NHS
Norfolk and Suffolk
Integrated Care Board

A meeting of the NHS Norfolk and Suffolk Integrated Care Board

Wednesday 15 July 2026 10.30am

New Green Centre (Main Hall), Thurston, IP31 3TG

Chair: Will Pope

Item	Time	Agenda Item	Purpose	Lead
1.	10.30	**Welcome, introductions and apologies**	N/A	**Chair**
2.	10.32	**Notification of Questions from the Public**	N/A	**Chair**
3.	10.35	**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.	10.40	**Patient Story**	Information	**Andy Wall** (Cardiac Arrest Survivor and ICB colleague) and, **Claudine Keelan** (Clinical Specialist Occupational Therapist, NNUH)
5.	11.00	**East of England Ambulance Service NHS Trust (EEAST) Update**	Information	**Neill Moloney** (Chief Executive, EEAST)
6.	11:30	**Minutes from previous meeting and matters arising**	Approval	**Chair**
7.	11:35	**Action Log**	Information	**Chair**
8.	11:40	**Chief Executive Update**	Information	**Ed Garratt** (Chief Executive)
9.	11:50	**Strategic Commissioning Policy and Toolkit**	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)
10.	12:00	**Mental Health Strategic Plan**	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)
11.	12:10	**Stroke Business Case**	Information	**Richard Watson**

				(Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)
12.	12:20	**Norfolk and Suffolk Health and Care Expo 2026**	Information	**Michelle Grant-Richardson**
13.	12:30	**Break**	N/A	**Chair**
14.	12:40	**East Coast Partnership & WorkWell**	Information	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
15.	12.50	**Lord Mann Review: Tackling Antisemitism and Racism in the NHS**	Information	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
16.	1.00	**2025 NHS Staff Survey Results**	Information	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
17.	1.05	**Integrated Performance Report**	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)
18.	1.15	**Finance Report**	Information	**Howard Martin** (Executive Finance and Contracts Director)
19.	1.20	**Committee Highlight Reports**	Information	Committee Chairs
20.	1.25	**Governance Update and Amendments to Governance Handbook**	Approval	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
21.	1.30	**Risk Management and Board Assurance Framework**	Approval	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
22.	1.35	**Questions from the Public**	N/A	Chair
23.	1.45	**Any Other Business**	N/A	Chair

Date, time and venue of future Public Board Meetings:

- 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

NHS Norfolk and Suffolk ICB July 2026 Board Meeting

Supporting information for Patient Story

Andy Wall, Cardiac Arrest Survivor and ICB colleague

Claudine Keelan, Clinical Specialist Occupational Therapist, NNUH

Purpose

To provide Board members with clinical context to accompany Andy Wall's patient story and highlight the importance of a coordinated approach to out-of-hospital cardiac arrest (OHCA), from rapid emergency response through to rehabilitation and long-term recovery.

Background

Andy Wall, a member of NHS Norfolk and Suffolk Integrated Care Board staff, experienced an out-of-hospital cardiac arrest at Carrow Road during a Norwich City Football Club match on 5 August 2023.

His survival was made possible because every link in the chain of survival worked exactly as intended. Immediate recognition of his cardiac arrest, rapid bystander action, high-quality CPR, prompt defibrillation by medical teams on site, advanced life support delivered by clinicians from the East of England Ambulance Service (EEAST) and East Anglian Air Ambulance, followed by specialist treatment and rehabilitation at Norfolk and Norwich University Hospital (NNUH), together gave Andy the opportunity not only to survive, but to recover.

Following stabilisation at the scene, Andy was transferred by EEAST to NNUH where he received expert cardiac care alongside specialist multidisciplinary assessment and rehabilitation.

Today, Andy has returned to work, enjoys family life with his wife and children, and has become a passionate ambassador for CPR awareness through the Sky Bet and British Heart Foundation's *Every Minute Matters* campaign.

His story demonstrates what can be achieved when prevention, public action, emergency response, specialist hospital care and rehabilitation work seamlessly together. From learning CPR before it is ever needed, to the rapid response of emergency services and the expert rehabilitation that followed, every stage of the pathway contributed to Andy's recovery.

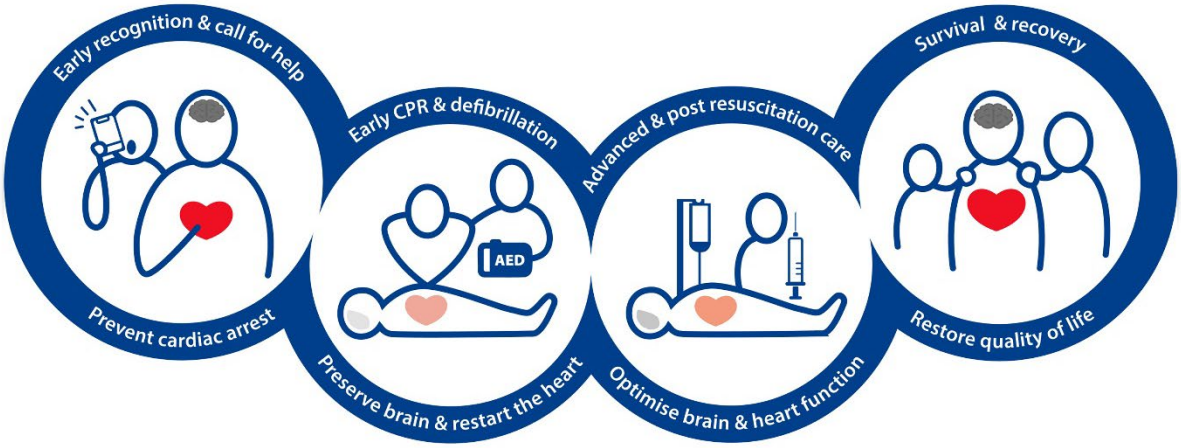


Figure 1 Chain of Survival, European Resuscitation Council

Every minute matters

Around 40,000 people experience an out-of-hospital cardiac arrest in the UK every year, yet fewer than one in ten survive.

For someone experiencing a cardiac arrest, every minute without CPR and defibrillation reduces the likelihood of survival. Brain injury begins within minutes when oxygen is no longer reaching the brain.

Immediate CPR keeps oxygen circulating until the heart can be restarted and advanced medical care can be delivered. When CPR is started immediately and a defibrillator is used within the first three to five minutes, survival rates increase significantly.

However, not everyone has the same opportunity. Survival from out-of-hospital cardiac arrest can vary depending on where someone collapses, whether bystanders feel confident to perform CPR, access to a public defibrillator and how quickly emergency services are able to reach them. Improving public awareness of CPR and increasing access to defibrillators are important ways to reduce these inequalities and give more people the best possible chance of survival.

Andy survived because each stage of that response happened quickly and effectively.

The rapid actions of Andy's wife, fellow supporters, stadium staff, clinicians from EEAST and East Anglian Air Ambulance, together with the specialist care that followed at NNUH, gave Andy the best possible chance of survival and recovery.

His story illustrates why emergency response is never the responsibility of one organisation alone - it relies upon a coordinated system in which every link is equally important.

Clinical context

Surviving a cardiac arrest is only the beginning of recovery.

Growing international evidence demonstrates that many survivors continue to experience significant physical, cognitive and psychological challenges long after discharge from hospital.

Common issues include:

- fatigue
- memory and concentration difficulties
- anxiety and depression
- post-traumatic stress
- reduced confidence
- difficulties returning to work
- challenges resuming family and social life.

Recognising this, recent guidance from the European Resuscitation Council, Resuscitation Council UK and the British Cardiovascular Intervention Society recommends comprehensive multidisciplinary assessment before discharge, followed by structured rehabilitation and

specialist follow-up. This is further reinforced by the Resuscitation Council UK's Quality Standards for Cardiopulmonary Resuscitation Practice and Training (2024), which recognise rehabilitation and survivorship support as essential components of high-quality cardiac arrest care.

The importance of this work was further highlighted in the Resuscitation Council UK's 2026 report, *The Weakest Link: Recovery after Cardiac Arrest*, which identifies post-cardiac arrest rehabilitation as one of the least consistently developed parts of the patient pathway despite growing evidence of its impact on long-term outcomes and quality of life. The report highlights the multidisciplinary work taking place at Norfolk and Norwich University Hospital as an example of good practice in supporting patients beyond survival.

This approach recognises that good outcomes should not be measured simply by survival, but by supporting people to recover well, regain independence and return to meaningful lives.

Current pathway at Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospital has developed one of the UK's most comprehensive inpatient pathways for survivors of out-of-hospital cardiac arrest.

Every patient admitted following an OHCA receives a specialist multidisciplinary assessment before discharge. This includes assessment of cognition, fatigue, functional ability and psychological wellbeing by a specialist occupational therapist, alongside expert cardiology care.

Between 2023 and 2025, NHS England funding enabled the Trust to establish a dedicated follow-up clinic for survivors of out-of-hospital cardiac arrest.

The clinic provided coordinated rehabilitation and ongoing assessment for patients whose recovery often extends for many months beyond discharge from hospital. Feedback from patients, families and clinicians demonstrated the significant benefits of this coordinated approach.

Although the dedicated follow-up clinic is no longer commissioned, the inpatient pathway remains in place and continues to reflect emerging national and international best practice in cardiac arrest survivorship.

National and international leadership

The multidisciplinary team at NNUH has become recognised nationally and internationally for advancing understanding of recovery following out-of-hospital cardiac arrest.

Clinical Specialist Occupational Therapist Claudine Keelan, who supported Andy during his rehabilitation, is part of the European Commission-funded PREMEDICARE programme through the European Cooperation in Science and Technology (COST).

This collaboration brings together experts from more than 40 countries to better understand the long-term impact of cardiac arrest in younger survivors and will ultimately produce an international white paper to shape future standards of care.

Alongside this work, the NNUH has supported Claudine in leading a programme of research and knowledge exchange that has led to:

- published peer-reviewed research evaluating implementation of European survivorship guidelines;
- presented research at national and international conferences in the UK, Portugal and the Netherlands;
- contributed to multicentre audits informing implementation of the 2025 European Resuscitation Council recommendations;
- delivered invited national teaching on rehabilitation following cardiac arrest; and
- been recognised by Sudden Cardiac Arrest UK for its contribution to improving survivorship care.

This work positions Norfolk as a recognised contributor to an emerging field of international cardiovascular rehabilitation research.

As understanding of survivorship continues to evolve, local clinicians are helping to shape best practice rather than simply adopting it.

Clinical perspectives

Dr Tim Gilbert, Consultant Cardiologist at Norfolk and Norwich University Hospital, explains why coordinated follow-up is essential for cardiac arrest survivors:

"Survivors of out-of-hospital cardiac arrest require a joined-up approach between secondary and primary care. NNUH is well placed to lead this because we care for patients at the point of greatest clinical need and understand the challenges they face after discharge. Patients who receive coordinated rehabilitation achieve better outcomes, experience fewer hospital readmissions and emergency department attendances, and many are able to return to work and independent living."

Dr Ian Williams, Consultant Cardiologist and Lead for Cardiac Rhythm Management and Inherited Cardiac Conditions at Norfolk and Norwich University Hospital, describes the life-changing impact of cardiac arrest and the importance of specialist rehabilitation:

"Surviving a cardiac arrest is only the beginning of recovery. Many survivors experience lasting physical, cognitive and psychological challenges that affect every aspect of their lives and those of their families. Recovery requires skilled, coordinated support from the earliest stage of the patient journey through to rehabilitation in the community, enabling people to rebuild their confidence, independence and quality of life."

Dr Dan Raine, Consultant Cardiologist and Electrophysiologist at Norfolk and Norwich University Hospital, highlights the value of specialist rehabilitation following cardiac arrest:

"The cardiac arrest rehabilitation programme at Norfolk and Norwich University Hospital is an invaluable service. It provides essential physical, psychological and emotional support, helping survivors and their families understand what has happened, rebuild confidence and plan positively for the future."

Supporting survival together

Andy survived because every part of the system worked together.

His experience also highlights the vital role the public plays in improving survival from cardiac arrest.

Emergency services rely on members of the public recognising cardiac arrest, calling 999 immediately and beginning CPR before ambulance clinicians arrive. Every minute that passes without CPR reduces the likelihood of survival.

The British Heart Foundation's **RevivR** programme enables anyone to learn CPR in just 15 minutes and has already helped more than half a million people develop lifesaving skills.

Making CPR education simple, free and widely available also helps reduce health inequalities. Every additional person who has the confidence to recognise a cardiac arrest and begin CPR increases the likelihood that someone - regardless of where they live or who they are - will receive lifesaving treatment before emergency services arrive.

Inspired by Andy's experience, NHS Norfolk and Suffolk Integrated Care Board has encouraged all colleagues to complete the free RevivR training as part of its commitment to improving cardiac arrest awareness and increasing confidence in delivering lifesaving CPR.

For ambulance clinicians, earlier bystander CPR means they are more likely to arrive to a patient whose circulation has been maintained, increasing the likelihood of successful resuscitation and reducing the risk of permanent brain injury.

Andy has become a passionate advocate for the *Every Minute Matters* campaign because he knows first-hand that the actions of others in those first critical minutes gave him the opportunity to watch his children grow up, return to work and continue making memories with his family.

Why Andy's story matters

Figure 2 Andy at Wembley Stadium

Earlier this year, Andy became one of only four people to have a stand at Wembley Stadium temporarily renamed in his honour as part of Sky Bet and the British Heart Foundation's *Every Minute Matters* campaign - the first time in the stadium's history this has happened.

His story is one of exceptional care, but it is also one of extraordinary collaboration.

From fellow supporters and stadium staff, to EEAST clinicians, East Anglian Air Ambulance, specialist hospital teams and rehabilitation professionals, every part of the pathway contributed to his recovery.

Today, Andy is living proof that success is not measured simply by surviving a cardiac arrest.

It is measured by returning home, returning to work, rebuilding confidence, supporting a family and using lived experience to help save the lives of others.

Conclusion

Andy's experience demonstrates the strength of a health and care system working together around the needs of one patient.

His survival depended on immediate action by those around him, expert emergency care delivered by EEAST and East Anglian Air Ambulance, specialist treatment at Norfolk and Norwich University Hospital, and multidisciplinary rehabilitation that supported his return to work, family life and advocacy.

It also reminds us why every minute matters.

Increasing the number of people who feel confident to recognise cardiac arrest, call 999 and begin CPR will improve survival for more people before ambulance crews arrive. By making lifesaving skills more accessible and ensuring high-quality rehabilitation is available to those who survive, we also have an opportunity to reduce unwarranted variation in outcomes and give more people, regardless of where they live or their circumstances, the best possible chance not only to survive, but to recover well.

Together, Andy's story, the outstanding care provided by EEAST and NNUH, the internationally recognised work of local clinicians, and the promotion of the British Heart Foundation's RevivR campaign demonstrate how prevention, public action, emergency response, specialist care and rehabilitation combine to deliver the very best outcomes for patients. It is also a powerful example of the values that underpin our health and care system every day: the kindness of those who acted without hesitation, the collaboration that brought multiple organisations and professions together around one patient, and the ambition of local clinical teams who continue to shape best practice nationally and internationally.

Figure 3 Andy, his wife and the staff who helped save his life

NHS
East of England
Ambulance Service
NHS Trust

EEAST Update
N&S ICB Board

15 July 2026

OUR STRATEGY 2025-30 PLAN ON A PAGE

NHS East of England Ambulance Service NHS Trust

Our purpose

We care for **our patients**, **our communities** and **each other**, making every minute count to save lives and improve outcomes for patients

Our vision

Everyone in the east of England will have **high-quality**, **urgent** and **emergency care**, with providers of health and care services across the region working in partnership with EEAST to make this happen

What we will achieve

Patient Mission To provide **high-quality**, **urgent** and **emergency care** that is fair, responsive and focused on patient need.

People Mission To provide a **supportive**, **inclusive** and **empowering** environment for our people that supports individual and organisational performance.

Partnership Mission To connect patients to the **best care**, at the **right time, first time, every time,** through working with our partners.

Productivity Mission To be an **innovative**, **efficient** and **sustainable** healthcare partner, to meet the needs of our communities within the resources available to us.

What this means for you

Our patients

You can expect:

- ✔ **Quicker** emergency responses
- ✔ **Right care, first time, every time**
- ✔ **Improved** confidence in services

Our people – staff and volunteers

You can expect:

- ✔ **To do** what you were trained to do
- ✔ **Better** performance
- ✔ Feeling that **EEAST cares for you**

Our partners – providers and commissioners

You can expect:

- ✔ **More effective** collaboration
- ✔ **Better data** for decision-making
- ✔ **Shared** system priorities

How we will work: Our values

Accountable **Respectful** **Excellent**

#WeAre EEAST

The Patient Plan

East of England Ambulance Service NHS Trust

Our Patient Plan

What are the three priorities?

Click here to read the full Patient Plan

Faster emergency response for the sickest patients

Getting people the right care, first time

Supporting care closer to home

More Care closer to home – working with neighbourhood teams

Working closely with GPs, community and mental health teams

Supporting patients safely outside hospital where appropriate

What this means:

Better experiences for patients and less pressure on hospitals

Productivity

PA Consulting identified key efficiency metrics in September 2024 which contribute to C2 performance.

- Out of service
- Job cycle time (JCT)
- C2 on scene time
- Hospital Handover to clear
- Conveyance rates
- Hear and Treat
- Multiple attendance ratio (MAR)
- Abstraction & sickness absence
- Hospital handover

Significant improvement has been made on the efficiency measures within EEAST control

The focus for 2026/27 is:

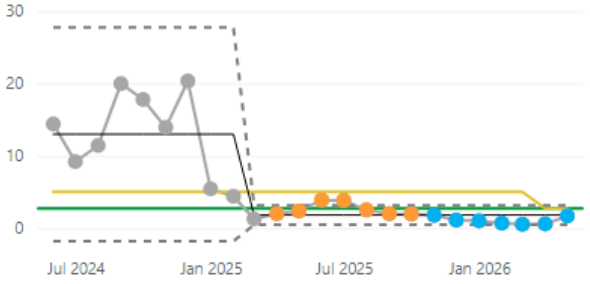
- Sickness absence
- Hear & Treat
- Hospital Handovers

Metric	Base line 2024/25	Target	Actual Trust June 2026	Actual N & S
Out of Service (ex. cohorting)	7.3%	**6%**	4.7%	4.3%
On Scene Time – Conveyed	45 mins	**42**	43.29	45
On Scene Time – Non-conveyed	74 mins	**01:10**	01:07	01:13
Handover to Clear	17.5 mins	**15 mins**	12.25	12.06
Conveyance Rate	62%	**62%**	58.7%	56.83%
Hear-&-Treat %		**16.5%**	18.2%	19.16%
Resources Per Incident (all calls, all resources) MAR	1.13	**1.18**	1.14	1.01
Sickness Absence	8%	**7.5%**	7.9%	8.4%
Average Hospital Handover	30 mins	**30 mins**	48 mins	43.16

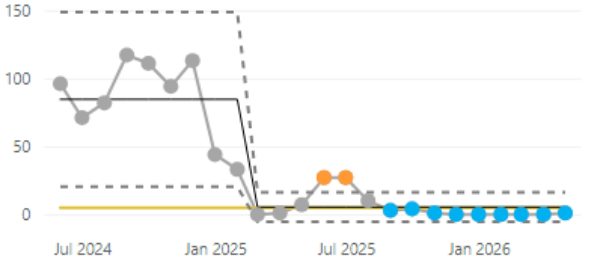
999 call answer performance 2025/26

East of England Ambulance Service NHS Trust

Call Answer Mean (A3) (seconds): Trust



Call Pickup 95th Percentile (A5): Trust



- Significant improvement achieved against 999 call answer mean: Reducing from peaks of 20 seconds in 2024 to around 5-6 seconds early 2025 to approximately 1-2 seconds currently.
- 95th percentile call answer (measure of longest waiting calls) has also seen improvement: Reducing from peaks of over 2 minutes in 2024 to around 30 seconds and further improved to consistently under 1 second.
- Call answer performance has remained consistently below national target throughout 2025/26 and into this year demonstrating sustained service improvement and patient access despite a rise in 999 call demand.
- This has been achieved due to a focus on people activities and productivity measures including:
  - Recruitment and retention focus
  - Prioritising call handlers with emergency 999 calls
  - Efficiencies – reset on call handler shrinkage (not ready time)
  - Leadership development and support

Performance Update N&S

NHS East of England Ambulance Service NHS Trust

	January 26	February 26	March 26	April 26	May 26	June 26
C1 - N&S	00:10:22	00:09:46	00:09:12	00:08:45	00:09:07	00:09:38
Trust Average	00:09:13	00:08:45	00:08:09	00:08:04	00:08:16	00:08:50
C2- N&S	01:00:14	00:45:08	00:32:26	00:30:28	00:32:39	00:42:53
Trust Average	00:47:04	00:37:11	00:28:15	00:27:21	00:29:47	00:37:32

- June performance has been impacted by a significant increase in demand during the periods of extreme heat
- Increased hospital handover delays in Norfolk and Suffolk

Hear and Treat Activity N&S

East of England Ambulance Service NHS Trust

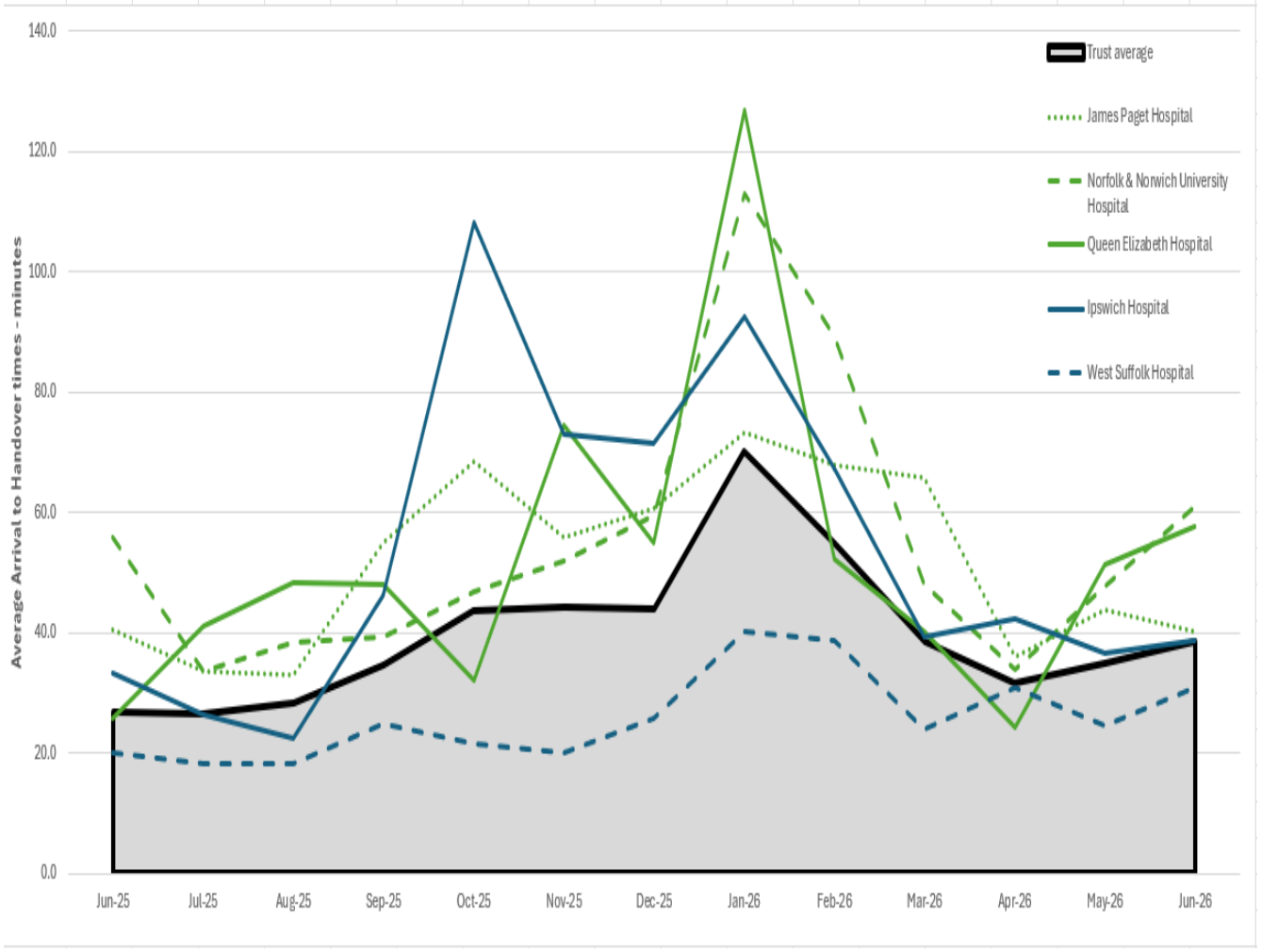
Current Position:

- N&S H&T in June 2026 was **19.52%** against a target of **16.50%**

Key Enablers:

- Sickness abstraction management
- ITK transfer for C5 activity, is now live in all areas as IC24-enabled functionality from 16th of June 2026.
- Transfer of C3/4 activity via ITK to PPG for UCCH activity, and conversations are ongoing with IC24.
- Productivity management of B6 CAS Clinicians.
- Reducing variation and reducing missed opportunities in navigation of calls to other providers (supported by regional ITK working group),

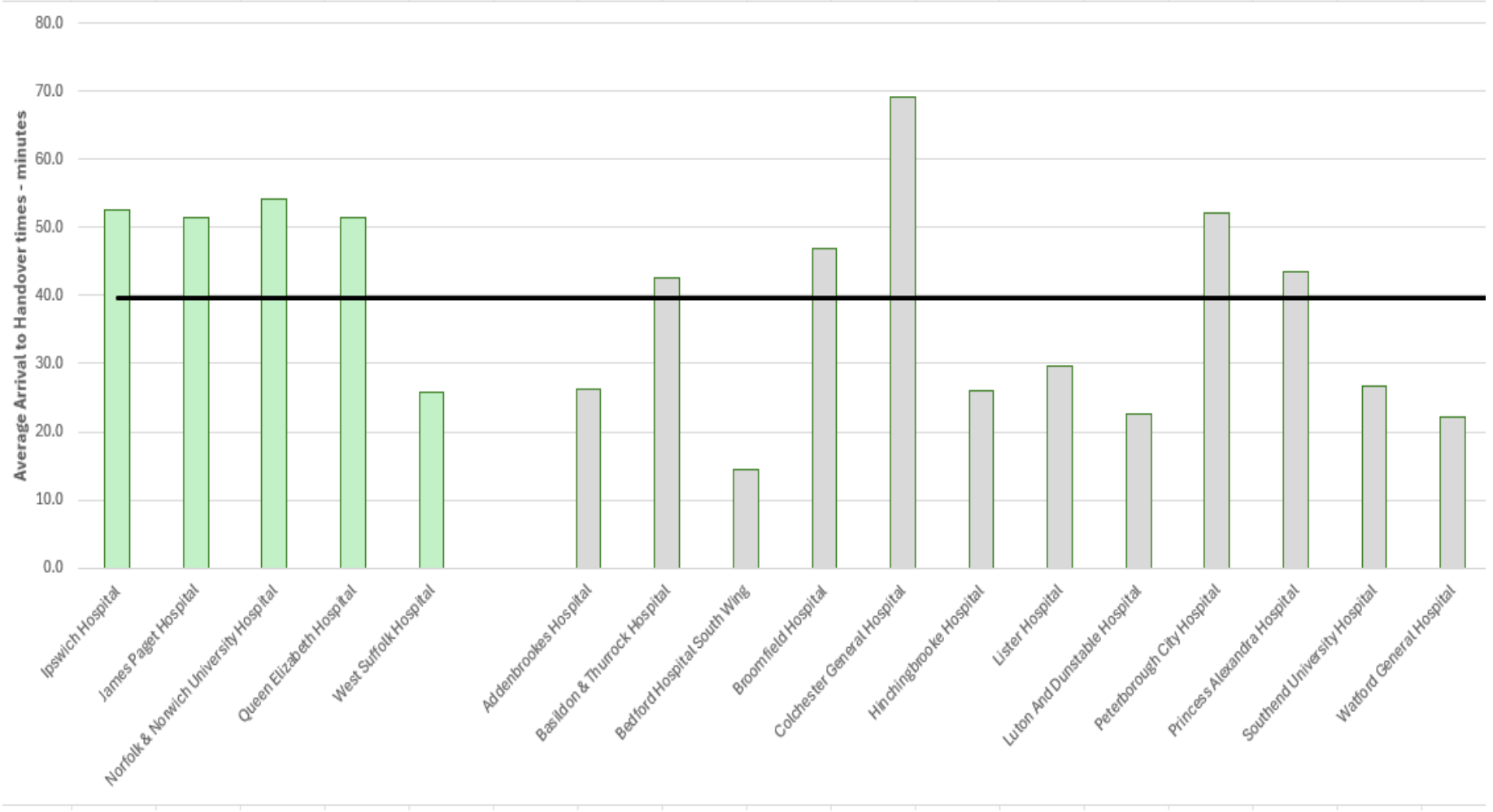
Arrival to Handover



- Total ambulance hours lost in January 2026 due to arrival-to-handover delays of over 30 minutes in Norfolk and Suffolk were **11,500** hours.

- For the 12 months to June 26, **60,422** hours were lost over 30 minutes in N&S

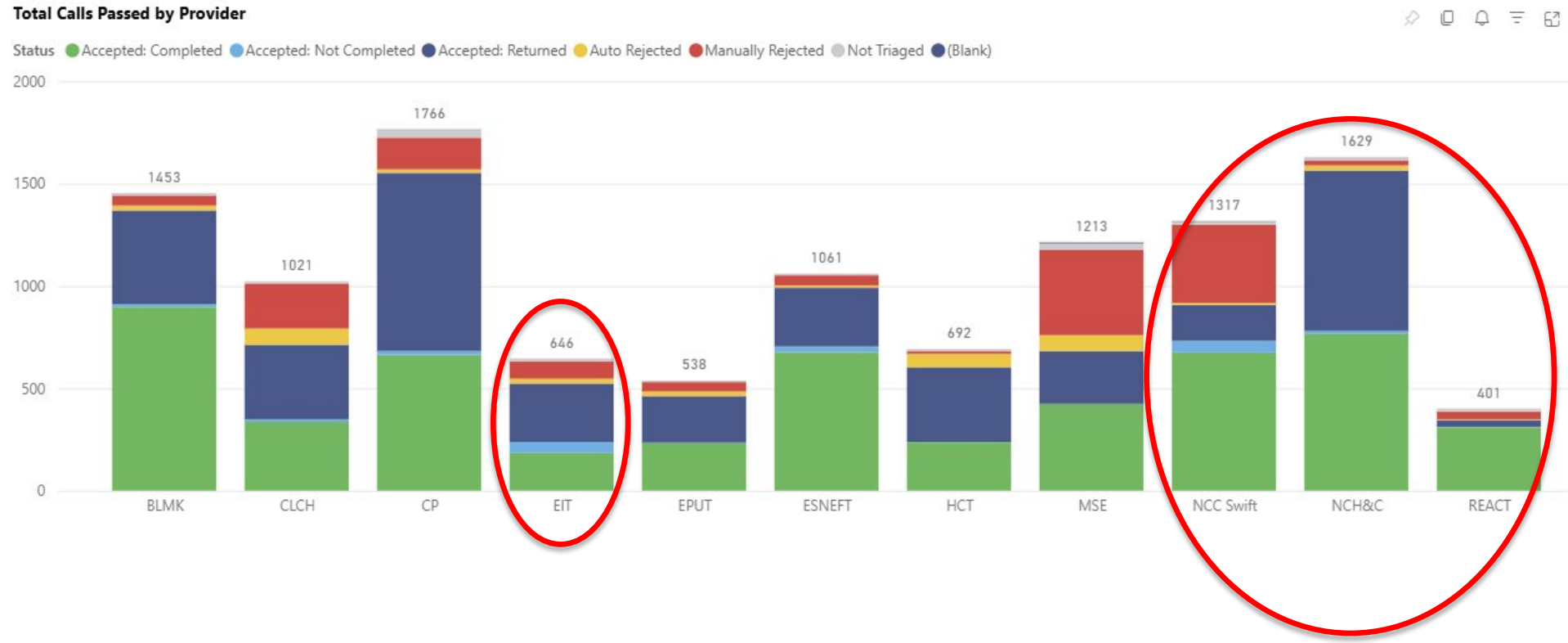
Arrival to Handover



UCCH

East of England Ambulance Service NHS Trust

The opportunities for more patients to be managed in the community
UCCH data April – June 2026



111 Activity

East of England Ambulance Service NHS Trust

This chart shows the % of calls received from 111 relative to the total number of calls per month.

- On average 21,600 ambulance service calls each month are generated from 111
- In the last 12 months this represents an average of 23%

	All Calls	111 calls	Percentage
Jul-25	93478	19283	21%
Aug-25	88921	19474	22%
Sep-25	89887	19764	22%
Oct-25	95871	20479	21%
Nov-25	92747	22703	24%
Dec-25	98373	26476	27%
Jan-26	100803	24728	25%
Feb-26	82196	20165	25%
Mar-26	87890	22243	25%
Apr-26	85650	20768	24%
May-26	94921	21738	23%
Jun-26	98270	20975	21%

Independent Culture Review

The Trust has made many improvements with regards to culture and many workstreams are underway.

However, there are still several concerning factors:

- High sickness levels
- High numbers of ER cases
- Staff survey results

The Trust has commissioned independent culture review that launched in May 2026 to look at operational workforce areas across the region.

A final report will be shared later in the year and will be designed to include recommendations which can be used as a template for cultural transformation across the organisation.

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East of England Ambulance Service
NHS Trust

We Are
Accountable

We Are
Respectful

We Strive To Be
Excellent

www.eastamb.nhs.uk

#WeAre EEAST

The minutes of a meeting of the NHS Norfolk and Suffolk Integrated Care Board held on Wednesday, 20 May 2026 at 12.30pm in the Main Hall, Hellesdon Hospital, Drayton High Road, Norwich, NR6 5BE .

Present

Members of the Board

Will Pope, Chair of the ICB
Kirsten Alderson, VCSE Member – Chair of the Suffolk VCFSE Assembly
Professor Lesley Dwyer, NHS Foundation Trust Partner Member – Chief Executive, Norfolk and Waveney University Hospitals Group.
Dr. 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
Dr. Ed Garratt, Chief Executive
David Holt, Non-Executive Member
Stuart Keeble, Local Authority Partner Member – Director of Public Health, Suffolk County Council
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)
Professor Frankie Swords, Executive Medical Director
Ian Wake, Local Authority Partner Member - Executive Director of Adult Social Service, Norfolk County Council
Janet Wood, Non-Executive Director

Regular Attendees

Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk)
Richard Watson, Executive Director of Strategy, Digital, and Commissioning

Also in attendance

Emma Bugg, Associate Director of Place and Neighbourhoods for the Central Norfolk
Cat Proctor, the Care Company
Lee Watson, Deputy Director of Public Health
Dr Clara Yates, Associate Director of Research and Innovation
Tom McColgan, Corporate Governance Manager (minutes)

1. Welcome, introductions and apologies

1.1. The Chair noted that apologies had been received from Maddie Baker-Woods, Executive Director, Primary Care and Neighbourhood Health for Suffolk; Matthew Winn, East of England Community Health and Care Trust; David Cargill, Primary Care Suffolk; Caroline Donovan, Provider Partner Member – NSFT.

1.2. The Chair thanked Cllr Fran Whymark and Cllr Steve Wiles, who had stood down from their roles on the ICB following the local elections, for their contributions to both the ICB (and its predecessors) and to the respective SNEE and Norfolk and Waveney Integrated Care Partnership Committees.

2. Notification of Questions from the Public

2.1. The Chair noted that ten questions had been received in advance of the Board and that they would be put to the Board at the appropriate point on the agenda.

3. Declarations of interest

3.1. No declarations of interest were made.

4. Minutes from previous meeting and matters arising

4.1. The minutes of the inaugural meeting of the Norfolk and Suffolk ICB and the final meetings of NHS Norfolk and Waveney ICB and NHS Suffolk and North East Essex ICB were approved as a correct record.

4.2. Elaine Noske, Non-Executive Member asked that the minutes and action log be formatted so that the Board was easily able to cross reference between them.

4.3. The Board noted that the County Council Co-Chairs of the Integrated Care Partnership Committee appointed at the previous meeting had now stood down and the positions were vacant. The Board also noted that following the previous meeting the Chair had appointed Elaine Noske, Non-Executive Member to chair the Norfolk and Waveney Primary Care and Neighbourhood Committee and the Suffolk Primary Care and Neighbourhood Committee.

5. Action Log

5.1. The Board noted the updates provided. The actions were noted.

5.2. Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk and Waveney) stated that he had had a constructive meeting with members of the Save Benjamin Court Campaign on 12 May. He stated that there would be a further meeting to help work up options for the future use of Benjamin Court.

6. Chief Executive Report

6.1. Ed Garratt, Chief Executive provided an update on the following matters:

- NHS Norfolk and Suffolk ICB had successfully been launched on 1 April 2026 and the Board joined Ed Garatt in thanking all those who had worked to establish the new ICB. The new organisation had three values: Kindness, Collaboration, and Ambition.
- The Board joined Ed Garratt in congratulating Professor Frankie Swords on her appointment to the role of National Medical Director for NHS England and the Department of Health and Social Care. Some of the examples of Prof. Swords's leadership at NHS Norfolk and Waveney ICB include the delivery of the biggest increase in the early diagnosis of cancer in the country and the biggest increase in referrals to digital weight management achieving 187% of target.
- Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning was also serving as the national Director for Strategic Commissioning delivering a Strategic Commissioning Framework for the NHS and had secured £11m of funding to support ICBs development.
- The ICB's Strategic Commissioning Committee had launched which will be the engine room of the ICB's transformation work.
- There had been a Great session on Neighbourhood Health held in Norfolk and supported by Norfolk County Council and an equivalent event in Suffolk was being held on 20 May 2026.
- The Board congratulated Norfolk County Council as their Children's Services had been rated outstanding across all areas which put them in the two percent of Local Authorities in the country.
- The Board congratulated Norfolk and Suffolk NHS Foundation Trust as their Older Adults Services had been rated 'good' by the CQC.
- East of England Ambulance Service NHS Trust had delivered their best performance for five years on category 1 and category 2 response times.
- A new National Nursing Degree Apprenticeship Scheme had launched and Norfolk and Suffolk had received its share of 2,000 new trainee nurses.
- The ICB had launched a new Norfolk and Suffolk Women's Health App.
- The New Hospital Programmes across Norfolk and Suffolk were proceeding at pace to deliver three new hospital sites across the next five years.
- The University of East Anglia had established a new Dental School to help train more dentists locally which would help to increase the availability of NHS Dental Services.

6.2. The Board **NOTED** the update.

7. Making the shift to Neighbourhood Working across Norfolk and Waveney

7.1. Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk and Waveney) and Ian Wake, Executive Director of Adult Social Service, Norfolk County Council were joined Cat Proctor, the Care Company

and Emma Bugg, Associate Director of Place and Neighbourhoods for the Central Norfolk to present the report. They highlighted the close working between the ICB, County Council, and other stakeholders that had helped to develop the neighbourhood health approach for Norfolk and Waveney. They spoke to the need to move towards seeing services users as complete people and building support around them. They also highlighted the 'needs paradox' where the more needs an individual had the harder it was for them to access support as it was split between an ever-greater number of services.

7.2. The Board heard Catherine's Story as relayed by Cat Proctor. The Board heard about Catherine, her life, and her experience accessing local health and care services. Catherine would have benefited from a joined up, person centred approach to her care especially at the end of her life. The care she received suffered from services operating in silos and clinical services not engaging with carers.

7.3. The Board also heard about progress made in enabling teams across Norfolk and Waveney to do things better and empowering staff to work together across organisations. This was not a single formal programme but had been achieved through local, staff led initiatives. The ICB's role was as a convener and enabler but there were not ICB led activities.

7.4. During the Board's consideration the following matters were discussed:

- The Board welcomed the report and thanked Cat for telling Catherine's story.
- The Board considered how it would be able to understand if the localised initiatives were having an impact at scale. A decline in overall prescription rates would likely be a sign of success (resulting from de-prescribing) as well as a decline in system resource required to deliver care.
- The Board noted the lack of regard given to care workers by clinical teams highlighted in Catherine's story recognising that care workers were often the professions who had the best knowledge and insight about a patient. The Board emphasised the need to foster a culture of professional respect towards care staff recognising that changing cultures and encouraging organisations to work differently was a significant endeavour which would require effort from all system partners.
- The Board discussed whether the Care Management Service which the ICB was commissioning across Suffolk could be expanded to include the whole of the ICB area. Similarly, if the integrated frailty service being developed across Norfolk and Waveney could be expanded to cover Suffolk patients.
- The Board heard about the opportunities to align systems and processes across the system to reduce the barriers to integrated working. The Board also considered how a comprehensive organisational development programme across partners could also help bring teams together.

7.5. The Board:

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

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

8.1. Richard Watson presented the Norfolk and Suffolk response to the four questions posed of ICBs and NHS Provider organisations by Sir Jim Mackey in his letter of 1 April 2026.

8.2. During the Board's consideration the following matters were discussed:

- The Board welcomed the response and encouraged members to take it through their respective organisational Board.
- The Board noted that NHS England had not yet set out how they planned to respond to the responses from ICBs, but the Board would welcome sight of the feedback sent by other ICBs.
- The Board noted that Primary Care was not represented amongst the signatories but and that given the short timescales it had not been possible to properly consult with all primary care providers in a way that would have allowed for a representative to sign the letter.
- The Board emphasised the need for the signatories to the letter to ensure that they delivered on the contents of the letter that was within their power to deliver. The Board considered how organisations could come together and hold themselves accountable for this delivery.

8.3. The Board **NOTED** the report.

9. Suffolk Annual Public Health Report 2025: Youth Social Action

9.1. Stuart Keeble, Director of Public Health and Protection, Suffolk County Council presented the report which focused on younger people particularly secondary aged pupils. The report was informed by youth social action and bringing people together to solve problems. It was intended to be for young people, by young people. This approach in Suffolk was not new but was scaled up. The consultation process had highlighted that the assumption that young people always preferred to engage digitally was not but actually true but was often the only option for young people in rural areas. Young People wanted somewhere to meet and not necessarily events. Transport also came up as a big issue facing young people. Stuart Keeble as highlighted the similarities with the previous year's report which focused on older people.

9.2. During the Board's consideration the following matters were discussed:

- The Board welcomed the report and welcomed the County Council's engagement with the VCSFE Assembly to help reach young people across Suffolk.
- In response to questions from the Board, Stuart Keeble stated that the focus of the work was on geographic areas but future engagement may focus on engaging with underrepresented groups. He emphasised that the learning from engagement that informed the annual report was that engagement needed to be about something young people wanted to talk about which may not necessarily be what the organisations seeking to engage with them expected it to be.
- The Board recognised the advantage of the new ICB area covering the two County Councils and being able to help share good practice as the ICB worked with Children's Services in Norfolk County Council and Suffolk County Council.
- The Board encouraged Suffolk County Council to share the report at the place board and alliances reflecting the emphasis in the report on localities.
- The Board emphasised the need to ensure that the insight that was gained through engagement was being used to inform commissioning.

9.3. The Board noted the findings of the APHR 2025 and supported the continued development of youth focussed co-produced, community-centred approaches

10. Norfolk Annual Public Health Report 2025.

10.1. Lee Watson, Deputy Director of Public Health presented the report which was on the topic of healthy aging. While the scope of the report was very broad, the Public Health Team had received positive feedback that it was helpful to have all of the information in one place. Norfolk had an older population than the average and over the next 15 years there would be an additional 82,000 residents over the age of 65. 40% of the county's working population were over the age of 50 and a large proportion of unpaid volunteers and carers were also over 50. A golden thread through the report was tackling age discrimination. The report also addressed the differences in healthy life expectancy across the county.

10.2. The Board welcomed the report and supported the Director of Public Health's findings and recommendations.

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

11. Norfolk and Waveney ICB Research and Innovation team annual report 2025-26

11.1. Professor Frankie Swords, Executive Medical Director was joined by Dr Clara Yates, Associate Director of Research and Innovation presented the report which set out the work of the Research and Innovation Team in NHS Norfolk and Waveney ICB. They emphasised that the work of the Team aligned with the new ICB's strategy and its community based approach supported the

ambitions of the NHS 10 Year Plan. They spoke to the work highlighted in the report.

11.2. During the Board's consideration the following matters were discussed:

- The Board welcomed the report and the work of the Research and Innovation Team particularly praising the capacity building work in primary care.
- The Board considered whether there was a greater opportunity for the ICB and Providers to work together to deliver a Research and Innovation function rather than having teams in each organisation. The Board was keen to explore the potential to have a more aligned approach to research across Norfolk and Suffolk building on the existing relationships between Research Teams and the ad hoc collaboration on research projects. The Board asked that a report be brought to a future meeting. **(AP1)**
- The Board received assurance that the ICB was intent on continuing the Community Voices Project across the new ICB area.

11.3. The Board **NOTED** the report.

12. Lampard Inquiry Update

12.1. Lisa Nobes, Executive Director of Nursing presented the report which provided a regular update on the work of the Lampard Inquiry. She confirmed that the new ICB had been identified as a core participant and, together with Essex ICB and Central East ICB, would continue to support the Inquiry in any way that it could.

12.2. The Board asked that the next update on the work of the Inquiry include information on any interim findings from the Inquiry or learning from the ICB resulting from the ICB's evidence gathering and how these were being implemented. **(AP2)**

12.3. The Board **NOTED** the report.

13. Out of Area Mental Health Inpatient Census

13.1. Lisa Nobes, Executive Director of Nursing presented the report which followed a direction from NHS England to cease all inappropriate out of area placements. ICBs were asked to complete a census of all patients placed out of area. The ICB identified 25 individuals placed out of area on the day of the census. These placements had not been directly commissioned by the ICB and so completing the census had not been a straight forward task. The ICB was now seeking to develop a single source of information across providers with all out of area placements listed and establish a Panel to provide oversight of the out of area placement process.

13.2. Lisa also provided an update on patients placed at St Andrew's Healthcare. She stated that all Norfolk and Suffolk patients at the site had robust discharge plans in place.

13.3. During the Board's consideration of the report the following matters were discussed:

- The Board welcomed the proposal to establish a system out of area placements database and oversight panel. The Board also recognised that there was an important distinction that needed to be drawn between appropriate and inappropriate out of area placements and that an out of area placements in and of itself was not necessarily inappropriate. There were valid reasons why a placement out of area may be best for a patient and it was important that this nuance was not lost.
- The Board considered the role of the proposed oversight Panel and the feasibility of this being an approval panel or whether its role would be to provide check and challenge to decisions. The Board also suggested that it may be beneficial for a Non-Executive Member to chair the Panel. The Board noted that the Executive Director of Nursing would finalises the terms of reference for the Panel with providers.
- The Board considered the size of the new ICB area and the implications that this had for out of area placements; an 'in area' site could be significantly further award from a patient's home than an out of area site.

13.4. The Board **NOTED** the report.

14. Integrated Performance Report

14.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning presented the report highlighting the evolving role of the ICB and NHS England particularly around who holds the acute NHS providers for performance and the need for the ICB to maintain contractual oversight while avoiding repetition. He provided an overview of how reporting against the National Oversight Framework would begin to look as the report developed and provided an overview of the key performance indicators included in the Framework.

14.2. Janet Wood, Non-Executive Member spoke to the Finance, Performance, and Workforce Committee's discussion of the performance report.

14.3. During the Board's consideration of the report the following matters were discussed:

- The Board supported the direction of travel set out for the design of the performance report.
- The Board were pleased by the ICB's overall positive performance against the National Oversight Framework KPIs but noted the poor performance on change in the size of waiting list in elective care. This was an area that had been identified as a priority over the next two years and the ICB had commissioned external support to help develop proposals to help address performance.
- The Board discussed the relationship between NHS England, ICBs, and NHS Providers which was moving to a position similar to the one that existed before the establishment of ICBs in 2022. However, the role of ICBs as strategic commissioners and contract managers meant that there was a risk

of duplication between oversight from NHSE and ICBs. The Board was keen that that changes not lead to a reversion back to old ways of working and that the successes of the last four years and positive relationships that had been built across Norfolk and Suffolk be built upon over the coming years.

14.4. The Board supported the proposed design of the performance report and approach to performance oversight at future meetings.

15. ICB Annual Budgets 26/27

15.1. Howard Martin, Executive Contacts and Finance Director confirmed that both NHS Norfolk and Waveney ICB and NHS Suffolk and North East Essex ICB had delivered their financial plans for 2025/26. NHS Norfolk and Suffolk ICB had set a balanced plan for 2026/27 but delivery was contingent upon the ICB successfully delivering against a significant cost improvement plan. He also spoke to the overall ICB financial plan which accounted for £4.59bn of NHS funding to purchase care for Norfolk and Suffolk.

15.2. Janet Wood, Non-Executive Director spoke to the detailed discussion of the financial plan and outturn positions at the Finance, Performance, and Workforce Committee.

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

16. **Committee Highlight Reports**

16.1. The Committee Chairs spoke to the Highlight reports.

17. Amendments to the Constitution and Governance Handbook Report

17.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report which set out a proposed amendment to the constitution to allow the ICB to recruit an additional Non-Executive Member. The report also sought approval for the terms of reference for the Norfolk and Waveney Primary Care and Neighbourhood Committee, the Suffolk Primary Care and Neighbourhood Committee, and an amended Finance, Workforce, and Performance Committee terms of reference.

17.2. The Board Approved

i. 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. 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.

18. Risk Management and Board Assurance Framework

18.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report which set out the interim arrangements for risk reporting to the Board while the Board Assurance Framework is developed.

18.2. The Board **APPROVED** the interim arrangements for risk reporting to Board.

19. Questions from the Public

19.1. The following questions were submitted to the Board in advance of the meeting and responses were provided on behalf of the Board and published on the ICB's website:

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”

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.”

20. Any Other Business

20.1. No other matters were raised.

The meeting ended at 3.30pm

NHS Norfolk and Suffolk ICB
Action log for July 2026

Actions arising

Ref:	Agenda Item	Action	Lead	Update	Target Date
AP1	**Norfolk and Waveney ICB Research and Innovation team annual report 2025-26**	Explore the potential for the ICB and Providers to work together to deliver a Research and Innovation function.	Dr Clara Yates		September 2026
AP2	**Lampard Inquiry Update**	Next update on the work of the Inquiry include information on any interim findings or learning from the ICB as a result of ICB's evidence gathering and how these were being implemented.	Lisa Nobes		November 2026

March 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	November 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	Session delivered. Closed	July 2026

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting Strategic Commissioning Committee

Agenda Item number: 09

Date: 15 July 2026

Title: Norfolk and Suffolk ICB Strategic Commissioning Policy and Toolkit

Lead Director: Richard Watson

Presenting Officer: Richard Watson

Author: Lizzie Mapplebeck and William Snagge

Purpose: To present the finalised Strategic Commissioning Policy and Toolkit (v1.1) for final review and approval.

Recommendations:

The Norfolk and Suffolk ICB Board is asked to:

1. Approve the Strategic Commissioning Policy and Toolkit (v1.1) as the ICB's single, mandatory approach to commissioning, decommissioning, service review and investment decisions.
2. Note outline plans for delivery of a training and development programme to support and embed organisational adoption.

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1 Background

1.1 The development of a local Strategic Commissioning Policy and Toolkit responds directly to:

1.1.1 The NHS England Strategic Commissioning Framework (November 2025), which sets expectations for all ICBs to adopt a consistent, evidence-based approach to commissioning.

1.1.2 The Model ICB Blueprint, which requires ICBs to operate differently, with greater strategic focus and reduced operating cost base.

1.1.3 The Norfolk and Suffolk ICB's strategic ambition to improve population health, reduce inequalities, and ensure consistent, high-quality, outcomes-based decision making

1.2 The Policy and Toolkit have been developed to translate national expectations into a practical, usable, and locally relevant commissioning framework, supporting commissioners across all directorates and programmes.

2 Core Purpose of the Strategic Commissioning Policy and Toolkit

2.1 To enable the ICB to act as an effective strategic commissioner; to support delivery of an outcomes-based, population health-focused commissioning model; and to align N&S ICB commissioning practice to the national four-stage commissioning cycle

3 Scope of the Strategic Commissioning Policy and Toolkit

3.1 The Policy applies to commissioning decisions; decommissioning decisions; service reviews, contract variations and extensions and all new investments.

4 Structure and Approach of the Strategic Commissioning Policy and Toolkit

4.1 The Policy is structured around the four-stage strategic commissioning cycle, with each stage including:

4.1.1 Key actions and activities
4.1.2 Critical considerations (including inequalities, digital, finance, etc.)
4.1.3 Required outputs and templates
4.1.4 Links to tools, data and enabling team support

4.2 The wider Toolkit includes a Proposition Mandate template (Stage One); Business Case template (Stage Two); Light Business Case template (Stage Two); Service Specification template (Stage Three); Strategic Plan template (Stage One); Supporting guidance, links and signposting to enabling functions.

4.3 Together, these form a practical "how-to" guide for commissioning, rather than a purely theoretical policy.

5 Peer Review Process and Approach

5.1 To support final refinement prior to approval, a structured peer review was undertaken during June 2026. The peer review was designed to:

5.1.1 Test the usability, clarity and completeness of the Policy and Toolkit.

5.1.2 Assess whether it supports consistent, high-quality commissioning decisions in practice.

5.1.3 Identify gaps, duplication, or areas of over/under-detail.

5.1.4 Understand training and support requirements for effective implementation.

5.1.5 A mixed-method engagement approach was used, including:

5.1.5.1 ICB-wide communications and open feedback invitation.

5.1.5.2 Short, structured survey aligned to key lines of enquiry.

5.1.5.3 Two commissioner-facing webinars (introduction and template “road test”).

5.1.5.4 Targeted engagement through team meetings and stakeholder discussions.

5.2 The peer review assessed both the policy narrative and commissioning pathway; and the functionality of the toolkit, including templates, links, and support offers.

5.3 Key lines of enquiry included navigation and usability, fitness for purpose of templates, right level of detail, clarity of roles and support, and confidence and training needs.

5.4 Lizzie Mapplebeck (Associate Director of Strategic Change) and William Snagge (Senior Manager of Strategic Planning and Change) met with the following teams: Safeguarding; Quality; Mental Health and Urgent and Emergency Care; Research and Innovation; Estates; Contracts and Procurement; Ipswich and East Neighbourhood; West Suffolk Neighbourhood; Primary Care; Digital, the Commissioning Directorate; and the Finance Team.

5.5 Emails and e-survey feedback was received from 47 individuals or teams

5.6 Two awareness raising webinars (the first as a general introduction, and the second with a focus on templates and key toolkit resources), were promoted to all staff. They were attended (live) by 271 and 191 people respectively.

6 Peer Review Outcomes and Changes

6.1 Emerging Themes (High Level): Peer Review feedback indicated that the Policy and Toolkit were well received as a clear and necessary step towards consistent strategic commissioning across the ICB, providing a strong end-to-end commissioning pathway, and supporting improved structure and assurance.

6.2 The Policy and Toolkit were particularly valued for bringing clarity to “what good looks like” at each stage, providing standardised templates and expectations, and improving visibility of enabling team support.

6.3 Key Areas for Refinement: Comon feedback themes indicated refinements were required in relation to:

- Navigation and usability
    - Ensuring commissioners can quickly find relevant sections for live work
- Proportionate detail
    - Removing unnecessary narrative in some areas
    - Adding clarity where risk of misunderstanding exists
- Templates and supporting artefacts
    - Ensuring all core templates are complete, consistent and usable as a minimum viable set
- Roles, responsibilities and support
    - Clarifying “who does what” across commissioning and enabling teams
- Training and implementation support
    - Identifying priority areas where additional guidance or support will be required

6.4 Feedback categorised into minor (clarity/usability) and material (structural/content) changes was used to inform prioritised changes, balancing pace with integrity of the overall model. All changes were made with a series of next steps documented (see ongoing development).

7 Implementation and Next Steps

7.1 Following approval, the Strategic Planning and Change team focus will shift to embedding the Policy and Toolkit in practice, working with key partners across the organisation to enable this.

7.2 The Strategic Commissioning Policy and Toolkit has been reviewed by the Strategic Commissioning Delivery Group (24 June 2026) and the Strategic Commissioning Committee (07 July 2026).

7.3 Implementation of priorities is underway and includes:

7.3.1 Publication of the Strategic Commissioning Policy and Toolkit and all supporting templates and a Frequently Asked Questions on the intranet.

7.3.2 Clear communication of mandatory use across the ICB.

7.3.3 Targeted rollout of training and support offers (see below).

7.3.4 Engagement with enabling teams to support delivery.

7.3.5 Establishment of version control and change processes.

8 Ongoing Development

8.1 The Policy and Toolkit will be iteratively developed based on user feedback and system maturity. It will be refreshed at regular intervals to reflect learning from implementation, national developments, and local strategic priorities

8.2 This reflects the intention for the Toolkit to operate as a living, user-led system of support, rather than a static document.

9 Targeted rollout of training and support offer

9.1 Early findings suggest a broadly positive view of the Strategic Commissioning Policy and Toolkit's intent and structure, but a clear need for practical upskilling in how to apply it consistently in live commissioning work, particularly in relation to roles and governance, proportionality, evidence and evaluation, market engagement, and the use of enabling team support.

9.2 The strongest demand is for a blended support offer comprising concise "how to" guides, flowcharts, worked examples, recorded webinars and practical clinics, rather than theory alone. This work will be developed with support from relevant enabling teams, including Communications and Engagement and Organisational Development teams, and aligned where possible to the emerging national Strategic Commissioning Development Programme, including wider resources on commissioning capability, intelligence and action learning.

9.3 Suggested OD Programme to include

- Health Economics
- Being Evidence Led
- Finding Data
- Evaluation Skills
- Being Outcomes Focused
- Co-Production
- Completing Templates
- Understanding Finances
- Co-Production
- Change Management
- Market Management

10 Conclusion

10.1 The Strategic Commissioning Policy and Toolkit represents a critical enabler of the ICB's transition to a mature strategic commissioning model, supporting:

10.1.1 Greater consistency and transparency in decision-making
10.1.2 Improved alignment to population health outcomes and inequalities priorities
10.1.3 Stronger use of data, evidence and system insight
10.1.4 More effective, efficient, and assured commissioning practice

10.2 The peer review process has provided confidence in the overall direction of the approach, alongside identification of clear and actionable refinements to strengthen usability and implementation, which have subsequently been incorporated into the latest version.

10.3 Approval of the Strategic Commissioning Policy and Toolkit v1.1 and supporting documents are recommended.

11 Appendices

- **Appendix 3a:** The Strategic Commissioning Policy and Toolkit v1.1 (separate document)
- **Appendix 3b:** Proposition Mandate template v1.1 (separate document)
- **Appendix 3c:** Business Case template v1.1 (separate document)
- **Appendix 3d:** Light Business Case template v1.1 (separate document)
- **Appendix 3e:** Service Specification template v1.1 (separate document)
- **Appendix 3f:** Strategic Plan template v1.1 (separate document)
- **Appendix 3g:** Frequently Asked Questions **(**separate document)
- **Appendix 3h:** Change Control Log **(**separate document)

NHS
Norfolk and Suffolk
Integrated Care Board

Strategic Commissioning Policy and Toolkit

A practical user guide for ICB staff v1.1 dated July 2026

Policy Owner: Strategic Planning & Change Team

Please always check on the Intranet for the latest version.

Contents

This policy is structured as a continuous four-stage cycle; from initial concept through to impact evaluation, designed to guide you through the mandatory strategic commissioning cycle, specialist resources, key templates and decision-making steps required to deliver effective, evidence-based strategic commissioning for our population.

Section One: Purpose and Foundations

Section One of this policy gets us started by breaking down what strategic commissioning is and introducing our new four-stage commissioning cycle. We'll explain exactly why this policy is here, who should be using it, and how to get the most out of it in your day-to-day work. We also introduce the importance of being evidence led, commissioning for outcomes, working with people, communities and partners and governance.

Our Strategy

Everything we do connects back to our 5-Year Strategy, the Population Health Improvement Plan and the need for us to be strategic commissioners

Better Together

We show how commissioners, enabling functions and the wider system can work collaboratively throughout the cycle

Our Goal

Ultimately, this policy is here to make sure this process is easy to understand and fully embedded to truly improve population health

Ready to dive in?

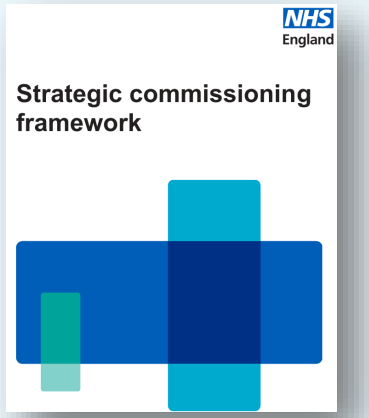
This section is all about setting us up for success. By understanding and embedding the Strategic Commissioning Cycle, we can deliver health improvements for our local Norfolk and Suffolk population.

Let's take a closer look at how we'll make it happen

Purpose of the Policy

Bridging the Frameworks

We've linked our local policy directly to the National Strategic Commissioning Framework. This ensures our decision-making stays in step with national expectations and the newly refreshed commissioning cycle. **View the National Framework here**



Who should use the policy

This policy is designed for all ICB staff, regardless of where you sit in our system.

Pan ICB: Staff working across Norfolk and Suffolk or on county-wide footprints

Alliances, Places or Neighbourhoods: Teams delivering change at local level

When to use the policy

New Investments: All in-year funding decisions and new service designs

Service Reviews and Transformation Programmes: Evaluating existing services or contracts to ensure they still deliver value and undergoing redesign and transformation programmes

Decommissioning: Managing the complex process of stopping or reducing services safely

In short: If it's a commissioning activity, this policy applies

Purpose of the Policy

Your Mandatory Toolkit: Guidance & Templates

Think of this policy as your roadmap. It guides you through the essential checks at each of the four stages.

