Woods	The item is on the Board forward plan	June 2026
Performance Report for January 2026.	To bring a report to a future board meeting on patient flow and discharge	Richard Watson	The item is on the Board forward plan	July 2026

March 2026

Agenda Item	Action	Lead	Update	Target Date
Public Questions	Meeting with Save Benjamin Court Campaign	Mark Burgis	Meeting took place 12.05.26.	May 2026
Winter Plan Review	A programme of lessons learned meetings would be taking place across March and April with a report back to Board.	Richard Watson	On Board forward plan for the June Development Session	June 2026
Strategy and PHIP	The Board stated that it would welcome a development session or sessions to build the Board's skill around health economics to support the ambitions in the Strategy.	Richard Watson	On Board forward plan. Target date TBC.	TBC
PHM Annual Report	To arrange a Board Development Session on PHM particularly the Health Insight tool.	Dr Frankie Swords	On Board forward plan. Target date TBC.	TBC

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 7
Date: 20 May 2026

Title: Making the shift to neighbourhood working across Norfolk and Waveney

Lead Directors Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk and Waveney)

Authors: Amanda Sear, Ian Wake, Nick Clinch and Ali Gurney, Primary Care and Adult Social Services

Purpose: Information

Recommendation: The Board are asked to:

- approve the continued system-wide shift across Norfolk and Waveney towards neighbourhood-based ways of working, in line with national policy and local ambition; and
- endorse the progressive alignment of leadership, governance, planning and commissioning to make this shift, rather than defaulting to organisational or service-led approaches; and
- agreement to design neighbourhood delivery as a learning, relational system

Related item on the Board Assurance Framework:

There is no single, standalone Board Assurance Framework risk linked to this item. Instead, it describes an organisational approach that underpins and cuts across multiple existing BAF risks.

How the ICB leads and makes decisions in relation to this approach matters, particularly at times of system pressure. If decisions are taken reactively, or the approach set out in the paper is applied retrospectively rather than used to shape choices up front, it is less likely to address the underlying structural pressures facing the system. Consistent use of agreed population health and commissioning principles is therefore central to delivering the commitments we have made, within the resources available.

Background

Over time, health and care services across Norfolk and Waveney have evolved around transactional, eligibility-based and organisationally siloed models of delivery. These arrangements have largely been shaped by organisational accountability, contractual structures and service-specific pressures, rather than by the structural pressures experienced by residents and communities which drive demand.

While these models have enabled scale and specialisation, they also create system-level limitations. In practice, residents can experience fragmented journeys through services, repeated assessments and multiple hand-offs. Intervention often takes place late, once needs have escalated, contributing to avoidable escalation and persistent levels of “failure demand” across health and care.

These characteristics are increasingly misaligned with the context the system is now operating within. Residents’ needs are more complex and interconnected, reflecting long-term conditions, mental health needs and the wider determinants of health. At the same time, the system has set clear ambitions around prevention, equity and sustainability - ambitions that are difficult to deliver through fragmented, service-led approaches alone.

In response to these challenges, national policy signals a clear shift towards neighbourhood-based ways of working — not as a structural reorganisation, but as a means of better aligning leadership, planning, commissioning and delivery around communities, relationships and shared outcomes. Addressing the current misalignment therefore requires a deliberate ICB, and syste, response, positioning integrated planning, resource allocation and delivery around natural neighbourhoods in order to improve population outcomes and avoid further compounding existing system constraints.

While this paper focuses primarily on Norfolk and Waveney, it is being considered by a Norfolk and Suffolk Board. Across Suffolk, there is an established case management approach that has been developed over recent years, alongside other hyper-local examples across both geographies where the characteristics of neighbourhood-based working are already making a positive difference for residents. These approaches are often context-specific and shaped by local relationships, leadership and community assets. The opportunity for the system now is to learn deliberately from what is working, and to understand what needs to change at a system level so that these approaches can be more consistently supported, strengthened and scaled, leading to demonstrable improvements in population outcomes in line with our shared plans

This direction of travel has already been agreed locally. On 4 March 2026, the Norfolk and Waveney Integrated Care Partnership formally endorsed the emerging Neighbourhood Plan as the system framework, confirming neighbourhood-based working as the strategic direction of travel across Norfolk and Waveney.

This paper builds on that agreement, focusing on how the system can progressively align leadership, governance, planning and commissioning to support implementation, rather than reinforcing existing transactional or organisationally siloed approaches. March N&W ICP Papers - Neighbourhood Working

While the Neighbourhood Plan sets out what we are seeking to build, experience locally and nationally shows that how the system learns, adapts and makes decisions is what ultimately determines impact. The next section therefore focuses on the operating environment required for neighbourhood working to succeed at scale

Key Issues and Risks

The shift to neighbourhood-based ways of working represents a fundamental change in how the system plans, leads and organises care. The key issues and risks associated with this change are primarily strategic and systemic, rather than operational, and relate to how the approach is understood, designed and enabled at scale.

This paper covers three key issues critical to mitigating the risks inherent in large-scale transformation:

Strategic plan for neighbourhood working in Norfolk & Waveney

Partners in Norfolk and Waveney's Integrated Care System have developed and agreed (via the Integrated Care Partnership) a 'Neighbourhood Plan' for the system. Through the ICS Conference, Executive Management Teams, partnership discussions and a System Neighbourhood Steering Group, partners have developed a shared ambition to organise health and care, prevention and support around residents, within their local communities and neighbourhoods. The plan reflects this shared ambition and provides the enabling framework to move from aspiration to coordinated system delivery.

Norfolk & Waveney partners have committed to strengthening neighbourhood working as a key enabling approach within the ICS strategy, NHS 10-Year Health Plan, local authority transformation programmes and VCSE partnership priorities. Current arrangements, shaped by historical commissioning boundaries and organisational processes, do not fully respond to the complexity of need or persistent inequalities experienced across communities.

The emerging Neighbourhood Plan sets out how partners across Norfolk and Waveney will organise, govern and develop neighbourhood working in a more joined-up, community-focused and preventative way. It responds to clear feedback from staff, partners and communities that the system needs to shift from complex, service-driven arrangements to more locally rooted, relational models based on trust, shared understanding and working alongside residents on what matters to them. Neighbourhoods in this plan are shaped around real communities and natural patterns of population and identity, rather than organisational boundaries. Because population need does not follow organisational lines, the solutions cannot be bound by them either. A credible neighbourhood way of working must therefore be designed around the realities of people's lives, not the structures of our institutions.

A central part of this approach is developing a shared evidence base for each neighbourhood. This includes quantitative data, community voice, local insight, lived experience and social care intelligence. Neighbourhood Profiles will be "living documents", updated regularly as new insight emerges. They will give all partners a fuller, more grounded picture of need, strengths and priorities, and support more open conversations about where to focus resources fairly.

The plan also describes the shared capabilities neighbourhood teams will need, without prescribing a rigid structure. These include accessible, relationship-centred roles rooted in

communities; the ability to “pull in” the right professionals as needed rather than rely on traditional referral routes; and multi-agency working that brings together primary care, community health, mental health, social care, public health, housing providers and VCSE partners. This allows each neighbourhood to build an integrated offer that fits its identity, maturity and community strengths.

Prevention is at the heart of the model. The shared Prevent, Reduce and Delay approach brings together clinical prevention, social care insight, early help, public health action and community-based support. Neighbourhood teams will focus on helping people earlier, reducing avoidable escalation, and supporting those with complex or deteriorating needs in a more coordinated, relational and consistent way. This includes recognising and responding to the wider factors that shape people’s lives, such as housing, income, social connection and caring pressures.

The plan sets out a practical governance approach built around three environments:

- A Strategic Enabling Environment, providing sponsorship, alignment of resources and clear expectations.
- A Sense-Making Environment, bringing partners together to share insight, review neighbourhood profiles and build a shared understanding of what the evidence is telling us.
- An Enabling and Delivery Environment, focusing on coordinated local delivery, problem-solving and supporting neighbourhood teams to test and learn.

This governance is designed to be proportionate, transparent and supportive, helping neighbourhoods mature at different paces without losing shared direction.

A system-wide learning and metrics approach underpins the work. Rather than focusing on performance management, the plan emphasises learning, collaboration and transparency. It uses rapid learning cycles and a blend of data, lived experience and operational insight. Measures will focus on population outcomes, partnership behaviours, shared planning and the ability to adapt based on what neighbourhoods are learning.

A new collaborative way of working – creating the environment for neighbourhoods to thrive

Across health, care, and wider public services, there is a persistent pattern: rising demand and cost, fragmented service responses, and opportunity for improved lived experience for people with complex need. Compounding this is limited system learning despite extensive data, reporting, and assurance.

Traditional responses to these patterns have frequently focused on new strategies and plans, structural change and tighter performance management. These approaches have often not been sufficient to change outcomes for people with complex, interconnected needs.

There is an alternative: designing the system to learn from real work, in real time, and to convert that learning into system change. Three critical modes are required to operate together:

- Delivery – doing the work with citizens and communities
- Learning – systematically reflecting on what is happening and why
- Sense-making – synthesising learning into decisions about what should change (frequently the 'mode' that is missed/not deliberately designed in to how we work)

Evidence from practice – Brian's story

Brian's story is as an illustrative example of a wider, replicated pattern. Brian lives in an Integrated Care System outside of Norfolk and Suffolk where partners have made practical steps to change how they work together at neighbourhood with positive effect:

Over 9 years, Brian experienced:

- 3,300+ service interactions
- Over 5,000 public sector workers involved
- Approximately 800 assessments
- Increasing utilisation of services over time
- Highest category of A&E attendance
- Total public sector cost exceeding £2m

Despite all services being delivered as specifie, and with positive inspection outcomes from regulators, outcomes for Brian deteriorated: his health worsened, independence reduced, and need for support escalated.

What Changed:

Following a change in approach to a model of neighbourhood working that focused on a model of support similar to that being adopted in Norfolk and Wavaney (community focused, relational and broad in its involvements of statutory partners and community assets), a different approach was put in place in support Brian:

- Low-cost, bespoke, non-specialist relational input was introduced.
- Specialist services were used less frequently, but more effectively and in context
- Access bureaucracy was reduced.
- Decisions were made closer to Brian.

The result:

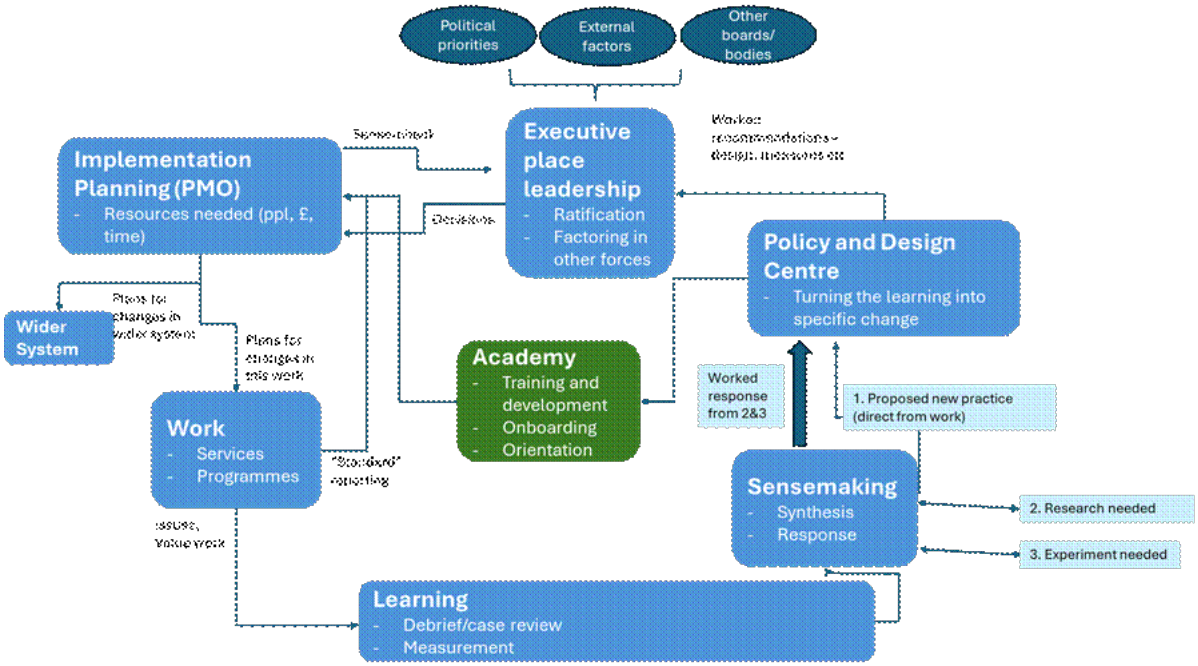
In the 12–24 months post-intervention, 100% of demand was "value demand" that supported Brian rather than responded to failure of crisis (compared to 16.2% previously). Brian's life improved dramatically, and his need to access statutory services was approximately 0.3% of previous levels.

Following a focused session with ICB Executive Management Team leaders, this new approach to creating an 'environment' where neighbourhood working can thrive will be developed. This approach will help build a way of working that can then be the bedrock for different types of intervention that neighbourhood teams can deliver, such as a focus on

frailty or relationally-led support for people with multiple complex need. Practically, this will mean implementing the following approach where we build enabling, delivery and sensemaking into our system:

1. Delivery - Neighbourhood teams that deliver relational practice with peoples, pulling in services and programmes. These teams will be empowered with the ability to act, adapt, and respond in real time
2. Learning – Structured spaces and approaches for routine debriefs, case reviews, and journalling. Focus on issues, patterns, and value work with measurement that supports learning, not just assurance.
3. Sense-making - Structured synthesis of learning, with conscious ways of working that promote decision making on whether issues require new practice, research, experimentation or system or policy change.

These environments are not organisational charts or committees; they are capabilities that must be deliberately designed and resourced. However, the following illustrative diagram shows how they will be built within our system:



This way of working has clear implications for how the ICS governs and leads. Assurance must extend beyond delivery against plan to include learning capability. Commissioning and policy must be open to redesign based on lived experience. Executive leadership must participate in sense-making, not just sign-off. Investment decisions should prioritise system learning infrastructure, not only programmes. Evaluation should focus on patterns, trajectories, and experience, not isolated metrics.

There are two key next steps:

1. Agreement to design neighbourhood delivery as a learning, relational system

2. Agreement to create or strengthen formal sense-making spaces linked to executive decision-making

Practical immediate delivery planning

NHS Norfolk and Suffolk Integrated Care Board (ICB) has commissioned PA Consulting to support the development of the system-owned Neighbourhood Health model and delivery approach for Norfolk and Waveney.

This work will align with the Norfolk and Waveney plan for neighbourhood working, ensuring a clear and consistent vision, set of priorities, and high-level principles for how neighbourhood health will be delivered across the system. It will define a practical and deliverable Neighbourhood Health model that reflects both national expectations and local ambitions. It will move the system from strategic intent to implementation, supporting improved outcomes, stronger prevention, and more care delivered closer to home.

PA Consulting are providing structured support, analysis and facilitation to enable system partners to reach shared agreement. The outputs will be developed collaboratively and owned by the system. The programme will produce:

- A codified Neighbourhood Health model for Norfolk and Waveney, aligned to the system's agreed neighbourhood working plan
- A supporting business case and investment plan, grounded in population need and aligned to system priorities
- A phased implementation roadmap, setting out how neighbourhood health will be developed and delivered over time

This work will build on existing place-based arrangements and current transformation programmes. It will ensure alignment across system partners and avoid duplication, bringing together current initiatives into a coherent, system-wide model.

PA Consulting's role is to support engagement and enable alignment, not to impose solutions. The focus will be on achieving practical, system-wide agreement and clarity on delivery.

Appendix A

This appendix provides an illustrative example of neighbourhood-based working in practice from Anglia Square in Norwich. It is not intended as a model for direct replication. Instead, it highlights the learning generated by locally rooted, relational approaches, and how this learning can inform the system-level changes required to deliver improved and consistent outcomes for residents at scale

Committees and Groups

The Norfolk and Waveney Approach to Developing Neighbourhoods, sponsored by Ian Wake and Ed Garratt went to Norfolk & Waveney Integrated care Partnership on 4 March 2026 – details of the paper can be found here March N&W ICP Papers - Neighbourhood Working

An ICS EMT workshop itook place on 8 May 2026 and discussions from this are reflected in the body of the paper.

North City Centre Integrated Neighbourhood Development

“support closer to home, engaging differently, learning together”

In Norwich’s North City Centre, around 4,000 residents live in one of the most deprived areas in the country. People in this community experience significantly poorer health outcomes, including higher levels of poor mental health, poor respiratory health, alcohol-related harm and self-harm. Young people unemployment has tripled in 9 years, 1 in 4 people are unemployed or unable to work, and 25% more deaths than expected in this area from heart disease, stroke or other circulatory diseases.

Recognising both the challenges and the opportunity for change, Central Norfolk Place and Neighbourhood Team has been working with partners across Norwich to develop a new, neighbourhood approach. Building on a Reducing Inequalities Target Area (RITA), and with the backdrop of the Anglia Square redevelopment and new space at St Saviours Yard, this area provides a unique environment to test new ways of working.

Since 2024, operational leaders, system partners and community voices have come together to build trust and collaboration, forming a small Integrated Neighbourhood Team. Through this work, a shared challenge quickly emerged: high levels of missed appointments across services. In response, the team agreed a common goal—to make access to care and support easier for local residents.

Using a Human Learning Systems approach, the team is now testing new ways of working to better meet the needs of the community. This includes bringing care and support closer to home by delivering services within local community spaces such as St Saviours Yard, adopting a Making Every Contact Count (MECC) approach, and co-locating staff to enable more joined-up, responsive care.

This work is creating a live test environment for integrated care, rooted in the community and driven by collaboration. By focusing on access, relationships and local presence, the team aims to improve engagement, reduce missed appointments, and ultimately achieve better health outcomes—while generating learning that can be shared across the wider system.

St Saviour’s Yard will provide local entrepreneurs, artists, makers and boutique stores with a new and vibrant destination to work, showcase craft and trade from. Just a short distance from Norwich City Centre, the site will offer affordable and sustainable workspace for the city’s creative community.

NORTH CITY CENTRE INTEGRATED NEIGHBOURHOOD

SHOEBOX

- Key roles and partnerships established across 25+ partners including INT partners
- Resident engagement shaping local priorities and insight using Podcasts, focus groups, and pop-up events in development
- Focus groups on wellbeing, community spirit, volunteering, and neighbourhood environment
- Growing collaboration with local organisations and groups

NORWICH CITY COUNCIL

- Exploring opportunities linked to the Anglia Square development
- Strengthening engagement with INTERACT housing support services
- Offering under utilised Sheltered spaces in local area (see EoE H&C)
- Aligning with Reducing Inequality Target Area (RITA) plans
- Attendance at MDT meetings

NSFT

- Hosting three St Saviour's Yard units on behalf of the INT for co-location, assessment delivery, and digital inclusion, using MECC approach
- worked with City College ASPIRE team creating work experience opportunities (painting the units) for young people inc. links with Dulux Academy to reduce barriers to work
- Ensuring units are Trauma informed using psychology expertise
- Attendance at MDT meetings

NORFOLK COUNTY COUNCIL

- Integrated Care Coordinators testing neighbourhood coordinator functions
- Adult Social Care teams engaged in INT development and attendance at MDT meetings
- Digital inclusion support – scoping
- Development worker working with Aviva at St Saviour's Yard to deliver community engagement plan
- Desk/room booking system being developed for INT
- Reed Health services exploring use of local spaces for smoking cessation

EAST OF ENGLAND H&C

- Engagement from the High Intensity User Team and Community Matrons
- Attendance at MDT meetings
- Developing non-MSK clinics within underused communal spaces in sheltered accommodation as a ripple effect of the North City Centre huddle

CGL

- Bespoke ICC email contact established
- Attendance at MDT meetings
- Engaged in INT development, including learning from CGL non-attendance processes
- Exploring digital options within the Shared Care Record (ShCR)

MIND

- connecting Enhanced Recovery Workers with the developing INT – reducing inequalities and working with people who need different engagement.

SUPPORTNOW

- SupportNow connects VCSE, housing, and support services across three tiers of need
- Initial partners: CAB, Age UK Norwich, and Norwich City Council housing support services
- North City Centre pilot focused on complex Tier 3 needs and links with VCSE and NHS/statutory services

CASTLE PARTNERSHIP

- Shared clinical spaces agreement in scope with Gurney Practice
- Attendance at MDT meetings
- Supporting infection control measures across St Saviour's Yard units
- Collaborative working across coordination roles (Care co, ICC and Social Prescribers) to reduce duplication and improve joined-up support

NORFOLK AND SUFFOLK ICB

- Integrator/convenor function through the Neighbourhood and Place Team
- Driving progress and partnership working across the INT
- Providing a psychologically safe space to develop and test new ideas and approaches
- Developing Eclipse data set
- Produced operational friendly data pack
- Evaluation team supporting Place team with evaluation model

Using population health data, operational activity data, local intelligence, and resident insights, we continue to build a neighbourhood picture that informs all planning and delivery across our work

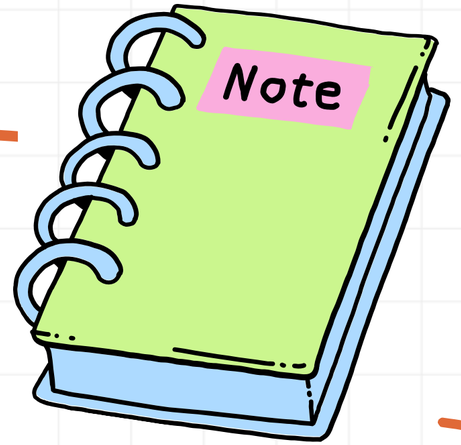
promoting increased use of the Shared Care Record across partner organisations and exploring access for Norwich City Council and CGL. Trial secured for the additional Care Community Module in the ShCR to act as single record, support shared risk assessments and personalised care planning across neighbourhood teams

LEARNING EVERYDAY

We use a mixed-method approach to understand impact across a complex change process, grounded in a human learning system that is intentionally agile. Insights shape decisions and guide each phase of development, starting with a small population while keeping scalability in view as the work evolves.

Our learning is captured through weekly huddles, learning cycles (HLS), MDTs, Cases reviews, workforce and resident feedback, capturing ripples and using data sources.

OUR LEARNING TO DATE



RELATIONSHIPS

Relationships are key. They take time to develop and need to start early. Permission to connect outside BAU or individual cases has been critical in building trust, improving understanding, and creating psychologically safe environments. Enabling people to work differently across organisational boundaries is often essential, with fear and organisational culture sometimes acting as barriers to progress.

We started with a 30 minute huddle once a week....

CONVENOR FUNCTION

Integrators and conveners play a critical role – not to deliver the work directly, but to maintain momentum, provide constructive challenge, ask the right questions, and identify new opportunities for collaboration and impact.

This is potential risk/gap in light of the changes across the ICB

DATA AND INSIGHTS

Build with the community – understand how people live, not just where they live. Resident insight is essential; don't assume to know best.
Turn data into stories, not just dashboards. Use insight to shape new ways of working around real community needs.

Local groups helped us reach residents where statutory services and the NHS were not always trusted. This insight is bringing the right support into the community.

ESTATES

We believe that shared team spaces, supported by new ways of working enable collaboration.
Our ambition is to work from accessible community-based spaces, such as local high street settings, but funding and estate constraints remain a significant challenge.

We will be starting with units in St Saviours Yard https://www.stsavioursyard.co.uk/

ENABLERS

IG, digital, data, workforce development and other enabling functions are not add-ons or afterthoughts – they are fundamental to delivery. They have been both our greatest challenge and our greatest success. Just as operational teams must come together to work effectively, so too must our enabling functions.

We have needed changes to policies, process and procedures to secure the units in St Saviours Yard,

DIGITAL

We have learned that a shared view of the persons situaton, through a single patient record, is vital. Real-time risk assessments and personalised care and support plans are essential to effective integrated working. Significant productivity loss and relationship strain often result from limited visibility of each other's activity and plans, especially with those with complex or high risk needs.

The trial of the InterSystems Care Community module within the ShCR will be an important test of this approach.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 8
Date: 20 May 2026

Title: Norfolk and Suffolk response to 1 April 2026 letter from Sir Jim Mackey.

Lead Director: Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning

Author: Alexander Royan, Director of Strategic Planning and Resilience, Digital and Intelligence

Purpose: Information

Recommendation: To note the Norfolk and Suffolk response to the four questions posed by Sir Jim Mackey in his letter of 1 April 2026.

1. Background

1.1. The attached response has been approved by all the signatory organisations and was reviewed by the ICB Strategic Commissioning Committee on 12 May 2026.

To • NHS England Chief Executive
cc • NHS England Regional Director
• NHS Trust Chief Executives

County Hall
Martineau Lane
Norwich
NR1 2DH

13 May 2026

Dear Sir Jim,

Thank you for your letter, which is welcome and timely. We have just developed our medium-term plans to deliver the priority performance metrics and launched the Norfolk and Suffolk Integrated Care Board (ICB). We have also published the ICB's inaugural five-year Strategy - "A Healthier Future for Norfolk and Suffolk" and five-year Population Health Improvement Plan (PHIP).

We appreciate the opportunity to highlight our successes, reaffirm our intent to restore NHS performance, and share how we are placing Neighbourhood as the central focus of strategic commissioning.

Overall, while 2025/26 has undoubtedly been a challenging year, we agree it has also been a successful one. Despite the scale and pace of change, we have achieved many important local successes and built strong foundations for collaboration. This progress reflects the exceptional leadership and commitment of our healthcare providers alongside the system leadership and partnership working of ICB colleagues, as well as a shared determination to work together for the benefit of our population.

Looking to the future, we will harness this partnership and the opportunity to combine the best of both legacy ICBs to create a healthcare system shaped by strategic commissioning. We will maintain the momentum of performance improvements, improve our capability for strategic commissioning, and identify and address healthcare gaps through disciplined governance, learning and collaboration. Our people are fundamental to delivering our vision and ambitions. Their expertise, commitment and compassion make it possible, and we are committed to supporting them, investing in their development, and ensuring they feel valued.

In the short-term, our priority is to deliver the best possible care for our population. We aim to remain on plan and deliver a breakeven financial position. We will work to achieve national standards in performance and quality of care, and ensure every pound spent delivers value. Our focus will be on recovery and sustained improvement as a foundation for our strategic ambitions.

Looking further ahead, the long-term goal is simple yet profound. We want people to live longer, healthier, and happier lives, supported by safe, joined-up, and compassionate care. Central to this will be delivering new models of care that shifts our focus towards prevention and neighbourhood-based care, underpinned by evidence-led, digitally enabled transformation.

Below, we have set out our response to your four questions; we hope you find this helpful and we look forward to continuing to work closely with you and colleagues as we move forward together.

Kind regards,

Dr Ed Garratt OBE DL, Chief Executive, Norfolk and Suffolk Integrated Care Board
[add signature]

Dr Ewen Cameron, Chief Executive, West Suffolk NHS Foundation Trust
[add signature]

Caroline Donovan, Chief Executive, Norfolk and Suffolk NHS Foundation Trust
[add signature]

Professor Lesley Dwyer, Group Chief Executive, Norfolk and Waveney University Hospital Group
[add signature]

Adele Madin, Chief Executive, East Coast Community Healthcare CIC
[add signature]

Adrian Marr, Interim Chief Executive, East Suffolk and North Essex NHS Foundation Trust
[add signature]

Matthew Winn, Chief Executive, East of England Community Health and Care
[add signature]

1. **What strategic commissioning means in your local system and how you intend to develop this over the next 3 years**

Our aim and strategic intent is for the Norfolk and Suffolk healthcare system to operate as a leading example of how strategic commissioning is delivered to improve population health.

