

Questions submitted prior to the 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

Question 1, submitted by Colleen Giacomelli

Please could the ICB report on whether a vocational rehab service is being considered for the two neighbourhood hubs to support people in returning to work after a period of ill health/ stay well in work while managing a long term health condition/ reduce time GPs spend on writing fit notes. If so, do they have occupational therapists with vocational rehab experience (physical and mental health) offering guidance on what is needed for that service? Speaking from our work within the post covid service, vocational rehab is a complex intervention that requires experienced health professionals to set up and deliver, in order for it to be effective, alongside collaboration with other agencies.

Response

“Neighbourhood Health Centres (NHC) are a central theme in the Government’s 10 year health plan and something the ICB is currently considering carefully. The NHC model is intended to support more integrated, neighbourhood based approaches to care, shaped by local need and delivered collaboratively across partners, recognising the importance of supporting people to remain well in work and/or return to work following a period of absence. Any proposal for centres will require further detailed development, including the articulation of a clinical model, engagement with local partners including adult social care and practices, and careful consideration of affordability and value for money. No decisions have been taken at this stage.”

Question 2, submitted by Anthony Dooley

My thought is, that rather than uttering nonsense in response to questions from the public as has been the experience of myself and others in the past, the newly created ICB for Norfolk and Suffolk commits, as Amanda has shown is possible for example, to responding to such questions with written responses in addition any initial verbal statements at ICB meetings. These written responses should be sent to the member of the public who submitted it/ them asap after the meeting and subsequently recorded in the public domain in the minutes. Accordingly, I would ask that the meeting on May 20th adopts this as practice for the ICB, and hence wish this as a question for the board.

Response

“Thank you for sharing your thoughts with us. NHS Norfolk and Suffolk Integrated Care Board is in the process of reviewing the way in which we deal with questions for the board and your feedback will be considered as part of this process.”

Question 3, submitted by Anthony Dooley

As for the statement from Dr Sethi, it clearly failed to address my question preferring the ludicrous ‘two ronnies’ approach that I have characterised many verbal responses in the past. Accordingly, I wish to resubmit my question about the disgraceful action of MIND, and if he is incapable of actually addressing it perhaps someone else could. I don’t need to be told MIND is the employer, that is the reason this disgraceful behaviour occurred, because of outsourcing. My question is thus about outsourcing, in this case by NSFT, but could be extended sadly to other providers you commission; the worst example being the appalling behaviour of ESNEFT towards the provision of ‘soft services’ last year.

So, my question to the new board is, will it expect providers commissioned to provide services to do so ‘in house’, and that any existing outsourced services will be expected to be brought in house when contracts come up for renewal?

Response

“We acknowledge that issues around outsourcing and service quality can raise strong concerns, and it is important that those are heard. From the Board’s perspective, our role as an Integrated Care Board is not to mandate a single delivery model, such as requiring all services to be provided in house, but to be clear about the standards we expect and to hold providers to account for delivering safe, high quality care. Providers themselves are responsible for how they organise their services, including whether elements are delivered directly or through other organisations. However, what is absolutely clear is that accountability always remains with the provider. Outsourcing does not remove responsibility for quality, safety, or how services are delivered.

Our expectation is that all providers we commission, regardless of the model they use, meet required standards, ensure proper oversight of any contracted services, and act quickly where there are concerns or failings. Where specific issues are raised, these are followed up through our established assurance and contract management processes, and we will take action where standards are not met. Looking ahead, when services are reviewed or contracts renewed, we will continue to consider the most appropriate delivery model on a case by case basis, based on quality, resilience, and value for the population in line with the appropriate regulations which include the Procurement Act 2023 and the Provider Selection Regime, not a presumption that one model should apply in all circumstances.”

Question 4, submitted by Anthony Dooley

I understand that NSFT rented two floors from County Hall in Norwich at considerable expense only to use one. Given that I have sat through meetings of the ICB where the issue of value for money is often referred to, what is the view taken by the ICB towards NSFT in what was clearly a waste of public money that could have been spent eg on services for those with mental health issues such as those in Waveney who currently languish on waiting lists for ‘talking therapies’, and what processes of scrutiny will the ICB have in place to ensure those whom it commissions do not waste public money in ways such as this? Clearly, I am asking about the waste of public money by NSFT based on a report I received that I believed was accurate.

Response

“As part of NSFT’s ongoing efforts to ensure efficient use of our estate and to support a more collaborative working environment, the Trust took the decision to reduce costs and only occupy one floor at County Hall, Norwich, from September 2025. The initial move to

County Hall in 2024 also reduced our corporate costs and allowed the Trust to focus further resources on meeting the needs of our service users.”

Question 5, submitted by Anthony Dooley

What processes have you as Commissioners of Acute Hospital Trusts in Norfolk and Suffolk put in place to ensure that every occasion of ‘corridor care’ in those Hospitals is recorded, and the data thus generated is put in the public domain on a regular basis, say every three months, to provide evidence on the shortage of beds in each Hospital and thus the need to restore some of the beds that used to be available. Please provide the definition of ‘corridor care’ you use.

Response

“Corridor care is something that NHS Norfolk and Suffolk ICB is committed to reducing, by working with healthcare providers to optimise demand and capacity. The ICB has a System Control Centre managed by our Urgent and Emergency Care resilience team, which ensures we have a real-time, system-wide view of operational pressures across hospitals. This includes a view on the operational status of hospitals and episodes of corridor care, based on information in situational reports provided by trusts.

