Suffolk and North East Essex

Integrated Care Board

Annual Report and Accounts

1 April 2025 – 31 March 2026

Contents

PERFORMANCE REPORT

Performance Overview

This section of the Annual Report looks at how the ICB has performed over the last reporting period. It provides information on the purpose and activities of the ICB, describes the environment in which we work, our organisational structure and objectives as well as strategies for achieving these to meet the needs of our local population during 2025/2026. There is further detail in the Performance Analysis, Accountability Report, and Accounts sections.

Introduction

Welcome to our Annual Report and Accounts for 2025/26. During 2025/26 our ICB has continued to develop and deliver a range of improvements for the benefit of the communities that we serve.

Over the last year, significant work has been undertaken to support the reorganisation of Integrated Care Boards (ICBs). In the future, ICBs will focus on leading local health systems to improve population health, setting long-term plans based on evidence, and managing NHS funding to deliver the best possible outcomes within available resources.

These changes are part of a wider transformation of the NHS, driven by ongoing financial pressures. The aim is to reduce administrative costs and refocus ICBs on their core role of planning and commissioning services. This means placing greater emphasis on long-term population health and ensuring high-quality services are in place, rather than delivering services directly.

NHS Norfolk and Suffolk Integrated Care Board (N&S ICB) was formally established on 1 April 2026 and became fully operational on that date. It took over all planning and commissioning responsibilities from NHS Suffolk and North East Essex ICB and NHS Norfolk and Waveney ICB, which have now been closed. N&S ICB now covers the counties of Norfolk and Suffolk, serving around 1.7 million people.

In addition, responsibility for services in the Colchester and Tendring areas transferred to NHS Essex ICB, which also became operational on 1 April 2026.

This reorganisation, alongside wider changes across the NHS, forms part of the Government's 10 Year Health Plan.

Below outlines some of the work that has been undertaken and achieved by Suffolk and North east Essex ICB from April 2025 to March 2026.

Practice completes sale of former public house to increase access to GP services
Patients in north west Ipswich are set to benefit from additional space and better access to GP services after the Cardinal Medical Practice completed the purchase of a former public house. The scheme was given approval by Ipswich Borough Council's Planning

Committee. It will see the renovation of the former Inkerman pub into an extension of the adjacent Norwich Road Surgery.

Obesity support service recognised for two HSJ awards

A partnership between the ICB, East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and Reset Health aimed at providing local people with obesity support has won two awards at this year's HSJ Partnership Awards. Before the partnership was established, patients were experiencing waiting times of over two years, with no local service available. As a result of this partnership working, they now typically wait eight days for care, closer to where they live. The work received recognition for Best Partnership Delivering Virtual Care and Best Partnership Supporting Personalised Care Pathways. Judges said it was strong recognition of the hard work by colleagues at Reset Health, ESNEFT and the ICB and their dedication to improve outcomes for their patients.

Tackling health inequalities in east Suffolk

A new collaborative approach to tackling health inequalities affecting residents across east Suffolk has been launched, with partners – including the ICB - working together to improve people's access to health services, education, employment and housing. The East Suffolk Marmot Place was officially launched at the end of November and was attended by representatives from East Suffolk Council, Suffolk County Council and both ICBs which cover east Suffolk.

First dental conference signals more tailored support for the local NHS dental workforce

Thirty dental clinicians from across Suffolk and north east Essex attended an inaugural NHS Dental Conference to learn about the support they can access to deliver NHS care. Accessing ongoing training and development to accrue CPD points, navigating changes to the dental contract, preparing for CQC visits, and submitting funding bids are just some of the ways the Training Hub can assist dental practices.

New guidance book produced to help engagement with diverse communities

A guidance book to assist researchers to effectively engage with diverse communities has been co-produced by the Suffolk and north east Essex Integrated Care Partnership (ICP) together with the local Research Engagement Network (REN). REN includes local community champions, the National Institute of Health and Care Research (NIHR) and the universities of Essex and Suffolk. The guidance provides insights into best practices, recommended approaches and pitfalls to avoid. Printed copies are also available on request from the ICP.

Refurbished surgery marks first milestone of multi-million regeneration scheme

The first major milestone of an £18.2 million scheme was reached with the opening of the Hawthorn Surgery in Colchester. The Heart of Greenstead aims to provide improvements and opportunities to the area of Greenstead. Funding for the scheme comes from the Town Deal Funding which ministers awarded to Colchester City Council in 2022. The opening of the surgery at a cost of £573,000, formed a key part of phase one of the regeneration scheme.

New chair of national group 'humbled' to have been appointed to role
The Deputy Medical Director of the Suffolk and North East Essex ICB said he is ‘truly humbled’ after he was elected Chair of the Asian Professionals National Alliance (APNA) NHS. Dr Tanvir Alam succeeds co-chairs Professor Jagtar Singh CBE and Asma Nafees to lead the group. APNA NHS is a voluntary organisation constituting health and social care professionals of South Asian heritage working in the NHS and Local Authorities.

New ambulance hub in Ipswich will enhance local services
The East of England Ambulance Service NHS Trust (EEAST) opened a new £12.8m hub in Ipswich during October 2025. Leaders at EEAST said the facility on Ransomes Industrial Estate would enhance operational delivery, staff wellbeing and would make a "huge difference" in the trust's ability to get vehicles back on the road and attending incidents as quickly as possible.

Jaywick Sands Healthy Homes Team nominated for national award
An innovative project that works with Jaywick Sands tenants and landlords to improve housing conditions and ultimately the health of residents was recognised in the Outstanding Achievement category in the 2025 National Healthy Housing awards. The Jaywick Sands Healthy Homes Team (JSHHT) is a partnership between Tendring District Council and the ICB, working closely with GP practices, Essex County Fire and Rescue Service, Peabody Housing and the Essex County Council Energy Hub team.

Patients will benefit from new hospital health app
The new app was introduced by ESNEFT that allowed patients to manage their information from their hospital record. Through MyChart, patients can now manage their appointments, contact their care team, and take more control of their care.

Elective care
We have continued to strengthen elective care services and improve collaboration between primary and secondary care. Waiting list recovery has progressed steadily, with the number of patients waiting more than 52 weeks across both acute trusts reducing by 2,333 (55%) over the past year. Work remains focused on further reducing waiting times and delivering against national elective care commitments

Patients in north east Essex started to benefit from increased access to specialist cardiac service
Patients in north east Essex in need of a specialist cardiac procedure are now benefiting from care closer to home after a specialist local service started. It has led to easier access to percutaneous coronary intervention (PCI) and shorter waiting times for patients. PCI is a treatment to remove plaque build-up and open a blocked artery. The new arrangements mean more patients in the Colchester and Tendring areas are now receiving the procedure at the specialist Heart Centre in Ipswich.

SNEE ICB selected to participate in national neighbourhood health programme
The ICB was selected to participate in the national neighbourhood health implementation programme and became the only system in the country that had full coverage in all geographical areas it serves (Ipswich and east Suffolk, west Suffolk and

north east Essex). Leaders say at its heart, the implementation programme will further support effective neighbourhood working, bringing a greater focus to care around people's local places. This will ensure services are more joined up to enable preventative outcomes for residents.

System celebrates excellence
Over 350 staff and volunteers attended last year's Can do Health and Care Awards. ICB Chair, Professor Will Pope, spoke of his 'pride' on learning about the inspiring stories of colleagues who went the extra mile for staff and for their colleagues. He also paid tribute to the unsung heroes who worked tirelessly and were not always recognised for their efforts. There were ten award categories which brought together individuals and teams.

HRH The Princess of Wales visited Colchester Hospital
Her Royal Highness the Princess of Wales visited Colchester Hospital where she heard from patients and staff about the healing power of nature. The Princess joined patients, staff and volunteers in the Royal Horticultural Society (RHS) Wellbeing Garden before speaking to members of the Cancer Wellbeing Centre team at the hospital and the patients who use its services. Her Royal Highness spent time with them to understand how gardens and wellbeing services in healthcare settings play a crucial in promoting good health outcomes and supporting recovery time.

Sharing health messages through the Latitude Festival
Teams of health professionals took their advice about staying well to revellers during the 2025 Latitude Festival. They were able to speak to clinicians and staff about a range of services, vaccinations and how they can prevent getting ill. Festival goers were also able to find out how to access the most appropriate services according to their needs.

Suffolk's major employers support SNEE ICB at House of Lords
Some of Suffolk's anchor institutions together with the ICB have visited the House of Lords to highlight the work taking place to bolster employment opportunities in and around Felixstowe. The Deputy Director of Partnerships at Ipswich and East Suffolk Alliance, Louise Hardwick, visited Westminster along with representatives from Sizewell C, Ipswich Town Foundation, Hutchinson Ports and the Port of Felixstowe as part of the Coastal Communities Navigators initiative. The visit highlighted the diverse range of major employers based on England's coastline.

Early Age Health Check pilot to start in Tendring
A new service that will trial health checks for people aged 30 to 39 in Clacton to improve early identification and modification of cardiovascular disease launched. The Early Age Health Check pilot aims to encourage those people to have an NHS Health Check, to determine if they are at higher risk of getting illnesses such as strokes, heart disease and diabetes. The earlier age group has been chosen due to the lower healthy life expectancy in Clacton compared to the national average.

More dental care provision made available across SNEE

During the year, thousands of extra appointments were made available for patients in need of urgent dental care. The move formed part of a national drive to increase access. The new Urgent Care Dental Service brings additional high-quality, unscheduled dental care closer to home for local people and built on the system's Dental Priority Access and Stabilisation Service.

System medication waste campaign
During the year, the ICB launched a campaign which urged people to only order the medication they need from their repeat prescriptions. A report by the Department of Health estimated that unused medicines cost the NHS around £300 million every year. The campaign which ran throughout the year reminded people who have repeat prescriptions about the importance to check what medicines they have at home before placing an order.

Vaccination programme
Vaccination delivery remained a key strength, with COVID-19 and flu uptake consistently exceeding national averages. Nearly 215,000 COVID-19 vaccinations and over 284,000 flu vaccinations were delivered, placing SNEE among the top-performing systems nationally. The programme also demonstrated innovation, becoming the first NHS area to deliver maternal pertussis vaccination through community pharmacy and achieving strong uptake of RSV vaccinations through the same route.

Coastal community work recognised nationally
A prospectus that highlighted community work in coastal areas around the country, including Felixstowe, aimed at improving health and employment opportunities was launched by England's Chief Medical Officer. Professor Sir Chris Whitty unveiled Rising with the Tide which included examples of schemes in six ICB areas across England, which included Suffolk and north east Essex.

Coverage of Mental Health Support Teams increased
Expanded coverage to 58% of mainstream education settings with nine teams in place, increasing access to support and enabling earlier intervention.

Developments in respiratory diagnosis
Became the first ICB nationally to implement N-Tidal Diagnosis, an AI-enabled diagnostic tool for Chronic Obstructive Pulmonary Disease (COPD), embedding it within the agreed clinical pathway and supporting diagnostic transformation in primary care.

Cardiovascular disease
Over 2025/26, the ICB partnered with SiSU UK for a second year to mobilise five health stations across the patch to enable the population to carry out independent health checks. There were 7,919 health checks completed over this period, which identified one in five users having a high blood pressure reading and signposting them to support.

Be Well Bus

Since launching in November 2023, the Be Well Bus has supported almost 9,000 residents across Suffolk, providing health checks and early identification of conditions such as high blood pressure and high cholesterol. Through partnerships with organisations including the Ipswich Town Foundation, Sizewell C, Port of Felixstowe and the University of Suffolk, the service has successfully brought health and wellbeing support directly into local communities.

Highest performing category of NHS England assessment

During the spring of 2025, the ICB was placed in the 'highest performing' category 1 of ICB systems in the country. NHS England conducted a review of all ICBs in England as part of its NHS Oversight Framework Segmentation (NOF). It found strong system leadership from a high performing board, established and effective partnership working and a commitment to continual improvement. The assessment concluded there was a strong drive by the ICB to ensure equal access to services among all communities, noted the ICB had delivered a fully breakeven financial plan for 2024/25 and was a national exemplar for improving population health.

Thank you to all staff and volunteers who work not only within the Suffolk and North east Essex ICB but across our wider ICS for all your hard work and commitment over this year and previous years.

Professor Will Pope

Chairman

Dr Ed Garratt OBE

Chief Executive (Accountable Officer)

16 June 2026

Performance analysis

This section presents an analysis of the ICB's performance against national and local objectives, with a focus on the key metrics set out in the 2025/26 National Priorities and Operational Planning Guidance.

It also outlines progress in delivering the ICB's Joint Forward Plan 2025–2030, including the overall delivery of Health and Wellbeing Strategies and the key enablers supporting improvement.

The section concludes with updates on reducing health inequalities, engaging with people and communities, safeguarding, sustainability and improving quality.

Joint Forward Plan

The Joint Forward Plan (JFP) sets out a five-year delivery plan for the SNEE ICB. It explains how the ICB, as a statutory organisation, will contribute to the collective ambitions of the SNEE Integrated Care System (ICS), both as an NHS commissioner and through its role in bringing together health and care partners to provide shared leadership and joint action to improve the health and wellbeing of the one million people who live locally.

As part of the ICS's shared vision to deliver the best possible health outcomes for more than one million people living in SNEE, we aim to enable everyone to 'Live Well'. Our JFP delivery priorities are organised around the six Live Well domains and are underpinned by a focus on reducing health inequalities for our local population, ensuring that equality, diversity and inclusion (EDI) are central to all our work.

For each Live Well domain, which sets out the outcomes we are seeking to achieve, SNEE ICB is making an overarching five-year commitment. These commitments reflect the outcomes we will strive to deliver as set out in the SNEE ICS strategy, what we have heard matters most to our population, and what our workforce and partners have told us we need to improve or do differently to enhance the services we provide.