To make things easier, we've provided templates for every key decision point.

Expert Support: One-stop document for locating support

You’re not on your own. This policy signposts our commissioning staff to the specialist teams and resources across our organisation.

Everything you need to undertake commissioning effectively is just a roadmap away.

Remember: This policy is mandatory for all ICB staff and for all commissioning and decommissioning decisions … we are all commissioners (no matter your ICB role!)

What is Strategic Commissioning?

> *A continuous, evidence-based process to plan, purchase, monitor, and evaluate services over the longer term to improve population health, reduce inequalities, and ensure equitable access to high-quality care.*
>
> **— STRATEGIC COMMISSIONING FRAMEWORK, PAGE 3**

Ownership & Accountability

Commissioners hold the accountability for every service line—whether **commissioning / redesigning or decommissioning**—in line with ICB policies.

Process Integrity

Ensuring the **four-stage cycle** is followed and all mandatory ICB decision points are strictly adhered to.

Collaborative Expertise

Taking responsibility for drawing on **cross-directorate support**, leveraging specialist teams for advice throughout the cycle.

ICB Strategy and PHIP

Our strategy is the essential reference point for every commissioning action. It connects our high-level vision to the daily work of our staff. Resource allocation and priority setting must explicitly align with our published:

- Population Health & Commissioning Strategy
- Population Health Improvement Plan (PHIP)
- Detailed Commissioning Intentions

Our five-year plan focuses on immediate challenges and long-term improvements. These are to be delivered alongside the Strategy and PHIP.

In the first two years (2026/27 to 2027/28) we will recover and sustain our services, design and deliver differently:

- Stabilise services and address urgent quality, performance and financial challenges
- Reduce waiting times and improve access to care
- Develop new ways of delivering care, including neighbourhood health services

Over the following three (2028/29 to 2030/31) years we will:

- Focus more on preventing illness rather than treating it
- Deliver more care closer to home or at home
- Use digital tools and data to improve services
- Work with partners to build stronger, healthier communities

All documents mentioned on this page can be found on the intranet page here

ICB Strategy and PHIP

Our strategy translates into four ambition areas and a life-course approach to deliver our three outcomes.

Our Vision

Norfolk and Suffolk residents live longer, healthier, happier lives with access to safe, joined-up, patient-centred care

Our Ambitions

From sickness to prevention
Focus more on preventing illness and supporting people to stay healthy for longer.

Care closer to home
Improve care in local communities and bring more specialist services back into the local health system.

From analogue to digital
Use data and technology to make healthcare more efficient and easier to access.

Social and economic development
Work with partners to build stronger communities and tackle the wider factors that affect health.

Our Clinical Priorities (Live Well Lifecourse)

Start Well
Giving children the best start in life

Be Well
Supporting healthy lifestyles

Feel Well
Improving mental health & wellbeing

Stay Well
Better treatment & management of conditions

Age Well
Supporting healthy ageing & dementia care

Die Well
High quality end-of-life care

Our Outcomes

Improve healthy life expectancy for all

Reduce health inequalities

Improve access to consistently high-quality services

Translating Strategy to Delivery

To ensure genuine strategic commissioning, proposals cannot simply map upward to our system-level outcomes. Commissioners must demonstrate a clear line of sight through a structured logic model. The Population Health Improvement Plan (PHIP) serves as our formal bridge, translating high-level strategy into realistic, defensible commissioning intentions.

From Big Ideas to Real Action

The Big Goal
The overarching system ambitions (x 4) and outcomes (x3) detailed in the 5 Year Population Health and Commissioning Strategy

The Focus
The commissioning intentions detailed in the Population Health Improvement Plan (PHIP)

The 'Middle' Result
This is the proof that it's working. Long before we see an improved healthy life expectancy for all (one of the big goals), we see people's health behaviours changing. It is the first measurable sign of success.

The Action
This is what we commission. It is the contract we sign, the new workforce, or the new clinic we open. It is the physical thing happening in the community.

Why do we need to do this…

In the past, we could justify almost any project by saying it "helps people stay healthy." That is too broad. We need a way to prove that our specific projects are the best use of our time and money.

Real World Example	The Big Goal	The Focus	The 'Middle' Result	The Action
Helping people with diabetes avoid hospital stays	Improve healthy life expectancy for all	Be Well Commissioning Intention	Patients keep blood sugar in a safe range	Buying a patient education app and coaching

What is Actually Different

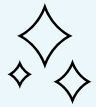
Old World

Focuses heavily on historical metrics, standard procurement, and reactive management

Inputs
Activity
Contracts
Reactive

New World

Centre's decisions around population data, strategic alignment, and systemic outcomes



Outcomes
Population
Pathways
Prevention

A fundamental shift from funding transactional, activity-based service contracts to outcome-led, population-focused strategic commissioning.

The implementation of the toolkit transforms how key decisions are structured, evaluated, and finalised across the landscape.

Succeeding in outcomes-led commissioning requires shifting individual actions and process definitions.

Day-to-Day Operational Impact

What To Stop (or reduce significantly)

X Commissioning services based primarily on historical activity curves or legacy contracts.
X Prioritising inputs and outputs (e.g., activity volumes) at the expense of end outcomes.
X Structuring service-by-service commissioning isolated from comprehensive pathway views.
X Approving isolated, one-off business cases with zero follow-up tracking or evaluations.
X Automatic contract rollovers and renewals without regular performance challenge or strategic redesigns.

What To Focus On (Day to day)

✓ Starting with defined population needs and outcomes rather than copying rigid service specifications.
✓ Developing incredibly clear, outcome-focused commissioning intentions and business cases.
✓ Leveraging industry tools like logic models and Theory of Change (ToC) to rigorously test overall impact.
✓ Embedding evaluation plans and key benefits tracking from the absolute beginning.
✓ Actively shaping the market and its partners, rather than treating procurement as a passive admin step.

> A shift from funding services based on what they do, to investing in interventions based on the outcomes they will deliver for our population.

— STRATEGIC COMMISSIONING CORE OBJECTIVE

Strategic Commissioning Principles

Strategic commissioning will be the primary mechanism by which we deliver our system ambitions—improving outcomes, tackling inequalities, and ensuring the long-term sustainability of services for the population of Norfolk and Suffolk.

To operationalise this, all commissioning decisions, must follow a set of commissioning principles.

The following five principles serve as the framework for transitioning from traditional commissioning to a strategic commissioning value-based, population-led approach across Norfolk and Suffolk.

Five Strategic Commissioning Principles

- **Population Health Outcomes**
- **Equity and Inclusion**
- **Collaboration and Integrated Delivery**
- **Evidence Based and Digital First**
- **Quality, Value and Sustainability**

Detail on the five strategic commissioning principles overleaf

Strategic Commissioning Principles

Population Health Outcomes	• **Outcome-Led:** We shift from transactional purchasing to population level outcomes, focusing on long-term health improvements rather than annual activity targets. • **Staged Lifecycle:** We follow the national four-stage cycle: Understand, Strategise, Deliver, and Evaluate. • **Proactive Prevention:** We prioritise shifting the system from sickness to prevention, targeting the root causes of ill health (the Marmot "building blocks" of health: housing, work, and environment).
Equity and Inclusion	• **The "Core20PLUS5" Approach:** Commissioning decisions will target the most deprived 20% of the population and specific "PLUS" groups (e.g., homeless, learning disabilities) to reduce life expectancy gaps. • **Addressing Health Inequalities:** Commissioning decisions must reduce health inequalities and improve equitable access to consistently high-quality healthcare. Commissioning decisions must consider how the wider determinants of health may be impacted (e.g. housing). • **Lived Experiences:** We will maximise engagement with communities to obtain insight on lived experience including co-production with children, young people and families.
Collaboration and Integrated Delivery	• **Subsidiarity:** Decisions are made at the most appropriate scale; Neighbourhoods, Places or System level to ensure local sensitivity whilst maintaining strategic alignment. Commissioning at scale to deliver at place. • **Partnership as Default:** We commission 'with' rather than 'for' partners, empowering providers to generate solutions. This includes the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, local authorities, and provider collaboratives. • **Joined-up Care:** Services must be commissioned to be simple to navigate, removing barriers between primary, secondary, and social care and ensure transition planning from childhood to adulthood .
Evidence Based and Digital First	• **Data Intelligence:** Using person-level linked data (Population Health Management) to segment the population and model demand before resources are allocated. • **Digital Enablement:** Moving from analogue to digital to make services more efficient, accessible, and responsive to modern patient needs. • **Continuous Learning:** Formal evaluation must track outcomes and value for money to drive iterative improvement. • **Innovative:** Innovation is embedded through new processes, pathways, and technologies, with systematic identification, testing, and scaling
Quality, Value and Sustainability	• **Intelligent Payor Function:** Resource allocation is aligned with strategic priorities using payment models that incentivise positive health outcomes rather than volume. • **Social & Economic Development:** Recognising the NHS as an anchor institution, commissioning decisions should support local social development such as local employment, reducing health inequalities, regeneration and environmental sustainability. • **Quality:** Assess procurements from a quality perspective, monitor quality and safety as part of contracts, to drive quality improvement, proactively manage risks and ensure that all service changes have quality embedded throughout.

Strategic Commissioning Cycle

Stage One: Local Context

What: Evidence (data, intelligence and insights) highlights population need or commissioning challenge.
Action: Understand the problem, gather the evidence (including lived experience) and define the desired outcomes.
Output: A Proposition Mandate.

Stage Two: Aligning Population Health Strategy

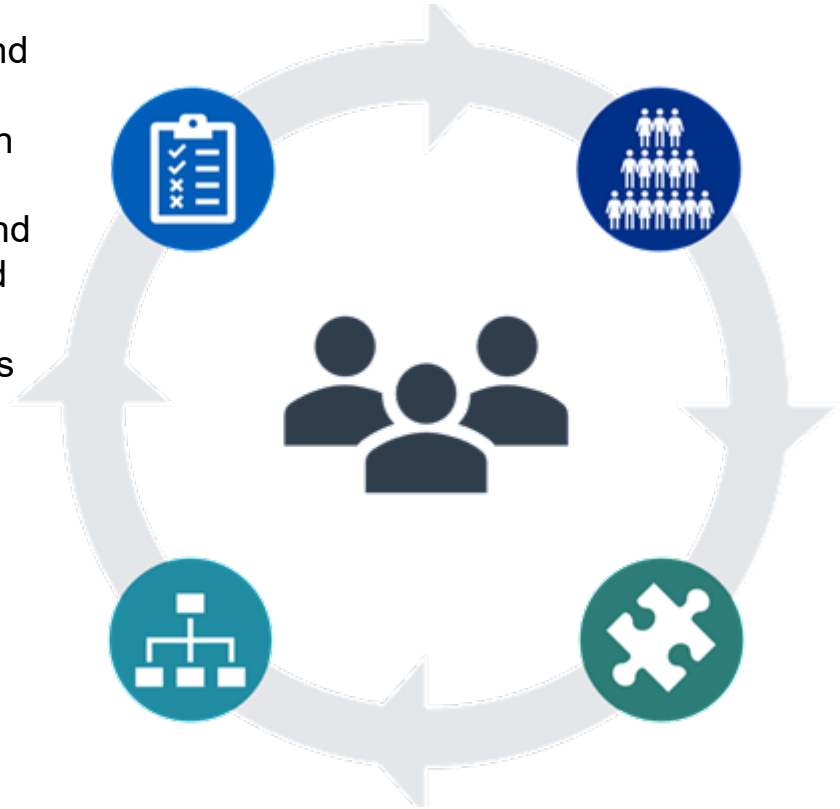
What: Developing the solution.
Action: Using the proposition mandate, engage with the market to initiate service ideas and proposals.
Output: A fully costed Business Case (including evaluation outline plan) supported by Impact Assessments.

Stage Three: Delivery and Resource Allocation

What: Commissioning the service.
Action: Development of a service specification and the undertaking of a procurement exercise.
Output: A Service Specification and Contract.

Stage Four: Evaluating Impact

What: Understanding the effects, for whom and why.
Action: Work through steps in ICB evaluation reference guide to understand the nature of impact: scoping, planning and co-designing and conducting evaluation, making decisions and disseminating knowledge.
Output: Summary of clear evaluation findings and corresponding plans for action.



Scope and Proportionality

This policy applies to all commissioning decisions, including service designs, redesigns, reviews, and transformations. New investments, funding extensions, in-year decisions, or decommissioning. Contract variations and evaluations. Rule of Thumb: **If it's a commissioning decision this policy applies**. When in doubt (or if it is a "maybe"), check with the Strategic Planning and Change Team for advice.

What if my item/project/service….?	Proposition Mandate	Full Business Case	Light Business Case	Service Specification	Evaluation Plan
…is worth less than £500,000	✓ Yes	X No	✓ Yes	✓ Yes	✓ Yes
…has non-recurrent funding (> than £500,000)	✓ Yes	✓ Yes	X No	✓ Yes	✓ Yes
…has funding from company/organisation	? Maybe	? Maybe	? Maybe	? Maybe	✓ Yes
…is a small or timebound project (> than £500,000)	✓ Yes	✓ Yes	X No	✓ Yes	✓ Yes
…is a large, multifaceted project (> than £500,000)	✓ Yes	✓ Yes	X No	✓ Yes	✓ Yes
…is prescriptive, we have no influence on how the money is spent	X No	X No	X No	X No	✓ Yes
…is being implemented at neighbourhood level (> than £500,000)	✓ Yes	✓ Yes	X No	✓ Yes	✓ Yes
…is nationally mandated (> than £500,000)	✓ Yes	✓ Yes	X No	✓ Yes	✓ Yes
…is a contract variation	✓ Yes	? Maybe	? Maybe	X No	? Maybe
…a pilot or extension of a pilot (> than £500,000)	✓ Yes	✓ Yes	X No	✓ Yes	✓ Yes
…is looking to be decommissioned (> than £500,000)	✓ No	✓ Yes	X No	✓ Yes	✓ Yes

ICB Statutory Duties

Statutory duties are delivered through the continuous strategic commissioning cycle, ensuring legislative compliance and system integration are unified.

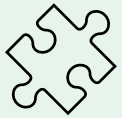
Stage One: Local Context

Core Statutory Duties

- NHS Constitution & Public Sector Equality Duty (PSED) alignment
- Health Inequalities across the life course
- Triple Aim duties
- Joint Strategic Needs Assessment (JSNA)
- Safeguarding responsibilities

System Integration

- Needs Assessment & demand profiling (SEND, complex needs, youth justice, vulnerable cohorts, older people, Looked After Children)
- Community & VCFSE engagement (families, carers, CYP, partners)



Stage Two: Strategic Alignment

Core Statutory Duties

- Improving health & healthcare outcomes (embed safeguarding by design, create 'whole pathways')
- Tackling inequalities in experience
- Wider socio-economic development
- Alignment with statutory frameworks: Children Acts, SEND legislation, Equality Act, Working Together

System Integration

5-Year Strategy alignment

Integrating children & family pathways (health, care and education)

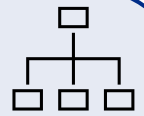
Stage Four: Evaluating Impact

Core Statutory Duties

- Monitoring safety, outcomes & feedback
- CQC Assurance
- Financial oversight
- Quality, Safety and Safeguarding outcomes
- Impact on inequalities and experiences (communities, CYP, families, SEND, Looked After Children)

System Integration

- System learning feedback loops
- Real-time data: Measuring access equity



Stage Three: Delivery and Resource

Core Statutory Duties

- Allocate resources fairly, ensure quality through contracting and assurance
- PSR compliance & market management
- Financial balance & value for money
- Governance & contract oversight
- Safeguarding, transition requirements, equality and inequality duties in service specifications and contracts

System Integration

- Primary & Community care resource shift
- Collaborative procurement models
- Transparent, evidence-led allocation

Being Evidence Led

Central to Strategic Commissioning is the ability to be truly evidence-led. As a good strategic commissioning organisation, we should be **using reliable evidence** to reach our ambitions through:

Engaging with population health insights to understand our population needs

Using our segmentation model to identify priority cohorts and inform pathway redesign

Using health economic principles to understand the economic consequences of decisions

Overseeing the development and implementation of high-quality impact evaluation in relation to commissioning

Ensuring important learning from this evaluation informs all our initial planning conversations

Segmentation Modelling

Using our linked data to segment our 1.8m population into groups based on similar characteristics and needs, provides a vital framework for understanding need across the ICB. For instance, the 13% of our population who reside in our Adult End of Life segment account for 56% of our emergency bed days. This can be viewed at ICB, Alliance or Neighbourhood level. Understanding how each of these groups interact with our services, how they change over time and what drives the progression between them can help us develop strategies and plan our services. Population segmentation should include CYP-specific cohorts, including vulnerable children, neurodiverse children, children in care, care leavers and transition-age young people.

Commissioning Outcomes

The Legacy Approach

Transactional Commissioning

Historically focused on Inputs & Outputs. Payments were triggered by activity volume (e.g., number of appointments or procedures) without sight of overall system impact. Leading to…

X Fragmented interventions

X Siloed financial reporting

X Limited focus on health equity

The Strategic Approach

Stewardship of Outcomes

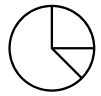
Reimagining commissioning as a continuous process to improve Population Health. We move beyond "receiving and treating" to a proactive, person-centric model. Leading to …

✓ Bio-psycho-social risk management

✓ Allocative & Technical efficiency

✓ Measurable accurate outcomes

Define Outcomes: The Commissioner's role is to determine the long-term outcomes (e.g., Healthy Life Expectancy) and the evidence base behind them



Model Contribution: Identifying the "80/20" factors. We estimate the relative contribution of various activities to ensure fair, achievable contracts

Commission Activity: Purchasing specific, high-value interventions while retaining strategic oversight of the entire care pathway

Closing the Loop: As Strategic Commissioners, we are responsible for the learning and review cycle. We model the system's logic, monitor the relative impact of each factor, and reallocate resources to the most impactful interventions

Success = Healthy Life Expectancy + Reduced Inequality + Value for Money

Logic Models and Theory of Change

Moving from **"what we fund"** to **"what difference it makes"** to strengthen evaluation, resource allocation, and systemic impact.

The Core Objective

We use a Theory of Change upfront to test whether a strategy should work conceptually, and a Logic Model during operationalisation to ensure it remains deliverable, trackable, and outcome-led.

While complementary, both tools serve distinct strategic purposes at different phases of the commissioning pathway.

The Operational Pathway

Logic Model (the "What & How")

A tactical, linear blueprint focusing on operational delivery and concrete program management.

- Linear Summary: Displays direct, logical pathways of cause and effect.
- Structure: Maps inputs to activities, outputs, outcomes, and impact.
- Action-Oriented: Expressly documents what we will physically do and fund.
- Core Use Case: Invaluable for delivery, KPI tracking, and operational monitoring.

The Strategic Philosophy

Theory of Change (the "Why")

A backward-mapped strategic roadmap outlining structural shifts and system assumptions.

- Backward-Mapped: Starts with desired population impact and works backward.
- Explanatory: Deconstructs the underlying logic of why changes should happen.
- Assumption-Heavy: Proactively explores environmental risks, evidence, and variables.
- Core Use Case: Used for co-design, high-level pathway strategy, and stress-testing.

Involving Partners, People and Communities

It's essential to involve and value partners and people with lived experience from the beginning, treating them as equals, valuing their knowledge, expertise and skills.

Mutually Beneficial Strategic Partnerships

What Partners can Bring

Lived Experience: Expert knowledge, understanding, skills and resources
Reach & Access: Trusted relationships with underserved populations
Social Value: Creative solutions, flexibility and person-centred delivery.

What the ICB can Provide

Stability: Multi-year investments, fair funding and proportionate monitoring
Resources: Shared data and evidence.
One Workforce: Opportunities for integrated staff training

The Essentials of being a Good Partner

Reciprocal Benefits
Partnerships are not one-sided. We can provide stability and funding; partners can offer insight and expertise, community reach and cultural understanding to improve commissioning.

Nurtured Development
Partnerships cannot be "picked up" only when convenient. They grow over time through regular, flexible opportunities to meet, build trust and listen to one another.

Balance of Power
Actively seek to redistribute power.
Parity: work as equals
Accountability: holding each other to account for what we do
Subsidiarity: local decision making

Diversity of Partners
Ask yourself if you're working with the breadth of partners available. The Partnerships, People and Communities Team can help you identify who is missing.

The Spectrum of Involvement

Inform and consult
"Doing for" - Sharing information and gathering feedback.

Engagement
"Doing with" - Ongoing two-way dialogue and participation opportunities.

Co-production
"Equal Partners" Decisions made jointly with partners, people and communities. Parity of knowledge, redistribution of power, trauma-informed approaches, and recognising lived experience as expert evidence

Reducing Health Inequalities

Ambition: Systematically reduce unfair and avoidable differences in health outcomes by embedding equity in all commissioning decisions, aligned to system-wide health outcomes. Additional resources can be found here.

Core20PLUS5

- Focus on the most deprived 20% and local PLUS priority groups.
- Target 5 clinical areas driving inequalities: Maternity, Mental Health, CVD, Respiratory, Cancer (Adults).
- Use data to identify, prioritise and track impact.

Proportionate Universalism

- 'Everyone needs something, some people need more' - scale service intensity proportionate to the level of need.
- Shift access and resources towards underserved communities.
- Balance fairness with efficient resource utilisation.

Marmot Principles

- Act on wider determinants: housing, employment, education.
- Prioritise early intervention and prevention strategies.
- Strengthen community resilience and social value.
- Promote fair access and inclusive growth.

PHM Principles

- Use linked data segmentation to understand needs.
- Identify variation gaps and target interventions.
- Embed continuous improvement.

What This Means for Commissioning

- ✓ Equity in full cycle
- ✓ Contract requirements
- ✓ PHM informed decisions
- ✓ Redesigned pathways
- ✓ Core20PLUS5 population design
- ✓ Co-production

Understanding Variation

- X Unwarranted: Inequity in delivery/ access not explained by choice or need. (Tackle)
- ✓ Warranted: Appropriate differences based on high-need or evidence. (Protect)

Working with the Market

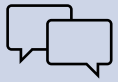
As strategic commissioners progress from reactive to proactive commissioning working with the market throughout the cycle, we need to ensure a diverse, innovative, and sustainable provider landscape that delivers our strategic outcomes. Market shaping is understanding the markets we source from and recognising our influence on the markets. To deliver high quality services, positive patient experience and promote healthy sustainable markets over the short, medium and long term we need to understand, engage, develop and manage the markets.

Market Knowledge

What is it: Awareness of the market - market intelligence which assesses the health of the market and consideration of how your service specification, commercial strategy and contract design can be adapted to address potential limitations or support markets.

How do we do it: Involves a blend of active research, data analysis, and supplier interaction, such as industry reports, supplier offers, benchmarking, researching other commissioning approaches, understanding market strengths, weaknesses, barriers to entry and competition.

When should we do it: Stage 1 and 4



Market Engagement

What is it: Listening to the market - engagement exercises are designed to understand interests and constraints of potential providers to deliver specifications, understand their views on the services to be delivered and provider appetite to support the services being commissioned.

How do we do it: Publicise the procurement pipeline in advance, engage to seek opinion on market approach, specifications and any other element which providers would have an informative perspective on.

When should we do it: Stage 2 and 3

Market Development

What is it: Supportive and proactive - ensuring in advance that there are diverse, sustainable quality markets which can react as demand changes. Working with the market to shape supply by growing market entries, improving provider awareness, skills and readiness, improving contractual compliance and increasing supply chain sustainability.

How do we do it: Talking with providers, reviewing completed procurements to learn supplier support needed, providing development resources, publishing demand forecasts from PHM.

When should we do it: Stage 1, 2 and 3

Market Management

What is it: Managing the supply using the tools available to leverage the market to deliver good quality services at the right levels.

How do we do it: Using benefits to reward good quality and adherence to contracts. Encouraging entry by actively opening market opportunities before there is need. Introducing flexible contract terms and conditions to allow adaption, considering innovative delivery options and leveraging competition.

When should we do it: Stage 3 and 4

Working with Clinical Stewards

Shifting clinical leadership from localised provider advocacy to objective population-level stewardship.

Paradigm & Mindset Shift

Old model: clinical representatives
Advocating for localised supply preservation, bound to representing single services or specialties. Clinical stewards are not there to “represent” services; they are there to “steward” outcomes for the whole population.

New model: system stewards
Objective partners focusing on pathway equity, high-value outcomes, and strategic prioritisation.

- ✓ **Triple Balance:** Managing clinical quality, population equity, and financial viability.
- ✓ **Value Allocation:** Leading difficult value reallocation and pathway redesigns.

Adding Value in the Cycle

1. **Understand**
   Sense-check needs/demands & clinical risk variations.
2. **Strategise**
   Support pathway design & best-practice validation.
3. **Deliver**
   Embed quality metrics & safety directly into specs.
4. **Evaluate**
   Interpret outcome data & assess actual practice impact.

Practical System Influence

- Challenging acute over-reliance by shifting focus to community and prevention.
- Addressing unwarranted clinical thresholds & treatment variations.
- Shaping pathway standard frameworks.

Core Check

"Will this intervention tangibly improve clinical outcomes and reduce health inequalities for our regional population?"

Stewardship Alignment: Clinical stewards ensure commissioning decisions are not just financially viable — but **clinically meaningful, equitable, and structured to deliver real outcomes for the whole population.**

Commissioning All-Age Services (Life-Course Approach)

The Strategic Vision: Moving away from siloed age cohorts to deliver continuous, person-centred support aligned with long-term prevention. As strategic commissioners we must transition to a whole life-course framework that recognises distinct needs at each life stage (CYP, adults, older adults) to plan, commission, and evaluate integrated pathways to improve population-level health and eliminate systematic care inequalities.

Core Principles

- Prevention-Led: Acting early to improve long-term outcomes and shift from sickness to prevention.
- Person-Centred: Supporting resilience, independence, family, and unpaid carers.
- Joint Integration: Co-designed pathways across health, social care, VCFSE, and housing.
- Equity Focus: Targeted resource shifts addressing structural population health variations.

The Life-Stage Lens

Children and Young People (0-25)
Prioritising safeguarding, SEND, neurodiversity, mental health, youth justice, and family-centred transition pathways.
Outcomes: Wellbeing, resilience, education, and independence.

Adults and Older Adults
Focusing on prevention, long-term condition planning, frailty, community/social integration, and recognising unpaid carer impacts.
Outcomes: Independence, participation, & ageing well.

How the all-age approach integrates into the Strategic Commissioning Cycle

Stage One: Understand
Map life-course needs, health inequalities, and lived experiences across different transition points.

Stage Two: Design
Build age-appropriate, fully-integrated pathway frameworks with explicitly designed transition protocols.

Stage Three: Deliver
Implement collaborative solutions, utilising joint specs and contracts across provider alliances.

Stage Four: Evaluate
Measure long-term developmental and health outcomes for individuals, families, and communities.

ICB Strategic Alignment: Adopting an all-age lens directly empowers the delivery of key integrated care priorities: embedding robust prevention, achieving complete pathway integration, and addressing generational inequalities closer to home.

What Does Good Co-Commissioning Look Like?

Current health systems face fragmented funding and siloed delivery. Co-commissioning moves organisations from transactional purchasing to transformational population health management. By aligning NHS, Public Health, and Local Authority goals, we create a seamless pathway for patients and maximise the impact of every pound spent.

The Core Pillars of 'Good'

Unified Data and Insights

Consolidating Public Health epidemiology, Joint Strategic Needs Assessments (JSNA), and healthcare analytics. This forms a single system asset, allowing for targeted population risk stratification and joint needs assessment.

Shared Risk and Pooled Budgets

Moving from transactional relationships to formal partnerships using Section 75 pooled budgets, aligned Better Care Fund (BCF) plans, and unified decision-making place boards.

Left Shift

Aligning clinical services with the wider social determinants of health (housing, work, education) to reduce health inequalities.

The Co-Commissioning Journey

1. Joint Analysis

Integrate health & council teams to deliver comprehensive local needs assessment and identify core gaps.

2. Co-Design

Develop a unified strategy that directly links the ICB 5-Year Plan with Local Authority priorities.

3. Pool Resources

Utilise pooled allocations or virtual alignment to optimise purchasing power and prevent duplication.

4. Evaluate Outcomes

Assess multi-agency system pathways using patient-centric, clinical, and socioeconomic impact metrics.

Decommissioning Ethically and Effectively

Decommissioning is not an exercise in cuts. It is a structured, evidence-based process that helps the NHS stop doing lower-value activities so that resources can be reinvested into interventions that deliver greater benefit, reduce inequalities and improve outcomes for the population.

A National Framework for Ethical and Effective Decommissioning and Disinvestment has been developed (available here). It provides an evidence-based, transparent eight-stage approach to stopping, reducing or redesigning low-value services, enabling resources to be redirected to higher-value care while maintaining quality, safety and equity. The framework should be used as a guide alongside the local templates.

1. Horizon-scanning and identification: Identify services, pathways, or interventions that may be inefficient, ineffective, or misaligned with population needs.
2. Prioritisation and shortlisting: Rank identified candidates for review based on transparent, evidence-based criteria.
3. Iterative appraisal and option development: Develop, test, and appraise potential service change options.
4. Communication and engagement: Build legitimacy, trust, and understanding among all stakeholders early in the process.
5. Decision-making and governance: Ensure transparent, fair, and defensible decisions supported by governance assurance.
6. Implementation and transition: Deliver service changes safely, fairly, and efficiently while managing risks.
7. Monitoring, evaluation and learning: Track impacts, verify outcomes, and feed learning back into future cycles.
8. Reinvestment and continuous improvement: Ensure decommissioned resources are transparently and strategically reinvested.

Key Principles for Successful Decommissioning

Transparent governance and clear decision-making

Strong clinical leadership and meaningful stakeholder engagement

Focus on redesigning low-value care rather than indiscriminate cuts

Decisions based on quality, outcomes, equity and value—not cost alone

Robust implementation, monitoring, evaluation and reinvestment planning

Role of Commissioners and Providers Together

		Strategic Commissioning (ICB)	Collaboration	Delivery (Provider)
Understanding the Need (Stage 1)	Population Health and Lived Experiences	Analytics and provision	Shared interpretation	Provision
	Defining the Problem	Defining the problem statement	Engagement and discussion	Shaping the problem statement
	Developing Outcomes	Alignment with strategic direction	Co-production	Alignment with reality
Defining the Solution and Allocating Resources (Stages 2 & 3)	Developing the Solution	Engage with the market	Engagement and discussion	Multi-provider collaboration to develop solutions
	Finance and Resource Allocation	Define financial envelope & write business case	Transparency and shared knowledge	Allocate pathway finances
	Contracting and Procurement	Create service specifications and lead procurement	Engagement and discussion	Engage with procurement exercise and sub-contract
Evaluating Outcomes (Stage 4)	Quality	System governance and accountability	Shared definition of expectations	Pathway outcomes accountability
	Performance	System outcomes accountability	Shared definition of expectations	Pathway outcomes accountability
	Transformation	Evaluation of outcomes to drive next steps	Transparency and shared knowledge	Evaluation of outcomes to support next steps

Governance and Getting Approvals

What Different Groups can Approve and Spend

The Scheme of Reservation and Delegation (SoRD) establishes clear governance by formally identifying which decisions are kept exclusively for the Board's approval and which decisions are distributed to specific committees, executives, or staff. As part of this the financial amount each committees, executives, or staff can spend is also detailed.

The Approval Pathway

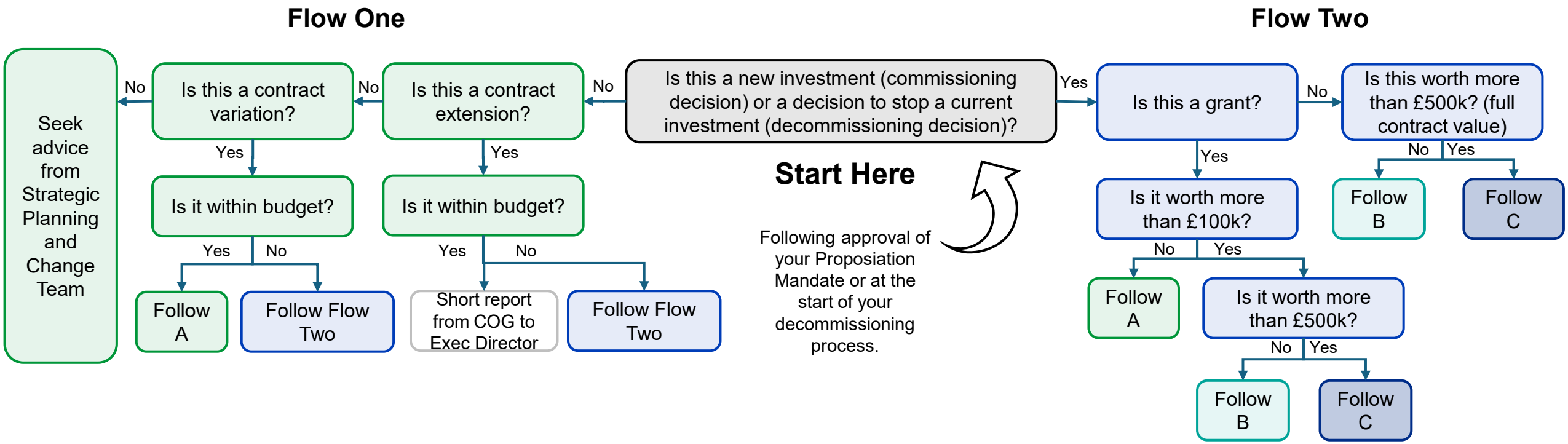
Clarity on the approval route for **Proposition Mandates** and **Business Cases** is essential for operational efficiency. You will need to follow the correct approval pathway for your commissioning (or decommissioning) decision.

To initiate any new decision (regardless of if it is a new investment (including a grant), or a contract variation) a **Proposition Mandate** must be completed. This is to be developed by the Commissioning Oversight Group (COG) and approved by the relevant Committee (there are no other approval requirements). The only exception to this is a decision to decommission – these decisions do not require a **Proposition Mandate** they go straight to **Business Case** stage.

The process overleaf provides a clear process on the required next steps following the completion of a **Proposition Mandate** for new investments or the first step for decommissioning decisions. .

Intranet Resources: Detailed financial delegations and committee hierarchies are found in the Governance Handbook. Specific committee Terms of Reference (ToR) are maintained online for reference Click here to access the Governance Handbook

Governance and Getting Approvals



A	COG to develop Light Business Case	COG to provide recommendation for approval of Light Business Case to relevant Executive Director (via email)	COG and Executive Director to provide recommendation of approval for Light Business Case to Director of Finance (via email)
B	COG to Light develop Business Case	Light Business Case to proceed to Strategic Commissioning Delivery Group (SCDG) or Place Committee (for Place decisions) with supporting paper from COG with recommendation for approval	SCDG or Place Committee to approve Business Case
C	COG to develop Business Case	Business Case to proceed to Strategic Commissioning Committee (SCC) or Place Committee (for Place decisions) with supporting paper from COG with recommendation for approval	SCC or Place Committee to approve Business Case

Section Two: Translating into Action

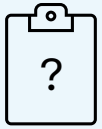
Section Two of this policy translates national expectations into practical actions for Norfolk and Suffolk ICB for each stage of the Strategic Commissioning Cycle. We'll explain each stage and provide…

Core Activity

Clear definitions of what needs to be done at every stage of the cycle

Key Considerations

The critical questions to ask and factors to weigh up when undertaking activity



ICB Resources

Identification of the expert teams best placed to support and advise you

Local Outputs

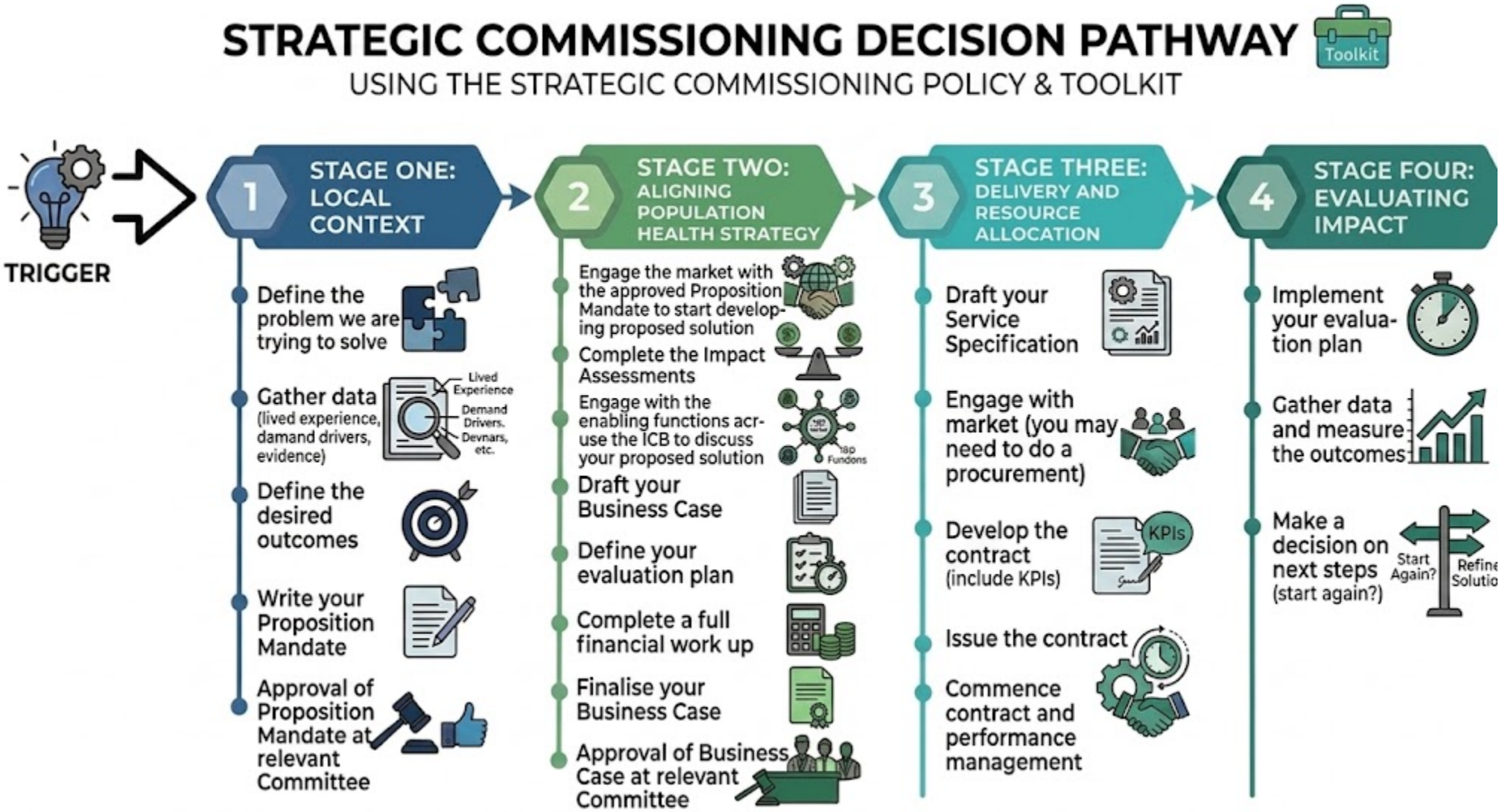
A summary of what is produced at each stage, including mandatory templates

Remember…

Take a Collaborative Approach: Specialist resources are not mutually exclusive. Activities often span multiple Directorates, and we will work as one system to support your progress

Let's take a closer look at how we'll make it happen

Strategic Commissioning Cycle Pathway



Strategic Commissioning Cycle Checklists

STAGE ONE: Local Context (Understanding the Problem)

Goal: Gather evidence, data, and insights to build a watertight case of population need and achieve "agreement in principle" before designing a solution.

1. Core Activities & Considerations
- ❑ Define the Problem
- ❑ Review Baseline Data
- ❑ Embed Lived Experience
- ❑ Review Evidence & Best
- ❑ Assess System Dynamics

2. Mandatory Output & Templates
- ❑ Proposition Mandate

3. Expert Teams to Engage Early
- ❑ Healthcare Intelligence
- ❑ Health Equity Team.
- ❑ Communications / People & Communities Teams
- ❑ Innovation Team.

STAGE TWO: Aligning Population Health Strategy (Developing the Solution)

Goal: Translate your approved Proposition Mandate into a detailed, robust, and costed business case by actively working with the market.

1. Core Activities & Considerations
- ❑ Co-Design with the Market
- ❑ Build the Logic Model
- ❑ Secure Enabling Statements
- ❑ Pass the Four Impact Filter
- ❑ Conduct Financial Workup

2. Mandatory Outputs & Templates
- ❑ Full / Light Business Case
- ❑ Full Financial Workup Template
- ❑ Impact Assessments (EHIA, QIA, SIA, DPIA)
- ❑ Evaluation Planning Template

3. Expert Teams to Engage
- ❑ Finance Team
- ❑ Quality & Safeguarding Teams
- ❑ Sustainability Team
- ❑ IG / Digital Teams.
- ❑ Healthcare Intelligence
- ❑ Strategic Planning and Change Team
- ❑ Enabling Teams

STAGE THREE: Delivery and Resource Allocation (Commissioning the Service)

Goal: Turn your approved Business Case into a market-ready, legally binding contract and specification.

1. Core Activities & Considerations
- ❑ Commercial Timeline Planning
- ❑ Determine Procurement Route
- ❑ Workforce Reality Check
- ❑ Incorporate Technical Enablers
- ❑ Contract for Outcomes

2. Mandatory Outputs & Templates
- ❑ Service Specification
- ❑ The Legally Binding Contract
- ❑ Waiver of Competitive Tendering Template
- ❑ PSR Awards and Notices Documents
- ❑ TUPE Data Collection Workbook

3. Expert Teams to Engage
- ❑ Contracts Team
- ❑ Procurement Team.
- ❑ Strategic Workforce Team / Training Hub
- ❑ Estates Team.

STAGE FOUR: Evaluating Impact (The Learning Loop)

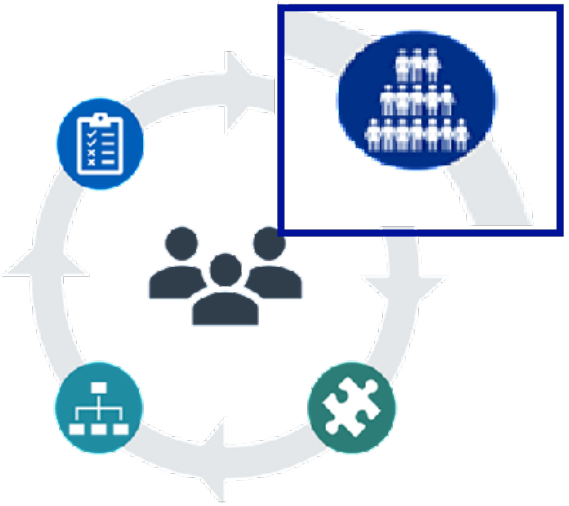
Goal: Measure the effects of the service, monitor contractual compliance, and feed the learning systematically back into Stage One.

1. Core Activities & Considerations
- ❑ Activate Performance Monitoring
- ❑ Execute the Evaluation Plan
- ❑ Minimise Burden
- ❑ Assess Equity and Value
- ❑ Close the Loop

2. Mandatory Outputs & Templates
- ❑ Monitoring and Detailed Evaluation Outputs / Reports
- ❑ Clear Evaluation Findings & Action Plan

3. Expert Teams to Engage
- ❑ Healthcare Intelligence
- ❑ Contracts and Quality Team

Stage One



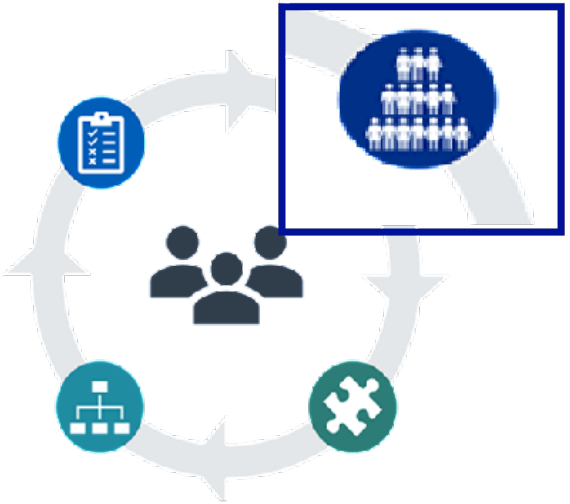
Stage One: Local Context

What: Evidence (data, intelligence and insights) highlights population need or commissioning challenge.

Action: Understand the problem, gather the evidence and define the desired outcomes.

Output: A Proposition Mandate.

Stage One: Introduction and Core Activity



Stage One is our foundation. During this stage we are gathering lots of data, information and intelligence to move beyond surface-level data, to build a joined-up picture of our population. This involves analysing:

- Population Needs: Needs, risks, and health inequalities.
- System Dynamics: Demand drivers, horizon scanning, innovation insights, best practice, provision quality, and current performance.
- Research and evaluation: Evidence from local and national evaluations, other research evidence (academic and grey literature)
- Community Voice: Integrating partner insights and direct feedback from our population.

To move from intelligence to action, Commissioners are required to complete a **Proposition Mandate** during stage one using a theory of change / logic model. This document defines:

- The Problem: What specific challenge are we solving?
- The Evidence: A summary of data-driven insights and lived experience
- The Outcomes: What does success look like?
- Strategic Alignment: How does this deliver on the PHIP and 5-Year Strategy?
- The Goal: To provide enough detail to gain "agreement in principle" to start, stop, or negotiate a service.

Stage one is the most fundamental part of the cycle. The next few slides offer plenty of considerations and resources to help you build a watertight case - it's a lot to think about and ensures we invest in the right things.

Stage One: Considerations

To build a compelling Proposition Mandate, Stage One requires a rigorous enquiry into the root causes of system pressure, the depth of our community engagement, and the strategic value of our proposal.

Problem & Needs

- ? Is there a clear, shared view of population need beyond waiting lists?
- ? Is the status quo working well, or not working at all?
- ? Is there imminent innovation or change on the horizon to factor in?
- ? Are known data gaps identified and mitigated?
- ? Has system wide evidence been synthesised?
- ? Are there any learning from Safeguarding or Quality?
- ? Have vulnerable cohorts been specifically identified?

Voice & Experience

- ? Have service users and unpaid carers influenced the problem definition?
- ? Have engagement approaches reached quieter voices?
- ? Is lived experience included as core evidence in the mandate?
- ? Is there a clear “you said, we did” narrative established?
- ? Has complaint data been reviewed?
- ? Has the workforce been engaged and had input into the problem statement?

Impact & Strategy

- ? Is the proposal aligned with the ICB’s Population Health Strategy?
- ? How are sustainability and social value incorporated?
- ? Does the mandate require any specific regulatory approvals?
- ? Are the outcomes clear and able to be measured?
- ? Is there a national mandate / requirement?
- ? Have you considered carbon and social value?
- ? Have CYP statutory duties been considered?

Stage One: Resources

Activity	Example Resources (not exhaustive)	ICB Support Teams
Baseline Data and Population Data	**External:** Office for National Statistics (ONS), Fingertips, Norfolk & Suffolk Joint Strategic Needs Assessments (JSNA) CYP and SEND JSNAs, comparative benchmarking such as the Model Health System and Get It Right First Time (GIRFT). **Internal:** Linked person-level datasets, segmentation & risk stratification.	**(1) Healthcare Intelligence (2) PHM** Can advise on what resources are available and how to use them
Inequalities	**External:** Healthwatch Reports, academic evidence. Youth Justice information. Department for Education attendance and exclusion data. **Internal:** Outcome/Experience data, Equality and Health Inequality Impact Assessments (EHIA) and Quality Impact Assessments (QIA).	**(1) Healthcare Intelligence (2) Health Equity (3) CYP Team** Support with EHIA & baseline data analysis
Lived Experience and Community Engagement	**External:** Kings Fund, Health Foundation research & other academic evidence. **Internal:** Alliance/Place reports, Community feedback logs, VCSFE Assembly outputs and insights, insight from clinical stewards and primary care, summary of previous engagement activities, complaints data.	**(1) Comms (2) People & Communities** Can support with C&E activity, and capturing local voices
Demand, Capacity and Value	**External:** Model Health System, NHS Federated Data Platform. **Internal:** Finance & Community analytics, Opportunity analysis.	**(1) Finance, (2) Healthcare Intelligence** Specialist support with value/opportunity mapping

Stage One: Resources

Activity	Example Resources (not exhaustive)	ICB Support Teams
Strategic Assessment and Risk	**External:** NHS England segmentation / National Oversight Framework (NOF) rating and cross-border intelligence, new NICE guidelines and medicines formulary. **Internal:** Board Assurance Framework (BAF) risk register entries, PALS and complaint's themes, quality issues.	**(1) Strategic Planning, Resilience & Change (2) Corporate Governance** Horizon scanning and comparison with others
Contract and Service Baseline	**External:** Board reports, annual reports, 5-year plans, CQC reports - meet with current providers to sense check the reality & engage early. **Internal:** Current contracts and services (including co-commissioned), performance and challenges with existing contacts/providers. Input from clinical stewards.	**(1) Commissioners (2) Contracts** Sharing of operational experience
Evidence and Evaluation	**External:** National evaluation studies and examples. Learning from OFSTED/CQC/Charity Commission. National Inquiries. Provider Safeguarding Data. **Internal:** Specific 'how to' guides and support with access to sources and critical appraisal of evidence, templates and checklists that embed evaluation at start. Learning from safeguarding reviews. Safeguarding working across the ICB.	**(1) Evaluation (2) Safeguarding** Expert advice and support
Workforce	**External:** Workforce data e.g. skill mix, pay costs, staff surveys, bank & agency fill, Provider Productivity on Model Health System. **Internal:** Pipeline of training needs for a re-designed workforce, local placement plans.	**(1) Strategic Workforce (2) Training Hub** Planning for a redesigned workforce

Stage One: Templates

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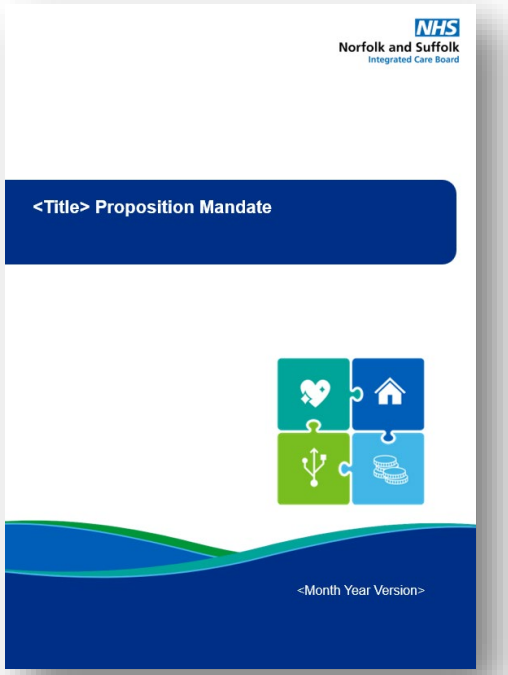

Proposition Mandate

- The Proposition Mandate is to be completed to provide the ICB with a suitable level of information to enable a decision to be made if resources should be invested in the commencement of a new commissioning decision.
- This is the first document you will complete and submit to the relevant committee (and possibly ICB Board) for decision for new commissioning decisions. It is to be completed in Stage One (stage two is not able to commence unless a Proposition Mandate has been approved).
- You do not need to complete this document if you intend to decommission, you can go straight to a Business Case.
- This document is intended to be short; it should not be describing the solution.
- The document is intended to describe the problem, provide evidence of need and describe what outcomes look to be achieved.
- The document review section must be completed prior to submission.
- The Strategic Planning & Change Team can assist with ensuring alignment to Strategy & PHIP.

Stage Two

Stage Two: Aligning Population Health Strategy

What: Developing the solution.

Action: Using the Proposition Mandate, engage with the market to initiate service ideas and proposals.

Output: A fully costed Business Case (including evaluation outline plan) supported by Impact Assessments.

Stage Two: Introduction and Core Activity

Stage Two marks the transition from conceptual intelligence capture to strategic development, evolving your Proposition Mandate into a robust, costed Business Case using a theory of change / logic model. This stage requires commissioners to actively work with the market to develop a solution informed by existing evidence, evaluation and pipeline innovations (not just local design preferences).

Commissioners will need to work up:

Business Case

Adhering to specific £ threshold values and proving robust value for money methodology.

Prioritisation Rationale

Justification to enable Committees to approve moving money around the system.

Impact Assessments

Sustainability, Equality, Quality and Data Protection Impact Assessments.

Service Specification

Development of a service specification can commence in Stage Two, but it is not an output of Stage Two

Why this is important: Rigorous design ensures system sustainability. It prevents fragmentation and ensures that every intervention is financially viable and clinically effective for our 1.7 million residents. The next few slides offer plenty of considerations and resources to help you build a strategic Business Case.

Stage Two: Considerations

Stage Two moves from "defining the problem" to "blueprinting the solution“, requiring a deep-dive into clinical safety, financial viability, and long-term strategic impact. The commissioner will lead this process.

Clinical and Model

? Has the market been engaged and supported the development of the solution?
? Have we understood the opportunities for innovation?
? Has the solution been tested against experience and clinical safety?
? Are clinical stewards involved early enough to shape the model?
? Do we reflect future demand (1-3-5 years) or just current pressure?
? Are pathway continuity and system interfaces fully mapped?
? Are there known quality risks or unwarranted variations influencing the design?
? What are the implications for transition to adult services?

Impact and Compliance

? Have inequalities been explicitly tested via EHIA/EQIA?
? Are DPIA, Sustainability, and Quality Impact Assessments complete?
? Have we addressed digital interoperability and IG requirements?
? Has risk stratification been used to understand differential impacts?
? Are all partners aligned on what success looks like?
? Is formal Consultation required?
? Has evaluation information been reviewed and considered?
? Has the supplier completed a Digital Technology Assessment Criteria (DTAC)?

Value and Delivery

? Is the full cost envelope understood?
? Have opportunity costs and trade-offs been made explicit?
? Have joint commissioning or pooled budget opportunities been explored?
? What market management is required, and what are the procurement options?
? How will the solution measure and capture cashable savings or released capacity across the system?
? How does the solution demonstrate long-term cost-effectiveness and maximum value for population health outcomes?

Stage Two: Resources

Activity	Example Resources (not exhaustive)	ICB Support Teams
Running a transparent prioritisation process	**Internal:** Norfolk and Suffolk ICB principles of decision making, Norfolk & Suffolk ICB Strategy and PHIP.	**(1) Strategic Planning, Resilience & Change** Responsible for co-ordinating via the Strategic Commissioning Delivery Group (SCDG)
Testing feasibility and affordability	**External:** Federated Data Platform. **Internal**: Financial envelope and budget available incl. Better Care Fund, Norfolk and Suffolk ICB principles of prioritisation if money needs to be moved around the system, Norfolk and Suffolk ICB population segmentation model for long- and short-term impact realisation. Digital checklist.	**(1) Strategic Planning, Resilience & Change (2) Finance** Responsible for co-ordinating via the SCDG and affordability info
Embedding quality, inequality, sustainability & IG considerations	**Internal:** Previous SNEE/N&W ICB Health Equity Impact Reports 2025/26, Equality Impact Assessments, Quality Impact Assessments, Sustainability Toolkit, Data Protection Impact Assessment.	**(1) Sustainability (2) IG (3) Inequalities (4) Quality** Support with impact assessments
Agreeing governance, accountability and refresh	**Internal:** Named SRO and Commissioning Team for each Commissioning Intention / Service Review.	**(1) Strategic Planning, Resilience & Change** Responsible for co-ordinating via the Strategic Commissioning Delivery Group

Stage Two: Templates

LINK

Business Case

- A Business Case must be completed when the ICB is in control of how money is being spent. This includes:
  - Commissioning a new service or initiative (of any value) under any circumstance.
  - Decommissioning a service (including following service reviews).
- A Business Case is commenced once a Proposition Mandate has been approved in Stage One of the Strategic Commissioning Cycle (or following a service review).
- Some sections, including ‘section one: Business Case information’ can be copied from your approved Proposition Mandate.
- You need to receive a statement from each of the ‘enabling functions’ (section 5), even if the statement is ‘no recommendation’. This should be done early on in the development to ensure recommendations are considered in the proposed solution.
- The proposed solution in the Business Case should be developed with the market to ensure it is a feasible, functional service model.
- This document is intended to be detailed; it should provide the approver with all the detail they need to be able to make a fully informed decision.
- As less detailed version of the Business Case is available, named a ‘Light Business Case’ for decisions with a financial implication of less than £500,000.
- It is to be submitted to the relevant committee (and possibly ICB Board) for approval.

Stage Two: Templates

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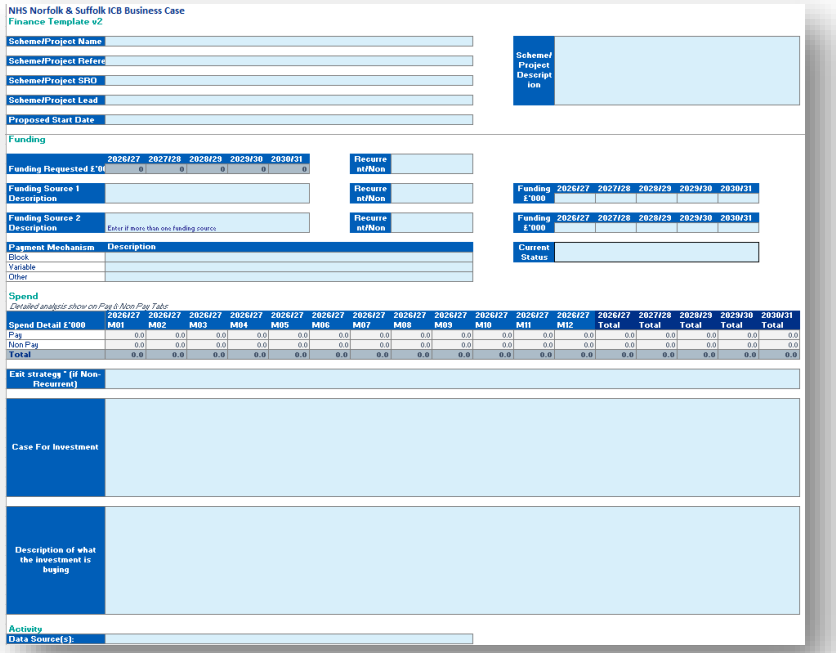

NHS Norfolk & Suffolk ICB Business Case
Finance Template v2

Scheme/Project Name
Scheme/Project Refere
Scheme/Project SRO
Scheme/Project Lead
Proposed Start Date
Scheme/Project Description

Funding

Funding Requested £'0 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | 2030/31 | Recurrent/Non
Funding Source 1 Description | Recurrent/Non | Funding £'000 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | 2030/31
Funding Source 2 Description | Enter if more than one funding source | Recurrent/Non | Funding £'000 | 2026/27 | 2027/28 | 2028/29 | 2029/30 | 2030/31
Current Status

Payment Mechanism | Description
Block
Variable
Other

Spend
Detailed analysis show on Pay & Non Pay Tabs

Spend Detail £'000	2026/27 M01	2026/27 M02	2026/27 M03	2026/27 M04	2026/27 M05	2026/27 M06	2026/27 M07	2026/27 M08	2026/27 M09	2026/27 M10	2026/27 M11	2026/27 M12	2026/27 Total	2027/28 Total	2028/29 Total	2029/30 Total	2030/31 Total
Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Exit strategy * (if Non-Recurrent)
Case For Investment
Description of what the investment is buying

Activity
Data Source(s):

Financial Case

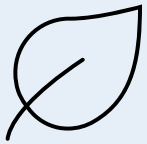
- To be able to complete the finance section of the Business Case a full financial workup needs to be completed.
- This should be done in collaboration with the Finance Lead for the programme.
- The primary purpose of the workup is to provide a standardised, multi-year financial appraisal framework to evaluate and cost proposed schemes, projects, or investments over a 5-year period (running from 2026/27 through 2030/31).
- Specifically, the document serves to:
  - Consolidate strategic projects (executive dashboard)
  - Model detailed project costs (pay & non-pay tabs)
  - Appraise activity & impact (activity costing/information tabs)
  - Calculate financial return on investment (summary tabs)

Stage Two: Templates

A robust Business Case must pass through these four essential filters (and be assured at the Impact Assessment Group) to ensure our proposals are safe, equitable, sustainable, and legally compliant. Impact assessments should be completed early in the Business Case process as they will help shape thinking.