The Norfolk and Suffolk Population Health and Commissioning Strategy (2026–2031) and the accompanying Population Health Improvement Plan sets out the Norfolk and Suffolk ICB's plans for how it will operate as a strategic commissioner. This provides the framework for how the ICB will take an evidence-led approach to planning, allocating, and evaluating resources to improve population health outcomes. This represents an important shift from transactional, activity-based commissioning to a model centred on allocative efficiency and health outcomes. The ICB will measure success in achieving this strategy by improvements in healthy life expectancy, reducing health inequalities, and improving access to services. Figure one shows our strategy on a page:

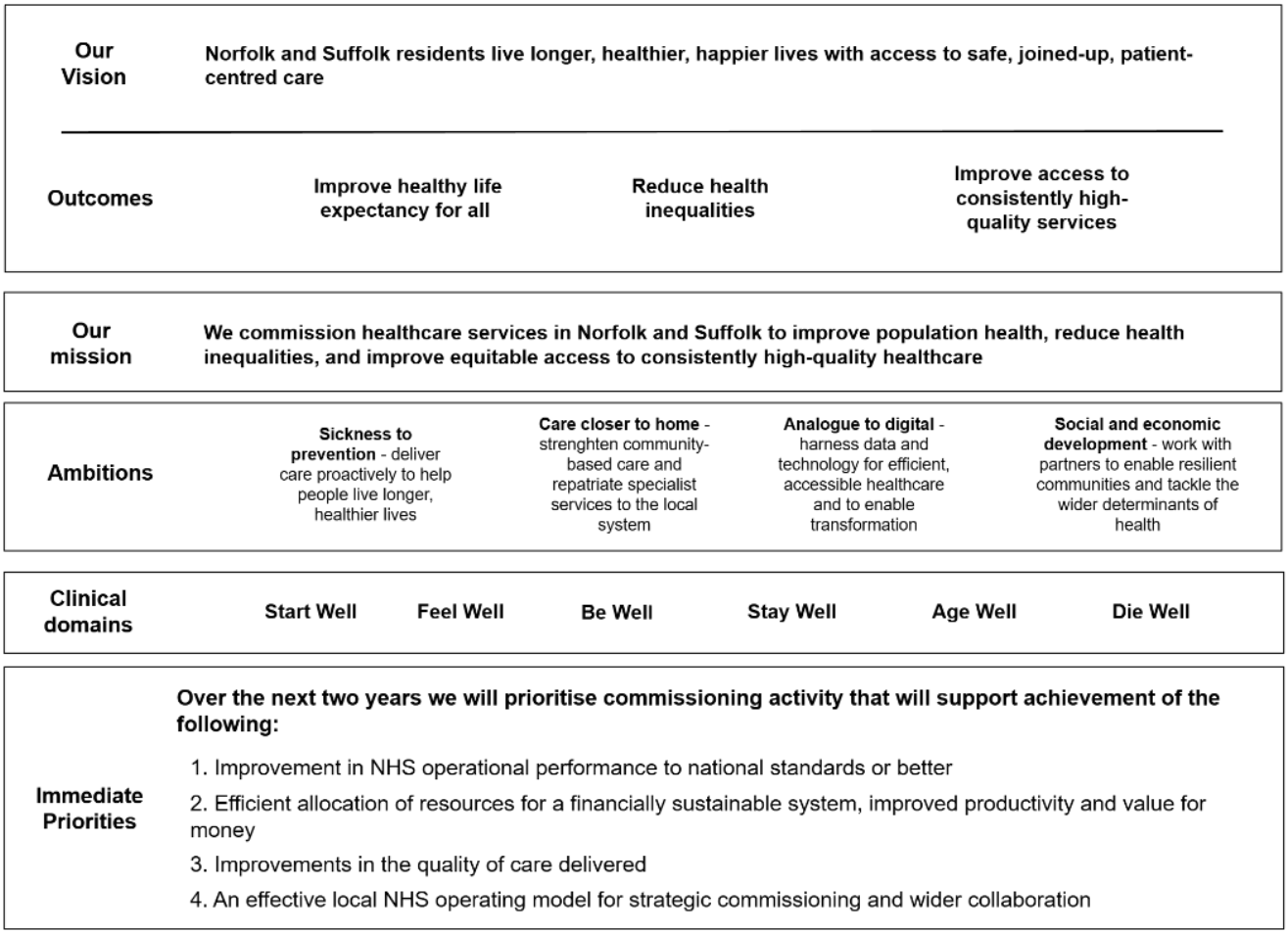


Figure 1 Norfolk and Suffolk ICB Population Health and Commissioning strategy - summary on a page

Our strategy must strike a balance between focussing on the commissioning activities that will best support achievement of population health outcomes in the longer-term (by five years) and those activities that will support addressing immediate challenges (within the next two years). Therefore, our priorities are set out in a two-stage, five-year plan, though this will be a continuum of work. Figure two sets out our five-year roadmap.

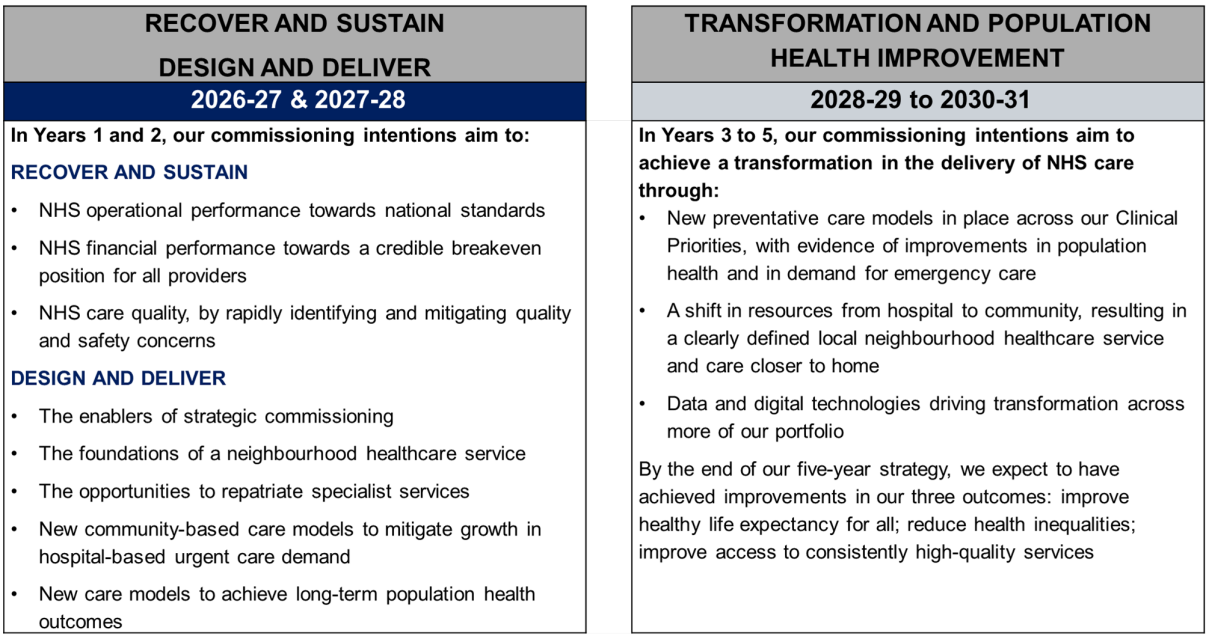


Figure 2 Norfolk and Suffolk ICB strategy roadmap

The ICB is developing a Strategic Commissioning Policy that aligns local decision-making with the national Strategic Commissioning Framework. The policy will operationalise strategic commissioning in Norfolk and Suffolk by directing staff to aligned tools, templates, policies and protocols, and by clearly defining the new role of each ICB team in contributing to the commissioning cycle. It will describe the role of the ICB and providers across the commissioning process which, in practice, means commissioners setting clear strategic outcomes and guardrails, with providers taking an active role in co-designing models of care, pathways and delivery approaches.

Strategic commissioning is therefore a shared goal in the Norfolk and Suffolk system. Providers will increasingly "step up" into system leadership roles, by proactively shaping service specifications; co-developing population health insight from shared datasets; working in partnership with other providers and acting as integrators; building commissioning-facing functions (data analytics, service modelling, outcomes and finance) and develop strategic intent aligned to population health outcomes.

As an example of strategic commissioning in practice, the ICB commissioned the first Care Management Service in the region. This is targeted at providing enhanced care for the small proportion of the population (~1 %) that is using around 60% of non-elective bed days in our acute providers. The ICB developed an outcomes-focussed service specification and financial envelope based on an extensive analysis of patient need. A partnership of acute, community and primary care providers, with VCFSE representation, codeveloped a service model which will be commissioned at scale via the community services contract. The ICB has set clear outcomes to reduce emergency admissions and non-elective bed days for the target cohort and we have collectively planned to achieve this enabled by a robust planned comprehensive evaluation a year after being commissioned.

We will further develop this approach, in line with the ICB's Population Health Improvement Plan, through six key areas:

1. *We will build on our shared data infrastructure and integrated datasets to strengthen our use of population health intelligence and enhance our ability to segment need across all settings, identify inequalities, and target interventions to those most likely to benefit.*

We have established the Norfolk and Suffolk Data Hub as a secure environment for linking and analysing health, care and wider determinants data. This brings together data across primary and secondary healthcare as well social care into a single longitudinal patient record. This acts as a 'single version of the truth' for developing strategy and plans across the healthcare system and enables quantification of benefits and implications of transformation for providers, including across sector and across system boundaries. Through the Norfolk and Suffolk Intelligence Function and the Protect NoW team, we will use population health intelligence and management approaches - including lived experience insights - to assess need and target resources where they deliver the greatest measurable impact. This will support all commissioning decisions and indeed we have already started this process with the Care Management Service highlighted above which enabled us to determine the 1% of our population the service should focus upon. The ICB will also enable providers to access linked data as a single source of truth to support co-development of new models of care.

2. *We will accelerate the shift toward prevention and community-based models of care, rebalancing investment upstream and mitigating growth in demand on acute services.*

To make immediate progress, we agreed two recurrent investment funds - £27m in 2026/27 rising to £60m in 2027/28 - for community-based, preventative schemes that will mitigate growth in acute-based care. This will accelerate delivery of our Population Health Improvement Plan, with an immediate eight priorities across integrated urgent care, neighbourhood health, end of life care, cardiovascular disease, stroke, weight management and smoking cessation, elective care demand management, and mental health. For each priority area we are leaning into the ICB role as a strategic commissioner through developing clear, evidence-based business cases which seek to:

- understand the population cohort(s) to focus on and their needs now and in the future
- set out the outcomes we are seeking to achieve and the broad model to deliver this
- the budget envelope available and the commissioning approach to be used
- the evaluation approach that will be utilised for ease case

One of the priority areas we are rapidly undertaking work on is in elective care demand management, to identify and appraise high impact opportunities, including through reform of the outpatient model into community-based models of care, to reduce elective waiting times. Collectively, these actions will mitigate growth in acute demand, improve system flow, shift performance towards constitutional standards, and deliver sustainable improvements in health outcomes.

3. *We will embed outcomes-based commissioning, ensuring investment decisions are linked to measurable improvements in outcomes and value.*

Across Norfolk and Suffolk investment will be rebalanced through outcomes-based community and primary care contracts that prioritise prevention, early diagnosis, self-management and reduction of unwarranted acute activity, particularly for Core20PLUS5 populations. This will be done on a thorough understanding of how this effects providers in different ways. The ICB's Population Health Improvement Plan aligns priority health outcomes with how the ICB will allocate resources. For example, commissioning for maternity and early years will focus on measurable outcomes such as reduced smoking in pregnancy, healthier births and improved child development. Investment in cardiovascular disease, cancer and diabetes prevention and earlier diagnosis will prioritise reductions in premature mortality and avoidable hospital admissions. Commissioning of community and mental health services will support people to

manage long-term conditions and remain in good health for longer, with outcomes focused on quality of life and reduced system demand. Whilst, frailty, falls and dementia services will be commissioned to improve independence, reduce emergency admissions and shorten hospital stays through integrated community and social care models. We have placed greater emphasis on formal service evaluation and commissioners are supported by evaluation resources as well as access to specialist health economics expertise to ensure investment decisions are based on assessments of value.

4. *We will develop place-based and neighbourhood commissioning through our Place Alliances, enabling more responsive, locally tailored decision-making while maintaining strategic oversight.*

We have five Place Alliances which are supported by delegation of commissioning responsibilities and budgets to Place under the leadership of an Executive Director of Primary Care and Neighbourhood Health (one for Norfolk and one for Suffolk). A key element of our place and neighbourhood commissioning will be the recommissioning of community health services across Norfolk and Suffolk. We have aligned the end dates of our four contracts so that within two years we can recommission these services to improve prevention, joined-up care, and consistent access through expanded community services. Place based commissioning will also enable stronger collaboration with primary care, social care and the voluntary sector to address local inequalities and variation in outcomes. A neighbourhood-based community model will be implemented Norfolk and Suffolk wide, aligning community geriatrician support, frailty assessment services, increased use of virtual wards, Home First and independent wellbeing practitioner support, and full neighbourhood coverage of community hospice services. Strategic oversight will be achieved through an Alliance of providers that ensures neighbourhood health plans support delivery of system goals whilst responding to local health and care needs.

5. *We will take a more active role in market shaping, supporting innovation and collaboration across providers, including the voluntary and community sector, to deliver more integrated and flexible models of care, including supporting the steps toward IHO approaches in appropriate fast movers.*

Cardiovascular disease is one of the ICB's eight priority areas and is a leading example of the ICB taking a significantly more active role in market shaping to move from fragmented commissioning towards integrated, outcomes-focused models of care. Building on our robust population health intelligence we identified the better identification and management of hypertension and lipids would have a demonstrable gain both in terms of population health outcomes and allocative efficiency. This has led to the development of a single, integrated prevention and optimisation pathway that brings together community identification, digital risk stratification, clinical decision support, medicines optimisation and sustained lifestyle support. Rather than commissioning isolated services, the ICB is proposing to commission a system integrator who will convene industry and delivery partners, and aligning investment to a coherent end-to-end pathway. This creates space for multiple providers, including VCFSE organisations, pharmacies and community partners, to contribute within a shared model, while avoiding duplication and unwarranted variation.

We will increasingly use this approach to support innovation that is adoption-ready, evidence-based and capable of operating at neighbourhood scale, particularly in areas of high inequality and unmet need. In CVD, this includes community-based diagnostics, digital self-monitoring, neighbourhood outreach and pharmacist-led optimisation, coordinated through a common digital spine that enables data sharing, clinical oversight and proactive targeting of

high-risk cohorts. This directly supports more flexible, preventative and neighbourhood-based models of care.

Critically, CVD also provides a test-bed for taking deliberate steps towards Integrated Health Organisation (IHO) approaches in fast-moving areas. By aligning commissioning intent, digital infrastructure, delivery partnerships and incentives around shared population outcomes, the ICB is creating the conditions for more integrated delivery models that can evolve over time. Learning from CVD will be applied to other priority pathways as we progressively shift towards integrated, value-based commissioning and delivery at neighbourhood level.

6. *We will strengthen commissioning capability and governance, ensuring we have the analytical, commercial, and transformation capacity required to operate effectively as a strategic commissioner within a streamlined operating model.*

We will strengthen commissioning capability and governance to secure the analytical, transformational and commercial capacity needed for effective strategic commissioning. This represents our commitment to the national development programme and achieving the highest standards of maturity across key strategic commissioning functions. Our strategic commissioning policy will ensure all ICB functions lean into new ways of working and each contribute to the overall aims of the ICB's strategy. This will pivot the Norfolk and Suffolk ICB toward strategic commissioning that prioritises population health and sustainable service transformation.

Over the next three years, we expect to deliver our medium-term plans whilst achieving early improvements in population health outcomes. We expect to have new preventative care models in place across our clinical priorities, a shift in resources from hospital to community as part of a clearly defined local neighbourhood healthcare service, and for data and digital technologies to be driving transformation across our portfolio.

2. **How you intend to develop neighbourhood care, what your strategic ambition is and how this links to your key challenges**

Our ambition is to accelerate the development of fully integrated neighbourhood health and care, building on existing Integrated Neighbourhood Teams (INTs) and moving decisively towards a genuinely place-based, multidisciplinary model. Following the Neighbourhood Health Framework, neighbourhood care in Norfolk and Suffolk will become the default way we manage demand and deliver outcomes, not an add-on to hospital services.

We will deliver this through five Places, each of which will be underpinned by a Place Alliance bringing together NHS providers, local authorities, VCFSE partners and communities. We continue to build on the nationally commended Suffolk INT model, which has been in place for many years, by commissioning a Care Management Service (initially for Suffolk) for the top 1% of acute non-elective bed day users and by sharply focusing on the outcomes achieved. We will apply learning from this and other exemplary models to deliver a new INT model across Norfolk.

Commissioning of community, out-of-hospital, end of life and neighbourhood services is delegated to place level. Each Place will have an Alliance of delivery partners that will together develop a Neighbourhood Health Plan, informed by insights on population health and lived experience, with measurable outcomes and accountability at neighbourhood level.

We enjoy close working with place-focussed Local Government colleagues, with aligned agendas and resource priorities. We will maintain these relationships as Local Government Reform is implemented.

Our vision is for primary care to be the foundation of a neighbourhood health model, using neighbourhood-based working to shape commissioning, focus improvement effort, and support better outcomes for defined populations. Through the Primary Care Action Plan, we will align activity around shared priorities - improving access, digital enablement, and proactive care for those with greatest need. The ICB aims to create the conditions for success through aligned incentives, shared measures, and neighbourhood collaboration, prioritising consistent delivery and learning over structural change.

The ICB is developing plans for recommissioning community services in Norfolk and Suffolk and will use this as the principal mechanism for achieving ambitious change in how these services are delivered. Our approach to community services, focussed on neighbourhood working, will be key to transforming how people access support in the community by reducing inequality, improving access, and sharing information digitally in real time to increase patient and carer ownership and participation in making the right clinical and lifestyle choices. Delivering this will require a true system-wide partnership approach, which we are committed to deliver.

There is a direct and critical relationship between neighbourhood health delivery and the long-term clinical and financial sustainability of the acute sector, and wider system. Effective neighbourhood delivery across Norfolk and Suffolk will enable earlier intervention, improved management of long-term conditions, and better coordination of care, reducing avoidable hospital attendance and supporting a more proactive and sustainable model of care.

Equally, transformation of the acute sector is essential to enabling neighbourhood delivery. Through the Norfolk and Waveney University Hospitals Group's 'One Strategy' programme, acute services, workforce, digital capability and estates are being redesigned to define a new role for acute providers within an integrated, neighbourhood-focused health system. This includes realising the opportunity presented by the near £3bn investment into Norfolk and Waveney through the New Hospital Programme to reshape the role of hospitals so that specialist, complex and infrastructure-dependent care remains concentrated within acute settings, while lower-acuity and routine care is increasingly delivered through neighbourhood models.

The New Hospital Programme provides a significant opportunity to align estate transformation with this shift, ensuring that future hospital infrastructure is designed around modern pathways of care rather than replicating existing models. This reciprocal "push and pull" between neighbourhood and acute transformation is fundamental to improving outcomes, enhancing patient experience, and securing the long-term sustainability of health services across Norfolk and Waveney.

Our strategic ambition for neighbourhood care is to deliver:

- Improved health and wellbeing for everyone, with proportionately greater effort where need is highest, by focussing on health equity and reducing health inequalities

- Proactive, anticipatory care for people with the highest and most complex needs

- Stronger prevention and early intervention

- Care delivered closer to home wherever clinically appropriate

- Clear ownership of defined population cohorts and outcomes

To achieve this, we will

- Strengthen and standardise neighbourhood teams, by bringing together community nursing, therapy, specialist services, primary care, social care, mental health and VCFSE input to establish and empower new teams that place neighbourhood as the centre of our health system.

- Consistently target high need cohorts from our segmentation modelling and risk stratification and, in doing so, embed a Population Health Management approach through neighbourhood health. Increasingly this will be coproduced with provider teams and facilitated through analytical collaboration and shared data as a single version of the truth.

- Embed Care Management Services for the top 1% of users of acute care as a core neighbourhood function, with integrated acute and community Trusts working in partnership with GP Federations and voluntary sector.

- Align community inpatient beds, urgent community response, and virtual models as integral neighbourhood assets rather than standalone services.

- Invest in outcomes, PROMs/PREMs, and evaluative population health data to evidence impact and continuously improve.

- Implement single points of access for elective care where infrastructure enables hosting, providing specialist advice to primary care referrers, reducing demand on acute services and enabling primary care to support patients where this is most appropriate.

- Work with providers and partners to develop the system estate to enable a shift to a prevention and neighbourhood-focused integrated health system.

- Support the integration, acceleration and deployment of a joint digital architecture to enable triage and routing, coordination and resource deployment to enable these new ways of working, collaborating and accountability.

- Continue to develop Community Diagnostic Centres, including at Newmarket to support the shift from hospital to community. This will support direct access diagnostic pathways and expansion of cancer screening, for example.

- Continue to engage in the Marmot Place programme already adopted by colleagues in East Suffolk and adopt the Marmot Principles.

- Further develop digital initiatives to support 24-hour access to virtual care that reduce demand on face-to-face services, such as by building on existing tools in community MSK services.

- Expand remote monitoring and virtual connection to specialist clinical skills for diagnosis or to other components of care (e.g. translation services, care assessments) to increase accessibility and productivity.

- Deliver seven new Neighbourhood Mental Health Centres across Norfolk and Suffolk over the next five years, drawing on national capital funding.

Our participation in the National Neighbourhood Health Implementation Programme (NNHIP) is a key enabler of this ambition. In East Suffolk, the programme focuses on people with, or at risk of, heart failure, strengthening proactive, joined-up management and reducing avoidable deterioration and emergency admissions. In West Suffolk, the NNHIP focuses on diabetes and diabetes prevention, supporting delivery of an Integrated Diabetes Service, earlier detection, prevention and improved outcomes for high-risk, newly diagnosed and existing patients.

This ambition directly addresses our most pressing challenges:

- Acute flow and capacity: neighbourhood care and integration is essential to ensure we have the right capacity within the acute hospitals to realise left shift.

- Rising demand and complexity: particularly frailty and SEND growth, which cannot be managed through hospital-centric models alone.

- Workforce sustainability: neighbourhood teams create more attractive, autonomous roles and enable staff to work to top of licence.

- Financial sustainability: shifting activity upstream is fundamental to system and Trust finances.

- Health inequalities: neighbourhood models allow targeted, place-based responses rather than one-size-fits-all services.

- Frailty: Care for people with moderate to severe frailty needs to be redesigned around proactive, integrated, community-based multidisciplinary services that focus on maintaining and restoring function, independence, and wellbeing. This includes planned proactive frailty support and same day acute frailty response at home to deliver hospital level care while reducing crises, admissions, and harm, with strong support for carers.

- Neurodevelopmental conditions: Rising waits for neurodevelopmental assessments need to be addressed through a consistent, system-wide, evidence-based approach to pathway design and capacity planning. This will build on collaborative provider models and targeted investment to manage current demand more sustainably while preparing for future pressures.

- Children and Young People: Across Norfolk care for children and young people with complex needs will increasingly be delivered in community settings through expanded specialist multidisciplinary teams rather than acute hospitals. A local Centre of Excellence will be developed to integrate community paediatrics with specialist.

3. **Whether you would like us to agree changes to financial flows and/or payment systems to help deliver this and, specifically, what these changes are**

We welcome the financial reforms implemented for 2026/27 including the development of blended tariffs, removal of system control totals, mandating of the disaggregation of the acute block contract, and growth funding redirected into community settings.

The acute block disaggregation and shift in community growth funding have released £27m in 2026/27 for Norfolk and Suffolk to invest directly into left shift, demonstrating that payment reform delivers real results.

However, further change is needed to embed equity and fairness, and to enable the financial economics of prevention to be genuinely sustainable; and perverse incentives are minimised, for example in relation to deficit support funding.

A. Funding Equity, Fairness, and Reflecting Deprivation

Carr-Hill and Primary Care Funding:

The Carr-Hill formula is methodologically outdated, using patient weightings derived in the late 1990s and a workload based rather than needs based approach. Critically, it contains no adjustment for deprivation. The problem compounds across all primary care income streams: QoF, PCN staffing, and enhanced services all skew toward more affluent areas, with practices in the most deprived areas receiving on average 9.8% less funding per needs adjusted patient (Nuffield Trust, 2024).

Alongside this we would like to see outcome-based contracts that actively reward inequality reduction, and reform of exception reporting, which currently harms patients in the most deprived communities. QoF rewards inputs made rather than outcomes achieved, and we would like to see a greater focus on population-based care across PCNs and neighbourhoods, alongside stronger integration requirements through the Community Pharmacy contract.

Proposal: *Accelerate the Carr-Hill review implementation and apply a mandatory deprivation weighting across all primary care funding streams, alongside reform of primary care contracts to reward outcomes rather than inputs.*

Market Forces Factor:

The Market Forces Factor (MFF) is explicitly designed to reflect unavoidable cost differences between providers, principally labour market costs, land values, and building costs and by design contains no adjustment for population deprivation or health need.

This means providers serving deprived communities, who face both higher clinical complexity and equivalent or greater input costs, receive no MFF recognition for the additional burden this places on their financial model. A specific deprivation correction factor should be incorporated to ensure that providers serving the most disadvantaged populations are not structurally underfunded relative to the cost and complexity of what they deliver.

Proposal: *Introduce a deprivation correction factor within the MFF methodology to reflect the additional cost burden on providers serving high-deprivation communities.*

Mental Health Funding Stability

We support moving away from mental health block contracts, but this must be a managed transition with a structured glide path. The Mental Health Investment Standard has been a critical safeguard for parity of esteem and must be preserved. However, we also recognise that

the MHIS in its current form measures only the quantum of investment, not the outcomes it generates for patients.

We would strongly support the development of a reformed MHIS that links investment to measurable patient outcomes, providing the system with a much clearer picture of the value generated by mental health spending and enabling better commissioning decisions over time.

Proposal: *Continuation of the MHIS with a mandate to evolve it toward outcomes-linked measurement, and to require a managed transition period before any new mental health payment model takes effect.*

B. Incentivising Cost Efficiency and Productivity

2% Net Uplift Efficiency Factor

The blanket efficiency factor has become a service cut in non acute settings where cost improvement headroom is exhausted, which risks undermining the growth in community capacity we need. A differentiation in how this is applied by care setting would be welcome, alongside giving commissioners greater flexibility to disaggregate contracts beyond the 2.5% cap where activity value is demonstrably below contract value (allowing therefore for discussions on potential mitigations where tariff is outdated and doesn't reflect current costs or inflation funding is below CPI/RPI).

Where this would affect potential tariff payments to Independent Sector providers, it should be addressed by a review of pricing relativities where prices do not reflect the most cost-effective delivery of activity.

Proposal: *Differentiate the efficiency factor by care setting, raise the disaggregation cap for commissioners with clear evidence of poor value, and review Independent Sector tariff prices to better reflect cost-effective delivery.*

Allocation Flexibility

We welcome the greater allocation flexibility already provided to ICBs and recognise this as an important step toward enabling genuine system level decision-making. The direction of travel is right, and we ask that this continues and accelerates, particularly for systems that have demonstrated strong governance and a consistent track record of financial delivery.

Proposal: *Continue and accelerate allocation flexibility across all funding streams, including delegated budgets, with the greatest discretion extended to high performing ICBs.*

C. Enabling and Incentivising the Shift Out of Hospital

Stranded Costs and Rebasing

The core structural barrier remains: reduced acute activity does not automatically release investable neighbourhood funding because acute fixed costs are slow to rebase. Explicit financial permission to invest ahead of cashable returns, would ease this problem significantly. Either by treating transformation costs as "below the line" for performance measurement, or through multi-year plan profiling where early deficits are offset by later surpluses.

Proposal: *Establish a formal below the line treatment for left-shift transformation costs and/or enable multi-year deficit/surplus profiling for systems with credible and approved prevention investment plans; enabling a broad consistency of approach to payment systems across the*

system, to protect comparability (including for those providers working across ICB boundaries etc)

Capital

NHSE approval processes for primary care capital continue to delay neighbourhood centre development. ICB delegated capital authority should be aligned with Foundation Trust limits, with flexibility to profile spend across the settlement period to reflect the genuine complexity of multi-organisation schemes.

Proposal: *Delegate primary care capital approval to ICBs at Foundation Trust equivalent limits and allow flexible profiling of capital across the full settlement period.*

Outcomes-Based and Capitated Neighbourhood Funding

Norfolk and Suffolk has the population health intelligence, financial track record, Place-based governance, and partnership maturity to move toward whole-population capitation. We want to develop local incentive schemes linked to shared neighbourhood outcomes with a structured glide path for managing stranded costs, and we are ready to work with NHSE on the development of these new models.

Proposal: *Establish the legal and contractual framework for whole-population capitation and invite Norfolk and Suffolk to work with NHSE on the development and piloting of these new models.*

Summary of Reform Requests

Theme	Area	Specific Ask
A. Equity & Deprivation	Carr-Hill / Primary Care	Accelerate review; apply mandatory deprivation weighting across all primary care funding streams; reform contracts to reward outcomes
	Market Forces Factor	Introduce a deprivation correction factor within MFF methodology
	Mental Health MHIS	Guarantee MHIS continuation; evolve toward outcomes-linked measurement; mandate managed payment transition
B. Efficiency & Productivity	2% Efficiency Factor	Differentiate by care setting; raise disaggregation cap where poor value is evidenced; review IS tariff pricing
	Allocation Flexibility	Continue and accelerate flexibility; greatest discretion to high-performing ICBs
C. Left Shift Enablement	Stranded Costs	Below-the-line treatment for transformation costs; multi-year deficit/surplus profiling
	Capital	Delegate primary care capital approval to ICBs at FT equivalent limits; flexible capital profiling across settlement period
	Neighbourhood Capitation	Establish capitation framework; N&S to work with NHSE as development and pilot partner

4. Whether there is anything further we need to do at the centre to help accelerate the pace of change locally, including getting out the way where necessary

To accelerate local delivery, we would like NHS England to focus on:

- Providing clear, stable national direction on neighbourhood health, outcomes-based commissioning and payment reform.
- Share high impact, evidence-based examples of new preventative care models and commissioning approaches, building on the emerging Modern Service Frameworks so that best practice can be scaled at pace.
- Ensuring schemes that are expected to have a significant impact on elective performance - particularly advice and guidance – are well evidenced with appropriate financial incentives in place across providers.