The SNEE ICS publishes a Joint Capital Resource Plan, which sets out our planned capital expenditure for the next financial year, along with details of associated risks and mitigations. The plan published detailed expenditure of £115m for the year across the four organisations, which was £25.4m above the capital limit set by NHSE due to insufficient allowance being added for the impact of lease capital (IFRS16) on replacement fleet costs at East of England Ambulance Trust.

The plan included funding

for the New Hospital

Programme, RAAC,

Estates Safety and

Primary Care, with the

majority of funding

supporting the system to

return to constitutional

standards.

JFP Strategic

Framework

Our vision

Deliver the best possible health outcomes for everyone living in SNEE.

Start Well

Our outcome: Giving children and young people the best start in life.
Our five-year commitment: We will ensure that children and young people have the best chance in life with a particular focus on those most in need.

Feel Well

Our outcome: Supporting the mental wellbeing of our population.
Our five-year commitment: We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to stay mentally well and to get support in the community to live and thrive when they need it.

Be Well

Our outcome: Empowering adults to make healthy lifestyle choices.
Our five-year commitment: We will empower people to lead healthy lifestyles and reduce the number of preventable deaths.

Stay Well

Our outcome: Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives.
Our five-year commitments:

Access to care: We will support people to access the right support, at the right time, in the right place for their health and care needs.

Early intervention: We will support adults with timely access to services to enable early detection and diagnosis of disease and risk factors to give people the best chance of maintaining a good quality of life.

Age Well

Our outcome: Supporting people to live safely and independently as they grow older.
Our five-year commitment: We will ensure that people who are ageing are able to live safely and independently, experiencing a good quality of life.

Die Well

Our outcome: Giving individuals nearing end of life choice around their care.
Our five-year commitment: We will enable people and their families to have high quality care and support from all health and care professionals involved at the end of their life.

Our cross-cutting priorities

- Reduce health inequalities
- Enshrine equality, diversity and inclusion in our ways of working

Our principles

- Collaborative
- Compassionate
- Courageous
- Community focused
- Creative
- Cost Effective

Current performance – National objectives

The ICB monitors performance monthly through its Committees and the System Oversight and Assurance Committee (SOAC). The metrics relating to the national operational planning priorities for 2025/26 are divided into the following:

- Reduce wait time for elective care
- Improve A&E waits and ambulance responses
- Improve access to GP and dentists
- Improve mental health and learning disability care

Elective care

Objectives:

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Table 1: Elective care key metrics

Metric	Latest month	Latest value	Target
Patients waiting no longer than 18 weeks for treatment	Mar-26	61.6%	65%
Patients waiting no longer than 18 weeks for first appointment	Mar-26	61.8%	72%
Reduce patients waiting over 52 weeks for treatment	Mar-26	0.6%	1%
Improve 62-day cancer standard	Mar-26	69.8%	75%
Improve 28-day cancer faster diagnosis standard	Mar-26	76.8%	80%

A&E waits and ambulance responses

Objectives:

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026
- Improve A&E waiting times, with a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
- Improve Category 2 ambulance response times to an average of 30 minutes

Table 2: A&E waits & ambulance responses key metrics

Metric	Latest month	Latest value	Target
Improve A&E 4-hour performance	Mar-26	77.1%	78%
Reduce patients waiting over 12 hours in ED	Mar-26	9.8%	11%
Reduce C2 ambulance response time	Mar-26	30 mins	30 mins

Access to GP and dentists

Objectives:

- Improve community services waiting times, with a focus on reducing long waits of over 52 weeks
- Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving Units of Dental Activity (UDAs) towards pre-pandemic levels

Table 3: GP & dentist key metrics

Metric	Latest onth	Latest value	Target
Improve experience of GP access	Dec-25	75.3%	73.6%
Increase urgent dental appointments	Feb-26	104,901	93,012

Mental health and learning disabilities care

Objectives:

- Reduce average length of stay in adult acute mental health beds
- Increase the number of Children and young people (CYP) accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction

Table 4: Mental health and learning disability key metrics

Metric	Latest month	Latest value	Target
Reduce average length of stay in adult acute mental health	Mar-26	54	54
Increase CYP access	Mar-26	14,105	14,266
Reduce reliance on inpatient care for learning disability and autistic patients	Dec-25	6	6

Health and wellbeing strategy and JFP Overview

We have consulted with both the Suffolk and Essex Health and Wellbeing Boards in the preparation of this document, and the final version will be shared with both boards through their information bulletins.

Start well year - giving children and young people the best start in life

Table 5: JFP Start Well target indicators

Target indicator	Target	Current performance	Target trajectory
Consistently achieve the national smoking at time of delivery target of 6% or less	<=6%	2.5% (Mar-26)	Target met
Reduce the wait for children and young people to no more than 12 weeks for child and adolescent mental health services (CAMHS), prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas by 2028	100% <12 weeks by 2028	74.0% (Dec-25)	Requires improvement
Reduce the wait for children and young people to no more than 18 weeks for Neurodevelopmental Diagnostic (NDD) services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas by 2028	100% <18 weeks by 2028	7.1% (Dec-25)	Requires improvement
Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas	<236.7 per 100k admissions	101.2 (25/26 cumulative – Oct-25)*	On track

*unresolved data quality issues after Oct-25

Start Well highlights

Maternity

Work is ongoing in collaboration with CYP Transformation and Maternity colleagues to identify and prioritise actions to increase the number of pregnant women receiving Midwifery Continuity of Carer, particularly within targeted communities.

The Baby and Bump programme provides pregnant people with bus travel vouchers to help them attend their maternity appointments. The programme has received really positive feedback, with Suffolk County Council's Transport Team exploring opportunities to provide additional funding to support its continued delivery.

Partnerships for Inclusion of Neurodiversity in Schools (PINS) Project - Suffolk

PINS Suffolk has demonstrated significant success in strengthening inclusion, early intervention and co-production across mainstream schools, aligning closely with the ambitions of the SEND White Paper. Delivered between September 2025 and the end of March 2026, the programme worked intensively with 28 primary schools, impacting over 6,200 pupils.

Through a bespoke menu of support, whole-school audits, targeted training and multi-agency collaboration, schools increased their confidence and capability to meet the needs of neurodivergent children within mainstream settings. Over 90 mental health

workshops and 23 consultations reached more than 950 school staff and parents/carers, with measurable improvements in knowledge and confidence.

Crucially, PINS Suffolk embedded co-production at the heart of delivery, strengthening partnerships between schools and parent/carers, reducing reliance on escalation, and creating sustainable, needs-led approaches to inclusion. The programme has left a strong legacy through co-produced resources, workforce development and scalable models that continue to support inclusive practice across Suffolk.

Specialist Asthma Outreach Nurses – Suffolk and North East Essex

The Specialist Children and Young People's Asthma Outreach Nursing Service across Suffolk and North East Essex is making a measurable contribution to the Joint Forward Plan ambition to reduce hospital admissions for asthma, particularly for children and young people living in the most deprived communities. Through proactive, community-based outreach, the service identifies high-risk children early using population health intelligence and delivers timely, preventative interventions before deterioration into crisis.

This approach has led to improved asthma control, reduced use of reliever medication, elimination of repeat emergency department attendances, and avoided escalation to urgent and emergency care. By working intensively with families in their homes, schools and communities, the service tackles wider determinants such as poor housing conditions, deprivation and barriers to access, directly addressing health inequalities.

As a result, children experience fewer symptoms, reduced school absence, and improved participation in education and physical activity, while families are empowered with the skills and confidence to manage asthma effectively. This prevention-focused model strengthens Start Well outcomes, reduces avoidable hospital admissions, and lays the foundations for better lifelong respiratory health in those communities at greatest risk.

CYP Weight Management Pathway – Norfolk, Suffolk and North East Essex

Gaining executive approval for the introduction of the Norfolk and Suffolk Children and Young People's Weight Management and Complex Obesity Pathway from 2026/27 represents a step-change in the system's ability to deliver the Joint Forward Plan. Particularly the ambition to halt recent increases in overweight and obesity at Reception and Year 6 by 2028 and maintain prevalence below the national average.

By closing long-standing gaps in commissioned provision, particularly for children at or above the 98th centile who were previously excluded from support, the pathway establishes a fully integrated, NICE-aligned model from early identification through to specialist intervention. A single point of access ensures that all identified children can access appropriate support, preventing escalation to severe obesity during the critical primary school years. The pathway embeds early intervention, whole-family working

and youth social prescribing to address physical inactivity, deprivation-related barriers and social determinants, with targeted delivery in areas of highest need.

By stabilising unhealthy weight trajectories earlier, improving engagement among deprived cohorts and reinstating continuity of specialist support, the pathway provides a credible, evidence-based mechanism to stabilise prevalence in Reception and Year 6, reduce progression from overweight to obesity, and support sustainable reductions in inequality, ensuring Norfolk and Suffolk remains below the national average by 2028.

In addition, a Healthy Behaviour Facilitator is working directly with schools to deliver the Bitewise programme, supporting children and families to adopt healthier behaviours with food and physical activity.

Mental Health Support Teams (MHSTs) – Suffolk

In 2025/26, Suffolk's Mental Health Support Teams (MHSTs) played a critical role in delivering the Joint Forward Plan ambition that no child or young person waits more than 12 weeks for CAMHS or 18 weeks for neurodevelopmental diagnostic services by 2028. Working directly in and alongside education settings, MHSTs provided timely, evidence-based early intervention for mild to moderate mental health needs, supporting children and young people before difficulties escalated to Specialist CAMHS or crisis pathways.

Coverage expanded to 58% of mainstream education settings, with nine teams in place and further growth under way, enabling faster access to support, clearer 'right door, first time' pathways, and reduced avoidable escalation. MHSTs also strengthened whole-school approaches, consultation and advice for education staff, and targeted support for children with SEND and emerging neurodevelopmental needs who often face the longest waits and poorest access.

By prioritising outreach to underserved cohorts, including those living in the 20% most deprived areas and children outside mainstream education, MHST delivery in 2025/26 reduced pressure on specialist services, improved equity of access, and laid strong foundations for meeting national waiting time standards while narrowing inequalities in mental health and neurodevelopmental care.

ND Support Services – Suffolk and North East Essex

In 2025/26, Suffolk and North East Essex commissioned new neurodevelopmental (ND) support services to strengthen and standardise the care pathway for children and young people awaiting, undergoing or following an autism and/or ADHD assessment, directly supporting the Joint Forward Plan ambition to deliver improved and consistent ways of working across the system.

The services will provide targeted, need-led support from the point of acceptance onto the diagnostic pathway, ensuring children, young people and families are not left without help during extended waiting periods. Through coordinated referral from ND

pathway coordinators, comprehensive needs assessment, and a flexible menu of community-based, evidence-informed interventions, families receive timely psychoeducation, peer and one-to-one support, practical strategies and clear information before and after diagnosis.

By embedding clear roles, shared standards, robust signposting via Local Offers, and regular multi-agency oversight, the model reduces fragmentation, avoids duplication and ensures continuity of support regardless of diagnostic outcome. This approach improves experience, equity and outcomes for families, strengthens integration between health, education, local authority and VCSE partners, and establishes a more consistent, transparent and person-centred ND pathway across Suffolk and North East Essex.

Feel well year - supporting the mental wellbeing of our population

Table x: JFP Feel Well target indicators

Target indicator	Target	Current performance	Target trajectory
Achieve a 5% year-on-year increase in the number of adults supported by community mental health services	>8.4k (24/25 baseline)	9,160 (Mar-26)	Target met
Achieve a year-on-year reduction in hospital admission rate for mental health conditions	<206.2 per 100k admissions	117.8 (25/26 cumulative – Oct-25)*	On track
Identify and reduce health inequalities among people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full, annual, physical health check and follow-up interventions by 2028	90% by 2028	74.7% (Qtr4 25/26)	Requires improvement

* unresolved data quality issues after Oct-25

Feel Well highlights

The ICB, working with providers across Suffolk and North East Essex, has consistently achieved the national target of 75% of people with severe mental illness (SMI) receiving an annual physical health check. The system was one of only four ICBs nationally to meet this target in 2024/25.

During 2025/26, innovative approaches to patient engagement, collaboration with VCFSE partners, and the use of population health intelligence have supported continued progress. SNEE ICB remains on track to achieve the 90% target by 2028.

With the culmination of the 'Equity in Mind' programme during 2025/26 more than 4,000 people in Suffolk received emotional wellbeing and mental health support through voluntary, community, faith, and social enterprise groups (VCFSE). The ICB funded programme managed in partnership with Suffolk Community Foundation was designed to strengthen and sustainably increase the capacity of VCFSE providers to work with people with mental health needs. Grants totalling £796,612 were given to 15 organisations; and 78% of the funded organisations engaged with people living with

severe mental health issues. The grants also helped the organisations to build new partnerships and work more closely with each other and with statutory health and mental health providers.

Working with VCSE provider Mid and North Essex Mind, the North east Essex Sanctuary operates across Colchester and Tendring to support people experiencing mental health difficulties or crisis within their communities. The service offers mental health well-being support, individualised interventions, group support, and alternatives to urgent care.
Individuals can self-refer or be referred by professionals, attending the Sanctuary as an alternative to A&E. Referrals peaked at over 600 in November 2025, with more than 50% being new referrals.

In 2025, Mid and North Essex Mind was also commissioned to deliver a UEC Link Worker Service based at Colchester General Hospital. This service supports individuals presenting with low to moderate mental health needs, providing emotional and therapeutic support in a non-clinical setting. The service has helped prevent admissions to emergency departments and inpatient care.

The two mental health joint response vehicles, delivered by EEAST and EPUT across NEE and EEAST and NSFT across Suffolk, provides rapid mental health crisis support within the community. In both areas fewer than 25% of cases resulted in conveyance to emergency departments, reducing the number of patients requiring hospital admission.