Equality Impact Assessment

Fulfils our legal duties to identify how proposals will proactively reduce health inequalities and improve access for marginalised voices. LINK



Sustainability Impact Assessment

Aligns commissioning decisions with 'Greener NHS' commitments by evaluating environmental footprints and promoting local social value. LINK

Quality Impact Assessment

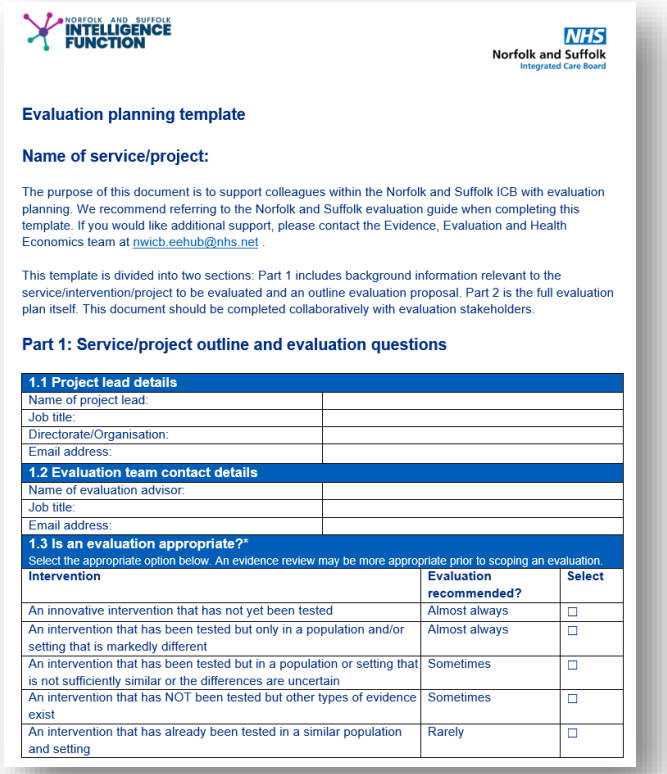
Identifies and mitigates potential risks to clinical safety, patient experience, or service effectiveness, ensuring redesigns enhance the standard of care. LINK

Data Protection Impact Assessment

Safeguards patient privacy by ensuring new digital interfaces and data-sharing arrangements are secure and legally compliant. LINK

Stage Two: Templates

LINK



NORFOLK AND SUFFOLK INTELLIGENCE FUNCTION

NHS Norfolk and Suffolk Integrated Care Board

Evaluation planning template

Name of service/project:

The purpose of this document is to support colleagues within the Norfolk and Suffolk ICB with evaluation planning. We recommend referring to the Norfolk and Suffolk evaluation guide when completing this template. If you would like additional support, please contact the Evidence, Evaluation and Health Economics team at nwicb.eehub@nhs.net .

This template is divided into two sections: Part 1 includes background information relevant to the service/intervention/project to be evaluated and an outline evaluation proposal. Part 2 is the full evaluation plan itself. This document should be completed collaboratively with evaluation stakeholders.

Part 1: Service/project outline and evaluation questions

1.1 Project lead details	
Name of project lead:	
Job title:	
Directorate/Organisation:	
Email address:	
1.2 Evaluation team contact details	
Name of evaluation advisor:	
Job title:	
Email address:	

1.3 Is an evaluation appropriate?*

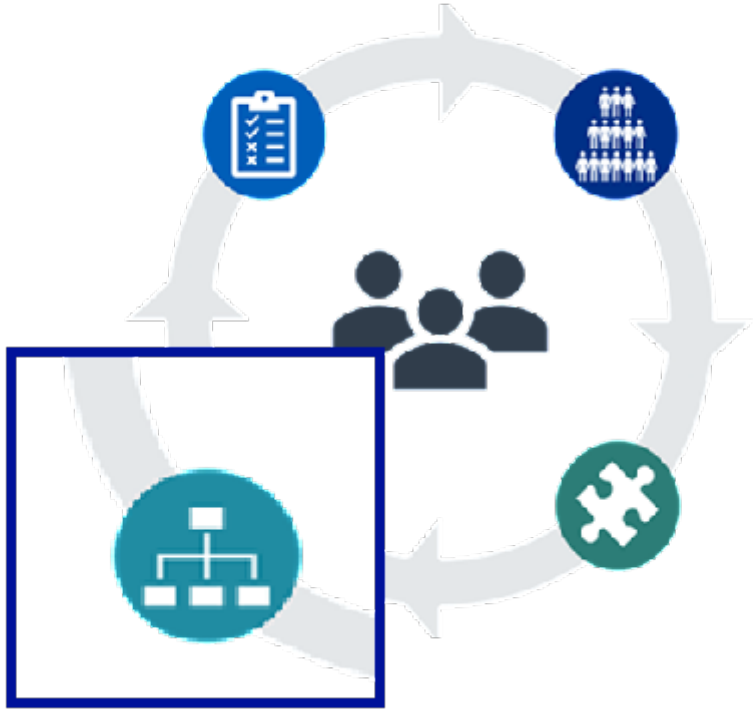
Select the appropriate option below. An evidence review may be more appropriate prior to scoping an evaluation.

Intervention	**Evaluation recommended?**	**Select**
An innovative intervention that has not yet been tested	Almost always	☐
An intervention that has been tested but only in a population and/or setting that is markedly different	Almost always	☐
An intervention that has been tested but in a population or setting that is not sufficiently similar or the differences are uncertain	Sometimes	☐
An intervention that has NOT been tested but other types of evidence exist	Sometimes	☐
An intervention that has already been tested in a similar population and setting	Rarely	☐

Evaluation Planning Template

- The purpose of the Evaluation Planning template is to support colleagues within the Norfolk and Suffolk ICB with evaluation planning.
- Evaluation Planning needs to be completed as part of your Business Case.
- It is recommend referring to the Norfolk and Suffolk evaluation guide when completing this template. If you would like additional support, please contact the Evidence, Evaluation and Health Economics team at nwicb.eehub@nhs.net
- This template is divided into two sections:
  - Part 1 includes background information relevant to the service/intervention/project to be evaluated and an outline evaluation proposal.
  - Part 2 is the full evaluation plan itself. This document should be completed collaboratively with evaluation stakeholders.

Stage Three



Stage Three: Delivery and Resource Allocation

What: Commissioning the service.

Action: Development of a service specification and the undertaking of a procurement exercise.

Output: A Service Specification, Procurement Documentation and a Contract.

Stage Three: Introduction and Core Activity

Stage Three transforms strategic intent into operational reality, moving from designed Business Cases to live, market-ready Service Specifications developed in partnership with providers. This stage requires commissioners to continue to actively work with the market.

Strategic Intent
Focusing on market stewardship and performance management to deliver long-term population health outcomes.

Resource Allocation
Targeting funding to areas of highest need as identified in the PHIP.

Market Shaping
Developing a diverse provider landscape to ensure resilience and quality.

Outcome Contracting
Moving from activity-based to outcome-based performance monitoring.

The Market Ready Specification
Working with the market to make ideas, models and solutions a reality

Outcome-Based Specification: Detailed service requirements based on provider-collaborative driven solutions that are focused on tangible population health improvements.

Provider Selection Regime (PSR) Compliance: Navigating the PSR for contract awards, grants, and Service Level Agreements (SLAs).

Monitoring & Evaluation: Agreeing clear metrics to support both real-time delivery and long-term impact analysis, building on the (monitoring and) evaluation outline plan set out in the business case.

Critical Factor: Procurement readiness requires collaborative work with the Contract Team. Allow a 6–12-month lead-time for this phase. The next few slides offer plenty of considerations and resources to help you navigate this.

Stage Three: Considerations

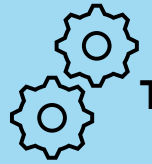
To transition from design to delivery, Stage Three demands a rigorous commercial reality check, ensuring our ambitions are matched by market capacity, workforce readiness, and robust contractual architecture.

Market and Workforce

- ? Has market capacity and provider sustainability been assessed?
- ? Is the proposed workforce deliverable at the assumed scale and pace?
- ? Does it rely on scarce, fragile, or hard-to-recruit roles?
- ? Have training, skill mix, and productivity been considered?
- ? Has learning from safeguarding reviews been fed into commissioning and procurement?

Commercial Logic

- ? Have you built in enough time (6–12 months) for procurement?
- ? Is the commissioning route (grant vs. contract) appropriate?
- ? Are payment mechanisms and risk/benefit aligned to outcomes?
- ? Are Service Specifications and data requirements fully worked up and agreeable with the market?



Technical Enablers

- ? Are estates and travel constraints fully understood?
- ? Does delivery rely on digital or data capability that does not yet exist?
- ? Has information governance and data-sharing been addressed early?
- ? Have you considered the environment/ climate impacts?

Stage Three: Resources

Activity	Example Resources (not exhaustive)	ICB Support Teams
Procurement and market management	**External:** NHS Payment Scheme, NHS Provider Selection Regime, Procurement Act 2023, best practice / learning from national procurement forums & national innovation. **Internal:** Norfolk and Suffolk ICB Standing Financial Instructions which set out the delegated levels of authority for decision making and spend. Procurement Policy.	**(1) Procurement** Offering advice on all aspects of buying goods or services
Workforce availability, Digital, IG and Estates	**Internal**: BAF entries and risk assessments, estates inventory and ICB Estates Strategies, pipeline for role re-design and re-training the workforce, our Neighbourhood Plans and Provider 5-Year Integrated Plans. Digital checklist.	**(1) Strategic Workforce (2) Digital and (3) Estates (4) IG** Sense checking the enablers for "Going Live"
Evaluation	**Internal:** A full monitoring and detailed evaluation plan template, Guidance on how to assess the ethical risks of service evaluations, Norfolk and Suffolk evaluation guide.	**(1) Evidence, Evaluation and Health Economics** Support and advice to develop the full evaluation plan
Service Specification and Contract	**External:** NHS Standard Contract Service Specification template , NHS Standard Contract. **Internal:** Norfolk & Suffolk ICB Outcomes-based Service Specification template with guidance on how to complete it. Indicative Activity Plan (IAP) template, monitoring templates, Grants and MOU's.	**(1) Contracts (2) Commissioning Finance** Support with and advice on all aspects of a Service Specification and legally binding contract

Stage Three: Templates

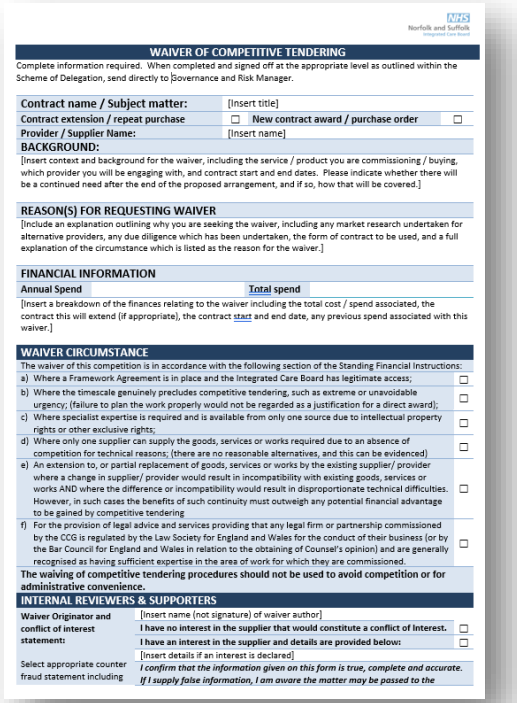
LINK

Service Specification

- Service Specifications can be commenced prior to approval of a Business Case, but they should not be completed until Business Case approval.
- A Service Specification is a critical contractual blueprint that translates a business case into a high-quality, operational reality.
- The Service Specification will cover the ‘Why’. It establishes a clear problem statement, quantifying the risks of inaction and ensuring the service aligns with national and local strategic aims.
- Using the outcome of the market engagement the specification will outline the functional service model and identifies the necessary enablers.
- It identifies high-level outcomes—such as improving healthy life expectancy and reducing health inequalities, and how these will be evaluated and attributed to the service (linked to the Evaluation Plan done as part of the Business Case).
- Once finalised this document forms part of the contract – do not enter contract information into this document.
- It is to be submitted to the relevant committee (and possibly ICB Board) for approval.

Stage Three: Templates

LINK



WAIVER OF COMPETITIVE TENDERING

Complete information required. When completed and signed off at the appropriate level as outlined within the Scheme of Delegation, send directly to Governance and Risk Manager.

Contract name / Subject matter:	[Insert title]
Contract extension / repeat purchase	☐ **New contract award / purchase order** ☐
Provider / Supplier Name:	[Insert name]

BACKGROUND:

[Insert context and background for the waiver, including the service / product you are commissioning / buying, which provider you will be engaging with, and contract start and end dates. Please indicate whether there will be a continued need after the end of the proposed arrangement, and if so, how that will be covered.]

REASON(S) FOR REQUESTING WAIVER

[Include an explanation outlining why you are seeking the waiver, including any market research undertaken for alternative providers, any due diligence which has been undertaken, the form of contract to be used, and a full explanation of the circumstance which is listed as the reason for the waiver.]

FINANCIAL INFORMATION

Annual Spend	**Total spend**

[Insert a breakdown of the finances relating to the waiver including the total cost / spend associated, the contract this will extend (if appropriate), the contract start and end date, any previous spend associated with this waiver.]

WAIVER CIRCUMSTANCE

The waiver of this competition is in accordance with the following section of the Standing Financial Instructions:

a) Where a Framework Agreement is in place and the Integrated Care Board has legitimate access;	☐
b) Where the timescale genuinely precludes competitive tendering, such as extreme or unavoidable urgency; (failure to plan the work properly would not be regarded as a justification for a direct award);	☐
c) Where specialist expertise is required and is available from only one source due to intellectual property rights or other exclusive rights;	☐
d) Where only one supplier can supply the goods, services or works required due to an absence of competition for technical reasons; (there are no reasonable alternatives, and this can be evidenced)	☐
e) An extension to, or partial replacement of goods, services or works by the existing supplier/ provider where a change in supplier/ provider would result in incompatibility with existing goods, services or works AND where the difference or incompatibility would result in disproportionate technical difficulties. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering	☐
f) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the CCG is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.	☐

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience.

INTERNAL REVIEWERS & SUPPORTERS

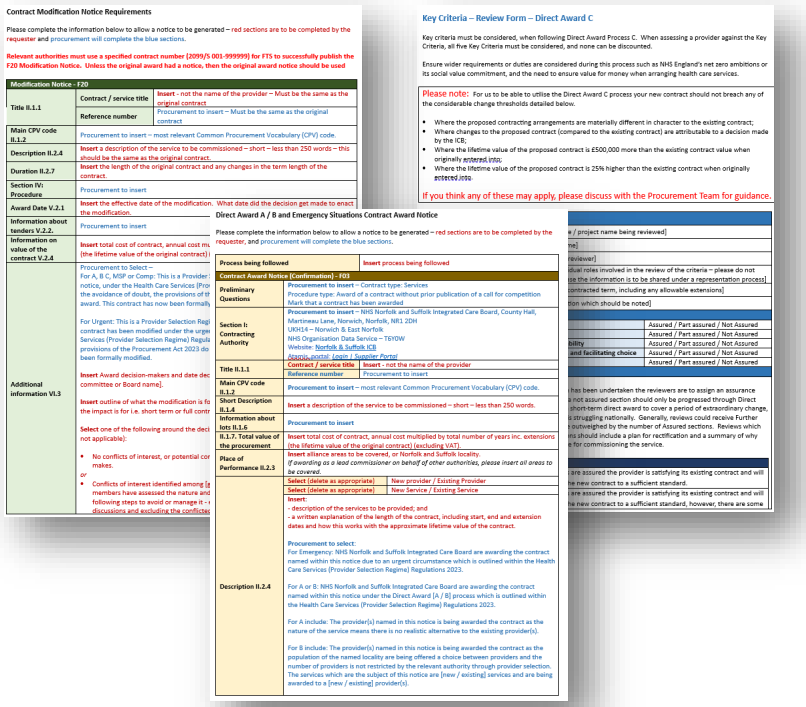
Waiver Originator and conflict of interest statement:	[Insert name (not signature) of waiver author]	
	I have no interest in the supplier that would constitute a conflict of interest.	☐
	I have an interest in the supplier and details are provided below:	☐
	[Insert details if an interest is declared]	
Select appropriate counter fraud statement including	***I confirm that the information given on this form is true, complete and accurate. If I supply false information, I am aware the matter may be passed to the***	

Waiver of Competitive Tendering Template

- In the NHS, commissioners are typically required to competitively tender contracts to ensure transparency, fairness, and value for money.
- This document is the mandatory governance form used by staff when there is a requirement to award a contract directly to a specific supplier, extend an existing contract, or make a repeat purchase.
- Key Sections included in the template:
  - Contract and Supplier Details
  - Background and Justification
  - Financial Information
  - Waiver Circumstances (Standing Financial Instructions)
  - Value for Money & Risk Management
  - Governance & Sign-off

Stage Three: Templates

LINK



Awards and Notices

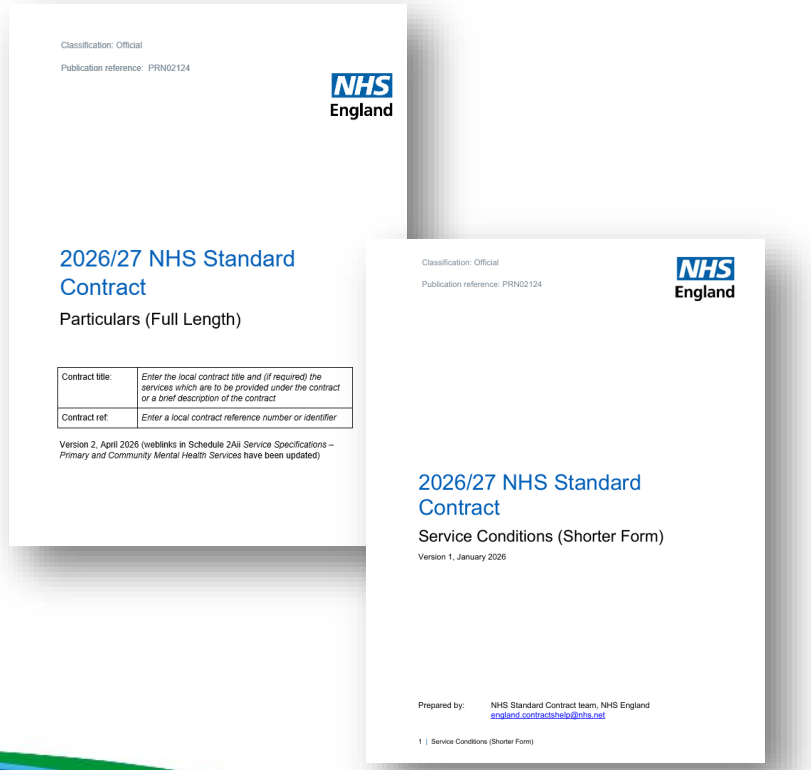
Procurement templates standardise the contractual, financial, and workforce data required across the ICB to legally authorise contract modifications and direct awards. Completing them accurately is critical to maintaining strict constitutional governance, preventing costly legal challenges under public contracting regulations, and fulfilling legal employment duties that protect transferring frontline staff. All contracts should include Key Performance Indicators (KPIs).

Templates include:

- **Direct Award A, B, and Emergency Notice Framework:** This template captures the essential contractual, financial, and decision-making data required to generate a formal ‘Find a Tender Service (FTS) F03 Confirmation Notice’ when a contract is awarded directly without prior publication, including during crisis or emergency situations.
- **Direct Award C Key Criteria Review Form:** Used specifically for Direct Award Process C, this form requires commissioners to objectively evaluate and assure a current provider against five un-discountable statutory criteria (Quality, Value, Integration/Sustainability, Access/Equalities, and Social Value) before a contract can be safely renewed without major material changes.
- **Contract Modification Notice (F20) Requirements:** This document acts as an information-gathering tool to publish an ‘FTS Modification Notice’ whenever an existing contract needs to be amended, capturing changes to term length, lifetime financial values, and the justification for the modification.
- **TUPE Data Collection Workbook:** A standardised workforce spreadsheet designed to safely capture anonymized, granular employment data (such as gross salaries, Agenda for Change bands, continuous service dates, and pension status) for staff members who would legally transfer to a new provider if a service is re-tendered.

Stage Three: Templates

LINK



Contracts and Grants

When and Why ICBs Develop Contracts

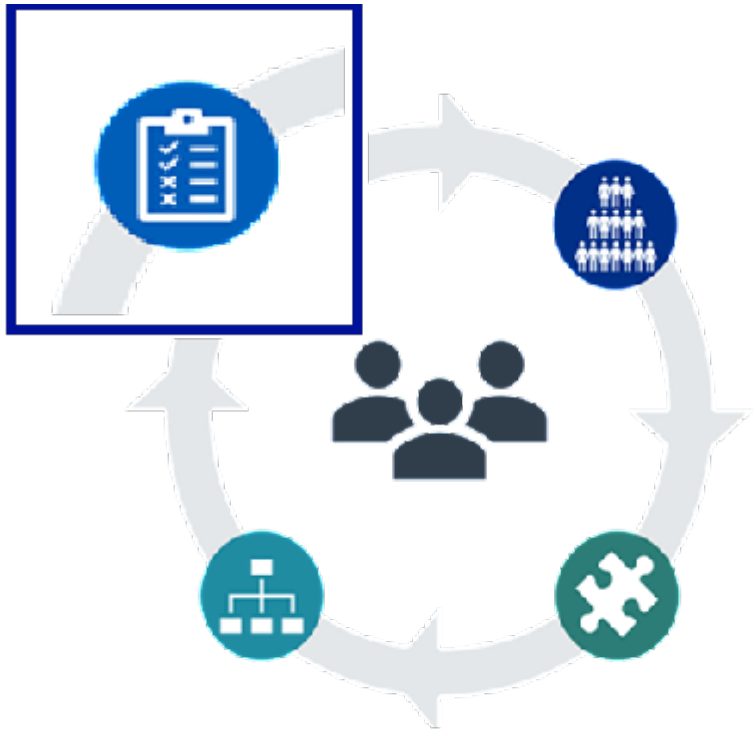
- **Legal & Governance:** Required to establish formal accountability, authorise public spend, and ensure robust value for money.
- **Quality & Safety:** Essential to legally bind providers to clinical safety standards and mandatory quality audits.
- **Strategic Delivery:** Used to lock in targeted outcomes that improve local care and reduce regional health inequalities.
- **Pathways & Changes:** Necessary when extending contract lengths, shifting financial parameters, or altering service models.

The 9 Types of Contracts Available

- NHS Standard Contract (Long Form) – Large-scale or complex healthcare services.
- NHS Standard Contract (Short Form) – Smaller, less complex clinical services.
- Grants – To support voluntary, community, and non-profit organisation schemes.
- LES / DES – Local or national enhanced services commissioned from GP practices.
- IT Contracts – Software licensing, digital systems, and remote hardware.
- T&Cs of Goods – Straightforward procurement of equipment and physical consumables.
- T&Cs of Services – Non-clinical professional, corporate, or operational services.
- T&Cs of Goods and Services – Combined agreements for physical supplies and maintenance.
- Frameworks

For expert advice on which framework to use, contact the **Contracts Team** (or the **Primary Care Team** for LES/DES).

Stage Four



Stage Four: Evaluating Impact

What: Understanding the effects, for whom and why.

Action: Work through steps in ICB evaluation reference guide to understand the nature of impact: scoping, planning and co-designing and conducting evaluation, making decisions and disseminating knowledge.

Output: Summary of clear evaluation findings and corresponding plans for action.

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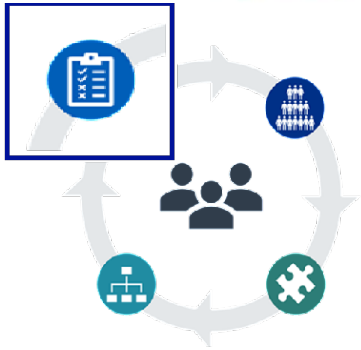
Stage Four: Introduction and Core Activity



Stage 4 is the implementation of the evaluation plan designed at stages two and three of the cycle, involving collection, analysis and interpretation of data and subsequent decision making for our next strategic iteration. Stage Four commences instantly after Stage Three has been completed, the contract should immediately begin to be performance monitored via the contracted Key Performance Indicators (KPIs) detailed in the contract.

The Learning Loop

- **4-to-1 Continuum:** Results directly feed back into Stage One to inform future ICB strategic activities.
- **Outcome Verification:** Return to the original Proposition Mandate to review if expected impacts were realised.
- **Evidence-Based Change:** Systematically identify "what works well" versus "what requires redesign."

.

Accountability

- **Proportionate Governance:** Ensure monitoring is adequate to support outcomes without creating undue burden.
- **Holistic Review:** Use qualitative (descriptive, non-numerical) and quantitative (numerical) data.
- **Sharing Best Practice:** Identify and disseminate “why" outcomes were achieved across the system.

ICB Evaluation Team Support: Access professional expertise for advising, coordinating, and supporting evaluations. All evaluation plans must be agreed up-front during stages 2 and 3 of the commissioning cycle.

Stage Four: Considerations

Effective evaluation requires a clear, co-designed and pragmatic evaluation approach (to be set out in the monitoring and evaluation plan during stages 2 and 3). Conducting evaluation should be guided by the evaluation plan's overarching evaluation question, aims, objectives and methods of data collection and analysis that address these. Evaluation reporting should be clear and actionable".

Metrics and Data

- ? Are outcome measures and monitoring realistically achievable?
- ? Have we avoided unnecessary reporting burden?
- ? Is there a clear owner for data quality and refresh cycles?
- ? Is there a clear line of sight from need to decision to outcomes?
- ? Does the data address the overarching evaluation question?

Governance and Risk

- ? Is the governance proportionate to risk, scale, and impact?
- ? Are escalation routes and decision rights clearly defined?
- ? Is the final decision supported by a robust evidence base?
- ? Have ethical considerations in relation to data collection and analysis been satisfactorily addressed?
- ? Is the data compatible with the original use for which the data was collected?

Strategic Feedback

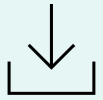
- ? How will learning feed back into future commissioning (Stage One)?
- ? Have we identified the mechanisms to translate findings into strategic iteration?
- ? Is there a clear and accurate interpretation of findings that will inform strategic decision making?
- ? Have evaluation outputs been discussed with stakeholders and plans made for prioritising actions and follow-up?

Stage Four: Resources

Activity	Example Resources (not exhaustive)	ICB Support Teams
Identifying Outcomes and Impact	**External:** Contract levers in the NHS Standard Contract, NHS Quality Strategy. **Internal:** Contract monitoring meetings / action logs, evaluation team short guide on evaluating outcomes and impact and guide on using evidence in strategic commissioning, evaluation plan and outputs, stakeholder input, outcomes dashboard.	**(1) Evaluation (2) Data & Commissioning Analytics (3) IG** Support with measurement & reporting
Identify stop, change & scale decisions	**External:** The Health Innovation Network, stakeholder input: local universities, York Health Economics Consortium, Healthwatch, Provider Safeguarding Assurance, OFSTED/CQC meetings, Provider Quality Reports, GP annual audit, Section 11. **Internal:** Outcome measures, patient and staff experience surveys, evaluation reports, stakeholder input, Contracting Safeguarding KPIs.	**(1) Evaluation (2) Safeguarding** Support with informed decision making based on outcomes, impact and evidence
Linking equity to value for money	**External: N**ational guidance and evidence such as Federated Data Platform (FDP), Get It Right First Time (GIRFT) , Quality Improvement (QI) methodologies, Model Health System and RightCare benchmarking. **Internal:** Health Equity Assessment Tool (national tool, local interpretation), Evaluation Reports.	**(1) Healthcare Intelligence (2) Health Equity** Support to link equity and VFM
Informing next steps	**External:** National training resources (when available). **Internal:** Evidence briefings, evaluation reports, and internal training.	**(1) Strategic Planning, Resilience & Change (2) Healthcare Intelligence** To loop back into Stage One

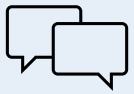
Section Three: Feedback and Resources

Section Three of this policy explains how to feedback and connects commissioners to enabling resources. As a reminder, this Policy is mandated for all commissioning activity, ensuring Norfolk and Suffolk ICB remains aligned with national standards while fostering a culture of continuous improvement.



A Mandated Framework

Aligning local decision-making with the National Strategic Commissioning Framework. This toolkit is our primary gateway for system-wide service redesign.



Iterative Co-Creation

This is a live document. As you apply the policy, your feedback is vital to ensure it is refreshed and improved to reflect best practice and evolving system needs.

Annual Toolkit Audit

The ICB will be audited annually for strategic commissioning capability across the full cycle, ensuring we maintain a leading evidence base for population health.

Capability & Skills

A comprehensive training needs analysis and dedicated development programme will be provided to enhance our strategic commissioning skills at all levels.

Was this helpful? We'd really like to hear from you!

Strategic Planning and Change Team: nwicb.strategicplanningteam@nhs.net

The remaining slides provide a description of team's core offers, links to specific resources and named contacts for each of the enabling functions across the ICB. Teams are listed in alphabetical order.

Enabling Teams: Strategic Commissioning Offer and Resources

Clinical Stewards

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

Clinical Steward is the clinical voice in strategic commissioning. Their role is to articulate what population value looks like for their pathway, define the outcomes and standards we should be commissioning, bring clinical credibility and population health intelligence to ICB strategic decisions, and act as a critical friend across providers in pursuit of those outcomes.

More of:
- Shaping commissioning intent and outcomes frameworks.
- Proactive clinical voice in strategic commissioning.
- Involvement across whole population pathways.

Less of:
- Advising on individual cases and pathways
- Reactive engagement with operational issues
- Involvement in fewer specialty decisions

Ownership and Delivery

Accountable for (We Own): Ensuring that decisions made by commissioning teams are clinically sound and aligned with system priorities, ensuring that health inequalities are considered across pathways, interpreting clinical evidence to support commissioning decisions, horizon scanning national guidelines and changes that will affect clinical pathways, identifying best practice and learning opportunities from outside the ICB system.

Responsible for (We Do): Bringing the clinical community on the improvement journey, identifying clinical stakeholders and coproduction opportunities, supporting negotiation with providers (regarding strategic programmes, not operational day to day issues), providing clinical advice to aligned programmes, identifying cross-programme themes and opportunities for collaboration.

Reference Points and Reports

National: What is stewardship and why does it matter to ICBs?

Local: Clinical Stewards are in place for: Cancer, Planned Care, Medicines, Norwich Place, West Norfolk Place, East Norfolk Place, West Suffolk Place, East Suffolk Place, CYP and Maternity, Urgent and Emergency Care, Mental Health (all age), Population Health Management, Inequalities, Fragility, End of Life, Long Term Conditions, Digital and Dental.

Policies and Templates

Combined Documents: None

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Remember we are clinical experts in our stewardship areas, not representatives of General Practice. Not all of us are GPs! Engage with us early within strategic planning, and we can help identify the clinical stakeholders required for co-production

Contact us: Contact individual stewards directly, or via Deputy Medical Directors (Dr David Brandon, Dr Mike Smith)

Communications and Engagement Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

We provide expert communications and engagement support for commissioning activity, leading system-wide stakeholder engagement, behavioural-change campaigns and aligned messaging to deliver coordinated commissioning.

More of: Providing strategic advice. Contact the team at the start of the commissioning process if you need advice. Engagement or consultation processes may need to be built in.

Less of: Unable to be embedded in individual teams. Onus on commissioning leads to flag potential issues, or positive PR opportunities to our team for advice and support.

Ownership and Delivery

Accountable for (We Own): Corporate website, intranet, media monitoring, newsletters, virtual staff briefing, Strategy Studio vodcast.

Responsible for (We Do): Informing/educating, engagement/consultations, handling parliamentary hub requests, producing press releases/statements/MP briefings, media training, media monitoring, maintaining social media, horizon scanning.

Reference Points and Reports

National: Understanding accessibility requirements for public sector bodies, BBC News style guide, NHE Statutory guidance

Local: Accessible information, House writing style guide

Intranet: Corporate branding and templates

Policies and Templates

Combined Documents: brand documents

Retained Documents: These can be found on the ‘archive’ area of the intranet

Predecessor Tools: None

Our Commissioning Pro-Tip:
If you’re considering significant change to a service, please contact our team to discuss. You may need to engage or consult with patients around how the changes may affect them.

Contact us: nwicb.communications@nhs.net

Contracts Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The Contracts Team ensures robust, compliant and value-for-money NHS contracts that support delivery of strategic plans, operational priorities and financial sustainability. We provide contracting expertise and assurance, working collaboratively with commissioners, providers and system partners.

More of: Strategic input into planning, proactive contract development and assurance, driving value for money, providing expert advice on contractual, regulatory and compliance requirements.

Less of: Reactive or ad hoc contracting without clear alignment to priorities, administrative or manual processes that do not add value, leading activities outside the core contracting remit.

Ownership and Delivery

Accountable for (We Own): Healthcare contracts, ensuring they are robust, compliant and deliver value for money, ensuring effective monitoring and assurance. Maintaining the integrity and governance of the ICB contract portfolio, including accurate contract records, audit and documentation controls. Ensuring contracts enable delivery of strategic commissioning priorities, alignment to financial plans, activity and system outcomes.

Responsible for (We Do): Negotiating, drafting, issuing and managing NHS contracts, service variations and other contractual requirements i.e. IAPs. Managing contractual processes such as activity queries, performance notices, risk logs and escalation routes. Providing expert advice on contract matters and outcomes across commissioning, service development and procurement

Reference Points and Reports

National: NHS Oversight Framework, NHS Strategic Commissioning Framework, NHS Standard, Goods and/or Services Contracts & Technical Guidance, Medium term planning framework, Choice regulation

Local: Medium Term Planning Framework, Service Reviews, checkpoint evaluations and business cases, Atamis database

Policies and Templates

Combined Documents: None

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Engage, there maybe different contracting options, every contract created creates BAU activity for all directorates. Set clear measurable outcomes aligned with review points. Always consider commissioning at scale.

Contact us: nwicb.contractsandprocurement@nhs.net

Data and Commissioning Analytics Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The Data and Commissioning Analytics Team provides analytical insight, performance intelligence and trusted data services to support commissioning, contracting and strategic decision-making across the ICB. We help turn complex data into clear evidence that supports oversight, planning, performance improvement and resource decisions. To create the space for more analytical support, our focus is increasingly on automation, consistent data models, self-service insight and reducing low-value reactive reporting.

More of: Strategic commissioning insight, Performance & contract intelligence, Automation & repeatable reporting, standardised data models, Self-service reporting through Insight Hub, Cross-team flexibility aligned to commissioning priorities, Evidence to support decision-making

Less of: Manual spreadsheet-based reporting, one-off ad hoc data requests, Duplicate reporting across teams, Reactive provider-led data drops, Unstructured “pet project” work, Low-value BAU reporting without strategic benefit.

Ownership and Delivery

Accountable for (We Own): Reporting standards and consistency. Data models and trusted insight. Prioritisation and work planning. Insight Hub and core reporting access. Data quality assurance

Responsible for (We Do): Board and committee reporting. Contract and performance analysis. Demand, capacity and pathway insight. Dashboard automation and development. Strategic analytical support. Dataset onboarding and task delivery

Reference Points and Reports

National: FDP, Making Data Count - Futures

Local: The Insight Hub, Request form

Policies and Templates

Combined Documents: The Insight Hub

Retained Documents None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Before requesting new analysis, check Insight Hub and existing standard reports, many common commissioning and performance questions may already have a trusted answer. Please also contact us at the start of your work

Contact us: Request form

Digital Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The ICB Digital function provides system leadership for digital strategy, architecture and assurance. We support ICB led digital programmes, adoption of automation and AI, digital skills development.

More of: Digital by design, optimising digital assets, digitally enabled pathways and workstreams.

Less of: Creating data silos, ad hoc standalone tools not aligned with national strategy.

Ownership and Delivery

Accountable for (We Own):
Digital strategy, direction, assurance and governance, Digital innovation and improvement.

Responsible for (We Do):
Manage a single, prioritised digital portfolio ensuring investment aligns to agreed architecture, interoperability and cyber guardrails.

Reference Points and Reports

National: NHS 10 Year Health Plan

Local: Population Health and Commissioning Strategy

Intranet: Digital Team Intranet Page

Policies and Templates

Combined Documents: None

Retained Documents: Service Specification Digital, Data and IG checklist

Predecessor Tools: None

Our Commissioning Pro-Tip:
Be Digital by Design, contact us at an early stage to discuss digital enablement

Contact us: nwicb.digital@nhs.net

Economic and Strategic Partnerships

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The Economic and Strategic Partnerships Team Lead the development of economic and strategic partnerships that improve population health and reduce inequalities, including Creative Health, health and housing, anchor institution programmes, employer engagement, major place-based initiatives, and infrastructure agreements. Secure external funding, provide strategic assurance, and strengthen system-wide collaboration to support inclusive growth, health equity, and improved outcomes.

More of: Providing strategic leadership, partnership expertise and practical support to enable system-wide improvement and reduce inequalities.

Less of: Reactive operational support, more strategic advice, partnership development and influencing partners and enabling system change.

Ownership and Delivery

Accountable for (We Own): Accountable for strategic direction for wider determinants of health, coordinating system partnerships, securing and managing external funding, delivering agreed programmes & ensuring alignment of economic, social and health inequality priorities across the system

Responsible for (We Do): Responsible for developing partnerships, coordinating delivery, influencing stakeholders, identifying opportunities & funding, sharing best practice, and supporting system priorities.

Reference Points and Reports

National: NHS commissioning » Armed Forces healthcare commissioning

NHS England » Strategic commissioning framework

https://ncch.org.uk/

Housing and health in local strategic health planning - GOV.UK

Policies and Templates

Combined Documents: Currently in progress frameworks/strategies for Creative Health, Health and Housing, Armed Forces, Employer/Anchor Institutions

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip: Connect the wider determinants of health to improve outcomes and reduce inequalities.

Contact us: louise.hardwick2@nhs.net

Estates

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The team provide strategic oversight, advice & guidance on the development, optimisation & use of system estate, & will provide support with the development of neighbourhood health through the integration of services across an optimised sustainable estate.

More of: Strategic advice, capacity mapping, void optimisation, business case oversight, strategic estate planning, medium term capital planning

Less of: Reactive space requests, unplanned estate changes, template completion

Ownership and Delivery

Accountable for (We Own): Estates Infrastructure Strategies, Neighbourhood Health Centre Pipeline, PCN Estate Strategies, 4-year GP estate capital plan.

Responsible for (We Do): Maximising estate utilisation, securing external funding, oversight of business case and estate capital investment, co-ordinating planning consultation responses, management GP rent & leases.

Reference Points and Reports

National: 10 Year Plan, https://www.england.nhs.uk/long-read/neighbourhood-health-centre-guidance-for-regions-and-integrated-care-boards/

Local: Estates Infrastructure Strategies, PCN Estates Strategies, 5 Year Population Health and Commissioning Strategy

Policies and Templates

Combined Documents: General Practice Estates Policy (in development)

Retained Documents: SNEE Estates Infrastructure Strategy, N&W Estates Infrastructure Strategy, Service Charge Policy

Predecessor Tools: None

Our Commissioning Pro-Tip:
Engage with the estates team as soon as possible to discuss your needs, the earlier were involved the easier it is to help find a solution.

Contact us: daniel.turner37@nhs.net & c.mcwalter@nhs.net

Evidence, Evaluation and Health Economics Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The team supports strategic commissioning through enabling ICB colleagues to access and use evidence effectively, plan and implement evaluation and use health economics considerations in decision making.

More of: Advice, guidance and training including where to access evidence and how to use it, how to design and oversee good evaluation, how to apply health economics principles in decision making.

Less of: Conducting evaluations

Ownership and Delivery

Accountable for (We Own): Evidence, evaluation and health economics guidance

Responsible for (We Do): Advising on evaluation planning, implementation and dissemination; good use of evidence; health economics input in planning and evaluation

Reference Points and Reports

National: 10 Year Plan, Medium Term Planning Framework, Strategic Commissioning Framework

Local: Guides on conducting health and healthcare care evaluation, on using evidence and on measuring impact in strategic commissioning, on ethical considerations in evaluation, and other resources addressing specific aspects of evaluation.

Policies and Templates

Combined Documents: Templates, checklists and guides to support evaluation planning and logic modelling

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Engage with us at the very beginning of your planning to ensure evidence and evaluation is appropriate, proportionate and used effectively.

Contact us: nwicb.eehub@nhs.net

Finance Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

Stewardship of Public Money to ensure NHS resources are used efficiently, effectively, and in line with regulations. Maintain financial control and governance. Safeguard against misuse, waste, or fraud.

More of Proactive finance business partnering to support timely and well considered business case development. Enabling financial considerations to be evaluated as part of strategic and operational service designs

Less of: Reactive and last-minute financial evaluations, leading to hold ups and rewrites.

Ownership and Delivery

Accountable for (We Own): Scheme of Reservation and Delegation (SORD), Business case financial template and register.

Responsible for (We Do): Maintaining Financial Ledger (IFSE2), Provider Finance Business Partnering support. Work with providers, and in conjunction with Commissioning and BI, to evaluate impact of transformation schemes.

Reference Points and Reports

National: NHSE Planning Framework, Government Accounting Manual, International Accounting Standards, Internal and External Audit services.

Local: Scheme of Reservation and Delegation (SORD), Business case investment evaluation / Return on Investment (ROI) process.

Policies and Templates

Combined Documents: SORD and templates to be on intranet soon. Use contacts below for documentation in the meantime.

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Contact finance as soon as possible. This will allow financial business partnering to be available from the outset.

Contact us: colinbright@nhs.net or julie.kerridge@nhs.net

Health Equity Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The health equity team provides expertise on health equity, ensuring it is embedded at the heart of commissioning, governance and performance. We provide strategic leadership, insight and practical support so that health inequalities and the wider determinants of health consistently inform priorities, investment and service design.

More of: Strategic advice & partnerships, expertise and practical support – enabling others

Less of: 'Doing' health inequalities for the organisation, the focus is on building capability across the org and wider system

Ownership and Delivery

Accountable for (We Own): NHSE Statement on Information on Health Inequalities/PSED compliance. Equality Delivery System (EDS2).

Responsible for (We Do): Monitoring unwarranted variation, supporting action (within the ICB and NHS providers) and reporting our impact
Developing and providing training, tools and practical support for commissioning
Developing and maintaining system strategic relationships that support health equity.

Reference Points and Reports

National: NHSE Statement on Information on Health Inequalities/ICB Health Inequalities Board Assurance Framework

Local: Health Inequalities Strategic Framework for Action

Intranet: https://nwknowledgenow.nhs.uk/content-category/healthcare-professionals/health-inequalities-resources-hub/

Policies and Templates

Combined Documents: This could link to EHIA, but it's not the only tool, we have a number on the resource hub - https://nwknowledgenow.nhs.uk/content-category/healthcare-professionals/health-inequalities-resources-hub/

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Everyone needs something, some people need more - sometimes variation is warranted, we need to aim for equity

Contact us: nwicb.healthinequalitiesconversation@nhs.net

Information Governance Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The IG Team provides expert guidance and support to enable commissioning activity. To ensure that patient and staff information is managed at all stages and in accordance with data protection legislation.

More of: Consistent and robust approach to strategic commissioning and ensuring that DPA is embedded in all stages.

Less of: Commissioned activity being delayed due to DPA and IG not being considered early enough

Ownership and Delivery

Accountable for (We Own): IG guidance, templates and policies on staff intranet, delivery assurance to NHSE on ICBs Data Protection Security Toolkit (DSPT) and in line with Data Protection and associated legislation.

Responsible for (We Do): Enabling commissioners with guidance and templates to ensure that data privacy by design is embedded in commissioning decisions.

Reference Points and Reports

National: NHSE national templates. Universal information governance (IG) templates - NHS England Digital ICO : https://ico.org.uk/for-organisations
DSPT: Data Security and Protection Toolkit

Local: Intranet: :Information Governance

Policies and Templates

Combined Documents: Risk Assessment & DPIA templates DPIAs & Risk Assessments, IG who we are

Our Commissioning Pro-Tip:
Always think about the data for the service you are commissioning, what happens at the end of the initiative – complete the exit / succession plan when agreeing the contract.

Contact us: nwicb.informationgovernance@nhs.net

Innovation

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The Innovation team's core offer is to support commissioners to identify and review innovations in health and care that deliver improved outcomes, quality and value. The team can support commissioners by providing across services, processes, products and technologies.

More of: [Strategic advice / Stage 1 design] horizon scanning, competitive and market insight, and structured assessment of impact, evidence base and regulatory considerations to inform commissioning decisions

Less of: Reactive ad-hoc data requests to review individual innovations

Ownership and Delivery

Accountable for (We Own): Liaison with innovation ecosystem partners, including InSite's, Health Innovation East, National Innovation Accelerator Programme

Responsible for (We Do): Innovator liaison and review; innovation network

Reference Points and Reports

National: NICE technology appraisal and highly specialised technologies guidance: the manual

Local: Innovation Toolkit

Policies and Templates

Combined Documents: pending release

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Engage early (Stage One) to ensure innovation is considered in the challenge identification and scope

Contact us: nwicb.researchinnovation@nhs.net

Medicines Optimisation

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The MO team is a multidisciplinary team including pharmacists, pharmacy technicians, and dietitians, which supports strategic commissioning of medicines, appliances, and nutrition borderline substances using population health data to inform and drive targeted initiatives to reduce health inequalities and improve outcomes. We deliver best value through co-development of effective medicines pathways. We work collaboratively across the system on medicines safety and antimicrobial stewardship.

More of: Involving the MO Team in all contract, service developments and commissioning intentions where medicines are involved

Less of: Reactive involvement in business cases and service specifications where local medicines commissioning arrangements exist

Ownership and Delivery

Accountable for (We Own): Supporting the system to make strategic, evidence-based decisions about medicines that improve population health and ensure best use of resources whilst meeting regulatory requirements.

Responsible for (We Do): Strategic medicines commissioning aligning safety, quality and cost-effective prescribing across the ICS.

Reference Points and Reports

National: NHSE Frameworks and pathways, NICE guidance and NICE Technology Appraisals (mandated implementation), NHSE Payment Scheme, Drug Tariff, Model ICB Medicines Optimisation Blueprint, National medicines optimisation opportunities (NHSBSA Dashboard)

Local: Formulary, TAG/IMOC decisions (medicines commissioning statements

Policies and Templates

Combined Documents: Pending release

Retained Documents: Medicines Optimisation (legacy Norfolk & Waveney, Knowledge NoW) or Medicines Optimisation (legacy Suffolk (password required))

Predecessor Tools: None

Our Commissioning Pro-Tip:
For any workstreams involving medicines, please contact the Medicines Optimisation Team as early as possible to provide expert advice

Contact us: nwicb.medsqueries@nhs.net

Partnerships, People and Communities

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The team provides expertise and guidance to help all colleagues within the ICB build and maintain effective strategic relationships with the diverse range of partners and people and communities across Norfolk and Suffolk.

More of: Looking outward to ensure genuine collaboration with partners, and that people with lived experience are included in conversations from the start.

Less of: 'Doing' partnership working, involvement and co-production for the ICB, our role is to build understanding and knowledge across the ICB and wider system.

Ownership and Delivery

Accountable for (We Own): Ensure the ICB meets its duty to involve people and communities in decisions about planning and commissioning of services and development of proposals for service changes. Ensure all stakeholders have a voice and are represented equally in decision making across the health and care system.

Responsible for (We Do): Leading strategic planning and oversight for how we work with partners including the voluntary and community sector, social care and people and communities to design, deliver and improve access to healthcare services.

Reference Points and Reports

National: NHS England » Working in partnership with people and communities: statutory guidance

Local: Lets Talk Health and Care and Cando Health & Care - Learning and Legacy Report

Policies and Templates

Combined Documents: Currently in progress to develop a new policy and toolkit for Working with Partners, People and Communities and a Reward, Recognition and Support Policy.

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
It's essential to involve and value partners and people with lived experience from the beginning, treating them as equals, valuing their knowledge, expertise and skills.

Contact us: rachel.jennings20@nhs.net

Place & Neighbourhoods

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

Strategic commissioning and service transformation across Place and neighborhoods. Taking a whole-pathway view from proactive care to intermediate care, to shift activity upstream, reduce acute pressure, and keep people supported in their communities. Partnership leadership, co-production and population health improvement.

More of: Strategic commissioning, contracting and outcome monitoring. Early engagement to shape integrated, outcomes-focused solutions using local insight and partnership working.

Less of: Operational project support and day-to-day service management. Less contract renewal by default; more needs-led commissioning. Late engagement leading to siloed service design, duplication and the need to retrofit integration..

Ownership and Delivery

Accountable for (We Own): Age Well, Die Well, Community Commissioning.

Responsible for (We Do): Lead Place partnerships and strengthen Alliance collaboration. Enable neighbourhood development and integrated working across partners. Ensure all new commissioning considers whether delivery can happen closer to home. Pathway leadership across proactive care, intermediate care and community services. Provide strategic leadership and commissioning expertise for community services and transformation, localised to Place.

The Place and Neighbourhood Teams provide leadership, coordination and support, but ownership for Neighbourhood Health sits across the whole system.

Reference Points and Reports

National: NHS Neighbourhood Health Framework, Neighbourhood health guidelines 2025/26 – NHS England NHS England » Standardising community health services NHS England » Next steps on neighbourhood health and new delivery models

Local: (Population Health Commissioning Strategy, PHIP, Commissioning Intentions)

Policies and Templates

Combined Documents: Community Services Specification (under development)

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip: Think Neighbourhood first – can what you are commissioning be delivered via a Neighbourhood model? Successful commissioning starts with outcomes, using shared ownership and co-design to shape solutions around local needs.

Contact us: Suffolk - nwicb.suffolkneighbourhoodteam@nhs.net

Norfolk: nwicb.nwneighbourhoodhealth@nhs.net

Population Health Management

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

PHM in Norfolk and Suffolk uses linked population data, analytics and scalable virtual support tools to help commissioners shift from reactive to proactive commissioning, enabling pathway redesign, targeted interventions, patient engagement and measurable outcomes.

More of: Analytical Support, Large Scale Project Delivery, Pathway Redesign and Supporting Direct Care interventions.

Less of: Requests for data that can be found on the insight hub.

Ownership and Delivery

Accountable for (We Own): PHM tools.

Responsible for (We Do): Intelligence Function: population segmentation, risk stratification, intelligence development, health economics, evaluation
PHM Delivery: use case development, pathway redesign, system integration and delivery at scale across health, care and common partners.

Reference Points and Reports

National: pending release

Local: PHIP, JSNA Chapters, Health Equity reports

Intranet: https://intelligencefunction.org/

Policies and Templates

Combined Documents: Pending release

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Think about evidence and evaluation throughout your project lifecycle, not just at the end, engage our team early – we can help.

Contact us: nwicb.phmdata@nhs.net

Primary Care Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

We provide commissioning oversight of primary care, ensuring delivery of contractual requirements while supporting improvement. We translate national and local priorities into clear commissioning intent, with delivery led by providers.

More of proactive, prioritised commissioning and support; population-focused approaches; clear expectations of independent contractors' role in system delivery

Less of reactive commissioning and support; organisation-focused approaches; unprioritised, request-led activity

Ownership and Delivery

Accountable for : Delegated commissioning responsibilities across all four primary care pillars (with vaccination programmes now included), contractual performance, quality, access and continuity of care. System oversight, assurance and proportionate escalation.

Responsible for : prioritising resource based on population need and variation; using PCAP to translate priorities into delivery. Commission local services to support Population Health Improvement Plan outcomes, providing support and intervention where required .

Reference Points and Reports

National: NHS England contractual requirements and guidance. National strategy and planning frameworks

Local: Primary Care Action Plan (PCAP) and IPR Reporting. Delivery Groups and Primary Care Governance

Policies and Templates

Combined documents: Delegated commissioning framework, including vaccination programmes; PCAP as the core commissioning and delivery framework
Retained documents: Existing contracts and local commissioned service (LCS/LES) specifications
Predecessor tools: Alignment of current processes into a single, consistent commissioning approach

Our Commissioning Pro-Tip: Avoid creating reactive activity at provider level without clear alignment to neighbourhood and system delivery Focus on population outcomes to support coherent provider development

Contact us: nwicb.generalpractice@nhs.net

Procurement & Market Management Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

Procurement covers obtaining goods or services and managing spend within the ICB. All spending must follow financial instructions, policies and regulations, with procurement and market management supporting strategic commissioning and value-driven decision-making.

More of: Strategic advice stage 3 of the commissioning cycle, and within stage 2 preparing the strategic direction for commissioning

Less of: Last minute procurement requests and reduced tender timelines.

Ownership and Delivery

Accountable for (We Own): Procurement policy & templates, PSR Annual Report, Atamis procurement, Market Management Policy & templates

Responsible for (We Do): Procurement processes including, decision on procurement route, Market Management review support

Reference Points and Reports

National: NHS Provider Selection Regime, Procurement Act 2023

Local: Norfolk & Suffolk ICB Procurement Policy

Intranet: Procurement

Policies and Templates

Combined Documents: Pending release

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Procurement should be involved early in commissioning to provide advice on market management, sourcing requirements, and any potential conflict or competition risks.

Contact us: procurement@snee.nhs.uk

Quality and Safety Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

We deliver the statutory duty to improve quality so that local people have access to safe and effective care that meets their needs and protects them from harm or abuse, ensuring that the quality, safety and experience of care we commission is a priority within the ICB.

More of: Robust quality oversight through contracts, strategic role, working with NHSE to escalate and manage quality risks.

Less of: Attendance at provider quality meetings. No capacity for operational clinical support into providers.

Ownership and Delivery

Accountable for (We Own): Quality standards, quality strategy, QEIA process, sign-off of provider Quality Accounts, ICB responsibility for IP&C and Health Protection. Adult Safeguarding and CYP Safeguarding.

Responsible for (We Do): Quality planning, control and improvement. System Quality Group, patient safety systems, contract and procurement input, escalation and management of quality risks and embedding NQB guidance.

Reference Points and Reports

National: Shared commitment to quality, Guidance on quality risk response and escalation in integrated care systems, Improving experience of care, Shared ambition for compassionate, inclusive leadership, national Infection Prevention and Control Manual.

Local: 5 Year Population Health and Commissioning Strategy

Policies and Templates

Combined Documents: QEIA documentation, Quality Visit Policy, Patient Safety Policies, Adult Safeguarding Policy, IP&C Policy.

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Start your QEIA early on in your commissioning activity and think about your evidence base, as well as how you plan to measure patient experience.

Contact us: nwicb.ics-incidents@nhs.net

Safeguarding All Age

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

We deliver the statutory duty across the lifespan to ensure effective and robust delivery of Safeguarding for our local population and services for Looked After Children and care leavers to protect them from harm or abuse within services we commission.

More of: Robust safeguarding oversight through contracts, strategic role, working with NHSE to escalate and manage safeguarding risks.

Less of: Less capacity for operational support for safeguarding for providers

Ownership and Delivery

Accountable for (We Own): Safeguarding Standards, statutory roles in safeguarding partnerships, adult, children and young people safeguarding and looked after children. Health system statutory review learning and primary care safeguarding.

Responsible for (We Do): Strategic leadership for health across all age safeguarding and looked after children, including MASA, CP-IS, FGM, SVD, maintaining safeguarding risk oversight, ensure statutory functions across the ICB are maintained in line with NHS statutory duties.

Reference Points and Reports

National: Safeguarding Accountability & Assurance framework 2026, The Care Act 2014, Working Together to Safeguard Children 2025, Promoting the Health of Looked After Children 2015, Children and Family Act 2026, Terrorism Act 2000, Domestic Abuse Act 2021, Children's Wellbeing in Schools Act 2026, FGM Act 2015,

Not exhaustive; these are the key documents.

Policies and Templates

Combined Documents: Safeguarding Children and Young People Safeguarding Policy. Adult Safeguarding Policy.

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Involve safeguarding early in all processes to ensure the safety and protection of our most vulnerable populations is the upmost priority.

Contact us: nwicb.designatesafeguardingteam@nhs.net

Strategic Planning and Change Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The team are available to provide advice and guidance on strategic commissioning (the whole cycle) and will provide support for strategic alignment for proposition mandates and business cases. We can support with developing strategies and strategic plans. We provide Board with assurance on delivery against the Strategy. We lead the planning cycle and provide direction on setting commissioning intentions.

More of: Strategic advice, strategic alignment, strategic planning, prioritisation, and medium-term planning

Less of: PMO support, template completion, ad hoc support.

Ownership and Delivery

Accountable for (We Own): 5 Year Population Health and Commissioning Strategy, Population Health Improvement Plan (PHIP), Operational Planning and the Strategic Commissioning Policy and Toolkit (and associated templates)

Responsible for (We Do): Leading Strategic Commissioning, Strategic Alignment, Strategic Planning and Big-Ticket Strategic Change Programmes.

Reference Points and Reports

National: 10 Year Plan, Medium Term Planning Framework, Strategic Commissioning Framework.

Local: 5 Year Population Health and Commissioning Strategy, PHIP, Strategic Commissioning Policy and Toolkit

Policies and Templates

Combined Documents: Strategic Commissioning Policy and Toolkit, Proposition Mandate Template, Business Case Template, Service Specification- Template, Strategic Plan Template. All found here

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Engage our team before you even put pen to paper on your change… the earlier the better, we can help get you started!

Contact us: nwicb.strategicplanningteam@nhs.net

Sustainability Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

Strategic and operational advice & support to reduce emissions & improve population health when planning and commissioning services. Subject matter expert on Green Plan delivery.

More of: Strategic advice / Stage one design to upstream sustainable procurement into service design

Less of: Reactive advice. Use the guides first.

Ownership and Delivery

Accountable for (We Own): Green Plan, Sustainability Impact Assessment (SIA), NHS NZ Supplier Roadmap; Carbon reduction plans & social value in procurement, NHS Climate Adaptation Framework, BAF climate resilience, ICS Air Quality Framework

Responsible for (We Do):
Leading & supporting other teams Green Plan Delivery, SME Impact assessments (SIA) & procurement, strategic & operational projects, TCFD GAM compliance? Trust S18 Standard Contract

Reference Points and Reports

National: Health and Care Act 2022 10 Year Plan, Delivering a net zero NHS, NHS Net Zero Supplier Roadmap, NHSE Green plan guidance, NHS Social Value Playbook Greener NHS: progress and forward look CQC well led Environmental sustainability

Local: 5 Year Population Health and Commissioning Strategy Council Air quality strategies, SCC draft climate HNA , N&S ICB Green Plan

Policies and Templates

Combined Documents: final version pending

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip:
Check the staff intranet page for guides and advice. Ensure you use the Sustainability Impact Assessment toolkit when creating any service or procurement.

Contact us: nsicb.sustainability@nhs.net

Women, Babies, Children, Young People (WBCYP)

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

Providing strategic leadership and oversight for WBCYP services. Commissioning for maternity ND and SEND aligned community paediatrics services including EoL and complex care. This includes key statutory functions (e.g. continuing care, CYP LD&A, Mental Health Act requirements (S117 aftercare), safeguarding, Youth Justice) and leading improvements in quality, safety, and outcomes across areas such as maternity. Providing SEND leadership within the organisation.

More of: Strategic, system-wide commissioning and leadership to deliver integrated, personalised services for WBCYP with complex needs and their families, working jointly across partners. Focus on outcomes, inequalities and opportunities for WBCYP.

Less of: Direct delivery, leadership and coordination of system programmes and provider activity, stepping back from convening, hands-on management and quality oversight roles.

Ownership and Delivery

Accountable for (We Own): Strategic commissioning, system leadership and assurance – setting direction, improving outcomes and reducing inequalities for WBCYP and complex care. Accountable for delivery of children's statutory function and SEND leadership. Leadership of ICB BCYP Network for staff to ensure the latest evidence, standards and national guidance is understood by those with responsibility for children service development.

Responsible for (We Do): Strategic Commissioning and quality– assessing, planning and funding services; manage key programmes and performance; provide expert advice and coordinate partners, with a shift to enabling and oversight rather than direct delivery.

Reference Points and Reports

National: SEND Reforms Families First Partnership, Best Start Family Hubs, Neighbourhood MDT Guidance for CYP

Policies and Templates

Combined Documents: None

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip: Take a whole life-course and whole-system approach focussing on outcomes and equity.

Contact us: nwicb.cypct@nhs.net

Strategic Workforce

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

By bringing workforce insight into commissioning decisions on service models, capacity, capability, affordability, risk, and deliverability throughout the cycle, we help ensure plans are realistic, sustainable, and able to achieve intended outcomes. The SWP Team provides advice and guidance ahead of and across all four stages of strategic commissioning, as workforce is a golden thread that connects strategic intent to service design, delivery planning, implementation, and review.

More of: Strategic Workforce Planning (SWP) provides a framework for analysing both the current and desired future position of the workforce, ensuring that services have the right people, with the right skills in the right place at the right time both now and in the future.

Less of: Looking at replacing 'like for like' roles and reviewing indicators such as headcount, sickness, turnover etc. Creating data silos, ad hoc requests, standalone tools not aligned with national strategy.

Ownership and Delivery

Accountable for (We Own): We own the quality, coherence, relevance, and practical value of workforce insight and advice across the commissioning cycle

Responsible for (We Do): We provide workforce analysis, strategic advice, options appraisal, risk identification triangulation, and planning assumptions to inform decisions on service models, capacity, capability, affordability, implementation, and review.

Reference Points and Reports

National: https://model.nhs.uk/; NHS Employers; Home - Skills for Care; The National Workforce Plan is due to be published, this will be included at this point

Local; Population Health Improvement Strategy; Home | Suffolk & North East Essex Training Hub; Norfolk and Suffolk Intelligence Function - Data analysis that inspires change; https://reporting.datahub.norfolkandsuffolk.ics.nhs.uk/ ; https://reporting.datahub.norfolkandsuffolk.ics.nhs.uk/pbi_report/primary-care-general-practice-workforce;

Policies and Templates

Combined Documents: Association of Health and Care Workforce Planning – Homepage - WRaPT | A strategic workforce planning tool for health and social care. - Six Steps Methodology to Integrated Workforce Planning® | Skills for Health

Retained Documents: None

Predecessor Tools: None

Our Commissioning Pro-Tip: Embedding workforce across the commissioning cycle ensures service ambitions are credible, affordable, and deliverable, with the capacity and capability needed to achieve outcomes both now and the future

nsicb.workforce@nhs.net

Work & Health Team

Our Strategic Commissioning Offer and Resources

Core Offer and Role Shift

The team provides expertise on economic development and reducing the barriers that health needs/disabilities have on employment, to improve health equity and life expectancy. We aim to ensure work & health and employment is embedded within commissioning, governance and performance.