Emergency Care Data standards are set at a national level by NHS England, including definitions of corridor care which providers and the ICB use. This information can be found on the NHS England website and defines corridor care as care delivered in non-designated clinical spaces where patients are managed for more than 45 minutes in a 24-hour period. Hospital trusts report urgent and emergency care performance through their own Board reporting; and NHS England has committed to publish corridor care data from May 2026 [NHS England » Additional actions to virtually eliminate corridor care](#)

The ICB reports publicly on Urgent and Emergency Care performance via the Board performance report. This includes measures of Urgent and Emergency Care performance, such as performance against the four-hour standard. This enables assessment of how hospital capacity has addressed demand. The ICB’s Nursing and Quality team have visited the acute trusts across Norfolk and Suffolk, giving feedback and supporting trusts to improve the quality and safety of care given in corridor spaces. NHS England have recently published a ‘Getting It Right First Time’ improvement guide, to help trusts reduce corridor care - [Corridor-Care-Improvement-Guide-Final-March-2026-V2.pdf](#).”

Question 6, submitted by Anthony Dooley

How are you ensuring that every patient’s negative experiences of engaging with or being affected by digital technology at Primary and Secondary care level is recorded so that you can address these negative experiences? I have had two such experiences recently which make me wonder how widespread this phenomenon is. If you don’t collect evidence, you can’t know what needs to be addressed.

Response

“All feedback received from patients about the services we commission is recorded and responded to. Where appropriate we will ask for comments and investigation from the provider of care. This valuable feedback is later used to help inform quality improvement work and future commissioning cycles. This process of evaluating and responding to feedback is replicated across all NHS providers.”

Question 7, submitted by Andrew Livingstone

In correspondence to Sir Jim Mackey, the ICB states that: “in the short term, our priority is to deliver the best possible care for our population.” How does the Board reconcile that statement with the continued refusal to allow patients in Norfolk and Waveney access to the Tier 3 specialist weight management pathway already commissioned elsewhere within the same Integrated Care Board footprint, despite those patients meeting the clinical criteria applied in Suffolk? To be clear, my question is not about the national rollout position or national prioritisation policy. It concerns the current position within this Integrated Care Board itself, where materially different access arrangements continue to exist within one merged commissioning structure.

At present, two clinically identical patients within the same ICB area may receive materially different access to specialist obesity services solely because of geography. Suffolk patients can access the pathway, while Norfolk and Waveney patients are told they must wait while services are “aligned”. Does the Board consider that arrangement consistent with:

- equitable access to healthcare;
- the ICB’s statutory duty to reduce inequalities in access to health services; and
- the stated commitment to deliver “the best possible care” in the short term?

Further, where clinicians have identified that delayed access to specialist intervention is itself contributing to deterioration in physical and mental health, does the Board consider “waiting for alignment” to be an adequate or clinically defensible interim position? Finally, if the Board accepts that inequality currently exists within the merged ICB footprint, what interim mitigation measures have been implemented to ensure patients are not disadvantaged during the transition period?

Response

“The ICB acknowledges that currently there are some differences around how patients access weight management support, based on whether they live in Norfolk and Waveney or Suffolk - this does not necessarily mean different services. Where contractually possible, we are working with different providers to ensure pathways align across the two counties. We are committed to ensuring patients receive quality services. We will provide a more detailed response to Mr Livingstone in due course.”

Question 8, submitted by Louise Sargeant

Can the Board explain how the ICB is meeting the requirements set out in NICE Quality Standard QS214 on rare diseases — particularly the need for coordinated, person centred care, clear points of contact, and effective navigation support — and what arrangements are in place to prevent patients with rare conditions being repeatedly redirected between services with no service accepting responsibility for assessment or treatment.

<https://www.nice.org.uk/guidance/qs214>

Response

“The NHS Norfolk and Suffolk ICB is fully committed to implementing the [NICE Quality Standard QS214 on Rare Diseases](#). The ICB commissions care structures designed to wrap around the individual and as a strategic commissioner we work closely with specialised commissioning teams to ensure that our patients have access and patient centred support from specialist centres for rare diseases. These centres are usually located

outside Norfolk and Suffolk in cities such as London and Cambridge. The ICB is committed to improve timely access to diagnostic investigations and treatment.”

Question 9, submitted by Louise Sargeant

Given that NICE Quality Standard QS214 requires clear, accurate information and effective navigation support for people with rare diseases, what steps is the ICB taking to ensure its staff understand the services they commission and provide correct information to the public, particularly in light of recent records showing many staff including senior staff providing incorrect advice about NSICB, APMS commissioning and a reluctance over the past 10 days to explain how to raise a complaint about the ICB itself.

Response

“Our website provides information and links which describe the services we commission. The ICB has directory of service that has been shared with system providers – this document is regularly updated. The ICB has a clear complaints procedure which is outlined on the website. Anyone needing to speak to someone can call our PALS service to raise a complaint on [0800 389 6819](tel:08003896819)”

Question 10, submitted by Louise Sargeant

Can the Board confirm whether the APMS service at 70–74 St Helens Street (Ipswich) is operating with the full suite of required governance documents (including policies, procedures and safety frameworks), and whether the relevant documents that patients are entitled to see are routinely made available to support informed access and safe use of the service.

Response

“A full length NHS standard contract was awarded to Essex Partnership University NHS Foundation Trust (EPUT) to provide this service adhering to Provider Selection Regime (PSR) rules. This contract includes nationally agreed conditions that all providers have to follow including clinical governance and patient safety standards. The ICB holds contract meetings with EPUT to provide assurance of the quality and safety of the service being delivered.”