Public Health education booklets are now in circulation, with accompanying online resources being actively promoted. Awareness-raising activity is also progressing, with a focus on improving understanding of anxiety (distinguishing typical emotional responses from more serious mental illness). Current efforts are primarily targeted at families through the distribution of booklets in schools, with further work needed to expand engagement within community settings. There continued to be a strong response from staff and volunteers working in statutory services and the VCSE sector to the suicide prevention training webinars delivered by Public Health in partnership with specialist providers. Topics covered include relationship breakup, poverty, substance misuse, autism, domestic abuse, safety planning and young people; over 1k people have participated.

Be well year- empowering adults to make healthy lifestyle choices

Table x: JFP Be Well target indicators

Target indicator	Target	Current performance	Target trajectory
Halt recent increases in the number of overweight and obese children in reception by 2028 and maintain prevalence below the national average	Reduce by 2028 against 21/22 baseline (22.6% Reception)	23.0% (24/25)	Requires improvement
Halt recent increases in the number of overweight and obese children in year 6 by 2028 and maintain prevalence below the national average	Reduce by 2028 against 21/22 baseline (35.1% Year 6)	33.6% (24/25)	On track

Reduce the number of smokers in our population in line with only 5% of the population being smokers by 2030	5% of population by 2030	13.7% (24/25)	Requires improvement
Increase each year the number of units of NHS dental activity delivered	>1,057k units (23/24 baseline)	1,065k (Feb-26 YTD)	Target met

Be Well highlights

Weight management

This year has marked a step-change in how weight management and obesity services are accessed and delivered across the system. We successfully secured external funding and led the design, commissioning, testing and launch of the Weight Management and Complex Obesity Service Single Point of Access (WMCOS SPoA) - a digital referral point for all weight management and obesity referrals. This is the first service of its kind in the country and provides a single, consistent access point across the full weight management and complex obesity pathway.

As part of the SPoA go-live, we revised and updated the ICB Clinical Access Policy to ensure alignment with national guidance and to support a clearer, more consistent referral process. This enabled the introduction of a tier-less model of care and a shift from managing patients in date-of-referral order to prioritisation based on clinical need. We are now accepting referrals into a fully integrated Complex Obesity Service, with pathways compliant with NICE TA875 and TA1026. Since going live on 16 February 2026, the SPoA has received over 1,600 referrals in its first eight weeks, demonstrating the need for a system-wide referral model. All GP practices across SNEE have now integrated the referral form into their clinical systems, and every practice has made at least one referral into the pathway.

Alongside this, we have established a Complex Obesity Service community outreach model across three locations, enabling access to obesity management medication in primary care settings. These locations have been intentionally selected in areas of higher deprivation and aligned to public transport hubs to improve equity of access. Approximately 22% of the Year 1 NHS England funding variation allocation has already been utilised for cohort one, and at current referral rates following the SPoA go-live, we are confident that the programme remains on track to meet its overall targets by the end of June 2026.

We have also seen a marked improvement in uptake of the national Digital Weight Management Service (DWMS). SNEE's performance has improved significantly, moving from the lowest-performing system in the East of England to third out of five systems. Utilisation has increased from just 4% pre-pilot to 38% of allocated capacity. While this does not yet represent full utilisation, it reflects substantial progress following the pilot phase and provides a strong foundation for further improvement.

Physical Health Strategic Partnership

A Physical Health Strategic Partnership has been established to coordinate commissioning across multiple organisations, aiming to promote healthier behaviours within the community. The Partnership is aligning priorities and pooling resources to

ensure a consistent approach to physical activity. This is demonstrated by the delivery of the Sport England-funded programme in Lakenheath, in collaboration with Active Suffolk.

A physical activity programme supporting individuals with significant health needs related to long-term conditions, falls, hypertension, and diabetes has been fully evaluated. The programme received international recognition and has been recommissioned by the ICB to continue delivery. National data previously indicated that physical inactivity in West Suffolk stood at 24%. The latest figures show a reduction to 20%, reflecting a 4% improvement and a corresponding increase in physical activity levels.

Be Well Bus celebrates two years on the road

Almost 9,000 people have been welcomed on board the Be Well Bus since it was launched in November 2023, with many receiving health checks for conditions such as high blood pressure and cholesterol. The mobile one-stop shop for health and wellbeing support in Suffolk brought expert health advice and wellbeing support to communities - partnering with leading organisations such as Ipswich Town Foundation, Sizewell C, Port of Felixstowe and University of Suffolk. While it was operating, more than 500 people who visited the bus were diagnosed with having high blood pressure and needing GP intervention – potentially preventing stroke, heart attack or even death.

The Be Well Bus continued to provide access to preventative and wider determinants of health initiatives across Ipswich and East Suffolk in 25/26. Blending a data led approach, with local intelligence and partnerships with VCFSE organisations, the Bus was able to target underserved localities and populations, aligning specific services with key health metrics. The Bus also attended many events and anchor institutions, co-producing visits to align community and workplace wellbeing priorities to that of the wider system.

Throughout the year, the Bus provided an offer focused on the Core20+5, delivered on a fixed rotation and timetable, building familiarity and improving accessibility for residents. Facilitating the mobile SiSU digital health check machine contributed to uptake of blood pressure and NHS adult health checks, as well as providing referrals to wider services such as Social Prescribing and Feel Good Suffolk.

Key statistics

75 Be Well Bus visits

30+ different locations

Approximately 3400 people attended the Be Well Bus

7 different anchor institutions have facilitated the Bus on site

812 SiSU Health checks provided

Case study

During a visit to Ipswich Town FC Fanzone, services on board spent time speaking to Charlie (name changed to protect privacy). It was identified she required further health and wellbeing support, with services taking the time to provide signposting to her GP, as well as learning resources.

A few weeks later, whilst supporting the Queer Health Matters event at Ipswich Waterfront, Person A popped on to the bus to let those on board know that she was fighting fit and feeling healthy again, thanking them for their time and advice.

A regional bid to Sport England is nearing completion, supported by strong collaboration with local communities to help shape future priorities. This partnership approach has already secured additional investment for the Mid and Babergh area, enabling delivery of inclusive initiatives to increase physical activity.

Work is ongoing with communities to co-produce programmes that build on local strengths and encourage more people to be active. Opportunities to extend this approach across the wider alliance are also being explored.

A place-based bid has been submitted, including targeted exercise referral programmes and wider community development initiatives. Early feasibility work on capital opportunities has also been completed to inform longer-term planning.

The Abbeycroft Exercise on Referral Pathway continues to support individuals with respiratory conditions and hypertension through tailored exercise programmes. There are currently over 1,000 people enrolled in the programme.

In addition, a new integrated weight management service has been launched across Suffolk and North East Essex, providing a single point of access and more coordinated support for residents.

There has been strong progress across dental services, particularly for prevention and vulnerable groups. Supervised toothbrushing programmes expanded significantly following national funding, with over 1,300 children participating across Suffolk and north east Essex. Targeted initiatives included school-based education with Ipswich Town FC Foundation and the deployment of a mobile Assessment and Treatment Service to areas of deprivation and special educational needs. The Dental Priority Access and Stabilisation Service (DPASS) continued to improve access for high-need populations, delivering over 20,000 appointments since launch and demonstrating clear impact in improving equity and oral health outcomes. Additional commissioning and contract extensions have expanded dental capacity and specialist care, particularly for people with learning disabilities, autism and dementia.

Stay Well

Stay Well year- supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives

Table x: JFP Stay Well target Indicators

Target Indicator	Target	Current performance	Target trajectory
Increase our GP practice teams each year to meet the growing demand whilst increasing the number of trainees and apprentices	>3,861 (24/25 baseline)	3,917 (Mar-26)	Target met
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026 and return performance towards the 18-week constitutional standard	1% by Mar-26	0.6% (Mar-26)	Target met
Increase by 10% each year the number of cases seen by the urgent community response service	>41k (24/25 baseline)	37,235 (Feb-26)	Requires improvement
Ensure that in March 2026, 78% of patients attending A&E services wait no longer than 4 hours in line with an ambition to return performance towards the national 95% standard	78% by Mar-26	77.1% (Mar-26)	Target not met
By the end of 2025-26, 75% of people aged 14 and over on a learning disability register will have had an annual health check and a health action plan completed, with an aim towards everyone on the learning disability register to receive an annual health check and action plan by 2029	75% by Mar-26	80.7% (Mar-26)	Target met
Increase the percentage of cancers diagnosed at stages 1 and 2 to 75% by 2028	75% by 2028	61.9% (Dec-25)	Requires improvement
Increase each year the identification rate of people with high blood pressure	>71.1% (23/24 baseline)	73.3% (24/25)	Target met
Improve rates of treatment to NICE guidance of people with high blood pressure	>72.1% (23/24 baseline)	72.5% (24/25)	Target met
More than 85% of people with atrial fibrillation are identified by 2028	85% by 2028	91.5% (24/25)	Target met
More than 90% of those at high risk of stroke are treated by 2028	90% by 2028	91.6% (24/25)	Target met

Stay Well highlights

Long term conditions

Respiratory

During 2025/26, the ICB has delivered substantial progress against its respiratory priorities, strengthening early diagnosis, community-based care, and system resilience. The system became the first ICB nationally to implement N-Tidal Diagnosis, an AI-enabled diagnostic tool for COPD, now embedded within the agreed clinical pathway and supporting diagnostic transformation in primary care. Primary care spirometry has been significantly improved, with the Suffolk Spirometry LES confirmed for 2025/26, a full-service specification completed, and procurement and contracting arrangements agreed for 2026/27, providing a sustainable platform for consistent, high-quality diagnostics.

Access to FeNO testing has expanded at scale, with 41 devices deployed across the system and 833 tests delivered up to January 2026, demonstrating sustained adoption and operational embedding by practices. FeNO capability has supported asthma pathways for the 73,800 patients on the asthma register, the NEE ARI Hub, and school nursing teams, strengthening early intervention and reducing unwarranted variation.

Recurrent funding for the Tobacco Dependency Treatment Programme (TDTP) has now been agreed for 2026/27 in Suffolk, in partnership with Suffolk Public Health, securing the ongoing delivery of this high-impact, evidence-based intervention. While some broader system-wide respiratory transformation activity has been temporarily paused pending confirmation of the future ICB operating structure, delivery throughout the year has remained prioritised on managing winter pressures, with close collaboration across acute providers, system partners, and public health to maintain patient flow, service resilience, and quality of care.

Stroke and neurorehabilitation

Progress has continued toward establishing a more coherent and sustainable community neurorehabilitation commissioning model, with the ICB to become sole commissioner of ICANHO services at contract renewal, incorporating Norfolk and Waveney through novation. The future model refocuses provision on clinical neurorehabilitation aligned to NHS pathways, with clearer delineation of responsibilities and social care-related elements signposted to Suffolk County Council services, supporting greater pathway clarity and long-term sustainability.

To ensure continuity of specialist rehabilitation provision and maintain sufficient capacity to meet anticipated demand, an urgent procurement process was undertaken during 2025/26. This secured six Level 2B rehabilitation, which are specialist rehabilitation beds for stroke patients needing intensive inpatient therapy after acute hospital treatment beds. This comprised of three beds at the Marbrook Centre (St Neots) and three beds at Eagle Wood (Peterborough). In parallel, work is progressing to develop longer-term commissioning arrangements within Suffolk, including exploration of an Any Suitable Provider framework to support sustainable and flexible future provision. In parallel, Early Supported Discharge (ESD) has been strengthened,

with six-month ICSS reviews now recurrently funded across Ipswich and East and West Suffolk, ensuring 100% of eligible stroke patients are offered a review, improving outcomes and supporting system flow.

Cardiovascular disease

A key priority for SNEE ICB over the past year has been to identify and treat high blood pressure in our communities. Over 2025/26, the ICB partnered with SiSU UK for a second year to mobilise five health stations across the patch to enable the population to carry out independent health checks. There were 7,919 health checks completed over this period, which identified one in five users having high blood pressure reading. These service users were then signposted towards appropriate support. SNEE continues to perform strongly in hypertension identification and treatment, currently ranking as the one of the top ICB in the region for hypertension management. As part of community outreach, blood pressure monitors were placed in Suffolk Libraries for public loans and have also now been supported across Essex libraries resulting in hundreds of recorded loans.

Diabetes

The SNEE NHS Diabetes Prevention Programme (NDPP) continues to perform strongly, receiving approximately 650 referrals per month. SNEE ICB has worked in partnership with primary care to improve the uptake of the eight care processes for diabetes, aiming to support earlier intervention and better long-term outcomes for patients.

All Primary Care Networks increased both proactive and reactive appointments over the winter period to help prevent hospital admissions, particularly for individuals with respiratory conditions.

SISU empowers individuals to take charge of their health and wellbeing. At West Suffolk Hospital, the service is seeing an average of over 170 people per month, with individuals referred back to their GP for ongoing support where appropriate.

In addition, 100 blood pressure monitors are now available in libraries, with 514 recorded loans to date 197 renewals and 317 one-time loans. By providing accessible health checks and digital tools, this initiative is helping to improve community health outcomes. Overall, these improvements are helping to reduce pressure on emergency services while ensuring patients receive timely, appropriate care.

Elective care

We have made steady progress in strengthening elective care services and improving collaboration between primary and secondary care.

Elective services have continued to recover with a reduction in patients waiting over 52 weeks. Overall, across both WSFT And ESNEFT, the number of people waiting over 52 weeks has reduced by 2,333 (55%) over the last year. We remain focused on continuing to reduce waiting times in line with national commitments.

Key to improved access and quality of care has been maximising the use of specialist advice by increasing system maturity against the national Advice and Guidance Operational Delivery Framework and continuing to support new state-of-the-art facilities, such as the Essex and Suffolk Elective Orthopaedic Centre (ESEOC). In addition, partners have worked collaboratively to optimise pathways between primary and secondary care providers, as well as improving productivity and quality of services in line with national guidance. Service reviews have been completed with patient and stakeholder engagement, identifying opportunities to improve the way in which services are commissioned and to support the national neighbourhood framework to bring care closer to home. Actions arising from the service reviews have been agreed for implementation in 2026/27 in line with the ICBs commissioning intentions.