More of: Integrated, proactive strategic commissioning with LA departments, DWP & system partners regarding the impact of employment/unemployment on health and health needs

Less of: Reactive or short term "sticking plasters" projects related to employment and wider determinants of health

Ownership and Delivery

Accountable for (We Own): National Work & Health programme compliance, Get Suffolk Working & Get Norfolk Working plan delivery, and ICB Economic Inactivity target (10 YP KPI)

Responsible for (We Do): Strategically lead the design, planning and commissioning of integrated system solutions to complex, multi-agency issues related to the root causes to unemployment, its impact, and interrelated health needs/disabilities.
Support with ICB strategic commissioning at system or neighbourhood level so that work & health/economic development are embedded, to assist with improved health outcomes, improved health equity and increased life expectancy and working life expectancy.

Reference Points and Reports

National: NHS 10 Year Plan, NHS Strategic Commissioning Framework, Get Britain Working, Keep Britain Working, Marmot review

Local: Intranet: ICB Work & Health Strategy – Fit for Work, Fit for Life
https://suffolkandnortheastessex.icb.nhs.uk/your-health-and-services/good-work-and-health/

Policies and Templates

Combined Documents: Norfolk and Suffolk ICB Economic Development Framework under development

Retained Documents: None

Predecessor Tools: SNEE Sustainability Impact Assessment

Our Commissioning Pro-Tip:

Employment has a significant impact on working aged people and their families, their health outcomes and life expectancy. Engage with us to help you improve these outcomes through often simple & low-cost approaches that can be embedded in your models of care.

Contact us: helen.bowles5@nhs.net

Thank you

Thank you for utilising the Norfolk and Suffolk Strategic Commissioning Policy and Toolkit. By following this cycle, you are ensuring that every pound we spend and every service we design is rooted in evidence and focused on equity.

Better Outcomes

Moving from measuring activity to achieving tangible health improvements for our residents

Reduced Inequality

Proactively reaching the most vulnerable voices in our community to close the health gap.

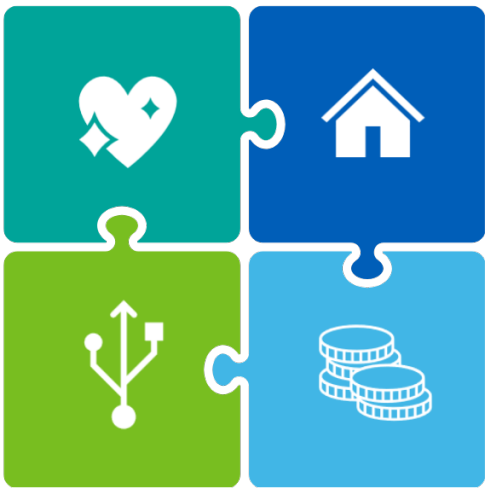
System Alignment

Ensuring Norfolk and Suffolk act as one cohesive system to deliver consistently high-quality care.

Our mission is to improve healthy life expectancy and ensure access to quality care for all. Together, we are turning that vision into a reality.

NHS
Norfolk and Suffolk
Integrated Care Board

<Title> Proposition Mandate



<Month Year Version>

1. Section One: Proposition Mandate Information

Proposition Mandate Title											
Directorate											
Senior Responsible Owner											
Author											
Date and Version											
Status	☐	Draft			☐	Final					
Type of Proposition	☐	Commissioning (No Proposition Mandate is required for decommissioning decisions)									
Trigger	☐	Safety	☐	Cost	☐	Regulation					
	☐	Demand	☐	Workforce	☐	Inequalities					
	☐	Strategy	☐	Reputation	☐	Other					
Trigger Detail											
Relevant Financial Year	☐	26/27	☐	27/28	☐	28/29	☐	29/30	☐	30/31	
Provider Impact	☐	Acute	☐	Community	☐	Ambulance					
	☐	Mental Health	☐	GP	☐	POD					
	☐	VCFSE	☐	None	☐	Other					
Funding Source											
Geography	☐	Norfolk	☐	Suffolk	☐	Norfolk and Suffolk	☐	Place			

Guidance Notes (delete this box before submission)

- This document is to be completed to provide the ICB with a suitable level of information to enable a decision to be made if resources should be invested in the commencement of a new commissioning decision.
- This is the first document you will complete and submit for decision for new commissioning decisions.
- You do not need to complete this document if you intend to decommission, you can go straight to a business case.
- This document is intended to be short; it should not be describing the solution.
- The document is intended to describe the problem, provide evidence of need and describe what outcomes look to be achieved.
- Headers are fixed. Do not delete headers. Sub Headers can be added.
- Some sections of the tables provide the author the option to select an option by clicking in the boxes, they will then be marked with a x
- Text written in black is to remain unless in <>.
- Text written in grey italics is guidance and should be deleted
- Text written in in green it is giving you an option to select
- The document review section must be completed prior to submission.
- The Strategic Planning & Change team can assist with alignment to Strategy & PHIP.

2. Section Two: Context

2.1. What decision is being sought

The proposition mandate is seeking approval to <commission / decommission / procure / scale / redesign> <*describe what you want to achieve (don't describe the problem)*>

2.2. Problem Statement

<What is failing today, who is affected. Do not describe what you want to improve just explain the problem. What is the root cause?>

<Insert text here>

2.3. Burning Platform

This is <urgent / important> now because <*detail why the ICB needs to act now*>

If the ICB does nothing, the consequence would be <*insert what would happen, what would be the harm, the cost, the risk etc*. >.

2.4. Evidence of Need

<This will be your biggest section. There are four key areas you must consider: lived experience; relevant previous commissioning lessons including pilots; provider performance including workforce; future demand forecasting.

< Key teams that can assist with advising what resources are available and how to use them, and supporting next steps include Healthcare Intelligence, Comms &

Engagement team (previous engagements), Partnerships, People & Communities, Primary Care, Places, Finance, People and Workforce, Medicines Optimisation.>

<Insert text here>

2.5. Outcomes

Start with the end in mind i.e. the improvement in health outcome(s) you want to achieve by doing this. Think about framing these outcomes around Clinical or Operational Outcomes, User/Stakeholder Outcomes, Sustainability & Value Outcomes. Key teams that can assist with advising you include the Healthcare Intelligence team.

<Insert text here>

3. Strategic Alignment

3.1. Alignment to our Four Ambitions

Ambition	Alignment
Sickness to Prevention: Focus more on preventing illness and supporting people to stay healthy for longer	☐
Care Closer to Home: Improve care in local communities and bring more specialist services back into the local health system	☐
Analogue to Digital: Use data and technology to make healthcare more efficient and easier to access	☐
Social and Economic Development: Work with partners to build stronger communities and tackle the wider factors that affect health	☐

3.2. Alignment to Our Three Outcomes

Outcome	Alignment
People living longer in good health • Increased healthy life expectancy across Norfolk and Suffolk • Reduced differences in life expectancy between communities	☐
Reduced unfair differences in health • Better health outcomes across different communities • More people supported to stay healthy for longer	☐
Better access to high-quality services • Shorter waiting times for tests and treatment, including cancer care • Faster ambulance response and emergency care • More appointments in primary care, pharmacy and dentistry • Shorter waits for community and mental health services	☐

3.3. Alignment to our immediate challenges

Immediate challenges (2026-27)	Alignment
Stabilise services and address urgent quality, performance and financial challenges	☐
Reduce waiting times and improve access to care	☐
Develop new ways of delivering care, including neighbourhood health services	☐

3.4. National, Regional and Local Policy Alignment

<Does this link to any national requirements the ICB must deliver? Are there any local policies that the ICB must deliver which are relevant to this mandate? If there is no alignment, completed this section with Not Applicable.>

<Insert text here>

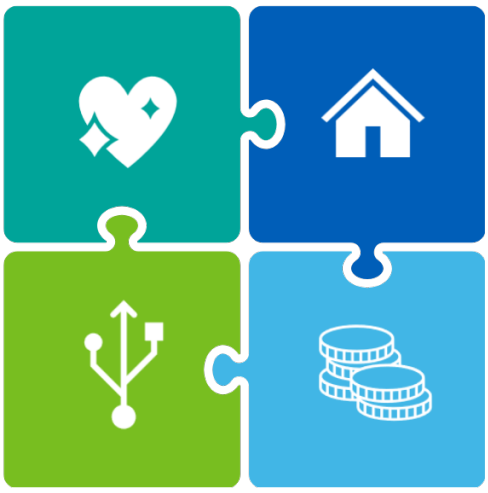
4. Document Review

Named leads that have reviewed this document prior to submission for approval.

Date	Function	Name
	Senior Responsible Owner	
	Contracts	
	Healthcare Function	
	Health Equity	
	People and Communities	
	Procurement	
	Strategic Planning and Change	

NHS
Norfolk and Suffolk
Integrated Care Board

<Title> Business Case



<Month Year Version>

Guidance Notes (delete this box before submission)

- A full Business Case (this document) is required if the financial implications total £500,000 or more. A Light Business Case can be used if the financial implications total less than £500,000.
- A Business Case must be completed when the ICB is in control of how money is being spent. This includes:
    - Commissioning a new service or initiative (of any value) under any circumstance
    - Decommissioning a service (including following service reviews)
- A Business Case is commenced once a Proposition Mandate has been approved in Stage One of the Strategic Commissioning framework (or following a service review). The business case development starts at the end of Stage One and concludes in Stage Two
- Some sections including section one: business case information can be copied from your approved proposition mandate.
- This document is intended to be detailed; it should provide the approver with all the detail they need to be able to make a fully informed decision.
- Headers are fixed. Do not delete headers. Sub Headers can be added.
- Some sections of the tables provide the author the option to select an option by clicking in the boxes, they will then be marked with a x
- Text written in black is to remain unless in <>.
- Text written in grey italics is guidance and should be deleted
- Text written in in green it is giving you an option to select
- The document review section must be completed prior to submission.
- The Strategic Planning & Change team can assist with alignment to Strategy & PHIP.
- The last page provides an image library to utilise should you wish to, delete the images from the last page before finalising.
- Do not use acronyms.
- Complete the Impact Assessments early in the process as they may shape your thinking.
- Complete Section 5 Key Function and Enabler Considerations early as they may inform your proposal.
- This document is the responsibility of the ICB Commissioner.

1. Business Case Information

Business Case Title											
Directorate											
Senior Responsible Owner				**Author**							
Date				**Version**							
Status	☐	Draft			☐	Final					
Type of Case	☐	Commissioning			☐	Decommissioning					
Trigger	☐	Safety	☐	Cost	☐	Regulation					
	☐	Demand	☐	Workforce	☐	Inequalities					
	☐	Strategy	☐	Reputation	☐	Other					
Trigger Detail											
Relevant Financial Year	☐	26/27	☐	27/28	☐	28/29	☐	29/30	☐	30/31	
Provider Impact	☐	Acute	☐	Community	☐	Ambulance					
	☐	Mental Health	☐	GP	☐	POD					
	☐	VCFSE	☐	None	☐	Other					
Funding Source											
Amount Requested											
Geography	☐	Norfolk	☐	Suffolk	☐	Norfolk and Suffolk	☐	Place			

2. Executive Summary

2.1. What decision is being sought

Copy and paste this section from your proposition mandate

This business case is seeking approval to <commission / decommission / procure / scale / redesign> <*describe what you want to achieve (don't describe the problem)*>

2.2. Problem Statement

Copy and paste this section from your proposition mandate.

<what is failing today, who is affected. Do not describe what you want to improve (this is covered in section 2.4 proposal) just explain the problem (be concise), and explain what the root cause is?>

<Insert text here>

2.3. Burning Platform

Copy and paste this section from your proposition mandate.

This is <urgent / important> now because <*detail why the ICB needs to act now*>

If the ICB does nothing, the consequence would be <*insert what would happen, what would be the harm, the cost, the risk etc.* >.

2.4. Proposal

The proposal should be informed by the market. This is a short summary of your proposal, the detail is included in section 4.4

< Provide a high-level summary of what you want to do, what are the components - be explicit. Use If we (the changed introduced) … Then (what changes) … Because (why it works) …>

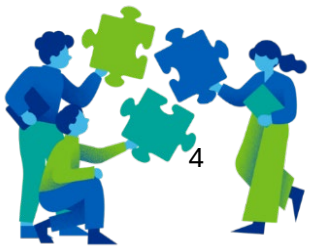
<Insert text here>

2.5. Outcomes

Build on the outcomes in you proposition mandate.

<Start with the end in mind i.e. the improvement in health outcome(s) you want to achieve by doing this.>

<Insert text here>



3. Strategic Case

<Work alongside the Strategic Planning and Change team to develop this section of your Business Case>

3.1. Alignment to our Four Ambitions

Ambition	Alignment	Why / how does it Align
Sickness to Prevention Focus more on preventing illness and supporting people to stay healthy for longer	☐	*Provide a short narrative to describe how the proposal addresses the ambition. Be concise. The Strategic Planning and Change Team can support. If there is no alignment state Not Applicable*
Care Closer to Home Improve care in local communities and bring more specialist services back into the local health system	☐	
Analogue to Digital Use data and technology to make healthcare more efficient and easier to access	☐	
Social and Economic Development Work with partners to build stronger communities and tackle the wider factors that affect health	☐	

3.2. Alignment to Our Three Outcomes

Outcome	Alignment	Why / how does it Align
People living longer in good health • Increased healthy life expectancy across Norfolk and Suffolk • Reduced differences in life expectancy between communities	☐	*Provide a short narrative to describe how the proposal addresses the outcome. Be concise. The Strategic Planning and Change Team can support. If there is no alignment state Not Applicable*
Reduced unfair differences in health • Better health outcomes across different communities • More people supported to stay healthy for longer	☐	
Better access to high-quality services • Shorter waiting times for tests and treatment, including cancer care • Faster ambulance response and emergency care • More appointments in primary care, pharmacy and dentistry • Shorter waits for community and mental health services	☐	

3.3. Alignment to our immediate challenges

Immediate challenges (2026-27)	Alignment	Why / how does it Align
Stabilise services and address urgent quality, performance and financial challenges	☐	*Provide a short narrative to describe how the proposal addresses the challenge. Be concise. The Strategic Planning and Change Team can support. If there is no alignment state Not Applicable*
Reduce waiting times and improve access to care	☐	
Develop new ways of delivering care, including neighbourhood health services	☐	

3.4. National and Regional Policy and Requirement Alignment

Copy and paste this section from your proposition mandate.

<Does this link to any national requirements the ICB must deliver? Are there any local policies that the ICB must deliver which are relevant to this mandate? If there is no alignment, completed this section with Not Applicable.>

<Insert text here>

4. Context and Case for Change

4.1. Introduction and Background

<Set out the Why: Briefly describe the current landscape. What specific event or data trend triggered this business case? Strategic Alignment: Mention how this proposal fits into the ICB overarching ambitions or outcomes. Identify the difference between the current state (where we are) and the desired state (where we need to be).>

<Insert text here>

4.2. Rationale for Change

<This builds on the problem statement, provide in detail the rationale of why the change is needed and the justification of why the ICB should approve the business case to make it happen>

<Insert text here>

4.3. Evidence of Need

<Build on section 2.4 from your proposition mandate. There are four key areas you must consider: lived experience; relevant previous commissioning lessons including pilots; provider performance including workforce; future demand forecasting>

<You must provide detail about the current baseline; this will help assess the options in later sections. Include information about the current position, e.g. this number of beds or this number of admissions etc.>

< Key teams that can assist with advising what resources are available to evidence need, and supporting next steps: Healthcare Intelligence, Comms & Engagement (for previous engagement), Partnerships, People & Communities, Economic & Strategic Partnerships & Health Equity, Primary Care, Places, Finance, People and Workforce, Medicines Optimisation.>

<Insert text here>

4.4. Proposal, Critical Success Factors and Scope

<Proposal: Provide information of the intended intervention / proposal. This section must include the outcome of the market engagement undertaken using the proposition mandate (unless this follows a service review). This section should include the clinical model being proposed.

Considerations: How does this address inequalities, what is the impact on deprived communities (drawn on your EQIA), what is the impact on Core20PLUS5. What evidence has informed the proposal?

Critical Success Factors: What are the must-haves for this to work? (e.g., staff buy-in, specific technology, or a set budget).

Scope: Be explicit about what is included and, crucially, what is out of scope to prevent scope creep>

<Insert text here>

4.5. Risks, Constraints and Dependencies

<Risks: Identify potential hurdles (financial, reputational, or operational) and briefly note how they might be mitigated.

Constraints: Note the fixed limits you must work within (e.g., a hard deadline, legal regulations, or a capped budget).

Dependencies: What else needs to happen for this to succeed? (e.g., "Success depends on the new community diagnostic centre opening by Q3").>

<Insert text here>

4.6. Implementation

<Describe the critical path milestones and the target "go-live" date. Ensure you have documented the key areas for operational readiness / what must be in place (for example., recruitment/ workforce, IT integration, or training) before the first patient/service user is seen)>

4.7. Evaluation Plan

<Build on your outcomes section in the proposition mandate.>

< Develop a plan for evaluation that addresses the outcomes and impacts you want to achieve. Think about framing these outcomes and impacts in a logic model around Clinical or Operational Outcomes, User/Stakeholder Outcomes, Sustainability & Value Outcomes.

In planning, consider how will you approach evaluation, what is the scope of the evaluation, what methods will you use.

Key teams that can assist with advising you include the Evidence and Evaluation team.>

<Insert text here>

5. Key Functions and Enabler Considerations

You are required to engage with a series of ICB teams during the development of this business case. Teams will provide you with a recommendation statement to insert into this section. The recommendation statement should help shape your thinking and should therefore be done early in the Business Case process. The recommendation statement does not need to be an endorsement. The recommendation statement should not be responded to by the commissioner.

This section of the business case sets out a series of recommendations from ICB key functions and enablers.

5.1. Contracts

<The contracts team ensures that commissioned healthcare services are legally secure, financially viable, and held to strict standards of safety and quality. They manage the entire contractual lifecycle—from drafting and negotiation to performance monitoring—ensuring that providers deliver value for money and meet the strategic health needs of the local population.>

The Contracts teams have been engaged during the development of this business case. The statement below is provided by the Contracts team.

<Insert statement>

5.2. Digital

<To ensure clinical safety and data security, any initiative involving patient-facing care or sensitive information must utilise approved, secure digital systems rather than informal tools like spreadsheets or generic email. Business cases must detail how digital solutions enable the entire pathway—from referral to outcome—while prioritising national platforms to avoid duplication and ensure system integration. All proposed technology must meet rigorous cyber security and information governance standards, ensuring that data is shared securely across multidisciplinary teams. Furthermore, the case must proactively address digital inclusion and accessibility to ensure that new technology expands care access rather than creating barriers>

The Digital team have been engaged during the development of this business case. The statement below is provided by the Digital team.

<insert statement>

5.3. Estates

<Estates is a key enabler to the transformation and delivery of services across the system. Utilisation of the right estate in the correct location supports the physical delivery of services to the patient population as well enabling the delivery of digital solutions and supporting non-patient facing teams and tasks.

The identification, selection and adaptation of the correct estate takes time, resource, and funding and therefore the estate requirements need to be considered and resolved early in the process for commissioning or adapting of any services.>

The Estates team have been engaged during the development of this business case. The statement below is provided by the Estates team.

<insert statement>

5.4. Healthcare Intelligence

< The ICB Healthcare Intelligence function transforms data, analytics, and research evidence into actionable insights that drive strategic decision-making and population health management. By evaluating service performance and identifying local health inequalities, this function enables the ICB to commission effective, evidence-based care that directly improves patient outcomes>

The Healthcare Intelligence team have been engaged during the development of this business case. The statement below is provided by the Healthcare Intelligence team.

<insert statement>

5.5. Innovation

<Innovations in health and care may include a process, a service, a product or technology, which represents a step change on what has gone before, that when implemented results in better health and care.>

The Innovation team have been engaged during the development of this business case. The statement below is provided by the Innovation team.

<Insert the statement from innovation here>

5.6. Medicines Optimisation

< The Medicines Optimisation Team supports the system to make strategic, evidence-based decisions about medicines that improve population health and ensure best use of resources. The Medicines Optimisation Team should be sighted on any business case that involves or impacts medicines use so a recommendation can be provided >

The Medicines Optimisation team have been engaged during the development of this business case. The statement below is provided by the Medicines Optimisation team.

<Insert the statement from Medicines Optimisation here>

5.7. People and Communities

<The Partnerships, People and Communities team supports strategic commissioning to build and maintain effective relationships with the diverse range of people, communities and partners across Norfolk and Suffolk. In order to understand what matters to people and communities and why, and to inform the development of services that are responsive to local needs, it is vital that we work in genuine and equal partnership and provide opportunities and tools for all voices to be heard.>

The People and Communities team have been engaged during the development of this business case. The statement below is provided by the People and Communities team.

<insert statement>

5.8. Procurement

<Procurement is the act of obtaining or buying goods or services and covers all spend undertaken within the ICB. The procurement team is responsible for providing advice, guidance and procurement process leadership for all healthcare and non-healthcare spend. They ensure all spend is undertaken in accordance with internal governance requirements and in line with external regulations and legislation. All competitive processes are to be undertaken by the procurement team; and they will support with direct awards (contracts and grants), further competition under frameworks and quotations.>

<The contracts team ensures that commissioned healthcare services are legally secure, financially viable, and held to strict standards of safety and quality. They manage the entire contractual lifecycle—from drafting and negotiation to performance monitoring—ensuring that providers deliver value for money and meet the strategic health needs of the local population.>

The Procurement team have been engaged during the development of this business case. The statement below is provided by the Procurement team.

<Insert statement>

5.9. Strategic Planning and Change

<The Strategic Planning and Change team provide strategic leadership to bridge the long-term vision (the strategy) with operational reality (delivery of the PHIP) by spearheading the approach to strategic commissioning and leading the annual planning cycle, prioritising investments, ensuring commissioning decisions are strategically aligned, ensuring rigorous governance and overseeing the successful delivery of transformative change that improves population health outcomes.>

The Strategic Planning and Change team have been engaged during the development of this business case. The statement below is provided by the Strategic Planning and Change team.

<insert statement>

5.10. Quality

<Quality is essential in providing system assurance and promoting improvements in health and wellbeing across care for our population. The team set expectations, monitor and triangulate qualitative and quantitative data, drive improvements through collaborative working and ensure our statutory responsibilities are met especially for Infection and prevention Control and Safeguarding. ICB quality is taking a population approach in addressing health inequalities. The goal is to support the system in being safe, effective, and well-led.>

The Quality team have been engaged during the development of this business case. The statement below is provided by the Quality team.

<insert statement>

5.11. Workforce

<Strategic Workforce Planning is the process of understanding current and future workforce needs to ensure the right people, with the right skills, behaviours and aptitude are in the right roles at the right time. It involves bringing together short-term operational planning and longer term strategic insight to align and redesign the workforce with organisational priorities, future service demand and population needs in a sustainable and equitable manner.>

The Workforce team have been engaged during the development of this business case. The statement below is provided by the Workforce team.

<insert statement>

6. Economic and Commercial Case

6.1. Option Analysis

	Option One (Minimalist)	Option Two (Intermediate)	Option Three (Maximum)
Summary *<A brief description of this specific approach>*			
Indicative Cost *<Provide a high-level estimate of the investment required (capital and ongoing revenue)>*			
Indicative Outcomes *<What would this specific option achieve? (Note: "Do Nothing" usually results in*			

	Option One (Minimalist)	Option Two (Intermediate)	Option Three (Maximum)
negative outcomes)>			
Pros *<The benefits, strengths, and opportunities of this route>*			
Cons *<The drawbacks, costs, and risks associated with this route.>*			

6.2. Recommended Option

<Provide a clear, justified conclusion. State clearly which option is being recommended for approval. Summarise why this option is superior to the others. Focus on the balance between cost, risk, and the ability to meet the Critical Success Factors. Briefly outline the immediate actions required if the business case is approved (e.g., "Initiate procurement" or "Begin recruitment").>

<Insert text here>

6.3. Contractual Model

6.3.1. Contract Structure

< Specify the contract type, overall duration, and any applicable break clauses or termination triggers. Clearly outline the performance milestones required for delivery, alongside the risk-sharing arrangements that explicitly define which partner carries the operational and financial risk>.

<Insert text here>

6.3.2. No Wrong-Pocket Mechanism

<Detail the financial or contractual frameworks designed to ensure that benefits and risks are equitably distributed across all system partners. Specifically, outline the mechanism used to either: (a) recycle acute care savings back into community investment, (b) hold acute trusts accountable for converting freed capacity into cash or activity, or (c) prevent community providers from carrying recruitment risks while acute trusts capture the financial upside.>

<Insert text here>

6.3.3. Payment Mechanism

<Outline how providers will be reimbursed by specifying whether the model utilises a block, activity, blended, capitation, or outcomes-based payment structure. Clearly justify how the chosen mechanism aligns financial incentives with your project's strategic goals and risk-sharing preferences.>

<Insert text here>

7. Financial Case

Note: This section must be completed with finance. To support the development of section 7 a full financial appraisal workup must also be completed, this template can be found here (this section summaries the full workup).

7.1. Costing

Value Requested	**£**
Recurrent or non-recurrent	(Recurrent / Non-Recurrent)
Funding Stream	
Payment Mechanism	(Block / Variable etc)
Current Status	(Existing / Enhancement to Existing / New)
• Status Details	
Spend Type	(Pay / Acute / Non-Pay)
• Amount	
• Description	

7.2. Activity

Note: This section must be completed with business intelligence.

Output Summary	
Narrative What are you getting for your money (e.g. beds, workforce etc.)	
Numerical How many are you getting (e.g. 6 beds, 1 WTE band 6 nurse etc)	

Impact Summary	
Narrative What does your output drive (e.g. shorter length of stay, avoided admissions, fewer ambulances, fewer admissions etc.)	
Numerical Quantify the impact (e.g. 10 avoided admissions, 30 fewer ambulances	

7.3. Return on Investment

	26/27	27/28	28/29	29/30	30/31	5 Year Total
Investment						
Cash out						
Non-cash out saving						
Cash avoided						
ROI Cash out						
ROI Total						

8. Appendix A: Document History and Reviews

8.1. Document History

Date	Version	Author	Changes
	0.1		
	0.2		
	1.0		

8.2. Document Review:

Named leads that have reviewed this document prior to submission for approval

Date	Function	Named Lead
	Senior Responsible Owner	
	Contracts	
	Digital	
	Estates	
	Finance	
	Health Equity	
	Healthcare Intelligence	
	Innovation	
	Medicines Optimisation	
	People and Communities	
	Place (as appropriate)	
	Procurement	
	Quality	
	Strategic Planning and Change	
	Sustainability	
	Workforce	

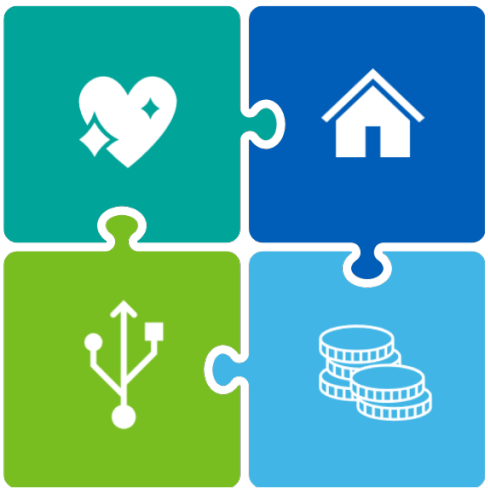
9. Appendix B: Impact Assessment Checklist

Impact Assessment	Date approved at Impact Assessment Group
Equalities Impact Assessment (EIA)	
Quality Impact Assessment (QIA)	
Sustainability Impact Assessment (SIA)	
Data Protection Impact Assessment (DPIA)	

Image Library – delete this page before submission

NHS
Norfolk and Suffolk
Integrated Care Board

<Title> Light Business Case



<Month Year Version>

Guidance Notes (delete this box before submission)

- A Light Business Case can only be used if the financial implications total less than £500,000 (full contract value). A full Business Case is required if the financial implications total £500,000 or more.
- A Business Case must be completed when the ICB is in control of how money is being spent. This includes:
    - Commissioning a new service or initiative (of any value) under any circumstance
    - Decommissioning a service (including following service reviews)
- A Business Case is commenced once a Proposition Mandate has been approved in Stage One of the Strategic Commissioning framework (or following a service review). The business case development starts at the end of Stage One and concludes in Stage Two
- Some sections including section one: business case information can be copied from your approved proposition mandate.
- This document is intended to be detailed; it should provide the approver with all the detail they need to be able to make a fully informed decision.
- Headers are fixed. Do not delete headers. Sub Headers can be added.
- Some sections of the tables provide the author the option to select an option by clicking in the boxes, they will then be marked with a x
- Text written in black is to remain unless in <>.
- Text written in grey italics is guidance and should be deleted
- Text written in in green it is giving you an option to select
- The document review section must be completed prior to submission.
- The Strategic Planning & Change team can assist with alignment to Strategy & PHIP.
- The last page provides an image library to utilise should you wish to, delete the images from the last page before finalising.

1. Light Business Case Information

Business Case Title											
Directorate											
Senior Responsible Owner				**Author**							
Date				**Version**							
Status	☐	Draft			☐	Final					
Type of Case	☐	Commissioning			☐	Decommissioning					
Trigger	☐	Safety	☐	Cost	☐	Regulation					
	☐	Demand	☐	Workforce	☐	Inequalities					
	☐	Strategy	☐	Reputation	☐	Other					
Trigger Detail											
Relevant Financial Year	☐	26/27	☐	27/28	☐	28/29	☐	29/30	☐	30/31	
Provider Impact	☐	Acute	☐	Community	☐	Ambulance					
	☐	Mental Health	☐	GP	☐	POD					
	☐	VCFSE	☐	None	☐	Other					
Funding Source											
Amount Requested											
Geography	☐	Norfolk	☐	Suffolk	☐	Norfolk and Suffolk	☐	Place			

2. Executive Summary

2.1. What decision is being sought

Copy and paste this section from your proposition mandate

This business case is seeking approval to <commission / decommission / procure / scale / redesign> <*describe what you want to achieve (don't describe the problem)*>

2.2. Problem Statement

Copy and paste this section from your proposition mandate.

<what is failing today, who is affected. Do not describe what you want to improve (this is covered in section 2.4 proposal) just explain the problem (be concise), and explain what the root cause is?>

<Insert text here>

2.3. Burning Platform

Copy and paste this section from your proposition mandate.

This is <urgent / important> now because <*detail why the ICB needs to act now*>

If the ICB does nothing, the consequence would be <*insert what would happen, what would be the harm, the cost, the risk etc.* >.

2.4. Proposal

The proposal should be informed by the market.

< Provide a high-level summary of what you want to do, what are the components - be explicit. Use If we (the changed introduced) … Then (what changes) … Because (why it works) …>

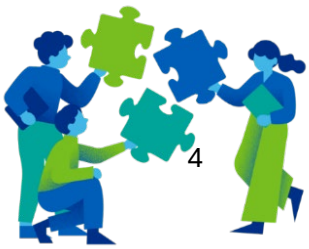
<Insert text here>

2.5. Outcomes

Build on the outcomes in you proposition mandate.

<Start with the end in mind i.e. the improvement in health outcome(s) you want to achieve by doing this.>

<Insert text here>



3. Strategic Case

< Briefly summarise how this proposal aligns with the ICB's core strategic priorities >

<Insert text here>

3.1. National and Regional Policy and Requirement Alignment

<Does this link to any national requirements the ICB must deliver? Are there any local policies that the ICB must deliver which are relevant to this mandate? If there is no alignment, completed this section with Not Applicable.>

<Insert text here>

4. Context and Case for Change

4.1. Introduction and Justification

<Build on your proposition mandate. Briefly describe the current landscape and the rationale of why the change is needed, what is evidence describes the need. Identify the difference between the current state (where we are) and the desired state (where we need to be).>

<Insert text here>

4.2. Proposal and Scope

<Proposal: Provide a high-level summary of the intended intervention. Scope: Be explicit about what is included and, crucially, what is out of scope to prevent scope creep>

<Insert text here>

4.3. Risks and Dependencies

<Risks: Identify the top three hurdles (financial, reputational, or operational) and briefly note how they might be mitigated.

Dependencies: What else needs to happen for this to succeed? (e.g., "Success depends on the new community diagnostic centre opening by Q3").>

<Insert text here>

4.4. Implementation

<Describe the critical path milestones and the target "go-live" date. Ensure you have documented the key areas for operational readiness / what must be in place (for example., recruitment/ workforce, IT integration, or training) before the first patient/service user is seen)>

<Insert text here>

4.5. Evaluation Plan

<Build on your outcomes section in the proposition mandate. Develop a plan for evaluation that addresses the outcomes and impacts you want to achieve. Think about framing these outcomes and impacts in a logic model around Clinical or Operational Outcomes, User/Stakeholder Outcomes, Sustainability & Value Outcomes. In planning, consider how will you approach evaluation, what is the scope of the evaluation, what methods will you use. Key teams that can assist with advising you include the Evidence and Evaluation team>

<Insert text here>

5. Key Functions and Enabler Considerations

You are required to seek a specialist statement from key function and enabler teams if there is a likely impact (e.g., "Does this project involve a new digital system? If yes, consult Digital. If no, skip.").

This section of the business case sets out a series of recommendations from ICB key functions and enablers.

Key Function and Enabler	Engagement Required? (Yes / No)	Name of Enabler Function Lead and date engaged
Contracts and Procurement		
Digital		
Estates		
Intelligence Function		
Innovation		
Medicines Optimisation		
People and Communities		
Strategic Planning and Change		
Quality		
Workforce		

<insert statements (if yes ticked about) from relevant key functions and enabler>

6. Economic and Commercial Case

6.1. Preferred Option

<Provide a clear, justified option. Summarise why this option is superior to 'do nothing'. Briefly outline the immediate actions required if the business case is approved (e.g., "Initiate procurement" or "Begin recruitment").>

<Insert text here>

6.2. Contractual Model

6.2.1. Contract Structure

< Specify the contract type, overall duration, and any applicable break clauses or termination triggers>.

<Insert text here>

6.2.2. Payment Mechanism

<Outline how providers will be reimbursed by specifying whether the model utilises a block, activity, blended, capitation, or outcomes-based payment structure.>

<Insert text here>

7. Financial Case

Note: This section must be completed with finance. To support the development of section 7 a full financial appraisal workup must also be completed, this template can be found here (this section summaries the full workup).

7.1. Costing

Value Requested	**£**
Recurrent or non-recurrent	(Recurrent / Non-Recurrent)
Funding Stream	
Payment Mechanism	(Block / Variable etc)
Current Status	(Existing / Enhancement to Existing / New)
• Status Details	
Spend Type	(Pay / Acute / Non-Pay)
• Amount	
• Description	

7.2. Activity

Note: This section must be completed with business intelligence.

Output Summary	
Narrative What are you getting for your money (e.g. beds, workforce etc.)	
Numerical How many are you getting (e.g. 6 beds, 1 WTE band 6 nurse etc)	

Impact Summary	
Narrative What does your output drive (e.g. shorter length of stay, avoided admissions, fewer ambulances, fewer admissions etc.)	
Numerical Quantify the impact (e.g. 10 avoided admissions, 30 fewer ambulances	

7.3. Return on Investment

	26/27	27/28	28/29	29/30	30/31	5 Year Total
Investment						
Cash out						
Non-cash out saving						
Cash avoided						
ROI Cash out						
ROI Total						

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8.2. Document Review:

Named leads that have reviewed this document prior to submission for approval

<if there is no requirement for review, please state N/A>

Date	Function	Named Lead
	Senior Responsible Owner	
	Intelligence Function	
	Contracts and Procurement	
	Digital	
	Finance	
	Health Equity	
	Innovation	
	Medicines Optimisation	
	People and Communities	
	Quality	
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Image Library – delete this page before submission

NHS
Norfolk and Suffolk
Integrated Care Board

<TITLE> Strategic Plan

<Month Year Version>

Guidance Notes (delete this box before submission)

- This document is not an operational plan; it should remain strategic and high level.
- Headers are fixed. Do not delete headers. Sub Headers can be added.
- To update the context table, click ‘References’ tab, click ‘Update Table’.
- Text written in black is to remain
- Text written in grey italics is guidance and should be deleted
- Text in orange should be replaced with the name of your strategic plan.
- The last page provides an image library to utilise should you wish to, delete the images from the last page before finalising.

1. Introduction and Context

1.1. Purpose of the Strategic Plan

This Strategic Plan describes the multi-year high-level plan for achieving the long-term goals and objectives for <name>. This <name> Strategic Plan provides a framework for future decision-making, ensuring strategic alignment and clear prioritisation for delivery.

1.2. Introduction and Background

Provide a high-level overview of why this plan is being developed now. Define the core problem or opportunity this strategic plan addresses. Briefly mention the history of the service or area and how this links the overarching ambition of the ICB.

<insert your text here>

1.3. Scope of the <name> Strategic Plan

Clearly define the boundaries. Specify which services, age groups, or geographical areas are included—and, crucially, what is out of scope. This prevents "mission creep" and manages stakeholder expectations regarding budget and delivery.

<insert text>

1.4. National Policy Context

Summarise the legislative and mandatory drivers. Reference specific Acts of Parliament, White Papers, or National Health/Social Care frameworks. Explain how these national mandates dictate the "must-dos" for this strategic plan.

<insert text>

1.5. Local Policy Context and Strategic Alignment

Connect the plan to the local landscape. Detail how this plan supports the delivery of the ICB Population Health and Commissioning Strategy, the Population Health Implementation Plan, including Commissioning Intentions. Use this space to show that the strategic plan isn't working in a vacuum but is actively contributing the wider organisational objectives.

<insert text>.

2. Evidence Base

2.1. Population Needs

Detail the current and future demographics of the specific population cohort. Focus on prevalence rates, health inequalities, and protected characteristics. Highlight "at-risk" groups and explain how their needs are expected to change over the life of the plan.

<insert text>

2.2. Data Insights

Present the "hard" evidence. Include key performance indicators (KPIs), current spend vs. budget, activity levels, and benchmarking against peer areas. Use data to identify gaps in current provision or areas of over-expenditure.

<insert text>

2.3. Lived Experience Insights

Incorporate the "soft" intelligence. Summarise findings from consultations, engagement workshops, or surveys with service users and their families. Use quotes or case studies to illustrate the human impact of the current state and what users want from the future.

<insert text>

3. <Name> Strategic Plan

3.1. Vision

State a concise, aspirational vision for the strategic plan. What will the world look like in 3 to 5 years if this plan is successful? It should be memorable, inspiring, and easy for partners to rally behind.

<insert text>

3.2. Outcomes

Define what success looks like in measurable terms. Focus on Outcomes (e.g., "Increased independence") rather than Outputs (e.g., "Number of assessments completed"). Think about person level outcomes and system level outcomes. Use the SMART acronym (Specific, Measurable, Achievable, Relevant, Time-bound).

<insert text>

3.3. Approach to Commissioning

Describe the commissioning model. Will you use a neighbourhood model, lead-provider framework, or spot-purchasing – think about scale? Explain how you will move from the current state to the future state (e.g., moving from residential-based care to community-based support).

<insert text>

3.4. Approach to Prioritisation

Explain how decisions will be made when resources are limited. Detail the criteria used to rank projects or services—such as return on investment (ROI), clinical safety, or statutory compliance.

<insert text>

3.5. Design Principles

Define the fundamental rules that will govern how services are shaped and delivered. These principles serve as a decision-making framework to ensure consistency throughout the commissioning lifecycle.

<insert text>

4. Delivering the Strategic Plan

4.1. Approach to Delivery and Implementation

Outline the "how." Who is responsible for the heavy lifting? Mention whether delivery will be phased and identify the key workstreams (e.g., Workforce, IT/Digital, Estates) required to make the plan a reality. Describe the service configuration (if known).

<insert text>

4.2. Approach to Evaluation

Define how you will monitor progress. Specify the frequency of reviews and the methodology (e.g., Social Value frameworks or Quality Assurance audits). How will you know if the plan needs to be "pivoted"?

<insert text>

4.3. Governance

Map out the decision-making hierarchy. Identify the Project Board, the Senior Responsible Officer (SRO), and the reporting lines to committees. Include a brief mention of transparency and accountability measures.

<insert text>

4.4. Risks

Identify the "showstoppers." List high-level strategic risks (e.g., financial volatility, provider failure, or legislative changes) and provide a summary of the mitigation strategies in place to manage them.

<insert text>

4.5. Planning Assumptions

State the "knowns" you are relying on. For example, "Assumes a 2% uplift in funding" or "Assumes the completion of the new community hub by Q3." If these assumptions prove false, the plan may need revision.

<insert text>

4.6. Dependencies

List the things outside your direct control that must happen for this plan to succeed. This might include the delivery of a separate IT transformation project or the recruitment of specific clinical staff by a provider.

<insert text>

4.7. Timescales

Provide a high-level roadmap. Include key milestones such as the procurement launch, "Go-Live" dates, and formal review periods. A visual Gantt chart or timeline graphic is highly recommended here.

<insert text>










Strategic Commissioning Policy and Toolkit Frequently Asked Questions

The questions detailed below were raised (or derived from discussion) during the Strategic Commissioning Policy and Toolkit Peer Review. If you have any further questions or require any additional support in relation to the application of the Strategic Commissioning Policy and Toolkit, please contact the Strategy, Planning and Change Team.

Training and Development

Q1. What national training will be available to support ICB staff to support the implementation of Strategic Commissioning?

A. A large scale national Strategic Commissioning Development Programme is available. The programme comprises five interconnected elements, whilst the Commissioning Academy foundational offer is available to all staff (available here **The Commissioning Academy - Futures**),all other elements are focused on specifics and staff will be invited to join these sessions.

Q2. What local training will be available to support ICB staff to support the implementation of Strategic Commissioning?

A. A full Organisational Development (OD) programme is being developed to support our staff, the programme will include:

- Health Economics
- Being Evidence Led
- Finding Data
- Evaluation Skills
- Being Outcomes Focused
- Co-Production
- Completing Templates
- Understanding Finances
- Change Management
- Working with the Market

Dates and availability will be shared on the intranet in the coming weeks.

Q3. How will we share best practice and lessons learned across the ICB to ensure continuous improvement in our ability to strategically commission?

A. Sharing best practice and lessons learned is important if we want to continue to grow and mature as Strategic Commissioners. No defined way has yet been developed, but it is in the pipeline.

Q4. Is there a plan to have a list of all new Proposition Mandates and Business Cases on the intranet, so all staff know what is on the horizon and in development?

A. Yes. There is a plan to create this shared space – we will let you know when it is live.

Q5. Will there be any training on how to get 'lived experience' in a consistent way?

A. Yes. There will be a training offer on “being evidence led” and an offer on “finding data”, these will include lived experience. There will also be a training offer on “co-production”.

Scope and Proportionality

Q6. What is in scope and out of scope of the Strategic Commissioning Policy and Toolkit?

A. All decisions that require the ICB to invest money, make a commissioning or decommissioning decision are in scope. Any investment where the ICB has no control over how the money is spent is out of scope (pass through monies).

Q7. Would a contract variation require the use of the Strategic Commissioning Policy and Toolkit and a Business Case?

A. Yes. We are custodians of a large amount of money, and we need to ensure we are spending it appropriately. With this in mind, we need to evidence the need, and understand what the outcomes are, how it is best to commission (i.e. the 4 stages of the commissioning cycle). Even with a contract variation we would still need to understand these things to ensure a contract variation is the correct solution.

Q8. How do we ensure the Strategic Commissioning Policy and Toolkit is used proportionally for small scale investments?

A. Small scale investments that total under £500,000 (full contract value) can be developed using a Light Business Case. Remember, as strategic commissioners we should be looking to commission at scale and deliver at place (we should be avoiding lots of small investments as this is not strategic). Think about collaborations or partnerships when commissioning with the VCSFE or small providers.

Q9. Does the Strategic Commissioning Policy and Toolkit apply regardless of funding / investment sources?

A. The Strategic Commissioning Policy and Toolkit applies to commissioning decisions where the ICB has influence over how the money is spent (regardless of the source of the funding or investment) e.g. if we receive ringfenced funding for mental health, we still have influence over the solution. If the ringfenced funds can only be issued to a single provider for a completely scoped service (i.e. we have absolutely no influence on the solution) then there is no need to apply the policy - as this is classed as 'pass through' monies.

Q10. Does the Strategic Commissioning Policy and Toolkit apply to decommissioning decisions?

A. Yes.

Q11. Does the Strategic Commissioning Policy and Toolkit apply to internal projects?

A. Yes.

Q12. Does the Strategic Commissioning Policy and Toolkit apply to the scaling up of pilots?

A. Yes.

Q13. Does the Strategic Commissioning Policy and Toolkit apply to very short-term initiatives, for example seasonal (winter) funding?

A. Yes. The Strategic Commissioning Policy and Toolkit applies to commissioning decisions of any length - planning for short term funding should be just as well informed and planned

as any other initiative, this is to ensure all money and resource is correctly strategically spent - we are no longer transactional buyers.

Q14. Is there a flexible / bedding in approach to Strategic Commissioning?

A. No. As of 01 April 2026, all ICBs are required to operate as Strategic Commissioners. The Strategic Commissioning Policy and Toolkit provides structure to this process; there are no shortcuts or bypasses. We must start as we mean to go on.

Capacity and Time

Q15. Is there capacity within the ICB teams to enable the full strategic commissioning cycle can be followed?

A. Implementing and following the full strategic commissioning cycle is not optional. All teams are working with fewer resources; we should be planning our commissioning with capacity in mind.

Q16. How long will it take to complete the whole strategic commissioning cycle?

A. There is no set timeframe - it will depend on the decision required. A small commissioning decision could be completed within two months, bigger decisions with long procurements may take over 12 months.

Each stage will require a workup; Stage One will require data gathering and development of a Proposition Mandate. Stage Two will require internal team engagement, completion of impact assessments and a finance work up and the development of a Business Case. Stage Three may require a procurement exercise and Stage Four could start instantly after stage three completes. The length of each of these stages is very dependent on the scale and decision required.

For approvals: a Proposition Mandate requires a one stage approval at the relevant committee. A Business Case will require a minimum of a two-stage approval (the relevant committee and at the Strategic Commissioning Committee (except for Neighbourhood and Primary Care items, which will take second stage approval from Place Committee) and possibly at the ICB Board (if the value exceeds the committee delegated amount).

Q17. Is there potential to automate some or all of the strategic commissioning cycle or use digital solutions to support with team capacity and time?

A. Yes, potentially. Digital teams will support the scoping of this.

Q18. For the teams who need to be consulted with through this process (enabling teams) are there generic contact details (rather than individual email addresses) to avoid individuals being overloaded?

A. Yes. Contact details for teams are detailed in section three of the Strategic Commissioning Policy and Toolkit.

Q19. Has the review of commissioning Business Cases been built into the workplans of each of the enabler teams, to ensure they have capacity and to minimise delays with turnaround?

A. It is hard to anticipate the required workload when we don't know what is yet on the horizon, but it is everyone's responsibility, as part of our new strategic commissioning organisation, to prioritise activity that supports delivery against this key national requirement.

Wider Health and Care System

Q20. Is feedback being sought from the County Councils, District Councils and Public Health?

A. This is an internal ICB policy and toolkit, our wider system will be engaged when we have agreed the final version to ensure there is a system wide understanding on how we will be commissioning moving forwards. The system is aware they will have more involvement in designing solutions as this is a national mandate.

Q21. Are providers aware of these changes; have they been engaged?

A. This is an internal ICB policy and toolkit, our wider system will be engaged when we have agreed the final version to ensure there is a system wide understanding on how we will be commissioning moving forwards. Providers are aware they will have more involvement in designing solutions as this is a national mandate.

Q22. Who counts as a "partner," and how should they be involved?

A: True strategic commissioning means moving away from "doing for" towards "doing with" (co-production). Partners include local authorities, provider collaboratives, housing associations, and the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector.

You must involve partners and people with lived experience from the beginning of Stage One to jointly shape problem definitions, rather than engaging them only when it is convenient or partway through the process.

Please also note that in some work with providers at the business case stage, we need to be wary of perceived and actual conflicts of interest and therefore it may be necessary to engage existing and potential providers through a formal market engagement process in the first instance (i.e. via publication of a Prior Information Notice), to ensure we don't contravene procurement regulations. Please take further advice from the procurement team when planning work with providers.

Strategic Commissioning Practicalities (Stages 1 to 4)

Q23. In Stage One we have to gather data, is there a standard way we can access this data?

A. The Healthcare Intelligence team is the go-to team to support with finding baseline data. The Strategic Commissioning Policy and Toolkit provides information about resources available and how to contact enabling teams.

Q24. In Stage One, Stage Two and Stage Four, how will we assure ourselves, through data, lived experience, and evaluation, that people and communities' involvement is influencing decisions and delivering the intended population health outcomes?

A. You should draw on clear metrics, feedback loops and evaluation processes, triangulating quantitative data, lived experience insight and outcome evaluation, to routinely evidence how involvement is shaping the commissioning decision and improving population health outcomes. The Strategic Commissioning Policy and Toolkit provides information about resources available to help and how to contact enabling teams that can support.

Q25. Should patient complaint data be utilised in Stages One, Two and Four?

A. Yes.

Q26. Who manages the bit between Stage Three and Four? Are commissioners still responsible for ongoing service reviews / contracts / operation meetings once a service is live?

A. Commissioners hold ultimate responsibility for every stage of the cycle. Including oversight of on-going delivery and evaluation once new provision is operationalised.

Q27. In Stage Four how will qualitative outcomes be captured?

A. You will define this in your Evaluation Plan (developed in Stage Two). Projected qualitative outcomes could be captured through structured qualitative methods, such as interviews, feedback loops and case studies, embedded within commissioning processes and evaluated systematically alongside quantitative data.

Q28. What is the difference between a Logic Model and a Theory of Change?

A: Both are required to bridge high-level strategy with delivery, but they serve distinct purposes:

- Theory of Change (The "Why"): A backward-mapped strategic roadmap used upfront during co-design. It deconstructs the underlying philosophy of why changes should happen and stress-tests assumptions and risks.
- Logic Model (The "What & How"): A tactical, linear operational blueprint. It maps physical inputs directly to activities, outputs, and near-term measurable outcomes for KPI and operational tracking.

<u>Templates (Proposition Mandates, Business Cases, Impact Assessments, Evaluation Plans and Service Specifications)</u>

Q29. For jointly commissioned service (with the Local Authority) will the new templates be accepted at their approval groups?

A. This is unlikely at the current time. Each organisation in the system has different statutory duties to fulfil and as such the reporting requirements and business templates will differ. It is worth engaging with the partner early on to avoid duplication where possible. The use of AI can support with transferring documents across different templates.

Q30. Are there any project tools available, such as project plans and workbooks?

A. The PMO capacity was significantly reduced in the restructure - this means the ability to support with development of project plans and highlight reports will not be available. The PMO arm of the Strategic Planning and Change Team can provide some project templates, you can contact the team here. Documentation supporting strategic commissioning (Proposition Mandates, Business Cases, Evaluation Plans and Service Specifications) has been developed and is available on the intranet here.

Q31. Are the Impact Assessments linked solely to the NHS or are we to consider and document potential wider impacts on other organisations / services / patients?

A. Impact Assessments should be completed through a system lens looking at all impacts across the system and our population.

Q32. When can I use the Light Business Case instead of the full Business Case?

A. The Light Business Case can be used if the total financial implication is less than £500,000 for the contractual term. For example, if the contract value of a service is £200,000 in total the Light Business Case can be used, but if the contract value of a service is £200,000 per year and the contract was for three years the Light Business Case cannot be used (as this would total £600,000).

Q33. If a provider is writing the Business Case, should they use our version or theirs?

A. If the decision will be made at an ICB Committee the ICB template should be used. The ICB Commissioners should be jointly responsible for the development of the Business Case to ensure ICB enabling teams are engaged and support the work up (including Quality, Equality, Sustainability, Information Governance, Safeguarding, Digital, Estates, Workforce, Strategic Planning, Contracts, Procurement etc.). If ICB funding is being utilised the relevant ICB Committee approving investment will need evidence that the Strategic Commissioning Policy and Toolkit and key templates have been applied.

Q34. Section 5 of the Business Case requires commissioners to receive statements from enabling teams, do these statements have to be endorsements (e.g. supportive)?

A. Early engagement with the enabling teams is important, the teams may help shape your thinking about your solution. The statements are recommendations, not endorsements. The approval committee can decide to disregard the recommendation should they chose. The statements do not require a response from the commissioners.

Q35. Do I need to complete a Proposition Mandate before every Business Case?

A. If your Business Case looks to commission a service, extend or vary a contract or issue a grant then you must complete and get approval of a Proposition Mandate beforehand. If your Business Case looks to decommission a service you do not need to complete a Proposition Mandate, you can go straight to developing a Business Case.

Q36. Who is responsible for the development of the Service Specification?

A. The commissioner holds the responsibility. Support is available from the Contracts Team for help and advice.

Q37. What is a Proposition Mandate, and when do I write one?

A: The Proposition Mandate is completed during Stage One. Its purpose is to describe a population problem and evidence of need - not to describe the solution. It must be approved by the relevant committee before you are allowed to progress to Stage Two.

Exception: You do not need a Proposition Mandate if you are explicitly decommissioning a service; you can go straight to developing a Business Case.

Q38. Where do I find financial delegations, committee structures, and templates?

A: All mandatory templates (including Proposition Mandates, Business Cases, and Evaluation templates) are hyperlinked within the policy toolkit document. For financial hierarchies, committee lines, and sign-off routes, consult the Governance Handbook on the intranet.

Norfolk and Suffolk
Integrated Care Board

Strategic Commissioning Policy and Toolkit Change Control Log

Note: all changes documented took place on v7.3 draft moving into v1.0 Final

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT01	02	Contents	Amendment	Pages and page numbers updated
PT02	06	What is Strategic Commissioning	Amendment	Change of word order from 'commissioning, decommissioning or service redesign' to commissioning / service redesign or decommissioning'
PT03	08	ICB Strategy and PHIP	Amendment	Provides clarity that the five-year plan is to be delivered alongside the Strategy and PHIP (not before).
PT04	09	Translating Strategy to Delivery	New Slide	Creation of a new slide that provides information on how to move from strategic priorities to delivery and outcomes
PT05	10	What is actually different	New Slide	New slides that compares the old world to the new, detailing what should stop (or reduce) and what to focus on from a day-to-day perspective
PT06	12	Strategic Commissioning Principles	Amendment	Equity and Inclusion principle now includes mention of wider determinates of health.

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT07	12	Strategic Commissioning Principles	Amendment	Quality, Value and Sustainability principle now includes mention of local employment, reducing health inequalities and regeneration.
PT08	12	Strategic Commissioning Principles	Amendment	Quality, Value and Sustainability principle now includes safety
PT09	12	Strategic Commissioning Principles	Amendment	Evidence based and digital first principle now includes innovation
PT10	12	Strategic Commissioning Principles	Amendment	Evidence based and digital first principle, continuous learning now reads: Formal evaluation must track outcomes and value for money to drive iterative improvement.
PT11	13	Strategic Commissioning Cycle	Amendment	Stage Four re-worded. What: Understanding the effects, for whom and why. (was 'measuring success') Action: Work through steps in ICB evaluation reference guide to understand the nature of impact: scoping, planning and co-designing and conducting evaluation, making decisions and disseminating knowledge (was: 'Complete analysis of the outcomes (data and lived experience) using the evaluation framework. Undertake service reviews. Make service adaptations as required.')

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
				Output: Summary of clear evaluation findings and corresponding plans for action (was: a completed evaluation framework')
PT12	13	Strategic Commissioning Cycle	Amendment	Stage Two output now includes… A fully costed Business Case (including evaluation outline plan)
PT13	14	Scope and Proportionality	New Slide	New slides that covers when the policy should be used and what templates apply – using scenarios to help.
PT14	15	ICB Statutory Duties	New Slide	New slide that explains how each stage of the commissioning cycles supports us to deliver our statutory and legal duties
PT15	19	Involving Partners, People and Communities	Amendment	Change in language and re-work of 'The Journey to Co-production' section to 'The Spectrum of Involvement'
PT16	20	Reducing Health Inequalities	New Slide	New slide providing and overview on inequalities and a series of principles to follow to ensure health equity.
PT17	21	Working with the Market	New Slide	New slide summarizing how we should engage, manage and work with the market throughout the four stages
PT18	22	Working With Clinical Stewards	New Slide	New slide that explains what Clinical Stewards are and how they work across the system and add value to strategic commissioning cycle

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT19	23	Commissioning All Age Services (Life Course Approach)	New Slide	New slides that describes what all-age commissioning means and how it fits into the strategic commissioning cycle
PT20	24	What Does Good Co-Commissioning Look Like	Amendment	New detail regarding pooled budgets
PT21	26	Governance and Getting Approvals	Amendment	Strategic Commissioning Committee (SCC) wording updated. Reads 'The SCC provides formal approval for all Proposition Mandates and Business Cases (except Place) following approval at the relevant Committee'
PT22	28	Strategic Commissioning Cycle Pathway	New Slide	New slide that provides the commissioning cycle as a clear pathway for commissioners to follow
PT23	29	Strategic Commissioning Cycle Checklist	New Slide	New slide that provides high level checklists for commissioners to use when working through the stages of the commissioning cycle
PT24	31	Stage One: Introduction and Core Activity	Amendment	Reference made to horizon scanning, innovation insights, best practice.
PT25	31	Stage One: Introduction and Core Activity	Amendment	New section - Research and evaluation: Evidence from local and national evaluations, other research evidence (academic and grey literature)
PT26	31	Stage One: Introduction and Core Activity	Amendment	Makes reference to the Proposition Mandate being developed using a theory of change / logic model

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT27	32	Stage One: Considerations	Amendment	Voice and experience now includes complaints data
PT28	32	Stage One: Considerations	Amendment	Problem and Need now includes ‘Are there any learning from Safeguarding or Quality?’
PT29	32	Stage One: Considerations	Amendment	Addition of ‘Has system wide evidence been synthesised’ into ‘Problem and Need’ consideration.
PT30	32	Stage One: Considerations	Amendment	Addition of ‘Is there a national mandate / requirement?’ ‘Problem and Need’ consideration.
PT31	34	Stage One: Resources	Amendment	Expansion of internal resources to include ‘and support with access to sources and critical appraisal of evidence’
PT32	34	Stage One: Resources	Amendment	Expansion of internal and external resources to make references to Safeguarding
PT33	34	Stage One: Resources	Amendment	Change of activity name from ‘Provider and Partner Engagement’ to ‘Contract and Service Baseline’
PT34	37	Stage Two: Introduction and Core Activities	Amendments	Clarity provided that commissioners need approval from Committees to move money around the wider system.
PT35	37	Stage Two: Introduction and Core Activities	Amendments	Makes reference to the Business Case being developed using a theory of change / logic model

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT36	37	Stage Two: Introduction and Core Activities	Amendments	Additon that informs the commissioners that the solution should be informed by existing evidence, evaluation and pipeline innovations (not just local design preferences).
PT37	38	Stage Two: Considerations	Amendment	Clinical and Model considerations now include ‘Have we understood the opportunities for innovation?’
PT38	38	Stage Two: Considerations	Amendment	Impact and Compliance considerations now include ‘Has evaluation information been reviewed and considered?’
PT39	38	Stage Two: Considerations	Amendment	Impact and Compliance considerations now include ‘Has the supplier completed a Digital Technology Assessment Criteria (DTAC)?’
PT40	39	Stage Two: Resources	Amendment	Additon of Quality in ‘Embedding quality, inequality, sustainability & IG considerations’
PT41	40	Stage Two Templates: Business Case	Amendment	Reference has been made to engaging teams for Section 5 (recommendations) early in the Business Case process
PT42	42	Stage Two Templates: Impact Assessments	Amendment	Reference has been made to completing the impact assessments early in the Business Case process
PT43	43	Stage Two: Templates: Evaluation Plan	New Slide	New template and guidance for Evaluation Planning.
PT44	45	Stage Three: Introduction and Core Activity	Amendment	Inclusion of the following word into the Market Ready Specification section (Monitoring and Evaluation bullet

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
				point) building on the (monitoring and) evaluation outline plan set out in the business case'
PT45	46	Stage Three: Considerations	Amendment	New consideration added to Market and Workforce 'Has learning from safeguarding reviews been fed into commissioning and procurement?'
PT46	47	Stage Three: Resources	Amendment	Merged service specification and contract line together
PT47	47	Stage Three: Resources	Amendment	New addition of Evaluation with reference to the relevant templates, guidance and Evidence, Evaluation and Health Economics team for support
PT48	47	Stage Three: Resources	Amendment	Addition of IG to ICB support team section for Workforce availability, Digital and Estates activity
PT49	48	Stage Three: Templates: Service Specification	Amendment	Service Specification: Reference made to the Evaluation Plan developed in Stage Two
PT50	49	Stage Three Templates: Waiver	Amendment	Removal of the word 'bypass'
PT51	51	Stage Three Templates: Contracts	Amendment	Reference made to KPIs featuring in all contracts. Added in Framework to the type of contract.
PT52	53	Stage Four: Introduction and Core Activity	Amendment	Introduction updated to: Stage 4 is the implementation of the evaluation plan designed at stages two and three of the cycle, involving collection, analysis and interpretation of

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
				data and subsequent decision making for our next strategic iteration. Stage Four commences instantly after Stage Three has been completed, the contract should immediately begin to be performance monitored via the contracted Key Performance Indicators (KPIs) detailed in the contract.
PT53	53	Stage Four: Introduction and Core Activity	Amendment	Holistic Review words amended to: Use qualitative (descriptive, non-numerical) and quantitative (numerical) data.
PT54	53	Stage Four: Introduction and Core Activity	Amendment	Proportionate Governance words amended to: Ensure monitoring and evaluation are adequate to measure outputs and assess outcomes without creating undue burden
PT55	53	Stage Four: Introduction and Core Activity	Amendment	Blue text at bottom updated to read: All evaluation plans must be agreed up-front during stages 2 and 3 of the commissioning cycle.
PT56	54	Stage Four: Considerations	Amendment	Intro changes to ‘effective evaluation requires a clear, co-designed and pragmatic evaluation approach (to be set out in the monitoring and evaluation plan during stages 2 and 3). Conducting evaluation should be guided by the evaluation plan’s overarching evaluation question, aims, objectives and methods of data collection and analysis that address these. Evaluation reporting should be clear and actionable”

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT57	54	Stage Four: Considerations	Amendment	New consideration added to Metrics and Data 'Does the data address the overarching evaluation question?'
PT58	54	Stage Four: Considerations	Amendment	New consideration added to Governance and Risk 'Have ethical considerations in relation to data collection and analysis been satisfactorily addressed?'
PT59	54	Stage Four: Considerations	Amendment	New consideration added to Governance and Risk 'Is the data compatible with the original use for which the data was collected?'
PT60	54	Stage Four: Considerations	Amendment	New consideration added to Strategic Feedback 'Is there a clear and accurate interpretation of findings that will inform strategic decision making?'
PT61	54	Stage Four: Considerations	Amendment	New consideration added to Strategic Feedback 'Have evaluation outputs been discussed with stakeholders and plans made for prioritising actions and follow-up?'
PT62	54	Stage Four: Considerations	Amendment	New consideration added to identify, stop, change and scale 'Contracting Safeguarding KPIs, Provider Safeguarding Assurance Meetings, OFSTED/CQC meetings, Provider Annual Quality Accounts/Reports, GP annual audit and Section 11'
PT63	55	Stage Four: Resources	Amendment	Activity renamed from 'Defining Success – Monitoring Outcomes' to 'Identifying Outcomes and Impact'

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT64	55	Stage Four: Resources	Amendment	Internal resources for Identifying Outcomes and Impact no includes ‘Contract monitoring meetings / action logs, evaluation team short guide on evaluating outcomes and impact and guide on using evidence in strategic commissioning, evaluation plan and outputs, stakeholder input, outcomes dashboard’
PT65	55	Stage Four: Resources	Amendment	Linking equity to value for money additional internal resource listed ‘evaluation report’
PT66	55	Stage Four: Resources	Amendment	Identify stop, change & scale decisions additional internal and external resources including ‘stakeholder input from local universities (University of East Anglia, University of Suffolk, University of Essex), York Health Economics Consortium, Healthwatch’
PT67	55	Stage Four: Resources	Amendment	‘Informing next year’ changed to ‘informing next steps’
PT68	58	Core Offer: Clinical Stewards	New	Clinical Stewards Core Offer slide added to the pack.
PT69	59	Core Offer: Communications and Engagement Team	Amendment	Added updates to ‘more of:’, ‘less of:’, and pro-tip boxes
PT70	60	Core Offer: Contracts team	Amendment	Pro- tip added and contract email address. Polices and templates section marked as None.