- Setting out very clearly how the new NHS Operating Model, as described in the 10 Year Health Plan, will be put into practice, with particular focus on what regional teams will do to drive provider performance assurance and intervention whilst setting out how that will dovetail with the ICB's role.

- Giving systems greater local discretion and flexibility to adapt contracts, financial flows and governance arrangements where there is strong local alignment and demonstrable collaborative working, in line with our commentary on payment/financial flow reforms.

- Enable flexible capital and asset planning to unlock the system estate as a core enabler of shifting care from acute settings to neighbourhood delivery.

- Reducing unnecessary central assurance and reporting requirements that slow down local innovation, particularly regarding Neighbourhood Health where local systems are best positioned to know what works and set local expectations on outcomes.

- Supporting system leaders to take calculated risks in redesigning services, particularly around financial flows, and support multi-year financial planning.

- Quick turnaround on decisions regarding voluntary redundancy and Mutually Agreed Resignation Schemes.

- Prompt funding approval decision on capital investment bids in Q1 to give providers the best chance to spend in-year, as well as enabling some revenue resource alongside capital schemes or clarity from the outset if unavailable.

- Successfully rolling out the Strategic Commissioning Development Programme and associated supporting resources for commissioners.

- Ensure the Federated Data Platform supports Strategic Commissioning by implementing a national solution to information governance barriers preventing universal access to Primary Care data.

- Enhancing understanding of the unique difficulties of providing health and care for rural and coastal communities and how care can be delivered to them in a different way.

- Giving clarity of the date of transfer of delegated functions to ICBs and an understanding of how assurance will move to an integrated approach across ICB functions.

Where 'getting out of the way' matters:

- Avoid over-specifying national models that limit local tailoring to rural and mixed geographies like much of Norfolk and Suffolk.

- Minimise parallel national programmes that pull capacity away from neighbourhood delivery.

- Trust high-performing systems to lead change without excessive gatekeeping or short-term resets.

- Lighten oversight of the temporary workforce spend and some lobbying around freeing up our opportunities to recruit internationally.

Overall, we believe there is a balance to strike between detailed top-down directed initiatives and a completely local approach; we would be supportive of a balanced approach that sets outcomes to be met, provides best practice parameters, and gives scope to local leaders to adapt to the needs of the Norfolk and Suffolk population.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 9
Date: 20 May 2026

Title: Suffolk Annual Public Health Report 2025: Youth Social Action

Lead Director: Stuart Keeble, Executive Director of Public Health, Communities and Public Safety, Suffolk County Council

Author: Martin Seymour, Assistant Director and Consultant in Public Health; Nicki Cooper, Senior Manager; Steve Gray, Project Manager, Children and Families Team.

Purpose: To provide the Board with an overview of the Suffolk Annual Public Health Report (APHR) 2025 which focuses on Youth Social Action as a population health approach, and to highlight implications for prevention, health inequalities and system working.

Recommendation: The Board is asked to:

- Note the findings of the APHR 2025
- Consider the implications for Integrated Care System (ICS) priorities, particularly prevention and health inequalities
- Support continued development of youth focussed co-produced, community-centred approaches

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1. Background

1.1. The Annual Public Health Report is a statutory responsibility of the Director of Public Health. It is an opportunity to give an independent voice on a topic of local significance or importance and provides an evidence base to inform system priorities and decision-making.

1.2. This report provides the ICB Board with an overview of the 2025 Suffolk Annual Public Health Report (APHR) and the associated programme of work on **Youth Social Action: empowering young people to shape a better future**. It outlines the public health rationale, national policy context, delivery model, evaluation, and implications for the Integrated Care System.

1.3. This approach reflects a broader shift in public health thinking, recognising that health outcomes are shaped not only by services but by social connection, opportunity and environment. The report positions young people not as passive recipients of services, but as active contributors to improving their own wellbeing and that of their communities. For more information on why youth social action is important see the evidence base slides on the Healthy Suffolk website.

1.4. The Annual Public Health Report adopts a different approach to our previous annual public health reports using a co-produced, participatory methodology grounded in young people's lived experience.

1.5. It has been informed by young people through three youth-led hackathons across Suffolk, enabling young people to identify priorities, design solutions and directly inform the report and subsequent programme design. The hackathons were facilitated by Volunteering Matters and their youth ambassadors and were held in November 2025 at Suffolk New College, Abbeygate Sixth Form College and Lowestoft Ormiston Denes Academy, alongside an immersive workshop at Northgate High School Sixth Form.

1.6. In total, 190 young people took part. These sessions combined collaborative group discussion and short presentations, enabling participants to explore and share their ideas around community, public health and youth-led social action.

1.7. In addition, 122 young people completed a survey that gathered demographic data and qualitative responses about their experiences of living in Suffolk.

1.8. The report is available via the Healthy Suffolk website: APHR 2025

2. Key Issues and risks

2.1. Youth social action includes volunteering, peer-led support, campaigning and community action led by young people. From a public health perspective, these activities support wellbeing, build resilience, strengthen social connection and address wider determinants of health.

2.2. The approach aligns with the National Youth Strategy 2026 and the national #iWill movement, which promote youth voice, meaningful participation and action to reduce inequalities. Suffolk County Council is a signatory to the Power of Youth Charter, embedding these principles locally. The Charter is linked to the #iWill movement, which is backed by ambassadors and champions across the country. In Suffolk, this work is supported by local charities, including Volunteering Matters.

2.3. Engagement with young people across Suffolk through these hackathons, surveys and workshops identified a consistent set of seven themes relating to the determinants of health and wellbeing for young people:

- **Youth Social Action is a lifeline, not a trend:** Young people shared how being involved in social action helps them feel empowered, connected and hopeful, but many feel this is still undervalued or unsupported. Young people emphasised the importance of consistent, long-term approaches rather than one-off engagement.

- **Community should mean safety, support and belonging:** Young people identified feeling safe, included and connected as fundamental to wellbeing. Access to welcoming, affordable spaces was seen as essential.
- **Mental Health depends on connection, not just services:** Young people talked about how hard it is to access support but also highlighted the importance of peer support, trusted relationships and safe environments, alongside challenges in accessing formal services**.**
- **Barriers to access are everywhere:** Structural barriers including transport, cost, rural isolation and digital exclusion were identified as limiting participation and opportunity, contributing to health inequalities**.**
- **The education system feels disconnected from real life:** Young people want schools and colleges that support the whole person, not just their grades. They spoke about how education impacts social health, mental wellbeing and life opportunities.
- **Young people need space to thrive:** Physical activity, creative outlets and social connection were all described as essential for wellbeing, but access to these is uneven. Many raised the lack of affordable gyms, youth centres and local opportunities.
- **Young people want to be seen, heard and celebrated:** Not all young people feel heard. There is a need to actively consider which groups are underrepresented and how barriers to participation can be removed. Young people expressed a strong desire to be involved in decisions that affect them, with a clear expectation that engagement leads to visible action rather than consultation alone. Meaningful participation is essential.

2.4. Young people experience unequal health outcomes linked to deprivation, access, transport and inclusion. Youth social action helps mitigate these inequalities by engaging those furthest from opportunity, creating safe spaces for connection and embedding shared decision-making. The findings of the APHR reinforce that these inequalities are experienced in practical, everyday ways, particularly through barriers such as transport, cost and access to opportunities. Addressing these factors is critical to improving both participation and long-term health outcomes.

2.5. Youth social action can therefore be understood as a preventative approach, strengthening protective factors such as confidence, resilience and social connection, and reducing longer-term demand on services.

2.6. The Annual Public Health Report makes five recommendations to translate commitments on Youth Social Action into sustained system change, embedding youth-led approaches into prevention, reducing inequalities and place-based working across Suffolk. These include:

- **Invest in connection, not just services;** Young people are asking for more ways to connect with each other through shared experiences. We therefore need to prioritise activities, events and environments that build trust, joy and relationships.

- **Support local infrastructure that young people trust:** Young people need real places to meet, talk and feel at home, including youth led community hubs, safe gathering places and recreational areas for hobbies, sports and creative activities – space that is co-created with young people.

- **Shift systems to meet youth needs:** Public systems must become more responsive and fairer to reflect what young people need.

- **Amplify youth leadership and lived experience:** Young people are ready to act and need support to turn ideas into impact.

- **Make access and inclusion a guarantee:** The system must remove barriers and actively support inclusion.

2.7. The Annual Public Health Report was launched at an event held at Ipswich Town Football Club. Attendees were invited to complete a pledge for one action they are going to carry out to embed Youth Social Action into their lives and work. Collectively, the pledges show that attendees committed to:

    - listening to young people,

    - embedding youth social action in everyday work,

    - actively creating opportunities for young people,

    - championing youth voice, and

    - sustaining this commitment both professionally and personally with a clear emphasis on long term culture change rather than one off activity.

2.8. **Programme delivery – going beyond the report and turning words into action.**

- A further engagement and co-production programme has commenced with funding secured from the National Lottery #iWill fund, matched locally with contributions from Public Health, Communities and Public Safety, Suffolk Community Foundation and the Police and Crime Commissioner to deliver a county-wide programme led jointly by Public Health, Communities and Public Safety, and Volunteering Matters.

- The programme is focused on system and place-based change rather than short-term activities and will comprise a series of twelve further hackathons leading to a broad programme of youth-designed and youth-delivered interventions, with young people involved in implementation, influence over commissioning, and scaling of effective approaches. Suffolk is an early adopter of this model.

- An independent evaluation by the University of Suffolk will assess impact on wellbeing, confidence and system learning, informing future commissioning and prevention strategies. This evaluation will be undertaken by young people trained as young evaluators and supported by the University, providing a unique learning experience and an opportunity for youth voice.

2.9. Broader, system-wide actions are required to embed Youth Social Action across policy and commissioning, investing in volunteering as prevention and challenging stigma. This has direct relevance for the Integrated Care Board and wider system partners, particularly in supporting prevention, reducing health inequalities and strengthening community-centred approaches. Embedding youth voice and

participation within system design offers an opportunity to improve both effectiveness and trust.

2.10. A delivery focussed action plan is being developed to translate the Annual Public Health Report commitments into sustained system change. This will sit alongside the #iWill funded programme and will aim to embed youth social action, co-production and youth voice, help tackle structural barriers and inequalities and deliver system alignment and culture change.

2.11. It is important to recognise that we are not starting from scratch and that work of this nature has been ongoing in the ICB, the districts and borough, with education partners and in the VCFSE sector. We therefore propose bringing together a Youth Social Action System Coordination Group, reporting into the Health and Wellbeing Board, to take forward this action planning.

2.12. **Risks:**

- Risk that youth voice is not consistently embedded across system decision-making, limiting impact
- Risk that structural barriers (e.g. transport, cost) remain unaddressed, continuing to drive inequalities
- Risk that engagement activity is not followed by visible action, impacting trust and participation

These risks can be mitigated through:

- Embedding co-production within system processes
- Aligning approaches with place-based and community-centred delivery
- Ensuring clear feedback loops and visible outcomes from engagement

3. Patient and Public Engagement

3.1. The APHR is based on extensive engagement with young people across Suffolk, including:

- Hackathon-style events
- Surveys and structured discussions
- Partnership working with community and voluntary sector organisations

3.2. This approach enabled direct insight into young people's lived experience and priorities and represents a shift toward co-production as a core approach, rather than a supplementary activity.

4. Committees and Groups

4.1. The Annual Public Health Report was launched at a Health and Wellbeing Board event on 15 January 2025.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 10
Date: 20 May 2026

Title: Norfolk Director of Public Health Annual Report 2025/26: *Healthy Ageing – Thriving through the years*

Lead Director: Derek Ward, Norfolk Director of Public Health

Author: Lee Watson, Norfolk Deputy Director of Public Health

Purpose: The Director of Public Health has a statutory duty to produce an annual report on the health of their local population. This year Norfolk's report focuses on healthy ageing and highlights actions that can be taken to ensure people live in good health for longer. The Board is asked to consider the findings and champion the key messages and recommendations to drive collaborative action across Norfolk and Suffolk.

Recommendation:

The ICB is asked to:

- Endorse the recommendations in the report and encourage partners to reflect on how these may relate to their own work.
- Share the Norfolk Director of Public Health's Annual Report 2025/26 with relevant partners.

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1. Background

1.1. The Director of Public Health's Annual Report 2025/26, authored by Suzanne Meredith (previous Norfolk DPH) focusses on healthy ageing in Norfolk, which is a significant issue given the county's growing older population and their vital role in local communities. The report explores how Norfolk can support people to live and age well through three key lenses: communities, places and people.

1.2. The report is organised into the following sections:

- Setting the scene – Norfolk's current population and 15-year projections, life expectancy and health inequalities, causes of ill health and opportunities for prevention.

- Healthy communities – the roles older people play as workers, volunteers and carers; the importance of social connection; and how digital inclusion and age-positive communication enable participation and reduce exclusion.
- Healthy places – how homes, public spaces and transport shape ageing; and how good design can reduce isolation and support independence.
- Healthy people – influences on health behaviours and opportunities to protect health through vaccination, screening, health checks, and physical activity.

2. Key Issues and risks

2.1. The key findings of the report are:

- Healthy ageing is achievable for all – it starts early and depends on supportive environments, connected communities, and accessible services that focus on preventing ill health.
- Norfolk's ageing population is growing rapidly, especially in rural and coastal areas, impacting health, housing, transport, and community infrastructure.
- Inequalities shape ageing – deprivation leads to shorter lives and more ill-health; tackling these gaps is essential.
- Independence and inclusion matter – most older people live in mainstream housing; age-friendly design, transport, digital access, and diverse housing options support autonomy.
- Community connection protects health – belonging, volunteering, and co-production foster resilience; older people are assets, and ageism must be challenged.
- Prevention and healthy behaviours are key – physical activity, healthy diets, screening, and quitting smoking reduce long-term conditions; poverty and unhealthy environments make this more challenging.

2.2. The report suggests recommendations for residents, organisations and system partners that reflect the strengths and opportunities presented in the report.

2.3. **Recommended actions for Norfolk residents**

- Healthy ageing starts early, but it's never too late to start. Circumstances and behaviours throughout life shape health in later years, but meaningful gains are possible at any age.
- Move more for strength and balance. Try to be active every day and add strength and balance twice a week (e.g. sit-to-stand, Tai Chi, resistance bands, gardening). Consider building active travel into journeys.
- Protect your health. Take up invitations for vaccinations (flu, COVID-19, shingles and RSV where eligible), screening (bowel, breast, cervical and abdominal aortic aneurysm) and NHS Health Checks (for those eligible aged 40–74).
- Stay connected. Join a local group, volunteer, or check in with a neighbour. Even one regular weekly connection protects mental and physical health.
- Ask for help if you don't know where to start. Norfolk has a wide range of support available across topics that contribute to healthy ageing. Don't struggle alone – reach out to friends, family or professionals. For more information go to Norfolk County Council's Healthy Ageing webpages.

2.4. **Recommended actions for individual organisations in Norfolk**

- Be age-friendly employers. Follow age-friendly employer principles, including where possible offering flexible work, age-inclusive recruitment, and workplace adjustments so people aged 50+ can stay, progress or return to work.

- Design for inclusion to tackle discrimination and stigma. Make venues and services easier to use: step-free access, clear signs, seating, quiet hours, hearing loops, large print and plain-language age positive communications all can help. Organisations can use tools such as Norfolk's Healthy Ageing campaign resources, to support communications. To access go to Norfolk Healthy Ageing Campaign Assets.
- Build connection into everything you do. Create low-cost, regular activities and "connector" roles to welcome newcomers and link people to support. This is especially important in rural or coastal areas where transport may be a significant barrier.
- Support digital confidence. Explore digital barriers with residents and support available to improve this, offer public Wi-Fi/data in estates where possible, and link those experiencing digital exclusion with others that can help.
- Co-produce with older people. Involve older residents from the start in designing groups, classes, services or policy improvements – and act on their feedback.

2.5. **Recommended actions for system partners in Norfolk**

- Embed Healthy Ageing considerations in all policies and strategies. Plan for Norfolk's growing older population and its impact on health, housing, transport, and infrastructure. These policies and strategies should consider targeted action to tackle inequalities, using population health data to prioritise key geographies and cohorts for intensified prevention activity. Tools such as the Norfolk and Waveney Health Inequalities Toolkit are available to support decision making.
- Support mental health in later life. Improve understanding of mental health and mental illness in later life in Norfolk, and the evidence-based approaches to respond.
- Work together to tackle multiple health risks. Commissioners and services should seek to work relationally and collaborate to support people in a holistic way, tailoring support, empowering residents to live their best life as they define it and designing services around what matters to each resident. This means providing whole life help rather than addressing various issues in isolation.
- Collaborate to create age-friendly places and communities. Build upon existing impetus to use Age Friendly principles to improve our places and communities across the eight domains (Outdoor Spaces & Buildings, Transportation, Housing, Social Participation, Respect & Social Inclusion, Civic Participation & Employment, Communication & Information, and Community Support & Health Services).
- Use this Director of Public Health annual report as a resource to inform and enhance transformation and integration across Norfolk. It provides an opportunity for all partnerships including the Health and Wellbeing Board, Place Boards and Health and Wellbeing Partnerships to explore opportunities within their influence to support healthy ageing in Norfolk.

2.6. These recommendations are intended to provide guidance on how we collectively ensure Norfolk is a place where everyone can live and age well. By investing in prevention, early intervention, and reducing inequalities, Norfolk can enable more people to live longer, healthier, and more independent lives.

2.7. The full Director of Public Health Annual Report can be found on the Norfolk Joint Strategic Needs Assessment (JSNA) website on Norfolk Insight – Director of Public Health reports (select 2025-26). Please download and open the PDF in Adobe Reader for full accessibility including alternative text and screen reader functionality.

2.8. Additional resources gathered to produce this report are also available on the JSNA website.

3. Patient and Public Engagement

3.1. The report builds upon evidence and insights gathered during Norfolk Public Health's 2024 strategic review on healthy ageing and shaped through consultation with internal and external stakeholders. Partners contributed case studies and photographs to showcase the work already underway to help residents age well and to share learning across organisations. It draws on nationally recognised sources, including the Centre for Ageing Better and the National Institute for Clinical Excellence (NICE), alongside robust local data to provide Norfolk-specific context and highlight variations across the county – enabling tailored local solutions.

4. Committees and Groups

4.1. Norfolk Director of Public Health Annual Report 2025/26 has been presented to:

- Norfolk County Council Cabinet (2nd March 2026)
- Norfolk Health and Wellbeing Board (4th March 2026)
- Great Yarmouth Health and Wellbeing Partnership (16th March 2026)
- North Norfolk Health and Wellbeing Partnership (31st March 2026)
- Breckland Health and Wellbeing Partnership (1st May 2026)

The report is scheduled to be presented to Broadland and South Norfolk (19th May 2026) and Norwich (June 2026) Health and Wellbeing Partnerships.

5. Alignment with Suffolk

5.1 The Suffolk 2024 Director of Public Health Report also focussed on Ageing Well demonstrating the aligned demographic shifts of the two counties. The Suffolk report also advocated for an inclusive approach to ageing, emphasising the importance of creating age friendly environments that support healthy ageing, reduce disparities and promote proactive measures for social connection, inclusion and quality of life. This report can be found at: www.healthysuffolk.org.uk/jsna/annual-public-health-reports.

The report has supported the following work to progress across Suffolk:

- Better promotion of community support available to people as they age, across both physical and mental health
- Development of a programme of work to ensure movement and physical activity are built into routine care, supporting the prevention of frailty
- Ageing Well approaches built into the Ipswich Place Partnership programme, supporting work to reduce barriers to Ageing Well
- Delivery of Ageism training across the system to support a more age inclusive approach
- Prevention workstreams built into West Suffolk and Ipswich and East Alliance delivery plans for Frailty and Dementia, which has included the development of a suite of training resources to build awareness and knowledge around the modifiable risk factors to support left shift prevention

Suffolk and Norfolk Public Health teams will continue to work closely together and in collaboration with NHS colleagues and wider system partners to drive forward the recommendations across both Director of Public Health reports.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 11
Date: 20 May 2026

Title: Norfolk and Waveney ICB Research and Innovation team annual report 2025-26

Lead Director: Dr Frankie Swords, Executive Medical Director

Author: Dr Clara Yates, Associate Director of Research and Innovation

Purpose: For information

Recommendation: That the Board notes the work of the Research and Innovation team in Norfolk and Waveney ICB during 2025-26.

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1. Background

1.1. This is the final annual report of the Norfolk and Waveney ICB Research and Innovation team and shares the work conducted during 2025-26

1.2. The activity is aligned to ICB/ICS strategies including the NWICS Joint Forward Plan and Clinical Strategy and the NSICB Population Health Improvement Plan.

1.3. Key achievements are shared here, guided by our ICS R&I strategy principles:

1.4. **Focused on our communities:**

- £100k NHSE funding for continuation of Research Engagement Network programme to increase representation of underserved populations in research
- Establishment of 5 Community Research Hubs in Norfolk, led by VCSE
- Recruitment of 18 children via community groups into a type 1 diabetes early detection study

1.5. **Driven by a confident and capable workforce**:

- Upskilling ICB and ICS staff in logic modelling, impact mapping and evaluation to support commissioning decisions

- Through membership of the national InSites programme, coordinate the design and delivery of 12 bitesize innovation training modules
- Supporting and facilitating a GP locum to apply for and deliver a NIHR ARC Fellowship investigating the barriers and facilitators to delivering research in prison healthcare settings

1.6. **Collaborative and coordinated**

- Enabled 56 of our 105 (53%) General Practices in Norfolk and Waveney to recruit almost 2000 participants to NIHR badged research during 25/26
- £614k Research Capability Funding (RCF) award as a direct result of our collaborative working with academic colleagues and hosting of NIHR research grants; in 2025-26 we hosted 16 grants with a total value of £18.5 million
- Supported the successful £1million application to NIHR for the Breckland and Norfolk region Primary Care Commercial Research Delivery Centre (PC-CRDC)

1.7. **Embedded in everything we do**:

- Worked with the Central Norfolk Place team, NSFT, PCNs and local authority colleagues to develop and evaluate a pathway for Kneu Health, a digital tool to support people waiting for memory assessment

1.8. This report demonstrates the positive impact research and innovation can have across health and care. This was also demonstrated loud and clear through our Norfolk and Waveney Health and Care Research Celebration in March 2026. This brought over 100 system partners together to network share and celebrate success across Norfolk and Waveney.

2. Key Issues and risks

2.1. Currently there are no risks on the BAF. The team hold a risk register in line with corporate governance requirements and research governance standards

2.2. Key risks relate to the funding of the team which is drawn from multiple external funding streams set at a national level. These are mitigated through robust three year financial plans and continued representation at a national level through the Research and Development Forum.

3. Patient and Public Engagement

3.1. The Research Engagement Network is the main mechanism by which the R&I team ensure engagement with our population around research.

3.2. It is a condition of funding that all research developed by our academic partners and supported by the ICB includes robust community engagement and public and patient invovlement.

4. Committees and Groups

4.1. This report was approved at Norfolk and Suffolk ICB Quality Committee on 7th May 2026

4.2.

Appendix 1:
NWICB Research and Innovation team annual report 2025-26

NHS
Norfolk and Suffolk
Integrated Care Board

Research and Innovation Team

Annual report (Norfolk and Waveney)

April 2025 - March 2026

Contents

120 Research Celebration attendees

£100K REN funding

11 RCF Project Awards

£614k RCF

5 community research hubs established in Norwich, Great Yarmouth, Waveney, West Norfolk and Thetford.

16 PCNs funded through RCF to build research capacity and capability.

Evidence and evaluation

11 evidence reviews

5 active evaluations

3 completed evaluations

41 advice and support activities

Research grants and studies

16 active projects worth **£18.5m**

53% general practices involved in research

Awarded funding for a Primary Care Commercial Research Delivery Centre **1 of only 14 in the UK**

1944 partipants took part in research across **26** studies in primary care

88 partipants in a N&W school recruited to a study on Youth Loneliness

Innovation

28 innovation champions

200 innovation network members

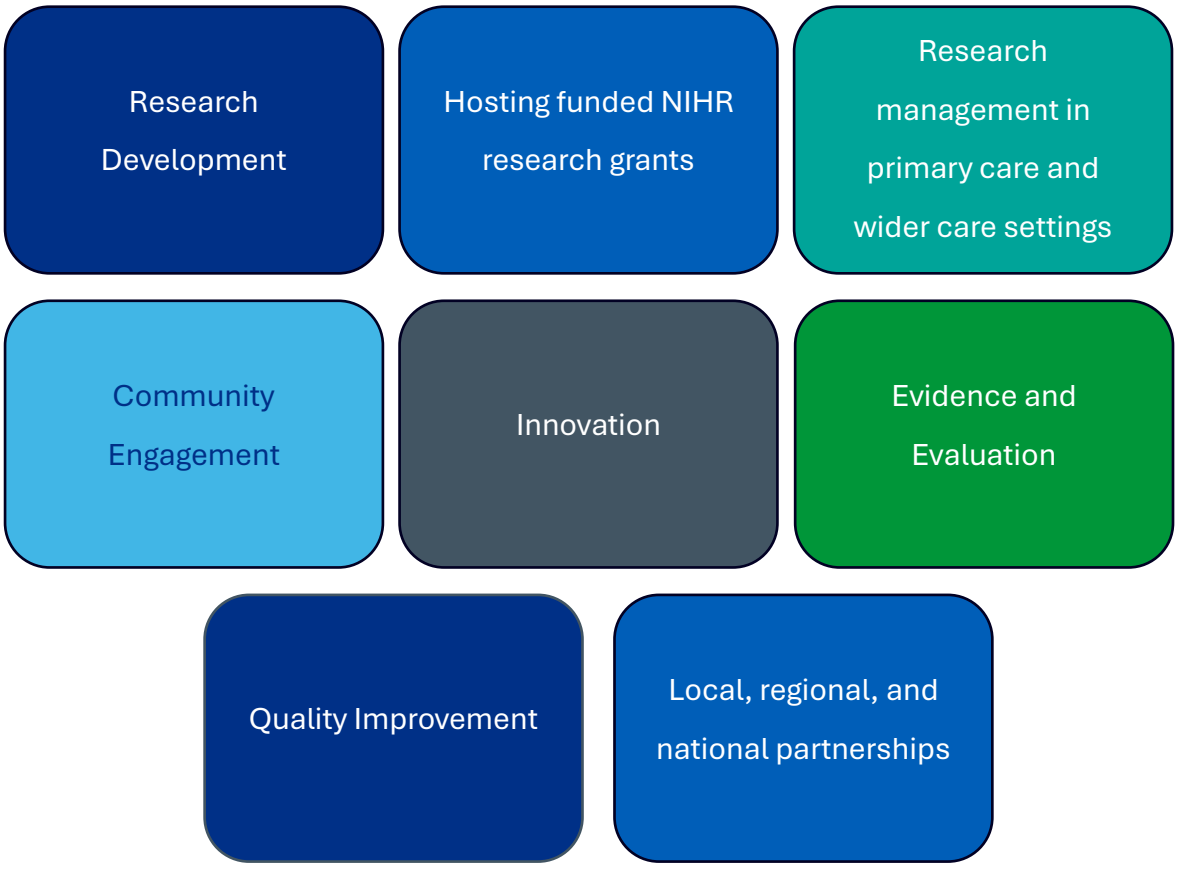
4 North Norfolk PCNs deployed dementia virtual monitoring

1. Introduction

The Research and Innovation (R&I) team at NHS Norfolk and Suffolk ICB have diverse and complimentary expertise across the R&I pathway. From supporting development of early-stage research ideas all the way through to implementation of service innovations. Our work over the period 2025/26 was aligned with the four principals defined in the Norfolk and Waveney ICS Research and Innovation strategy:

1. Focused on our communities
2. Driven by a confident and capable workforce
3. Collaborative and coordinated
4. Embedded in everything we do

We believe that R&I are the tools which enable the health and care system to improve. R&I increase the quality and efficiency of services for the benefit of everyone. In this report we share how the R&I team worked between April 2025 and March 2026 through our core functions of:



This approach, bringing together Research, Innovation, Development and Quality Improvement aligned to our strategy was the focus or our award-winning poster (Sponsor Choice Poster (1st Place) “Research and Innovation at Norfolk and Waveney ICB” – see Appendix 1) at the National Research and Development Forum in May 2025 and demonstrates national recognition.