An action plan is in place across the Suffolk and North East Essex system, and by the end of Quarter 4, progress assessments show improvements across all areas. In addition, a nationally mandated elective single point of access is scheduled to be introduced across 10 specialties from October 2026.

A key milestone has been the establishment of the West Suffolk Clinical Interface Group, which has been operating since May 2025 with appropriate governance in place. This forum supports improved joint working and decision-making across the system.

The evaluation of the Third Space Service is underway, and a supporting business case is in development to inform future plans for 2026/27. The Third Space Service is a remote monitoring service for patients with particular conditions that require regular testing to remain healthy.

Overall, these initiatives are helping to improve access, streamline pathways, and support more effective use of specialist expertise.

Urgent and Emergency Care (UEC)

Over the past year, we have made strong progress in improving urgent and emergency care services and supporting patients to receive care in the most appropriate setting.

We have expanded our Virtual Wards (also known as hospital at home) to allow patients to get the care they need at home safely and conveniently, rather than being in hospital. The NHS is increasingly introducing Virtual Wards to support people at the place they call home, including care homes.

Offered acrossacross all six Integrated Neighbourhood Teams, enabling more patients to be safely supported at home and helping to avoid unnecessary hospital admissions.
Additional investment in point-of-care testing has strengthened this model, and new pathways now allow patients to be stepped up into Virtual Wards from community services and primary care. Specialist clinical leadership, including a community geriatrician, is now in place, with further work underway to enable referrals from ambulance services and urgent care settings. The Shared Service Delivery Model has

begun roll out to provide Urgent Community Response via the Early Intervention Team and Integrated Neighbourhood teams.

We have also continued to develop ambulatory care pathways, offering effective alternatives to ED attendance. This includes improving direct referral routes into Same day emergency care (SDEC) from NHS 111, 999, primary care and community services, and increasing specialist involvement earlier in the patient journey.

Use of GP streaming within Emergency Department (ED) has been lower than expected; however, changes introduced in the second quarter mean GPs are now working directly on the ED floor to assess and redirect patients more quickly. There has been an expansion of the accepted criteria which was implemented for Q4 which should impact utilisation percentage.

Ambulance handover times have remained on track throughout the year and show an improvement on 2024/2026 performance. The UEC Delivery Group has continued through 2025/26 to work on improving overall UEC performance. ED waiting times remain below the national four-hour target but have remained on track and show a marked improvement compared to last year.

A review of the Level 1 Falls pilot has been completed, which enabled commissioning and procurement discussions. Funding has been sourced to fully commission a West Suffolk Level 1 Falls service in 2026/27.

Age Well

Table x: JFP Age Well target indicators

Target indicator	Target	Current performance	Target trajectory
Reduce each year the rate of emergency hospital admissions due to falls amongst the population aged over 65	<1.6k per 100k admissions	928.3 (25/26 cumulative – Oct-25) *	Requires improvement
Return performance against the dementia diagnosis rate towards the national standard of 66.7%	66.7%	60.5% (Mar-26)	Requires improvement

* unresolved data quality issues after Oct-25

Aging Well highlights

Our Age Well work aims to support all of our population who are aging to live safely and independently, whilst experiencing a good quality of life.

The last 12 months have seen significant focus on prevention and proactive care, as well as focus on clinical guidance and support for clinicians caring for more complex patients with frailty. Age Well is also linked to the case management service pilot and will link to the National Neighbourhood Health Implementation Programme (NNHIP) heart failure focus as this develops.

The IES Age Well Domain Steering Group is an established place for planning and oversight of the Age Well workstream, with good representation from a wide variety of statutory and voluntary groups and providers. It is chaired by Kirsten Alderson CEO of Suffolk Family Carers. The group has been pursuing key themes from the Age Well joint forward plan. Health inequalities have been and will continue to be a significant focus of the group.

Within the steering group the ICB and its partners have held deep dives into the key areas that form Age Well, including carers, care homes, dementia, and falls and frailty which are all part of our joint forward plan objectives. With a focus on how this interacts and overlaps with the other domains particularly Die Well, Be Well and Stay Well. The creation of the 'A practical guide to help you age well in Ipswich and east Suffolk - Live healthily, happily and independently for longer' was a significant piece of work and it is the focus of early proactive work linking with public health on their frailty and prevention work and directly supports the age well objectives.

The District and Borough Council led strength and balance classes, continue to offer easier access to the OTAGO based exercise group designed to prevent or reduce falls through self-referral. This remains an integral part of our preventative offer and links closely to the NNHIP aims and of course to the goal of reduction of fall-related admissions that is one of our key targets.

IES have also supported neighbourhood level projects around Age Well, there have been numerous events, in a variety of styles offering advice and expertise around falls management and ageing well. Practitioners from dementia support, social prescribing, Feel Good Suffolk and others were also present to offer wide support and information to attendees around ageing well. Other projects such as Staying Well Information and Support Hub (SWISH) which offers information, support, and guidance on local services to people within their community have also been supported.

We have used our comprehensive falls and frailty review to inform local strategy for support and prevention. The review brings together national guidance and local evidence to support our approach to falls and frailty. It also includes a scoping of local falls pathways, which has informed the development of our fall's strategy.

There has been a piece of targeted work around risk stratification and a co-location project within the Stowmarket area. Using PHM data, a risk stratified approach has been taken to identify the most complex patients within the area. Early work includes using this data to contact and signpost people to support to better meet their needs in order to help people Age Well.

A considerable amount of work has been undertaken in the last year to understand frailty services and opportunities to improve frailty outcomes. Services have been mapped against the British Geriatric Society Frailty Toolkit, with identified opportunities translated into a comprehensive action plan across seven workstreams including: frailty prevention; moderate/severe frailty and length of stay; falls; dementia; end of life; care

homes; and digital. Delivery is now underway by cross-system partners and is being overseen by the newly established Age Well Steering Group. Achievements include:

- The delivery of public facing communication campaigns, such as International Older People's Day and Falls Awareness week, to improve knowledge and awareness of healthy ageing messages
- A successful frailty week campaign at West Suffolk Hospital in November 2025 for staff and public
- Delivery of staff training sessions around ageing well, ageism awareness, dementia awareness, and dementia modifiable risk factors reduction
- Dementia risk reduction messages embedded into population health and lifestyle services, including Feel Good Suffolk and NHS Health Checks;
- Good progress made in reducing waiting lists and improving pathway flow for dementia diagnosis in West Suffolk
- Piloting of Falls Assessment clinics at West Suffolk Hospital and in the community
- Development of a multi-agency Falls Prevention Strategy

Priority Three: Effective Monitoring of the Enhanced Health in Care Homes (EHCH) Framework**.** Work is progressing to support primary care and Suffolk County Council in delivering the EHCH framework within care homes. The West Suffolk Care Home Forum has been established, with its first meeting held in November. Training needs and development opportunities have been identified and shared with the care sector.

Die Well domain

Enabling people nearing the end of life to have choice over their care.

Table x: JFP Die Well target indicators

Target Indicator	Target	Current Performance	Target Trajectory
Increase each year the percentage of people identified as approaching the end of life	>0.7% (Mar-25 baseline)	0.8% (Jan-26)	On track

End of life

We are committed to ensuring that individuals and their families receive high-quality, coordinated care and support from all health and care professionals involved at the end of life.

During 2025/2026, significant progress has been made in strengthening end of life care across the system. Work to improve the identification of people in the final 12 months of life has been completed, supported by the introduction of a GP Enhanced Service now availible in Suffolk. This provides a stronger foundation for earlier recognition and more proactive care planning.

Alongside this, there has been a clear focus on increasing advance care planning conversations. The My Care Choices Register, due to launch by the end of Q4, will play a central role in this. Supported by the GP Enhanced Service, the register will enable advance care plans to be recorded digitally and shared across health services, care homes, and social care, improving visibility and coordination of care.

The introduction of the My Care Choices Register also represents a key milestone in delivering a digital end of life register across Norfolk and Suffolk. Funding has been secured and the necessary infrastructure established, with Suffolk leading implementation ahead of wider rollout.

Community services have been further strengthened to support more people to receive care at home. At St Elizabeth Hospice, a staffing review has led to the introduction of a named nurse within each Integrated Neighbourhood Team in Ipswich and East Suffolk, ensuring earlier access to specialist palliative care. The Care Choices Service has also been aligned with these teams, offering volunteer support to increase the number of ReSPECT conversations.

In addition, Virtual Ward provision at St Elizabeth Hospice has been extended throughout 2025/2026, with plans in development to sustain this model longer term. The system has also been recognised for its community-led approach, achieving Compassionate City status through Compassionate Communities UK. This reflects the breadth of grassroots initiatives supporting individuals and families through death, dying, and bereavement, including volunteer-led groups, advance care planning support, inclusion projects, and creative and school-based programme.

Increasing the number of people identified in the final 12 months of life and improving the proportion with a documented care plan including Advance Care Plans (ACP), Preferred Place of Death (PPoD), and Preferred Place of Care (PPoC) remains a key priority.

The recent launch of the My Care Choices Register (MCCR) across Suffolk enables advance care planning conversations to take place. A GP Enhanced Service (ES) has been published to support GP practices to use the MCCR. Multiple GP practices have signed up to date.

An out of hours specialist palliative and end of life care (SPEoLC) response service (pilot) launched in July 2025 to support those at end of life to receive specialist care in their preferred place of death. The pilot has been evaluated and proven extremely successful. 99.7% of patients remained at home during the pilot period for out of hours support.

Integrated Specialist Palliative and End of Life Care has been commissioned through the Better Care Fund to support more joined-up working between St Nicholas Hospice Care and West Suffolk Foundation Trust. This approach aims to ensure patients are supported in their preferred place of care by the most appropriate professional, while also strengthening early intervention and supporting delivery of the national two-hour response standard for end of life care.

Cross cutting areas

Vaccination delivery remained a major strength for SNEE, with COVID-19 and flu uptake consistently above national averages. Nearly 215,000 COVID-19 vaccinations were delivered across the Spring and Autumn/Winter programmes, with SNEE ranking in the top 15 nationally for uptake. The flu programme reached over 284,000 people, performing particularly well among over-65s and young children. Innovation was also evident, with an SNEE pharmacy becoming the first in the NHS to deliver a maternal pertussis vaccination, alongside strong delivery of RSV vaccinations through community pharmacy.

Community pharmacy continued to play an increasingly important role in prevention, access and system resilience. Pharmacies expanded services in hypertension detection, contraception, smoking cessation, urgent care and Pharmacy First, supporting GP and urgent care pathways. Patient satisfaction remained high, and pharmacies played a key role in digital inclusion, supporting over 2,000 people to adopt the NHS App. New smoking cessation treatments were trialled successfully, and Pharmacy First saw rapid growth, with around 50,000 people accessing care for common infections and over 30,000 urgent medication supply consultations, reinforcing pharmacies as a vital, trusted frontline service.

The ICB published its first Work and Health strategic plan called Fit for Work, Fit for Life in November 2025, outlining the actions it would take to help people with health needs to stay in work, return to work, or enter work. Safe and secure work improves our health and wellbeing and reduces health inequalities, so it is a priority to help our working aged people access employment (paid or voluntary).

The plan explains that health services can:

- Assist employers by providing them with training about common health conditions and how to make small adjustments to their employee's workspace, duties, or work hours to help them remain well in work
- Help employees to prevent or shorten sick leave through early support and health interventions when they first feel unwell to create a stay at work or return to work plan with them and their employer. They may need adjustments in their work, advice on managing their health condition, wider advice on housing, caring duties or other out-of-work issues that are impacting them
- Offer advice on accessible, inclusive, and healthy workplaces
- Provide targeted help to people who particularly find it hard to work due to their health needs such as people who are neurodivergent, have a learning disability, carers, and young people, by reaching out to them, offering specific advice on how to manage their disability and/or health needs within work, and education to their employer on their needs

Since the plan was published a website has been created Good Work and Health - NHS Suffolk and North East Essex ICB which includes the Fit for Work, Fit for Life plan, a guide on what reasonable adjustments can be put into workplaces, short films developed for employers explaining how to help their employers with common health needs, and links to the diverse support that is available across our area. A public facing communications campaign was also launched to help residents, employers, and health professionals understand that work is good for your health and the importance of supporting people to be well in work. In collaboration with education colleagues there has been a focus on designing a way to identify young people from an early age who may need additional help to move into education, employment, or training post 16 years. This work will continue into next year, along with other new preventative services aimed at reducing the risk of health being a barrier to people working.

Reducing health inequalities

Table 1. Inequalities summary by deprivation and ethnicity (where available)

Area	Metric	Time period	Least deprived	Most deprived	White	All other ethnic groups combined	Asian	Black	Mixed	Other
Elective care	Elective waiting list - average weeks waited	w/e 15-Mar-26	16.4	17.2	16.8	17.3	N/A	N/A	N/A	N/A
Elective care	Waiters over 18 weeks	w/e 15-Mar-26	39.4%	42.2%	40.2%	42.3%	N/A	N/A	N/A	N/A
Urgent & Emergency Care	Emergency admissions for under 18s (rate per 1,000)	Oct-24 to Sep-25	83.0	116.1	N/A	N/A	N/A	N/A	N/A	N/A
Mental Health	Rates of Mental Health Act detentions (rate per 1,000)	2024/25	56.8	157.4	77.8	N/A	53.7	202	143.5	150.3
Cancer	Cancer early diagnosis	Jan-Dec 2025	61.5%	56.5%	62.2%	N/A	59.3%	65.9%	55.8%	N/A

	(stage 1/2)									

Comparisons of the metrics in table 1 by deprivation indicate that there are inequalities for those waiting to be treated, with patients living in the most deprived areas waiting on average a week longer for treatment. Under 18s are more likely to have an emergency admission if they live in the most deprived areas in SNEE. There are significant deprivation inequalities in the rates of Mental Health Act detentions, with those living in the most deprived areas nearly three times more likely to be detained than those living in the least deprived areas. Early cancer diagnosis rates are approximately 5% higher in the least deprived areas in SNEE.