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT71	62	Core Offer: Digital Team	Amendment	Contact email address added
PT72	63	Core Offer: Economic and Strategic Partnerships	New	Economic and strategic and partnership Core Offer slide added to the pack.
PT73	65	Core Offer: Evidence, Evaluation and Health Economics Team	Amendment	Reference Points and Reports – Local section updated. Updated email address.
PT74	68	Core Offer: Information Governance team	New	Information Governance Core Offer slide added to the pack.
PT75	70	Core Offer: Medicines Optimisation	Amendment	Core Offer and Role Shift narrative updated.
PT76	72	Core Offer: Place & Neighbourhoods	New	Place & Neighbourhoods Core Offer slide added to pack.
PT78	74	Core Offer: Primary Care Team	New	Primary Care Offer added to the pack.
PT79	75	Core Offer: Procurement & Market Management Team	Amendment	Added information to the ‘less of:’ box
PT80	76	Core Offer: Quality and Safety Team	Amendment	Added contact email address. Included reference to CYP Safeguarding throughout.
PT81	77	Core Offer: Safeguarding team	New	Safeguarding Core Offer slide added to the pack.

Strategic Commissioning Policy and Toolkit				
Change Ref	**New Slide Ref**	**Slide Title**	**Change Type (new / amendment)**	**Change Summary**
PT82	78	Core Offer: Strategic Planning and Change Team	Amendment	SPC email address amended.
PT83	79	Core Offer: Sustainability Team	Amendment	Contact email address added.
PT84	80	Core Offer: Women, Babies, Children, Young People	New	Women, Babies, Children, Young People Core Offer slide added to pack.
PT85	81	Core Offer: Work & Health Team	New	Work & Health Core Offer added to the pack.
PT86	82	Core Offer: Workforce	Amendment	Updates to Workforce slide added, including ‘less of:’ box, and policies and templates information
NA	NA	Throughout	Amendment	All acronyms supported with the correct expansion
NA	NA	Throughout	Amendment	Reference to BI Team changed to Commissioning Analytics Team or Population Health Management, Evaluation and Economics Team or together Healthcare Intelligence Team

Supporting Strategic Templates				
Change Ref	**Document**	**Section**	**Change Type (new / amendment)**	**Change Summary**
BC01	Business Case	Introduction Guidance	Amendment	Guidance updated. Reads 'Do not use acronyms. Complete the Impact Assessments early in the process as they may shape your thinking. Complete Section 5 Key Function and Enabler Considerations early as they may inform your proposal. This document is the responsibility of the ICB Commissioner.'
BC02	Business Case	3. Strategic Alignment	Amendment	Removal of alignment to long term challenges to reduce duplication (covered in section 3.1)
BC03	Business Case	4.4 Proposal, Critical Success Factors and Scope	Amendment	New guidance added. Reads 'Considerations: How does this address inequalities, what is the impact on deprived communities (drawn on your EQIA), what is the impact on Core20PLUS5. What evidence has informed the proposal? '
BC04	Business Case	4.4 Proposal, Critical Success Factors and Scope	Amendment	New guidance added. Reads 'This section should include the clinical model being proposed.'
BC05	Business Case	5. Key Function and Enabler Considerations	Amendment	New guidance added. Reads 'The recommendation statement should help shape your thinking and should therefore be done early in the Business Case process. The recommendation statement does not need to be an endorsement. The recommendation statement should not be responded to by the commissioner.' Contracts and Procurements split.

Supporting Strategic Templates				
Change Ref	**Document**	**Section**	**Change Type (new / amendment)**	**Change Summary**
BC06	Business Case	4.7 Evaluation Plan	Amendment	Evaluation Framework re-named Evaluation Plan. Additional guidance added. Reads 'Use the Evaluation Plan template and guidance to help define how will you approach evaluation, what is the scope of the evaluation, what is the aim of the evaluation, what methods will you use, when will you do it, who will do it.'
BC07	Business Case	8.2 Document Review	Amendment	Contracts and Procurement split. Additon of Estates and Place
LBC01	Light Business Case	Introduction Guidance	Amendment	Guidance text updated. Reads 'A Light Business Case can only be used if the financial implications total less than £100,000 (full contract value).'
SS01	Service Specification	7. Enablers	Amendment	New guidance around IG added. Reads 'providers will need to detail how they plan to process data, provide privacy notice information, outline patient onboarding, and describe the process for transferring patients at the end of the contract.'
PM01	Proposition Mandate	1. Proposition Mandate Information	Amendment	Removal of 'decommissioning' from 'Type of Proposition' as no Proposition Mandate is required for decommissioning decisions
PM02	Proposition Mandate	3. Strategic Alignment	Amendment	Removal of alignment to long term challenges to reduce duplication (covered in section 3.1)

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number:10

Date: 15 July 2026

Title: Strategic Plan for Mental Health, 2026-2031

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

Author: Andy Vowles, Director, Cambridge Health Consulting

Purpose: To update the Board on work to develop the ICB's strategic plan for mental health, and to seek endorsement of the proposed priorities and delivery mechanisms

Recommendation: The Board is asked to endorse the draft strategic plan, and to agree:

- **the improvement priorities outlined**
- **the proposed system delivery arrangements**

1. Background

1.1. Over the last six months, the ICB has been progressing work to produce a five year strategic plan for mental health. The plan:

- Flows from the ICB Population Health and Commissioning Strategy and the Population Health Improvement Plan

- Is underpinned by the refreshed mental health needs assessments that have now been completed across both Norfolk and Suffolk
- Is focused on those areas that the ICB itself will lead and is accountable for (as opposed to being a comprehensive 'whole system' strategy)
- Takes an all-age approach
- Includes within its scope all elements of mental health, from prevention through to more specialist treatment
- Excludes learning disabilities and neurodiversity as well as dementia (which are the subject of separate plans).

1.2. The strategic plan has been developed in consultation with partners from across the system, including:

- Both county councils (children's and adult services and public health)
- Service providers
- Healthwatch (Norfolk and Suffolk)
- VCSFE organisations
- Suffolk and Norfolk constabularies
- Specialist commissioners

1.3. Development work included individual interviews, presentations to and discussions at a wide range of existing meetings and fora, and a cross-system workshop in late March.

1.4. The draft strategic plan is attached at Annex A.

2. Key Issues and risks

2.1. The draft plan sets out seven main mental health priorities for the ICB for the strategic period (section 3). These are largely drawn from the ICB Population Health and Improvement Plan, and are:

- Perinatal – development and commissioning of consistent, integrated pathways
- Early years – with partners, improved identification of children and families with the greatest need, and the integration of commissioning
- School aged children and young people – roll out of mental health support teams to all schools and colleges
- Neighbourhoods – embedding mental health support in every Integrated Neighbourhood Team

- Adults with complex needs – commissioning new community based pathways, including an assertive and intensive outreach service and support for people with complex emotional needs (personality disorder)

- Adults in crisis – commissioning alternative ICB-wide pathways for adults experiencing a mental health crisis

- Adult specialist placements – consistent, evidence based ICB-wide approach to commissioning all specialist placements

2.2. In each case, the draft plan sets out why each priority has been selected, what the ICB's commitment is, and an overview of the proposed delivery arrangements.

2.3. Section 4 of the draft plan considers how the system might work together in order to deliver the ICB's priorities (set out in the plan), as well as those of other partners and those that are shared (such as prevention). It considers and evaluates a number of options, based on learning from previous arrangements, which include the former (ICB-led) Mental Health Collaborative in Suffolk, forums run by partners such as the Children's and Young People Strategic Alliance in Norfolk (led by the county council) and other local arrangements.

2.4. The conclusion reached, and which is largely supported by stakeholders, is that the ICB should not in future lead any formal mental health collaboratives, either at whole ICB or county level. This in recognition of several factors including: learning from what has and has not worked in previous arrangements; the changing role of providers, who are increasingly leading work that may in the past have been undertaken by the ICB; the size and complexity of the footprint; and the significantly reduced capacity within the ICB.

2.5. Instead, the conclusion reached (and the recommendation to the Committee) is that in future delivery arrangements more flexible, largely determined by the nature of each priority or objective, with leadership coming from the organisation that has lead accountability.

2.6. However, in recognition of the fact that there are a number of whole system priorities that a great many partners have a role in progressing (such as a comprehensive approach to prevention), there is widespread support for the establishment of a quarterly Norfolk and Suffolk wide Mental Health Network. It is anticipated that this will be co-led by a coalition of partners but will, in the first instance, be mobilised by the ICB.

3. Patient and Public Engagement

3.1. There has not been direct patient or public engagement in the preparation of this plan. However, a number of groups that represent patients and the public, such as Healthwatch, Service User Forum and VCSE Assemblies, have been integral to the development of the plan. The plan itself also includes a summary of service user and carer views, which draws on previous engagement activities by the predecessor ICBs as well as partners such as the county councils.

4. Committees and Groups

4.1. A working draft of this plan has been widely shared both within the ICB and across the wider system. The comments received have been considered and, where appropriate, reflected in this final draft.

4.2. The mental health plan was agreed at the N&S ICB Strategic Commissioning Committee meeting on 16 June 2026.

Annex A

Norfolk and Suffolk
Integrated Care Board

Strategic Plan for Mental Health 2026-2031

Final Draft

V1.6

June 2026

June 2026

Table of Contents

1. Introduction

1.1. Purpose of this Strategic Plan

The purpose of this strategic plan is twofold. First, it sets out the ICB's priorities for emotional wellbeing and mental health for the period 2026-2031, and gives an overview of how they will be delivered. Its focus is on the areas that the ICB has responsibility for and which we will lead; it is not intended to be a comprehensive, whole-system plan that considers all elements of emotional wellbeing and mental health.

Second, while this is very much an ICB plan, it outlines how – in our view – the wider system might in future collaborate to best effect. This is in recognition of the fact that no one organisation's plans exist in isolation – improving mental health outcomes for local people requires partnerships, alignment of plans and, in many cases, integrated delivery.

This strategic plan sits under the ICB's overarching Population Health and Commissioning Strategy[1], and its more detailed Population Health Improvement Plan. It is intended to be the first of a series of ICB service focused strategic plans, reflecting the particular importance attached to mental health within the new organisation.

While the ICB is a new organisation, its predecessor bodies had mental health plans and work programmes for both Norfolk and Suffolk, which have been reviewed and, where there is alignment, built into this document. Alongside this, the current and emerging plans of partners locally have been considered, reflecting our wider objective to – where possible - align plans and priorities.

1.2. Scope of this Strategic Plan

This strategic plan considers the ICB's priorities along a spectrum from prevention and early intervention (such as perinatal services) through to more specialist clinical interventions (such as supporting people in crisis). It also takes an all age approach, spanning perinatal, children and young people and adults.

This plan does not consider in any detail two other important areas that are relevant to wider emotional wellbeing and mental health. These are services for people with a learning disability and/or autism or who are neurodiverse, and support for people with dementia. In the case of the former, there are other partnership based plans that set out collective planning arrangements and shared priorities; and in the case of the latter, developing a responsive and integrated approach to supporting people with dementia is being progressed at a local, Alliance based level, reflecting the different issues and challenges across the footprint.

[1] https://www.norfolkandsuffolk.icb.nhs.uk/documents/population-health-and-commissioning-strategy/

1.3. Structure of this Strategic Plan

There are four main sections to this plan:

- Strategic context, which summarises the national and local environment within which this plan was developed
- The ICB priorities, which sets out the main areas of focus for the ICB over the next five years
- Delivery arrangements, which considers what form future system-wide mental health collaborative arrangements might take
- Next steps, which gives and overview of how this strategic plan will move into the delivery phase.

2. Context

This section sets out the national and local context within which we have developed, and will be implementing, our strategic plan for mental health.

2.1. National Context

In 2025 NHS England published its Ten-Year Health Plan[2], which outlined three main shifts for the future NHS, each of which is highly relevant to mental health:

- Hospital to community – with more care delivered locally and at home
- Sickness to prevention – helping people to make healthier choices and where required earlier intervention
- Analogue to digital – using technology to enable people to manage their care and to increase efficiency

At the same time, the role, configuration and capacity of ICBs has undergone significant change. ICBs have, in general, consolidated, resulting in fewer organisations covering larger geographic areas. As outlined in NHS England's Strategic Commissioning Framework[3], the focus of ICBs has been recast, positioning them primarily as strategic commissioners focused on population health, reducing inequalities and ensuring value. And, alongside these changes, ICB running costs have reduced by up to half, significantly reducing their capacity. Taken together, these changes reframe ICBs' role in the local system.

In recent months NHS England has also published other national frameworks that are highly relevant to this strategic plan. This includes detailed guidance on neighbourhood health, which considers the structure and composition of the new neighbourhood health centres. Work is also progressing nationally on the development of mental health specific modern service frameworks, such as supporting people with severe mental illness.

Finally, as well as changes to NHS structures, the Government is progressing a major reorganisation of local government. These changes are an important consideration in the development of this strategic plan, as local authorities are central partners in supporting the emotional wellbeing and mental health of local people. In Norfolk and Suffolk, this reorganisation is likely to result in the existing two county and 12 district and borough councils being replaced by six new unitary authorities, three in Norfolk and three in Suffolk.

2.2. Local Context

Norfolk and Suffolk Integrated Care Board

In April 2026 the new Norfolk and Suffolk ICB was formally established, replacing the two previous organisations. The new ICB has recently published both its overarching strategy (the Population Health and Commissioning Strategy, 2026/27-2030/31), and

[2] https://www.england.nhs.uk/long-term-plan/

[3] https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

the more detailed Population Health Improvement Plan[4], which covers the same period. Both of these documents build on and reflect plans developed by the legacy ICBs, as well as key local strategies such as the two county-based Health and Wellbeing Strategies, the refreshed Norfolk and Suffolk NHS Foundation (NSFT) strategy and other partners' plans.

The ICB's Population Health and Commissioning Strategy articulates the new organisation's overall mission and vision, as well as its ambitions and the six main clinical domains that provide the framework within which our work is organised. It also sets out local thinking about strategic commissioning and how the new organisation will approach its core future function, including the central role clinical leaders from all disciplines – medical, nursing and therapies – will have.

The more detailed Population Health Improvement Plan describes the ICB's commissioning intentions for the five-year period and, in doing so, sets out how the wider ambitions and outcomes identified in the Population Health and Commissioning Strategy will be delivered. This plan describes the priorities within the "Feel Well' domain, which largely focus on mental health, and as such sets the main priorities that now form the principal focus of this strategic plan for mental health.

Although the new ICB is a single organisation, much of its work is at 'place' level (also known as Alliances). There are five places across the footprint:

- West Norfolk
- Great Yarmouth and Waveney
- Central Norfolk
- West Suffolk
- Ipswich and East Suffolk

Needs Assessment – Mental Health in Norfolk and Suffolk

Both Norfolk and Suffolk County Councils have recently produced comprehensive mental health needs assessments[5]. These are invaluable resources for the wider system, helping all local organisations and partners, including the ICB, to focus their work on the right issues and areas. Together, the needs assessments provide a single, central source of evidence that can support the increasing alignment of all partners' strategic plans.

The needs assessments provide a thorough analysis of key elements of mental health locally, including:

- Almost 15% of adults locally have a diagnosis of depression

[4] https://www.norfolkandsuffolk.icb.nhs.uk/about/governance/population-health-and-commissioning-strategy/

[5] http://www.healthysuffolk.org.uk/JSNA

Insert Norfolk link once available

- Adults with a severe mental illness locally experience particularly poor outcomes; people in this group are almost five times more likely to die before the age of 75 than the general population
- Mental health need among children and young people is high and increasing
- There are concerns over the emotional wellbeing of almost half of all children who are looked after
- About 1 in 100 people registered with a GP have a diagnosis of schizophrenia, bipolar affective disorder or other psychoses
- The prevalence of perinatal mental health conditions is high, at approximately 26%
- The rates of admission among children as a result of self-harm is higher than average, particularly in Suffolk.

The needs assessments highlight the strong link between deprivation, inequality and higher levels of mental health need, with a particular focus on local places including Lowestoft and Kings Lynn. They also identify a range of underlying factors that profoundly affect mental health, including:

- The importance of strong family and wider societal relationships as a protective factor
- The impact of socioeconomic and environmental factors, with poverty and low quality or insecure housing both being associated with poor mental health
- The key role of health behaviours, such as diet, physical activity, sleep and screen time, in influencing an individual's mental health
- The importance of psychological factors, such as people's sense of identity, belonging, resilience and ability to overcome setbacks
- The clear inter-relationship between multiple factors such as physical illness, deprivation and environment in negatively affecting mental health

Taken together, the needs assessments highlight the following areas as priorities for action by partners across the local system:

- Reduce inequalities in mental health need through targeted, place based approaches
- Strengthen early intervention and crisis prevention for children and young people
- Reduce premature and excess mortality by addressing physical health inequalities for people with severe mental illness
- Improve mental health support for care-experienced children and families
- Improve early identification and support for people with common mental health conditions
- Plan for the mental health needs of an aging population
- Improve mental health intelligence and data integration

The needs assessments include the development of a small number of recommendations for action, many of which have informed the development of the strategic plan.

Service User Voice and Experience

The voices of people with lived experience, together with perspectives from families and carers, offer invaluable insights into where the mental health system functions effectively and where improvements are needed.

In developing this strategic commissioning plan, our approach has been to review and assimilate what we already know about service users, families and carers' priorities and preferences, and have woven this information into our priorities. This approach was shared with, and supported by, a number of representative groups locally.

In common with partners from across the system, the ICB shares a commitment to coproduction – designing the detailed programmes that will flow from this strategic plan in concert with service users, families and carers.

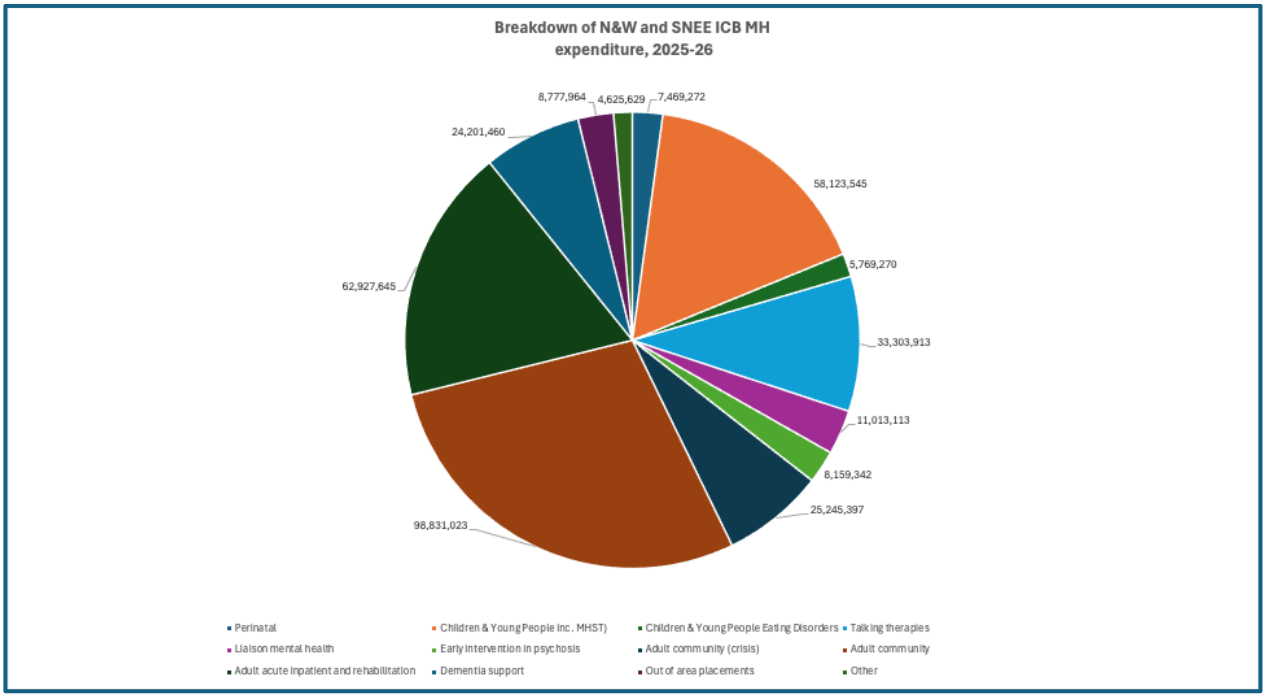
Based on the extensive coproduction and engagement work of the predecessor ICBs, as well as local initiatives such as the Mental Health Charter and evidence from other local partners, the following are some of the key themes and learning:

- Access and navigation: people want to be able to access the right help at the right time, are often uncertain about how to access support, especially out of hours, and often face difficulties navigating complex service pathways
- Waiting for support: people are concerned about long waits, and describe the period between seeking help and receiving treatment as particularly challenging
- Kindness and compassion: people want to be listened to respectfully, and to be able to have safe, sensitive conversations in environments that are appropriate
- Shared decision-making: people don't want to be 'done to', they want genuine, respectful involvement in all elements of care planning
- Young people's experiences: children and young people emphasise the importance of accessible support in schools and communities as well as of having trusted adults who can listen and offer guidance
- Carer experiences: carers supporting people with serious mental illness regularly highlight the need for clearer information, better communication with services and more involvement in care planning

Mental Health Provision – Current Landscape

Last year, the predecessor ICBs spent approximately £348m on mental health services across Norfolk and Suffolk (excluding specialist, prescribing and continuing health care).

Within this, the largest areas of expenditure were adult community mental health, excluding crisis services (£98m), adult acute inpatient and rehabilitation (£63m) and children's community services, including mental health support teams (£58m):



In 2025/26, about 80% of the two ICBs' total expenditure on mental health was invested in services provided by Norfolk and Suffolk Foundation Trust (NSFT), the main NHS provider locally.

Although the majority of the ICBs' mental health expenditure was with NSFT, there are a very wide range of organisations that provide mental health support and wider wellbeing services to people across Norfolk and Suffolk. Some of these – for example a number of children's services in Norfolk - are directly commissioned by the ICB to provide services, while others are funded in a different way, for example by the county councils, via their own fundraising or through sub-contracts.

Pathways for mental health support vary considerably both across and within the two counties, and also by age group. The needs assessments completed by the two county councils both describe current provision and highlight key issues to be addressed across pathways.

3. The ICB Priorities for Mental Health

3.1. Delivering the ICB's Vision and Outcomes

In our Population Health and Commissioning Strategy, we outlined a simple vision – to improve health outcomes for every resident of Norfolk and Suffolk. We also identified three overarching outcomes which will help to make this vision a reality and which will guide our activity. These are:

- Improving healthy life expectancy
- Reducing health inequalities
- Ensuring access to consistently high quality care

Improving emotional wellbeing and mental health for people across Norfolk and Suffolk will be central to successfully meeting each of these over-arching outcomes.

Improving healthy life expectancy must encompass mental as well as physical health. For example, we know that around 15% of the adult population have a diagnosis of depression – so if we are to improve 'healthy life', we need to do more to develop models of care that help to prevent depression, diagnose it early and provide effective interventions.

Similarly, health inequalities in mental health are stark. For example, we know that people with a severe mental illness will, on overage, die ten years younger than the wider population. So, if we are to reduce overall inequalities, this must be an area of focus.

Finally, we know that specialist, evidence-based interventions for people who need them are highly effective in improving mental health, but services can sometimes be difficult to access and/or are not of uniformly high quality. Improving access to, and guaranteeing the quality of, mental health services must therefore be a priority.

As outlined above, our new organisation is increasingly focused on our role as a strategic commissioner, and our capacity is greatly reduced compared with predecessor bodies. Therefore, we know we cannot do everything. The priorities set out below form the main elements of our change programme for mental health for the coming years, and have been selected on the basis that, delivered in partnership with others, they will make a significant contribution to meeting our three primary outcomes.

3.2. Our Priorities for Mental Health

We recently outlined our broad strategic commissioning priorities in the Population Health Improvement Plan, which covered all service areas, including mental health. These flow from and build on the direction set out in the Government's 10 Year Plan for the NHS.

There was extensive engagement with partners on this plan, and the wider Population Health and Commissioning Strategy, while the ICB was operating in shadow form.

The ‘Feel Well’ element of the Population Health Improvement Plan set out our three high-level ambitions for mental health:

- Reduce the proportion of people (of all ages) experiencing low life satisfaction, high anxiety or low happiness
- Reduce premature mortality of people with severe mental illness
- Reduce attendance at hospital emergency departments, and subsequent admission rates, for people with severe mental illness

Making progress toward meeting these outcomes was a key factor in determining our strategic priorities for mental health. In the following, we confirm our priorities, explain why we selected them and set out our high-level plans for delivering each commitment.

These are the commitments that that we, the ICB, will lead, working alongside colleagues from across the system. We fully recognise that this is only one part of our wider system’s work on mental health, and that in addition to leading some elements, we have a key role both in helping to ensure our plans are aligned with others, and in supporting partners to progress their priorities and improvement plans.

In addition, work in a number of other important areas will continue to be developed, outside the specific priorities that are highlighted below. These include strengthening employment support for people with severe mental ill health, improving therapeutic support for survivors and victims of domestic abuse, the procurement of an ICB-wide all-age eating disorder service, and strengthening the contribution of mental health practitioners in primary care.

Although this is plan for a five-year strategic period, inevitably there is more detail for the coming two to three years. This is partly because the ICB is developing as a new organisation, and also because there are a number of national Modern Service Frameworks (MSF) for mental health under development, the requirements of which this plan will need to reflect. For example, the Severe Mental Illness (SMI) Modern Service Framework is due to be published in Autumn 2026, which will help to establish clear, evidence based quality standards and end unwarranted variation in adult mental health care.

One area that is not highlighted in this section as a separate work programme is prevention, early intervention and the wider determinants of mental health. This is for two reasons: first, prevention is of such importance that it is woven into almost all of the ICB’s work (for example on neighbourhoods) and is a key part of our wider strategic objective to deliver a ‘shift left’; and, second, prevention and early intervention is a shared responsibility across many system partners, not for the ICB to lead on its own. As such, it is one of the suggested areas of focus for the whole system mental health Network outlined in section 4 of this plan.

Our approach to mental health is age inclusive, recognising that there are a number of key stages of transition (for example from young person to adult, and adult to older person) that require the support and services our system offers to be flexible and focused on individual need, rather than constrained by rigid age boundaries.

Nevertheless, in developing this strategic plan we have chosen to take a 'life course' approach, as this helps to ensure there is clarity on the priorities identified as well as being aligned with approach taken in the mental health needs assessments that have been completed across both counties. The main areas are:

- Perinatal
- Children and Young People
- Adults (including older adults)

Perinatal

Why this is a priority

We know that good perinatal mental health is a key factor that influences not just the health of expectant and new parents, but also of the wellbeing of the infant and young child. A positive start in life is also one of the key determinants of future life chances, and can have a significant bearing on narrowing inequalities.

We also know that prevalence of perinatal mental health conditions locally is high, with an estimated rate of 26% - more than one in four – and that early identification (through maternity care) is key. Our data suggests that currently access to specialist perinatal mental health services is limited, relative to estimated need, and our access rates are below target across both counties.

Our commitment

At present there are gaps and inconsistencies across Norfolk and Suffolk in the support we commission for expectant and new parents as well as infants. To address this, our commitment is that by April 2028 we will commission a comprehensive, integrated offer for perinatal mental health and parent-infant relationship support.

How we will deliver this commitment

We plan to phase delivery of this commitment over the first part of this strategic plan. Our initial focus in 2026/27 will be on identifying gaps by comparing local provision with national standards and recommendations, together with an evaluation of outcomes, This will enable a clear picture of the quality and effectiveness of the current service to be formed. Our immediate aim is to ensure that there are equitable standards across Norfolk and Suffolk, and to make our commissioning approach consistent across both counties.

We will work with local service providers, the East of England Provider Collaborative, place partnerships, maternity services, safeguarding and colleagues from local authorities and the voluntary, community, faith and social enterprise (VCFSE) sector to map current pathways and to identify future delivery requirements and options for improvement. This will encompass specialist perinatal mental health services, parent–infant relationship support (including for fathers) and universal services, ensuring that there is alignment with emerging neighbourhood models of care as well as new local authority-led Best Start Family Hubs.

Our priorities will likely include improving continuity between inpatient Mother and Baby Units and community services; strengthening outreach and step-down support; and using population health and inequalities data to better target access and investment. We will also consider the support provided to women who experience miscarriage, as well as Sudden Infant Death (SID).

Informed by this work, we will develop an integrated perinatal mental health pathway to support future commission intentions, with a view to strengthened arrangements being in place by April 2028.

Children and Young People

Why this is a priority

There is clear evidence that childhood experiences have a profound impact on mental health in later life, and we know that the signs of poor mental health as an adult are often evident in childhood (up to half of all mental health conditions experienced by adults were identifiable by the age of 14). Therefore, focusing on and seeking to improve childhood emotional wellbeing and mental health is a priority both for the ICB and the wider system – as well as being vital for individual children, it is a critical element of wider efforts to prevent future ill health and to narrow inequalities.

We also know that locally there are growing numbers of children and young people who are experiencing anxiety, depression and emotional distress, and that demand for mental health support is rising sharply. In addition, our data shows that inequalities emerge early, with higher levels of need and service uptake in deprived areas, and that in our system we have unusually high rates of admissions for children who have self-harmed.

Addressing these issues, and ensuring as many children as possible experience a positive, secure childhood and develop key life-course skills such as resilience, involves parents, families, schools, social care, the NHS as well as wider communities. Our contribution is to be an active partner to a wider coalition.

Our commitments

<u>Early years</u>
Early years (approximately 0-5) are key years in every child's physical, emotional and cognitive development. There is strong evidence of the relationship between experiencing childhood trauma and adverse events and future emotional wellbeing, school attendance and self-harm.

As such, with partners we will develop new ways of proactively identifying families with children aged 0-5 who would benefit from targeted, trauma-informed multiagency support. This will seek to identity families who may not be currently accessing services, with a particular focus on inequalities. Supported by this intelligence, we will jointly commission integrated pathways of support, including for children with developmental delay, Special Educational Needs and/or neurodiversity. We anticipate that this work will take us until April 2028 to complete.

Over the longer term (to 2030), we will collaborate with partners to establish integrated neighbourhood teams for families with young children. This will simplify access to services, and better integrate support provided by midwives, health visitors, GPs, early years practitioners and VCFSE partners.

School-aged children

Most children spend the majority of their time either at home or at school. As a result, the mental health advice and support that the NHS provides to schools, teaching staff, partners and individual students is a key component in promoting emotional wellbeing and good mental health.

During the period covered by this strategic plan, we will expand the coverage of our Mental Health Support Teams to all schools, including those in the independent sector and further education colleges. By April 2028, we plan to have 77% coverage, and by April 2029 this will have risen to 92%, reaching 100% coverage by April 2030.

This is a significant investment in new capacity, which will enable more children to be supported earlier, with the potential to help alleviate pressure (such as long waiting times) in other parts of the system.

How we will deliver these commitments

We will deliver these commitments through continued close partnership working across health, education, local government and the VCFSE sector, recognising the importance of integrated, place-based approaches across the life course.

Early years

During 2026/27 we will work with place partnerships and providers to develop a collective approach to using shared intelligence to support earlier identification of need, particularly in the early years. Alongside this, we will work with existing partnerships to develop more integrated pathways for children and families, including looking at the potential to develop different models of commissioning and provision that are tailored to local needs.

School-aged children

For school-aged children and young people, we will support the phased expansion of Mental Health Support Teams, ensuring alignment with the proposed Young Futures Hubs[6], wider neighbourhood working and other community-based mental health services.

Working within the national framework, we will tailor delivery models across Norfolk and Suffolk to best meet the needs of children and schools. We will seek to build on existing local learning such as the children's hub currently operating in Kings Lynn (as part of a national pilot) as well as ensuring that these new teams that are fully aligned with other children's services.

To inform this work, during 2026/27 we will complete a review of the current delivery of MHSTs, with a focus on identifying areas of inequity or variation in access. We will draw on this baseline to develop, in concert with partners, a three-year delivery plan,

[6] https://www.gov.uk/guidance/young-futures-hubs

ensuring that by April 2030 all schools (including in the independent sector) and colleges have an MHST in place.

Over the medium term we will, with partners, strengthen transitions and seek to reduce fragmentation across all children's provision through aligned commissioning, engagement with children and families, and, where required, targeted procurement activity. As this new capacity is introduced, will also ensure that there is a sharper focus on preventing crisis and on self-harm, both areas highlighted in the recent needs assessments.

Adults

For adults, we will focus on four main areas:

- Embedding community mental health in neighbourhood models of care
- Redesign of alternative pathways for people in crisis
- Support for people with complex needs
- Introduction of a single unified model for commissioning specialist mental health placements

Why these are priorities

Embedding mental health in neighbourhoods

NHS England's Ten Year Health Plan sets out three major shifts for the future of the NHS, one of which is a move from hospital to community, with more care delivered locally and at home. A key component of this shift is the establishment of neighbourhoods, which bring together and integrate many services at a local level, including mental health.

As well as being a national priority, there are important local drivers for embedding community mental health in our neighbourhoods. For example, we know that many people experience physical and mental health difficulties at the same time, indicating that we need to be able to support early diagnosis and access to suitable, integrated pathways.

Similarly, we know that targeted, place based approaches are key to reducing premature mortality for people with a severe mental illness, as evidence-based interventions largely relate to physical health, such as improved uptake of health checks, targeted smoking cessation programmes and cardiovascular risk management.

Finally, it is clear that a neighbourhood approach will be key in reducing inequalities in mental health. We know from the recent needs assessments that there is strong correlation between poor mental health and deprivation and coastal communities, and that addressing these issues requires a highly localised, cross-partner approach.

We have considerable learning and experience locally that will support the further development of this model. This includes the two Alliances in Suffolk, which have been operating a partnership model for many years, the current Integrated

Neighbourhood Teams (INTs), which support the delivery of integrated services, and primary care networks, which bring together local GP practices.

Support for people with complex needs

As outlined in the previous section, people with severe mental health conditions have a lower life expectancy than the general population, and reducing premature mortality in this group is one of the three priority mental health outcomes for the ICB.

Some people with severe mental health conditions benefit from a community-based intensive and assertive support service, particularly for those individuals where engagement is a challenge. At present, there gaps and inconsistency in this support, and as well as strengthening services, there are opportunities to better involve partners from the VCFSE sector.

A further priority group is supporting people with complex emotional needs (personality disorder). At present, support in Norfolk and Suffolk is primarily provided through the NHS and local mental health charities. Pathways include specialised community mental health teams and psychoeducational recovery courses for traits like Borderline/ Emotionally Unstable Personality Disorder (BPD/EUPD).

Across the ICB, there is currently a lack of consistent, stabilising and relationally continuous support for this group of people, who often struggle to engage with community treatment leading to repeated crisis service use, reactive and repeated inpatient care.

Alternative pathways for people in crisis

We know that across the two counties we do not yet have a consistent, evidence based approach to supporting people who are experiencing a mental health crisis or who require urgent support. Too often the pathways are complex, fragmented and not responsive enough.

We also know from partners in acute hospitals that too many people experiencing a mental health crisis attend their emergency departments, which is rarely the most appropriate place for them. Further, a proportion of these people are then admitted, often not because an acute hospital is the right place to meet their needs, but because capacity in more appropriate facilities is lacking. Finally, we know that in some places there is insufficient focus at an early enough stage on planning and delivering rehabilitation and reablement.

Mental health specialist placements

For many years, our local system has reactively purchased placements for individuals outside the two counties, either when there is no capacity locally and/or where appropriate services are not available. Although there have been improvements recently, we do not yet have a consistent ICB-wide, evidence based model for commissioning these placements that ensures all people receive clinically appropriate care that is as close to home as possible. We also know that there are opportunities to better align and integrate work with local authority colleagues in the way post discharge (Section 117) support is provided.

Our commitments

Embedding mental health in neighbourhoods

As we develop neighbourhood models of care we will, with partners, ensure that community based mental health services are, for the first time, fully embedded. By the end of the period covered by this strategic plan, mental health practitioners will be included as core members of Integrated Neighbourhood Teams in every locality. We will ensure that this is reflected in all our neighbourhood delivery plans.

Our broad approach to neighbourhood development is all age, although we recognise (as outlined above) there will need to be flexibility and pragmatism to ensure services are fully aligned with those of partners (for example, the children's zones in Norfolk).

Our aim in developing neighbourhoods is to ensure that our local model:

- Provides accessible and simplified support
- Enables a focus on prevention and early intervention
- Embeds VCFSE provision
- Helps to prevent crisis and escalation to acute services

One recent development that we believe can accelerate this work is the development of new community mental health hubs across Norfolk and Suffolk. Led by NSFT, these will be facilities that could form a physical walk-in base for a wide range of VCFSE, primary care, community, hospital and local authority services. The development of these hubs is an opportunity to 'reimagine' how some community mental health services are provided locally, testing a range of new delivery models.

Although not led by the ICB, we are keen to roll out the first of these hubs in the most deprived parts of the two counties, as we know from the needs assessment that people living in these areas are more likely to experience poor mental health, and that this is one if the key factors that drives inequality.

Support for people with complex needs

As a priority, we will support NSFT with the development of a business case to provide a consistent, comprehensive community-based assertive and intensive outreach response service for Norfolk and Suffolk. We will ensure that this is a partnership-based approach, with the Trust working alongside partners from the VCFSE sector in order to make sure that the service is as accessible as possible, making best use of all local experience and capacity.

Our aim is to ensure that there is timely, accessible support for this group of people. Over time, we would expect this to result in improved outcomes, including in improved life expectancy, and a reduction in the need for crisis and emergency support.

In addition, during 2026/27, we will work with NSFT and system partners to develop a business case to review and refresh our service offer for people with complex

emotional needs, with the aim of ensuring there is consistent, evidence based provision across the two counties.

Alternative pathways for people in crisis

As outlined above, we need to ensure that across Norfolk and Suffolk there is a consistent, evidence-based approach to supporting people in crisis or that have an urgent mental health need, and that access to these pathways is both straightforward and timely. By further developing these alternative pathways, our aim is to reduce pressure and reliance on acute services.

To deliver this, by April 2027 we intend to, with the involvement of system partners and service users, review and then recommission all relevant alternative crisis pathways. This encompasses about £6m of ICB expenditure, encompassing existing crisis hubs/sanctuary houses, steam cafes and community connectors. We are currently developing a detailed business case to progress this element of our programme.

Alongside strengthening these crisis pathways, we will work in partnership with NSFT and other system partners to design and implement two new Mental Health Emergency Departments, ensuring that these new facilities form a seamless part of the wider urgent care pathway.

Mental health placements

By April 2027, we will complete a review of our current approaches to commissioning adult specialist placements, to ensure there is a clear picture need and likely future commissioning requirements. Building on this, by April 2028, we will implement a new, consistent ICB-wide model for commissioning all relevant adult placements across both counties.

How we will deliver these commitments

Delivery of our adult mental health priorities will focus on system leadership, our commissioning functions and close collaboration with place, NHS providers, VCFSE partners and service users.

Embedding mental health in neighbourhoods

As we develop neighbourhoods, we will ensure that relevant community mental health services are fully embedded. Starting in 2026, we will progress this work alongside partners, seeking to integrate statutory and VCFSE provision, targeting the areas of highest need and with a focus on prevention and early intervention.

Towards the end of 2026/27, we aim to have completed the procurement and mobilisation of the first phase of the mental health wellbeing hub approach, and in early 2027/28 we plan to introduce the single point of access.

We will monitor progress across four main domains:

- Improved access and navigation – more referrals through the single point of access, reduced waiting times
- Prevention – reductions in crisis presentations and increased utilisation of community pathways

- Integration – evidence of integration with INTs and hubs, increased population reach, including on underserved groups
- Experience and outcomes – service user feedback, reduction in crisis episodes

Alongside this, we will prioritise the development of the seven new community hubs across Norfolk and Suffolk, with a phased roll out that starts with the areas of highest deprivation and greatest need for mental health support (Kings Lynn and Lowestoft).

Support for people with complex needs

In the first quarter of 2026/27, we will review and decide whether to support the current business case for a consistent ICB-wide intensive and assertive outreach support service. The proposed model is a partnership involving NSFT, VCFSE, acute hospitals, local authorities and the police.

Subject to the business case, in late 2026/27 we will work with partners to codesign the detailed implementation of the model, including the development of standard operating procedures, with a view to the new service going live in early 2027/28.

In the first quarter of 2026/27 we will review and decide whether to support the business case for supporting people with complex emotional needs. Subject to agreement of the business case, we will work with partners to codesign the implementation of the new model with a view to the new service going live in early 2027/28.

Alternative pathways for people in crisis

During 2026/27 we will lead a system-wide review of existing pathways for people experiencing a mental health crisis, drawing on existing activity, outcomes and inequalities data. This will enable a clear baseline to be established, and for key gaps to be identified.

We will use this analysis to shape the development of consistent, evidence-based alternative pathways of care across the two counties, and to determine our approach to recommissioning services. Our aim is to ensure that new, ICB-wide pathways are mobilised in mid-2027.

A key consideration as we progress this work will be the establishment of Mental Health Emergency Departments in Norwich and Ipswich, ensuring they are fully aligned with local urgent care systems and alternatives to admission, and make a positive contribution to reducing pressure on main hospital emergency departments.

We will also consider how, as a system, we can improve and strengthen existing arrangements for the provision of Section 117 aftercare for people who have been admitted to hospital under relevant sections of the Mental Health Act

This work is being prioritised within the ICB (and the wider system), and we aim to have completed the review and the resulting recommissioning by April 2027.

Alongside this, we will continue to work closely with NSFT and other partners to develop and agree business cases to improve the way the system helps people with

complex emotional needs, and how intensive and assertive support is provided. A particular area of focus will continue to be on the support provided to the relatively small number of people that regularly use, or who are in frequent contact with, a range of local services (such as emergency admissions and the police).

Mental health specialist placements

We will complete a review of the current arrangements for commissioning specialist support during 2026/27. This will build in work on the recent Inpatient Delivery Plans, and will seek to remodel the offer for people who need specialist rehabilitation support, reducing the number of people who are not supported locally. Our work will include analysis of recent trends, utilising population health management data and close liaison with NSFT to identify service gaps and potential areas of service redesign.

We aim to have completed this work by April 2028, by which point there will be a consistent, ICB-wide approach which enables support locally to be the default, with non-local placements becoming the exception.

3.3. Commissioning approach

Delivery of most of the priorities set out above will require a partnership approach, in order to codesign services that are evidence based, aligned with other provision locally and that meet service users' needs and preferences.

In some instances, this codesign phase will be followed by a procurement process, which does not always sit comfortably alongside a partnership based approach. The framework within which the ICB operates is the Provider Selection Regime[7], which sets out when procurement is likely to be appropriate, and what form it might take. The ICB is currently finalising its own strategic commissioning toolkit, which aims to build on the PSR regulations to help the ICB to use its procurement function appropriately, sensitively and intelligently.

3.4. System and Partners' priorities

Shared system ambitions

Over time, we are keen to work with partners to test whether we can come together and act in concert to identify, agree and deliver a small number of shared objectives. We know from discussions with partners as we have developed this plan that there is interest in and support for this concept.

This idea been referred to as setting 'shared system ambitions'. This would involve collectively identifying two or three medium term priority outcomes that are ambitious, aligned with the key issues identified in the two needs assessments and that require multi-partner engagement to successfully deliver. Once agreed, one partner could, on behalf of the wider system, take the lead in delivery, convening partners as required and establishing a system-delivery plan.

[7] https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/

As well as focusing collective effort on key issues, a shared system ambitions programme would encourage the development of new ways of working and could result in a template for the future.

Early examples of possible whole system ambitions are:

- Increase the life expectancy of people with severe mental illness
- Reduce the number of children and young people who are not attending school due to poor mental health
- Reduce the proportion of adults reporting low life satisfaction, high anxiety or low happiness

Progressing the shared system ambitions would form one of the core functions of the Norfolk and Suffolk mental health network that we propose in section 4.4.

Contributing to partners' plans and priorities

This section has largely focused on our priorities for mental health as a newly established ICB; it sets out the main areas of work that we will be responsible for leading and convening, involving partners as we do so.

Alongside this, we recognise that there are a wide range of other issues and priorities that need to be addressed if we are to improve wider wellbeing and mental health, and that many of these are led by that other partners. Examples include:

- Initiatives that focus on prevention, early intervention and wider determinants of mental health, including healthy workplaces
- County-based suicide prevention strategies
- Public health commissioned services such as health visiting
- County-led children's services such as early help
- Social care support for people with mental ill health

Our clear commitment, through this strategy, is to be an active partner in these areas, including where appropriate in key alliances such as the Children and Young People's Alliance in Norfolk. This is in recognition that although we have a leadership role in many (mostly NHS) priorities, we have an equally important role in supporting others in the delivery of theirs.

4. System Delivery

This section sets out some considerations on how the wider Norfolk and Suffolk system might collaborate to deliver priorities and shared outcomes for mental health, and increasingly align strategies and plans. This includes our view on what the ICB's role in these arrangements might be in the future.

4.1. Background

Promoting and enabling emotional wellbeing and good mental health is not the preserve of a single organisation. The underlying causes of poor mental health are varied and complex, as are the range of people and bodies that have a role in addressing them – from individuals, communities and VCFSE organisations through to statutory services provided by local authorities and the NHS.

Although the broad objectives of such a diverse consistency are widely shared – supporting good mental health – the priorities of partners inevitably differ. Larger statutory organisations (including the ICB) tend to have – and are often required to have – their own strategic plans that primarily focus on what they are directly accountable for delivering. In addition, there are a very large number of other organisations, including those in the VCFSE sector, who often provide support in very specific geographical areas or on particular topics, who will have their own priorities and plans.

In addition, leadership responsibility for mental health and wider wellbeing is widely distributed. Taken together, the number of stakeholders involved in mental health and the variety of leaders creates a challenge for the system: how best to collaborate and align plans in order to meet shared objectives.

4.2. Alignment of Strategic Plans

Creating a set of strategies and plans for emotional wellbeing and mental health that are fully aligned is likely to be an objective that takes many years to deliver, if it is possible at all. However, what is possible is for key partners to recognise this issue, and to agree to set a shared goal of increasingly aligning strategic and transformation plans. This would require each partner, as it develops its own internal ('vertical') plans, to simultaneously give careful thought to how they align with others' priorities (the 'horizontal').

In developing this ICB strategic plan, we have discussed the importance of alignment with a wide range of local partners, and there is a broad consensus supporting this direction of travel. We have tried to model this approach in the development of this strategic plan, by sharing and discussing the priorities we set out, as well as by considering how best to work together. We know that other partners – for example NSFT as part of the refresh of their strategic plan – are doing the same, which we welcome.

As a system there are other steps we can take to better align and integrate our activities, for example by: ensuring we all have regard to the refreshed needs assessments in determining our priorities; that where possible our plans are mutually

reinforcing; and that where it makes sense to do so we combine resources to deliver improvements.

4.3. Previous Mental Health Collaborative Arrangements

Because there is a clear need to share and where possible align work programmes, and to collaborative to deliver priorities, in recent years both the Norfolk and Suffolk systems have developed a range of collaborative arrangements for mental health. These arrangements seek to bring partners together to set shared goals, coordinate work and in some instances integrate delivery.

Previous arrangements

Arrangements for partnership working on mental health have evolved differently across the two counties.

In Norfolk, there is a separation between the arrangements for Children and Young People and those for Adults. In the former, the County Council has led the development of a shared system strategy ('Flourish'), and has convened an effective CYP Strategic Alliance, which has four principal objectives, including improving children's emotional wellbeing and mental health. Although there have been various system groups focusing on adult mental health in Norfolk, at present there is no standing adult-focused mental health alliance or collaborative in place.

In Suffolk, in 2023 an all-age mental health collaborative, led by the ICB, was launched. This collaborative brought together partners from across the system, and had delegated authority over the ICB mental health commissioning functions and budget. The 'core' collaborative, which was formally a sub-committee of the ICB to enable functions to be delegated, was supported by a range of sub-groups, including on service areas (e.g. crisis, community, children and young people), as well as service user experience and VCFSE partnership groups.

Learning from previous collaboratives and partnerships

One advantage of having had different arrangements locally is that there is an opportunity for learning, and to draw on this experience as we consider the options for new system-wide arrangements. The following points bear consideration:

- Having delegated authority over functions and budgets (as was the case in Suffolk) can be effective in raising the profile of a collaborative, securing senior engagements in forming the basis for a system-based approach to decision making
- Equally, other examples demonstrate that it is possible to have effective partnerships without formal delegation where there is a clear shared strategy and effective leadership, as demonstrated by the successful CYP Strategic Alliance in Norfolk
- Being clear about – and remaining true to – the purpose and scope of the forum is key, otherwise there is a tendency for the agenda to grow, diluting its impacts and creating a large and unwieldy membership

- Ensuring joint or collaborative arrangements are effective requires considerable management and leadership capacity – liaising with partners, setting priorities, ensuring the right issues go the right forum at the right time, curating meeting agendas and ensuring all papers are clear
- Getting the geography right can be challenging – for example, on occasion large collaboratives may be too removed from service delivery to really understand the more local issues within smaller geographic areas, while those on a smaller footprint can find their influence over decision making is limited.

4.4. Future Collaborative Arrangements

Approach

In developing this strategic plan, we engaged with partners to both review the existing collaborative arrangements, and to understand their views and perspectives on how we, as a system, might organise ourselves in the future. Understandably given how complex a topic this is, there are a range of perspectives.

Key considerations

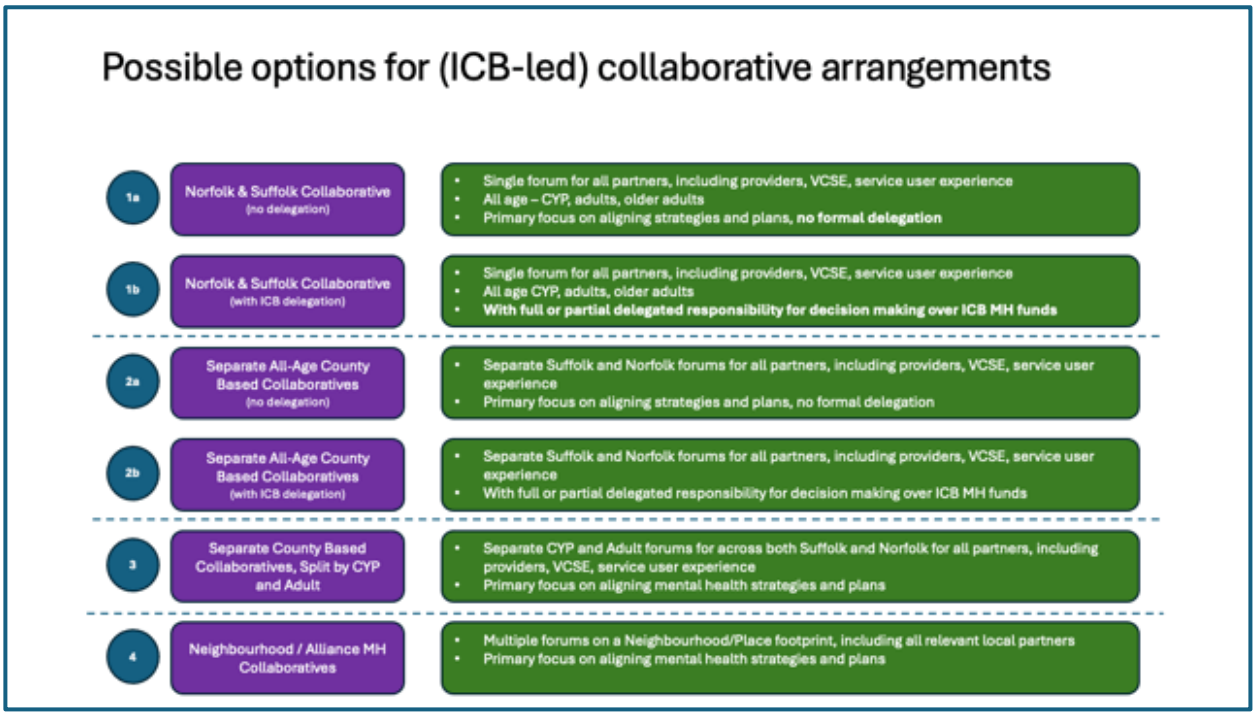
In forming a view on what shape future collaborative arrangements could take, and crucially what the new ICB's role in them should be, there are a number of factors for the ICB to consider. These include:

- Added value – the degree of confidence that the collaborative arrangements will be purposeful: effective in delivering the priorities set out in this plan and, more broadly, in improving outcomes and services
- delegation and decision making – whether the new ICB is likely to be in a position to delegate some or all mental health commissioning responsibility to a system forum, or to another partner, either now or in the future
- geographic footprint – if there are to be one or more ICB-led partnership forums, what the footprint(s) should be, recognising the wide scope of the issues and services that need to be considered
- age – whether there should be an age split in order to have a strong focus on the different needs of children and adults, or if an all age approach may be preferable
- capacity – given the very significant reduction in ICB staffing levels, and the learning about the capacity required to lead effective partnership forums, the extent to which the ICB will have the bandwidth to effectively support one or more partnership forum(s)
- other partners' arrangements – the ICB is only one body with a role in mental health locally, and there are existing arrangements (such as the Strategic Alliance in Norfolk) which already work well. Therefore, consideration of which other organisations might continue to, or may in future take on, a leadership or convenor role, is key

As part of the work to develop this strategic plan, a number of potential options for future collaborative arrangements.

Options considered

Eight main options were considered as part of our analysis of partnership arrangements that could be led by the ICB.



The first two options (1a and 1b) both take the form of single, all of Norfolk and Suffolk, all age Collaborative. The key difference between the two options is that the first assumes there is no formal delegation of commissioning responsibilities by the ICB, while the second assumes there are delegated arrangements in place.

The next two options assume that there are separate county based, all age collaboratives. The first (2a) is a model where there is no formal delegation from the ICB, while the second (2b) is a delegated model, where ICB commissioning responsibilities are formally delegated into each of the county-based collaboratives.

The next option (3) is for separate county based collaboratives, split by age, with different groups for children and young people and adults. In this option, therefore, there are four collaboratives – separate children's and adults groups in Norfolk and in Suffolk. A variant of this option - the same arrangement but with ICB functions and budgets delegated into the four groups - was considered, but was not developed in any detail as it was felt to be unrealistic in the near term, due to the practical difficulties of disaggregating ICB functions and budgets in this way, and the complex governance arrangements that would be required (e.g. multiple sub-committees of the ICB).

The final option considered (4) takes a much more localised approach, and assumes that there are a number of mental health collaboratives on a much more local footprint – for example at ICB Alliance or at neighbourhood level. As in option 3, a variation of this model, which included delegation of ICB functions and budgets, was considered but was not developed in detail, for the reasons set out above.

Delegation of ICB functions to another partner

A further option we have looked at is whether the ICB might decide to formally delegate some of its mental health commissioning functions to another partner.

One model we considered in some detail is the potential for NSFT, as the main mental health provider locally and the only statutory organisation with the same footprint as the ICB, to take on some of the ICB's commissioning responsibilities. In this model, the ICB would delegate responsibility for the delivery of one or more outcomes or pathways and would, within a formal agreement, transfer the relevant commissioning budget to the trust.

NSFT would then be responsible for designing and implementing the delivery of the agreed outcomes or pathways, including directly commissioning other partners as required. This model (often referred to as a lead provider) is in operation in some other parts of the country in mental health to enable integration of services.

An alternative model, which is much less common, would be for the ICB to delegate responsibility for some of its mental health commissioning functions to a local authority partner. An example could be the commissioning of children's mental health services, if the objective were to fully integrate the commissioning (and potentially provision) of the key mental health, wider care and education services.

Analysis and conclusions

Each of the options set out was reviewed against the key considerations set out above to help determine which – if any - might be feasible and potentially effective.

A central factor in initially narrowing down the range of options was determining whether the ICB, as a new organisation operating on a new footprint, would realistically be in a position to formally delegate commissioning functions and budgets into a new collaborative arrangements.

The conclusion reached was that this is unlikely in the near term, due to the likely practical difficulties associated with the disaggregation of functions and budgets, as well as the complex governance that would be required to enable it. There were also concerns over the ability of the ICB to effectively support potentially complex delegated forums given the significant reduction in its internal capacity. This removed two of the options considered (1b and 2b).

The next critical factor considered in assessing the options was factoring in the significant impact of the reduced capacity of the ICB. This resulted in a clear view that it would not be possible for the ICB to lead multiple collaboratives within its footprint. This led to options 2a, 3 and 4 being removed, due to the new ICB lacking the resources to be the lead partner or convenor (although other partners could establish or continue to lead partnership groups on these footprints, with the ICB as a contributor).

The option of the ICB delegating functions to another partner (such as NSFT or one of the two county councils) has clear potential advantages, including:

- promoting integration
- being better aligned with the new ICB's focus as a strategic commissioner
- helping mitigate the reduction in ICB capacity

As a result, this is a direction of travel that is broadly supported. However, in the short term there are disadvantages and potential risks that likely make this option challenging to progress.

In the case of NSFT (as their refreshed strategy recognises) while significant progress has been made in improving services and in putting strong foundations in place, there is more to do ensure that all core services are delivered to a consistently high standard. This needs to remain the trust's primary focus in the near future, rather than risking stretching capacity by adding in, on a large scale at least, new commissioning responsibilities.

A preferable approach is likely to be to support the development of these capabilities over time, with the trust increasingly taking a system leadership role in the implementation of relevant priorities set out in this plan. Elements of this approach are already in place, with for example the Trust taking a lead/system convenor role in a number of areas, including the:

- codesign and development of community mental health hubs
- preparation, with partners, of the business case for intensive and assertive outreach, for consideration by the ICB

In the case of both county councils, the delegation of ICB mental health commissioning functions is not likely to be a realistic option at this point. This is primarily due to the significant organisation change that is likely to result from the Government's plans to restructure local government. This will result in the two county and 12 district and borough councils likely to be replaced by six new unitary authorities in 2027.

Finally, consideration was given to whether any of the models outlined above would be effective in helping to deliver the priorities set out in this strategic plan. On balance, the conclusion reached was that most of the options would not be, and that a different approach where partnerships are formed around specific priorities and programmes deliverables, might be required.

Taken together, the options appraisal suggests that the only model for an ICB led mental health collaborative that has the potential to add value to the system, and be that could potentially be supported within the ICB capacity constraints, would be a single, whole Norfolk and Suffolk all age collaborative (without formal delegation).

However, having assessed this possible option in greater depth and discussed it with partners, there are significant reservations over whether this is the right way forward. Particular concerns include:

- that a collaborative encompassing all issues of emotional wellbeing and mental health would have too broad a scope, potentially limiting its effectiveness
- that an all Norfolk and Suffolk footprint would be too large, making it less relevant for partners who have a more local focus
- that the membership would likely be very large, which could impede clear decision making
- that, if purely ICB led, the forum risks becoming a briefing or overly discursive (rather than action-orientated) meeting

As a result, we have been developing – and would like to propose -an alternative approach that focuses more on how the system collaborates to deliver partners' priorities and shared projects rather than on developing a standing collaborative architecture.