Our priorities for R&I are based on our ICS Joint Forward Plan (JFP) and Clinical Strategy, and are also aligned to the new Norfolk and Suffolk ICB Population health improvement plan:

- Cancer: early detection and screening
- Mental health: transforming mental health services
- Urgent and emergency care: improving flow and ambulance conveyance
- Elective recovery: digital solutions and innovations
- Cardiovascular disease (CVD) prevention
- Transforming care in later life: services that are fit for our ageing population

We also provided research management and development support to Norfolk Community Health and Care (NCH&C) NHS Trust and East Coast Community Health (ECCH) CIC via Service Level Agreements. We supported primary care across the East of England, in collaboration with NHS Cambridgeshire and Peterborough ICB, funded by the National Institute of Health and Care Research (NIHR) Regional Research Delivery Network East of England (RRDN).

We know that what we do would not be possible without the positive relationships we have with ICB colleagues including our Executive Leadership, colleagues at the University of East Anglia (UEA) and University of Suffolk (UoS), the voluntary, community and social enterprise (VCSE) sector, the NIHR RRDN EoE, Health Innovation East (HIE), the NIHR Applied Research Collaborative East of England (ARC EoE), local authorities, NHS England, provider organisations, clinical and care professionals, primary care practices and primary care networks (PCNs) and we thank everyone for their support.

2. Focused on our communities

The overarching aim from our strategy is to ensure that research and innovation is informed by the needs and preferences of our population.

This aspect of our work is supported by NHS England Research Engagement Network (REN) and we received a further £100,000 this year, to strengthen our links with multiple VCSE organisations and build on our work of previous years.

We also have a particular focus on hearing from under-represented groups[1] including asylum seekers and people with learning disabilities. We are committed to using the information shared with us and providing feedback to organisations we have spoken with on how their insight has been used. Fundamental to our approach is one which builds trust with communities which is sustained over time, and where VCSE organisations are equal partners in the process and reimbursed appropriately (see community research hubs case study below).

In 2025-26, through a series of more than 20 workshops, we have brought together over 20 VCSE groups and their communities with the RRDN, UEA Citizens Academy, NHS staff and researchers to talk about inclusive research.

We worked with community groups based in Lowestoft, Great Yarmouth, King's Lynn, Thetford and Norwich to help them establish and lead community research hubs. This work started in Dec 2025 and the hubs have had conversations with the RRDN and ICB about which studies will work well with their communities. They have focussed on how they recruit people in their communities into open research studies with support from the RRDN.

[1] Improving inclusion of under-served groups in clinical research: Guidance from INCLUDE project | NIHR

Case study: Community Research Hubs

At the Great Yarmouth community research hub's first local network meeting, community groups met to learn more about research and talk to RRDN research nurses about the ELSA study (EarLy Surveillance for Auto immune diabetes). Out of this meeting The Bread Kitchen, who support children not in mainstream education, agreed to invite the nurses to talk to the families they support. Shrublands My Youth Group also agreed to invite the nurses to visit their group. Over a series of four visits to each of these groups the research nurses spent time building trust with families before recruitment. This approach led to the successful recruitment of 18 children to the ELSA study in a familiar, community led environment.

By working in partnership with local community groups—and supporting them to gain a greater understanding of research—the hub has demonstrated that research can be delivered ethically and sustainably in community settings, improving participation, trust, and long-term engagement.

3. Driven by a confident and capable workforce

Enabling our health and care workforce to take part in research and innovation can increase job satisfaction, enable organisations to recruit and retain[2] staff and improve health outcomes for our population[3]. We have a range of support offers for our workforce to gain new skills and contribute to a culture of continuous improvement, including developing a series of bite-sized QI training, aimed at colleagues in primary care but also suitable for our VCSE partners.

ICB organisational capability

We have continued to advance ICB organisational capability through our collaborative approach to active evaluation work and our ongoing advice and support activities such as logic modelling and impact mapping. For example, we supported the Health Inequalities and VCSE Partnering Team in impact mapping the Women's Health Community Voices project. This identified achievements, successes, barriers and challenges, many of which were relevant to the wider integrated care system. Considerations for moving forward included: building in resourcing for aftercare, reducing decision-making timescales, improving communication, refining scope and collaborating with VCSE organisations from the outset.

Our logic modelling facilitation has continued across system-wide projects, often leading to advice on developing impact evaluation of integrated services. For example, we supported North City Integrated Neighbourhood Team in discussing evaluation considerations and Norfolk Community Services in approaching logic modelling, evaluation and data collection.

We completed the year with an updated meta review of learning from our evaluations, suggesting feedback for improvement in organisational approaches to service design and evaluation. This included further advocating the use of logic modelling at the earliest stage of project planning, embedding a culture of learning and using data appropriately.

[2] Academic factors in medical recruitment: evidence to support improvements in medical recruitment and retention by improving the academic content in medical posts. https://doi.org/10.1136/postgradmedj-2019-136501
[3] Research Activity and the Association with Mortality. https://doi.org/10.1371/journal.pone.0118253

Research and Innovation culture and training

We remain the only ICB to be an NHS England InSites peer network innovation programme in England and we have received a further £100,000 funding to support this work. We have continued to offer ongoing support and training to 28 innovation champions representing health and care organisations across Norfolk & Waveney. This has included providing external training opportunities, including a series of three workshops focusing on enabling colleagues to build a culture of innovation within their organisations. We also coordinated the development and delivery of 12 bite-size innovation training videos on behalf of the InSites programme, working with Health Tech Enterprise (HTE). These were launched in early 2026 with live sessions and cover topics including finding funding, IP and commercialisation and compliance frameworks. The videos are accessible for all on the InSites you tube channel.

In August 2025, the James Paget University Hospital were awarded the NIHR Health and Care Professional Internship programme for the East of England. The Research and Innovation team provided support in developing this application and building support across the system. Successful interns to the first cohort of the programme started in January 2026 and represent a wide range of providers from across the East of England. This is a great achievement for our local acute Trust and we continue to support the programme through our membership on the core programme group, workshop delivery support and mentoring to individual interns.

We also use part of our Research Capability Funding (RCF) allocation to support the development of research capacity and capability in primary care. This year we awarded £100,000 to 16 Primary Care Networks PCNs (80% of Norfolk and Waveney PCNs) to enhance their ability to engage in developing or delivering research that will benefit their patients and communities. Most of the PCNs used the funds to buy out time for clinicians to develop their skills or have the time to review study information to enable them to participate in research projects. We worked closely with the RRDN to align with their approach to building capacity and capability.

Case Study – Dr Olajide Popoola, NIHR ARC Fellowship

At the end of 2024/25 the team supported Dr Popoola, to successfully apply for a Research Fellowship with the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC). This supports individuals with hands-on experience to lead small-scale academic projects through protected time, academic supervision and a structure training programme over a 1 year period.

As a GP locum, the ICB agreed to oversee the project, manage the funding, and support Dr Popoola in lieu of an employer, without which he would have been unable to apply for the fellowship. Academic support was provided by the ARC.

Dr Popoola's project explored barriers and facilitators to the delivery of healthcare research within prisons, a group typically underserved by healthcare research through a narrative literature review and a series of stakeholder workshops.

Whilst the findings of this project are still being analysed, this work has had immediate impact through conversations and engagement of prison staff, opening the doors to future delivery of research in prison settings; Dr Popoola was a winner of the poster competition at the ARC Fellowship Showcase and had an abstract accepted for the Society of Academic Primary Care (SAPC) conference in June 2026. A related project has had a poster accepted at the Research and Development Forum Conference in May 2026. Building on this work we supported Dr Popoola and the RRDN with a strategic funding application for supporting research delivery in prisons, that while unsuccessful, has laid the groundwork for a future application to the 27/28 RRDN strategic funding round.

4. Collaborative and coordinated

As a R&I team we have had the opportunity to collaborate with colleagues across multiple different organisations in the region. We have also been able to bring other partners together, coordinating their work even if the ICB team is not directly involved in the project. Here we present some examples demonstrating the benefits of collaborating, from supporting efficient research delivery to sharing examples of learning from Quality Improvement (QI) projects, increasing equitable access to high quality, effective care.

Collaboration for research

Collaboration is essential to the delivery of research projects. Increasingly research studies are following an individual through their pathway of care for example the participant may be discharged from acute to community services during the research. Collaboration between research active organisations can enable increased access to research opportunities beyond the patient population served by an individual organisation. This can cause logistical, financial and contractual complexities which can delay set-up and delivery. For example, an acute trust may be undertaking a research project which requires healthy volunteers who might be easier to recruit via primary care. We have worked with our local provider Trusts to problem solve and develop solutions to these challenges, and this work has expanded to our Suffolk providers to ensure a consistent approach to collaboration across the new ICB footprint. We continue to work closely with the RRDN and our Trust partners to address barriers and co-create solutions and agreed ways of working to facilitate cross-organisational research delivery, and to link into national worth through our national forums.

We also continue to support Primary Care engagement and participation in research. 56 of our 105 (53%) General Practices in Norfolk and Waveney recruited almost 2000 participants to NIHR badged research during 25/26, supported by the ICB R&I team, with a similar amount recruited in Suffolk and North East Essex. In line with the experience across the country, overall recruitment remains low compared to previous years due to a drop in large recruiting studies, however we have seen an increase in the number of practices recruiting to research (53% compared to 35% in 24/25) and

have seen an increased interest from practices in undertaking commercial research, with both ECCH and Hoveton and Wroxham securing their first commercial studies.

In 2025/26 the ICB had 16 active NIHR research grants, totalling £18.5 million. In recognition of this, the ICB is awarded RCF on an annual basis and in 2025/26 we were awarded £614,000. As in previous years, we continued to use RCF to support our research workforce to develop more research grant applications in primary and community care and wider community settings. We ensure that the topic areas are aligned to R&I health and care priorities. We also ensure that equality, diversity and inclusion are addressed so that opportunities to take part in research are open to as many people as possible, linking with our REN programmes. We made 11 RCF grant development awards covering areas such as advanced planning in care homes, pollution around schools, hospice research, approved mental health practitioners (AMHPs), and missing young people. In total we supported the submission of 41 research applications, 28 of which have the ICB is named as the host organisation, 20 of which had received RCF support previously.

We have also supported three applications to the NIHR Doctoral and Advanced Fellowship programme and Professorship scheme.

Development of commercial research delivery expertise

In August 2024 the DHSC secured £400m investment through the Voluntary Scheme for Branded Medicine Pricing, Access and Growth (VPAG) to boost clinical trials, delivered through the UK Clinical Research Delivery (UKCRD) Programme. Building capacity and capability for commercial research in Primary Care is a key workstream of this programme. This included:

- Development of Commercial Research Delivery Centres (CRDCs), including 14 Primary Care led CRDCs.
- Launch of a capital investment call of which £10m was ringfenced for Primary Care
- Establishing Commercial Trials Fellowships for GPs
- Implementing a NCVR Research Champions Programme for GPs

The Norfolk and Waveney R&I team have been instrumental in supporting practices to apply for many of these schemes. One notable success is a £1 million award over

three years to support the establishment of a Primary Care CRDC with Breckland Alliance – one of only 14 in the country. Three practices in Norfolk and Waveney have also secured Capital Investment to improve their facilities in delivery of commercial research. One of our local GPs has also been awarded a commercial trials fellowship in association with University of Exeter. Finally, we have also had significant success in NCVR, with 29 practices now signed up to the scheme.

Case study: Commercial Research in Primary Care

Commercial research activity has continued to grow steadily, with seven commercial studies assured in 25/26 and a further seven in the pipeline. The NCVR programme has also expanded significantly, with 29 practices now signed up to the scheme, a 71% increase across Norfolk and Waveney since late January 2026, demonstrating significant interest in commercial work. As a result of our work with practices, we now have a number of practices being selected for commercial research for the first time.

A significant highlight of the year was supporting Breckland Alliance to become one of only 14 Primary Care Commercial Research Delivery Centres (CDRCs) in the UK, recognising the experience and expertise of the Breckland Team in delivering commercial research. The R&I team supported their application, resulting in a £1 million award over 3 years. The CRDC will collaborate with life sciences organisations and local partners to support the delivery of industry-sponsored research and build local capability and capacity for commercial research in Primary Care, and helping strengthen the UK's position as one of the best places in the world for companies to conduct research.

Targeted support has also been provided to practices requiring additional assistance in starting commercial research, and work has also been undertaken to streamline processes with local Trusts, ensuring that the necessary hospital clinical services (such as pathology) are in place to support the successful delivery of commercial studies in primary care.

RDN Wider Care Settings and Strategic Funding applications

After 25/26 there will be changes in funding mechanisms for delivery of research through the RRDN, moving away from regional initiatives to a nationally consistent, locally implemented system. Organisations in the region were invited to apply for this funding over the winter period, and the R&I team worked with the RRDN locality managers in Norfolk and Waveney and Suffolk and North East Essex to support Practices and wider care settings to understand, and apply for these funding opportunities, through targeted lunch and learn sessions, communications and one to one support for applications. Despite over £9m worth of applications being received for £1.4m funding in the East of England, we have secured funding to support research capability work in hospices; primary care and community engagement initiatives. In addition to the strategic funding, 72 organisations including schools, hospices and care homes in Norfolk and Waveney and Suffolk and North East Essex successfully applied for wider care setting funding representing 51% of the total applications that were funded in the East of England.

	GPs	Schools	Pharmacy	Hospice	Care Homes	Other[1]	TOTAL
N&W	38	1	0	3	0	2	44
SNEE	20	2	2	2	2	0	28
EoE Total	115	6	5	6	2	6	140

[1] WCS funding was also awarded to two community Trusts, one MH Trust, two CICs and one acute Trust

Coordination for improvement

This year we developed a bitesize quality improvement training series in collaboration with colleagues from across the system. This covered the basics of QI to support colleagues in primary care and outside of hospitals.

We have continued to bring the system together at monthly Quality Faculty meetings to hear from colleagues undertaking quality improvement projects across many different providers. We have supported colleagues to set up and shared QI projects on a range of areas in line with our system Population Health Management strategy and Joint Forward Plan:

- improving electronic blood requests,
- Diabetes 360 reviews,
- reducing falls in older people in a dementia hospital setting and
- implementing an accurate acuity score on a virtual ward.

These discussions have generated opportunities for system-wide collaboration to spread and share these initiatives.

Collaboration for Innovation

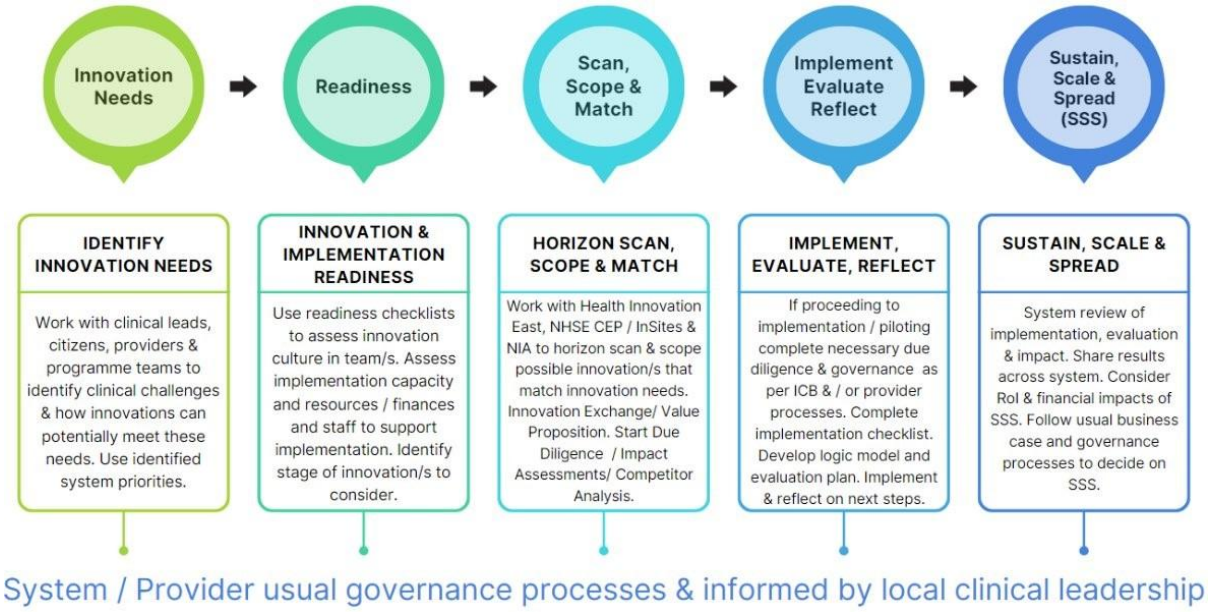
Collaborating with Cambridge and Peterborough ICB and Suffolk and North East Essex ICB we successfully applied to be part of the Accelerating Innovation Systems (AIS) programme, funded by the Health Foundation. This national programme set out to understand how ICBs work with their partner Health Innovation Network and to capture practical learning about how ICBS, as strategic commissioners, can accelerate the adoption of impactful health and care innovations. Through a series of interviews and learning sessions we contributed to the development of three resources:

- a guide to driving innovation adoption through strategic commissioning
- a ICB-HIN maturity matrix, a framework for supporting closer partnership working between ICBs and HINs
- ICB innovation cycle posters featuring key steps to embed innovation adoption within strategic commissioning

During 2026 we will be using the learning from this programme to shape and articulate how we work with our HIN, Health Innovation East

5. Embedded in everything we do

The R&I strategy made a commitment that we will influence and support partners to incorporate research and innovation into the design, planning and delivery of services and infrastructure. The examples provided throughout this report demonstrate how we have done this using the R&I strategy principles. From aligning our RCF project grant call outs to system JFP and clinical strategy priorities, ensuring locally developed research benefits our population to working with teams to use our innovation toolkit:



Together these approaches mean we are embedding R&I in everything we do. Our final case study illustrates how using the toolkit led to the implementation of Kneu Health across four Primary Care Networks (PCNs) in North Norfolk, aligning with the government's 10 year plan shifts of moving care from analogue to digital and closer to home.

Case study: Kneu Health

We have worked with the Central Norfolk Place team, Norfolk & Suffolk NHS Foundation Trust (NSFT), Primary Care and Council colleagues to develop and evaluate a pilot pathway for Kneu Health. This digital cognitive and memory assessment app/platform aims to support patients and carers waiting for memory assessment services in some parts of North Norfolk. It offers remote, digital methods of monitoring memory and cognition and signposting to national and local resources. This could lead to:

- improved patient experience while waiting
- increased monitoring of presenting concerns
- improved identification of escalation if required
- reduction in memory assessment service waiting times
- reduced memory assessment sessions / duration

The 12 month pilot started in January 2026 and we are collaborating with Health Innovation East to lead on the evaluation.

6. National collaboration & influence

We recognise that we are unusual in having such a strong and diverse R&I offer in our ICB. As such, we consider that we have a duty to contribute to regional and national research and innovation programmes of work and policy.

These include the following areas:

- We contributed to a NHSE led national working group to develop measures for ICB Boards to understand Integrated Care Systems (ICSs) Research Performance (in addition to NIHR/DHSC key performance indicators)
- Our Research Manager is a regional champion for the national contract value review (NCVR)[4] process. NCVR is a standardised, national approach to costing for commercial contract research, first introduced in 2023 for Trusts to speed up commercial research set up times. NCVR is voluntary for Primary Care but as a result of the work undertaken in the last quarter of 25/26, 29 practices in Norfolk and Waveney were signed up to NCVR, representing a 71% increase since January 2026.
- We provide the co-chair to the R&D Forum ICB Research Leads Working group.
- We are active members of the Primary Care and Commissioning Working Group, and Wider Health and Care and Community Working Group.
- The Health Research Authority (HRA) convenes a group of Research champions from across the UK representing all sectors and regions to provide an NHS R&D perspective on the work the HRA does to regulate and streamline research. The Head of Research Management and Finance is one of the two East of England Champions and the only Champion nationally, with a focus specifically on Primary Care research
- We also remain the only ICB on the NHS England InSites programme. This enables us to access and share learning from leading innovative trusts across the other 17 sites and the core team, as well as providing £100,000 to support our innovation programme of work. Through InSites we have also contributed to projects to streamline innovation in the NHS, including through an evaluation framework and innovation passport

[4] NHS Accelerated Access Collaborative » National contract value review

- We have developed close strategic partnerships with HIE and Heads of Innovation in EoE which have led to collaborative innovation initiatives and sharing of best practice
- We are part of a national community of practice for Evidence and Evaluation in ICBs and Commissioning Support Units

7. Closing remarks

This report demonstrates the positive impact research and innovation can have across health and care. This was demonstrated loud and clear through our Norfolk and Waveney Health and Care Research Celebration in March 2026. This brought system partners together to network, share and celebrate the amazing research successes across Norfolk and Waveney.

This is a time of great challenge and some uncertainty for the NHS. However, research and innovation are key tools and perhaps more important than ever to help the NHS to evolve to meet those challenges, to adapt to the changing needs of our population and to innovate our way to the three left shifts required of us. We believe that strategic commissioning organisations benefit from a strong research evidence base, where evidence, quantitative and qualitative data and insights are used in how commissioning and services are planned. We are also determined that our communities and their views are incorporated into research design and how we choose and deploy innovative solutions for improvement. This is integral to ensuring care is commissioned and delivered to achieve the best population health outcomes, reduce inequalities, and improve access to high quality care for our populations.

Report compiled by the NSICB Research and Innovation Team, April 2026

Appendix 1

Research and Innovation at Norfolk and Waveney ICB

Clara Yates, Michael Twigg, Clare Symms, Tim Clarke on behalf of the R&I Team

NHS Norfolk and Waveney Integrated Care Board

Who we are

Norfolk and Waveney ICB have a combined Research and Innovation Team, offering a single point of access to advice and guidance on research, quality improvement, evaluation and innovation. We support initiatives across primary care and wider settings as well as acting as a system -wide convener for improvement activities across the Integrated Care System (ICS). We are part funded through the ICB, RDN, RCF and external income, such as grants and other funding awards.

What we do

Research	Innovation	Quality Improvement (QI)	Evidence and Evaluation
• Develop, host and contract NIHR research meeting ICS needs • Management and set-up of research in Primary Care and community settings	• Systematic identification of needs; support for adoption and implementation • Build innovation culture, capability and competency	• Support primary care • Convene the system-wide Quality Faculty • Embed QI approach across the ICS	• Using research evidence in decision making within the ICB and ICS • Commissioner training and capability building

Work underpinned through community engagement

Our work is driven by our ICS wide Research and Innovation Strategy which outline our 4 key principles – Research and innovation in Norfolk and Waveney will be:

Focused on our communities

Multiple NHS England Research Engagement Network (REN) programmes have brought communities, delivery teams and researchers together to develop and deliver research that is meaningful to our communities.
IMPACT: Community volunteers in Shrublands, Lowestoft, completed research surveys with participants who would have otherwise been unable to participate due to low literacy levels.

Driven by a confident and capable workforce

Awarding Research Capability Funding (RCF) to support primary care to build capacity and capability for research; supporting funding bids, fellowships and awards from primary care; through to co-ordination and delivery of training for QI, innovation and evaluation.
IMPACT: A local locum GP successfully applied for and was awarded an NIHR ARC Fellowship with the support of the R&I team.

Co-ordinated and collaborative

Promote and foster positive relationships across Norfolk and Waveney.
IMPACT: ICS colleagues jointly applied for NIHR infrastructure funding; Collectively using SORT to identify and meet research training needs in providers across the ICS; collaborative research workshop delivered within the ICS.

Embedded in everything we do

Access to expert advice and guidance, signposting to other sources of support; facilitating use of research outputs
IMPACT: Innovation discussions leading to research opportunities; work undertaken with researcher to embed research outputs around deprescribing into clinical practices

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 12
Date: 20 May 2026

Title: The Lampard Inquiry Update

Lead Director: Lisa Nobes, Executive Director of Nursing

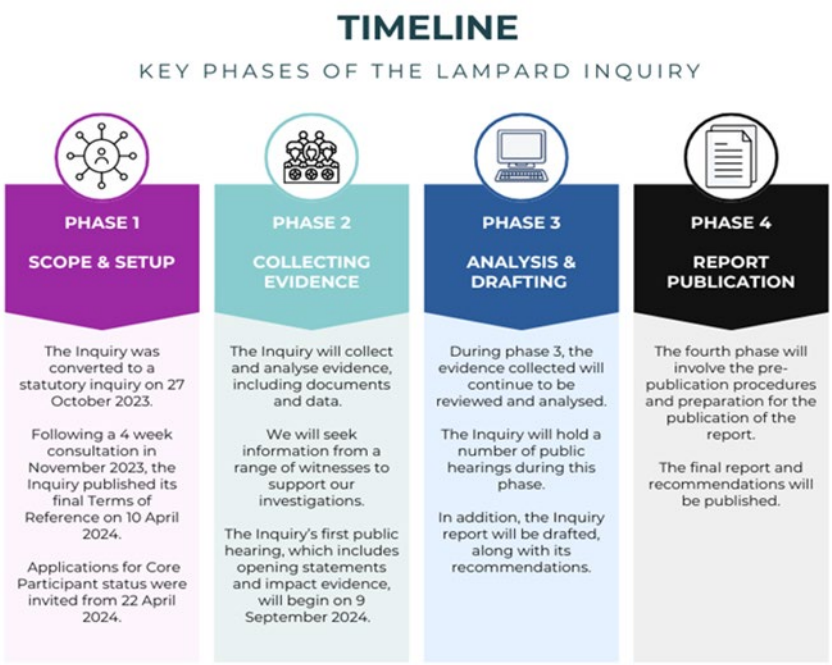
Authors: Phil Read, Associate Director of Delivery, Essex ICB and Olivia Burrows, Lampard Project Manager.
Purpose: Information

Recommendation: The Board are asked to note the report.

1. Introduction

In June 2023 it was announced that the Essex Mental Health Independent Inquiry (established in 2021) would be granted statutory status (Public Inquiry) under the Inquiries Act 2005. In April 2024 final Terms of Reference were published, and the first public hearings began on 9th September 2024. The purpose of the Inquiry is to investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex ("the Trust(s)") between 1st January 2000 and 31st December 2023.

A schematic of the phases of the Inquiry is shown below.



2. Main content of Report

2.1 The ICBs Approach

Following the reorganisation of ICBs in April 2026 the three newly formed ICBs of NHS Essex ICB, NHS Central East ICB and NHS Norfolk and Suffolk ICB shall continue to work collaboratively to support the work of the Lampard Inquiry. This approach ensures continuity and stability in the management of this important work programme and ensures the ICBs continue responding collectively and effectively to the requirements of the Inquiry.

All ICBs have applied to continue being designated a 'core participant' to the Inquiry. A core participant is an individual, organisation or institution that has a specific interest in the work of the Inquiry. Core participants have a formal role and special rights in the Inquiry process.

NHS Essex ICB will lead on the response from the ICBs to the Lampard Inquiry. Mills & Reeve LLP have been appointed as Legal advisors. Samantha Broadfoot KC is appointed as legal representation to the Lampard Inquiry representing the three ICBs. We continue to work within our allocated budget with incurred legal and programme costs monitored and reported through each of the ICBs.

The 3 nominated ICB Executive Leads are:

- Dr Matthew Sweeting, Executive Medical Director, NHS Essex ICB
- Lisa Nobes, Chief Nurse, NHS Norfolk and Suffolk ICB
- Sarah Stanley, Executive Clinical Director Total Quality Management, NHS Central East ICB

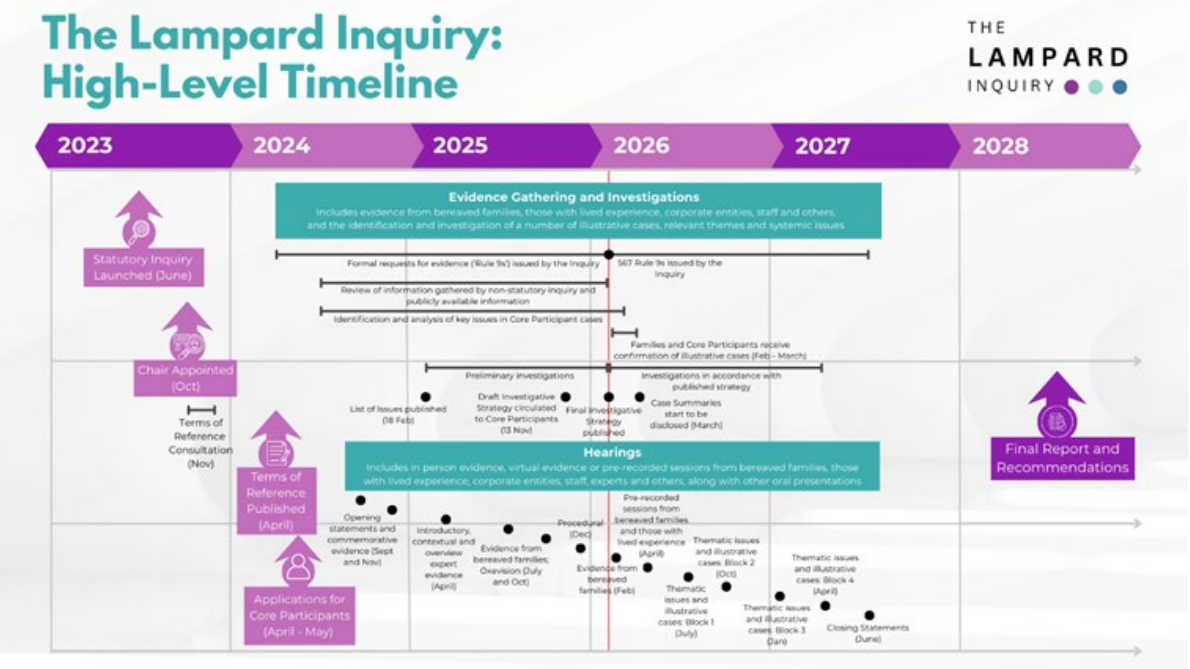
Each of the ICBs will continue to have a designated lead to work alongside the project team.