Ethnicity inequalities are significant around Mental Health Act detentions. Cancer diagnosis rates also vary considerably between ethnic groups, but not in such a clear way.

Table 2. Inequalities summary by East of England ICB (lowest benchmark level available)

Area	Metric	Time period	Suffolk & North East Essex	Mid & South Essex	Herts & West Essex	Norfolk & Waveney	Beds, Luton & Milton Keynes	Cambridge & Peterborough
Mental health	Severe Mental Illness full health checks	Qtr4 25/26	74.7%	64.6%	53.4%	65.2%	61.9%	69.6%
Mental health	Dementia diagnosis rate	Mar-26	60.5%	67.7%	65.9%	63.8%	70.0%	62.6%
Mental health	Learning Disability annual health checks	Mar-26	80.7%	69.7%	82.5%	76.4%	74.3%	73.3%

The metrics in table 2 are not available at deprivation or ethnicity level, so regional comparisons provide a view on any geographical disparities for the SNEE population. Rates for patients receiving a full SMI health check are highest in SNEE compared to the other ICBs in the East of England region and second highest in the region for LD health checks. Dementia diagnosis rates do not fare so well with SNEE the worst performing ICB in the East of England.

Health inequalities highlights

Delivered in partnership with the Suffolk and North East Essex Integrated Care Board and the University of Suffolk Dental CIC, it brings together strategic funding, clinical expertise and community insight to address a well-evidenced local need. This programme represents a highly collaborative and impactful approach to improving children's oral health in Ipswich. By targeting primary school pupils particularly in areas of higher deprivation the initiative responds directly to concerning rates of dental decay, fillings and extractions. Its structured six-week delivery model provides children with

consistent, engaging education on key topics such as toothbrushing, nutrition and dental care, while football-themed content linked to Ipswich Town Football Club ensures the sessions are relatable, memorable and effective in capturing young audiences.

The programme's success lies not only in its engaging in-school delivery, but also in its ability to extend impact beyond the classroom. By providing toothbrushing packs, workbooks and accessible digital resources, it ensures that thousands of children and families can benefit, including those not directly participating in sessions. Crucially, the project actively involves parents and carers, equipping them with trusted information and practical tools to reinforce positive behaviours at home. With the potential to reach over 6,000 children across up to 16 schools, the programme is well-positioned to create lasting behavioural change, improve confidence and wellbeing, and reduce oral health inequalities. Supported by strong governance and aligned with wider public health priorities, it offers a sustainable model for early intervention that can ease long-term pressure on dental services while delivering meaningful improvements in children's health outcomes.

Social prescribing

Over the past two years, social prescribing has demonstrated significant impact in improving both individual wellbeing and system-wide outcomes. Link workers have supported a growing number of people to access tailored, non-clinical interventions, with local programmes reporting that over 70–80% of participants experienced improvements in wellbeing and reductions in loneliness. This personalised approach has empowered individuals to address what matters most to them, contributing to improved mental health, increased physical activity, and greater confidence in self-managing long-term conditions. In targeted programmes, such as those focused on lifestyle and prevention, interventions linked to social prescribing have been associated with measurable benefits physical activity interventions alone can reduce risk factors comparable to some clinical treatments, reinforcing the value of prevention-led care.

At a service level, social prescribing has also played a key role in reducing demand on primary care and wider health services. Evidence from the past two years indicates reductions of around 20–30% in GP appointments among individuals engaged with social prescribing, alongside decreases in A&E attendance for frequent users. By connecting people to appropriate community resources, the model has helped shift demand away from clinical settings while maintaining positive outcomes. In addition, partnerships across health, voluntary, and community sectors have expanded significantly, increasing both the reach and diversity of support available. This has been particularly important in addressing health inequalities, with programmes successfully engaging underserved groups and improving access to services that tackle wider determinants of health such as housing, employment, and social isolation.

Over the past two years, the Suffolk Community Based Approach has demonstrated clear and measurable impact in supporting people with complex conditions, shifting care away from reactive, hospital-based services toward proactive, community-led support. Since becoming operational in September 2022, the programme has supported over 2,000 individuals with complex needs through a coordinated model rooted in social prescribing and strong partnerships with VCFSE organisations. This approach has delivered an 18% improvement in Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) scores, evidencing meaningful gains in wellbeing, resilience, and individuals' ability to manage their health. Given the well-established

links between wellbeing and physical health outcomes including improved immune response, reduced disease progression, and increased longevity these improvements represent not only enhanced patient experience but also longer-term health benefits.

Alongside improved wellbeing, the programmes have demonstrated significant system-wide impact in reducing demand on acute services. Data from the last two years shows that of 832 individuals who previously attended A&E, 310 (37%) did not return following engagement with HI interventions. Similarly, among those who had experienced unplanned hospital admissions, 216 individuals (approximately 25%) were not readmitted after receiving support. These outcomes highlight the effectiveness of non-medical, community-based interventions in preventing escalation and stabilising complex patients. With 465 referrals recorded in 2024/25 alone driven by needs such as mental health (116 referrals), physical activity (115), and long-term condition management (73) the programme is clearly aligned with local health priorities and operating at meaningful scale. Collectively, this evidence demonstrates that the model is not only improving outcomes for individuals but also delivering tangible reductions in system pressure, strengthening the case for continued investment and expansion.

Engaging people and communities

People and communities

In the past year the ICB has continued to build upon its new approach to how it delivers its core functions of working with people and communities that sought to reduce duplication, remove the risk of 'the same people, being asked the same questions, by multiple organisations' and ensure there was greater partnership working to enable all voices to have the opportunity to be heard.

Our approach was underpinned by the principle that strong relationships and understanding how people and communities experience health and care is fundamental to how we work as an effective health and care system. We know there are an extensive number of established organisations, groups and networks embedded within neighbourhoods, alliances and the ICS that work closely with communities to ensure their voices are heard. These groups are our key partners who can provide strategic insight and oversight to how we work collectively with people and communities to ensure that all voices and experiences are heard.

In 2024 we made a commitment that engagement and co-production will underpin and guide all activity of the ICB, working at neighbourhood, place and system level to lead change, placing people's experiences and expertise at the heart of health and care service development and delivery. This includes embedding co-production principles, ensuring adequate resources for community partnerships, and empowering people to lead in service transformation. By working collaboratively with our partners including those with lived experience, we have been able to embed a robust governance framework for involvement, engagement and co-production and over the past 12 months have made good progress in embedding an Insight and Oversight model for co-production and rolling out training for co-production.

Building strong foundation for working with people and communities

The People and Communities Assembly is a group who develop and learn from each other – a community of practice for involvement, co-production and co-delivery. Launched in November 2024 it has continued to grow with membership now sitting at 341. Everyone is welcome to join the People and Communities Assembly.

People & Communities | Lets Talk SNEE

In the past 12 months there have been five meetings, held online and in-person alternately, which have included discussion on the following:

- The continuation of developing a set of principles to govern the Assemblies work centred upon; insight and oversight, equality and diversity, accessibility and communication, community-focused, and learning
- The role of people with lived experience in the commissioning cycle and the procurement process
- Mental health services based in the community
- Personalised care and personal health budgets
- Shaping the future of diabetes services
- Community services in Suffolk
- Urgent dental service
- The Research Engagement Network (REN)
- SNEE ICS learning and legacy workshop
- Changes to the Let's Talk SNEE platform
- The Care Management Service in Suffolk

The average attendance at online meetings was 70, and the average at the in-person meetings was 35. The attendees ranged from people with lived experience, family carers, VCFSE volunteers and colleagues, local authority colleagues, NHS provider colleagues, Integrated Care Board colleagues, people in engagement/co-production roles, researchers, academics and education, with representation from across Suffolk and Essex, and occasionally Norfolk and Cambridgeshire.

The attendee's feedback of the People and Communities Assembly is overall very positive (via an anonymous form following each meeting), members consistently reported feeling informed, inspired, and valued, and praised the Assembly's openness, quality of presentations, and inclusive environment. Suggestions for improvement included allocating more time for discussion, simplifying language, and continuing to elevate lived experience voices.

Across the year, strong themes emerged: the importance of genuine co-production, navigating significant system change, improving accessibility and reducing inequalities, strengthening community partnerships, and maintaining transparency. The Assembly remains a vital space for shaping health and care together, ensuring people's experiences and insights continue to guide system priorities and service development.

In addition to the Assembly, the ICB has also commissioned Healthwatch Essex and Healthwatch Suffolk to be key partners to help progress the people and communities' function across the ICS, by working closely with their co-production, research and community engagement officers and volunteers. In the past year they have provided support on

- Bespoke community engagement as part of co-producing a system-wide integrated urgent care strategic plan
- Co-design of the orthodontics service review engagement opportunity and engagement with young people and parent/carers
- Co-facilitators of the Suffolk Community Services Insight and Oversight Group, co-designing and co-delivering a public engagement to co-produce the principles for the future of community services

They have also supported our approach to embedding principles to co-production across the workforce of the ICS and have delivered five training sessions attended by 93 people working across the ICS including individuals with lived experience, local authorities, ICB and the VCFSE sector.

Embedding co-production through a 45-degree insight and oversight approach

A key outcome of a SNEE-funded PhD exploring co-production within integrated care, was the early development of the 45-degree approach. This shows that when working together in co-production, equal representation and contribution from both 'lived' and 'learned' expertise is key to ensure relevant knowledge and context when working together. It equalises 'people' and 'system' voices in decision-making within integrated care (Conquer, 2025).

The 45-degree approach can be translated into an Insight and Oversight Group model for co-production. This combines both 'lived' and 'learned' expertise, involving 'community' and 'system' voices to form a group of people to progress programmes of health and care service development. Group members can both provide:

- Oversight: by guiding the development of the programme through co-production and engagement processes
- Insight: by involving and engaging and co-producing with people in communities and the workforce.

An Insight and Oversight Group co-produce a programme's direction, make collective decisions, and involve others with expertise and insights from a range backgrounds and lived experiences. By embedding the 45-degree approach it ensures co-production starts from an inclusive and accessible foundation to allow people with lived experience, voluntary sector representatives and community groups to work alongside those representing service providers, governance, data, and commissioning colleagues.

Reward, recognition and support

Over the past year SNEE ICP have led the co-development of an East of England Guidance for Reward, Recognition and Support working in collaboration with Cambridgeshire and Peterborough and Mid and South Essex ICBs. The document provides principles and a framework to help inform local policy development alongside a toolkit with further guidance and examples of good practice.

The five principles highlight the importance of

- Providing a safe and welcoming environment
- Inclusivity matters
- Representation
- Involvement with meaning
- Reward and Remuneration

The framework goes on to provide advice on how to implement the principles with helpful tips and suggestions on:

- Supporting the wellbeing of participants
- Giving thought to accessibility and inclusion
- Ensuring there is representation from diverse groups
- The importance of providing pastoral support to participants
- Ensuring that feedback is meaningful and transparent
- Consideration to all aspects of reward and remuneration

The guidance builds upon the insight gathered by the Patients Association to support initial engagement and incorporated local views and experiences from the three systems into the final document. Now that the guidance has been shared each ICB will develop their own policies and procedures for how they work with people and communities. Through this work we have achieved a more joined-up, collaborative way of working – supported by a cross-system community of practice that will enable organisations to share learning, reduce duplication and navigate system change in a way that keeps people and communities genuinely at the heart of service development and delivery.

How we've worked with communities to assist with the planning and commissioning of services

Orthodontic services review

SNEE ICB worked closely with young people, parents and carers to shape the future of orthodontic care through a flexible programme of engagement including two online focus groups, one-to-one conversations arranged at times convenient for families, and the option to invite the team to existing groups or sessions. All project information, including sign-up opportunities, was hosted on Let's Talk SNEE, supported by promotional posters and flyers co-designed by young people volunteering with Healthwatch Essex, and shared by Healthwatch Suffolk and Healthwatch Essex. Participants also received a £10 thank you voucher in recognition of their time and contribution.

Orthodontic Services | Lets Talk SNEE

A total of 21 people with lived experience took part, including young adults, parents, carers and families at different stages of the orthodontic pathway from those waiting through to those who had completed treatment. Participants were drawn from Ipswich and East Suffolk, West Suffolk and North East Essex, and included individuals with additional needs, such as neurodivergent young people, as well as a dental nurse apprentice contributing both lived and professional insight. Engagement questions were co- produced with young Healthwatch Essex volunteers.

Insights directly informed commissioning recommendations and identified key priorities, including long waiting times, inconsistent communication, limited appointment availability, travel distances, and unclear eligibility criteria. Experiences of pain, anxiety

and limited emergency support highlighted the need for improved repair pathways, clearer information, and better emotional support. Feedback from neurodivergent participants emphasised the importance of stronger reasonable adjustments. Despite these challenges, families also reported positive outcomes, including improved confidence, comfort and oral health.

The orthodontic service review is ongoing, with findings presented to the steering group, including ICP representatives and a young participant, to inform next steps.

Diabetes service user group

SNEE ICB worked with people living with diabetes and family carers to develop a new integrated diabetes service specification. Following discussion at the People and Communities Assembly, engagement took place through weekly online meetings in August and early September 2025, with additional opportunities to provide written feedback.

The Diabetes Service User Group included 38 members: people with Type 1 and Type 2 diabetes, carers, family members, ICB and ICP colleagues, and clinical representatives including GPs and specialist nurses. Meetings were facilitated by the Co-production Lead and Senior Transformation Lead, with representation from the Ipswich and east Suffolk, west Suffolk and north east Essex areas.