There are a number of features of this proposed approach:

- not having any standing, formal ICB-led mental health collaboratives
- instead, designing future partnership arrangements around specific programmes of work and priorities, convened by the organisation that has primary accountability for their delivery
- establishing a new, quarterly Norfork and Suffolk mental health network to agree shared priorities and design joint working arrangements where these are required

In additional to the above, within the available capacity we will continue to support, and actively contribute to, relevant mental health focused forums that are led by other partners, such as the CYP Strategic Alliance in Norfolk, and the parallel arrangement that is planned in Suffolk.

Finally, there are a range of other system meetings – for example at Alliance level – that will bring together partners at a more local level and which will continue to consider mental health alongside physical health.

Developing a Norfolk and Suffolk Mental Health Network

Although we have concluded that there should not in future be permanent, ICB-led mental health collaboratives, it is nevertheless clear that delivering better emotional wellbeing and mental health support for local people requires coordination and for many partners to work closely together. Some mechanism for the system to come together is likely to be beneficial, as long as the potential disadvantages outlined above can be mitigated.

The shared challenge for the system is how to achieve this in way that is effective and that adds value and that helps partners to deliver priorities, without creating a planning infrastructure that is bureaucratic, time consuming for members or which requires significant capacity to maintain.

In our view, what is required is a flexible, dynamic arrangement that brings partners together to support and enable collaboration, focused on the issues and topics where partnership working is required. The proposed mental health network could fulfil this function.

We envisage that the proposed network would:

- meet approximately quarterly for half a day
- include all relevant statutory and non-statuary partners and stakeholders from across Norfolk and Suffolk
- be tasked with:
    - progressing work on the identification of a small number of shared system ambitions (as set out in Section 3.3)
    - coordinating work on system-wide issues where no one organisation has the lead, such as prevention and early intervention
    - mapping actions partners are taking to meet the recommendations of the new Norfolk and Suffolk needs assessments, including the identification of any gaps and how these will be filled
    - agreeing how, where required, partners might come together to deliver an outcome, objective or programme (such as the development of the new mental health hubs)
- support the ongoing alignment of partners' strategies and delivery plans
- provide an opportunity for updates on key topics
- offer a regular opportunity for strengthening relationships

For such a network to be effective and purposeful, it would need the right culture, with members being committed to using the forum to progress and coordinate the delivery of agreed priorities. It would also need to be flexible, with the ability to establish workstreams or sub-groups to develop specific pieces of work.

Ideally, this network should be co-sponsored by a broad range of partners, to ensure it is a collective endeavour that has a genuine system focus. This could be achieved by having rotating leads/chairs, by jointly setting agendas and ensuring there is distributed leadership, with different partners leading on different topics.

Therefore, while the ICB is willing to commit to mobilising and being the convenor of the proposed network initially, we would welcome a joint approach with other partners. We aim to hold the first meeting of the network in summer of 2026, with a likely focus on agreeing the scope and work plan for the network.

This proposed approach also reflects the sovereignty of individual organisations, each of which has their own strategies and plans in support of mental health and emotional wellbeing.

Contribution of partners from the VCFSE sector

Across Norfolk and Suffolk, there are several hundred organisations from the voluntary, community and social enterprise sector that make a vital contribution to supporting emotional wellbeing and mental health. As noted above, these organisations vary greatly in their scale, scope and geographic focus, and while in some instances VCFSE organisations are directly commissioned to provide services, many others do so by drawing on their own resources.

The value of this contribution is highlighted in the ICB's Population Health Improvement Plan, which sets an objective of moving "a greater proportion of mental health funding to the VCFSE sector to promote early intervention and prevention". There are already measures in place to support delivery of this objective, with for example a proportion of the potential funding for a recent business case developed by NSFT being 'ringfenced' for VCFSE led activity. We will continue to pursue this approach as we commission new, and recommission existing, services.

Alongside this, we will discuss with colleagues, including those in the VCFSE Assembly, what other mechanisms could be put in pace to enable an expanded role for VCFSE partners in supporting the emotional wellbeing and mental health of local people.

5. Next Steps

5.1. Approach to Delivery

Section 3 outlines the main priorities for the ICB over the period of this strategy, with seven key areas identified:

- commission a comprehensive, integrated support offer for perinatal mental health and parent-infant relationship support
- proactively identify families with children aged 0-5 who would benefit from targeted, multiagency support and develop more integrated models of commissioning and provision
- expand the coverage of Mental Health Support Teams to all schools, including those in the independent sector and further education colleges
- ensure that community based mental health services are fully embedded within new neighbourhood delivery models
- strengthen support for people with complex needs
- review and recommission all relevant crisis and urgent care pathways to ensure there is a consistent, evidence based approach
- implement a new, consistent ICB-wide model for commissioning all relevant specialist adult placements

Detailed implementation plans, including timelines and milestones, are being developed for each of the seven areas and will be shared with partners in order to:

- ensure that plans are clear, transparent and as far as possible aligned with partners' work and timescales
- enable joint working arrangements (for example on early years) to be developed
- establish a framework that enables progress to be tracked and shared

The proposed quarterly Mental Health Network is likely to be a key forum for sharing and iterating these implementation plans.

5.2. Provisional Delivery Milestones

Year	Quarter	Provisional Milestone
2026/27	Apr-Jun	• ICB Strategic Plan agreed by ICB Strategic Commissioning Committee • MHST – ICB approval of funding for expansion • Support for people with complex needs – review business case • Preparation of implementation plans for strategic priorities
	Jul-Sept	• Initial quarterly meeting of N&S MH Network

		• Support for people with complex needs – codesign of detailed service and review of business case • Mobilisation of implementation plans
	Oct-Dec	• MHST – market engagement and procurement • Neighbourhoods - embed integration of community mental health into neighbourhood plans • Support for people with complex needs – finalise standard operating procedures • Quarterly meeting of N&S MH Network
	Jan-Mar	• Perinatal – complete baseline review of existing service • Early years – agree collective approach to sharing intelligence • Neighbourhoods – mobilisation of first phase • Alternative crisis pathways – complete baseline review and recommissioning • Specialist placements – mapping and review of existing arrangements complete • Quarterly meeting of N&S MH Network
2027/28	Apr-Jun	• MHST – contract award • Neighbourhoods – single point of access go live • Support for people with complex needs – new service operational • Alternative crisis pathways – new services mobilised • Quarterly meeting of N&S MH Network
	Jul-Sept	• MHST – contract mobilisation • Quarterly meeting of N&S MH Network
	Oct-Dec	• Quarterly meeting of N&S MH Network • Support for people with complex needs – new service operational (complex emotional needs)
	Jan-Mar	• MHST – teams in place at 77% of schools and colleges • Perinatal – complete commissioning of integrated offer of support • Early years – jointly commissioned pathways in place • Specialist placements – consistent ICB-wide commissioning model in place • Quarterly meeting of N&S MH Network
2028/29	Apr-Jun	• Neighbourhoods – phased integration of community mental health services • Quarterly meeting of N&S MH Network
	Jul-Sept	• Quarterly meeting of N&S MH Network
	Oct-Dec	• Quarterly meeting of N&S MH Network
	Jan-Mar	• MHST – teams in place at 92% of schools and colleges • Quarterly meeting of N&S MH Network
2029/30	Apr-Jun	• Neighbourhoods – phased integration of community mental health services • Quarterly meeting of N&S MH Network

	Jul-Sept	• Quarterly meeting of N&S MH Network
	Oct-Dec	• Quarterly meeting of N&S MH Network
	Jan-Mar	• MHST – teams in place at 100% of schools and colleges • Quarterly meeting of N&S MH Network

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 11
Date: 15 July 2026

Title: Community Stroke Services Business Case (Left Shift) 2026/27

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

Authors:

Jamie Weavers, Planned Care and Long Term Conditions Commissioning Senior Manager
Lucy Ainsley, Planned Care and Long Term Conditions Commissioning Senior Manager

Purpose:

To provide the Board with an update on the approved Community Stroke Services Business Case.

The proposal has been developed to address rising demand, variation in access to community stroke rehabilitation, and gaps against national standards, and supports the ICB's strategic priority to shift care closer to home.

The business case has been reviewed and approved through the ICB's governance processes, including consideration by the Strategic Commissioning Committee.

Recommendation:

The Board is asked to note the approved business case.

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1. Background

1.1. Stroke is a leading cause of adult disability, with approximately 3,400 people experiencing a stroke each year across Norfolk and Suffolk and around 37,000 people living with its effects. Demand is expected to increase by 21% over the next decade, alongside growing clinical complexity.

1.2. Community stroke rehabilitation services have been operating below the workforce levels set out in the national Integrated Community Stroke Service (ICSS) model—a nationally defined standard for stroke rehabilitation that sets out the expected multidisciplinary team, therapy intensity, and rapid response times to support early

discharge and ongoing recovery in the community. This has resulted in variation in access, delays to discharge and reduced therapy intensity.

1.3. This business case was developed in response to rising demand, variation in access to community stroke rehabilitation, and constraints in community capacity impacting timely discharge from hospital. It supports strengthening community stroke services to improve outcomes and independence for patients, and to enable earlier and safer discharge from hospital. The approach aligns with national policy, including NICE stroke rehabilitation guidance and NHS England's Integrated Community Stroke Service (ICSS) model, and supports the ICB's strategic priority to deliver care closer to home.

1.4. The approved investment represents approximately £2.5 million recurrent funding to strengthen community stroke rehabilitation capacity across Norfolk and Suffolk. This investment underpins the expansion of the multidisciplinary workforce and delivery of the Integrated Community Stroke Service (ICSS) model.

1.5. The financial case demonstrates a non-cash-releasing return on investment, with benefits primarily realised through released operational capacity. This includes an estimated reduction in hospital length of stay and the release of approximately 7,398 bed days per year. Using a tariff-based proxy for bed day value, this equates to a non-cash-releasing return on investment of approximately 46% (benefit–cost ratio of 1.46:1), indicating that the model delivers greater system value than the recurrent investment required.

1.6. The model remains financially positive even with a 25–30% reduction in expected benefit realisation, providing additional assurance on the robustness of the assumptions and overall value for money.

1.7. It is important to note that the financial benefits are expressed as capacity rather than direct cash savings. The model takes a prudent approach, focusing on bed day release only, and does not fully capture wider system benefits such as reduced admissions, improved patient outcomes, or reduced demand on social care.

1.8. The approved investment will deliver a significant expansion in community stroke workforce capacity, including the introduction of approximately 40 additional roles across multi-disciplinary teams. This will increase overall staffing levels from an average baseline of approximately 38% towards around 60% of the Integrated Community Stroke Service (ICSS) model.

1.9. This increase in capacity is expected to support earlier discharge from hospital, improve access to timely and intensive rehabilitation, and reduce unwarranted variation in provision. As a result, the model is expected to release approximately 7,398 bed days per year, contributing to improved patient flow, reduced delays in discharge and better utilisation of specialist stroke bed capacity.

2. Key Issues and risks

2.1. The key issues addressed through the approved business case included:

- Rising demand for stroke services and increasing patient complexity.

- Insufficient community rehabilitation capacity, contributing to delayed discharge and pressure on acute services.

- Unwarranted variation in access and service provision across localities.

- Provision falling short of national standards, including Integrated Community Stroke Service (ICSS) and NICE guidance.

2.2. The key risks associated with implementation include:

- Workforce recruitment challenges impacting the pace of delivery and benefit realisation.

- Demand growth exceeding planned capacity assumptions.

- Variation in delivery across providers affecting equity of access and outcomes.

- Benefits being realised primarily as released operational capacity rather than direct cash releasing savings.

These risks are being managed through programme governance, mobilisation oversight and a structured monitoring and evaluation framework.

3. Patient and Public Engagement

3.1. The development of the business case was informed by engagement with patients, carers and system partners.

3.2. The Norfolk and Suffolk Stroke Lived Experience Group provided direct insight into patient experience, including challenges at discharge, variation in service provision and the importance of timely, responsive support following hospital care.

3.3. The approach was also shaped through collaboration with acute and community providers, voluntary sector organisations and the Stroke Association.

3.4. There is an ongoing commitment to co-production, including continued involvement of the Lived Experience Group, use of patient-reported outcome and experience measures, and regular feedback to inform service improvement.

4. Committees and Groups

4.1. The business case was developed and assured through established system governance arrangements.

4.2. It was considered and approved by the ICB Strategic Commissioning Committee 16 June 2026.

4.3. Development and assurance were supported through:

- The Stroke Oversight Group, including acute providers, community services, VCSE partners and patient representatives.

- Multi-disciplinary and cross-system engagement, including commissioners, providers and NHS England regional teams.

4.4. Ongoing oversight and assurance are delivered through:

- The Long-Term Conditions Programme governance framework.
- Routine performance monitoring and evaluation arrangements set out within the business case.
- Regular reporting to relevant programme boards, governance groups and executive committees, providing assurance on performance, risk management, benefits realisation and compliance with agreed standards.

4.5. Formal assurance was also provided through a range of corporate functions, including Quality, Digital, Estates, Intelligence, Innovation, and People and Communities. Assessments considered areas such as service quality and safety, digital capability and infrastructure, estate implications, data and intelligence requirements, opportunities for innovation, workforce considerations, and the impact on patients, staff, and local communities.

4.6. In addition, Equalities Impact Assessments and Quality Impact Assessments were completed and formally approved in May 2026, providing assurance that potential impacts had been thoroughly evaluated and that appropriate mitigating actions had been identified where necessary.

Norfolk and Suffolk Health and Care Expo 2026

- A unique annual opportunity to bring together the wider health and care community from across Norfolk and Suffolk
- 2026 focus on Rural Health
- An inclusive event - everyone welcome and encouraged to participate
- Planned, organised, and delivered entirely by an in-house ICB team
- Celebrates and showcases the valuable contributions made by individuals and organisations across the system

🚜
Key Content contributed by the local Agricultural Community

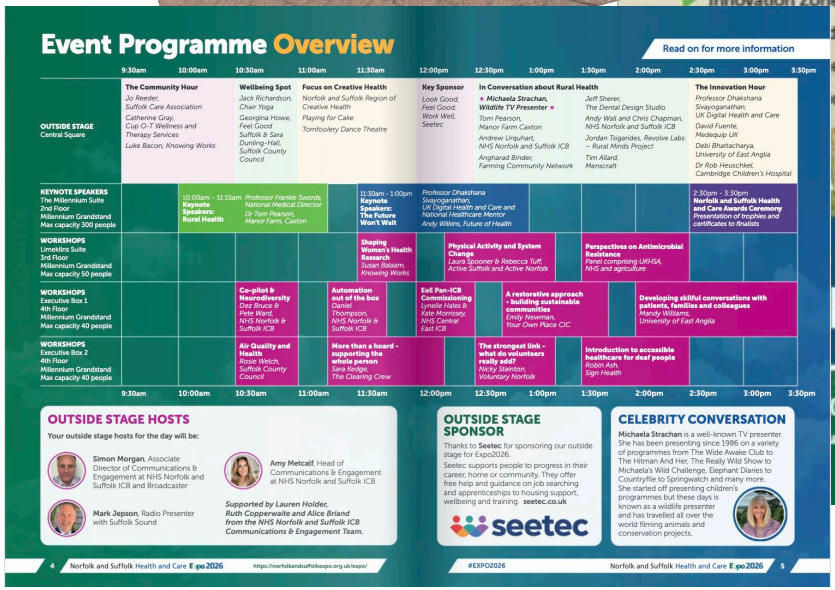
🌾
Keynote Session – Rural Health including National Medical Director & local farmer

🎤
Keynote Speakers – The Future Won't Wait

🏛️
160 Exhibitors across 7 Exhibition Zones

🛠️
12 Workshops

💬
Discussions & Performances on Outside Stage



Norfolk and Suffolk Health and Care Expo 2026

- Welcomed over 1,500 delegates from across Norfolk and Suffolk
- Expanded opportunities for students to attend and engage with the event
- Successfully attracted more frontline staff to the awards
- A diverse delegate audience representing a very broad range of backgrounds, roles and organisations

Norfolk and Suffolk
HEALTH AND CARE AWARDS 2026

Suffolk County Council

Norfolk County Council

NHS Norfolk and Suffolk Integrated Care Board

176
NOMINATIONS

80
FINALISTS

8
CATEGORIES

Michaela Strachan
TROPHIES PRESENTED BY

Feedback

Just thought I would share how fantastic Friday was, we gained so much from being there, lots of positive discussions and networking opportunities.

Anglian Care Trust

I would like to personally thank you for organising such a fantastic event on Friday, it was a great day and worthwhile us joining you.

Norfolk and Waveney Mind

Thank you so much for running such a successful event!

Caroline Donovan, CEO
Norfolk and Suffolk NHS Foundation Trust

I had such a fabulous time on Friday! Thank you for giving us the opportunity and I really, really hope we can work together on Expo 2027!
You put together something magical!

Seetec

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number:14
Date: 15 July 2026

Title: **East Coast Partnership & WorkWell**

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

Author: **Helen Bowles, Head of Work and Health**

Purpose: **Information**

Recommendation: To note the paper

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1. Introduction

In November 2025, Suffolk & North East Essex Integrated Care Board (ICB) Board approved the Work & Health strategic plan which began to outline the role the ICB needed to undertake to contribute to socioeconomic development. In March 2026, the combined Norfolk & Waveney and Suffolk & North East Essex ICB Boards approved the commencement of designing and delivering the WorkWell service, aimed at supporting people with health needs who are struggling to remain in work and be healthy.

This paper will summarise some of the actions taken to date which were proposed in the ICB Work & Health strategic plan, Get Norfolk Working and Get Suffolk Working Plans, and will spotlight three initiatives that are under development which will have a positive impact for people who are facing barriers to employment or remaining in employment. These are WorkWell, East Coast Partnership and Widening Access Demonstrator programme.

2. Background

One of the four roles of an ICB is to support wider socioeconomic development. Employment is one of the most influential wider determinants of health, impacting the individual and their family/household's health and wellbeing. The relationship between work and health is intrinsic, with good work supporting positive long term health outcomes, and good health enabling participation in meaningful employment.

Within Norfolk and Suffolk we issue approximately 240,000 individual fit notes per annum, and 5.9% of our population is economically inactive due to health needs. Other health barriers impacting economic activity are caring responsibilities, women's health conditions, and young

people with SEND. The level of comorbidities and forecasted increases in long term conditions mean that this challenge will only increase.

Key Issues and risks

There are no significant risks or issues associated with socioeconomic development activities. WorkWell has an ambitious mobilisation date which is nationally driven, but this has been mitigated by rapid codesign and a phased rollout option if required.

3. Patient and Public Engagement

People with lived experience were engaged with during the development of the strategic plan, and a public campaign about work and health was completed in Suffolk during Spring 2026.

WorkWell has reached out to people via the Let's Talk Health & Care platform and through VCFSE and community leaders. A panel has been created to contribute to the procurement and selection process and will continue to be part of the continuous improvement cycle embedded within WorkWell.

Employers are also consulted with, a WorkWell survey has been circulated, respective Chambers of Commerce have been collaborating with employers to gain their input into supporting people with health needs, and the Suffolk Good Health @ Work service has workplace ambassadors who have also been engaged with.

4. Committees and Groups

Due to the transitioning phase of the ICB the report has been through Executive Committee. In the future the Health Equity Committee and/or Workforce Committee's will be used for oversight and assurance.

Socioeconomic Development Programme within Norfolk & Suffolk ICB

1. Introduction

As discussed above, employment is one of the most influential wider determinants of health, impacting the individual and their family/household's health and wellbeing. Health needs can be a barrier to accessing and remaining in employment and so the ICB has a pivotal role in:

- Commissioning healthcare to minimise the risk of work absence due to health needs
- Working with public health to advise employers on how to create healthy workplace, and how to recruit, support, and retain people with health needs
- Ensuring our commissioning optimises social value to support employment of underrepresented groups, supports the local economy and population, supports social mobility within our communities, and offers sustainability.
- Acting as system leader, bringing together anchor institutions to improve socioeconomic conditions, reduce health inequalities, and support inclusive economic growth across its population—working in partnership with local authorities, employers, VCFSE organisations, education providers, and the voluntary and community sector

The aim is to improve population health and reduce health inequalities by strengthening socioeconomic conditions, with a particular focus on people and communities facing the greatest disadvantage.

This paper will outline the progress the ICB has made to date in achieving this aim, spotlighting three initiatives that are due to be realised during the next twelve months.

2. Background

There are more people in the UK who are economically inactive due to health conditions or disabilities, than for any other reason. In 2025, there were nearly 800,000 or 40% more people of working-age who were economically inactive for health reasons, than there were in 2019. This is nearly ten times the growth of the working age population during the same period.

By 2030, 600,000 more people across the UK could become economically inactive if current trends continue, losing out on opportunities in the workplace, experiencing financial hardship, suffering from health inequalities, widening the skills gap, and making an already tight labour market even more so. Sickness absence is also forecast to increase by 21%.

One in five of all working-age people (approximately 200,000 people within Norfolk and Suffolk) report having a work limiting health condition, so there are more people who are in work with a work-limiting health condition than those who are economically inactive because of one. The challenge of addressing economic inactivity is therefore as much within the workplace as it is in helping people into employment.

Within Norfolk and Suffolk we issue approximately 240,000 individual fit notes per annum, and 5.9% of our population is economically inactive due to health needs. We are seeing a growing number of young people not accessing education, employment, or training post 16, and under 24 year olds requiring universal credit due to their health needs, namely mental health conditions (including neurodiversity, learning disabilities and autism). The highest proportion of people who are off sick due to health needs are over the age of 50 years, presenting with multiple conditions, but their primary need is most often musculoskeletal or mental health related.

Other health barriers impacting economic activity are caring responsibilities, neurological and nervous system, women's health conditions, and young people with SEND.

The level of comorbidities and forecasted increases in long term conditions mean that this challenge will only increase; leading to a position in the next 5 – 10 years where we will have insufficient working aged people in Norfolk and Suffolk to meet the economic, health and care needs of our communities. It is therefore important that we:

1. **optimise young people and working aged people's general health and wellbeing to reduce the risk of them developing work limiting conditions**
2. **maximise opportunities for people with health needs to be in employment for their health needs and for our local economy to thrive**
3. **be an inclusive employer within health and social care, with diverse entry routes into professions**

In November 2025, Suffolk & North East Essex ICB Board approved a Work & Health strategic plan which began to outline the role the ICB needed to undertake to contribute to socioeconomic development. It addressed health promotion and prevention, sickness absence, inclusive employment, healthy workplaces, health inequalities, and being a role model employer. Written in unison with the Get Suffolk Working plan it aligned to system aims of an all industry supply pipeline, comprehensive skills and development offer, local employment, and social value. It became a Joint DWP, Local Authority (LA), and ICB strategy. The Get Norfolk Working plan was developed along similar themes and so also aligns with the Work & Health strategic plan.

As can be seen in the figure below, there are a large number of activities that the ICB and wider health system contributes towards which optimises socioeconomic development within our communities, as well as individual resident's health and wellbeing outcomes and reducing inequalities.

The ICB has historically linked with major infrastructure projects (MIP) and large employers within our communities to identify opportunities for growth, employment, and investment in population health and wellbeing. There is a dedicated post within the ICB to ensure integrated working with Sizewell C, and Place based teams in West Norfolk and East Suffolk have been embedded in the Marmot programme to address the wider determinants of health, including employment.

Dr Ed Garratt co-chairs the Coastal Navigator Network due to the unique inequalities faced by people living in our coastal communities. A number of communities around the UK coastal line are

part of the network and have been developing a strong evidence base of supporting the needs of the communities, including employment.

This paper will summarise some of the actions taken to date which were proposed in the ICB Work & Health strategic plan, Get Norfolk Working and Get Suffolk Working Plans, and will spotlight three other initiatives that are under development which will have a positive impact for people who are facing barriers to employment or remaining in employment.

3. Fit for Work, Fit for Life Strategic Plan Implementation

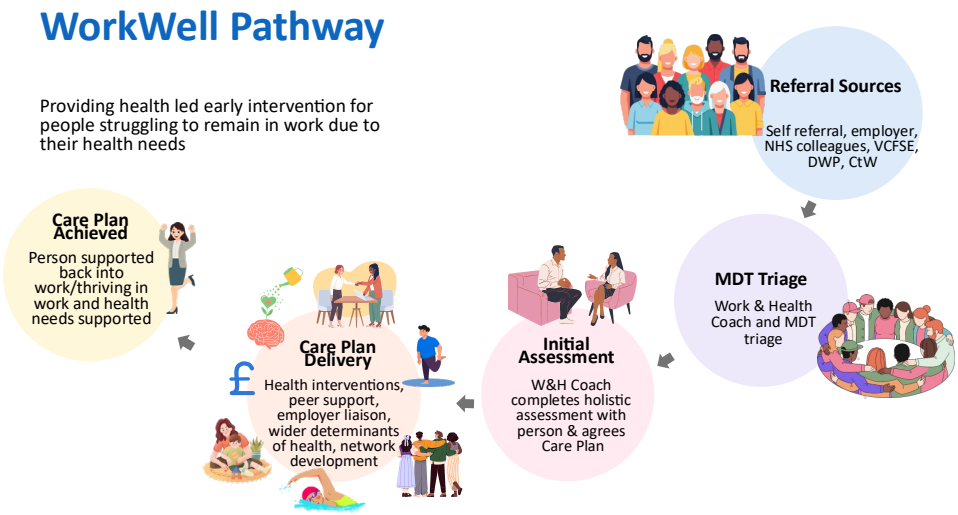
Since the strategic plan was approved in November 2025 the implementation phase has so far included the following:

- Publication of a Reasonable Adjustments and Accessible Workplace guide for employers
- Dedicated ICB webpage bringing together all employment, skills and development offers into one central location on behalf of the LA, DWP, and ICB
- Public and Employers Communications campaign in Suffolk explaining how work contributes to Good Health in collaboration with public health
- Commissioning of public and employers' campaign for Norfolk (Norfolk County Council led)
- Publication of a risk of NEET identification tool for Primary Schools and roadmap of support throughout secondary school
- Design of WorkWell as early intervention service for people struggling to remain in work
- Piloting "Health and Employment Days" in Ipswich, bringing together system partners who can offer health, employment, financial, carer and other support, aimed at helping people to meet their health needs and move nearer to work

4. Spotlighted Initiatives

4.1 WorkWell Procurement

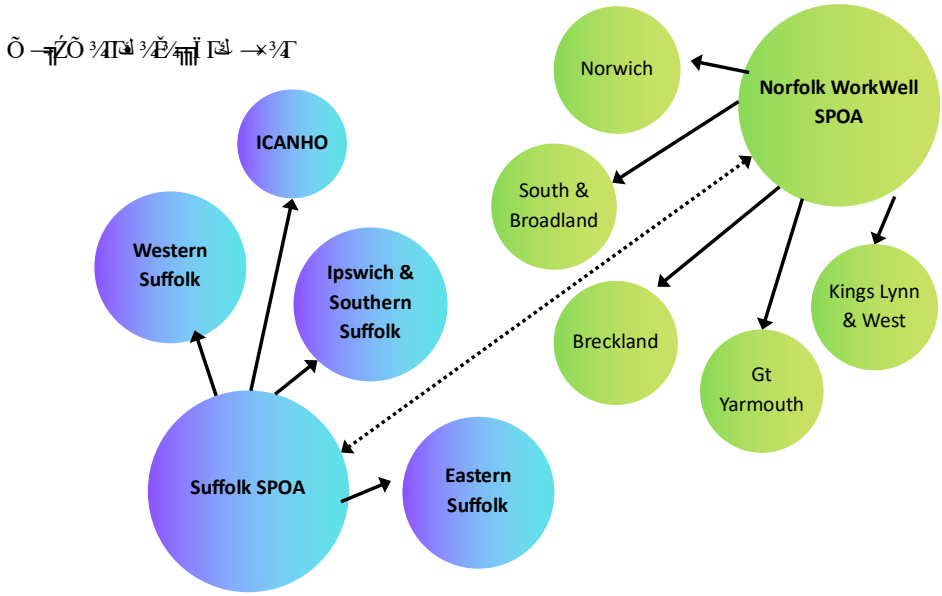
The combined ICB Boards approved the decision to move forward with designing and delivering the WorkWell service on 25th March 2026. Nationally funded, WorkWell will offer a health and employment support service providing integrated holistic early help for people with health-related barriers to work. WorkWell is aimed at anyone with a disability or health condition who is in work or who has recently fallen out of work. A small clinical team will be able to conduct assessments, provide brief interventions, and complete fit notes; and local work & health coaches will provide intense health and employment support. The service will also consult with employers on the appropriate reasonable adjustments a person may require, and enable participants to access the right health, employment, skills, or development support appropriate to their individual needs.



Since the Board meeting in March a comprehensive co-design and market development phase has been completed, engaging with over one hundred provider and VCFSE organisations through face to face events, online briefings, and Q&A sessions. A campaign was launched through Lets Talk Health & Care to find people with lived experience of struggling to remain in work due to their health needs. They gave us rich feedback and advice on how the service should be designed. A small panel will assist in the procurement and selection process and will continue to support the provider organisations and ICB with the continuous improvement of the service. Views of employers were sought directly through surveys, face to face conversations, and through system partners such as the County Councils and Chambers of Commerce.

As a result, a service specification was produced and the procurement was launched on 12th June. The ICB is commissioning two providers/collaborations, one for Norfolk and one for Suffolk, however the services will work together to offer choice for participants, particularly those people who reside in “border communities.” The two county model was chosen to optimise the market, minimise the risk of commencing a new type of service within a noticeably short mobilisation period, and to facilitate place based delivery and relationship development within the supported employment ecosystem.

ICANHO is a specialist provider already commissioned by the ICB to deliver holistic rehabilitation for people with traumatic and acquired brain injuries. As part of WorkWell, the ICB has therefore co-commissioned them with the regional DWP team to offer return to work support for people with brain injury and/or stroke (and their carers), to provider return to work support. The Norfolk cost envelope is higher to enable the provider to offer an equivalent service for Norfolk residents.



The Clarification Question period of the procurement was completed on 10th July, and so we are receiving tender submissions until 24th July. The preferred bidders will be announced week commencing 21st September 2026. The aim is to realise the expected mobilisation date of 2nd November, but the ICB has had a discussion with senior management within the DHSC & DWP Team to agree a mitigation plan if this is not safe or practical to achieve.

4.2 East Coast Partnership

The East Coast Partnership has been established to improve employment, skills, health, and opportunity across the coastal communities of Great Yarmouth, Lowestoft, and Felixstowe. It forms part of the wider Coastal Navigators Network, bringing together partners across employment, education, health, local government, the voluntary sector, and employers to create a more coordinated system of support for local residents.

Whilst each locality has significant assets, there are longstanding challenges around educational attainment, economic inactivity, and health inequalities that continue to limit opportunities for local people and restrict workforce development across the region.

The Partnership has an initial ambition to achieve 500 positive destinations during Year One. Evidence suggests that between 1,500 and 2,000 residents across the three towns are currently disengaged from employment, education, or training. Achieving 500 positive destinations would therefore engage approximately 25% of this cohort, representing a significant contribution towards improving economic participation.

A positive destination is intentionally broader than employment alone and may include work experience, volunteering, skills training, apprenticeships, supported employment, part-time or full-time employment, and other meaningful progression towards sustainable careers. The emphasis is on creating realistic, achievable progression routes that build confidence, skills, and long-term employability rather than focusing solely on immediate job outcomes which we know is important for people who have been out of work for a period of time and/or have health needs.

The Partnership will develop a Community of Practice that enables system partners to share intelligence, coordinate activity, and continuously adapt delivery in response to local need. Central to this approach is collaborating closely with employers to:

- Increase awareness of local opportunities.
- Improve employer engagement and recruitment pathways.

- Place greater emphasis on confidence, competencies and lived experience alongside formal qualifications.
- Secure tangible commitments from employers and training providers.
- Create sustainable career pathways rather than isolated interventions.

The Partnership's Year One focus is on establishing the infrastructure required to deliver sustainable outcomes e.g. mapping existing employment, training, and progression opportunities across the three towns, establishing the community of practice, identifying funding and resource opportunities to support coordinated delivery. This foundation will enable the Partnership to better coordinate existing provision, reduce duplication, improve referral pathways, and maximise the impact of investment across East Suffolk and the wider East Coast.

The East Coast Partnership provides an opportunity to:

- Improve employment and skills outcomes across coastal communities.
- Reduce economic inactivity through earlier intervention and coordinated support.
- Contribute to NHS prevention priorities by supporting individuals experiencing long-term sickness back towards work and wellbeing.
- Strengthen employer engagement and address local workforce shortages.
- Create sustainable career pathways aligned with local labour market demand.
- Develop a collaborative, evidence-led Community of Practice capable of attracting future investment and supporting long-term system change.

The programme is being project managed by Breaking Barriers Innovation who run the Coastal Navigators Network, with oversight from the DWP and ICB.

4.3 Widening Access Demonstrators Programme

National funding was achieved to participate in the Widening Access Demonstrator (WAD) programme. It aims to create supported pathways into health and care roles for young people aged 18–25 in Great Yarmouth and Felixstowe who face barriers to employment. Targeting those who are not in education, employment or training (NEET), the programme brings together NHS employers and local partners to provide tailored, wraparound support. This includes pre-employment training, work experience opportunities, and in-role support to help individuals secure and sustain employment. The intended outcome is to widen participation in the workforce while addressing local recruitment challenges, by developing a more inclusive and accessible pathway for young people.

Progress to date has focused on establishing key delivery partnerships across both localities. The programme will be led by the Apollo Project (East Coast College), which has a strong track record in supporting cohorts of participants through pre-employment activity into sustainable job opportunities. Delivery is being developed in close collaboration with DWP partners, alongside VCFSE organisations, such as Level Two in Felixstowe.

• 120 participants will be recruited, with the aim of at least 100 participants undertaking the Pre-Employment Programme across Great Yarmouth and Felixstowe by 31 December 2026
• 80 participants will be supported by the Apollo project to achieve positive outcomes/destinations including the provision of further health and care training as appropriate by 28 February 2027

• at least 20 participants supported into health and care employment by 31 March 2027

Participants will start on the programme from early September 2026 and be recruited throughout the academic year. Job applications and positive job destinations will start to be realised from early 2027.

In addition, the programme seeks to establish Intergenerational Hubs, working with wider family networks to help break cycles of worklessness and support long-term positive outcomes. Again, this will be achieved by collaborating with local community leaders, VCFSE and statutory colleagues.

The programme will contribute towards the ICB's role in increasing positive employment destinations in Great Yarmouth, Lowestoft, and Felixstowe as part of the East Coast Partnership programme (see section 3.4).

5 Conclusion

The ICB is delivering on the aims of the Work & Health strategic plan, and growing its programme of socioeconomic development, to comprehensively fulfil its forth Pillar of contributing to the economic development of the local community. The ICB has a strong leadership role within the counties and has been proactive in system coordination and strategy development. A cohesive triumvirate leadership team has now been established with the regional DWP and the County Councils, working in partnership with system colleagues to develop system, Place, and neighbourhood level collaborative working to improve health and employment outcomes. This will take a short while to embed before tangible outcomes will be seen, as supported health and employment programmes can be intensive and complex in nature. However, the ICB should start to see a measurable impact from early 2027/28.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number:15
Date: 15 July 2026

Title: Lord Mann Review: Tackling Antisemitism and Racism in the NHS

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

Author: Ben Askew, Associate Director of People and Workforce

Purpose: This paper provides an overview of Lord Mann's independent review into antisemitism and wider racism in the NHS, the Government's acceptance of all recommendations (June 2026), and the implications for remuneration, leadership accountability, and organisational governance.

Recommendation: To approve.

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1. Background

1.1. In October 2025, Lord John Mann was commissioned to undertake a system-wide review of antisemitism and racism across the NHS and healthcare regulatory system. The Government accepted all 36 recommendations in full on 4 June 2026.

1.2. The review was prompted by evidence of rising antisemitism within the NHS, alongside persistent racial discrimination affecting staff and patients. It found that Jewish staff experience "routine ostracism" and that discrimination against this group has been increasing, in contrast to other groups.

1.3. More broadly, the review highlighted that racism is systemic, with significant impacts on workforce experience, organisational culture, and patient confidence in accessing care.

1.4. The full report and Government Statements can be found via the links below:

- Written Ministerial Statement - Written statements - Written questions, answers and statements - UK Parliament

- Lord Mann review report - Lord Mann review on antisemitism and other forms of racism in the NHS - GOV.UK
- Government response - Government response to the Lord Mann review on antisemitism and other forms of racism in the NHS

2. Key Findings

2.1. The report sets out several critical findings:

- Widespread and normalised discrimination: Antisemitism and racism are present across NHS settings and, in some cases, have become normalised.
- Disproportionate impact: Staff from Black and minority ethnic backgrounds and Jewish staff are more likely to experience discrimination from colleagues, managers, and the public.
- Patient impact: Some patients report reduced trust and confidence in the NHS, with concerns about discrimination influencing their willingness to seek care.
- Inconsistent organisational response: There is variation in leadership capability, culture, and practice across organisations.
- Weak reporting and investigation systems: Processes for addressing racism are often unclear or ineffective.

3. Summary of Key Recommendations

3.1. The review makes 36 recommendations. Core themes relevant to Remuneration Committee oversight include:

3.2. Leadership and Accountability

- Make tackling racism (including antisemitism) a core organisational priority.
- Ensure visible board-level ownership and oversight.
- Embed equality, diversity and inclusion (EDI) objectives into senior leaders' roles and performance frameworks.

3.3. Data and Transparency

- Strengthen collection and use of workforce and patient data.
- Use WRES and staff survey data to drive improvement.
- Improve public transparency and reporting of progress.

3.4. Policies and Governance

- Standardise reporting and investigation processes.
- Ensure all staff understand behavioural expectations.
- Review policies on uniform, branding, and social media, including guidance on political symbols.

3.5. Staff Experience and Culture

- Take stronger action on racism from patients and the public.
- Provide robust support mechanisms for affected staff.
- Foster psychologically safe and inclusive environments.

3.6. Capability and Training

- Introduce mandatory training on antisemitism, anti-racism, and cultural competence, including for senior leaders.

- Strengthen organisational capability to recognise and respond to discrimination effectively.

3.7. At national level, reforms also include mandatory training for NHS leaders, new staff standards on tackling racism, and clearer accountability expectations for employers.

4. Implications for Remuneration Committee

4.1. The review has direct and material implications for Renumeration Committee responsibilities:

4.2. Executive Pay and Performance

- A clear expectation that EDI outcomes (including tackling racism) are embedded in executive objectives.
- Opportunity to link performance-related pay and appraisal outcomes to demonstrable progress on workforce equality metrics (e.g. WRES indicators, staff survey results).

Action: Ensure that all appraisals have embedded EDI actions and pay award decisions include reference to achievement of objectives where relevant and within frameworks.

4.3. Leadership Accountability

- Requirement for explicit board-level ownership, likely requiring clearer delineation in Executive portfolios and objectives.
- Greater focus on Chief Executive and Chief People Officer accountability for culture and staff experience outcomes.

Action: Completion of further work (via People Committee or equivalent) on embedding recommendations into organisational policy and culture.

4.4. Capability and Development

- Mandatory anti-racism and antisemitism training for senior leaders will need to be tracked and assured.

Action: To provide Renumeration Committee with oversight of mandatory training rates and to provide Renumeration Committee oversight of leadership development investment linked to inclusion and cultural competence.

4.5. Governance and Assurance

- Increased scrutiny of how organisations measure and report progress on tackling racism.

Action: Linked to Audit requirements and Renumeration Committee oversight on employee relations matters/investigations, to include clear indicators on regular Staff Matters reporting to highlight any cases linked to racism, non-compliance or poor leadership behaviour.

Action: Provide Renumeration Committee with a count on number of days for investigations.

The Board is asked to:

1. Note the Government's acceptance of Lord Mann's recommendations on tackling antisemitism and racism within the NHS.
2. Note the consideration of the review by the Remuneration Committee and its implications for leadership accountability and organisational culture.
3. Approve the recommendation of the Remuneration Committee that WRES and WDES indicators continue to be used as measures of leadership effectiveness, workforce experience and organisational culture.
4. Support the continued inclusion of equality, diversity and inclusion objectives within Executive Director appraisal arrangements.
5. Note that implementation and progress will be monitored through existing Board, People Committee and Remuneration Committee reporting arrangements.

Item 16

Norfolk and Suffolk
Integrated Care Board

NHS Staff Survey 2025

Norfolk and Waveney and Suffolk and North-East Essex Results

Index

Introduction and Key Considerations

Given the context of the on-going restructure and newly merged ICB, the approach to this year's staff survey results and resulting actions must differ from previous years.

This slide pack is intended for EMT and RemCom only due to sensitivity.

Organisational Development will work with Communications to ensure a clear, consistent message to staff that we are committed to responding meaningfully to feedback.

Key considerations include:

- The current restructure phase and organisational change context
- The merger of two organisations, where comparing legacy ICB results risks creating division at a time when we are working to unite and move forward
- Priority actions to support the restructure and then new ICB
- Balancing the need to prioritise areas requiring improvement, while also building on what is working well
- Avoiding duplication or confusion through separate action plans, proposing that survey actions are integrated into the wider OD programme
- Ensuring sufficient capacity to deliver meaningful, focused action in response to feedback

This slide pack includes and compares the legacy ICB results for information and discussion.

Proposed next steps and actions are suggested on slides 19-20, for discussion and agreement.

Working together to improve NHS staff experiences – our NHS Staff Survey Results

The principal aim of the national NHS survey is to gather information that will help individual NHS organisations to improve the working lives of their staff and so help to provide better care for patients. The survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey is aligned to the NHS People Promise.

The annual survey, completed by all NHS organisations in England, focuses on nine themes, aligned to the NHS People Promise and provides a detailed insight into how staff feel about culture, their wellbeing, levels of engagement and motivation, equality, diversity and inclusion, safety, and quality of care.

There is a wide range of evidence that highlights how good staff and patient experience go hand in hand, which is why making sure our staff are happy and supported is so crucial. We know there is always room for improvement, and we will continue to work with our teams to improve our offer to ensure we support staff wellbeing as best we can.

We are committed to improving staff experiences across the NHS and take part in the National Staff Survey (NSS) annually. The 2025 survey opened for responses in October 2025 and closed December 2025.

The response rate for NHS Suffolk and North East Essex ICB was 65% (327 responses) and for NHS Norfolk and Waveney ICB it was 66% (438 responses). Our comparator group comprises other Integrated Care Boards (ICBs) which had a median 65% response rate.

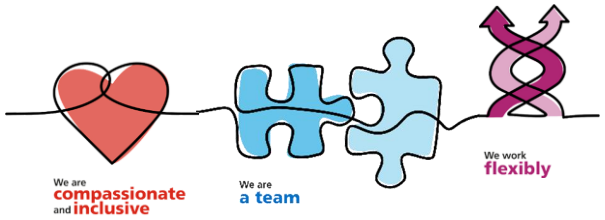
Nationally, overall NHS results declined in 2025, and Norfolk and Waveney's results are consistent with this broader trend, however Suffolk and North East Essex were above the national average, and amongst some of the best results for ICBs.

SNEE staff engagement score was 6.83 and NW 5.96 – the comparable average was 6.28.

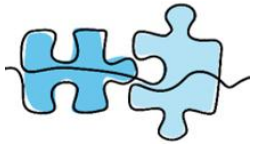
Highlights and Overview

Highlights

SNEE ICB has recorded the best result in the benchmark group in 7 out of 9 People Promise elements



Both Norfolk and Waveney ICB and SNEE ICB deliver their strongest scores against the *We are Compassionate and Inclusive*, *We Work Flexibly* and *We are a Team* People Promise elements

The *We are a Team* People Promise score for SNEE ICB shows growth year-on-year 

Whilst the Norfolk and Waveney scores have moved below the median score for the benchmark group, they continue to trend more closely to the median range than the low range scores in 6 out of 9 elements

Overview

The results for SNEE ICB provide a positive picture in comparison with other ICBs within the benchmark group. SNEE ICB scores represent the best result in the benchmark group for 7 out of 9 People Promise elements and are significantly above the average result for the group in the other 2 cases.

For Norfolk and Waveney ICB, the results provide a contrasting view. Whilst scores for all of the People Promise elements are above the worst result for the benchmark group, they also fall below the average result for the group.

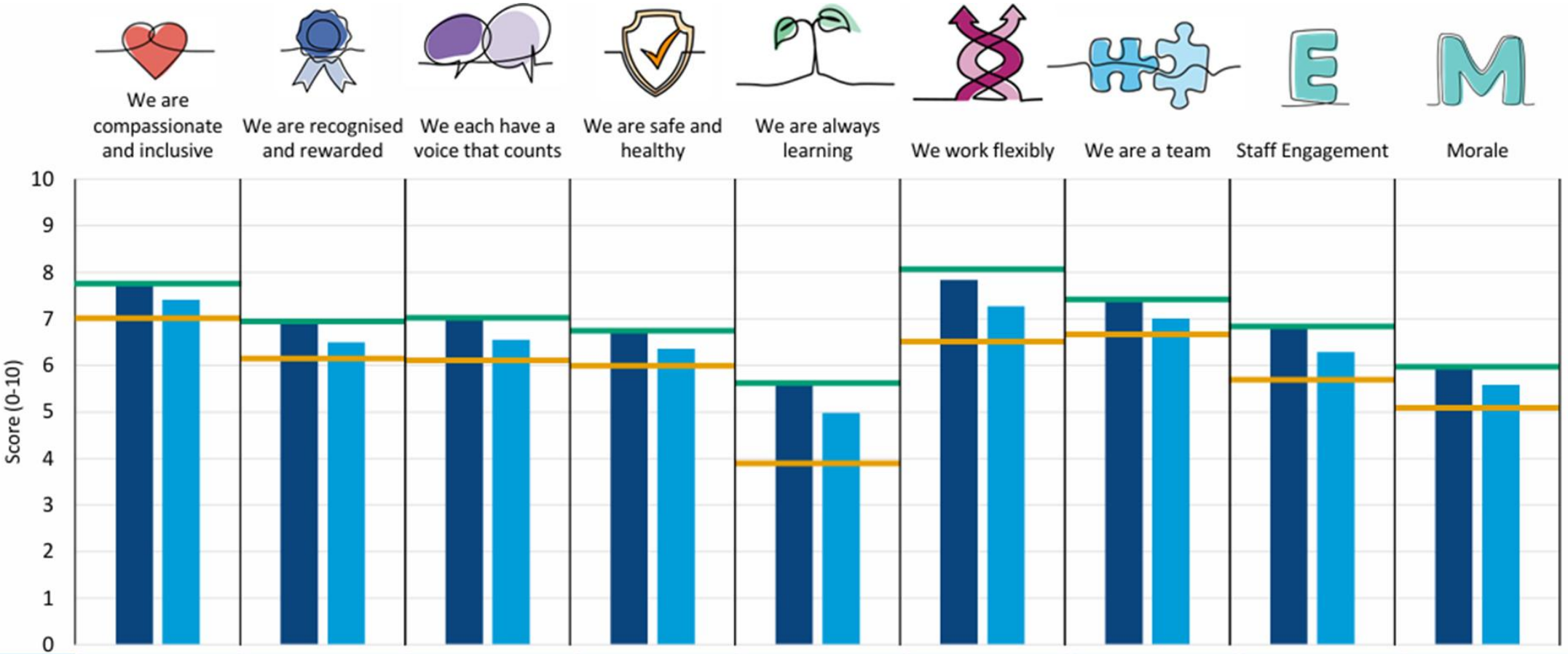
NHS National Staff Survey by People Promise Themes

Norfolk and Waveney
Integrated Care Board

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.06	6.36	6.44	6.06	4.75	7.19	6.86	5.96	5.36
Best result	7.76	6.95	7.03	6.75	5.62	8.07	7.42	6.83	5.97
Average result	7.40	6.49	6.55	6.36	4.98	7.27	7.00	6.28	5.58
Worst result	7.01	6.15	6.11	5.99	3.89	6.52	6.67	5.69	5.09
Responses	438	438	436	435	420	437	438	438	438

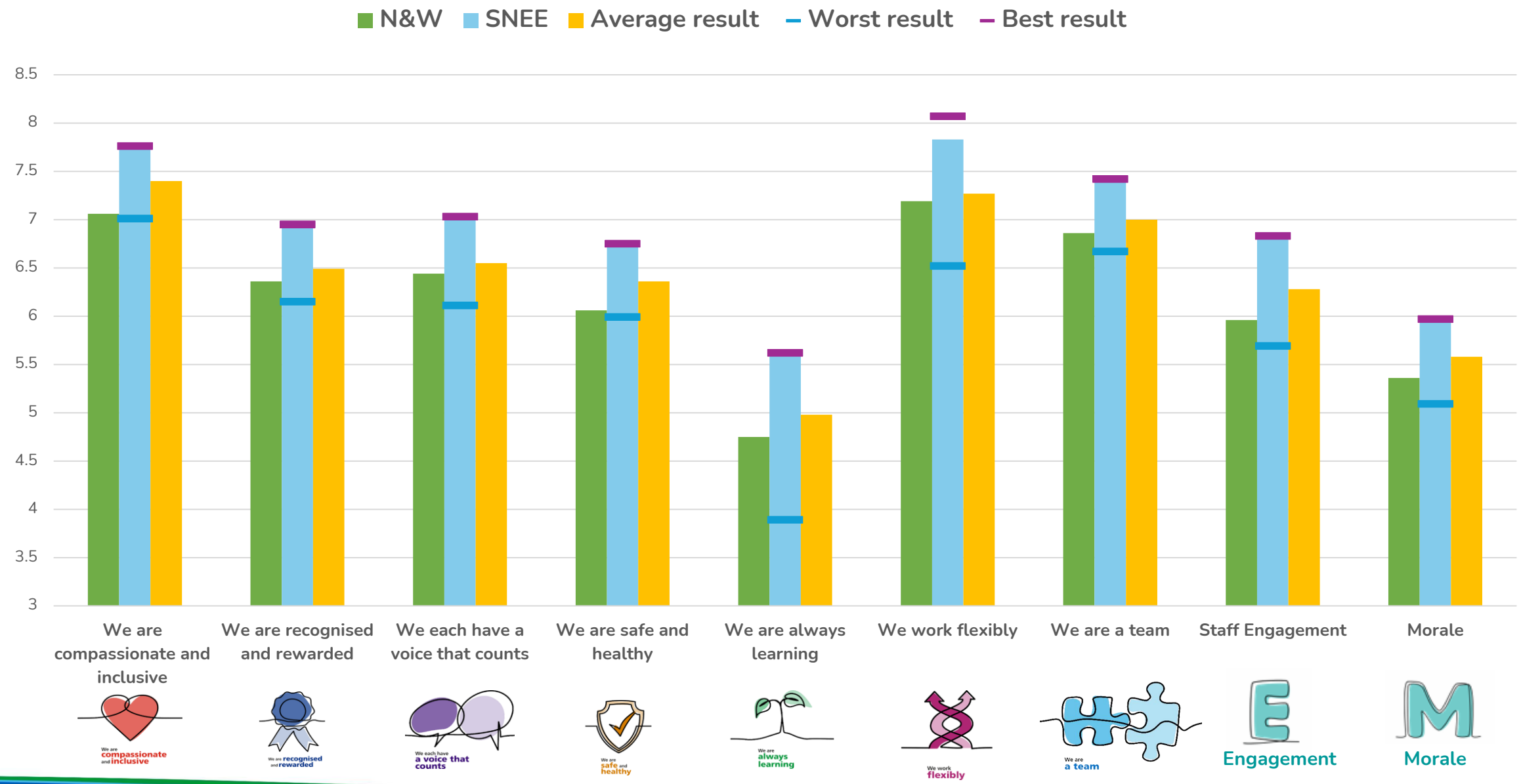
NHS National Staff Survey by People Promise Themes

NHS
Suffolk and North East Essex
Integrated Care Board (ICB)

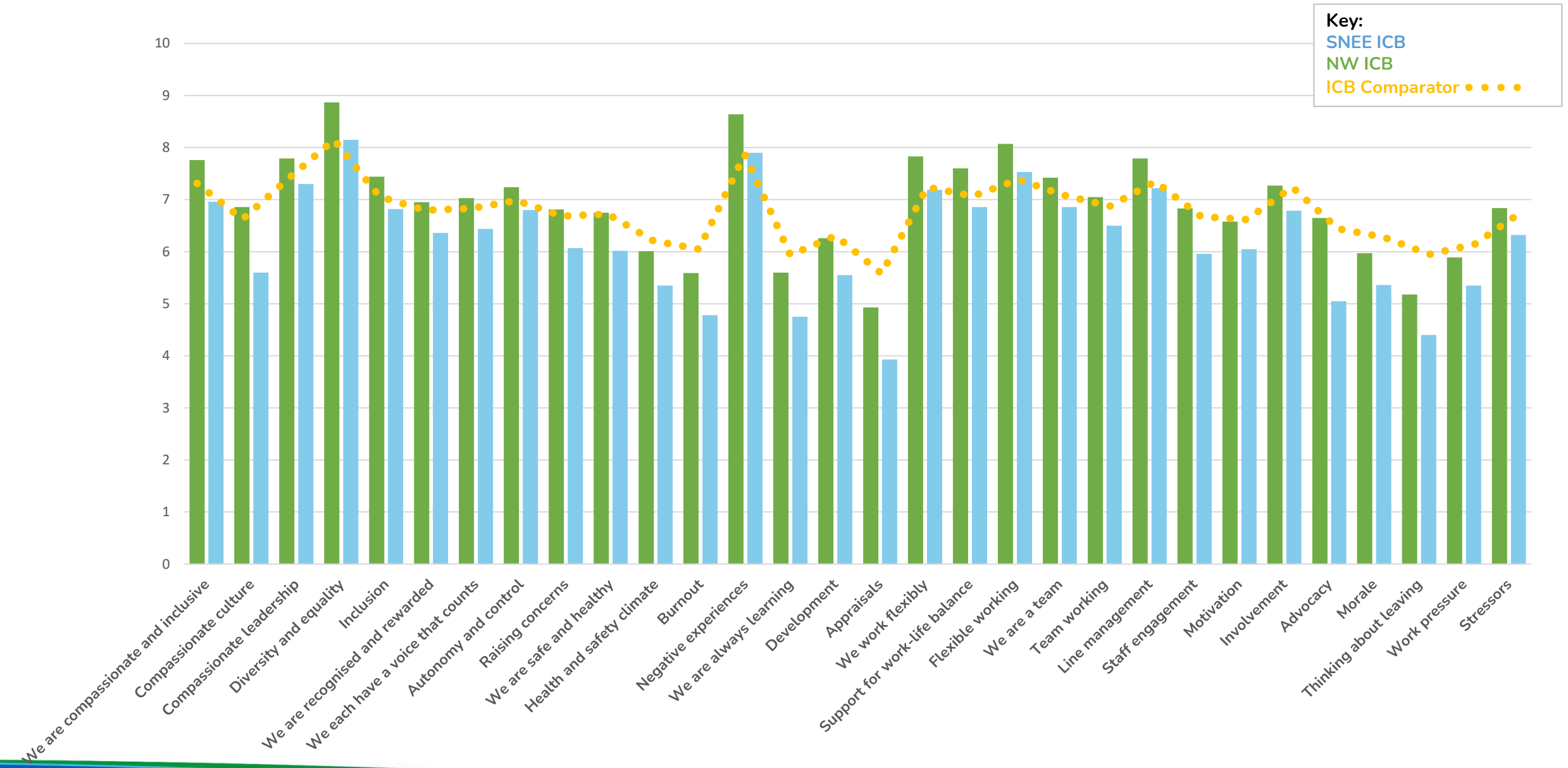


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.76	6.95	7.03	6.75	5.60	7.83	7.42	6.83	5.97
Best result	7.76	6.95	7.03	6.75	5.62	8.07	7.42	6.83	5.97
Average result	7.40	6.49	6.55	6.36	4.98	7.27	7.00	6.28	5.58
Worst result	7.01	6.15	6.11	5.99	3.89	6.52	6.67	5.69	5.09
Responses	327	327	323	327	316	327	327	327	327

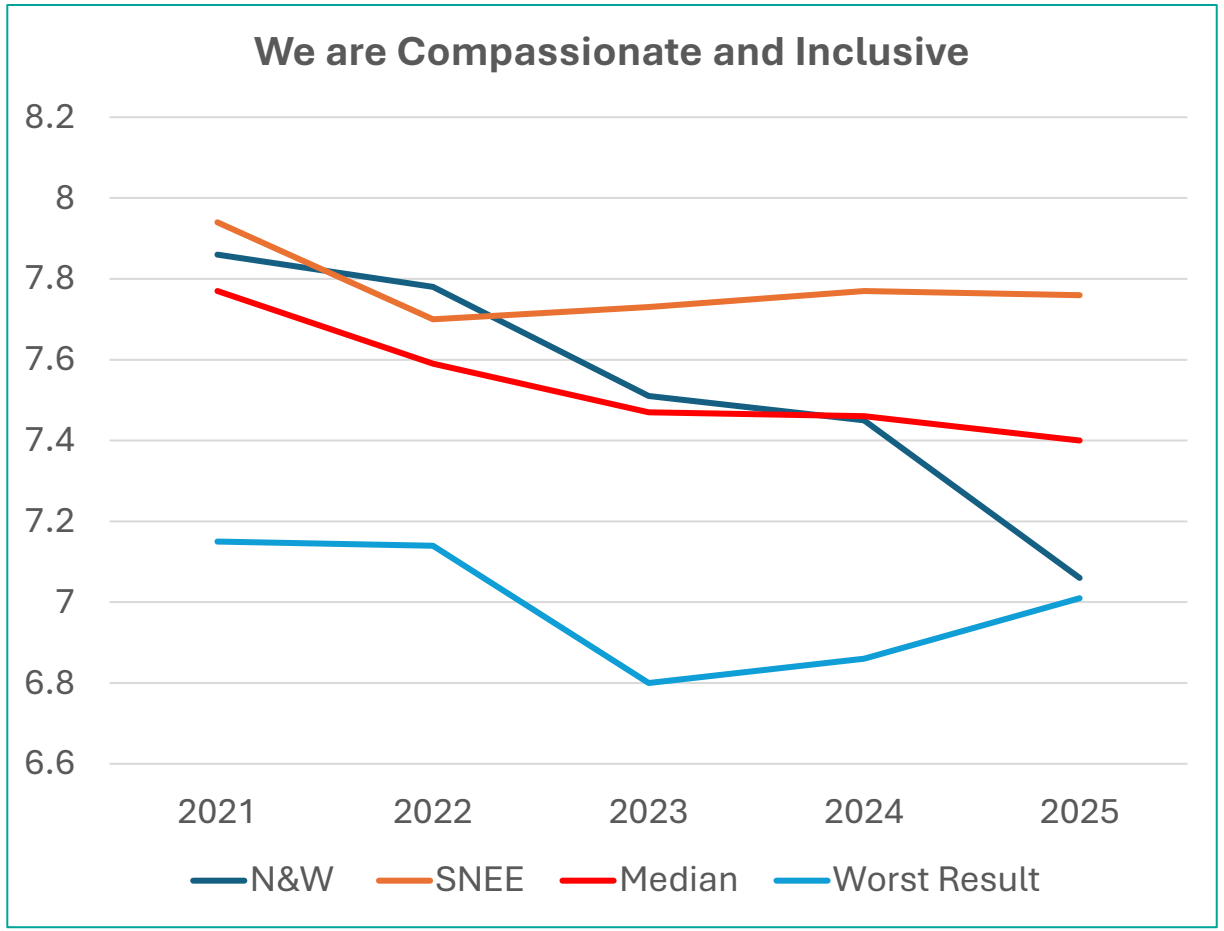
NHS National Staff Survey 2025 People Promise Themes (ICBs and Comparator Group Average)



NHS National Staff Survey 2025 by People Promise Sub-score Overview (ICBs and Comparator Group)



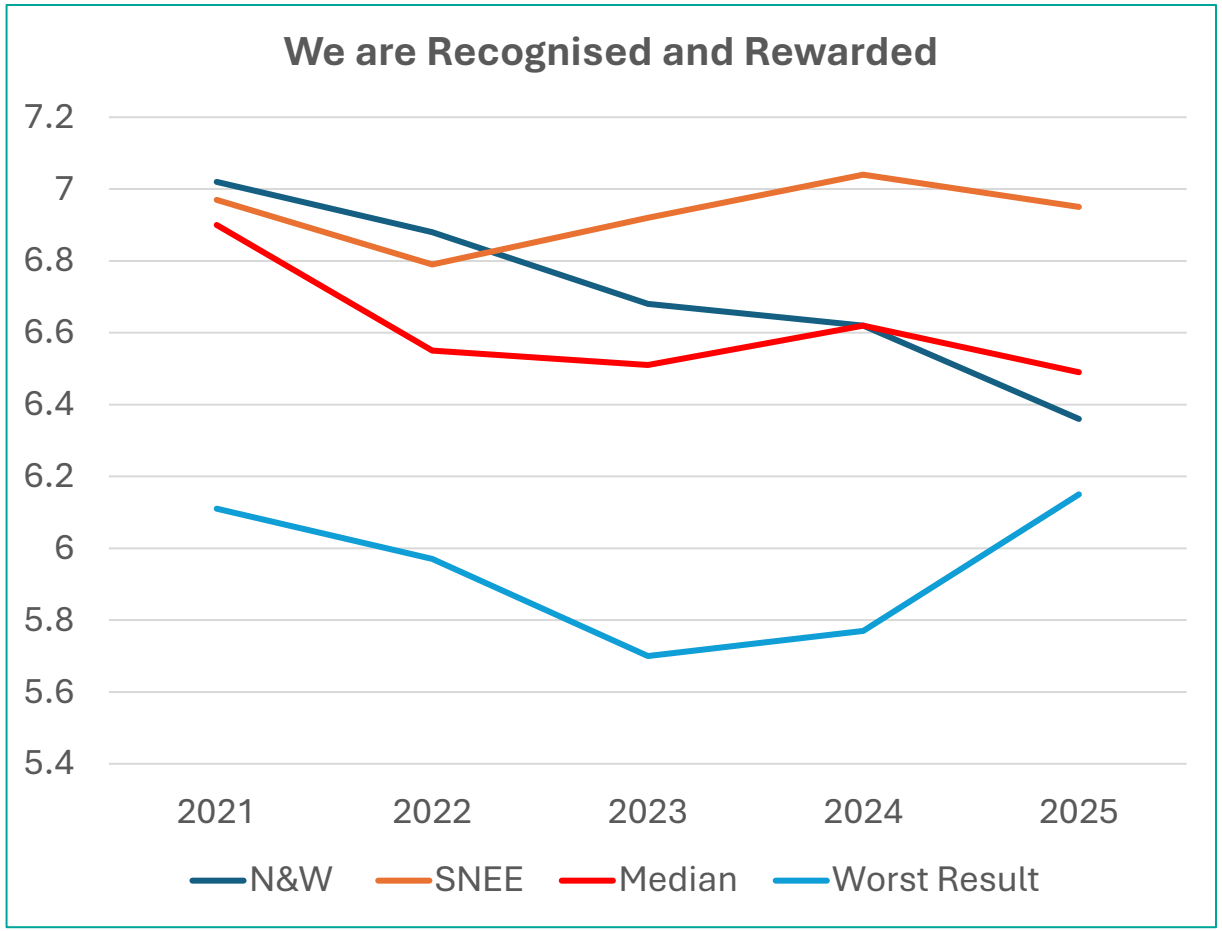
We are Compassionate and Inclusive



For SNEE ICB, this People Promise element is largely consistent with performance over the last two years of results. Whilst there has been a very, very marginal decrease, the score reflected the best performance within the benchmark group.