2.2 Inquiry Updates

Hearings and Inquiry Timeline

There has been delays in the Inquiry receiving witness statements and documents across several areas, which have impacted the ability of the Inquiry to progress as previously indicated. No delays are related to ICBs.

As a result, the Inquiry has provided an updated timeline, indicative hearing plan, and areas of work to meet the Inquiry's Terms of Reference. The Inquiry will now hold hearings until June 2027, with a final report and recommendations due in 2028. Revised Inquiry timeline has now been published (see below):



The indicative public hearing plan has set out dates for future hearings and what is expected to be covered in evidence at the hearings. This is subject to change, however, as the Inquiry has already changed what evidence will be heard in July. The dates for future hearings are:

2026 Scheduled Hearing Dates:

- 6th to 23rd July 2026
- 5th to 22nd October 2026

2027 Scheduled Hearing Dates:

- 25th January to 11th February 2027
- 26th April to 13th May 2027
- 14th to 24th June 2027

These hearings will be held at Arundel House, London, except for the hearings in October 2026, which will be in Chelmsford. The hearings will also be streamed with a ten-minute delay.

From March 2026, the Inquiry moved to its substantive 'investigative phase' to consider systemic issues and the concerns raised by bereaved families in the evidence gathered to date. In this phase, evidence is being obtained from members of staff and healthcare professionals. The Inquiry is considering if any additional steps are needed regarding undertakings for those giving evidence.

The Inquiry have published a FAQ section on their website for staff witnesses. The ICBs have processes in place to provide support to anyone contacted by the Inquiry regarding evidence related to the ICBs (or former Clinical Commissioning Groups and/or Primary Care Trusts) and have an established protocol for providing legal support which has been agreed by the Inquiry.

F*eedback from Core Participants*

The Inquiry held 2 additional sessions in November and December 2025 to provide opportunity for core participants to address the Chair on procedural issues and the draft investigative strategy. Feedback was given to the Inquiry directly from bereaved families in the form of a Q&A session, as well as several oral and written submissions of evidence from core participants.

The ICBs were not required to and did not make a formal submission as part of this feedback. The Chair's formal response to the submissions have been published alongside a final version of the Inquiry's investigative strategy.

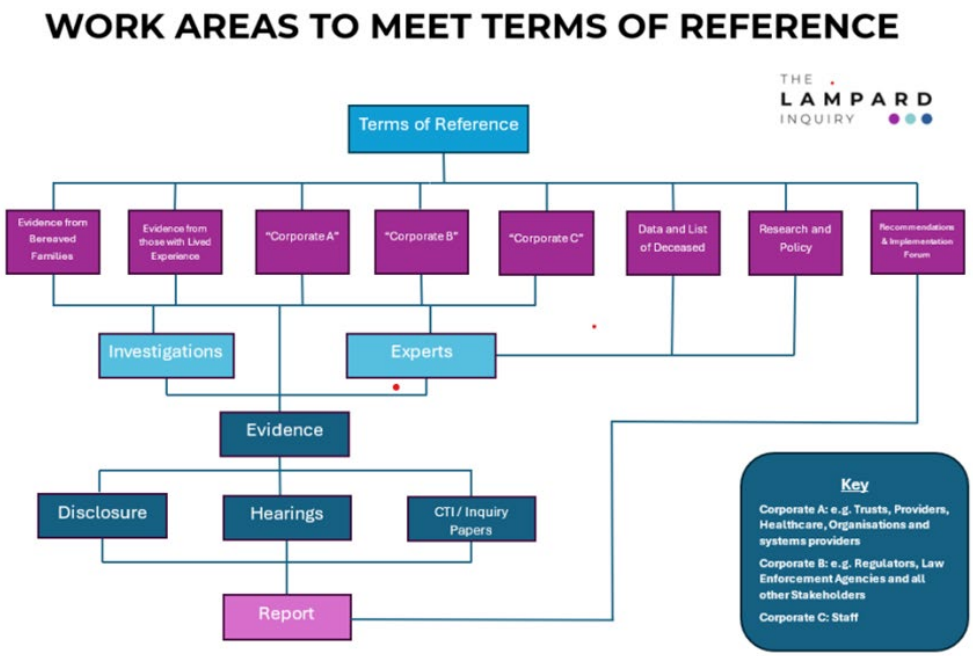
Statement of Approach – Investigating Illustrative Cases

The Chair considered all suggestions and submissions received in relation to the draft investigative strategy, which has now been finalised as the Inquiry's Statement of Approach – Investigating Illustrative Cases.

The Inquiry will take the approach to investigating cases in 'clusters', rather than considered chronologically. However, a chronical review of issues in each cluster will still take place, with a particular focus on what changes have been made to better provision of mental health care, and what impact the change has had.

The clusters for cases are subheadings within Thematic Issues and Illustrative Cases Blocks 1 – 4 of the hearings. This list will be kept under review by the Inquiry, a full overview for each cluster is detailed in the investigative strategy.

The Inquiry has also provided a diagram setting out how its current work areas are operating together to meet the Inquiry Terms of Reference:



2.3 Public Hearings

In October 2025 and February 2026, the Inquiry heard evidence from bereaved families.

The Inquiry held pre-recorded evidence sessions between 20th April 2026 and 7th May 2026 to hear evidence from a number of bereaved families who have provided written statements to the Inquiry. These sessions have not yet been made public.

On 24th April 2026, the Inquiry confirmed that the July hearings would be refocused on 'urgent emerging matters' identified in evidence. The July hearings will now focus on:

- Observations and Use of Technology;
- Resuscitation;
- Further Evidence from bereaved families;
- Core Participant Submissions; and
- EPUT Engagement and Compliance Issues.

The Chair has confirmed she is prepared to make interim recommendations on observations and the use of technology, and resuscitation. Should any recommendations be made, the ICBs project team will be a position to ensure the ICBs respond and engage with the Inquiry.

Hearing recordings are available online: The Lampard Inquiry - investigating mental health deaths in Essex

2.4 Inquiry Rule9 Requests for Information

In December 2025, the ICBs received a further Rule 9 request from the Inquiry, making this the 3rd received to date by the ICBs

A ‘Rule 9 request’ is a written request for information, including witness statements in response to specific questions, and/or relevant documents. This is made under Rule 9 of the Inquiry Rules 2006 and sets out exactly what information the Inquiry is requesting, as well as a deadline for the request.

This Rule 9 request related to previous requests made to the ICBs, as well as additional requests for further information. Following ongoing discussions with the Inquiry, a final draft statement was submitted to the Inquiry on 13th March 2026, as well as a significant number of appendices and exhibited documents.

2.5 Updated ICB Programme

Following the ICB changes in April 2026, the project team completed a governance review to refocus the ICBs programme of work and objectives for 26/27. The project team will meet with key ICB individuals on a monthly basis from May 2026 to provide updates on the Inquiry work and what may be required going forward.

The review has also identified 3 primary objectives for the project team to lead, alongside responding to the Inquiry accurately, without delay, and in line with parameters set by the Inquiry:

1. Supporting the Inquiry and providers with current safeguarding and quality concerns raised via the Inquiry.
2. Supporting individuals impacted by the Inquiry.
3. Learning from the Inquiry through formal recommendations and internally identified learning.

As part of the programme, NHS Essex ICB will review historic documentation related to mental health and other programmes such as the Mental Health Task Force, which was set up collaboratively between the 7 Essex CCGs in 2020. This review aims to assess all recommendations and learning, which will then be revisited to ensure implementation is built into the work plan of the ICB if not already done so.

ICB Boards will continue to receive 6 monthly progress reports with any areas of immediate concern escalated to Executive Officers for their consideration and oversight.

3. Findings/Conclusion

The three newly formed ICBs continue to work collaboratively to support the work of The Lampard Inquiry. Robust programme arrangements are in place including senior leadership oversight and assurance.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 13
Date: 20 May 2026

Title: Out of Area Mental Health Inpatient Census

Lead Director: Lisa Nobes, Executive Chief Nurse.

Author: Wendy Scott, Director Clinical Services.

Purpose:

1.To update the Integrated Care Board on the Out of Area Mental Health Inpatient Census, provide assurance that the ICB knows where all of their patients who have been placed Out of Area are currently receiving care and confirmation that the ICB will end all adult Out of Area Placements by March 2028 (Acute, PICU and Rehabilitation).

2. Update on patients placed at St Andrew's Healthcare.

Background

Out of Area Mental Health Inpatient Census - National Context and Requirement

On 02 April 2026, NHS England (NHSE) wrote to Integrated Care Boards (ICBs) following discussions at the NHSE Executive Board, highlighting an urgent national need to improve patient safety within mental health hospitals, with a particular focus on patients placed out of area.

In recognition of gaps in oversight for patients placed out of area, and learning from previous quality failings, ICBs were required through the 2023/24 Planning Guidance to identify the location of all patients for whom they are responsible, and to develop plans to return each individual to appropriate care closer to home.

However, recent quality challenges have demonstrated that progress in achieving this ambition has not been consistent across all systems. While most patients are subject to regular oversight through established care management arrangements, there remain

cases where patients are placed far from home and the responsible commissioner is either unaware of the placement, not effectively overseeing the quality of care, or not actively progressing plans to repatriate care closer to home.

The Medium-Term Planning Framework (MTPF) further strengthens this direction, requiring all ICBs to align commissioning with the national Inpatient Commissioning Framework from 2027/28. In practice, this means the cessation of all out-of-area placements and locked rehabilitation settings by March 2028.

As part of this national response, ICBs were asked:

1. **To complete an Out of Area Mental Health Inpatient Census, structured around a set of Key Lines of Enquiry (KLOEs)**. The definitions included all patient cohorts, including those admitted to inpatient units within other providers, including local providers,
2. **By the end of Quarter 1 of 26/27, update the ICB on your intention to achieve the MTPF commitment.** This will include:

    a) assurance that the ICB knows where all of their patients who have been placed out of area are currently receiving care
    b) confirmation that the ICB will end all adult Out of Area Placements by March 2028 (Acute, PICU and Rehabilitation).

1.Out of Area Mental Health Inpatient Census

At the time of the census the information gathered showed that 25 individuals from Norfolk and Suffolk were placed out of area in a variety of placements such as rehabilitation placements, adult acute placements, neuro-rehabilitation placements, personality disorder services, acute placement for people with learning disabilities and a national psychosis centre.

The patient numbers within this report are a collective number covering NSFT, HPFT and ICB in terms of commissioning and placing.

A challenge in acquiring these figures is that there is not a singular source/register of patients placed out of area and it is currently held in a number of departments as well as organisations. Therefore there is a need to strengthen the collective system oversight across Norfolk and Suffolk ICB.

Recommendations

The Board is asked to support the development of a single, centralised source of information for all inpatient out-of-area placements, including those admitted locally with another provider, operating as a live document that supports ongoing system-wide conversation and oversight.

The Board is asked to support a panel oversight process for out of area placement requests. This should be accompanied by the adoption of a consistent, quality and outcomes-based definition of “appropriate placement,” aligned to the continuity of care principles, which frames our conversations.

This approach will strengthen system oversight, improve patient safety, support timely repatriation, and enable the delivery of the required transformation from inpatient and out-of-area provision toward high-quality community-based or local inpatient alternatives.

Our system is committed to the cessation of all out-of-area placements and locked rehabilitation settings by March 2028.

2.St Andrew's Healthcare Update.

There have been repeated and well-documented failings within out-of-area and block-contracted healthcare settings, including at Cawston Park, Whorton Hall, and more recently St Andrew's Healthcare, Northampton. The outcome of the large-scale inquiry into St Andrew's Healthcare has now been released and highlights serious and concerning issues relating to the quality and safety of care provided.

In response, systems have been asked to ensure robust oversight of all patients placed within such settings and to identify and secure suitable alternative provision by June 2026.

The Norfolk &Suffolk ICB position is that 3 Norfolk and Suffolk people remain at St.Andrew's Healthcare, Northampton (2 Suffolk people and 1 Norfolk person). Discharge plans are in place for each person.

All patients have 8 weekly oversight visits completed by either the ICB or the provider collaborative, dependent on the commissioner. Discharge plans are person centred, involving families if appropriate.

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NHS
Norfolk and Suffolk
Integrated Care Board

NSICB Board Performance Report

May 2026

Approach to Performance Management

- The role of the ICB in terms of performance management is changing in the context of the move towards ICBs becoming strategic commissioners. NHS Regional Teams are now expected to oversee the performance of NHS providers with ICBs still accountable for contractual management.
- There is clearly an interdependency between these two responsibilities which means NHS England and the ICB will need to continue working closely together with our NHS providers.
- In terms of our local arrangements, we are putting into the place the following arrangements.
- For each NHS provider there will be two key meetings:
    - **QCPM** – a monthly contract meeting which will explore in the round quality, finance and performance with the Trust concerned. Colleagues from the various ICB teams will attend as appropriate.
    - **Exec to Exec** – a meeting every 6-8 weeks between the executive director team of the ICB and each NHS provider (not including CEOs other than NSFT). This meeting is semi-formal and is an opportunity for discussions of issues escalated by the appropriate QCPM but more broadly a space for discussions on strategy, change and any issues either side wishes to discuss.
- Internally, the ICB will have:
    - A series of MDTs meeting monthly related to each major commissioning area (planned care, UEC, mental health, children and young people, NDD etc) which will be chaired by the appropriate Director or Deputy Director of Commissioning and will bring together appropriate leads relating to that commissioning area from finance, contracts, intelligence, quality, place and commissioning. The MDT will act as the engine room for the commissioning programme including any performance concerns raised and/or issues coming from a provider. It will be agreed in the MDT who is best placed from the MDT to lead a particular issue.
    - A Strategic Commissioning Group, meeting monthly and chaired by the Deputy CEO and bringing together key senior leads from across the organisation to oversee the whole commissioning programme for which the MDTs will dock into.
    - A Finance and Performance Cttee meeting bimonthly overseeing the ICBs finance and performance duties.
- To support the appropriate oversight of performance within the ICB the following will be produced
    - A monthly performance report which focusses on the medium-term national planning metrics with the 26/27 metrics and will set out our actual performance against targets with an accompanying narrative.
    - A quarterly performance report which focusses on:
        - ICB specific NOF KPIs which the ICB is held accountable for and will be assessed against their achievement on an annual basis to inform the ICB's wider NOF rating.
        - The Population Health Improvement Plan (PHIP) KPIS and accompanying narrative to assess our progress with the main KPIs and deliverables the ICB has committed to.
- The rest of this paper acts as the monthly performance report.

NHS Oversight Framework – What it means for ICBs

- Clear role: ICBs are overseen primarily as strategic commissioners, responsible for shifting resources to prevention, community capacity and neighbourhood health
- Delivery segmentation: ICBs are placed in a national segment (1–4) based on performance across defined domains; segmentation signals delivery risk, not leadership quality.
- What is measured: ICB performance is assessed across population health & inequalities, allocating resources, experience, effectiveness, safety, finance/productivity, and people.
- Finance matters: A financial deficit prevents an ICB being in segment 1 or 2, regardless of delivery elsewhere.
- Capability assessment: Annual assessments focus on leadership, governance, strategic commissioning maturity and system leadership; delivery and capability are considered together.
- Oversight response: NHSE regions apply proportionate oversight—lighter touch where delivery is strong and capability high; intensified support or intervention where risk is higher.
- Primary care accountability: ICBs are explicitly accountable for primary care commissioning and oversight, including delegated services and complaints handling.
- Transparency: ICB segmentation and league-table data are published quarterly, forming part of the public accountability framework.
- Support offer: During 2026/27, NHSE will provide a structured development offer to strengthen ICB commissioning capability and board leadership.

Domain	Subject area	Metric	Preferred direction (higher/lower)	Data period	Suffolk & North East Essex ICB	Norfolk & Waveney ICB
Domain 1 - Population health, prevention and reducing inequality	Preventing ill health	Cervical cancer screening rates	High	to Jun-25	4	4
		Breast cancer screening rates	High	to Mar-24	4	4
		Bowel cancer screening rates	High	to Mar-24	4	4
		Percentage of pregnant women who quit smoking (banded score)	Low	to Sep-24	1	1
		Percentage of patients supported by obesity programmes	N/A	Q2 25/26	2	1
		MMR vaccine uptake rate	High	to Sep-25	4	4
	Reducing inequality	Deprivation and ethnicity gap in pre-term births	Low	Q1 25/26	1	1
		Deprivation gap in early cancer diagnosis gap	Low	Q2 25/26	2	1
		Deprivation gap in lipid and hypertension management	Low	to Sep-25	1	1
Domain 2A - Allocating resources	Elective care	Annual change in the size of the waiting list	Low	to Sep-25	4	4
	Community care	Level of growth in community care contacts	High	-	-	-
	Cancer care	Percentage of all cancers diagnosed at stage 1 or 2	High	to Sep-25	3	2
	Urgent care	Occupied bed days per 100k head of population	N/A	Q2 25/26	2	1
	Primary care	% of urgent GP appointments seen within 24 hours	High	-	-	-
Domain 3 - Experience of care	Experience	% of complaints open beyond 6 months	Low	-	-	-
		% of patients rating their experience if GP access as good	High	Sep-25	4	3
		Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional	High	Sep-25	4	2
	Patient flow	Number of inpatients with a learning disability or autism per 1 million pop	Low	-	-	-
		Adult inappropriate OOA placement bed days as a % of all bed days	Low	Q2 25/26	3	1
		Average number of days from discharge ready date and actual discharge date	Low	Sep-25	1	3
Domain 4 - Effectiveness of care	Outcomes	% of people with 3 + hospital contacts in the last 90 days of life	Low	-	-	-
		Over 65s bed days per 100k pop	Low	-	-	-
	Managing long term conditions	Percentage of patients who receive all 8 diabetes care processes	High	to Mar-24	4	3
		Percentage of patients with GP recorded CVD whose blood pressure is managed to NICE guidance	High	Q1 25/26	4	4
		Percentage of patients with GP recorded hypertension who have their cholesterol levels managed to NICE guidance	High	Q1 25/26	3	1
		% of patients on GP SMI registers to receive a full physical health check in last 12 months	High	-	-	-
		% of patients on GP LD registers to receive a full physical health check and action plan in last 12 months (banded score) *	Low	Q2 25/26	3	4
Domain 5 - Patient safety	Safe practice	Percentage of children (aged 0 – 9) prescribed antibiotics	-	to Sep-25	N/A	N/A
	Safe outcomes	Number of neonatal deaths and stillbirths per 1,000 total births	Low	2023	2	3
Domain 6 - Finance, productivity & innovation	Finance	Planned surplus/deficit	High	Sep-25	4	3
		Variance year-to-date to financial plan	N/A	Sep-25	4	4
	Productivity	Implied productivity growth	High	Sep-25	4	1
Domain 7 - People	People and culture	Sickness absence rate	Low	Q2 25/26	1	2
		NHS staff survey engagement theme score	High	2024	4	2
	Workforce	GP headcount per captita	High	-	-	-

NHS Oversight Framework – What it means for ICBs

- This table on the previous slide shows the latest reported performance for N&W and SNEE ICBs.
- Our first assessment will be based on Q4 performance when we were two ICBs and this therefore includes North East Essex and so we can expect a shift in performance from that area leaving.
- The table shows which quartile the ICBs are in, with the colours illustrating whether we are performing in the best quartile (green) or worst (red) - note that direction of best vs worst can be quartile 1 or 4 depending on the metric.
- There are 35 ICB scoring metrics, of which we can report 26 via national benchmarking tools. We can expect others to be made available soon.
- Three metrics as being a bit vague on what is good vs poor performance – e.g. acute bed days per 100K population – so have removed them from summary below as we need more guidance.
- Of the remaining 23:
    - SNEE is in the best quartile for 16 and N&W 10.
    - SNEE is in the worst two quartiles for 3 metrics, and N&W for 9 metrics
- Areas where both ICBs rank comparatively poorly are:
    - Annual change in size of elective waiting list – needs to be -7% to be in best quartile and our biggest overall issue
    - % of patients on GP LD registers to receive a full physical health check and action plan in last 12 months – noting this tends to improve towards year-end
    - Areas where SNEE ranks comparatively poorly are:
    - Adult inappropriate OOA placement bed days as a % of all bed days – this will drop out as the issue relates solely to North East Essex
- Areas where N&W ranks comparatively poorly are:
    - % of all cancers diagnosed at stages 1 and 2 – about 2 %points between the two ICBs
    - % of patients reporting they could get a GP appointment
    - Days lost due to delayed discharges
    - Percentage hypertension patients with cholesterol levels managed to NICE guidance (not 100% sure on right metric here)
    - Number of neonatal deaths and stillbirths per 1,000 total births
    - Implied productivity growth
    - NHS staff survey engagement theme score
- Each performance metric will be allocated to an Executive Director(s) and a quarterly performance report will be produced and shared with the committee and a summarised version with the Board. The first of these will be produced at the end of June for the July meeting schedule.

Integrated Performance Report

Performance summary - COMMISSIONER VIEW

NHS Norfolk and Suffolk Integrated Care Board

Medium Term Planning Framework Metrics (2026/27 targets)*

Theme	Metric	Success Measure	Reporting Date	Achievement	2026/27 Target	Variation
Elective, cancer & diagnostics	18-week RTT	Improve the percentage of patients waiting no longer than 18 weeks for treatment	Feb-26	60.1%	68.4%	H
	6 week waits	Improve performance against the DM01 diagnostics 6-week wait standard	Feb-26	25.4%	14%	
	28-day FDS	Improve performance against cancer constitutional standards	Feb-26	78.5%	80%	H
	31-day standard	Improve performance against cancer constitutional standards	Feb-26	90.5%	94%	
	62-day standard	Improve performance against cancer constitutional standards	Feb-26	66.1%	80%	H
Mental health, learning disabilities & autism	Individual placement and support access	Meet the existing commitments to expand NHS Talking Therapies and Individual Placement and Support	Feb-26	1,430	1,610	L
	NHS Talking Therapies - reliable recovery rate	Meet the existing commitments to expand NHS Talking Therapies and Individual Placement and Support	Feb-26	48.7%	51%	
	NHS Talking Therapies - reliable improvement rate	Meet the existing commitments to expand NHS Talking Therapies and Individual Placement and Support	Feb-26	68.8%	69%	
	Out of area placements	Eliminating inappropriate out-of-area placements	Feb-26	0	0	L
Primary care & community services	Clinically urgent patients seen on same day	Same day appointments for all clinically urgent patients (face to face, phone or online)	Mar-26	76.0%	90%	H
	Community health service activity within 18 weeks	Address long waiting times for community health services	Feb-26	77.8%	78%	
Urgent & emergency care	A&E 4 hour waits	4-hour A&E performance	Mar-26	76.7%	82%	
	Reduce number who wait over 12 hours	12-hour A&E performance	Mar-26	56,540	56,353	
	Ambulance C2 mean response times	NORFOLK AND WAVENEY	Feb-26	48.5	25 mins	
		SUFFOLK AND NORTH EAST ESSEX	Feb-26	41.3	25 mins	

*A small number of metrics remain under development where data flows, technical definitions or agreed methodologies are still being finalised.
Work is underway to resolve these gaps ahead of formal 2026/27 reporting and assurance processes.

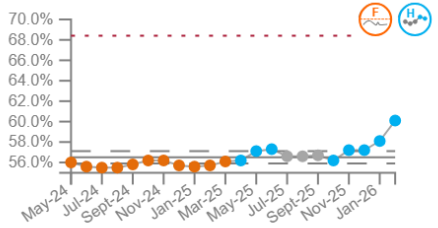
Integrated Performance Report

SPC summary - COMMISSIONER VIEW

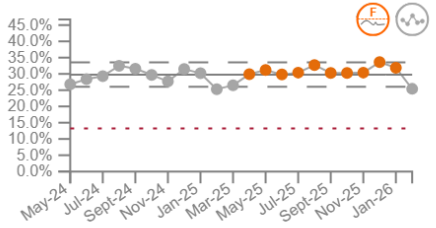
NHS Norfolk and Suffolk Integrated Care Board

Elective, cancer & diagnostics

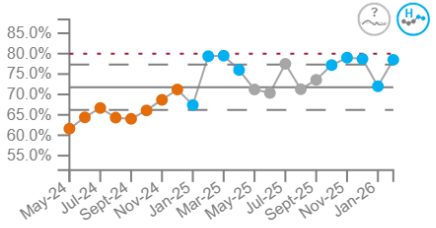
18-week RTT



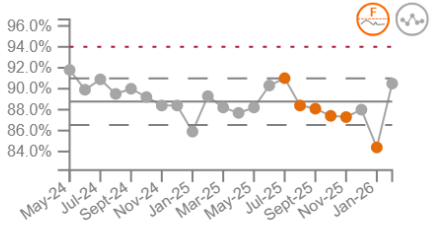
Diagnostic 6-week waits



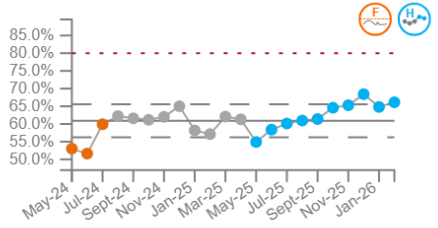
Cancer 28-day FDS



Cancer 31-day standard

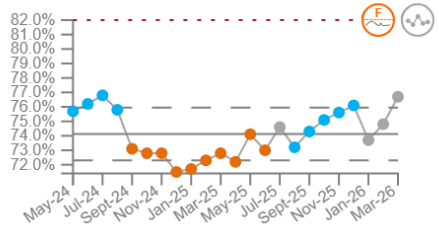


Cancer 62-day standard

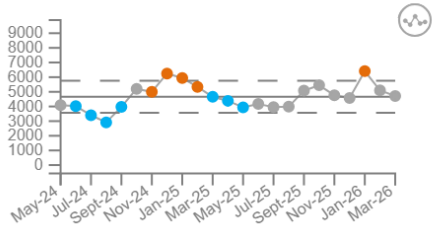


Urgent & emergency care

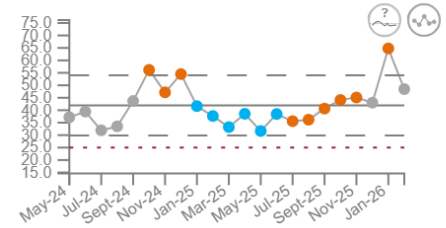
A&E 4hr waits



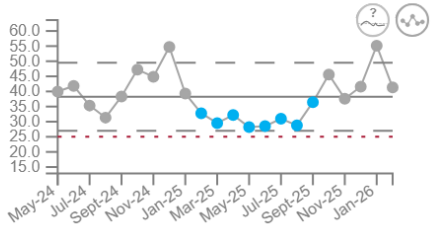
Reduce 12 hour waits in ED



Ambulance C2 responses (N&W)

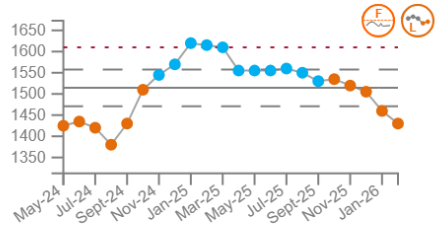


Ambulance C2 responses (SNEE)