Discussions covered access to education and specialist support, consistency of routine care (including foot checks and HbA1c monitoring), self-management, use of technology, and communication between primary and secondary care. Mental health was a key theme, highlighting the emotional impact of diabetes and the need for trauma-informed care. Barriers affecting ethnic minorities, rural communities and people with disabilities were identified. Feedback informed the inclusion of flexible, culturally-appropriate education and ongoing self-management support within the specification. Variation in access and experience across the system led to a commitment to a more consistent and equitable model across all three Health and Wellbeing Alliances, including integrated clinical psychology and mental health support.

A weekly traffic light system (green/amber/red) showed how feedback was being used, ensuring transparency. Members will continue to be involved in future service development and procurement.

Urgent care strategic plan

SNEE ICB worked with people and communities across Suffolk and north east Essex to co-produce a new Integrated Urgent Care Strategic Plan. Engagement began through the People and Communities Assembly and continued via a 50-member Insight and Oversight Group, including people with lived experience, voluntary and community organisations, staff and commissioners. This group formed four task and finish groups, with the ‘listening’ group co-designing an accessible engagement toolkit, including a survey, community conversations and an online ideas board.

The Future of Urgent Health and Care Services

Engagement captured 483 voices across the system through 27 community conversations, 113 survey responses, 18 ideas board submissions and 77 accessible surveys. A wide range of communities were involved, including those experiencing health inequalities, with analysis supported by a health inequalities tool.

Key themes included challenges around access, navigation, communication, workforce, digital inclusion and service integration. Specific needs relating to mental health, neurodivergence, sensory impairment, learning disability, pregnancy, homelessness and language were explored in depth, highlighting the importance of trauma-informed care, inclusive communication and human-centred approaches. Participants also shared future-focused ideas such as mobile urgent care units, quiet waiting spaces, integrated hubs, clearer signposting and lived experience-led training.

This co-production directly shaped the Strategic Plan, including four strategic pillars (accessibility, clinical excellence, agility and innovation, and efficiency) and nine case study scenarios grounded in real experiences. It informed key commitments such as improving NHS 111 access, creating a single point of coordination, strengthening shared records and triage, expanding community-based urgent care, improving digital and non-digital access, and embedding inclusive, trauma-informed workforce training.

The plan also prioritises improving access for digitally excluded groups, rural communities and those facing long-standing inequalities. The co-production programme has been recognised as a leading example of strategic commissioning, and participants will continue to be involved as the programme moves into procurement and implementation.

ME, CFS and Long Covid service user group

SNEE ICB worked with people living with ME, CFS and Long Covid, and family carers, to support the procurement and mobilisation of a new specialist service. Engagement began with an online survey and focus groups, followed by the creation of a Service User Participation Group (SUPG) to ensure lived experience shaped service design and decision-making.

From November 2024 to September 2025, the SUPG met monthly online, with around 15 participants per session. Agendas were informed by survey findings, focus group feedback and group discussions. The group worked closely with the Co-production Lead and Long-Term Conditions Programme Manager, who ensured clear communication and supported meaningful participation.

Community Services in Suffolk

SNEE ICB worked closely with people with lived experience, voluntary and community organisations, and system partners to co-produce the overarching principles for how NHS community services in Suffolk (excluding Waveney) should be delivered over the next decade. The opportunity was first presented at the People and Communities

Assembly in September 2025, after which an open membership Insight and Oversight (I&O) Group was formed. The group included 87 members representing 52 organisations, meeting monthly between October 2025 and April 2026. To support accessibility and inclusion, each organisation was offered a grant of £250-£500 for their time and expertise, and health inequalities mapping was completed to ensure a wide range of experiences were represented.

Suffolk Community Services

The Insight and Oversight (I&O) Group codesigned the engagement approach, including questions, definitions and methods, and developed a fully accessible engagement toolkit. This included an online survey, a voice-to-text accessible version, paper copies, community conversations, a “magic wand” ideas board, and a “share your story” option.

Promotional materials (including Easy Read and BSL videos, large-print materials, and materials translated into 14 languages) were produced in collaboration with voluntary sector partners. The engagement ran for five weeks between January and February 2026, with I&O Group members promoting and facilitating the work across communities.

A total of 904 people took part, including 567 participants across 40 community conversations, 264 individual survey responses, 40 ideas board submissions, 31 accessible surveys and two-story submissions. Participants represented a wide range of experiences including long-term conditions, older people, digital exclusion, dementia, caring responsibilities, mental health needs, neurodivergence, learning disability, sensory impairment and physical disability, from a diverse range of ethnic and cultural backgrounds., Some had experience of financial hardship, homelessness, and living in rural areas with limited transport. Conversations took place in varied community spaces including libraries, leisure centres, cafes, retirement apartments, cultural groups, drop-ins, youth groups, and home visits, ensuring broad reach across Suffolk.

Issues were explored across five overarching themes: access, provision, location, treatment and care, and whole-system working. Participants described strong examples of community care when accessed promptly, but identified persistent barriers including long waits, poor signposting, difficulty contacting services, digital exclusion, limited local provision, unclear referral routes, fragmented pathways, and insufficient support for carers. People emphasised the importance of accessible communication, better information about available services, support for independence at home, and proactive long-term care planning. The engagement highlighted the need for community services that are local, accessible, proactive, consistent, and well-coordinated across the system. People value community settings outside hospitals or GP practices, including schools, libraries, family hubs, and trusted voluntary sector venues.
These findings will now be used by the I&O Group to co-produce the guiding principles for the future community services model. Members will also have the opportunity to contribute to a co-production evaluation with the University of Suffolk, and future procurement activities throughout 2027.

How we've worked with People and Communities at Place

There are many examples of our partners involving people and communities at place and neighbourhood level across Suffolk and north east Essex, and in order to shine a light on the excellent work and share examples of good practice, a Co-production and Co-delivery Award was presented to the team as part of the 2025 SNEE ICS Health and Care Awards.
Projects that were recognised and celebrated included:

- Co-designing a service to enable people to access interim support whilst awaiting their ADHD/ASD assessment in Suffolk
- The co-design of the Suffolk Dementia Strategy
- Co-delivery of an awareness campaign for prostate cancer
- Co-creation and co-delivery of the Compassionate Communities Network in north east Essex
- Co-design of a cookery project to support refugees and migrants in north east Essex
- Co-design of dementia-friendly services in Clacton
- Co-design of a new service specification and care pathway for people with ME and CFS
- Co-production and co-delivery of the Women's Health Programme
- Co-design and delivery of services for parent carers in Suffolk
- Co-design of materials and outreach models for cervical screening in Suffolk
- Co-design and delivery of the Transgender Health Inclusion Network for Care

Read more about the ICS 'Can Do' Health and Care Awards 2025https://www.sneeics.org.uk/involving-everyone/can-do-health-and-care-awards-2025/

SNEE ICS Patient Participation Group (PPG) Network

We completed an audit of all 94 practices across Suffolk and north east Essex to identify any new gaps in services and provide guidance and support for the re-establishment of Patient Participation Groups (PPGs). We also attended a number of PPG meetings to support the development of governance structures and strengthen group effectiveness.

The Network has continued to meet on a bi-monthly basis and has seen growing levels of participation.

Key activities delivered this year include:

- Development of a Best Practice Toolkit in collaboration with Community Action Suffolk
- Co-design and delivery of a PPG awareness campaign in partnership with the ICB communications team
- Active involvement of network members in the People and Communities Forum, including promoting and participating in research opportunities,

https://www.sneeics.org.uk/working-together/working-together-as-people-and-communities/ppg-network/How we've worked with underserved communities

Research Engagement Network

The SNEE Research and Engagement Network brings together Research Community Champions, VCFSE organisations, and researchers to identify and address the barriers faced by people from underserved communities in accessing and sustaining participation in research.

Over the past year, we have continued to facilitate the development of the local network by engaging with established organisations while also expanding membership to better reflect the diversity of our local population. As a result, the network has grown to 84 members.

We have utilised the existing Let's Talk SNEE platform to share information, promote research opportunities, provide training resources, offer peer support, celebrate successes, and address challenges. The platform is also used to document meeting notes and actions for network members.

In addition, we have developed an encrypted WhatsApp group to enable timely sharing of local and regional opportunities and updates.

Working in partnership with Healthwatch Essex and our Community Champions, we have produced two accessible leaflets to raise awareness of research and support greater participation:

- What types of health research are there?
- What is health Research?

Our community groups have also collaborated to develop a guidance booklet for researchers, providing practical insights on how to effectively engage with and approach diverse communities.
https://sneeics.org.uk/resources/flipbooks/research-champions-information/

Suffolk and North East Essex Trans* Health Inclusion Network for Care (SNEE THINC)

SNEE THINC is a network aimed at improving health and care for transgender, non-binary, and gender-questioning individuals in Suffolk and north east Essex.

The network includes transgender and non-binary people, those exploring their gender identity, and health and care professionals. In 2025-2026 the network engaged three times with their 50+ members, including individuals identifying as transgender, non-binary and gender non-conforming, as well as representatives from various sectors such as community-led groups, voluntary organisations, GPs and primary care providers, hospital trusts, staff networks, Healthwatch and higher education.

The network continued to identify and gain a shared understanding of health inequalities faced by the community, and the challenges faced by transgender patients and health and care professionals in delivering equitable care. This year, the network most notably supported the stakeholder feedback to the draft East of England Adult

Gender Dysphoria Service. The engagement had a direct and measurable impact onnational decision-making, with lived-experience feedback incorporated into the paper that secured approval from both the National Gender Board and the National Commissioning Group for a new Adult Gender Service in the East of England. This insight helped shape the delivery model, justified doubling the financial envelope to reduce waiting times, and influenced national discussions on a “waiting well” offer and future primary care-led improvements in gender-affirming care.

SNEE THINC will continue to contribute to equitable health and care across the East of England and welcome more members and agenda items for group discussion and co-production.

How we use digital platforms to support wider engagement

Let’s Talk SNEE

From its creation in 2021, our engagement platform www.letstalksnee.co.uk has gone from strength to strength and now has over 1,800 registered participants. It is being utilised by many of our Suffolk and North East Essex Integrated Care System artners and in recent weeks our colleagues in Norfolk and Waveney Integrated Care Board have also begun to use the platform.

Many different forms of engagement are possible via the platform and over the past year we have run lots of new projects, making use of many of the engagement tools the platform offers, including surveys, quick polls, and ideas boards.

The site is fully moderated, meets all General Data Protection Regulation, information security and accessibility standards.

All participants registered on the site receive regular e-newsletters telling them what’s new and advising how they can get involved.

During the past year there have been:

- 24,492 visits to the site
- 4,061 contributions
- 228 additional registrations bringing total number of registered participants to 1,832

44 newsletters have also been sent (including some group specific ones to our Patient Participant Group Network)

We have received 2,851 contributions to the 78 active projects of which 26 were created in the past year.

Among these new projects are:

Mental Health Crisis in the Community: This project was one of the first on Let’s Talk SNEE. For this project, we worked with our partners in Norfolk to find out more about how people use crisis services in advance of the re-commissioning of a new contract in 2027.

Help Shape Community Health in Suffolk. Our Future: 2027-2037: We worked with over 45 community groups to find out which NHS community healthcare services had worked well for them.

Orthodontic Services: To help shape future services, we created an engagement project aimed at younger people and their parents or carers. As well as online engagement, we held a focus group and one-to-one discussions.

The Future of Dermatology Services in Suffolk and North East Essex: A project was undertaken to better understand people's experience of the service, helping us ensure that any future model is designed around the needs of those who use it.

We also worked closely with our partners in social care, developing a dedicated project space for Suffolk County Council'sDirect Payments group. This provides a secure, closed environment where members can review documents, share feedback and contribute to the development of future services.

How we work with partner organisations to reach people and communities

The Accessible Information Advisory Group

The ICB has funded local charity Thinklusive to co-ordinate and facilitate an Accessibility Advisory Group to advise the ICB on 'accessible information'. Accessible information is a vast and varied area and the local health landscape is complex. The group is representative of the local population and represents a range of accessibility needs. Thinklusive develops agenda items and creates accessible meeting materials, creating a robust slide-set for each meeting. This helps people to follow the meeting easily.https://www.letstalksnee.co.uk/accessible-information-advisory-group

The group consists of people with lived experience, notably people with learning disabilities, autism, physical disabilities, and sensory impairments alongside statutory partners from health and care, local authorities, PPGs, and local patient forums such as Alzheimer's, Carers and ADHD.

Items reviewed this past year include:

- Patient experiences of receiving healthcare
- Continuing Healthcare Equity and Choice Policy
- Accessible Information Standard
- Visual impairment engagement
- Stay Well for Treatment or Surgery material
- NHS Reasonable Adjustment Digital Flag information and patient-facing material

The SNEE ICS VCFSE Assembly

The VCFSE Assembly has over 140 VCFSE members from across the ICS. It meets bi-monthly and enables VCFSE sector partners across SNEE to:

- collaborate and connect effectively on key issues and the wider ICS ambitions, from locality and place level to whole ICS geography
- collaborate with one another, sharing strategic ideas and learning
- ensure that key workstreams agreed by the VCFSE Assembly are developed and progressed with the support of the SNEE ICS VCFSE Steering Group.

The Assembly serves as a vital route for the ICB and wider system partners to meet with the voluntary and community sector collectively in order to gather their views and expertise on specific issues that is representative of the communities that they support. In the past year agenda items have included:

- the changes within health and care, locally and nationally
- Strategic commissioning
- WorkWell
- The Civil Society Covenant
- Care Management Services
- National Neighbourhood Health Implementation Programme
- Suffolk Community Services Insight and Oversight Group

Our next steps

Working with people and communities will have even greater importance in the coming 12 months following the restructure of the ICB to the new Norfolk and Suffolk footprint and the focus on strategic commissioning and neighbourhood health. It's an opportunity to build upon the strong foundations we've developed over the past two years of embedding co-production and providing greater opportunities for public and patient voices to be heard, whilst learning from and adopting good practice from Norfolk.