The score for Norfolk and Waveney, however, revealed a sharp decline from the 2024 score. Scores against this People Promise element have been declining steadily in Norfolk and Waveney over the last five years. However, the decline in year-on-year performance of 0.39 points now sees Norfolk and Waveney's score move below the median benchmark score and drop to within 0.05 points of the worst score for the benchmark group.

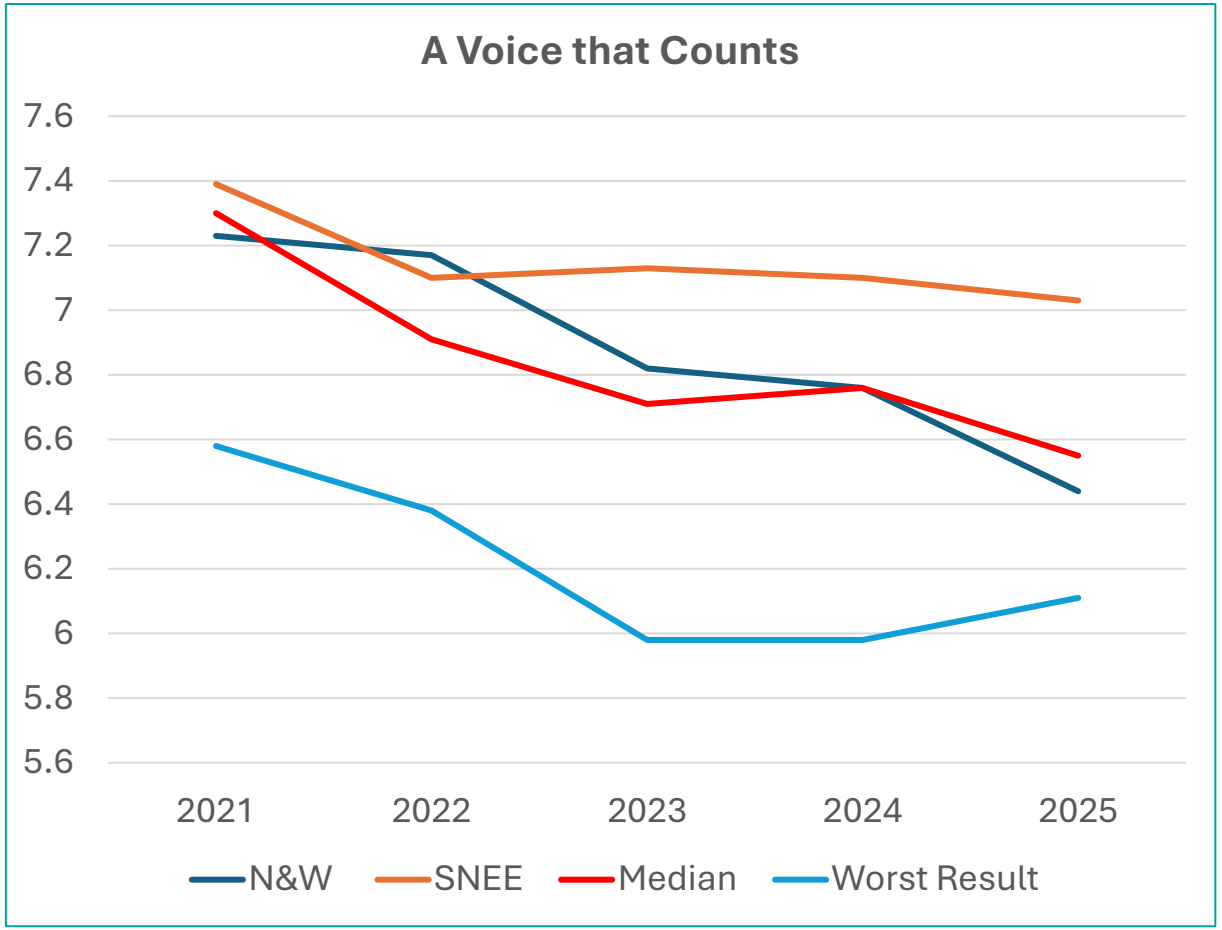
We are Recognised and Rewarded



Scores within SNEE ICB for this People Promise element declined for the first time since 2021, mirroring the median benchmark picture. Despite the decline, SNEE ICB's score still represented the high watermark for the benchmark group.

Norfolk and Waveney ICB's scores continue to decline following the 5- year trend within the organisation and is now trending below the median benchmark score and towards the worst score for this group.

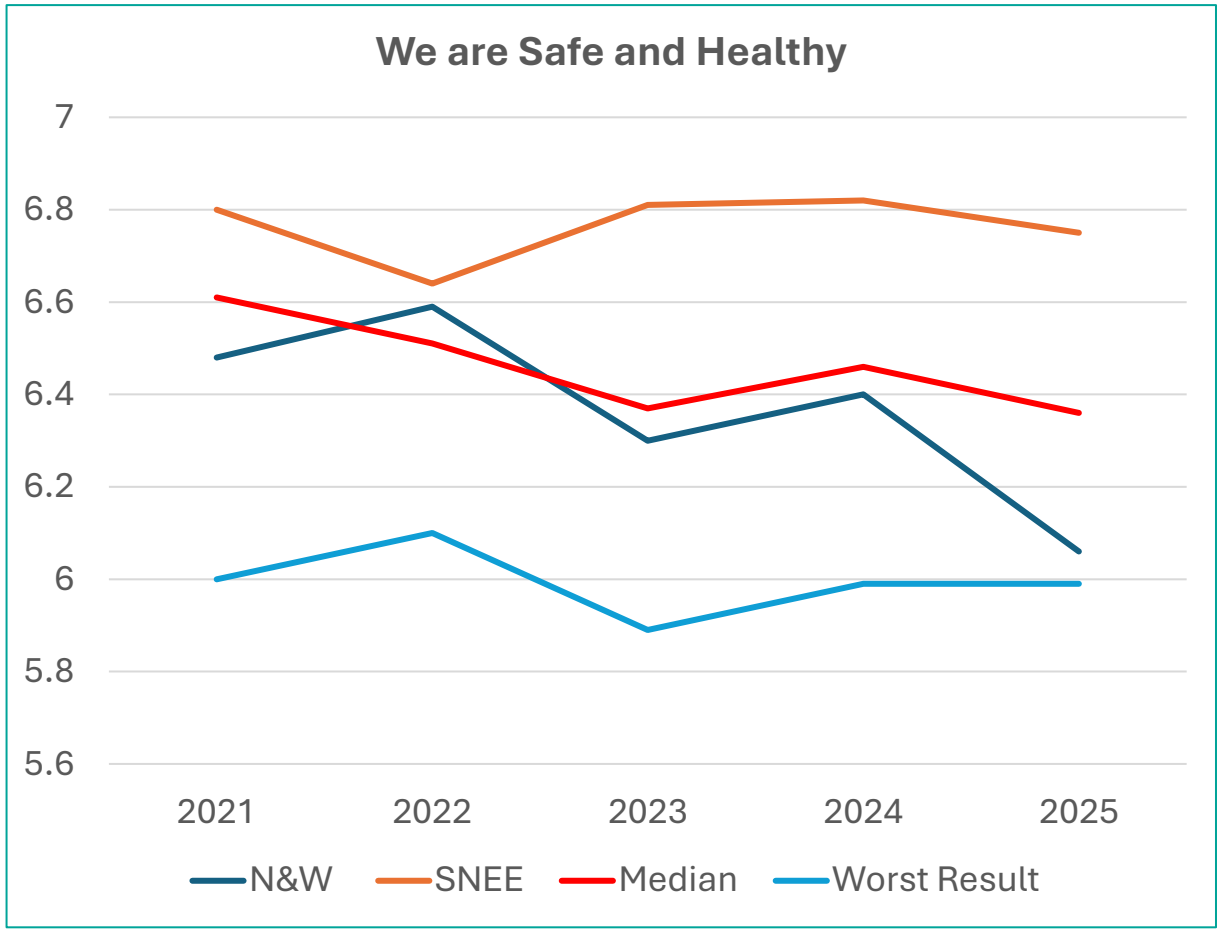
We each have a Voice that Counts



SNEE ICB's score for this People Promise element shows a small decline over the last 12 month but remains the best score for the benchmark group.

By comparison, Norfolk and Waveney ICB's scores have continued to decline over the last 5 years and show a steep decline from the 2024 position of 0.32 points. This decline has also seen Norfolk and Waveney move under the median benchmark score for this People Promise element, although it remains ahead of the worst result, by some distance.

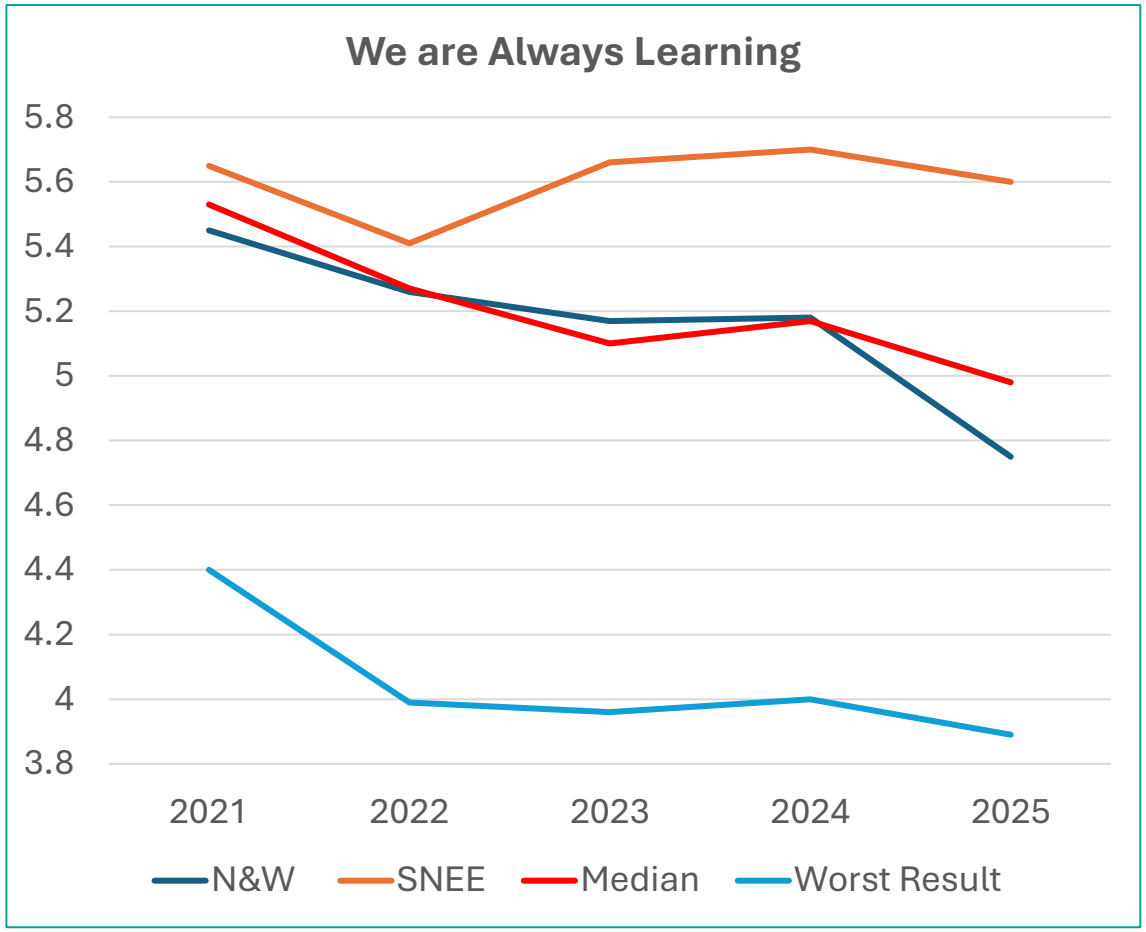
We are Safe and Healthy



SNEE ICB recorded the best result in the benchmark group for this People Promise, despite a small decline year-on- year.

In contrast, Norfolk and Waveney ICB, declined sharply year-on-year, pulling further away from the median benchmark result. This follows the 5-year trend of decline for Norfolk and Waveney.

We are Always Learning



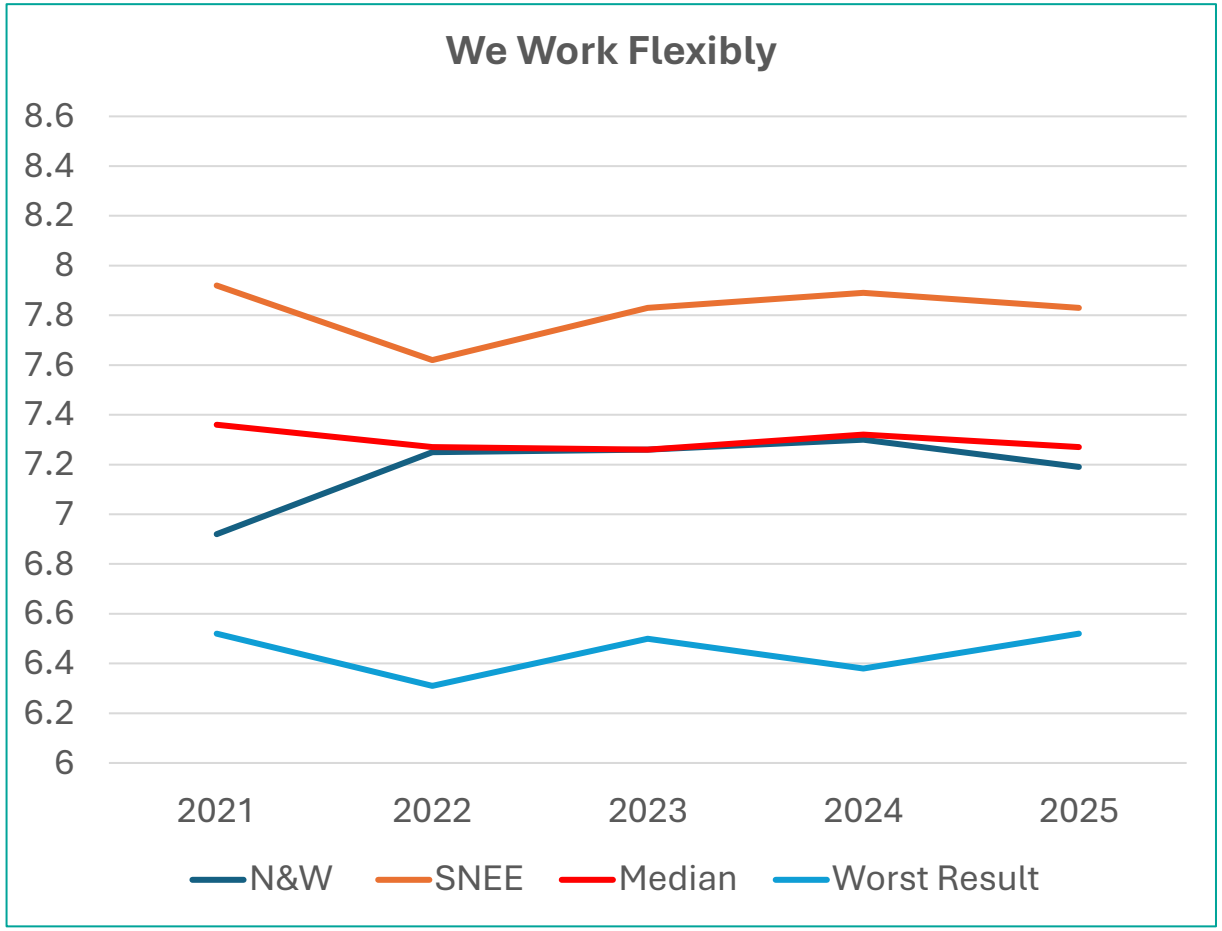
The benchmark scores for this People Promise element highlight that this is a challenging area nationally.

Both Norfolk and Waveney ICB and SNEE ICB have performed significantly better than the worst result in the benchmark group, with the Norfolk and Waveney score just dipping below the median result for the first time in five years. However, the score of 4.75 does reflect the lowest individual score for Norfolk and Waveney ICB in the 2025 Staff Survey.

SNEE ICB scores for this People Promise element follow a largely consistent trend, particularly over the last 3 years.

Of note, as the 2 ICBs join to become Norfolk and Suffolk, is that this People Promise element is an area where the gap between scores is larger than others, suggesting a variation in staff experience.

We Work Flexibly

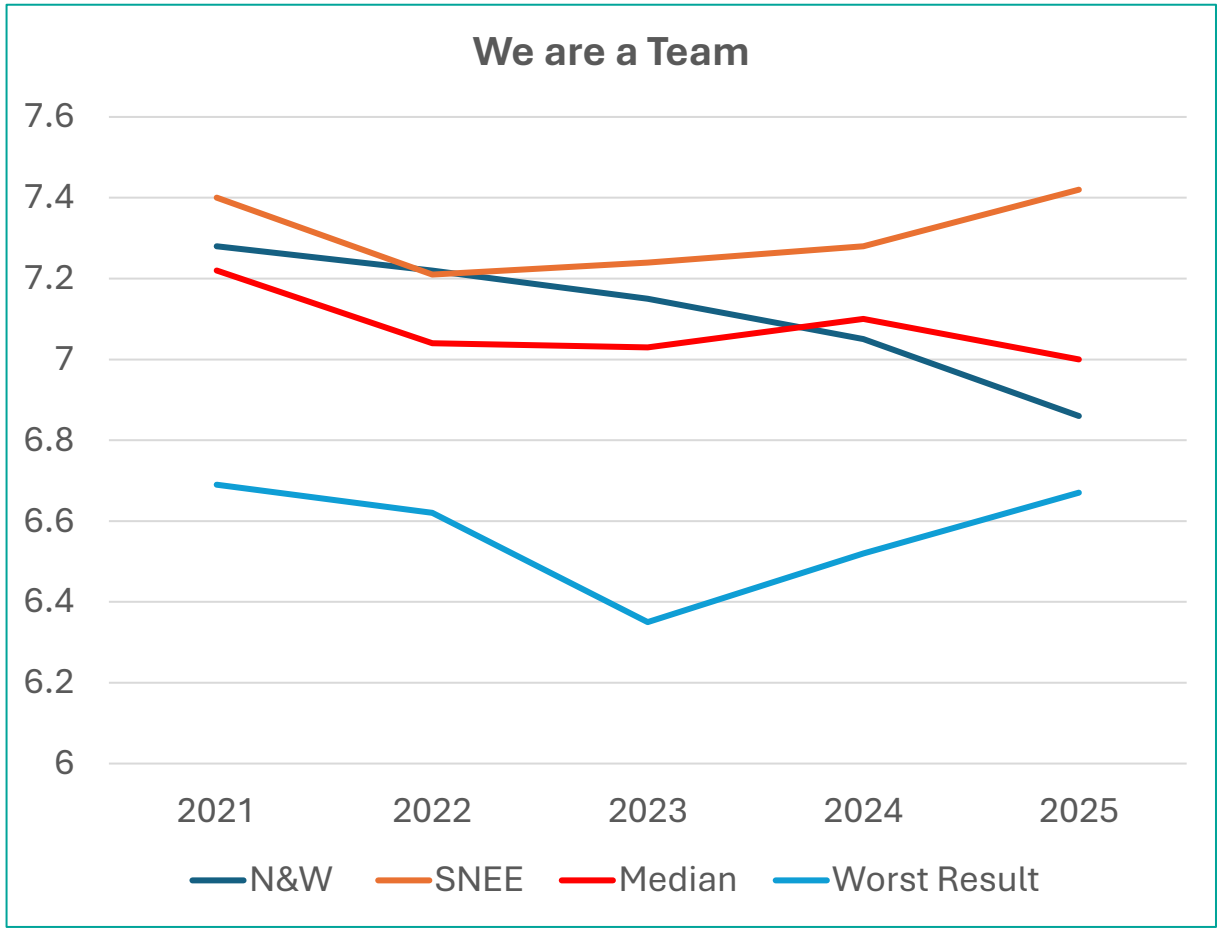


This People Promise element represents a high point in scores for both ICBs from the 2025 NHS Staff Survey results.

Both ICBs have delivered a consistent performance against this People Promise element, particularly over the last 4 years.

Whilst SNEE ICB is comfortably ahead of the median benchmark result, Norfolk and Waveney has dipped below for the first time since 2021, following a marginal decrease year-on-year.

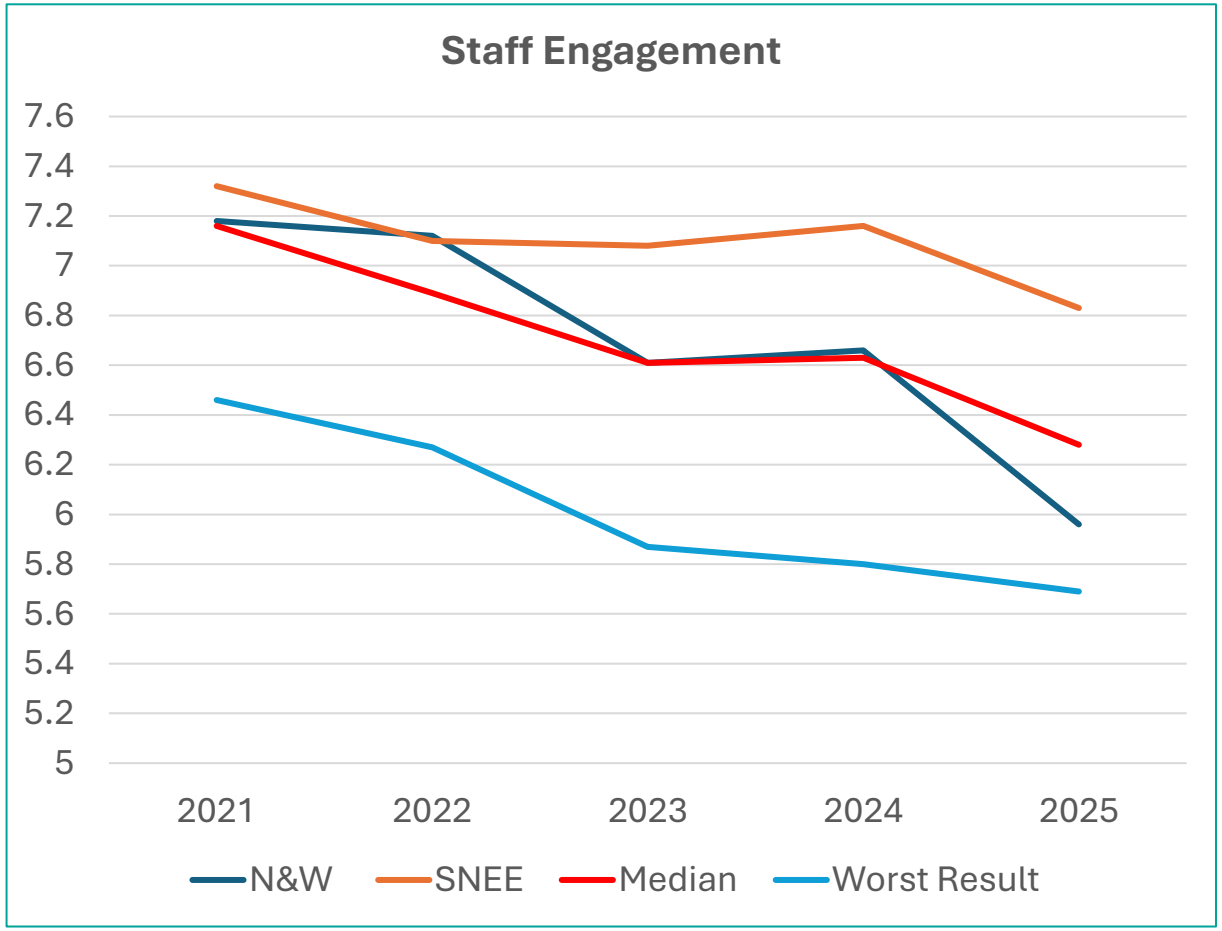
We are a Team



A significant success of the 2025 Staff Survey results, is the increase in score against this People Promise element, particularly when the median result for this theme has declined within the benchmark group. The rate of the improvement over the last year is also noticeably higher.

In Norfolk and Waveney, this People Promise element has been steadily declining over the last 5 year, albeit at a slower rate than other themes.

Staff Engagement

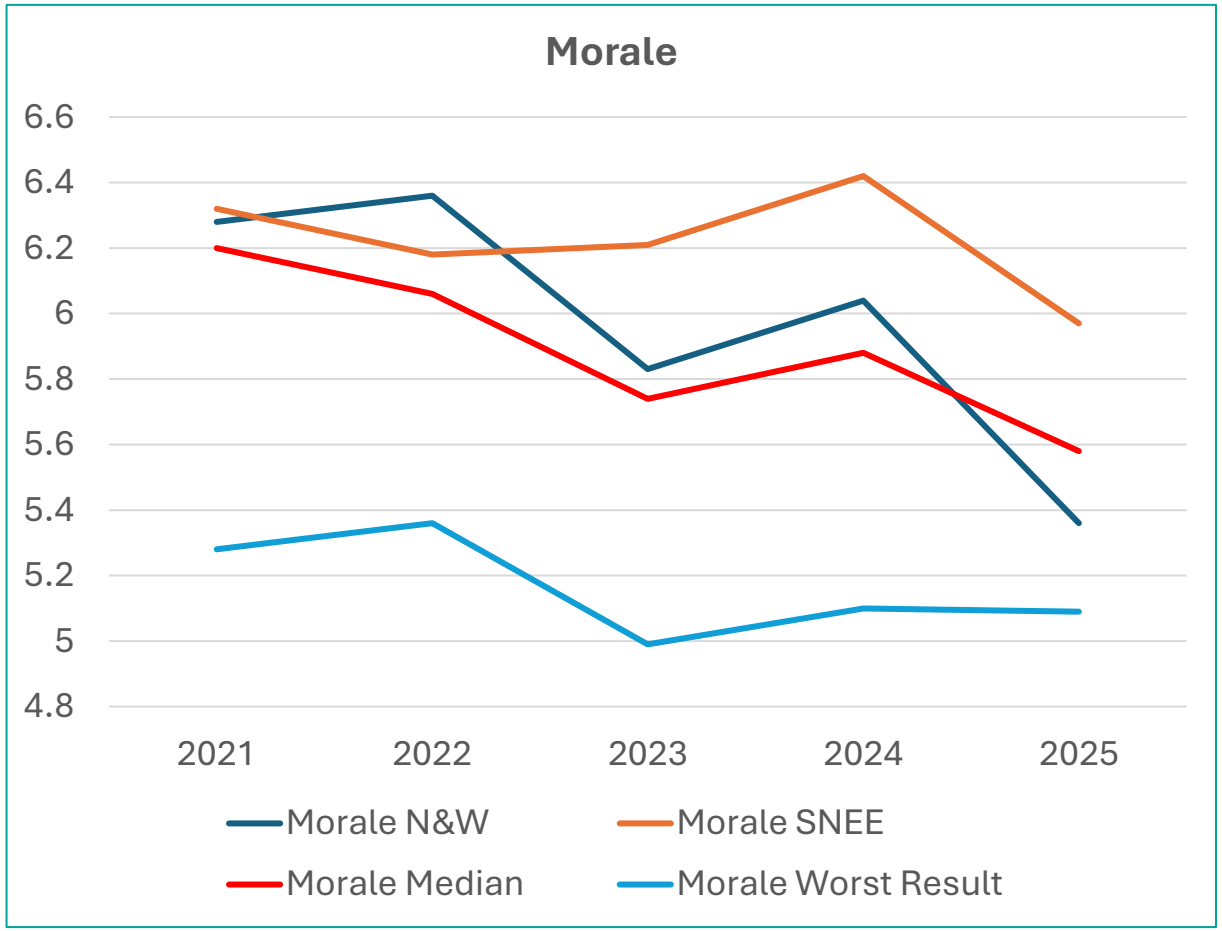


The median benchmark score for this People Promise element reveals that, nationally, there has been a decline in the staff experience associated with this theme.

Despite this trend, SNEE ICB has recorded the best result within the benchmark group. In Norfolk and Waveney, the score has dropped below the median result for the first time in 5 years.

This People Promise element does reflect the largest gap in scores between Norfolk and Waveney ICB and SNEE ICB, reflecting contrasting experiences of staff as the two ICBs come together.

Morale



Results, both locally and nationally, against this People Promise theme demonstrate the challenge of maintaining staff morale through significant organisation change, a point underlined by the declining median result for the benchmark group.

Both ICBs have, understandably, experienced declining scores year-on-year, with the Norfolk and Waveney score showing the sharpest decline of any of the People Promise elements from this year's results.

However, the SNEE ICB score represents the best result in the benchmark group which is a significant achievement.

Next Steps

Analysis:
Identification of themes (free-text responses) and 'hot spots' where staff experience differs the most.
Appreciative Inquiry, learning from what is good, our strengths; understating why, and applying it elsewhere.

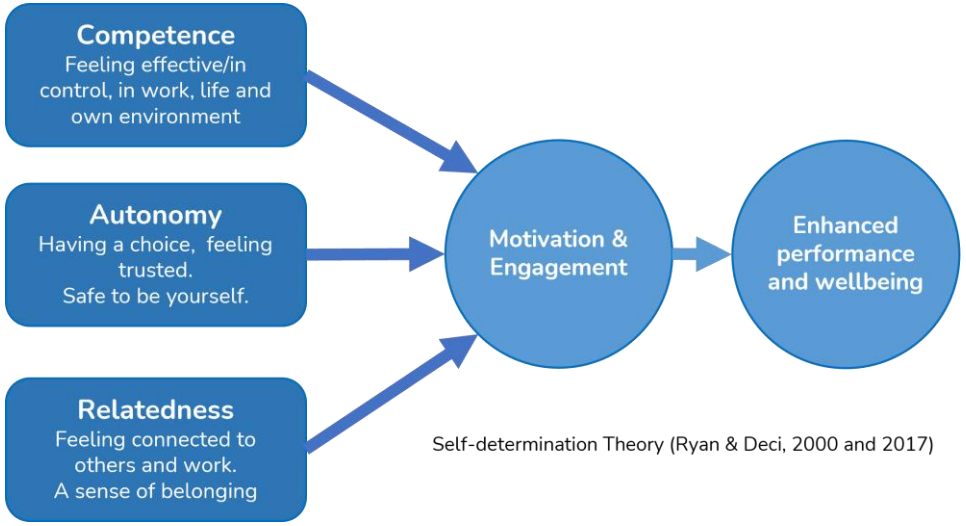
Reporting:
Discussion at EMT and RemCom. High level summary communicated to staff outlining approach and priority actions.

Approach:
Focus groups to co-create and develop solutions to improve on priority areas across the ICB using this feedback to shape priorities and focus of a wider and longer-term OD Plan

OD - Theory into Practice:

Self-Determination Theory (SDT) offers a useful lens for understanding how organisational changes, such as a restructure, can affect employee motivation, performance, and wellbeing. This theory suggests that people are most motivated and function best when three basic psychological needs are supported: autonomy, competence, and relatedness.

In the context of our restructure and survey results, these needs become especially important.



Self-determination Theory (Ryan & Deci, 2000 and 2017)

Proposed Priority Actions and Focus

1. **Appraisals and 1:1 Meetings** 
   - Align ICB priorities to team and individual objectives (sense of purpose, making a difference)
   - Training Needs Analysis (to understand development needs to support new ways of working)
   - Supports recognition, appreciation, feeling valued
   - Supports talent conversations
2. **Burnout** 
   - Normalise healthy working hours (decrease/demote long hours culture)
   - Effective use of meetings and e-mails
3. **Relationships** 
   - Living our values (behaviours, sense of ‘team’ and working together)
4. **Management and Leadership** 
   - Leadership and Management Development (demonstrating compassionate and inclusive leadership, ICB re-set and implementation of the 2026 NHS Leadership and Management Competency Framework
5. **OD Plan Development**
   - The survey insights inform the co-development of a broader, long-term OD programme, partnering with our staff to shape a culture that enables sustained, positive improvement.

Your Voice Matters – Our Annual Timeline

Initial Results

January

IQVIA our third-party provider creates high level results (under strict embargo)

Detailed Reports

February

Report aligning results to the People Promise themes created

High level analysis to understand themes, including in WRES & DES reporting and plans

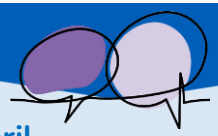
Sharing Results

March

Embargo Lifted

Results available publicly

Analysis



April

Headline results presented to EMT and RemCom, within staff communications and results included within Annual Plans

Communications plan agreed

Action Plans Agreed

May

EMT to receive a paper outlining the proposed approach to co-developing our ICB OD plan

Board Assurance

June

Staff focus groups to commence, incorporating staff ideas, suggestions and feedback from the results of this survey into actions and workstreams

On-Going & Review

July

Monitor and evaluate actions, communicate regularly on progress via updates via staff communications and local meetings

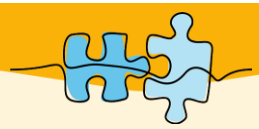
Planning

August

Ensure staff data is correct on ESR, and plan for next national staff survey

Agree and contract for 2026 NSS

Communicate

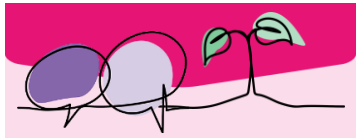


September

Communicate plans for the 2026 survey

Share progress on actions taken as a result of all staff feedback; NSS, People Pulse & Staff Groups

Launch



October

Launch the 2026 survey

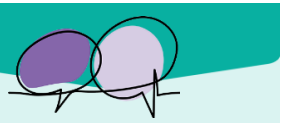
Review actions and approach to feedback, lessons learned and update plans to improve

Communicate

November

Monitor response rates and ensure that every member of staff has had the opportunity to participate

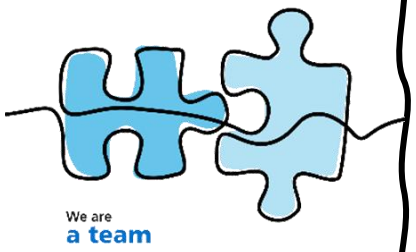
Close and Plan



December

Survey closes and timeline for communication of results shared with staff

Continuous Improvement 'We are Always Learning'



These slides have been prepared by:
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Key Contributors:
Neil Fisher, Senior Workforce Manager
Ellie Green, OD Practitioner

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NHS
Norfolk and Suffolk
Integrated Care Board

NSICB Board Performance Report

15 July 2026
Item 17

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	NHSE Plan Target	2026/27 Target	Variation	Assurance
Elective, cancer & diagnostics	18-week RTT	Improve the percentage of patients waiting no longer than 18 weeks for treatment	Apr-26	62.3%	55.1%	68.4%	H	F
	6 week waits	Improve performance against the DM01 diagnostics 6-week wait standard	Apr-26	29.0%	18.5%	14%		F
	28-day FDS	Improve performance against cancer constitutional standards	Apr-26	74.5%	77.6%	80%		?
	31-day standard	Improve performance against cancer constitutional standards	Apr-26	90.8%	92.0%	94%		F
	62-day standard	Improve performance against cancer constitutional standards	Apr-26	65.1%	68.3%	80%		F
Mental health, learning disabilities & autism	Individual placement and support access	Meet the existing commitments to expand Individual Placement and Support	Apr-26	1,285	1,581	1,610	L	
	NHS Talking Therapies - reliable recovery rate	Meet the existing commitments to expand NHS Talking Therapies	Apr-26	51.5%	57.5%	51%		?
	NHS Talking Therapies - reliable improvement rate	Meet the existing commitments to expand NHS Talking Therapies	Apr-26	72.2%	69.0%	69%	H	?
	Out of area placements	Eliminating inappropriate out-of-area placements	Apr-26	0	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)	Apr-26	77.3%	75.0%	90%	H	F
	Additional urgent dental appts per year	Deliver 700,000 additional urgent dental appointments against the July 2023 to June 2024 baseline period	Feb-26	8,495		9,933		
	Community health service activity within 18 weeks	Address long waiting times for community health services	Feb-26	77.8%		78%		?
	Pharmacy first and roll out new services	Embed pharmacy-first approaches, ensuring that local commissioning discussions utilise pharmacy capacity to support primary care pressures	Feb-26	19,347		15,995	H	
Urgent & emergency care	A&E 4 hour waits	4-hour A&E performance	May-26	76.2%	77.7%	82%		F
	Reduce number who wait over 12 hours	12-hour A&E performance	May-26	4,345	4,256	3,996		

Assurance against target is measured against submitted NHSE plan trajectories not the final medium term plan 26/27 target

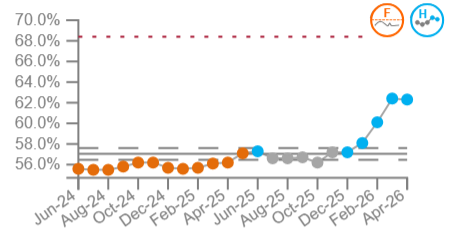
Integrated Performance Report

SPC summary - COMMISSIONER VIEW

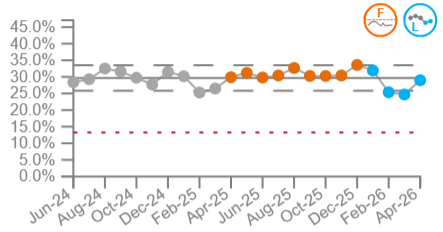
NHS Norfolk and Suffolk Integrated Care Board

Elective, cancer & diagnostics

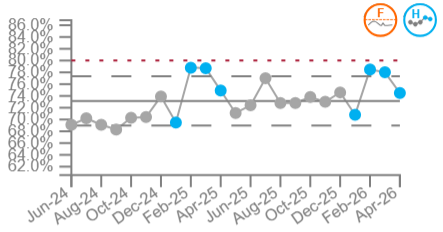
18-week RTT



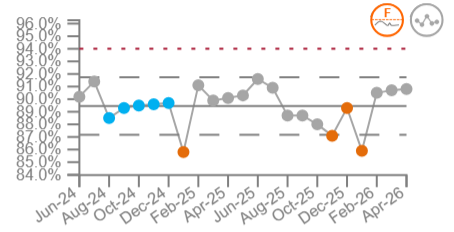
Diagnostic 6-week waits



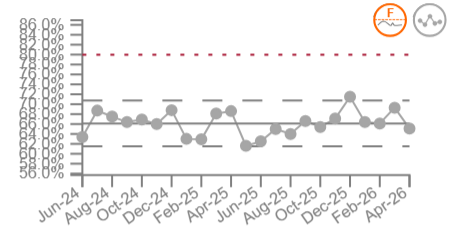
Cancer 28-day FDS



Cancer 31-day standard

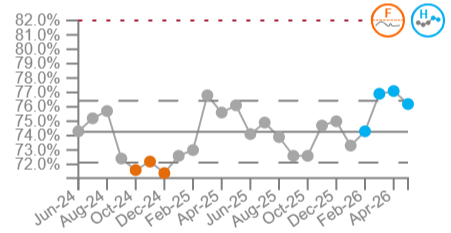


Cancer 62-day standard

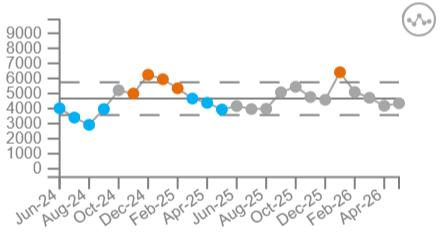


Urgent & emergency care

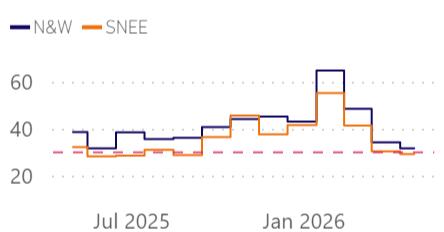
A&E 4hr performance



Reduce 12 hour waits in ED

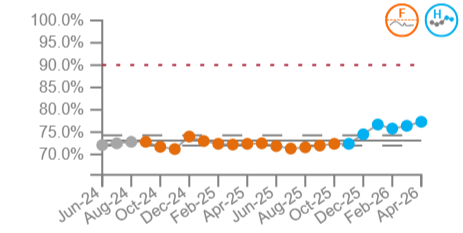


Ambulance C2 response (mins)

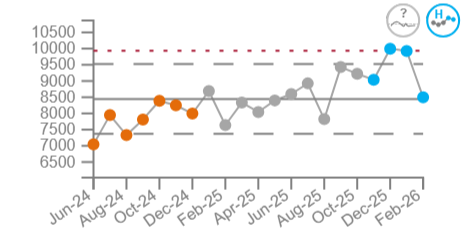


Primary care

Same day urgent GP appointments

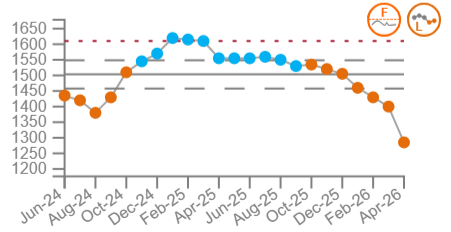


Urgent dental appointments

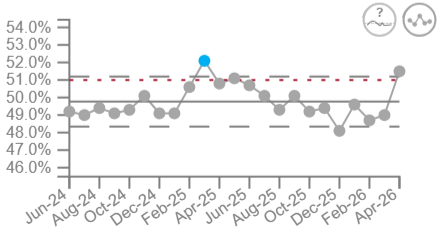


Mental health & LDA

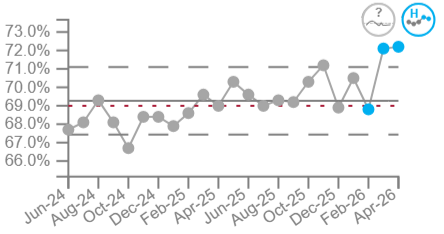
Individual placement & support



Talking therapies reliable recovery

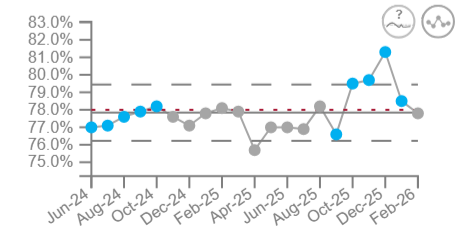


Talking therapies reliable improvement

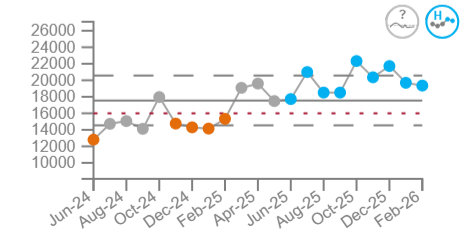


Community services

18-week community health services



Pharmacy first consultations



Performance Assurance Summary

Domain	Summary	Assurance Level & Board Focus
Elective Care and Diagnostics	There has been sustained improvement in RTT 18-week performance over recent months, alongside continued reductions in long waits. This provides assurance that focused elective recovery actions, including waiting list validation and additional recovery activity, are having an impact. However, the system remains below trajectory and diagnostic performance remains a material constraint. Diagnostic 6-week performance has improved month on month but remains significantly below the required standard, with diagnostic capacity identified as a key limiting factor for elective recovery. Variation between providers also remains evident, reflecting differences in capacity, pathway efficiency and demand management. The Board should therefore take assurance that elective recovery is improving but should note that delivery remains fragile and dependent on further improvement in diagnostic capacity, pathway productivity and reduction in provider-level variation.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Diagnostic capacity and provider variation may limit the pace and sustainability of elective recovery.
Cancer	Cancer performance remains mixed across the key standards. The 28-day Faster Diagnosis Standard has shown sustained improvement, and the 62-day standard has shown gradual improvement following a period of underperformance. However, the 31-day and 62-day standards remain below target, with the 62-day standard continuing to be the most challenged area. The main delivery risks relate to diagnostic and treatment capacity, delays in imaging, diagnostics and histopathology, and variation in pathway performance between providers. The Board should take assurance that cancer performance is subject to active oversight and that improvement actions are in place, including continued focus on pathway tracking, diagnostic utilisation and the development of the 2026/27 Cancer Strategic Plan. However, the current position does not yet provide full assurance that recovery is sufficiently embedded or sustainable.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Diagnostic and treatment capacity pressures continue to affect delivery of the cancer standards, particularly the 62-day pathway.
Urgent and Emergency Care	Urgent and emergency care remains under pressure, with continued variation across A&E 4-hour performance, 12-hour waits and ambulance response and handover indicators. There is evidence of improvement in some areas, but this is not yet consistent across the system. A&E 4-hour performance remains slightly below plan at system level, and 12-hour waits continue to vary significantly between providers. Ambulance Category 2 performance is also variable, with Norfolk and Waveney above the 30-minute plan and SNEE closer to plan. The key operational issues remain front-door demand, patient flow, ambulance handovers, discharge capacity and the effective use of alternatives to emergency attendance. Continued focus is required on GP streaming, redirection pathways and actions to improve system flow.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Continued pressure at the urgent and emergency care front door, ambulance handover delays and provider-level variation in flow.

Performance Assurance Summary

	Summary	Assurance Level & Board Focus
Mental Health	Mental Health performance information presents a mixed position across mental health indicators. Talking Therapies reliable improvement remains broadly on trajectory, reliable recovery is above target in Norfolk and Waveney, and out-of-area placements remain well controlled. However, Individual Placement and Support access remains below trajectory and there is variation in outcomes across the ICB footprint. Performance continues to be affected by workforce, demand, acuity and pathway factors. The Board should take assurance that some mental health indicators are performing well, particularly out-of-area placements and aspects of Talking Therapies. However, further assurance is required on recovery of areas below trajectory and the reduction of unwarranted variation across providers and geographies.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Workforce constraints, demand complexity and variation may limit improvement in access and outcomes.
Primary Care, Community and Wider Access	Community waiting times are achieving targets for adults, although performance is less consistent for children. GP front door and urgent care funding discussions are progressing slowly, and further work is required to understand delivery, impact and confidence across primary care, community services and wider access pathways.	**Assurance to the Board:** Limited to partial assurance. **Key residual risk:** Delivery confidence remains unclear across primary care, community and wider access pathways.
Overall Performance Assurance	The Committee provides the Board with partial assurance that the main performance risks are known, visible and subject to active oversight. There is evidence of improvement in several areas, including RTT long waits, elements of cancer performance, urgent and emergency care improvement, and selected mental health indicators. However, the Board should note that performance remains below the required standard in a number of domains. The main residual risks relate to diagnostic capacity, cancer pathway delivery, urgent and emergency care flow, provider-level variation, and the pace at which planned actions translate into sustained improvement. The Committee will continue to seek assurance that recovery actions are delivering measurable and sustained improvement.	

NHS Oversight Framework

NHS Oversight Framework: what it is and why it matters

The NHS Oversight Framework is the national mechanism used by NHSE to assess ICB and provider delivery. It brings together a focused set of metrics to provide a consistent view of performance, delivery risk and improvement requirements across the NHS.

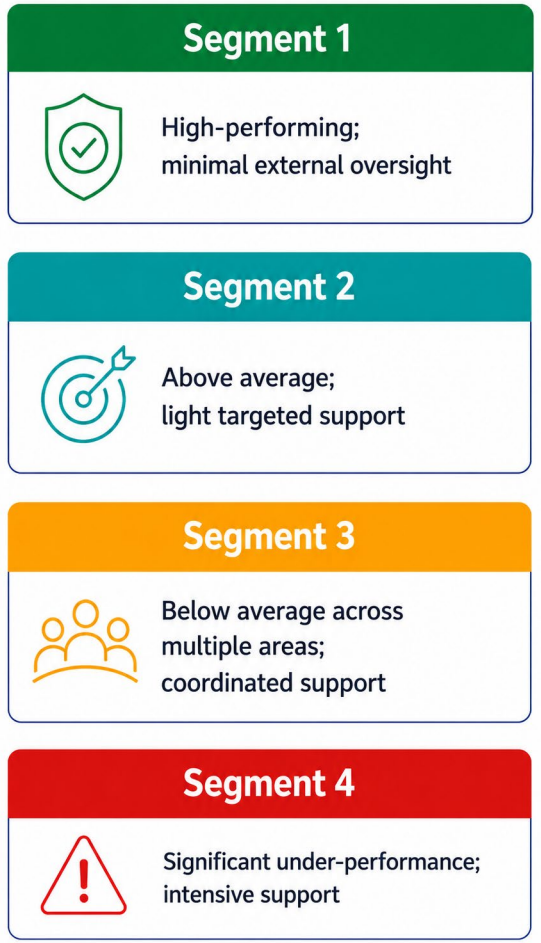
How the Oversight Framework Works

- ICBs are assessed across a range of domains, including access, outcomes, quality, safety, finance, workforce, patient experience and inequalities.
- Performance against scored metrics is translated into a delivery segment from 1 to 4.
- Segment 1 indicates strongest performance and lighter oversight.
- Segment 4 indicates significant delivery challenge and more intensive support or intervention.
- Scored metrics drive the formal assessment, but contextual metrics can still influence the oversight conversation.
- NHS England will also consider ICB capability, including leadership, governance, planning and improvement capability.
- An ICB in financial deficit cannot be placed in Segment 1 or 2.

Why this matters for the ICB

The NOF will shape how NHS England assesses our delivery, the level of oversight we receive, and the degree of autonomy, support or intervention available to us during 2026/27.

The four oversight segments



What this means for the ICB and how we will respond

The NHS Oversight Framework reinforces the ICB's role as a strategic commissioner: setting priorities, allocating resources, improving outcomes, reducing inequalities and ensuring delivery across the system.

The framework reinforces the need to demonstrate how resources are being allocated to improve outcomes, reduce inequalities and support the shift towards prevention and community-based care.

How will our reporting inform the organisation?

- The Board will receive a clear assurance view across national NOF metrics and agreed local Board KPIs, with formal monitoring through the Finan cem, Performance and Workforce Committee.
- Metrics will be grouped by domain, with clear ownership and accountability.
- Reporting will focus on areas off trajectory, significant variation, delivery risk and assurance.
- The framework will help align staff and teams around the priorities that matter most.
- It should support a culture of improvement, early escalation and "no surprises".
- Strong performance builds confidence and flexibility; weaker performance will result in closer oversight and support.

Reporting Frequency

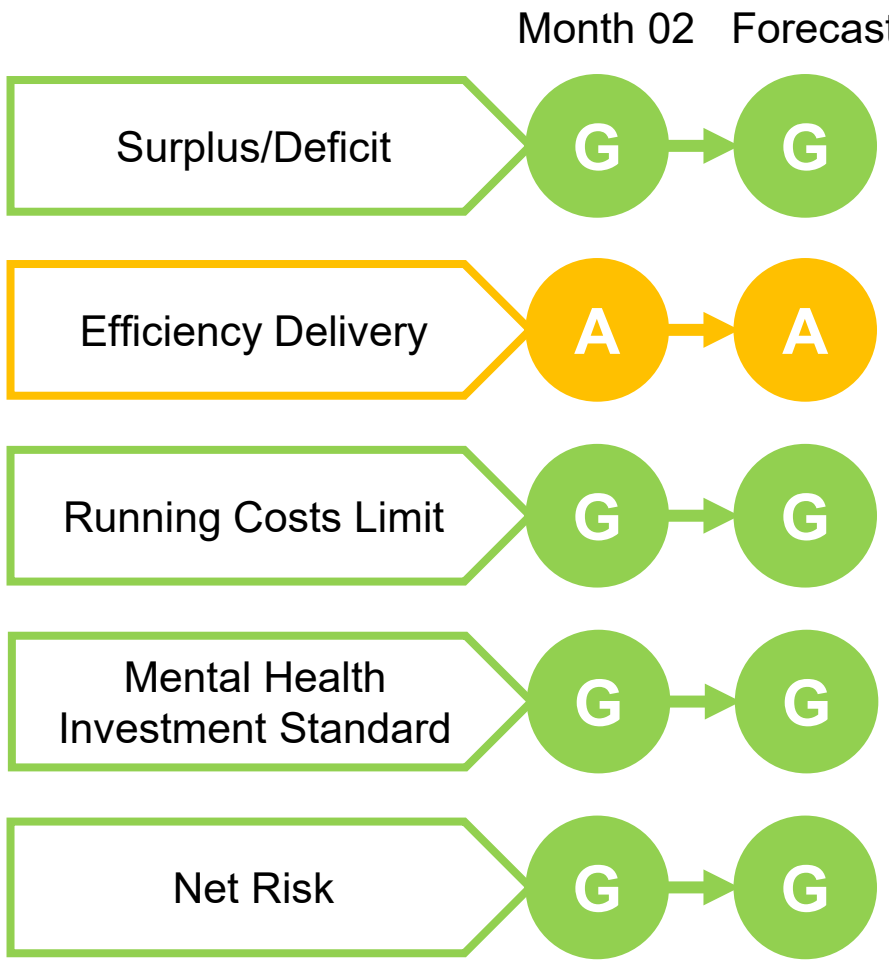
- NOF performance will be reported quarterly, aligned to the national publication of data.
- Q1 data is expected in August.
- The Q1 performance position will therefore be presented in the September Board report.
- Committee and Board reporting will focus on current performance, recovery actions, delivery confidence and residual risk.

NHS
Norfolk and Suffolk
Integrated Care Board

Summary Finance Report Month 02 2026/27

Board
15 July 2026
Item 18

Key Financial Metrics



The ICB reported on plan at Month 02 with break even year to date and breakeven forecast. At this stage lack of activity data and additional transactional volumes as part of the ICB transition have impacted on the ability to report accurately for Month 02.

Reported year to date delivery is at 87% and the forecast delivery is 100% of the £102m target. Although the forecast is likely to change next month following review of a small number of high risk schemes.

The forecast is on plan to remain within the £27.5m limit. (note: this is the statutory limit which is a subset of the national £19ph target)

The forecast is for achievement of the £372m target for core ICB and £43m for delegated Specialised Commissioning.

There has been no change to the reported net risk position this stage.

G On Plan

A Adverse variance to plan within manageable tolerance

R Adverse variance to plan above manageable tolerance / risk to financial duties

Summary

The ICB reported on plan at Month 02 with break even year to date and breakeven forecast. At this stage lack of activity data and additional transactional volumes as part of the ICB transition have impacted on the ability to report accurately for Month 02. Key areas of potential variable risk are:

Acute – Comprehensive activity data is not available at this stage, however where information has been provided the variable activity is within plan overall. There is still a risk with the contract dispute with CUHFT for 2026/27 now escalated to NHS England for determination.

Mental Health – The most significant risk area remains in ADHD and ASD diagnosis and treatment costs with Indicative Activity plans still in negotiation with a number of providers. The diagnosis waiting list is the key focus of the relevant Commissioning Oversight Group.

Continuing Care – There is a significant amount of work being undertaken to align processes post transition alongside high volumes of invoices which need to be resolved to provide a more accurate view of year to date expenditure and forecast by month 3.

Prescribing – Data had not been published at the point of reporting, however final data for month 12 was in line with expectations which provides some assurance re the accuracy of the baseline expenditure which informed the plan. Indicative price concession information shows there has been a significant increase over the last two months which is a risk to the reported and forecast position.

Delegated GP – We are still yet to receive final allocations and guidance on the GP contract for 2026/27 so are unable to fully ascertain if there is a funding risk in addition to the risk of Collective Action.

Category	1 Apr 26 to 31 May 26			Forecast to 31 Mar 27		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Revenue Resource Limit (in year)	(826.8)	(826.8)	0.0	(4,927.1)	(4,927.1)	0.0
TOTAL REVENUE RESOURCE LIMIT	**(826.8)**	**(826.8)**	**0.0**	**(4,927.1)**	**(4,927.1)**	**0.0**
Acute Services	388.8	388.8	0.0	2,290.4	2,290.4	0.0
Mental Health Services	79.2	79.2	0.0	475.1	475.1	0.0
Community Health Services	70.9	73.0	(2.1)	425.9	425.9	0.0
Continuing Care Services	44.7	44.7	0.0	255.2	255.2	0.0
Primary Care - Prescribing	56.6	56.7	(0.1)	329.5	329.5	0.0
Primary Care - Other	12.9	12.8	0.1	77.5	77.5	0.0
Delegated GP	68.6	68.4	0.2	411.6	411.6	0.0
Delegated Pharmacy, Optom, Dental	29.2	28.4	0.9	175.5	175.5	0.0
Delegated Specialised Commissioning	74.2	74.2	0.0	453.2	453.2	0.0
Other Commissioned Services	3.6	3.8	(0.1)	21.8	21.8	0.0
Other Programme	0.3	0.1	0.1	1.6	1.6	0.0
Programme Reserve & Contingency	(6.7)	(7.8)	1.0	(17.5)	(17.5)	0.0
Running Costs	4.5	4.5	(0.0)	27.3	27.3	0.0
TOTAL EXPENDITURE	**826.8**	**826.8**	**0.0**	**4,927.1**	**4,927.1**	**0.0**
IN YEAR SURPLUS/ (DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Efficiency Delivery Overview

Programme	SRO	Scheme Value (£000s)	Actuals at Month 2 (£000s)	YTD Plan at Month 2 (£000s)	Variance (£000s)	FOT (£000s)	Variance (£000s)	% Delivery (FOT/Scheme Value)	Pipeline Estimated Value (£000s)	Delivery RAG
Complex Care	Lisa Nobes	£18,991	£1,040	£1,040	£0	£18,991	£0	100%	£0	
Best Value Medicines	Mike Smith	£27,500	£2,906	£2,906	£0	£27,500	£0	100%	£0	
Clinical Policies	David Brandon	£1,000	£0	£166	-£166	£1,000	£0	100%	£0	
GP IT Costs	Richard Watson	£1,780	£297	£297	£0	£1,780	£0	100%	£0	
Contract and Service Reviews	Howard Martin & Richard Watson	£7,000	£0	£1,166	-£1,166	£7,000	£0	100%	£0	
Contract Management (Acute IAPs)	Howard Martin	£1,000	£0	£166	-£166	£1,000	£0	100%	£0	
Contracting Out of Area	Howard Martin	£1,000	£0	£166	-£166	£1,000	£0	100%	£0	
Finance	Howard Martin	£6,421	£1,065	£1,065	£0	£6,421	£0	100%	£73	
Corporate	Amanda Lyes	£36,306	£6,051	£6,051	£0	£36,306	£0	100%	£0	
Estates	Amanda Lyes	£807	£139	£139	-£1	£807	£0	100%	£0	
Demand Management (Left Shift)	Maddie Baker-Woods & Mark Burgis	£0	£0	£0	£0	£0	£0		£0	
LES Review	Maddie Baker-Woods & Mark Burgis	£0	£0	£0	£0	£0	£0		£0	
		£101,805	**£11,497**	**£13,162**	**-£1,665**	**£101,805**	**£0**	**100%**	**£73**	

Delivery Rag Key
<80%
80%<>99%
100% +

- The total savings target for 2026/27 is £101.9m. At month 2 we have reported the forecast in line with plan, however there will be a likely change next month due to the risk with Contact and Service reviews and Clinical Policies.
- Overall delivery is rated Amber, reflecting strong progress alongside a small number of material risks requiring active management.
- The majority of programme areas are progressing in line with plan with actual delivery figures available later this month. There is a potential shortfall of c£7.2m not yet reflected in the forecast driven by underperformance in a small number of programmes.
- Contract and Service Reviews continues with a significant delivery gap. Phase 2 of the reviews is ongoing with a Peer review meeting being held on 19.06.26 ready for recommendations to go to the Executive Committee on 24.06.26.
- Clinical Threshold Policies continues with a high delivery risk, with potential for no savings.
- National stock shortages and price concessions are an increasing risk to delivery of significant Best Value Medicines schemes.

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 19.
Date: 15 July 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) Quality Committee
c) Strategic Commissioning Committee
d) Norfolk and Waveney Primary Care and Neighbourhood Committee
e) Suffolk Primary Care and Neighbourhood Committee

Recommendation: To note.