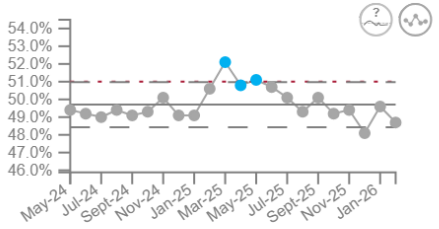


Mental health & LDA

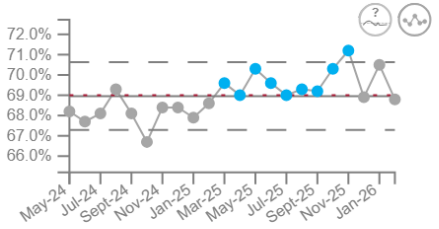
Individual placement & support



Talking therapies reliable recovery

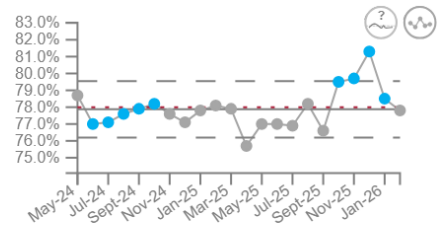


Talking therapies reliable improvement

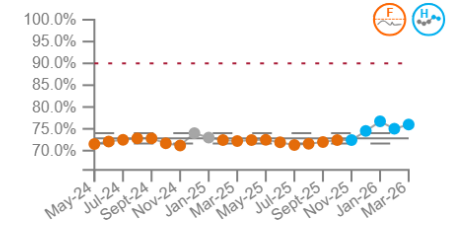


Primary care & community services

18-week community health services



Same day urgent GP appointments



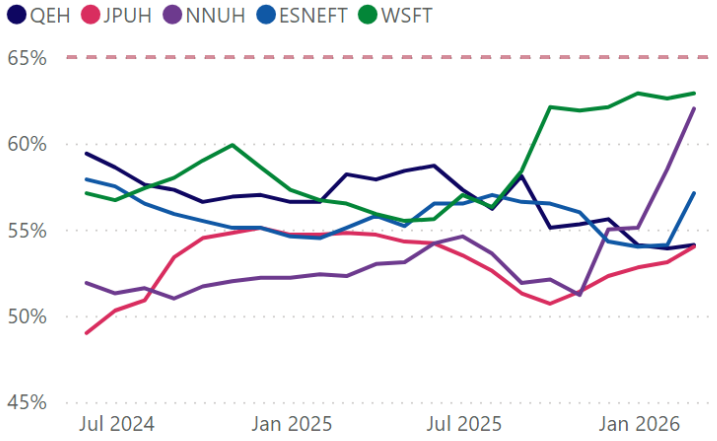
Integrated Performance Report

Elective & diagnostics provider performance

NHS
Norfolk and Suffolk
Integrated Care Board

18-week RTT (target 68.4%)

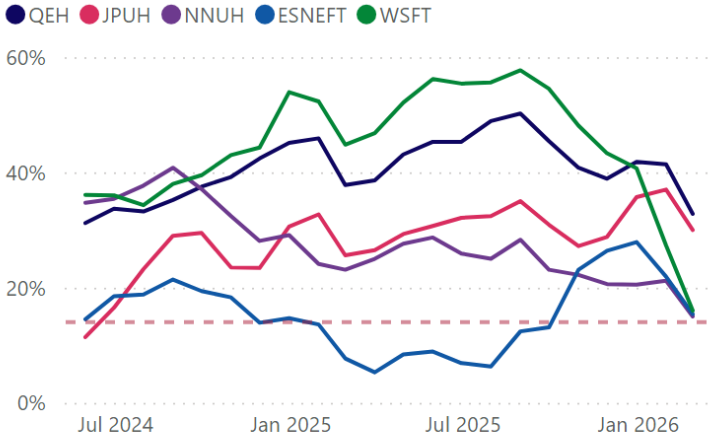
Feb-26



Provider	Current Month	Var.	Ass.
QEH	54.1%	L	F
JPUH	54.0%		F
NNUH	62.0%	H	F
ESNEFT	57.1%		F
WSFT	62.9%	H	F

Diagnostic 6-week waits (target 14%)

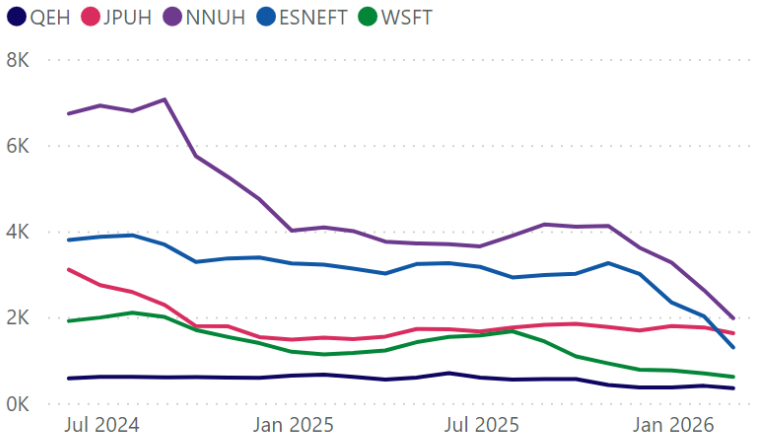
Feb-26



Provider	Current Month	Var.	Ass.
QEH	32.8%	L	F
JPUH	30.0%		F
NNUH	15.0%	L	F
ESNEFT	15.4%		F
WSFT	16.0%	L	F

52+ week RTT waits

Feb-26



Provider	Current Month	Var.
QEH	346	L
JPUH	1,623	L
NNUH	1,974	L
ESNEFT	1,293	L
WSFT	609	L

18-week referral to treatment (RTT)

Specialty outliers

All

Specialty	Within 18wks
Plastic Surgery Service	47.3%
Trauma and Orthopaedic Service	47.6%
General Surgery Service	51.9%
Ear Nose and Throat Service	52.7%
Neurology Service	52.9%
Oral Surgery Service	54.4%
Gynaecology Service	55.0%
Gastroenterology Service	59.1%
Urology Service	59.3%
Other - Paediatric Services	60.2%

Diagnostics 6-week waits

Test outliers

All

Diagnostic Test	6+ week waiters
URODYNAMICS	59.9%
AUDIOLOGY_ASSESSMENTS	50.0%
ELECTROPHYSIOLOGY	50.0%
COLONOSCOPY	33.1%
FLEXI_SIGMOIDOSCOPY	32.8%
GASTROSCOPY	27.8%
SLEEP_STUDIES	25.1%
CYSTOSCOPY	23.7%
MRI	19.7%
PERIPHERAL_NEUROPHYS	19.5%

RTT & Diagnostics Narrative

Performance position – summary and context: *(provide an overview of the data position)*	RTT 18 week performance has demonstrated sustained improvement over the last five months, reaching 60.1% in February 2026 against the 65% target. 52+ week waits also continue to show sustained improvement across providers. DM01 6 week waits reduced slightly between January and February but remain above the 20% standard at 25.4%, with no sustained improvement currently evident. Provider variation remains material across both RTT and diagnostic performance, with diagnostic capacity continuing to represent the principal constraint affecting elective and cancer recovery.
Root causes and contributing factors: *(identify the key drivers for the position)*	NHS England funded Q4 sprint activity has supported increased outpatient activity and waiting list validation, contributing to sustained RTT improvement and reductions in long waits. Ongoing diagnostic workforce and capacity constraints continue to affect DM01 performance and wider elective recovery. Provider variation suggests differences in pathway efficiency and available capacity across the system.
Key actions and risks to action delivery: *(what actions are being taken, by when and whom, and what are the risk to delivery of those actions)*	**Actions** • Providers continue to focus on elective recovery, pathway management and diagnostic utilisation. • The ICB is developing longer term recovery and demand management plans aligned to provider trajectories through commissioning PA Consulting with a output report expected by the end of June 2026. • Focus remains on reducing unwarranted variation across elective and diagnostic pathways. **Risks** • Diagnostic workforce and capacity pressures continue to affect recovery delivery. • Continued reliance on non recurrent recovery activity may affect sustainability of improvement. • Provider variation remains across elective and diagnostic performance.
Insights and impacts: *(quality and/or equality impacts e.g. health inequality insights)*	Diagnostic delays continue to affect both elective and cancer pathways, contributing to delays in patient access and treatment. Variation between providers may also result in inequitable patient access and experience across the system.
celebration: *(identify areas for celebration and spreading success)*	**Celebration** • RTT 18 week performance has demonstrated sustained improvement over recent months. • 52+ week RTT waits continue to show sustained improvement across providers. • notable 18 week performance gains in both NNUH and WSFT this period.

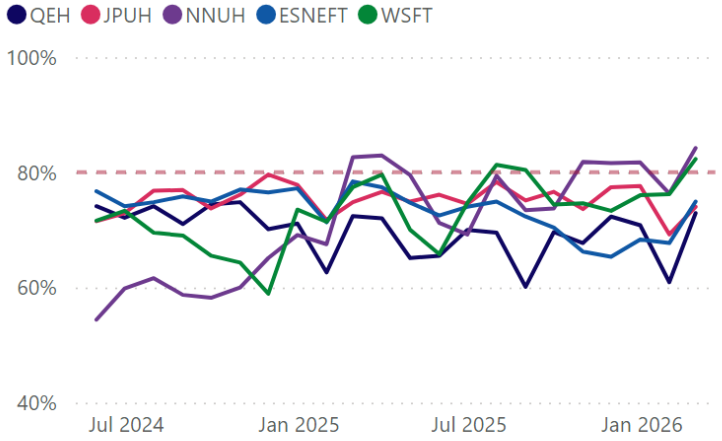
Integrated Performance Report

Cancer provider performance

NHS Norfolk and Suffolk Integrated Care Board

28-day faster diagnosis standard (target 80%)

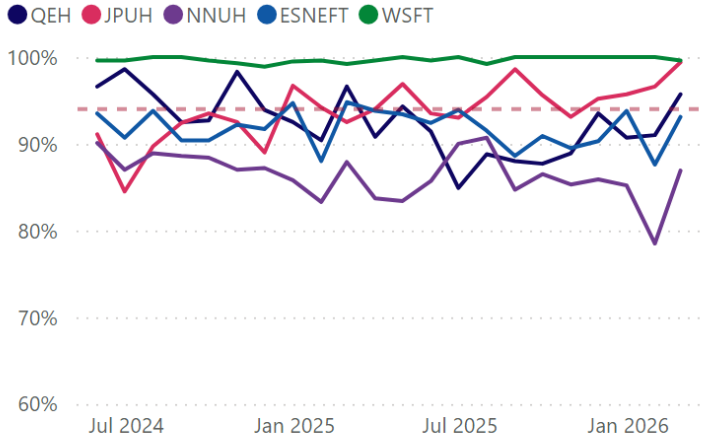
Feb-26



Provider	Current Month	Var.	Ass.
QEH	72.9%		
JPUH	74.0%		
NNUH	84.2%	H	
ESNEFT	74.9%		F
WSFT	82.3%	H	

31-day standard (target 94%)

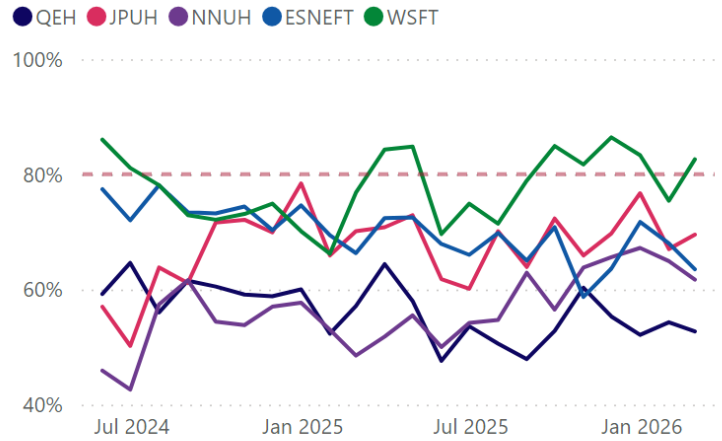
Feb-26



Provider	Current Month	Var.	Ass.
QEH	95.7%		
JPUH	99.4%		
NNUH	86.9%		F
ESNEFT	93.1%		
WSFT	99.6%		P

62-day standard (target 80%)

Feb-26



Provider	Current Month	Var.	Ass.
QEH	52.7%		F
JPUH	69.5%		
NNUH	61.7%	H	F
ESNEFT	63.5%		
WSFT	82.6%		

Cancer types with lowest performance:

28-day FDS (<70%)

QEH: gynaecological, urological malignancies, lower GI

JPUH: urological malignancies, gynaecological, lung

NNUH: sarcoma, haematological malignancies, gynaecological

ESNEFT: lower GI, haematological malignancies, children's, urological malignancies

WSFT: non-specific symptoms, testicular, urological malignancies

31-day standard (<85%)

QEH: gynaecological, skin

JPUH: skin

NNUH: prostate, head & neck, skin

ESNEFT: skin, urological

WSFT: lower GI

62-day standard (<50%)

QEH: prostate, lung

JPUH: gynaecological, lung

NNUH: prostate, head & neck, lower GI, gynaecological

ESNEFT: head & neck, lower GI

WSFT: prostate, lower GI

Cancer types with small numbers have been excluded

Cancer Narrative

Performance position – summary and context: *(provide an overview of the data position)*	Cancer performance remains mixed across standards. The 28 day Faster Diagnosis Standard (FDS) has demonstrated sustained improvement over recent months, reaching 78.5% against the 80% target. The 31 day standard remains below the 94% target at 90.5%, with no sustained improvement currently evident. The 62 day standard remains the most challenged area at 66.1% against the 80% target, although gradual sustained improvement has been observed over recent months. Provider variation remains evident across all cancer standards, with diagnostic and treatment capacity continuing to affect pathway delivery.
Root causes and contributing factors: *(identify the key drivers for the position)*	Diagnostic and treatment capacity constraints remain the principal factors affecting cancer pathway performance, particularly within the 62 day pathway. Delays in imaging, diagnostics and onward treatment capacity continue to affect pathway timeliness. Q4 recovery activity has supported pathway validation and strengthened operational oversight, however sustained demand and ongoing operational pressures continue to affect recovery.
Key actions and risks to action delivery: *(what actions are being taken, by when and whom, and what are the risk to delivery of those actions)*	**Actions** • Providers continue to focus on pathway tracking, reducing diagnostic delays and strengthening pathway management across all care stages. • Work continues to maximise diagnostic utilisation and reduce unwarranted variation between providers. • System partners continue to support recovery activity aligned to provider trajectories and pathway performance • A Cancer Strategic Plan is planned to be developed over the next two quarters. **Risks** • Diagnostic workforce and treatment capacity pressures continue to affect recovery delivery. • Delays between diagnosis and treatment continue to impact 62 day performance. • Reliance on short term recovery activity may affect sustainability of improvement. • Provider variation remains across cancer pathway performance.
Insights and impacts: *(quality and/or equality impacts e.g. health inequality insights)*	Diagnostic and treatment delays continue to affect cancer waiting time standards and timely access to treatment. The continued gap within the 62 day pathway may impact patient experience and outcomes if not improved sustainably. Variation between providers may also contribute to inequitable access and pathway performance across the system.
celebration: *(identify areas for celebration and spreading success)*	**Celebration** • The 28 day Faster Diagnosis Standard has demonstrated sustained improvement over recent months. • The 62 day standard has shown gradual sustained improvement following a prolonged period of underperformance. • Q4 recovery activity has strengthened pathway oversight and validation processes across providers. • WSFT achieved all target performance levels this period

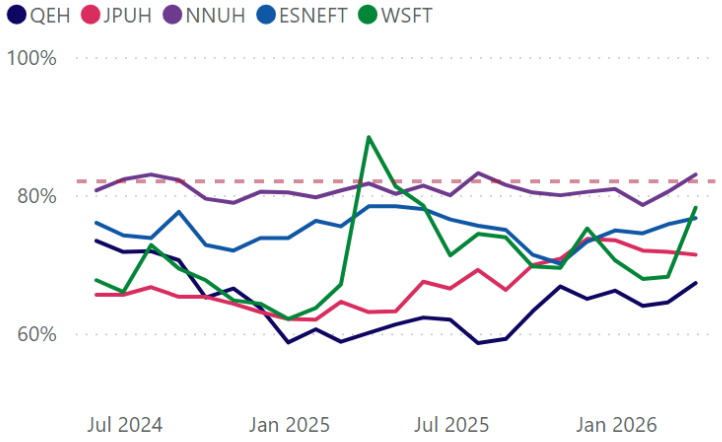
Integrated Performance Report

UEC provider performance

NHS Norfolk and Suffolk Integrated Care Board

A&E 4 hour waits (target 82%)

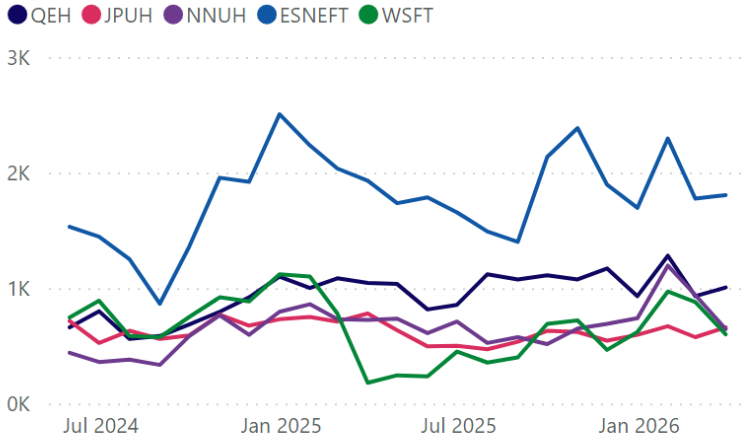
Mar-26



Provider	Current Month	Var.	Ass.
QEH	67.3%		
JPUH	71.4%		
NNUH	83.0%		
ESNEFT	76.7%		
WSFT	78.2%		

Reduce number waiting over 12 hours in ED

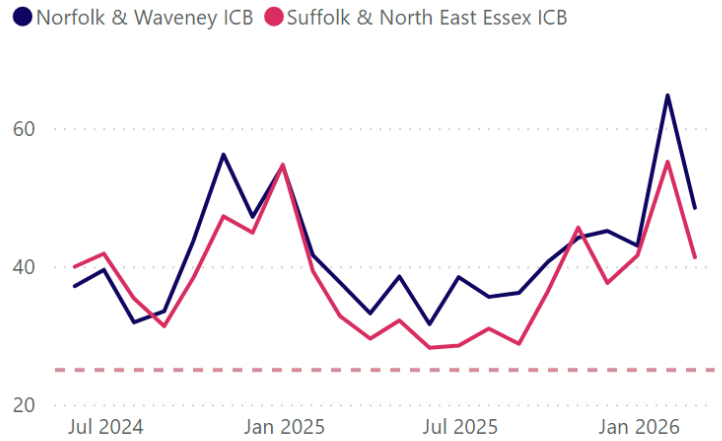
Mar-26



Provider	Current Month	Var.
QEH	1,005	
JPUH	660	
NNUH	645	
ESNEFT	1,805	
WSFT	600	

Ambulance C2 responses (target 25mins)

Feb-26



ICB	Current Month	Var.	Ass.
Norfolk & Waveney ICB	48.5		
Suffolk & North East Essex ICB	41.3		

UEC Narrative

Performance position – summary and context: *(provide an overview of the data position)*	A&E 4 hour performance remains variable across providers. March 2026 performance ranges from 67.3% at QEHKL to 83.0% at NNUH, with the N&S system position at 76.7% against the 78% 2025/26 year end target. A&E 12 hour waits also remain variable, ranging from 4.3% at NNUH to 14.4% at QEHKL with system performance continuing to show improvements from a significant peak in January. EEAST Category 2 performance remains above the 2026/27 target of 25 minutes, at 48 minutes for N&S.
Root causes and contributing factors: *(identify the key drivers for the position)*	February 2026 continued to reflect winter pressures, with ongoing pressure at the front door and within the ambulance service. Provider level variation in 4 hour and 12 hour performance indicates differing levels of pressure across acute sites.
Key actions and risks to action delivery: *(what actions are being taken, by when and whom, and what are the risk to delivery of those actions)*	**Actions** • EEAST is working with acute providers to maintain focus on ambulance handovers and rapid release of crews. • N&W ED providers are working with local primary care providers to support GP streaming with most of these patients being discharged with no Primary Care follow up or intervention. • UCCH MDT continues to support redirection from EEAST and ED into other care pathways where appropriate.
Insights and impacts: *(quality and/or equality impacts e.g. health inequality insights)*	Ambulance handover delays continue to have an impact, with average delays reported as ESNFT 1 hour 7 minutes, JPUH 1 hour 5 minutes, NNUH 1 hour 24 minutes, QEHKL 51 minutes and WSFT 38 minutes. These delays affect ambulance availability and contribute to wider urgent and emergency care pressure.
celebration: *(identify areas for celebration and spreading success)*	**Celebration** • Early improvement in performance has been observed during March across EEAST and acute providers across Norfolk and Suffolk.

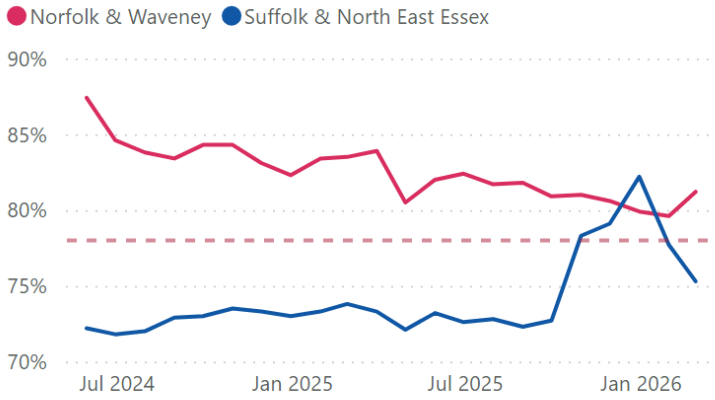
Integrated Performance Report

Community services/primary care alliance performance

NHS
Norfolk and Suffolk
Integrated Care Board

Community health service activity within 18 wks (target 78%)

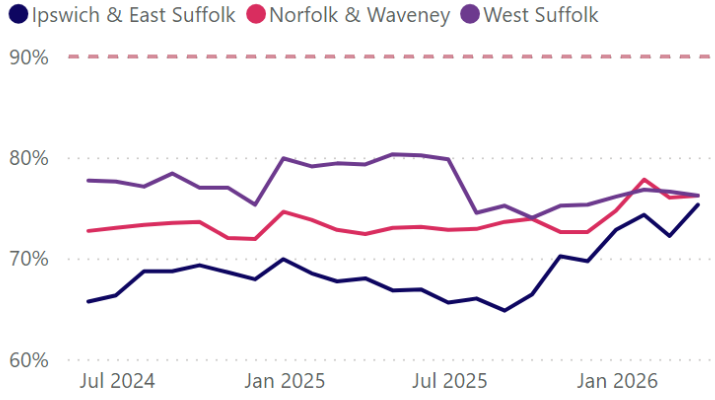
Feb-26



Alliance	Current Month	Var.	Ass.
Norfolk & Waveney	81.2%		
Suffolk & North East Essex	75.3%		

Same day appts for clinically urgent patients (target 90%)

Mar-26



Alliance	Current Month	Var.	Ass.
Ipswich & East Suffolk	75.3%		
Norfolk & Waveney	76.2%		
West Suffolk	76.2%		

Primary & Community Care Narrative

Performance position – summary and context: *(provide an overview of the data position)*	Whilst around 40% of all general practice appointments already take place on the same day, current system estimates indicate around 75% of clinically urgent need is assessed on the same day against a trajectory of 90% by March 2027, highlighting that responding to clinically urgent need is an established part of routine primary care delivery. Confidence in the baseline remains moderate due to historic variation in practice level recording and definitions. This is expected to improve following implementation of ED27 guidance and recent contractual changes.
Root causes and contributing factors: *(identify the key drivers for the position)*	Historic variation in recording and definitions has limited confidence in the current baseline position. Updated national guidance and contractual changes are expected to improve consistency of data capture. Delivery continues to be challenged by increasing demand, rising clinical complexity and variable workforce and digital capacity across primary care.
Key actions and risks to action delivery: *(what actions are being taken, by when and whom, and what are the risk to delivery of those actions)*	**Actions** • Implement consistent recording of clinically urgent same day activity in line with ED27 guidance and contractual requirements. • Use improved data visibility to strengthen system oversight and support delivery planning. • Finalise the Primary Care Action Plan (PCAP) by 29 May, setting out delivery milestones and governance arrangements.. **Risks** • Variation in workforce, digital capability and neighbourhood readiness may affect consistency of implementation. • Risk of misinterpretation of the system trajectory as an individual practice performance target.
Insights and impacts: *(quality and/or equality impacts e.g. health inequality insights)*	Improved recording and data quality will support better identification of clinically urgent demand and unmet need across the system, enabling more targeted deployment of neighbourhood and multidisciplinary services, including Pharmacy First. Over time, this is expected to improve equitable access to same day primary care and support patients being directed to the most appropriate service first time, reducing any inequalities.
celebration: *(identify areas for celebration and spreading success)*	**Celebration** • Same day assessment of clinically urgent need is already routinely delivered across general practice, with around 78% of clinically urgent appointments taking place on the same day. • Strong engagement across primary care in implementing ED27 guidance and developing neighbourhood based approaches to clinically urgent demand.

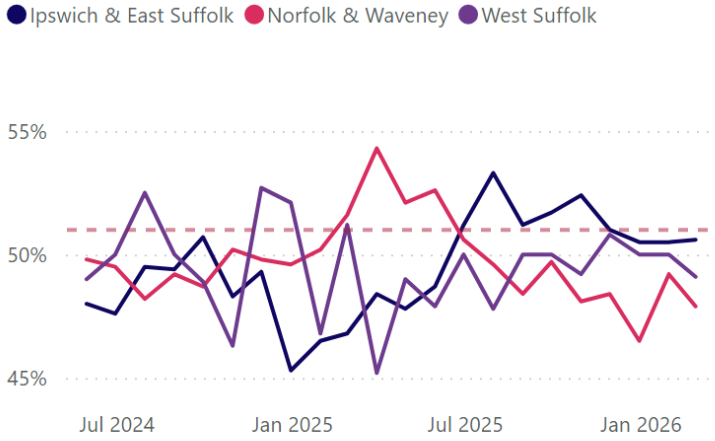
Integrated Performance Report

Mental health alliance performance

NHS Norfolk and Suffolk Integrated Care Board

NHS TT - reliable recovery rate (target 51%)

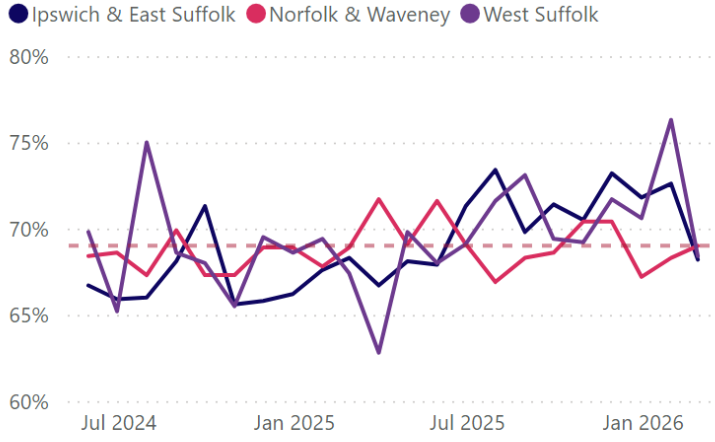
Feb-26



Alliance	Current Month	Var.	Ass.
Ipswich & East Suffolk	50.6%		
Norfolk & Waveney	47.9%		
West Suffolk	49.1%		

NHS TT - reliable improvement rate (target 69%)

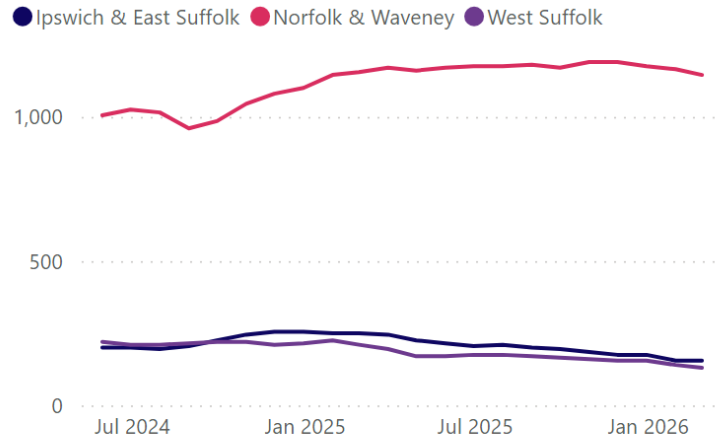
Feb-26



Alliance	Current Month	Var.	Ass.
Ipswich & East Suffolk	68.2%		
Norfolk & Waveney	69.0%		
West Suffolk	68.4%		

Individual placement & support access

Feb-26



Alliance	Current Month	Var.
Ipswich & East Suffolk	155	
Norfolk & Waveney	1,145	
West Suffolk	130	

Mental Health Narrative

Performance position – summary and context: *(provide an overview of the data position)*	Performance remains mixed against Medium Term Planning Framework expectations. Individual Placement and Support (IPS) delivery for Norfolk and Suffolk is below the February 2026 plan of 1,145, with growth slowing following earlier improvement. Within NHS Talking Therapies, reliable improvement remains broadly in line with plan at approximately 69%, whilst reliable recovery remains below the 51% planning assumption at approximately 48%, with variation across providers. Out of area placements continue to be effectively managed, with no inappropriate placements reported.
Root causes and contributing factors: *(identify the key drivers for the position)*	Key contributing factors include workforce capacity and turnover, particularly impacting IPS growth and sustained recovery outcomes. Demand within Talking Therapies continues to increase alongside growing complexity of presenting need, affecting recovery performance disproportionately. Variation in pathway flow and productivity across programmes continues to limit overall system improvement.
Key actions and risks to action delivery: *(what actions are being taken, by when and whom, and what are the risk to delivery of those actions)*	**Actions** • Targeted workforce recruitment and retention initiatives are underway across mental health services. • Increased focus is being placed on clinical and operational productivity within Talking Therapies. • Closer performance management of IPS trajectories and quality improvement support is being implemented where recovery performance remains below plan. **Risks** • Ongoing workforce shortages continue to affect delivery and recovery improvement. • Sustained growth in demand and increasing complexity of need may continue to impact performance. • There is a time lag between recruitment, training and measurable improvement in performance outcomes.
Insights and impacts: *(quality and/or equality impacts e.g. health inequality insights)*	Lower recovery performance within Talking Therapies disproportionately impacts people with higher complexity needs and those experiencing wider social deprivation. IPS growth remains important in supporting parity of esteem and economic inclusion for people with severe mental illness. Improving consistency across providers is expected to support more equitable access and outcomes across the ICB footprint.
celebration: *(identify areas for celebration and spreading success)*	**Celebration** • Talking Therapies improvement performance remains broadly in line with expectations. • Continued effective management of out of area placements, with no inappropriate placements reported. • Partners remain committed to expanding IPS capacity despite ongoing workforce and demand pressures.