Mental Health expenditure

All ICBs were required to plan to achieve the Mental Health Investment Standard in 2025/26 and were required to spend greater than or equal to the 2025/26 target spend number provided by NHS England and NHS Improvement.

The 2025/26 target spend was £197.0m and the actual spend was £197.2m.

Financial Years	2025/26	2024/25
Mental Health Spend	£197.2 million	£173.4 million
ICB Programme Allocation	£2,298.4 million	£2,131.2 million
Mental Health Spend as a proportion of ICB Programme Allocation	9%	8%

Children and Young People (CYP) safeguarding

[1]Working Together to Safeguard Children 2018 - links into 2023 updated version of Working Together to Safeguard Children 2023

SNEE ICB discharges its duties in safeguarding babies, children, young people, children in care (CiC) and care leavers and unaccompanied asylum seeking children (UASC) and adults. The ICB does this by having in place the SNEE ICB Executive Chief Nurse who is accountable for the statutory commissioning assurance functions of NHS Safeguarding. Theseinclude Child Protection Information Sharing (CP-IS), female genital mutilation (FGM), looked after children/children in care , Prevent, as well as the duties outlined in the Working Together guidance, Serious Violence Duty, modern slavery and human trafficking, domestic abuse and the Mental Capacity Act.

The SNEE safeguarding team work using a 'Think Family Across the Life Span' approach. Whilst using this approach, the designated professionals maintain their individual specialities and expertise pertaining to their area. We have a full complement of designated professionals across adults and children, with a health team within the Suffolk Multi Agency Safeguarding Hub (MASH).

SNEE ICB, with its two local authority partners, complies with the statutory arrangements as set out in the Children's Act 2004 to have in place a Child Death Review process, and both localities have a Child Death Review Team.

The designated health professionals provide clinical expertise and strategic advice to ensure the needs of children and young people are at the forefront of commissioned health services and are highly valued by the ICB, our health economy and wider partners. The team leads and influences safeguarding practice and policy across our complex system. Across Suffolk and north east Essex, the team have continued to maintain and build trusted relationships with partners to ensure that the voice of local children and adults is evident in all we do.

The ICB has a range of statutory safeguarding duties delivered predominantly through their safeguarding team and guided by a range of national guidance including the NHS England Safeguarding Accountability and Assurance Framework (SAAF). The SAAF requires the production of an annual report demonstrating the statutory compliance of the ICB with its safeguarding functions.

This report therefore focuses on the work of the ICB safeguarding team, its work with and alongside the safeguarding partnerships within the SNEE system as well as our health partners and covers the period April 2025 to March 2026.

The team has responded to NHSE regional and national team requests for regular data and information, usually on a quarterly basis. The NHSE Safeguarding Case Review Tracker (SCRT) holds the ICB team's information on adult and children's reviews being carried out and completed and captures the recommendations and learning. This is shared directly with NHSE.

As requested, we submit quarterly via the NHSE Safeguarding Commissioning Assurance Toolkit (SCAT).

Across both areas CP-IS Phase 2 implementation is in progress, including engagement with providers to ensure digital and safeguarding requirements are being met to get the programme into the provider settings.

We have liaised with NHSE Head of Safeguarding and the regional teams to set up webinars for those involved in the implementation of CP-IS in order to best support staff, share knowledge and gain clarity on requirements. Feedback has been positive.

The team reports back to our Children Partnerships/Boards, Safeguarding Adult Boards and Community Safety Partnership on the progress made against recommendations agreed as outcomes from statutory safeguarding reviews (Rapid Reviews, Child Safeguarding Partnership Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews and Domestic Abuse Related Death Reviews).

We report to the Corporate Parenting Board in relation to how the health needs of children in care and care leavers are being met, including any risks in access to services, for example dental care, and timeliness of initial and review health assessments for this cohort in line with statutory guidelines. In Suffolk, our work for children in care and care leavers has focused on their mental health needs, identifying the gaps and recognising the high-risk times of transition, especially for those in residential care homes. Multi- agency work is ongoing to support at times of crisis; training needs to be considered and the incorporation of the UK Trauma Council's recommendations to improve mental health services for all our care experienced young people. This includes gaining the voices of those in and leaving care at our children and young people led Corporate Parenting Board sessions.
https://uktraumacouncil.link/documents/Hiller et al. National Recommendations MH Provision for CiC.pdf

Within the ICB's Joint Forward Plan (JFP) is a section dedicated to our commitment to safeguarding children and adults at risk. Within this we have set out our plans to keep our population safer at home and within our communities, as well as plans for safer system working, focusing on areas we recognise as key, including domestic abuse, trauma informed practice and our safeguarding front doors.

We ensure that the organisations we commission to provide health and care services maintain policies and procedures to ensure the safety of people at risk of abuse and neglect, and that processes are in place that enable us to learn lessons from cases where adults and children die or are seriously harmed, and abuse and neglect was already known or suspected.

Reviews published throughout this report period can be found via the below websites, with links and recommendations from our locality included in the SNEE Safeguarding Annual report

- Child Reviews — Suffolk Safeguarding Partnership
- Adults Reviews — Suffolk Safeguarding Partnership
- Essex Safeguarding Children Board
- Essex Safeguarding Adults Board

Suffolk cases identified for children,

- **Non-Accidental Injury (NAI) and physical abuse** is most visible in babies and children under the age of three

- **Sexual abuse** is most visible from age 11

- **Suicide, child mental health, exploitation and serious youth violence (SYV)** is most visible from ages 11– 17

- **Neglect** is visible across all ages

In collaboration with the Local Safeguarding Partnership and Safeguarding Boards, SNEE's Designated Safeguarding Professionals have disseminated the learning from national reviews and reports, supporting the embedding of recommendations into practice, policy, and systems.

This has included developing action plans for health and monitoring and supporting providers to embed the learning into practice. This has been achieved in collaboration with our partners and in ways that meet the needs of providers, including facilitated learning events, webinars, newsletters, presentations, training, and safeguarding supervision.

The Case Review Forum for all Suffolk health care providers provides opportunity to disseminate learning, monitor the implementation of actions from reviews and support best practice across the ICB. In Essex, the Designated Nurse has been instrumental in ensuring a safeguarding partnership approach to the initial consideration of all CSPR referrals into the partnership. Dissemination of learning and monitoring of the implementation of actions from Reviews for Essex is conducted across SNEE by the Essex Children's Safeguarding Board (ESCB).

Essex Safeguarding Children's Board (ESCB) have set out their arrangements in the Essex MASA 2024-25 document.

The ESCB has confirmed that the updated MASA will not be published until after 2026. The document sets out how the safeguarding partners in Essex, alongside the relevant agencies, work together to safeguard and promote the welfare of children.

Essex Safeguarding Adults Board (ESAB) set out arrangements in both their annual report and their strategy plan 2024-27.

The Suffolk Safeguarding Partnership (SSP) sets out the local partnership and governance arrangements in Suffolk for both adults and children.

https://static1.squarespace.com/static/62ea37b2f412d231ae2c2f35/t/68467b677a718e0fcfc85a11/1749449576235/SSPMulti-AgencySafeguardingArrangements%28MASA%292025-26.pdf

In Suffolk, the Suffolk Safeguarding Partnership, for both adults and children, holds a statutory responsibility to produce an annual report into the effectiveness and quality of multi-agency safeguarding practice locally.

The SSP has included the priorities for the coming years until 2025 in the Strategic Business Plan.

The plan shows strategic priorities across adults and children's, alongside specific actions and target timescales required to deliver against these priorities.

The Essex Safeguarding Adults Board Annual Report can be found online.

The ESCB collaborative approach extends to working closely with Southend and Thurrock Safeguarding Partnerships as well as others across the Eastern Region and nationally.

The North East Essex Team is part of the pan Southend, Essex, and Thurrock (SET) Safeguarding Clinical Network (for all designated professionals and named GPs for safeguarding children, LAC and safeguarding adults) which aims to work collaboratively across SET.

The evidence provided confirms the statutory processes we have followed, as set out in SAAF (2022) which confirms that we are meeting this duty. The SNEE Safeguarding annual report also evidences our compliance.

Environmental matters

SNEE ICB Annual report Sustainability 25/26

Task Force on Climate-related Financial Disclosures Compliance

Statement Introduction

The Department of Health and Social Security (DHSC) Group Accounting Manual (GAM) follows a phased approach to incorporating the Task Force on Climate-related Financial Disclosures (TCFD) recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, in line with HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. These TCFD disclosures, as interpreted and adapted for the public sector by the HM Treasury, will be gradually implemented into sustainability reporting until the 2025-26 financial year.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions, as these are calculated nationally by NHS England. The GAM has also adapted the requirements for scenario analysis in the strategy section of the TCFD disclosures to better fit the needs of the public sector.

For 2025/26, the phased approach incorporates the disclosure requirements of the following 'pillars' – 'governance', 'strategy', 'risk management', and 'metrics and targets'. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts (ARA) and in other external publications.

Governance pillar

In November 2025, the ICB Board approved an updated ICB Green Plan aligned to the requirements of the Health and Care Act 2022 sustainability requirements and NHS 10 year plan, this was also aligned with Norfolk and Wavely ICB to support the clustering of both organisations prior to merging.

The goal of our Green Plan is to deliver sustainable value and reduce environmental and financial costs whilst maintaining (or improving) the quality of care we provide and creating a positive social impact. Ours is an integrated approach that links

environmental, social, and economic thinking to support the new NHS 10 Year Plan with its three key shifts for a heathier society - ‘sickness to prevention’, hospital to community’ and ‘analogue to digital’.

This will be achieved by focusing on activities that deliver a three up and three down set of outcomes, namely; reduce carbon emissions, air pollution, and waste, increase our support for nature and our resilience to climate change, and deliver more social value to our communities through our efforts to help reduce inequality.

Governance and oversight

Our designated board-level net zero lead (Senior responsible officer – SRO) is Amanda Lyes. The SRO is required to oversee Green Plan delivery with clearly identified operational support. This support is provided by our Sustainability Lead and Green Plan theme leads.

Our Green Plan activity is managed through our Sustainability Steering Group. This is chaired by our SRO for Sustainability. Steering Group membership comprises of theme leads and senior managers who are responsible for discharging the delivery of specific elements of the Green Plan and informing and monitor their respective directorates and teams on climate-related issues. The purpose of the group is to provide good governance, assurance, oversight, and system accountability to ensure ICB compliance as a minimum with:

- statutory requirements
- CQC requirements of ‘environmental sustainability’ and ‘governance, management and sustainability, and
- Healthcare Safety Investigation Branch triple aims

The Sustainability Steering Group is accountable to the ICB Estates Committee. It provides a six-monthly update to the committee in addition to monthly updates on topical issues and sustainability matters. The sustainability steering group provides a six-monthly report to the Estates Committee and an annual report to the Board.

The ICB Board also receives updates on climate-related risk through a Board Assurance Framework on climate risk and resilience. This is updated for every Board meeting ensuring the Board has full visibility and oversight of climate-related issues.

All commissioning and procurement projects are required to include a sustainability impact assessment which is linked to the ICB’s three up and three down sustainability outcomes. These outcomes directly link to compliance with Health and Care Act 2022 statutory sustainability requirements. The Green Plan which set the strategic framework for our climate adaptation and mitigation approaches (by addressing climate-related risk and opportunities) has been triangulated with the ICB Joint Forward Plan, Estate Infrastructure Strategy and included in the draft Population Health Strategy

(commissioning intentions). Sustainability and Green Plan considerations are therefore integrated into processes.

Strategy pillar

ICB strategic risk number 29 is reported bi-monthly to the ICB Estates Committee and the public ICB Executive Board Report. The description is identified as; *impacts of climate change on healthcare capacity and resilience; commissioning services that are adapted to our current climate, mitigate against further climate change and deliver improved outcomes and value for money.*

Risks are due to:

- increases in extreme weather events (heatwaves, flooding, cold)
- prolonged and persistent change in weather patterns
- increases in exotic disease and pathogens
- disruption to supply chain medical products and technologies
- poor air quality

Impact(s) arising from the risks are:

- Health system capacity and resilience - health and social care delivery
- patients and staff suffering increased ill health – disproportionately impacting the most vulnerable in the population
- potentially unusable healthcare premises/infrastructure
- water scarcity, injury and mortality from extreme weather events, negative impact on mental health, respiratory illness, heat related illness, exotic vector borne illness

The current climate BAF risk rating is 16 and remains 'high'. A programme is in place as part of the Green Plan to mitigate the risk and drive system activity to adapt and be more resilient to climate change. This process helps identify the short, medium and longer-term risks and opportunities.

These are not formally defined with a specific time horizon with the ICB approach. However, extreme weather events have been prioritised as an immediate short-term climate-related risk and opportunity whilst a wider review via the BAF action plan process remains ongoing. The material impact of this was identified and prioritised by assessing relevant literature including NHSE 4th Health and climate adaptation report , Adverse Weather and Health Plan , NHSE Emergency preparedness, resilience and response (EPRR) guidance , NHSE Green plan guidance and WHO Operational framework for building climate-resilient health systems .

The BAF has an action plan which is used to determine actions and activities. An explanation of the process is provided in the 'Risk pillar' section.

The high-level impacts, risks and opportunities are in the ICB climate resilience BAF. The effect on ICB operations, strategy and financial planning is taken into account and prioritised for the short term. For example, in 2025/26, extreme weather events and surface water flooding impact is now included in decision making processes for primary care estates management and development. Impacts expected to have a medium and longer-term impact are included in the BAF with an expectation of an increase in exotic pathogens and vectors, more frequent heatwaves, more frequent extreme weather events and possible reduced air quality. All of which have the potential to impact the most vulnerable, place more pressure on frontline services and place additional cost burden on the NHS.