Audit and Risk COMMITTEE

Date: 15 June 2026

Chair: David Holt Non- Executive Member

Item Status	Update
Advise	• **Annual Report and Accounts (ARA) –** The main business of the meeting 15 June related to the sign off processes of both previous ICB's set of Annual Report and Accounts. The Committee referred to the Annual Report and Accounts Seminar held on 20 May 2026 during which members had the opportunity to address any queries relating to the accounts and supporting notes with the finance team. Following discussion on the updated drafts, the Committee recommended approval to the Board of both Annual Report and Accounts for the previous ICB's at the Board meeting later that day on 15 June 2026. This would support the final submission date of 19 June 2026.
Assure	• **Internal Audit Plan -** A updated draft internal Audit Plan was shared with the Committee. Work is underway with the programme noting Q1 audits. • **Policy Approval** – The Committee approved the following policies: • Data Protection & Confidentiality Policy • Records Management Policy • Information Rights Policy • Data Protection & Cyber Security Breach Management Policy

Quality COMMITTEE

Date: 04 June 2026 and 02 July 2026

Chair: Elaine Noske, Non-Executive Member

Item Status	Update
Advise	**Committee Risk Register (04/06/26 & 02/07/26):** Committee reviewed and approved the first combined Norfolk and Suffolk Quality Committee Risk Register, bringing together legacy risks into a single governance framework. Members discussed the importance of consistent risk scoring, clear escalation thresholds and ensuring committee focus remains on strategic quality risks where intervention can add value. Eleven risks are currently overseen by the Committee, with particular attention on urgent and emergency care pressures, paediatric audiology, TB service resilience, neurodevelopmental services, elective recovery and children's mental health waiting lists. The Committee requested ongoing assurance that risk ownership, mitigation and Board Assurance Framework alignment continue to mature. **Deep Dive – Paediatric Audiology (04/06/26**): Committee received an update regarding ongoing concerns surrounding paediatric audiology services at Queen Elizabeth Hospital King's Lynn. Members noted progress with clinical oversight and partnership working with Norfolk and Norwich University Hospital but sought further assurance regarding the review of historical cases, timescales for completion and communication with affected families. The Committee requested continued reporting until sufficient assurance is achieved. **Deep Dive – Asylum Seekers (02/07/26**): Committee considered emerging quality and safety risks relating to asylum seekers, following concerns regarding unplanned placement into local communities without adequate notification to health services. Members discussed access to primary care, safeguarding, communicable disease management and health inequalities, recognising the need for coordinated multi-agency responses. The Committee supported further work to strengthen pathways and improve system preparedness. **Quality Dashboard and Performance Oversight (02/07/26):** Committee reviewed the developing Quality Dashboard and Quality Scorecard, recognising the opportunity to strengthen triangulation of quantitative performance data with patient experience, complaints and quality intelligence to provide improved oversight of system quality and patient safety. Members requested continued refinement to support strategic decision-making and Board assurance. **Regulation, Standards and Best Practice (02/07/26):** Committee reviewed national maternity publications, including emerging learning from Nottingham maternity services and the Maternal Care Bundle. Members discussed how national recommendations should inform local improvement work, recognising the importance of embedding learning across maternity

	services, strengthening safety culture and ensuring continued oversight of implementation.
Assure	**Quality Visit Policy (04/06/26):** Committee approved the revised Quality Visit Policy, strengthening the ICB's approach to quality surveillance. The updated policy now includes learning visits to high-performing providers and voluntary sector organisations to support the identification and spread of good practice alongside assurance activity. **Research and Innovation Update (04/06/26 & 02/07/26**): Committee received updates on research and innovation activity across Norfolk and Suffolk, noting continued expansion of research hubs, increasing participation from underserved communities and stronger collaboration across system partners. Members welcomed the contribution of research to reducing health inequalities and improving patient outcomes and supported approval of the updated Research and Innovation report. **Mortality and Learning from Deaths Assurance (04/06/26):** Committee received assurance regarding the newly established joint Learning from Deaths arrangements, including oversight of Prevention of Future Death reports, mortality reviews and thematic learning across the system. Members discussed opportunities to address health inequalities, improve end-of-life pathways and strengthen learning across organisations. **Patient Experience (02/07/26):** Committee heard a powerful lived experience presentation describing a patient's journey following a heart attack, prolonged hospital stays and cardiac surgery. Members reflected on the importance of compassionate care, communication during periods of uncertainty and the positive impact of rehabilitation services. The patient story reinforced the Committee's continued focus on person-centred care and learning from experience to improve quality across the system. **Safeguarding Assurance Report (02/07/26):** Committee received assurance regarding safeguarding arrangements across Norfolk and Suffolk, reviewing statutory responsibilities, partnership working and current safeguarding activity. Members were satisfied that appropriate governance arrangements remain in place while recognising ongoing opportunities for continuous improvement. **Committee Approvals** Early Warning Deteriorating Quality Framework ICB Medicines Optimisation Oversight Group (MOOG) Terms of Reference N&S Therapeutics Advisory Group/Integrated Medicines Optimisation Committee (TAG/IMOC) Terms of Reference

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: 16 June 2026

Chair: Phanuel Mutumburi

Item Status	Update
Assure	**Community Stroke Services Business Case (Left Shift)** The Committee approved the business case which would provide a significant return on investment by releasing over 7,000 hospital bed days by delivering care closer to home. The Committee commended the business case as an exemplar of the new strategic commissioning approach the ICB needed to follow. The Committee was also keen to ensure that the ICB take the opportunity to expand the model if the interim evaluation showed that it was delivering the expected improvements.
Assure	**Strategic Plan for Mental Health, 2026-2031** The Committee approved the strategic plan for mental health which set out how the ICB would work with partners in its new role as strategic commissioner. The Committee did seek further information around assessing the delivery of the overall plan. The Committee looked forward to receiving further business cases for the activity set out in the plan.

Date: 7 July 2026

Chair: Phanuel Mutumburi

Item Status	Update
Advise	**NSFT Complex Emotional Needs (CEN) Business Case** The Committee supported a business case which would provide the initial steps in redesigning the Complex Emotional Needs pathway. The Committee approved the business case but have asked that officers report back in September detailing the baseline line data, expected activity levels, and evaluation metrics.
Advise	**N&S Alternative to Crisis Mental Health business case** The Committee approved a business case which would address the differences in crisis mental health support across Norfolk and Suffolk. The Committee noted the need for the service set out in the business case to link with the Mental Health Hubs which were due to open in the coming year. The Committee also stressed the need to ensure consistent engagement with the Voluntary Sector when developing proposals. The Committee has asked for a further report clarifying the evaluation framework in September.
Advise	**Planned Care Demand Management Plan**

	The Committee received a summary of the outcome of phase one of PA Consulting's work which established the evidence base to inform the next stages of the work. The Committee heard about the opportunities to explore an enhanced primary care service which had been presented by the two GP Federations.
Advise	**Newmarket CDC Expansion Business case** The Committee endorsed the Business Case for an expansion of the Newmarket CDC which would increase endoscopy capacity. The Committee noted that the expansion as proposed was only viable if patients were also referred from Cambridge. WSFT provided assurances that CUH were supportive of the expansion. The Business Case will come to Board for final approved.
Assure	**Preoperative Tobacco Dependency Treatment Service Business Case** The Committee supported a business case which provided additional resources to the tobacco dependency service focused on patients awaiting surgery. The Committee received assurances that patients would be sign posted to long-term support in the community to help them quit smoking for good. The Committee noted that this investment only applied to the two Suffolk Hospitals and that Norfolk and Waveney already had a comprehensive tobacco dependency service in place.
Assure	**End of Life Modelling and Evaluation** The Committee received the detailed approach to evaluation of three initiatives that it had supported in May. The Committee was satisfied that there was a robust approach to evaluation while recognising the complexity inherent in evaluating the effectiveness of end of life care.
Assure	**Intensive and Assertive Community Mental Health Service** The Committee received the detail of the evaluation methodology that supported the Intensive and Assertive Outreach Business Case that had been approved in May. The Committee asked officers to further test the sustainability of the staffing model assumed in the business case with the voluntary sector.
Assure	**Strategic Commissioning Policy** The Committee approved the Policy and Toolkit which was also being presented to Board.
Assure	**Strategic Commissioning Committee Governance inc. digital governance** The Committee established a number of Commissioning Oversight Groups which would assist the Committee by undertaking detailed work on business cases prior to them being presented.

Guidance

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Norfolk and Waveney Primary Care and Neighbourhoods Committee

Date: 17 June 2026

Chair: Elaine Noske

Item Status	Update
Assure	**Terms of Reference** The Committee reviewed and approved its terms of reference. Several amendments were agreed including a change in quoracy to ensure robust decision making. The Committee also agreed to review the membership to help ensure that commissioning at neighbourhood and place level was aligned between partners.
Advice	**Neighbourhood Health in Norfolk & Waveney** The Committee heard about the work that was underway to review the approach to neighbourhood working in Norfolk and Waveney supported by PA Consulting. The outcome of the work would come to a future committee meeting.

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.
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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.

Suffolk Primary Care and Neighbourhoods Committee

Date: 17 June 2026

Chair: Elaine Noske

Item Status	Update
Assure	**Terms of Reference** The Committee reviewed and approved its terms of reference. Several amendments were agreed including a change in quoracy to ensure robust decision making. The Committee also agreed to review the membership to help ensure that commissioning at neighbourhood and place level was aligned between partners.
Assure	**Draft Suffolk Alliance Governance and Neighbourhood working** The Committee endorsed the draft alliance governance structure for Suffolk which set out how the two Alliances, the neighbourhood teams, and the pathway specific groups would operate including how they would link into other areas of the ICB such as Strategic Commissioning Committee.

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:

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Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 20
Date: 15 July 2026

Title: Governance Update and Amendments to the Governance Handbook

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

Author: Tom McColgan, Corporate Governance Manager

Purpose: Decision

Recommendations: That the Board:

i. Notes the Non-Executive Member recruitment process.
ii. Approves the amendments to the Scheme of Reservation and Delegation.

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1. Non-Executive Member Recruitment

1.1. At the last meeting the Board approved an amendment to the constitution to create an additional Non-Executive Member position. This amendment has been approved by NHS England and we have now commenced recruitment.

1.2. The opportunity to apply to become a Non-Executive Member is being advertised on NHS Jobs and being promoted through local networks. The applications are open until 4 September.

1.3. The ICB is seeking to appoint a non-executive member who brings knowledge and experience that complements the existing expertise on the Board to enhance decision making by bringing different points of view

2. Amendments to the Scheme of Reservation and Delegations (SoRD)

2.1. There have been a number of queries relating to who can authorise contracts on behalf of the ICB. For the avoidance of doubt it is proposed to insert the below wording into scheme of reservations. This wording has been drafted in consultation with the Finance and Contracts Team.

Signing of contracts on behalf of the ICB

Contracts must be authorised by either the Chief Executive or Executive Finance and Contracts Director on behalf of the ICB.

Variations to contracts related to the ICB's management of delegated Primary Medical Care, Dental, Pharmacy and Optometry services where there are no material changes to terms or ICB liabilities (partner/ signatory changes for GMS/PMS contracts) may be authorised by the relevant Executive Director or Band 9/ 8D officer if authorised by the revenant Executive Director.

2.2. The delegations are in line with previous practice in both SNEE and NW ICBs.

2.3. The Executive Committee consider a report on the ICB's implementation of the Accessible Information Standard (AIS) which has been updated to clarify the ICB's role and responsibility both in regards to the information that it produces and commissioned services. The AIS asks that a Board Member assumes responsibility for the standard and Executive Committee have nominated the Executive Director of People, Governance and Corporate Services. The SoRD will be amended to reflect this new role as responsible Board Member.

2.4. The ICB is establishing and internal working group to carry out a self assessment against the AIS requirements. The ICB's website has been built with the web content accessibility standard in mind and had been rated as the most accessible ICB website nationally.

3. Patient and Public Engagement

3.1. N/A

4. Committees and Groups

4.1. Executive Committee considered the AIS and Remuneration Committee have reviewed the approach to recruiting an additional non-executive member.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 21
Date: 15 July 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: Information

Recommendation:

The Board is asked to note and support the strategic direction of risk management and the progress being made in strengthening the organisation's risk management framework, specifically:

- Risks with a score of 12 or above are now aligned to the appropriate committees for oversight, review and assurance, and will subsequently be linked to the Board Assurance Framework (BAF) as it is developed.
- Development of the Board Assurance Framework is progressing, with a detailed paper scheduled to go to the Executive Committee on 20 July.

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1. Background

1.1. Since 1 April 2026 Norfolk and Suffolk have implemented a new approach to risk management, introducing a centralised Corporate Risk Register (CRR) to hold all organisational risks.

1.2. Officers have undertaken a review to identify relevant risks to include on the CRR, this includes an assessment of historic risks to ensure they remain appropriate and are accurately scored within the context of the new organisation.

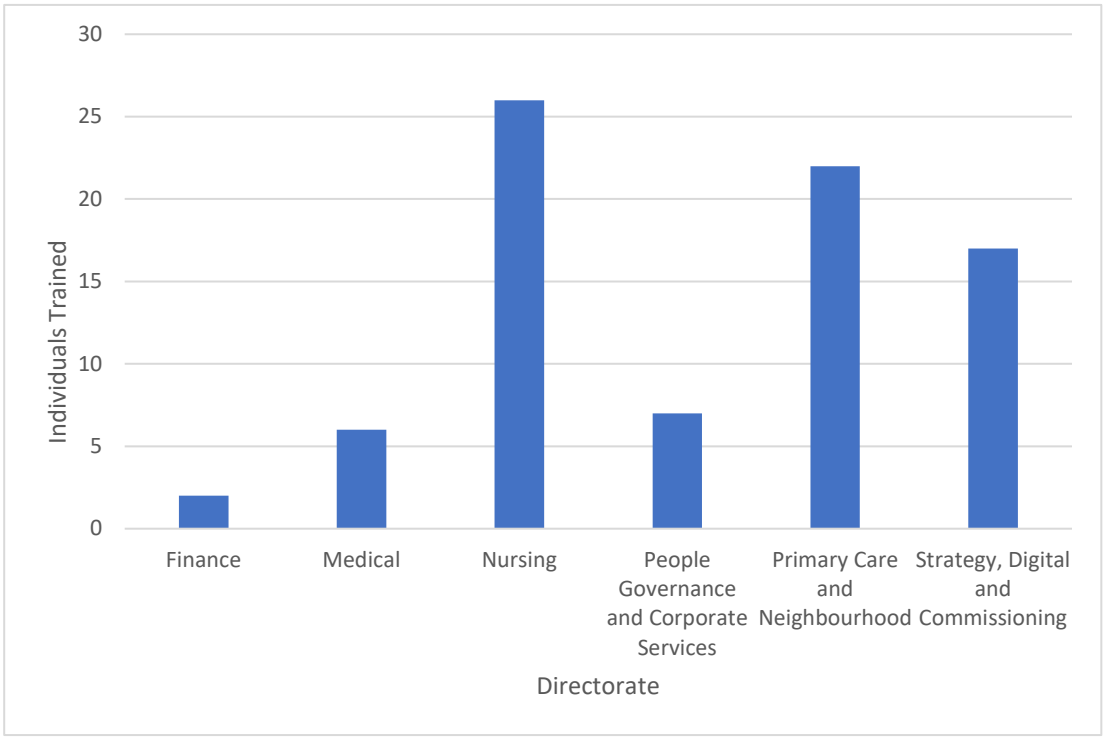
1.3. A total of 32 risks have been identified and are currently live on the CRR. Of these, 3 have a mitigated score of 12, 2 have a mitigated score of 15, 13 have a mitigated score of 16, and 5 have a mitigated score of 20.

1.4. Risks with a mitigated score of 12 and above have been aligned to relevant committees and will be reported accordingly to provide enhanced oversight. This process commenced with the Quality Committee on 2 July.

2. Key Issues and risks

Training

2.1. Following the launch of the Corporate Risk Register (CRR), training has been made available to all staff to support the use of the new system. Engagement has been good, with over 80 individuals attending sessions across all directorates.



2.2. Training has been offered organisation-wide, to promote a culture where risk management is recognised as everyone's responsibility. All staff with an interest in this area are encouraged to participate.

2.3. Feedback on the new processes has been positive, with staff recognising the user-friendly system. Additional training sessions have been scheduled through July, and ongoing support will be provided to ensure staff are confident in managing risks effectively.

Risk and Resilience Group

2.4. To support effective oversight of the Corporate Risk Register, a Risk and Resilience Group has been established. So far two meetings have been held, the first provided an introduction to the new processes and the purpose of the Group, while the second was the start of the standing agenda.

2.5. At the second meeting, the Group approved the addition of new risks to the CRR. The Group provided constructive check and challenge in relation to the newly

proposed risk. This was approved onto the risk register with a change in score to the unmitigated score. This approach strengthens the alignment of our risks across the organisation ensuring the highest risks are escalated appropriately.

2.6. The first spotlight was also presented at the second meeting, this initial spotlight session from the Emergency Preparedness, Resilience and Response (EPRR) team was well received, and a forward schedule is now being developed to invite other teams across directorates to participate in future sessions. Once the Board Assurance Framework (BAF) is established in September, a standing agenda item will be introduced to review a different BAF risk on a monthly basis.

3. Operational Risks

3.1. Listed below are the organisation's new risk and the operational risks scoring 12 and above including the Cyber Attack risk which has recently been reviewed and updated.

3.2. These risks are currently being considered at Committee level as the Risk Register continues to develop. This process is to ensure that risks are appropriately aligned to the relevant Committees and accurately reflect the organisation's risk profile.

3.3. Additional details of the risks including mitigations can be found in Appendix 1 which has a full extract of the risk register.

3.4. These risks provide an important foundation for identifying and informing future strategic risks, highlighting areas of significant exposure requiring organisational oversight. Once developed, these operational risks will be linked to the Board Assurance Framework (BAF) risks.

New Risk

- **Global supply chain instability** has a mitigated score of 9

Risks scoring 12 and above
(these risks were live at either Norfolk and Waveney ICB or Suffolk and North East Essex ICB)

- **Large-scale Cyber Attack impacting NSICB** has a mitigated score of 6
- **Histopathology delays affecting cancer pathways** has a mitigated score of 12, and is aligned to the Strategic Commissioning Committee.
- **Insufficient acute medical staffing in oncology** has a mitigated score of 12 and is aligned to the Strategic Commissioning Committee.
- **RAAC in ICS Buildings** has a mitigated score of 12 and is aligned to the Strategic Commissioning Committee.
- **Delay in completing BIA process** has a mitigated score of 15 and is aligned to the Executive Committee.
- **Failure to meet statutory ICB financial targets** has a mitigated score of 15 and is aligned to the Finance, Workforce and Performance Committee.

- **Lynch Syndrome testing and surveillance pathway** has a mitigated score of 16 and is aligned to the Strategic Commissioning Committee.

- **Failure to Meet Cancer Access Standards** has a mitigated score of 16 and is aligned to the Strategic Commissioning Committee.

- **Long Waits in Eds** has a mitigated score of 16 and is aligned to the Quality Committee.

- **EEAST Response Time and Patient Harms** has a mitigated score of 16 and is aligned to the Quality Committee.

- **Provision of Paediatric Audiology – Queen Elizabeth Hospital** has a mitigated score of 16 and is aligned to the Quality Committee.

- **Instrumental Assessment for CYP Dysphagia in NW** has a mitigated score of 16 and is aligned to the Quality Committee.

- **ISFE2 – Finance Ledger System Implementation** has a mitigated score of 16 and is aligned to the Finance, Workforce and Performance Committee.

- **Surge Capacity to Support Local Acute Trusts** has a mitigated score of 16 and is aligned to the Quality Committee.

- **Community Nursing Unallocated Visits** has a mitigated score of 16 and is aligned to the Quality Committee.

- **Children & Young People (CYP) Mental Health Waiting Lists** has a mitigated score of 16 and is aligned to the Quality Committee.

- **Mental Health 12 Hour Breach Risk** has a mitigated score of 16 and is aligned to the Quality Committee.

- **Impacts of climate change on health care capacity & resilience** has a mitigated score of 16 and is aligned to the Strategic Commissioning Committee.

- **Staff Burnout** has a mitigated score of 16 and is aligned to Remuneration Committee.

- **TB Service Resilience and Capacity** has a mitigated score of 20 and is aligned to the Quality Committee.

- **Neuro-Developmental Service (NDS) Community Paediatrics** has a mitigated score of 20 and is aligned to the Quality Committee.

- **Elective Recovery** has a mitigated score of 20 and is aligned to the Quality Committee.

- **RTT (Referral to Treatment) Objective** has a mitigated score of 20 and is aligned to Strategic Commissioning Committee.

- **Diagnostics 6-Week Standard** has a mitigated score of 20 and is aligned to Strategic Commissioning Committee.

4. Development of the Board Assurance Framework

4.1. A meeting was held on 10 June between the Audit Committee Non-Executive Members, the Executive Director of People, Governance and Corporate Services, and representatives from the Corporate Governance Team, with the ICB's internal auditors TIAA, to review the appropriate positioning and level of the Board Assurance Framework (BAF).

4.2. TIAA provided an overview of the purpose of a Board Assurance Framework and outlined how it can be effectively utilised as a tool to support the Board in its oversight responsibilities.

4.3. In this meeting, the Population Health Improvement Plan (PHIP) was reviewed to identify the organisation's objectives. Given the multiple layers of objectives in place, it was agreed that the Executive Committee would determine the most appropriate approach for aligning the BAF.

4.4. A paper is going to Executive Committee on 20 July outlining the options. Once a decision has been reached, full development of the BAF will commence. Operational risks will be mapped to the BAF, supporting a cumulative risk approach that demonstrates how multiple risks contribute to each strategic risk area.

4.5. As a key strategic document, the BAF should be developed in collaboration with Board Members to ensure it provides the level of strategic risk oversight required.

4.6. 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.

5. Patient and Public Engagement

5.1. There has been no patient engagement on this item.

6. Committees and Groups

6.1. 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.

7. Appendices

7.1. Appendix 1: Corporate Risk Register extract

ID	Risk Title	Status	Risk Description	Risk Type	Committee	Responsible Executive Director	Team	Operational Lead	Unmitigated score	Mitigations	Mitigation Effectiveness	Mitigated Score	Target Score	Affected Partner organisations
1	Global supply chain instability	Open	There is a risk that due to global supply chain instability that may affect varying health organisations and their associated supplies consumables as a result of geopolitical events could lead to NHS services and patient care.	Safety & Quality	Executive Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Business Continuity/EPRR	CHAPMAN, Christopher (NHS NORFOLK AND SUFFOLK ICB - 26A)	12	EPRR reps monitoring National and Regional updates, as well as LRF liaison with Ministry Housing Communities and Local Government (MHCLG)	3 - Some control with weaknesses	9	6	["N&SICB"]
2	Lynch Syndrome testing and surveillance pathway	Open	There is a risk that patients with Lynch syndrome are unable to access lynch syndrome testing and surveillance and so miss out on early detection of cancers which may lead to worse long term outcomes.	Safety & Quality	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	16	This risk cannot be mitigated unless the pathway is commissioned as defined nationally. A pre-implementation audit has been completed across the three trusts and educational webinars are being provided to Primary Care, to prepare for full implementation. A system specification, pathway and Standard Operating Procedure have been developed ready for implementation. Additional capacity for bowel screening to be offered to lynch positive patients has been. confirmed at the NNUH by the NHS E screening from April 2023.	2 - Adequately controlled	16	8	["EOE Cancer Alliance"]

3	Histopathology delays affecting cancer pathways	Open	There is a risk that whole cancer pathways are being delayed due to delays in Histopathology turn-around times. If this occurs it may lead to psychological harm for patients delayed in receiving a no cancer diagnosis, and physical harm due to delays in them receiving their diagnosis and treatment plans.	Safety & Quality	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Issues flagged with the EOE Alliance, and Regional NHSE team. NNUH Mitigations - Implementation of AI for Prostate biopsies. Recovery plan in place to support improvement to 80% of patients with a 10 day turnaround and a shift towards 80% within 7 days. Additional funding from cancer transformation resource to support urology histopathology pathways.	3 - Some control with weaknesses	**12**	**8**	["EOE Cancer Alliance"," Regional Diagnostics Team"]
4	Insufficient acute medical staffing in oncology	Open	There is a risk that patients will miss out on some cancer treatments and so have suboptimal outcomes due to insufficient medical staffing across all providers to meet current demand. This is particularly acute in breast oncology, where specialist staffing is insufficient to meet new NICE mandated treatments for breast cancer.	Safety & Quality	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Approach made to Alliance to support capacity and demand work and regional escalation of the inequity of staffing issues, trainees and inter-system mutual aid. Currently agreeing approach to baselining of medical staffing across the trusts. NNUH action to agree and send duty of candour letters where appropriate. Escalated to People Board re provider cancer specialty workforce plans and to influence/improve funding arrangements to support introduction of proposed new skill mix/advance practice into trusts. Provider exploration of International recruitment. Medical staffing agreed as one of our top priorities for the system cancer workforce plan. Progression of local non-medical multi-professional skill mix redesign projects (cancer nursing, therapeutic radiography). Progression of system cancer workforce strategy via Oncology Speciality Network. Oversight via N&W Cancer Transformation Oversight Group. Provider led process for business cases when needed. Work completed with support of quality team to ensure that trusts prioritise patients approaching the end of adjuvant treatment window to prevent harm occurring and provide appropriate support while waiting for this. System workforce steering group in place/leading local project work reporting into the Cancer Transformation Oversight Group. Trusts reviewing and agreeing locum cover and revision of cancer recovery plans and transformation resource diverted to support additional breast oncology activity.	5 - No control	**12**	**8**	["EOE Cancer Alliance"]

5	Failure to Meet Cancer Access Standards	Open	There is a risk that patients will come to harm due to the failure to meet access standards for cancer diagnosis and treatment. The incomplete implementation of the best practice timed pathways (BPTPs) contributes to this risk.	Safety & Quality	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	The Cancer Transformation Oversight Group works in close partnership with the regional cancer screening and Imms team and EOE Cancer Alliance, to optimise uptake/coverage of screening, provide fixed term transformation resource and to support system transformation projects which expand diagnostic and treatment capacity/transform how care is delivered to improve timeliness and efficiency. This work feeds into Elective recovery. There are particular concerns re skin, gynae and urology cancer pathways. These pathways are prioritised for transformation and resource to support backlog clearance and for diagnostics (histopathology). Utilisation of assigned system SDF funding to implement trust cancer and diagnostic improvement projects and to improve cancer waiting time performance. System cancer transformation support for agreed priority pathways (dermatology and gynae). Trusts to prioritise and plan for the BPTPs to be in place prior to fixed term transformation resource ending. Link to EOE Cancer Alliance in reach role to support performance improvement and the planned RCAT programme for 2025-6. Local initiatives are underway to raise awareness of worrying symptoms and encourage early presentation to Primary Care. There are a range of partnership transformation projects to support raising awareness of the signs and symptoms of cancer in health inclusion groups and areas of deprivation. The Rapid Diagnosis Service has now closed with an alternative NSS pathway being established. There is also the pilot of the C the Signs Primary Care Clinical Decision support tool to improve quality and reduce variation in urgent suspected cancer referrals. There is a unified prioritisation and harm review process of reviewing patients on waiting lists for possible harm, to ensure that elective capacity is used to deliver care to patients in order of clinical priority at all acute trusts	3 - Some control with weaknesses	**16**	**16**	["Cancer Alliance","Primary Care Urgent Suspected Cancer Referrals","Acute Group Model"]
6	Long Waits in EDs	Open	Clinical risks to patients delayed within EDs, in particular 12h DTA due to high occupancy which could cause deterioration in condition and deconditioning for older patients, which could in turn extend length of stay and have a detrimental affect on outcome. Please read in conjunction with Quality and Safety risks 34 surge capacity and risk 59 deconditioning and infection.	Safety & Quality	Quality Committee	BURGIS, Mark (NHS NORFOLK AND SUFFOLK ICB - 26A)	UEC	DEAR, Maisey (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Clinical oversight and monitoring Pressure relieving mattresses in use in all departments, although we are not seeing significant harms, patient experience is poor All Trusts have escalation processes in place for physical and mental health 12-hour DTA breaches. Use of surge beds across acute and community inpatient units provides some additional capacity to support flow and alleviate pressure on ED.	5 - No control	**16**	**6**	

7	Industrial Action Clinical Impact	Open	There is a risk that the reduction in medical staffing during periods of strike action will contribute to operational pressures across organisations, sites and departments. Although all resident doctors work under the supervisor of a senior doctor, they make up a significant amount of the medical workforce, working across various specialty areas.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	DEAR, Maisey (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	ICB Nursing & Quality Team continues to have oversight of adverse incidents reported through the provider Patient Safety Incident Review Framework (PSIRF). Ambulance Delay Group is able to stand up in the event of increased harms due to ambulance delays, which provides additional oversight of harm and risk. However, admission avoidance work is supporting UEC flow. ICS Chief Nurse Forum connects ICB and provider Chief Nurses and enables escalation of any trends in adverse incidents, as well as collective discussion and agreement of supportive actions. Clinical Risk Review Panel stood back up as of October/November 2025 as we moved into seasonal pressures; chaired by ICB Executive Medical Director. The N&W ICS Industrial Action meetings reinstated for the BMA Resident Doctor strike action in July, November and December. These are touchpoint meetings for the ICS to discuss requirements for an effective response during this period. Agenda Items to include Regional update; Risks/Issues; Escalations and Communications. This process can stand up again in the event of any further action scheduled during the mandated period (up to end of January 2026). Risk will continue to be monitored at Committee until mandate has ended / resolution of the resident doctor pay discussion. This will also enable us to to identify any emerging impact/harm on elective pathways. Providers have Business Continuity Plans in place and mutual aid can be stepped up across providers as required. ICS EPRR processes are also in place to provide an effective forum for joined up operational management and support across organisations. System Clinical Elective Harm Group is currently stood down. The three Acute hospitals are working on implementing this as part of the Hospital Group Model, to provide shared harm review oversight related to the elective pathways. ICB Quality Leads are engaged with individual provider harm review processes and have collective oversight in the meantime. Organisational-level and system hosted wellbeing support offers are available to staff.		**6**	**4**	

8	EEAST Response Time and Patient Harms	Open	Clinical risks to patients awaiting ambulances in community – C1 and C2 response times including inability to undertake rapid release of ambulances. Handover and inter-facility transfers resulting in patient harms, occurring during periods of significant system pressure.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	DEAR, Maisey (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Hospital flow and 'corridor care' has been well managed. Optica implementation is improving system view; NNUH and QEHKL embedded, JPUH now online and working on full implementation over next quarter. Oversight of C1/C2 ambulance response time performance has continued. C2 response mean for Feb 25 remains variable. C2 Segmentation is expected to be fully implemented by April 2025 Daily sit-rep to SCC ensures ICB is sighted on real-time demand and resource. HALO role across all Acute sites to support Emergency Departments (ED). 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions Interfacility transfers have improved with processes in place between organisations. (was previously 45 minute handover control). A new protocol for escalation of ambulance handover delays has been shared by NHSE. the protocol will come into effect on 17th December 2025. The protocol outlines the level of delay and the actions required. In hours -Level 1 45-90 mins - requires assurances from the local trust. Level 2 over 90 minutes - detailed offloading plans required. Level 3 over 3 hours - operational reviews and escalation to NHSE. Level 4 over 4 hours - immediate strategic contact with Trust leadership. Delays over 5 hours will be escalated to the NHSE regional director. Out of hours escalation involves discussions with acute Trusts and potential implementation of Intelligent Conveyancing. The protocol also outline parameters for rapid release measures and minimum safety care standards while patients are waiting on ambulances. Pre-alert and rapid release processes in place with safety netting for patients waiting to be seen. Ambulance and ED revalidations embedded. Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns e.g. Pharmacy First and Think 111. UEC Incident Group continues to review system-wide incidents and identify trends / themes. In August 2023, the ICB launched the Unscheduled Care Coordination Hub (UCCH) with the aim of reducing conveyances, this replaces and builds on the work of the previous 'Virtual Open Room' which triaged people waiting for an ambulance and re-routed appropriate calls directly into other community services. Funding agreed for the year ahead. Hours of operation increased in January 2025 to 08:00 - 22:00 coverage. Following an unannounced visit to EEAST by the CQC in February, there is an enhanced focus on C2 performance which is being additionally monitored through the rapid quality review process established by SNEE.		**16**	**9**	["EEAST"]
13	Provision of Paediatric Audiology – Queen Elizabeth Hospital	Open	There is a risk that Babies, Children and Young People (BCYP) experiencing hearing loss resident in the catchment area of QEHKL may not receive accurate and timely diagnosis. As a result of a review of paediatric hearing services at Queen Elizabeth Hospital Kings Lynn (QEH KL), quality concerns were raised, the service has temporarily closed to referrals in order to put in place an action plan. This could lead to long term harm as a result of missed opportunities to provide early and effective support to enable BCYP with hearing loss to develop their language and communication skills.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Utilising expert clinical to provide leadership and clinical oversight to the audiology pathway. Formal merge with NNUH Audiology Service complete. Monthly incident management group chaired by ICB Executive Nursing Director and attended by ICB Executive Medical Director. Monthly reporting to NHSE Eastern Region and National Team, reporting by ICB to Paediatric Audiology Oversight Groups. Mutual Aid from NNUH through Group Model. Ongoing recruitment for paediatric audiologist and Head of Service. QEH reporting through Enhanced Monitoring Reporting to SQG. Establishment of ENT and Audiology Specialty Clinical Networks through Norfolk and Waveney Hospitals Group Model.		**16**	**8**	["QEH","NNUH"]

14	Loss of Premises	Open	There is a risk of a loss of access to records and servers. Due to unexpected / unplanned loss or closure of one or more of the ICBs properties. This could lead to staff unable to complete their work, missed time sensitive documents and disruption to committee and board meetings impacting the running of the ICB.	Infrastructure	Executive Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Business Continuity/EPRR	CHAPMAN, Christopher (NHS NORFOLK AND SUFFOLK ICB - 26A)	**9**	The ICB has three main sites from where it works. If one site was lost, the organisation could move critical functions to another building i.e. registered address. Following the pandemic the ability for the organisation to work Remotely is now fully embedded across the organisation which would limit any loss of premises and subsequent disruption to activity to a minimum. This includes the ability to undertake recruitment and board meetings Remotely if required. If one site was lost, the organisation could move critical functions to another building i.e. registered address.	3 - Some control with weaknesses	**4**	**2**	
15	Loss of Workforce	Open	There is a risk that there is a unexpected or unplanned loss of ICB workforce. Due to strike action or illness or adverse weather. This could lead to the organisation being unable to undertake critical functions.	Safety & Quality	Executive Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Business Continuity/EPRR	CHAPMAN, Christopher (NHS NORFOLK AND SUFFOLK ICB - 26A)	**6**	BIAs being developed at team and directorate level to understand critical activities. Ability to work Remotely can be used to prevent spread of any pathogens within office spaces if an outbreak were to occur. - ICB has Infection Control Nurses who can advise on containing outbreaks to limit scale and duration if required. Remote working options mitigate severe weather impacts, but not completely as some staff may loose connectivity in their local area.	3 - Some control with weaknesses	**4**	**2**	

16	Loss of Utilities	Open	There is a risk of a loss of utilities at the ICB main sites. Due to an unexpected emergency situation. This could lead to the organisation not being able to complete critical functions.	Safety & Quality	Executive Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Business Continuity/EPRR	CHAPMAN, Christopher (NHS NORFOLK AND SUFFOLK ICB - 26A)	**9**	All staff have the capability to work Remotely, either from home or another NHS / Local Authority site. BIAs being created for all teams to identify critical activities and the impact of utility loss. It is still however possible that staff may loose utilities at home making remote work challenging. We would have to consider the use of different offices. The SOC could operate remotely for a number of days if required. It is not possible to mitigate the likelihood due to utility supply is outside the ICB control. We can only mitigate the consequences.		**6**	**3**	
17	Loss of IT	Open	There is a risk that IT systems cannot be accessed. Due to a global software issue (i.e. crowd strike patch issue) This could lead to staff not being able to complete business critical functions.	Safety & Quality	Executive Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Business Continuity/EPRR	CHAPMAN, Christopher (NHS NORFOLK AND SUFFOLK ICB - 26A)	**9**	ICB has a rigorous patching regime to keep security up to date however this may not prevent/ or cause the issue to occur if the cause of the outage is a patch as seen with crowd strike. Team BCPs being written. Hard Copies are now held within the System Operations Centre. Information Governance, Risk, IT and EPRR meetings established to review risks in this area.	3 - Some control with weaknesses	**9**	**6**	
18	Large-scale Cyber Attack impacting NSICB	Open	There is a risk that the ICB experiences a cyber incident. As a result of either social engineering, phishing, brute force, internal bad actors, external hackers. This could lead to impact on the critical services or functions the ICB delivers.	Reputation	Strategic Commissioning Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Digital and IT	WARD, Pete (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Mandatory Multi Factor Authentication (MFA), Annual Phishing Test, Staff training, DSPT, Annual Pen Test, Input into commissioning checklists from a cyber perspective, regular reports to groups (IG steering group, ARC), Annual IT Health checks, CareCERT, Cyber Resilience Group, Leaver processes for NHS mail, Microsoft Safe Links, NHSE support for Business Continuity, SCCM, SDWAN, Secure boundary protection.	2 - Adequately controlled	**6**	**4**	

19	Delay in completing BIA process	Open	There is a risk that BIAs will not be developed for all teams Due to work pressures This could lead to the ICB being non compliant against the NHS EPRR Core Standards as an NHS organisation and Cat 1 responder.	Reputation	Executive Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Business Continuity/EPRR	CHAPMAN, Christopher (NHS NORFOLK AND SUFFOLK ICB - 26A)	**15**	The organisation has an extant Incident Response Plan that includes existing business critical activities. However these may be out of date and need updating ultimately meaning we have out of date information in the plan. Although this will delay the response to a business interruption there would be Limited (1) patient impact. The ICB will only be able to be partially compliant in the EPRR core standards response for this year. Process restarted 06/2026 with a completion goal of 10/26.	3 - Some control with weaknesses	**15**	**1**	
20	Instrumental Assessment for CYP Dysphagia in NW	Open	There is a risk that babies, children and young people (BCYP) are unable to have their swallowing assessed via video fluoroscopy. As a result of there being no local service available to objectively assess the safety of swallow for the paediatric population across Norfolk and Waveney. This could lead to poor, potentially fatal outcomes for babies, children and young people with swallowing difficulties.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	CYPM	BEAN, Chris (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Agreement between ICB and NNUH to review neonatal SLT provision including the availability of Instrumental Assessment. Since the NNUH VFSS service ceased the Community and Acute SLT service has provided recommendations of modified diet and feeding strategies and has adopted a 'watch and wait' protocol. For some babies, children and young people (BCYP) this has been successful, but for others this has had long-lasting detrimental impact on The Respiratory Team at NNUH have been supportive in substantiating concerns to their paediatric colleagues at Addenbrookes for referrals for VFSS to be accepted. their lung health and in one case lung damage has been irreversible. The Addenbrookes team have continued to support referrals from Norfolk, but this has placed a significant financial and clinical pressure on their service. NNUH and CCS have agreed to provide data on the number of BCYP who have been referred for Instrumental Assessment, to include how many were accepted and how many were not. They will also provide case studies NNUH have been asked to monitor for adverse outcomes and to notify the ICB if children have been admitted to hospital This risk highlights a critical commissioning gap for Video Fluoroscopy and Neonatal SLT provision for NNUH, QEHKL and JPUH, which has been escalated to the ICB and documented as a QSC Risk since January 2023	5 - No control	**16**	**9**	["NNUH","EECHC"]
23	RAAC in ICS Buildings	Open	There is a risk that the RAAC will collapse in Hospitals across Norfolk and Suffolk due to a lack of structural integrity and there may be unassessed properties that may contain RAAC. This could lead to fatalities to staff or public, loss of the building, increased pressure on surrounding hospitals, dust contamination that may include asbestos, reputational damage to the organisation.	Infrastructure	Strategic Commissioning Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Estates	TURNER, Daniel (NHS NORFOLK AND SUFFOLK ICB - 26A)	**15**	Local and Regional plans in place and aligned with regional oversight group established. WSFT have surveillance program / remedial plan to ensure safety of patients, visitors and staff. WSFT internal expert leadership team. ICB has received assurance from all Primary Medical providers that they have not identified RAAC in their premises. Incidents or Events are routinely monitored through EPRR Team.	3 - Some control with weaknesses	**12**	**6**	["WSFT","jpuh","qehe","NNUH","ESNEFT","EEAST","EECHC"]

24	Failure to meet statutory ICB financial targets	Open	There is a risk the ICB does not break even on it's financial targets or exceeds the NHSE limits. Due to insufficient funding, ineffective controls, ineffective cost improvements, prescribing price inflation, additional cost of UEC, 50% savings requirement, system risk with WSFT deficit and TIF funding shortfall. This could lead to a failure to deliver financial planning targets, failure to deliver statutory duties and a loss of system autonomy and credibility.	Financial	Finance, Workforce and Performance Committee	MARTIN, Howard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Finance	THOMPSON, James (NHS NORFOLK AND SUFFOLK ICB - 26A)	**15**	Internal expenditure controls, including Vacancy Approval Panel. Contingency reserve. Projected underspends in Dental and Specialist Commissioning. Detailed Cost Improvement Plans. Double Lock Arrangements for WSFT. Production of the WSFT FRP and detailed review.	5 - No control	**15**	**12**	["WSFT"]
25	ISFE2 – Finance Ledger System Implementation	Open	There is a risk that ISFE2 (Integrated Single Financial environment) is not successfully rolled out. Due to NHS England and NHS Shared Business Services failed to meet certain milestones outlined in the project plan, multi-organisation access defects and design flaws, reporting suite issues, approval Hierarchy bugs / defects, process inefficiencies and forecasting limitations. This could lead to an inability to pay suppliers and staff, affects on efficiency and effectiveness of the Finance team, an inability to meet ICB statutory compliance and unable to carry out regular reporting.	Financial	Finance, Workforce and Performance Committee	MARTIN, Howard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Finance	THOMPSON, James (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Weekly operational call involving ICB and CSU lead Project hub document detailing workstreams, tasks and progress (including cutover plan) Project board meeting monthly involving finance, IT, CSU and comms Ledger / Balance sheet integrity, quality of returns and open transactions are in the hands of the ICB. All of which are in a good place. Hypercare support available Training provided to non-finance staff by the ICB – this has resulted in invoice levels reducing but not to the levels seen before ISFE2	5 - No control	**16**	**8**	

26	TB Service Resilience and Capacity	Open	There is a risk that the TB Services are unable to meet demand. As a result of insufficient TB specialist nurse resource. This could lead to a reduction in patient safety, quality of care and public health protection.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	ECCH are back to full establishment as per their contract, as of January 2026. However, additional workload is expected to be identified via UKHSA which will create a capacity challenge. The ICB provided NCH&C with non-recurrent funds until end of March 2024 and NCH&C recruited a Band 4 Nurse to support the Specialist TB Nurse. NCH&C Health Protection Field team funding is due to cease 31/03/25. Another paper went to ICB EMT in February 2025 requesting additional resource to strengthen community TB capacity. This has gone through triple lock and has been agreed. The funding is being used to secure two new posts; one clinical and once non-clinical to improve TB resilience within Central Norfolk. Investment requests submitted in January 2026, to make additional funding recurrent and to invest additional funds to develop the community TB service into a resilient longer term model. Taking forward jointly with Suffolk. The NCH&C Specialist TB Nurse has moved into the NCH&C IPAC Team structure to provide additional support and resilience. Paper went to ICB EMT in February 2025 and resource decision made to provide additional funding to support resilience in NCH&C over the next year, by putting additional roles into the team. On 23/07/25 N&W ICB and other colleagues who work within TB Services in N&W met with the national TB GIRFT review team. The meeting included an initial review of TB services across the system and some early actions to begin a fuller action plan were identified. This work will now be taken forward locally and an update provided to the national team in six months time. A paper summarising GIRFT recommendations across Norfolk and Suffolk is being prepared to support Executive oversight and drive forward the improvements. Additional funding requests are linked in to support delivery and mitigate the risks identified by the GIRFT review.	5 - No control	**20**	**16**	["EECHC"]
27	Neuro-Developmental Service (NDS) Community Paediatrics	Open	There is a risk that children and young people in Norfolk and Waveney may not all receive timely and equitable access to diagnostic pathways for NDS. As a result of high demand, limited capacity, recovery from COVID-19 and system pressures. This could lead to long term health, education and care implications, poor patient experience, poor service quality, financial cost pressures and removal from educational placements; worsening mental health and potential admission to tier 4 inpatient units.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	CYPM	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Identified as priority workstream within Children and Young People's System Collaborative Choice Policy and guidance in place NDD included as priority in Joint Forward plan for 2024/25 Successful bid for funding of for Partnerships for Inclusion of Neurodiversity in Schools Established quality assured provider framework. Additional investment approved 2021. Expressions of Interest for National Spending Review funding have been successful with the aim of easing demand and impact of long waits. Pre and post confirmation service commissioned to support families 2021/22. Non-recurrent £1m investment 2023/24 waiting list initiative.	4 - Not effective	**20**	**12**	

28	Surge Capacity to Support Local Acute Trusts	Open	There is a risk to the quality, safety, and dignity of patient care. As a result of hospitals struggling to meet demand, and discharge within current capacity as well as ongoing pressures related to seasonal illness and demand, patient flow and urgent and emergency care pressures This could lead to unintended harms during admission, including healthcare-related infections, deconditioning, and falls.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	NNUH Exec Length of Stay forum continues to review patients post discharge who were admitted for 45+ days with 50% or more of this time with no CTR, identifies themes/trends, learning and improvements. Optimised Patient Tracking and Intelligent Choices Application (OPTICA) system in place at the NNUH, QEH and JPUH providing more accurate NCTR figures. As the system embeds at JPUH, additional training has been recommended to ensure consistency of approach across the acutes. All 3 acutes have a TES policy which includes risk assessment for use of TES in times of extremis. N&Q senior lead nurses have oversight of these. Regular provider operational meetings in place, including Long Length of Stay, Red to Green, Complex Patient Reviews and Criteria-Led Discharge to facilitate patient flow and timely discharges. ICB supporting care assurance visits, providing feedback, and escalating concerns. System Resilience Team in place. System MADE events scheduled periodically to help accelerate discharges. ICB working closely with local authorities to support the Care Market. Targeted Non-Criteria to Reside (NCTR) reviews taking place to accelerate delayed discharges.		**16**	**8**	
29	Community Nursing Unallocated Visits	Open	There is a risk of delayed care for patients, cared for by Community Nursing Teams (CNT) across North, South, Norwich, and West localities/place. Due to an increase demand and complexity of referrals for community nursing. This could lead to poor patient experience, increase in complaints, impact on patient outcomes and, specifically, potential deterioration of wounds and other conditions requiring community follow up.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	"Waiting Safely" principles in place at provider level. Monitoring by the Clinical Reference Group (CRG), to review the impact and outcomes of periods of escalation. Aligning CN&T daytime hours across Norfolk; 8am to 8pm (involves a staff consultation) with an aim to release night-time capacity to better respond to 2-hour referrals. Whole system is now working on an 8-8 model. Piloting a dedicated Care Home Team with HomeLink. As of March 2025 this is having a positive impact and is being extended month on month, by NCH&C. CN&T (Community Nursing Teams) review currently taking place to identify areas where most demand is within community nursing. This is a combined review between NCHC (Norfolk Community Healthcare) and ICB (Integrated Care Board). Service improvements include. Review continues as of March 2025. South and North Norfolk continue to have a deficit is staffing. There has been a pause of both Virtual Ward teams in these areas; this has been escalated to Karin Bryant and Ross Collet who are meeting with NCH&C MD to understand the rationale. This could potentially have an impact on ED/UEC. Community Safer Staffing Escalation Group (SSEG) provides a daily forum for predicting staffing gaps to enable a swift response to changes in demand and associated risk through staff shortfalls, flexing staff across the localities. This is further supported by daily / twice daily operational planning meeting in each locality/place. Unallocated community visits are reported into SCC on a daily basis to enable oversight. Demand and Capacity Review; looking at future demand; skill mix. This is part of the overarching Better for All work being conducted by Kate Pointon at NCH&C; thorough review of all services provided, including workforce and skill mix. Updates to ICB/NCH&C partnership meeting on a monthly basis. Bank staff offered overtime/excess hours for CNT service. Prioritisation of COVID-19 and Influenza vaccination for staff. Monitoring of staff sickness and support of staff regarding moral injury. Oversight at the NCH&C Quality Committee and through the Trust's performance report which includes safer staffing. NCH&C (Norfolk Community Healthcare) Escalation Policy supports actions to prioritise and mitigate unallocated and deferrals. Internal twice weekly CTR meetings held by Trust. Splitting CN&T Teams into Planned and Unplanned Care Teams in each Locality with an aim to prevent diversion of planned resource to unplanned activity. Daily Primary Care Home lead review meetings, Mitigations put in place through triage and prioritise unallocated visits. Reported to Shrewd twice daily. NCHC have conducted their Better for all transformation programme looking at key areas where changes and		**16**	**8**	["ECCH","EECHC"]

30	Speech and Language Therapy	Open	There is a risk that children and young people may not have access to timely and safe speech and language therapy. Due to adversely impacted pathway waits for children awaiting clinical assessment for speech, language and communication needs. This could lead to poor patient outcomes for babies, children and young people.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Additional funding agreed to support mobilisation and backlog activity. Robust governance and reporting structure in place across Local Authority and ICB to monitor activity and performance Norfolk Stakeholder group for SLCN established to improve whole service offer for CYP. In December 2023 a new SLT Board was established, which will be held three times a year (one Board meeting per school term). This is for the purpose of: - Greater oversight of delivery, progress and achievement? - Drawing in wider engagement with SLT from e.g., Early Years & Prevention, Inclusion etc - Ensuring CCS have an incentive to report fully (as per contract). - Ensuring CCS have action plan in place to address recovery. - Ombudsman Report received by NCC - Commissioning reps for NCC have a good grasp of the issues and partnership working is strong - Plans underway to refresh performance outcomes framework - Paediatric inpatient SLT provision to continue at NNUH - Agreement between ICB and NNUH to review neonatal SLT provision to include video fluoroscopy provision.		**9**	**9**	["EECHC", "NCC"]
31	Children & Young People (CYP) Mental Health Waiting Lists	Open	There is a risk that children and young people may be unable to access timely support to meet their needs and waiting lists will increase Due to insufficient progress service capacity to meet the demand for children's mental health support. This may lead to poor experiences of care, poor outcomes, increased presentations of CYP in mental health crisis and long-term impacts on children to reach their potential.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	CYPM	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	MH Access Service now operational and triaging and allocating CYP to most appropriate service provider. £85K MHIS slippage flowed to VCSE provider to support a reduction in waiting lists 24/25 MHIS slippage identified to support waiting lists for MAP and Ormiston Fmailies (£179k and £300k accordingly) NSFT has cleared its 52+ week waits for assessment and has a recovery plan in place to meet the 4 week wait to assessment NSFT recovery action plan now in place which will include efficiencies, patient flow and reduction of waiting lists. NSFT is reviewing all CYP on treatment waiting list to understand what intervention CYP are waiting for. Waiting list initiatives to focus on priority areas to address long waits. Development of a Professionals Therapeutic Pathway (PTP) to capitalise on accredited therapeutic capacity from VCSE and Independent practitioners. This now has 35 independent practitioners, VCSE and national providers onboarded. The ICB has introduced Community Youth Teams, aligned with schools and primary care with a particular impact on supporting CYP back to education who have been absent due to emotional wellbeing and mental health issues. The ICB has commissioned LGBTQ+ Project to support CYP and adults with gender identity, by providing advice, guidance and a safe place to talk. They support around 600 individuals a year. 98% of individuals accessing the service reported a mental health concern, following support 75% felt they know longer required mental health support, reducing demand on commissioned therapeutic mental health provision	4 - Not effective	**16**	**6**	["NSFT"]

32	Mental Health 12 Hour Breach Risk	Open	There is a risk of breaching the Mental Health 12 Hour. Due to longer than needed stays within Emergency Departments. This could lead to potential harm and possible worsening of their mental Health condition as a direct result of the delay in transfer.	Safety & Quality	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Systemwide, 12 Hour Breach Working group to support delivery, chaired by Executive. 12-hour breach plan and trajectory jointly agreed by NHSE, NSFT and N&W ICB Governance structure within MH Partnership Board and Transformation Plan Mental Health Liaison Teams to Core 24 Standard at all acutes.	5 - No control	**16**	**8**	["NSFT"]
33	Elective Recovery	Open	There is a risk that elective care has prolonged waiting times beyond national and local targets. Due to Norfolk and Waveney not meeting constitutional commitments or in-year planning ambitions. This could lead to increased clinical harm and poorer outcomes for patients awaiting diagnosis and treatment (including cancer), worsen existing health inequalities, and negatively impact patient experience.	Reputation	Quality Committee	NOBES, Lisa (NHS NORFOLK AND SUFFOLK ICB - 26A)	Quality and Safety	WATTS, Karen (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Unified process of clinical harm review and prioritisation in line with national guidance. The Provider Productivity and Planning Oversight Group and the Scheduled Care Board have been established to to oversee all workstreams to improve performance and reduce harm, driving operational changes from Commissioning and Performance Committee. Workstreams include: Productivity; Diagnostics; Demand Management Independent Sector Providers (ISP) are being utilised to support capacity, with the use of Elective Recovery Funds (ERF). Insourcing and outsourcing opportunities being utilised to create capacity, with focus on challenged specialties. Cancer: Local engagement to raise awareness of signs/ symptoms of cancer and to encourage early presentation to Primary Care/linking with health inclusion groups and areas of deprivation. Non-Specific symptoms (NSS) pathway is in place via the system cancer Rapid Diagnostic Service and the “C the Signs” Primary Care Clinical Decision support tool to improve quality and reduce variation in urgent suspected cancer referrals. Mutual aid process agreed to enable patients to transfer to alternative providers using existing capacity. Within the ICS this has developed into the Group Model. New theatre capacity opened at NNUH in December 23. Additional orthopaedic capacity at NNUH (NaNOC) opened in July 2024 and JPUH is due to open spring 2025. All three N&W Acute Trusts have engaged in the national validation sprint, NHSE funded, and monitoring of effect is in place.	5 - No control	**20**	**12**	

34	Impacts of climate change on health care capacity & resilience	Open	There is a risk that commissioning services are unable to function. Due to climate change leading to an increase in extreme weather events, prolonged & persistent change in weather patterns, increase in exotic diseases & pathogens vectors, disruption to supply chain and poor air quality. This could lead to patient and staff ill health, unusable infrastructure, the health system unable to function effectively.	Infrastructure	Strategic Commissioning Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Estates	URQUHART, Andrew (NHS NORFOLK AND SUFFOLK ICB - 26A)	**25**	ICB Green Plan. Multi-agency planning by LRFs. Trust S18 SC annual report returns received. Surface water flooding plan. Air Quality system wide work. SIA Launch (commissioning). Standard NHS T&Cs (procurement). Mandatory net zero training (workforce).	3 - Some control with weaknesses	**16**	**6**	
35	Lack of access to Tier 3 and 4 weight management services	Open	There is a risk that patients are not able to access Tier 3 or 4 weight management services. As a result of insufficient funding available for provision of specialist Tier 3 Weight Management Services (T3WMS) to meet current demand. This could lead to suboptimal patient care with reduced short term quality of life and increased likelihood of long-term adverse effects.	Safety & Quality	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	HAWKINS, Jaime (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Clinical Threshold Policy agreed to ensure available capacity is prioritised for people with the highest clinical needs. CVD-R Programme Plan 2024/25 includes plan to design and plan future obesity and weight management model of care by 2025/26. The risks around obesity and healthy eating are recognised as a priority issue within the ICS. We are working with system partners through the Health Improvement and Transformation Group on an agreed programme of work, which includes delivery of a Healthy Weight Health Needs Assessment (HNA) and a review of the current NHS obesity Model of Care in Norfolk and Waveney that will feed into any future recommendations for systemwide action coming out of the HNA. IFR panel process in place to enable direct referral of patients to Tier 4 where there are exceptional and life-threatening circumstances Submitted prioritisation template in Q4 2022/23 for increased T3WMS budget in 2023/24. Funding envelope for commissioning of new service from 2024/25 confirmed by EMT to remain at same level as 2023/24. Market engagement activity being prepared to inform model, collect feedback on tariff/prices and inform development of a procurement. Will inform paper to EMT to recommend required budget for commissioned service to meet population need. Protect NoW project to promote uptake of NHS Digital Tier 2 weight management service, to reduce flow of referrals/escalation of needs. Right to Choose options available from October 2024 for patients to access specialist Tier 3 and 4 weight management services directly from external provider though this will have negative financial impact.# Project implemented to manage patients on waiting list of outgoing T3WMS provider - to ensure treatment in order of clinical priority, to ensure Tier 2 services considered before referral, revise eligibility criteria to prioritise higher risk patients from 25/07/2023, use of slippage in 2023/24 to fund additional places for highest risk patients and developing plans to support transfer of remaining lower risk waiters to alternative Right to Choose service.	2 - Adequately controlled	**9**	**9**	

36	RTT (Referral to Treatment) Objective	Open	There is a risk that the RTT objectives may not be met within the expected timescales. As a result of rising demand, impact of pressures from unplanned and urgent and emergency care on diverting resource allocation, system flow and workforce challenges negatively impacting available capacity. This could lead to reputational damage, reduced public trust in local services, patient harms, financial consequences.	Reputation	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Collaboration: Efforts are focused on changing how providers and stakeholders work collaboratively under the group model. This approach fosters collective accountability, shared learning, and integrated decision-making to enhance system-wide performance. Oversight and assurance: there is a scheme of oversight and assurance including: * bi-weekly tiering calls with NHSE * Monthly partnership meetings to oversee the contract * Committee and Programme Boards to set, support and oversee work that drives improvement. Quality and patient harm: Harm-prediction models and P coding are actively used to prioritise patients and manage risk. Proactive communication with patients on waiting lists is ongoing to address concerns and provide clarity on expected care timelines. Regular local-level clinical harm reviews are conducted to identify and support patients at the highest risk due to delays. Emphasis is placed on meeting cancer standards and prioritising P2 cases to ensure timely intervention. Interdependencies: Regular monitoring of UEC and elective care pressures is conducted through established governance structures involving COOs/DCOOs and MD/DMDs, ensuring effective oversight across the governance structure. Continuous tracking and updates on RAAC plank remediation progress at QEH and JPUH are in place to minimise disruptions to elective recovery efforts. Workforce recruitment and retention strategies are underway, aligned with the ICS People's Plan, and include insourcing where necessary to address immediate capacity gaps.	5 - No control	**20**	**8**	["NNUH"]
37	Diagnostics 6-Week Standard	Open	There is a risk that diagnostic timescales will not be consistently met This is due to diagnostic workforce challenges (especially in key workforce groups); rising demand; COVID19 backlog; infrastructure and resourcing capacity constraints; system inefficiencies and inconsistencies. This could lead to adverse impact on referral-to-treatment and cancer pathways and standards; disease progression and worsened disease outcomes; psychological harm to those waiting; operational and financial inefficiencies and longer-term impact on population health outcomes.	Reputation	Strategic Commissioning Committee	WATSON, Richard (NHS NORFOLK AND SUFFOLK ICB - 26A)	Planned Care, Cancer and Specialist Commissioning	MANN, Rebecca (NHS NORFOLK AND SUFFOLK ICB - 26A)	**20**	Maximising CDC - Equipment issues - late onboarding / start dates - Non-use of PEP (reliance on postal services) Continuous tracking of RTT, cancer pathway targets, and backlog data in appropriate governance. Exploration of alternative workforce models, including physician associates and advanced practitioners, and use of nurse-led clinics. Expansion of point-of-care testing and community-based diagnostics to ease secondary care pressures. Greater GP involvement in diagnostic referrals (e.g., blood tests, imaging). We have seen an increase in wait times with ISPs specifically Cora Health. It is projected that there will be 17,161 patient waiting for MRI by May 2026 with this provider if appropriate actions are not taken. Provider is currently booking at 8 weeks post referral with a 10 weeks wait. Recruitment and retention strategies for key diagnostic specialities (imaging, endoscopy, histopathology). Use of insourcing, outsourcing, and temporary staffing to address short-term gaps. Redesign of diagnostic services and workforce models to optimise diagnostic capacity. Investment in Community Diagnostic Centres (CDCs) to improve accessibility and reduce backlogs. Proactive updates for patients on waiting lists to manage expectations and reduce anxiety. (DNA reduction) PPPOG diagnostics working group exploring focus opportunities Regular engagement with NHSE, ICB, and provider teams to align improvements with national priorities. Collaborative working groups to address inefficiencies in diagnostic pathways.	5 - No control	**20**	**8**	["NNUH"]

38	Staff Burnout	Open	There is a risk of staff suffering from burnout Due to increased system pressures (increasing activity, workforce vacancies, sickness, and resilience) and the recent organisational change program. This could lead to mental and physical issues, an increase in staff absence and a significant impact on the services that they deliver.	Infrastructure	Remuneration Committee	LYES, Amanda (NHS NORFOLK AND SUFFOLK ICB - 26A)	Workforce	CATLIN, Jo (NHS NORFOLK AND SUFFOLK ICB - 26A)	**16**	Additional HR expertise has been enabled to support the pace and scale of the Change programme, and to maintain BAU for our staff from a HR perspective. ICB is participating in this years staff survey which was open in Sep/October. Outcomes from the survey will be released in the new year by NHS England. We are seeing an increase in ICB staff requesting support from the People Team - in particular line management culture change, new ways of working, developing teams. Staff wellbeing is a key consideration of the ICB Change Programme, with the Org Change Working Group regularly reviewing and factoring in updates from our staff, Change Buddies and Staff Involvement Group into the planning, response, and actions for the Change programme. The Staff Involvement Group and Senior Management Team flag issues regarding economic and cost of living rises - agreement in 2022 to add as a new risk to ICB corporate risk register as the impact of lifestyle pressures will impact on people's resilience and increase likelihood of burnout. This risk will be reviewed in Nov 2023 given the current macro context and mitigations implemented for financial wellbeing under risk BAF17. As of 2025 the pay award ended IA. Further IA to be outlined.	5 - No control	**16**	**4**	