What is an SPC chart?

Norfolk and Suffolk Integrated Care Board

What is an SPC chart?

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

Common cause (expected) and Special cause (unexpected) variation

Data naturally increases and decreases - if the changes aren't enough to be statistically significant, this is called common cause variation. The dots on the graph will stay grey.

If this variation is statistically significant, this is called special cause variation. The dots are instead shown as **blue** or **orange**, depending on whether a higher value is better or worse – **blue is used for improving performance**, **orange for concerning performance**.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean (black line)
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Summary icons

Two summary icons will show when there is enough data. These give an overview of the current variation (improvement, decline, no change) and assurance (if there is a target can we reliably hit it).

More resources

For more information and training resources visit the Making Data Count site

What is this chart telling us?

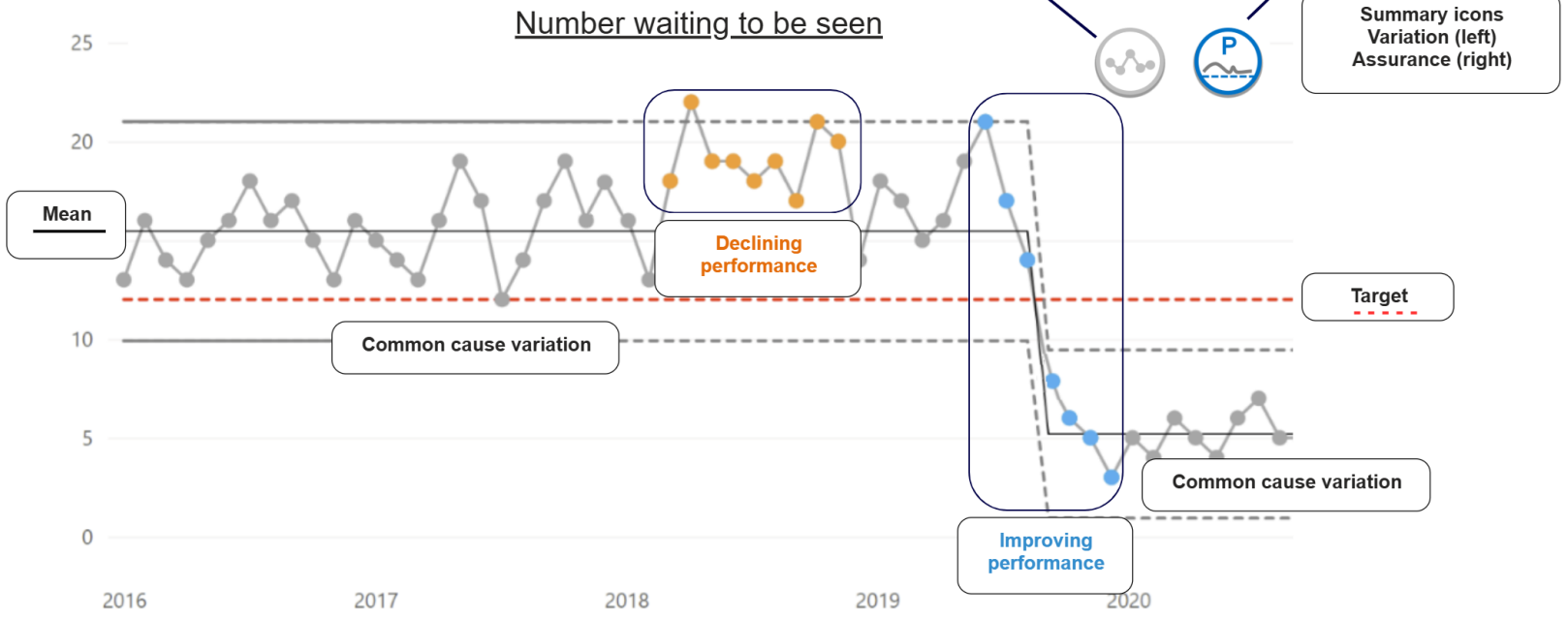
Between 2016 and 2018 there is a period of common cause variation (nothing significant has happened, these are expected highs and lows).

Between 2018 and 2019, there is a period of special cause variation where the number waiting is higher than normal. This signifies a **concern**.

Between mid 2019 and 2020 there is a period of special cause variation where the number waiting consistently drops. This signifies an **improvement**.

The summary icons in the top right of the chart tell us the current outlook. The variation icon (left) is telling us that the string of grey points from 2020 onwards shows common cause variation. The assurance icon is showing us that the data is **consistently passing the target**. So performance is now staying the same, but we are consistently meeting our target.

Variation			Assurance		
Are we improving, declining or staying the same?			Can we reliably hit the target?		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target



NHS
Norfolk and Suffolk
Integrated Care Board

ICB Financial Budgets 2026/27

Board
20 May 2026

Contents

ICB Financial Plan and Budgets

A balanced Norfolk & Suffolk ICB plan for the financial year 2026/27 was approved by the Board in February 2026.

The approved financial plan :

- Meets the ICB statutory financial duties to deliver a breakeven plan.
- Is compliant with the Mental Health Investment Standard growth target of 2.03%
- Meets the requirement to stay within the running costs limit for 26/27 subject to any further limit changes.
- Maintains the ring fence on Primary Dental Services.
- Requires at least £101m of efficiency delivery.

The financial budgets contained within this paper for Board approval are consistent with delivery of the approved plan.

These budgets have been reviewed by the ICB Finance, Workforce & Performance Committee for approval on 14 May 2026.

Summary Budgets (exc. Corporate) by Director

Budget Value (Table 1)

Responsible Director	Budget 2026/27 £000
Amanda Lyes	1,299
Frankie Swords	356,931
Howard Martin	56,148
Lisa Nobes	347,089
Maddie Baker-Woods	313,609
Maddie Baker-Woods/Mark Burgis	176,737
Mark Burgis	542,037
Richard Watson	3,081,066
Sub Total	**4,874,915**
Programme Running Costs	46,651
Admin Running Costs	27,255
Total ICB Plan	**4,948,821**

Efficiency (Table 2)

Responsible Director	Programme	Scheme Value £'000
Lisa Nobes	Complex Care	18,991
Frankie Swords	Best Value Medicines	27,525
Frankie Swords	Clinical Policies	1,000
Richard Watson	GP IT Costs	1,780
Howard Martin & Richard Watson	Contract and Service Reviews incl. Strategic Commissioning	7,000
Howard Martin	Contract Management (Acute IAPs)	1,000
Howard Martin	Contracting Out of Area	1,000
Howard Martin	Finance	6,421
Amanda Lyes	Corporate	36,306
Amanda Lyes	Estates	831
Total ICB Plan		**101,854**

- The budgets in table 1 are stated net of CIP (see Table 2 for further detail).
- Further work is underway to finalise Programme and Administrative Running Costs by responsible Director.
- These, and all other budgets, will remain under review during the year and may be transferred to the most appropriate Director as required.

Detailed Budgets (exc. Corporate) by Director

Amanda Lyes, Director of People, Governance and Corporate Services

Area of Spend	Details	Budget 2026/27 £000
Other Programme	Voids and subsidies	982
	Professional fees	317
Total		**1,299**

Howard Martin, Executive Director of Finance and Contracts

Area of Spend	Details	Budget 2026/27 £000
Acute	Acute Reserves	47,124
Other Programme	Other Programme Reserves	(5,104)
Reserves	Reserves & Contingencies	14,127
Total		**56,148**

Frankie Swords, Executive Medical Director

Area of Spend	Details	Budget 2026/27 £000
Prescribing	Prescribing	331,809
	Home Oxygen	4,664
	Central Drugs	10,127
Acute	High cost drugs & Devices	10,253
Other Programme	Exceptions & Prior Approval	78
Total		**356,931**

Detailed Budgets (exc. Corporate) by Director

Lisa Nobes, Executive Director of Nursing

Area of Spend	Details	Budget 2026/27 £000
Acute	Local Maternity Neonatal Services	557
CHC	CHC Adult - Fully Funded - Standard	129,371
	CHC Adult - Fully Funded Personal Health Budgets - Standard	44,816
	CHC Adult - Fully Funded - Fast Track	25,228
	CHC Adult - Fully Funded Personal Health Budgets - Fast Track	368
	CHC Adult - Joint Funded	6,689
	CHC Adult - Joint Funded Personal Health Budgets	219
	Childrens Continuing Care	5,604
	Childrens Continuing Care Personal Health Budgets	2,923
	Funded Nursing Care	25,315
Subtotal		**240,532**
Community	CYP Services - Norfolk	3,551
	CYP Services - Suffolk	2,545
	Neurorehabilitation	8,628
	Neuro Psych	1,196
Subtotal		**15,920**
Mental Health	ADHD RtC - CYP	376
	NDD - CYP	2,509
	ASD RtC - CYP	595
	S117 Costs	30,338
	LDA placements	36,121
	LDA Adult services	8,957
	LDA Adult Allocation	11,184
Subtotal		**90,080**
Total		**347,089**

Detailed Budgets (exc. Corporate) by Director

Maddie Baker-Woods, Suffolk Primary Care and Neighbourhood Health Director

Area of Spend	Details	Budget 2026/27 £000
Primary Care	Delegated GP	155,363
	Out of Hours	5,574
	Local Incentive Schemes	4,893
	Primary Care Transformation	325
	Covid Vaccination	125
Subtotal		**166,279**
Community	Community - Contract - Suffolk	110,336
	Community Services - Suffolk	1,144
	Community Other - Suffolk	1,072
	Better Care Fund - Suffolk	28,673
	Health Inequalities - Suffolk	165
	Carers - Suffolk	260
	CYP Palliative Care - Suffolk	218
	Palliative Care - Suffolk	405
	Hospices - Suffolk	5,057
Subtotal		**147,330**
Total		**313,609**

Mark Burgis, Norfolk Primary Care and Neighbourhood Health Director

Area of Spend	Details	Budget 2026/27 £000
Primary Care	Delegated GP	256,279
	Local Incentive Schemes	20,376
	Out of Hours	10,171
	Primary Care Transformation	0
	Commissioning Schemes	462
Subtotal		**287,289**
Community	Community - Contract Norfolk	184,957
	Community Services - Norfolk	10,907
	Community Other - Norfolk	1,475
	Better Care Fund - Norfolk	50,561
	Health Inequalities - Norfolk	48
	Community Equipment - Norfolk	5,144
	CYP Palliative Care - Norfolk	85
	Palliative Care - Norfolk	1,570
Subtotal		**254,748**
Total		**542,037**

Maddie Baker-Woods/ Mark Burgis, Joint Suffolk & Norfolk Primary Care and Neighbourhood Health Directors

Area of Spend	Details	Budget 2026/27 £000
Primary Care	Primary Dental	83,340
	Community Dental	5,995
	Secondary Dental	22,010
	Pharmacy	45,754
	Delegated Ophthalmic	18,368
	Other Programme Costs	297
Subtotal		**175,764**
Community	Community LVA - ICB	974
Total		**176,738**

Detailed Budgets (exc. Corporate) by Director

Richard Watson Executive Director of Strategy, Digital and Commissioning

Area of Spend	Details	Budget 2026/27 £000
Acute	Acute NHS Contracts	2,118,016
	Non NHS Contracts	72,834
	LVAs	8,434
	NCAs	3,561
	PTS	23,408
	Protect NOW	205
	Projects - Planned Care	3,903
	Projects - Unplanned Care	2,300
	Non Recurrent Allocations	499
Subtotal		**2,233,160**
Community	CYP Transformation	62
Other Programme	NHS 111	16,033
Specialised	Spec Comm - Acute	404,971
	Spec Comm - Mental Health	42,969
Subtotal		**447,941**

Area of Spend	Details	Budget 2026/27 £000
Mental Health	Adult Community Crisis	614
	Ambulance Response Services	240
	Community A Not Bed-Based Not Placements	54,079
	CYP Mental Health (Exc LD)	31,672
	Local NHS Acute MH & Rehab IP Services Adult	43
	Mental Health - Allocation - CYP	13,256
	Mental Health - LVA	2,245
	Mental Health - Other - Adult	34
	Mental Health Act	316
	Mental Health Placements In Hospitals	788
	Perinatal MH (Community)	64
	Suicide Prevention	332
	Mental Health - Contract	122,482
	Mental Health - Allocation - Adult	140,068
	Community B Supported Housing Services	1,069
	Dementia	5,195
	ADHD RtC - Adults	10,543
	ASD RtC - Adults	831
Subtotal		**383,870**
TOTAL		**3,081,066**

Recommendation

The Board is asked to approve:

- The 2026/27 budgets by Director which have been derived from the financial plan approved by the Board in February 2026.

The Board is asked to note:

- The delivery risks to the financial plan previously highlighted as part of the financial plan approval.
- Any changes to director budgetary responsibility, particularly resulting from the requirement to reduce ICB costs will be implemented as required during the year in line with the ICB Budgetary Control Framework.
- Final detailed budgets for Programme and Admin running costs by Director will be approved by the Chief Executive and Executive Director of Finance and Contracts in line with the ICB Budgetary Control Framework.

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 16.
Date: 20 May 2026

Title: Committee Highlight Reports.
Lead Director: Committee Chairs
Purpose: To receive highlight reports from Committees of the Integrated Care Board.

a) Audit and Risk Committee
b) Strategic Commissioning Committee
c) Remuneration Committee
d) Quality Committee

Recommendation: To note.

Audit and Risk COMMITTEE

Date: 5 May 2026

Chair: David Holt Non- Executive Member

Item Status	Update
Advise	• **Annual Report and Accounts (ARA) –** The Committee received an update on the process and progress of the preparation of both previous ICB's set of ARAs. Both sets are on track with the national timetable. The draft will be shared with the N&S Board for review and comment on 14 May. The draft will be shared again with NHSE and the ICB's External Auditors. The final version will be reviewed by ARC on 15 June with a recommendation for approval to the Board at a meeting of the Board on 15 June ahead of the Final submission date on 19 June 2026. • **Risk Management Approach –** The Committee received a report detailing the steps underway to underpin the ICB Risk Management approach. It was acknowledged by the Committee that this was proposed as an interim measure to ensure that the Board received a consistent overview of the current risks previously reported to the two previous ICBs. As the ICB determines its priorities and works with the relevant risk owners within the ICB the process will evolve to capture future risk based on the risk appetite of the new ICB. It was noted that the focused Board Development session on risk would further inform this work. The ARC are in support of this interim measure to support an interim BAF position as work continues. This work will be supported by the ICB Internal Auditors.
Assure	• **Counter Fraud Plan –** The Committee reviewed the draft Counter Fraud Plan for the new ICB. Comments were shared with the Counter Fraud lead and the report will be redrafted to ensure that any outstanding actions from both previous ICBs are considered within the plan. • **Internal Audit Plan -** A draft internal Audit Plan was shared with the Committee. Following comments and feedback the draft will be updated and presented to the next meeting. • **Policy Approval** – The Committee approved the following policies: • Policy Development Policy • Risk Management Policy, subject to a review following any changes as indicated above. • Standards of Business Conduct and Conflicts of Interest Policy • **Freedom to Speak Up Arrangements** – The Committee received a report detailing the arrangements which bring together key elements of both former ICBs FTSU arrangements and policy into a single unified service. The Committee approved the process and policy and have asked for a review of both in six months' time.

Guidance

Updates should contain a few sentences of bullet points which provide the context, key risks and opportunities, and the action(s) the Committee is taking.

There are three categories of item status:

- **Alert**: Items which the Committee is referring to Board for action i.e. to escalate a risk to the BAF, to call for a report to Board, to include as an item for a board development session etc.
- **Advise**: Items which the committee feels additional assurance is needed for the ICB to be satisfied that polices/ procedures/ services are delivering the expected outcomes. New risks that have been identified and need to be added to the ICB risk register.
- **Assure**: Items the committee has considered and is satisfied that the Board can be assured that polices/ procedures/ services are delivering the expected outcomes.

Strategic Commissioning Committee

Date: 12 May 2026

Chair: Phanuel Mutumburi, Non-Executive Member

Item Status	Update
Advise	**Intensive & Assertive Community Mental Health Business Case Proposal** The Committee supported a business case which would provide £2.5m of recurrent investment into an Intensive and Assertive outreach approach in the Community Mental Health Team. The service would be delivered by NSFT with local VCFSE providers. Investing in an I&A service was a national mandate and the model proposed for Norfolk and Suffolk would also deliver a shift to community care and an integration between providers. The service would be co-located with other NSFT service like the early intervention team and CAMHS. The Committee's approval was subject to further development of the understanding of the return on investment and evaluation framework which was expected to come back to the next meeting.
Advise	**Suffolk End of Life Business Case** The Committee supported a business case which provided a recurrent investment in three schemes which would enhance end of life care across Suffolk by investing in Hospice at Home/ Virtual Ward capacity, additional hospice beds, and improvements in recording patient wishes related to End of Life care. This would drive a shift in care from hospital to home in line with the ICB's Strategy. The Committee emphasised the need to explore a similar investment in Norfolk to ensure that there was parity of services across the counties and heard that there was funding available. The Committee approval was subject to further development of the understand of return on investment and the outcomes/ evaluation framework which would come to a future meeting.
Assure	**Response to the 1 April 2026 letter from Sir Jim Mackey** The Committee approved the response to the four questions posed by NHS England. The ICB and Norfolk and Suffolk Providers had prepared a collective response the questions which covered the development of strategic commissioning, development of neighbourhood care, changes to financial policies, and accelerating the pace of local change.
Assure	**Strategic Commissioning Policy Scope** The Committee welcomed the ICB's approach to developing a Strategic Commissioning Policy. They stressed the need to emphasis the inclusion of patient feedback through out the commissioning cycle and to ensure that the ICB was not commissioning in a silo but working with other local commissioners i.e. Local Authorities. The Committee would receive a the full policy in July.
Assure	**Planned Care Demand Management work programme** The Committee heard from PA Consulting about the work that they were undertaking to take a radical look at planned care demand management. The work was in its initial stages and the Committee advised on areas to review, stressing the need to speak to clinicians (both in primary care and secondary)

	and to look at demand metrics to help identify alternative ways to manage referrals. The Committee also emphasised the need to engage with the Alliances to ensure that neighbourhood working was included in the work.
Assure	**Strategic Workforce Governance** The Committee approved a governance structure which would oversee the development of a strategic workforce plan.
Assure	**ICB Closedown letter** The Committee noted that closedown letter which had been sent to the ICB particularly the elements that set out the role of the new ICB.

Guidance

Updates should contain a few sentences of bullet points which provide the context, key risks and opportunities, and the action(s) the Committee is taking.

There are three categories of item status:

- **Alert**: Items which the Committee is referring to Board for action i.e. to escalate a risk to the BAF, to call for a report to Board, to include as an item for a board development session etc.
- **Advise**: Items which the committee feels additional assurance is needed for the ICB to be satisfied that polices/ procedures/ services are delivering the expected outcomes. New risks that have been identified and need to be added to the ICB risk register.
- **Assure**: Items the committee has considered and is satisfied that the Board can be assured that polices/ procedures/ services are delivering the expected outcomes.

Remuneration Committee

Date: 7 May 2026

Chair: Janet Wood, Non-Executive Member

Item Status	Update
Advise	**ICB staff restructure** The cost reduction programme and staff restructure is a standing item on every agenda. The Committee heard about the progress of stage one of the restructure process which was drawing to a close with around 500 roles filled and 200 vacant with c.300 staff displaced. The majority of the vacant roles were expected to be filled through the second stage of the process although some required specialist qualifications. The ICB would be seeking to advertise these externally as it was unlikely that displaced staff would meet these requirements. The Committee also reviewed an analysis of appointed and displaced staff seeking assurance that no staffing group had been disproportionately affected. The Committee recommended that this work be further developed and included as part of a future report to Board, potentially aligned to the annual reporting of the WRES and WDES. The Committee also continued to review business cases associated with redundancy packages which are approved regionally. The approval of business cases happens in advance of staff being given notice of redundancy and it was hoped that many of the staff to which the business cases related would still be able secure alternative role.
Advise	**Staff Survey Results** The Committee noted the outcome of the staff surveys undertaken in 2025. The results showed a marked difference in staff satisfaction between NWICB and SNEEICB. The outcome of the staff survey and action plan would be communicated to staff through directorate briefings. The Committee stressed the importance of organisational development to ensure that the new ICB inherited a positive culture which benefited all staff. The Committee would be reviewing the development of an OD plan.
Assure	**Creation of an addition NEM position.** The Committee supported the creation of an additional NEM position and the appointment of an interim NEM which is included on the Board agenda.
Assure	**Staffing matters** The Committee is regularly updated on staffing matters to insure that HR policies are being fairly, proportionally, and transparently applied.
Assure	**HR Policies** The Committee approved the absence management policy which brought together the NWICB and SNEE policies. This is the first of a suite of HR policies which will be developed for NSICB, drawing on best practice from the two previous ICBs.

Guidance

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- **Assure**: Items the committee has considered and is satisfied that the Board can be assured that polices/ procedures/ services are delivering the expected outcomes.

Quality COMMITTEE

Date: 02 April 2026 and 07 May 2026

Chair: Elaine Noske, Non-Executive Member

Item Status	Update
Advise	**NHSE Performance and Quality Score Card (07/05/26):** Committee discussed the regional quality and performance scorecard, recognising the value in providing a regional performance perspective but noting the opportunity for local work on data and insights, with a focus on continuous improvement and better assurance for the Board on system challenges to delivering safe, effective services with a good patient experience through a wider lens than regulatory and performance standards. **Norfolk and Waveney ICB Research and Innovation Annual Report (07/05/26):** Committee reviewed and recommended the report, ahead of ratification at Board (see Board Agenda Item. 11). **SEND Programme Update (07/05/26):** Committee were briefed on the new statutory requirements, the need to submit reform plans, and the ongoing improvement work in both counties, including the establishment of improvement boards and focus on joint commissioning. Members discussed the harm caused by long waits for assessments, the need to track outcomes beyond process measures, and the importance of understanding both quantitative and qualitative impacts on children and families. This included the need to triangulate data with lived experience and promote a more inclusive culture that recognises diverse needs and avoids over-medicalisation. Committee highlighted the need for focus on immediate remedial actions alongside the longer-term system transformation priorities. **Healthwatch Suffolk Lived Experience Summary (07/05/26):** Knowing Works (Suffolk Healthwatch provider) presented the lived experience of a young woman who, after becoming a first-time mother, developed significant chronic pain and a deterioration in her mental health. Her experience of care across multiple different services was poor, highlighting fragmented care pathways, lack of effective communication, overemphasis on weight loss and mental health and the absence of advocacy support. The ICB responded by identifying key learning points that aligned with national reports on women's health and endometriosis. Learning actions include sharing the case study with other Acute Trusts in the system, reviewing harm and pain management provision, and updating resources for patients. Committee reflected the broader Women's Health Strategy and noted the need to ensure that this addresses the systemic issues raised by this case study. **ICB Nursing Directorate New Operating Models (07/05/26):** Committee were briefed on the new models for the ICB Nursing directorate teams; Quality and Safety, Infection Prevention and Control, Safeguarding, Women, Babies and CYP, NHS CHC and Clinical Services. The Director of Clinical Services highlighted the change in how the 'Learning from Lives and Deaths – People with a Learning Disability and Autistic People' (LeDeR) programme will be delivered with a new focus around population health management and

	prevention. Overall, it was noted that the coming year will be a transition period, requiring flexibility as roles and responsibilities evolve, with ongoing collaboration between teams and providers to ensure continuity and responsiveness. **Quality Committee Risk Register (07/05/26):** Committee received a combined risk register, covering updates on the existing registers from Norfolk and Waveney and Suffolk. The July session will review and agree a new combined register for the Norfolk and Suffolk Committee, in line with and informed by the corporate approach, with a quality and safety focus.
Assure	**Quality Committee Development Session (02/04/26):** The Chair met with the ICB Executive Director of Nursing, Executive Medical Director, and Director of Quality to review the planning and transition to a single Norfolk and Suffolk Quality Committee. This included a review of the Terms of Reference, combined Action Log and Forward Planner, discussing the membership and structure of the meetings going forward and the work plan for the year ahead. **Update on St Andrews Hospital, Northampton (07/05/26):** Committee were updated on the CQC actions in response to serious patient safety and safeguarding concerns. This focused on the discharge planning for Norfolk and Suffolk service users and schedule of Commissioner oversight visits to ensure we continue to be sighted on the safety and wellbeing of this cohort during a period of transition. **Terms of Reference (07/05/26):** Committee received an updated Terms of Reference for information, expanding on the remit and purpose of the Committee to reflect Board feedback and make it more person focused. **<u>Committee Approvals (07/05/26)</u>** • ICB Quality Oversight Meeting (QOM) Terms of Reference • ICB 'Tessa' LeDeR Practice Briefing • Norfolk and Waveney ICB Research and Innovation Annual Report

Guidance

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Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 17
Date: 20 May 2026

Title: Amendment to the Governance Handbook and Constitution

Lead Director: Amanda Lyes, Executive Director of People, Governance, and Corporate Services

Author: Tom McColgan, Corporate Governance Manager

Purpose: Approve

Recommendation: That the Board:

i. Approve an application to NHS England to amend the ICB's Constitution to increase the number of Non-Executive Member posts on Board to five.

ii. Approves the Terms of Reference for the Finance, Performance, and Workforce Committee, Suffolk Primary Care and Neighbourhood Committee, and Norfolk and Waveney Primary Care and Neighbourhood Committee.

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1. Background

1.1. On 1 April 2026 the Board adopted the Constitution and Governance Handbook. The membership of the Board is set in the constitution and ICB must seek approval from NHS England to amend the constitution. The Governance Handbook includes the terms of reference for all of the ICB Committees.

2. Options, key issues, and risks

Creation of an additional Non-Executive Member role

2.1. The Constitution adopted on 1 April 2026 included four non-executive members; this aligned with both historic ICBs. The Chair and Non-Executive Members have reviewed their capacity to provide robust support to the Committees. They that the additional capacity from appointing an additional Non-Executive Member would improve the level of Non-Executive scrutiny at committees which are currently largely supported by a single non-executive.

2.2. The ICB also now covers a large area and an additional Non-Executive Member could improve the geographical coverage of the non-executives if the ICB is able to identify a candidate from an area different to those already in post.

Committee Terms of Reference

2.3. The terms of reference for the Norfolk and Waveney Primary Care and Neighbourhood Committee and Suffolk Primary Care and Neighbourhood Committee were still in draft on 1 April so were not approved with the Governance Handbook. The drafts of these have now been finalised and are presented for approval. The Committees will oversee the commissioning of primary care, community, and end of life services as well as the development of neighbourhood working. The five Alliances will report into the Committees as will the Primary Care Commissioning Group.

2.4. The terms of reference for the Finance, Performance, and Workforce Committee have been reviewed by the Chair of the Committee and the Executive Finance and Contracts Director and updated to better reflect the changing approach to system finance.

3. Patient and Public Engagement

3.1. There has been no patient or public engagement on this item.

4. Committees and Groups

4.1. The Remuneration Committee had considered and supported the inclusion of an additional Non-Executive Member role.

Norfolk and Suffolk
Integrated Care Board

Finance, Performance and Workforce Committee Terms of Reference

NHS Norfolk and Suffolk Integrated Care Board

1. Purpose

1.1. The Finance, Performance and Workforce Committee (the Committee) has been established to maintain oversight of the:

I. Development and delivery of a robust, viable and sustainable ICB revenue and capital financial plan.

II. Key outcome, performance, quality, and transformation metrics.

III. Triangulation of the ICB plan with that of key system providers, including assurances on contract sign off and delivery.

2. Permissions

2.1. The Committee is authorised by the Board to:

I. Investigate any activity within its terms of reference

II. Scrutinise progress of improvements in the recurrent underlying financial position of the ICB. The Committee can recommend to the ICB Board the triggering of remedial actions in the event that forecasts deviate from plan or no progress is made in improving the current year and recurrent underlying position. Authority for triggering that action will be via the ICB Board based on that recommendation.

III. Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference

IV. Commission any reports it deems necessary to help fulfil its obligations

V. Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

VI. Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

3. Remit and Responsibilities

3.1. The Committee is responsible for maintaining oversight of the following areas:

Performance

3.2. Take an overview of performance and transformation at whole system, place and organisation levels in relation to ICS objectives, contractual key performance indicators, and wider national requirements.

3.3. Oversee the development of a dashboard of key outcome, performance, quality and transformation metrics incorporating escalations from other ICB Committees and Specialist Groups.

3.4. Oversee the ICB assurance process for delivery against the NHS Oversight Framework

ICB financial management framework

3.5. Scrutiny of progress of improvements in recurrent underlying financial positions for the ICB, including triangulation with all formal NHS ICS partners. The Committee can recommend to the ICB Board the triggering of remedial actions in the event that forecasts deviate from plan or no progress is made in improving the recurrent underlying position. Authority for triggering that action will be via the ICB Board based on that recommendation.

3.6. The Committee will develop the ICB financial planning processes to be used to make recommendations to the Board on the ICB financial plan in line with strategy and national guidance.

3.7. The Committee will seek assurance that the ICB capital strategy and associated plan properly balances clinical, strategic and affordability drivers, ensure effective oversight of future prioritisation and capital funding bids, and gain assurance that short, medium and long term commitments are built into the overall system capital plan

3.8. Oversee delivery of the ICB CIP, ensuring efficiency savings are identified, monitored, and reported, with exception reports on any material breaches of the agreed efficiency plan and the adequacy of proposed remedial action plans.

3.9. Advise on and appraise the deployment and monitoring of the impact of ICB and System transformation funding programmes ensuring proposals are robust, affordable, and aligned with the ICBs strategic objectives.

3.10 Ensure that suitable financial policies and procedures are in place for the ICB to comply with relevant regulatory, legal and code of conduct requirements in respect of investment decisions.

4. Triangulation with System Partners

4.1 Oversee triangulation of the ICB financial and performance plan with system providers, gaining assurance that provider contracts are signed off and aligned with ICB planning assumptions.

4.2 Seek assurance over provider contract delivery, monitoring financial and performance risks arising from provider positions that may impact on the ICB plan.

4.3 Ensure visibility and reporting of provider-related financial and performance risks as part of the overall review of ICB finances.

National framework

4.1. to advise the ICB on any changes to NHS and non-NHS funding regimes

4.2. to oversee national system level financial returns

4.3. to ensure the required preparatory work is scheduled to meet national planning timelines

Financial monitoring information

4.4. to articulate the financial position and financial impacts (both short and long-term) to support decision-making

4.5. to gain assurance that the ICB is working with ICS partners towards common approaches across the system such as financial reporting, estimates and judgements

4.6. to be sighted on the financial performance, productivity, performance, and workforce from system bodies, and implications on the ICB of non-delivery.

4.7. to oversee the development of financial, activity and workforce modelling to support the system wide priority areas

4.8. to ensure appropriate information is available to enable the system to manage financial issues, risks and opportunities across the ICS

4.9. to ensure visibility and reporting of system financial and associated risks as part of the overall review of system finances

Financial Performance

4.10. to oversee the management of the ICB financial target

4.11. to agree key outcomes to assess delivery of the system wide financial strategy

4.12. to monitor and report to the ICB, and to the Integrated Care Partnership as required, the overall financial performance against national and local metrics, highlighting areas of concern

4.13. to monitor and report to the ICB key service performance which should be taken into account in assessing the financial position

Communication

4.14. to co-ordinate and manage communications on financial governance with stakeholders internally and externally

4.15. to develop an approach with partners, including the Integrated Care Partnership, to ensure the relationships between cost, performance, quality and environmental sustainability are understood

Capital

4.16. to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used

4.17. **System Workforce and People**

4.18. Take an overview of workforce at whole system, place and organisation levels in relation to agreed metrics from Provider Workforce Returns (PWRs), National Workforce Reporting System (NWRS) and Provider Finance Returns (PFRs)

4.19. Oversee the development of a dashboard of the key outcome from the PWRs/NWRS/PFRs and interdependences with performance, quality and transformation metrics incorporating escalations from other ICB Committees and Specialist Groups

4.20. Analysis of progress in underlying workforce positions. The Committee can recommend to the ICB Board the triggering of remedial actions in the event that forecasts deviate from plan or no progress is made in improving the recurrent underlying position. Authority for triggering that action will be via the ICB Board based on that recommendation

5. Relationship with other ICB/ Partner bodies

5.1. The Committee has been established by the ICB Board and the Chair of the Committee will regularly provide reports to Board on the work of the Committee and will escalate any matters of concern to the Board.

5.2. The Committee will work closely with the other committees of the Board. The Committee may invite members of other committees to facilitate cross committee working, receive highlight reports from other committees, receive items referred by other committees, and refer items to other committees for consideration.

5.3. The Committee has established Groups set out at appendix 1 to action on behalf of the Committee according to the remit and authority set out in their terms of reference. It is anticipated that Groups will regularly report on their work to the Committee and escalate any matters of concern to the Committee.

6. Membership

6.1. The board will appoint no fewer than four members of the Committee including one who is an Independent Non-Executive Member of the Board. Other members of the committee need not be members of the board but may be.

Members should possess between them knowledge, skills, and experience in:

- Accounting
- Risk management
- And technical or specialist issues pertinent to the business of the committee

Committee membership:

- 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 Appointed)
- Primary Care ICB Board representative
- Executive Director of Finance and Contracts
- Deputy Chief Executive and Executive Director of Commissioning, Strategy, and Digital
- Executive Director of People, Governance, and Corporate Services
- Executive Director of Primary Care and Neighbourhood Health Norfolk
- Executive Director of Primary Care and Neighbourhood Health Suffolk
- Director of Strategic Planning and Resilience, Digital and Intelligence (non-voting member unless deputising for the Executive Director of Commissioning, Strategy, and Digital).
- Director of Operational Finance (non-voting member unless deputising for the Executive Finance and Contracts Director)

7. Chair (and Deputy Chair)

7.1. The Board shall appoint an ICB Non-Executive Member (who must not be the Audit Committee Chair) to serve as Chair of the Committee. The Committee may choose to appoint a deputy chair from among its members. The role of the deputy chair will be to serve as chair in the absence of the Chair to allow the Committee to continue to conduct business.

8. Attendees

8.1. The Chair of the Committee may invite any ICB staff member or partner to attend the meeting. This may be on a meeting by meeting basis or as a standing invite. Any attendees will only be permitted to address the meeting at the discretion of the Chair.

9. Secretary and Administration

9.1. The Chief Executive will arrange for administration of the Committee including the distribution of papers in advance of the meeting, the production of minutes, and the maintenance of records.

10. Meeting Quoracy and Decision

10.1. A minimum of one third of the membership of the Committee must be present for a meeting to be quorate and business to be conducted. In the absence of quoracy those in attendance may choose to continue the meeting as an ‘informal meeting’. Informal meetings cannot take any decision on behalf of the committee or receive assurance on behalf of the ICB Board.

11. Decision Making and Voting

11.1. Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

11.2. The Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

11.3. Only members of the Group can vote. Each member is allowed one vote and a majority will be conclusive on any matter.

11.4. Where there is a split vote, with no clear majority, the Chair will cast a second deciding vote.

12. ICB Values

12.1. Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

12.2. Members of, and those attending, shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

13. Equality, Diversity and Inclusion

13.1. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

14. Review

Date Approved:	1 April 2026
Next Review:	March 2027

Norfolk and Suffolk
Integrated Care Board

Suffolk Primary Care and Neighbourhood Committee Terms of Reference

NHS Norfolk and Suffolk Integrated Care Board

Contents

1. Purpose

1.1. The Board has established the Norfolk & Waveney Primary Care and Neighbourhood Committee to oversee the development of Neighbourhood working across the three Norfolk and Waveney Alliances: Great Yarmouth & Waveney, Norfolk Central, and West Norfolk.

1.2. The Committee will work to deliver the ICB's Mission Statement: 'We commission healthcare services in Norfolk and Suffolk to improve population health, reduce health inequalities, and improve equitable access to consistently high-quality healthcare.'

1.3. The Committee maintains oversight of the commissioning and performance of community services and primary care.

2. Permissions

2.1. The Committee is authorised by the Board to:

I. Investigate any activity within its terms of reference;

II. Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;

III. Commission any reports it deems necessary to help fulfil its obligations;

IV. Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

V. Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.2. The Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3. Remit and Responsibilities

3.1. To maintain overall responsibility and oversight and assurance of community services, Primary Care, End of Life Care, and the development of Neighbourhood working. The Committee will ensure that the ICB is commissioning services that help Norfolk and Suffolk residents live longer, healthier, happier lives with access to safe, joined-up, patient-centred care.

3.2. To ratify any funding decisions taken by the relevant Alliances and to enable and support collaboration across Alliances.

3.3. To monitor the performance of all commissioned community services, primary care, and end of life care providers.

3.4. Approve expenditure within Board approved budgets of up to: £12million for the Norfolk & Waveney Committee; £7m for the Suffolk Committee, on matters within the Committee's terms of reference and which relate to services which will be delivered entirely within the identified committee area.

3.5. To maintain oversight of and regularly review Primary Care research and innovation activity.

3.6. Review or extend arrangements for risk sharing and/or risk pooling with other organisations to services within the committees delegated area under section 75 of the NHS Act 2006.

4. Relationship with other ICB/ Partner bodies

4.1. The Committee has established three Alliances of Integrated Care System partners at Place, bringing together the ICB, NHS healthcare providers, primary care, local councils, blue light services, patient representatives, and Community, Voluntary, Social Enterprise, and Faith Organisations to work collectively together to deliver the shared ambition of the principles set out in the Population Health Improvement Plan. The Alliances lead on the development of Neighbourhood working and Commissioning of community services at Place.

4.2. The Committee has jointly established a Primary Care Commissioning Group with the Suffolk Primary care and Neighbourhood Committee which will lead on the commissioning of primary care across the ICB area.

4.3. The Committee has been established by the ICB Board and the Chair of the Committee will regularly provide reports to Board on the work of the Committee and will escalate any matters of concern to the Board.

4.4. The Committee will work closely with the other committees of the Board. The Committee may invite members of other committees to facilitate cross committee working, receive highlight reports from other committees, receive items referred by other committees, and refer items to other committees for consideration.

5. Membership

5.1. The Committee is made up of the following voting members:

- Chair – ICB Non-Executive Member
- Executive Director, Primary Care and Neighbourhood Health for Suffolk
- Executive Director, Primary Care and Neighbourhood Health for Norfolk
- Deputy Medical Director for Norfolk
- Deputy Medical Director for Suffolk
- Representative of the Executive Director of Nursing

- Representative of the Executive Contracts and Finance Director
- Representative of the Primary Care Commissioning Group

6. Chair (and Deputy Chair)

6.1. The Board shall appoint an independent member to Chair the Committee, this person may also be a member of the Board or not. The Committee shall appoint a deputy Chair from amongst its members who will chair the meeting in the absence of the Chair.

7. Attendees

7.1. The Chair may invite any ICB officer or representative from a parter organisation to attend all or part of a meeting. This may be a regular invitation or on an ad hoc basis.

8. Secretary and Administration

8.1. The Norfolk Primary Care and Neighbourhood Committee shall be supported by a secretariat function, to ensure that:

I. Meetings are timetabled and agreed in advance

II. The agenda and papers are prepared and distributed, 2 working days in advance of each meeting; having been agreed by the Chair with the support of the Director team

III. Minutes are taken and that a record of matters arising, action points, decisions and issues to be carried forward are kept

IV. A record of attendance is kept

V. The Executive Team are updated on pertinent issues/ areas of interest/ policy developments

VI. Action points are taken forward between meetings

VII. A forward plan of agenda items is in place

9. Meeting Quoracy and Decision

9.1. A minimum of three members of the Committee must be present for a meeting to be quorate and business to be conducted. In the absence of quoracy those in attendance may choose to continue the meeting as an ‘informal meeting’. Informal meetings cannot take any decision on behalf of the committee or receive assurance on behalf of the ICB Board.

10. Decision Making and Voting

10.1. Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

10.2. The Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

10.3. Only members of the Group can vote. Each member is allowed one vote and a majority will be conclusive on any matter.

10.4. Where there is a split vote, with no clear majority, the Chair will cast a second deciding vote.

11. ICB Values

11.1. Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

11.2. Members of, and those attending, shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

12. Equality, Diversity and Inclusion

12.1. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13. Review

Date Approved:	TBC
Next Review:	TBC

Norfolk and Suffolk
Integrated Care Board

Norfolk & Waveney Primary Care and Neighbourhood Group Terms of Reference

NHS Norfolk and Suffolk Integrated Care Board

Contents

1. Purpose

1.1. The Board has established the Norfolk & Waveney Primary Care and Neighbourhood Committee to oversee the development of Neighbourhood working across the three Norfolk and Waveney Alliances: Great Yarmouth & Waveney, Norfolk Central, and West Norfolk.

1.2. The Committee will work to deliver the ICB's Mission Statement: 'We commission healthcare services in Norfolk and Suffolk to improve population health, reduce health inequalities, and improve equitable access to consistently high-quality healthcare.'

1.3. The Committee maintains oversight of the commissioning and performance of community services and primary care.

2. Permissions

2.1. The Committee is authorised by the Board to:

I. Investigate any activity within its terms of reference;

II. Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;

III. Commission any reports it deems necessary to help fulfil its obligations;

IV. Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

V. Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.2. The Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3. Remit and Responsibilities

3.1. To maintain overall responsibility and oversight and assurance of community services, Primary Care, End of Life Care, and the development of Neighbourhood working. The Committee will ensure that the ICB is commissioning services that help Norfolk and Suffolk residents live longer, healthier, happier lives with access to safe, joined-up, patient-centred care.

3.2. To ratify any funding decisions taken by the relevant Alliances and to enable and support collaboration across Alliances.

3.3. To monitor the performance of all commissioned community services, primary care, and end of life care providers.

3.4. Approve expenditure within Board approved budgets of up to: £12million for the Norfolk & Waveney Committee; £7m for the Suffolk Committee, on matters within the Committee's terms of reference and which relate to services which will be delivered entirely within the identified committee area.

3.5. To maintain oversight of and regularly review Primary Care research and innovation activity.

3.6. Review or extend arrangements for risk sharing and/or risk pooling with other organisations to services within the committees delegated area under section 75 of the NHS Act 2006.

4. Relationship with other ICB/ Partner bodies

4.1. The Committee has established three Alliances of Integrated Care System partners at Place, bringing together the ICB, NHS healthcare providers, primary care, local councils, blue light services, patient representatives, and Community, Voluntary, Social Enterprise, and Faith Organisations to work collectively together to deliver the shared ambition of the principles set out in the Population Health Improvement Plan. The Alliances lead on the development of Neighbourhood working and Commissioning of community services at Place.

4.2. The Committee has jointly established a Primary Care Commissioning Group with the Suffolk Primary care and Neighbourhood Committee which will lead on the commissioning of primary care across the ICB area.

4.3. The Committee has been established by the ICB Board and the Chair of the Committee will regularly provide reports to Board on the work of the Committee and will escalate any matters of concern to the Board.

4.4. The Committee will work closely with the other committees of the Board. The Committee may invite members of other committees to facilitate cross committee working, receive highlight reports from other committees, receive items referred by other committees, and refer items to other committees for consideration.

5. Membership

5.1. The Committee is made up of the following voting members:

- Chair – ICB Non-Executive Member
- Executive Director, Primary Care and Neighbourhood Health for Suffolk
- Executive Director, Primary Care and Neighbourhood Health for Norfolk
- Deputy Medical Director for Norfolk
- Deputy Medical Director for Suffolk
- Representative of the Executive Director of Nursing

- Representative of the Executive Contracts and Finance Director
- Representative of the Primary Care Commissioning Group

6. Chair (and Deputy Chair)

6.1. The Board shall appoint an independent member to Chair the Committee, this person may also be a member of the Board or not. The Committee shall appoint a deputy Chair from amongst its members who will chair the meeting in the absence of the Chair.

7. Attendees

7.1. The Chair may invite any ICB officer or representative from a parter organisation to attend all or part of a meeting. This may be a regular invitation or on an ad hoc basis.

8. Secretary and Administration

8.1. The Norfolk Primary Care and Neighbourhood Committee shall be supported by a secretariat function, to ensure that:

I. Meetings are timetabled and agreed in advance

II. The agenda and papers are prepared and distributed, 2 working days in advance of each meeting; having been agreed by the Chair with the support of the Director team

III. Minutes are taken and that a record of matters arising, action points, decisions and issues to be carried forward are kept

IV. A record of attendance is kept

V. The Executive Team are updated on pertinent issues/ areas of interest/ policy developments

VI. Action points are taken forward between meetings

VII. A forward plan of agenda items is in place

9. Meeting Quoracy and Decision

9.1. A minimum of three members of the Committee must be present for a meeting to be quorate and business to be conducted. In the absence of quoracy those in attendance may choose to continue the meeting as an ‘informal meeting’. Informal meetings cannot take any decision on behalf of the committee or receive assurance on behalf of the ICB Board.

10. Decision Making and Voting

10.1. Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

10.2. The Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

10.3. Only members of the Group can vote. Each member is allowed one vote and a majority will be conclusive on any matter.

10.4. Where there is a split vote, with no clear majority, the Chair will cast a second deciding vote.

11. ICB Values

11.1. Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

11.2. Members of, and those attending, shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

12. Equality, Diversity and Inclusion

12.1. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

13. Review

Date Approved:	TBC
Next Review:	TBC

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 18
Date: 20 May 2026

Title: Risk Management and Board Assurance Framework

Lead Director: Amanda Lyes, Executive Director of People, Governance, and Corporate Services

Author: Tom McColgan, Corporate Governance Manager and Agnes Earl, Corporate Governance and Risk Management Officer

Purpose: Approval

Recommendation: That the Board supports the interim arrangements for risk reporting to Board.

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1. Background

1.1. All NHS organisations are required to maintain a Board Assurance Framework (BAF). HM Treasury's Assurance Framework states that 'An assurance framework offers continuous, reliable oversight of an organisation's stewardship and risk management, helping to improve services and resource use'.

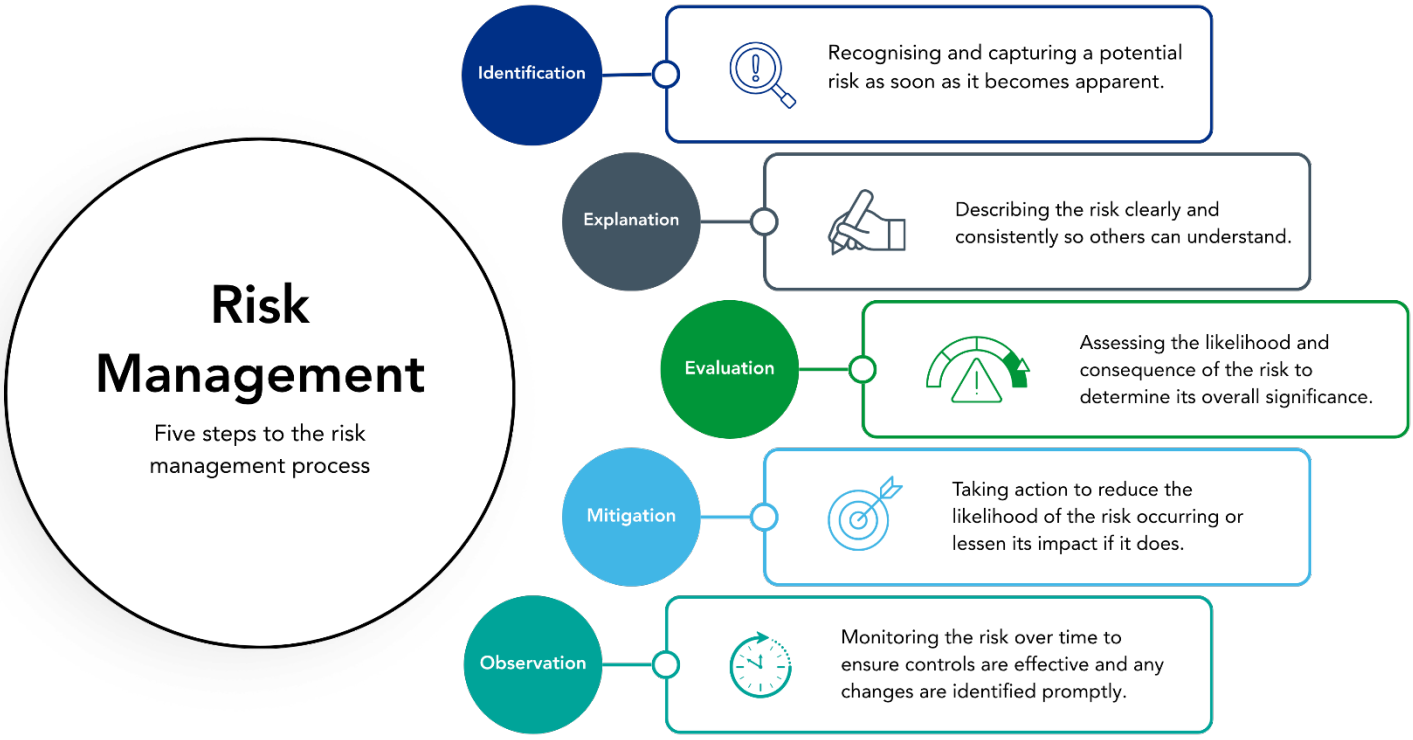
1.2. The two historic ICBs had taken different approaches to the Board Assurance Framework and the Audit Committee has recommended that an interim risk reporting approach be put in place. This will ensure that the Board remains sighted on risks while Board Members and the Audit Committee develop the BAF collaboratively through a development session.

1.3. The ICB also maintains a risk management framework through which it manages operational risks and escalates the highest rated risks to the Committees of the Board. The ICB's risk management policy was agreed by Audit Committee on 5 May 2026.

2. Key Issues and risks

Risk Management

2.1. The Audit Committee has delegated responsibility to ensure that the ICB has an effective risk management framework. The Committee agreed the risk management policy at its first meeting on 5 May 2026. The Policy is based upon best practice drawn from the Orange Book (the Government's guide to risk management), The International Standards Organisation's standard on risks management (31000), and previous practice at the historic ICBs. The diagram below summaries the risk management process that staff will follow.

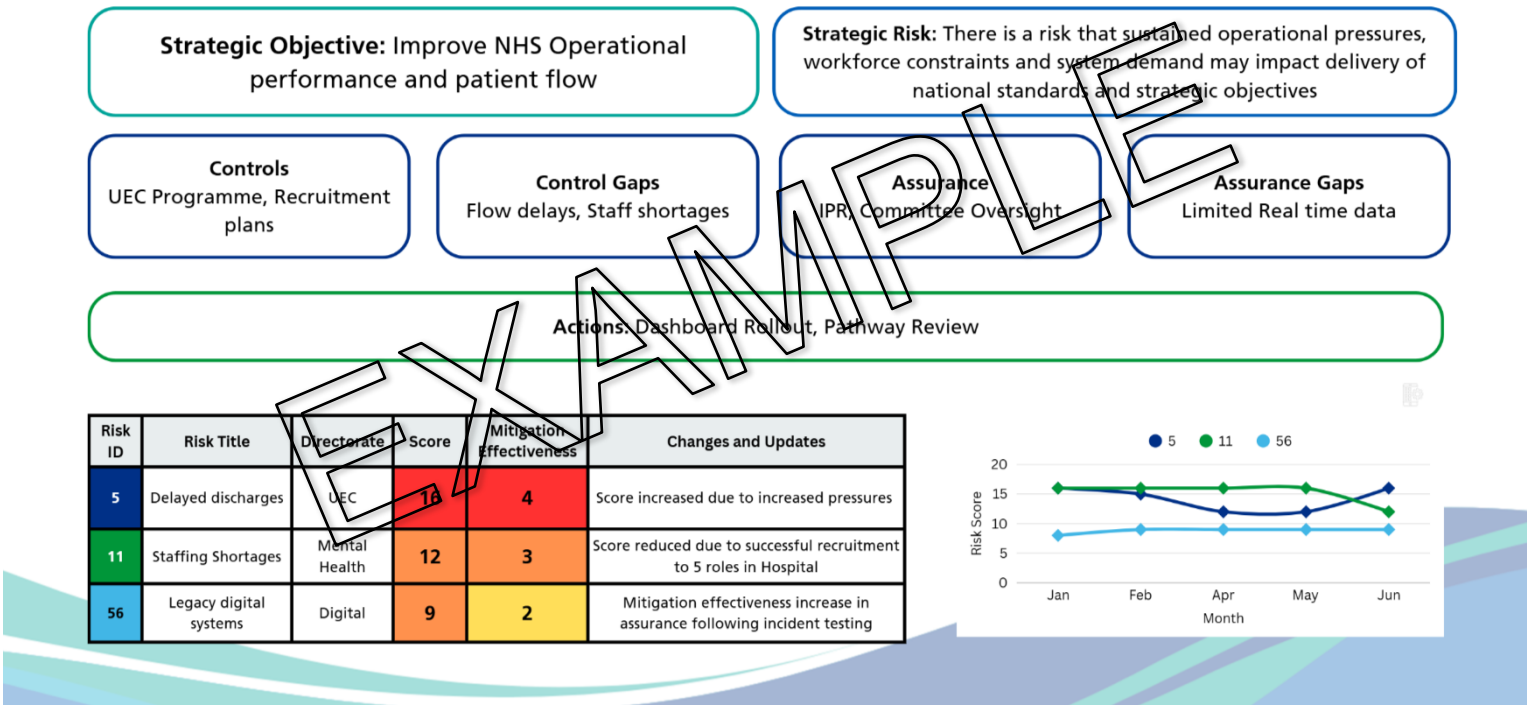


2.2. Risks are recorded on a central Corporate Risk Register accessible by staff across the organisation. The highest rated risks (12 and above) will be reported to the relevant Committees of the Board.

2.3. Staff are currently being trained in the risk process and the historic risks have been captured and transferred to the new ICB.

Interim Risk reporting at Board

2.4. Board will need to be made aware of emerging significant strategic risks or service areas where the ICB is carrying significant cumulative risk i.e. several interdependent operational risks which overall result in a risk to the ICB's strategic objectives. These will be identified through risk reports to the Committee and will form a risk report to Board from 15 July 2025 onwards. It is proposed that these risks will be reported as illustrated below with a link to the ICB Strategy, an overview of controls, current gaps in controls, assurance (using the three line of assurance model set out in the Orange Book), and gaps in assurances. For cumulative risk the linked operational risks will also be reported along with any change in scoring over time.



Development of the Board Assurance Framework

2.5. The Board Assurance Framework is part of a suite of documents together with the performance report, finance report, and Committee highlight reports that help the Board assess the delivery of its strategic objectives.

2.6. The Audit Committee felt that the BAF as a key strategic document should be developed with Board Members to ensure that it provides the overview of strategic risks that Members want.

2.7. The Board will also be asked to set the ICB's risk appetite. Risk appetite can be a powerful tool for guiding resource allocation. Areas with a higher risk appetite can carry a higher level of risk while the ICB concentrates investment in areas with lower risk appetite.

2.8. The ICB's Internal Auditors have offered to assist the Board in developing the BAF by initially facilitating a meeting of the Audit Committee on risk management before facilitating a risk management Board development session.

3. Patient and Public Engagement

3.1. There has been no patient engagement on this item.

4. Committees and Groups

4.1. The Audit Committee has oversight of the ICB's risk management framework. The Risk and Resilience Group (the ICB's operational risk management forum) will inform the development and continuous improvement of the ICB's risk management policy and practice.