These are assessed and prioritised in accordance with Green Plan targets and NHSE guidance. During 2025/26 examples include; the ICB Sustainability Impact Assessment includes a climate resilience section. Supply chain and value chain have been required to provide assurance on resilience when appropriate through procurement and commissioning of services. Adaptation and mitigation activities have included an assessment of primary care surface water flooding risk. Plus, the inclusion of surface water flooding in primary care estates options appraisal processes to mitigate against future risks and limit financial exposure. R&D innovation processes include an assessment of climate change and carbon reduction impacts. A data gathering exercise in 2024 and 2025 as part of the BAF action plan included digital carbon challenge, estates review, EPRR review, SIA review and a staff survey. The findings were used to support the BAF action plan to increase assurance and reduce exposure to risk.

The extent of physical and transition risk over time is assessed through the BAF action plan process and wider research. This includes an annual appraisal of the Word Economic Forum Global Risks Report and Analysis to assist transition risk identification. In 2025/26, the ICB adopted and used the NHSE Climate Adaptation Capability Framework to augment the BAF action plan process. The NHSE Climate Change Risk Assessment Tool has also been trialled to assess relevance in adaptation and mitigation for primary care high flood risk sites. The work remains ongoing to implement this to support primary care where appropriate, building on surface water flood risk assessment research. The ICB plans to use the tool in 2026/27 to develop a deeper scenario analysis to underpin our approach across other climate related risks and opportunities.

The ICB adoption of the NHS Climate Capability Adaptation Framework is now used to support this process. An assessment of progress is reviewed against a RAG rating to prioritise actions and identify gaps and risks within the ICB approach. Use of the tool is supporting the evolution of the ICB approach; actions and activities to continue adaptation and mitigation actions from the tool are used to support the BAF action plan. The BAF action plan is reviewed and monitored as an ongoing programme. Risks and opportunities identified through the process will be used to support ICB operations, strategy and financial planning. Current ICB self-assessed rating is 'intermediate',

noting a spread of activity is taking place across ‘starter, intermediate, mature and advanced’ maturity stages.

Risk management pillar

Relevant subject matter experts across the organisation review research, guidelines and relevant literature in line with NHSE Green Plan and other relevant guidelines. The ICB overall Green Plan framework has identified the key risks using the key texts listed under ‘Strategy pillar’ (risk identification). A set of guiding principles is published in our Green Plan. These risks are reviewed through our risk management process and operationalised through our BAF action plan. Climate risks are also included in primary care business case planning.

Risk assurance is provided through our Board Assurance Framework (BAF) Strategic Risk 29: Impacts of climate change on health care capacity and resilience; commissioning services that are adapted to our current climate, mitigate against further climate change and deliver improved outcomes and value for money. This is updated for each Board meeting and is used to drive system-wide actions and link Green Plan approaches together.

The BAF contains climate-related risks and impacts, assurances, lists control mechanisms and indentifies gaps in assurances against the risks. It uses an assurance rating to provide an overall score of the risk which assesses what mitigation and control measures are already in place. It contains a risk rating score (risk x impact) with a target risk rating. In order to achieve the target risk rating, a BAF action plan is in place with series of actions being taken which are assessed and reviewed regularly.

Risk and performance are managed through four means:

1. Board Assurance Framework; Risk assurance is provided through our Board Assurance Framework (BAF) Strategic Risk 29: Impacts of climate change on health care capacity and resilience; commissioning services that are adapted to our current climate, mitigate against further climate change and deliver improved outcomes and value for money.
2. ICB performance monitoring dashboard; a heatmap dashboard has been created to demonstrate progress against the Green Plan strategic objectives and key activities. The heatmap dashboard provides a snapshot of progress against the Green Plan strategic objectives and key activities on a quarterly basis, these are reported to the Steering Group. It uses a RAG rating to highlight risks and progress.
3. SNEE Sustainability Forum and NHS S18 Standard contract; an NHS forum to bring together SNEE ICS NHS sustainability leads to discuss matters relating to sustainability that support the organisations’ green plans. It provides an opportunity for attendees to reflect on issues and emerging opportunities and think strategically to provide check and challenge to the identified issues. The aim of the Sustainability Forum is to support the development and implementation of NHS green plan initiatives that improve SNEE NHS sustainability and help deliver associated commitments. The forum is also used

to support trusts that operate within Suffolk and north east Essex on S18 NHS Standard contract performance. A risk register is used with a RAG rating to identify any key areas that require support or action in terms of trust requirements for NHS S18 of the standard contract. The forum is not a formal sub-group within the governance structure. However, it is a key platform to drive system integration and support performance management and risk management.

4. Greener NHS - regional and national reporting; the ICB also completes the Greener NHS Data Collection via a quarterly collection. This provides a baseline for providers and ICSs against key deliverables for the Greener NHS Programme. The collection informs reporting within the programme and with regional teams, to the NHS England Board and externally, for example, through the NHS England Annual Report and Accounts.

An aggregation of these processes is integrated into the BAF action plan and reported to the ICB Estate Committee and Steering Groups. For management of the risks please refer to 'strategy pillar' (governance). The ICB also integrates external frameworks into its resilience approach where appropriate, including the Local Resilience Forums.

The processes for identifying, assessing and managing climate-related risks are integrated into the organisation's overall risk management approach. Please refer to the Governance and Risk Management pillars for further details.

Climate-related risk is confirmed as a principal risk for the ICB as it is included as a BAF entry.

Metrics and target pillar

The organisation discloses the metrics used to assess climate-related risks and opportunities in line with its strategy and risk management processes, including key metrics, methodologies, historical trends, and performance targets. Progress against these measures and targets is reported in the Green Plan.

Green Plan Progress

The ICB exercised its functions to ensure compliance with the statutory requirements of the Health and Care Act 2022 and Social Value Act 2014 (and Procurement Act) into our Joint Forward Plan. The ICB has committed to sustainability through inclusion as a key enabler in our JFP. The ICB approach towards having regard for contribution to Climate Change Act (Carbon emissions), Environment Act (principally based on four key elements: nature and biodiversity, water, waste and air pollution), 'due regard to sustainable use of resources' and climate adaptation is translated into our JFP for the purpose of policy and objective targets as 'three up three down' approach to deliver the following outcomes namely;

- to reduce carbon emissions, air pollution and waste.

- to increase (and improve) green spaces/nature, climate resilience and wider social value.

The updated SNEE Green Plan formally adopted this position as its key outcomes in November 2025.

Task Force on Climate-related Financial Disclosures Statement

SNEE ICB has considered the wider impact of climate-related risks within our broader responsibilities, as well as our direct objectives and priority outcomes. This is a 'gold standard' approach as stipulated in HM Treasury Sustainability Reporting Guidance 2024-25 and is included through our system-wide Green Plan and system-wide Board Assurance Framework on climate resilience. The ICB TCFD statement provides compliance with all high level and other recommended disclosure requirements as required in the GAM, with a minor exception by not stipulating two- and four-degree warming scenarios in our BAF approach.

Statement. Quality Care Commission 'Well Led' Framework. Staff feedback

The ICB conducted a staff sustainability survey obtaining a 10% response rate. We wanted to understand how staff viewed the Green Plan programme and identify areas of future support to use in the new Green Plan. Staff were asked to directly comment on the statement Respondents were asked;

to what extent do you agree with the following statement: 'I understand the positive and negative environmental impacts of our work activities?

72% staff agreed. 22% strongly agreed. 5% disagreed. 3% reported that they didn't know.

They were also asked: *to what extent do you agree with the following statement: 'The ICB aims to positively reduce our environmental impact*?
68% staff agreed. 22% strongly agreed. 1% disagreed. 1% strongly disagreed. 8% reported that they didn't know.

Staff feedback suggested we have built strong foundations - over 90% understand our environmental impacts and believe in the ICB's ambition to reduce them.

Engagement is highest for flagship resources - 63% find the Green Plan and 'lunch and learn' sessions useful, 74% value our Green Champion Network, and 81% rely on staff briefings.

Of our engagement tools, awareness rates were 90% for 'Nature at work', 85% for the staff *Grubtastic* newsletter, 98% for the Green Champions Network, and 83% for our staff volunteering policy. This shows that our awareness raising and engagement activities are working.

In regard to our sustainable travel support packages, 20% of respondents had used them and found them useful, 46% were aware but had not yet tested them, 29% were not aware, and 5% had tried them

but didn't find them useful. This shows that we have more to do around engaging staff on sustainable transport.

The feedback has helped the ICB identify areas for improvement and staff have provided fresh ideas for us to take forward, including bespoke support and interactive tools that also help patient engagement.

Trust performance S18 Standard Contract

In Q3 of 2025/26, the ICB and its partner trusts collectively reviewed progress on Section 18 Service conditions NHS Standard contract . Of the 18 conditions that our trusts are required to meet, the provisional aggregated RAG ratings were 13 green, five amber and zero red. The five amber areas are;

- air pollution reduction linked to new lower emission vehicle fleets.
- Phasing out fossil fuels for primary heating source and replace them with less polluting alternatives.
- Reducing greenhouse gas emissions from the provider's premises in line with targets in Delivering a 'Net Zero' National Health Service.
- Climate adaptation.
- Targeted approaches to social value in procurement.

Trust Green Plans continue to target these areas. Social value in procurement and commissioning will be reviewed with our trusts in 2026/27 as part of the ICBs strategic commissioning functioning linked to our Population Health Strategy.

All trusts within the SNEE footprint are complaint with the requirement to have a published Green Plan as per NHS Green Plan guidance.

Sustainability dashboard of Green Plan progress

The SNEE ICB Green Plan is a three-year rolling programme. It was launched in July 2022 and has 12 themed areas. The plan sets out 36 strategic objectives and 49 key activities which are spread across these 12 themed areas. These are further underpinned by numerous departmental action plans and activities. The Green Plan covers the ICB's work internally, external work with our trusts and other healthcare providers, and strategic partnership work which requires the ICB to influence and drive partnership behaviours across the ICS.

A heatmap dashboard has been created to demonstrate progress against the Green Plan strategic objectives and key activities. The dashboard uses a mixture of intensity-based activities and metrics. It is qualitative in nature, although hard data and metrics are utilised in areas where appropriate such as workforce, business mileage and inhaler switches. This forms part of a wider programme to update reporting procedures, create digital tools that increase visual engagement for staff and partners, and provide more transparent leadership. It also supports the ICB's ability to manage risks with increased efficiency and demonstrate good governance.

The heatmap dashboard provides a snapshot of progress against the Green Plan strategic objectives and key activities. It is created by recording key activity. The data is collected from meetings and discussing progress against projects from ICB theme

leads, trust monthly sustainability forum meetings, and partner-related work programmes. These are collated onto a master spreadsheet. Activity and planned activity are assessed and assigned a RAG rating. RAG ratings may vary quarter by quarter depending on the level of activity that has been reported to the ICB Sustainability Lead or that has occurred in the quarter.

In Q4, at each year end, an assessment is conducted to assign a final year RAG based on all four quarters' performance and planned actions.

During 2025/26, the three-year programme and ICB actions were evaluated and compared to the revised NHSE green plan guidance (released in February 2025). The ICB concluded that the existing plan, due to its scope and ambitious nature, already covered, and in some areas, exceeded the baseline requirements set out by NHSE (bar two minor anomalies). As such, whilst our three-year Green Plan was updated and approved by our Board in November 2025, the ICB continued using the existing strategic objective and key actions for consistency for the remainder of 2025/26 before the planned merge with Norfolk and Waveney ICB. In 2026/27, a revised dashboard will be used matching the new Green Plans. This will reduce the 85 activities into a more condensed set of priorities.

Green Plan progress of 36 strategic objectives and 49 key activities across 12 themed areas using a RAG rating:

- 65 are green (up by 12 from 24/25)*; evidenced. Risk minimal/unlikely*.
- 20 are Amber (down by 12 from 24/25); *commenced but not completed. More work required.*
- 0 are Red; *does not comply. Has not started. Risk to delivery likely or almost certain.*

The amber areas reflect:

Food and nutrition - ICB scope in this area is reduced in comparison to other themes. However, given the preventative healthcare impact of food and nutrition and the role it plays in climate emissions and nature, the ICB will continue with the theme, noting that progress will be slower and ad-hoc in comparison to other themed areas.

Estates and facilities - actions to improve estates sustainability are linked to the release of structural funds to support infrastructure improvement. NHS funding has initially focused on trust infrastructure, which is mostly completed in-house by the trusts with the ICB playing a supporting role. ICB primary care estates activity is ongoing but has been limited in some key areas without the structural funds to support primary care in the same manner as trusts. The ICB reviews other funding supports and mechanisms periodically on behalf of primary care as BAU activity. Baseline assessments have been completed, and an activity plan has been developed to support and target primary estates infrastructure. An area which will require more activity is increasing climate resilience and using nature as a solution to this green architecture/infrastructure and biophilic design.

Travel and transport - these relate to system partnership working in relation to EV charging infrastructure and a more consistent approach to reduce vehicle idling across the system.Both initiatives are ongoing.

Supply chain - activity that remains amber is linked to system partners' sustainability training and the implementation of whole carbon approaches (life cycle thinking) on consumption choices. This life cycle work has developed through the ICB commissioning process by using our Sustainability Impact Assessment which has led to direct waste reductions in appropriate clinical procurements. This is set to increase with the introduction of the UK Government Design for Life roadmap which provides a clear pathway. The ICB has committed to adopt this approach within its revised Green Plan. This in turn will support our efforts to ensure 'due regard to sustainable use of resources' (one of the NHS triple aims) and

Reduce waste. Updates and differences between public announcements and targets.

The SNEE ICB Green Plan for 2025 to 2028 contains a half yearly review (April – October 2025) of progress. There is some variation between the final year ARA report (dashboard) and the interim half year report that was presented to the Board in November 2025. Notably, supply chain has reduced amber RAG ratings and increased green RAG ratings across its objectives. This reflects progress in embedding the new social value model across our objectives. Within the Food and Nutrition theme, some areas have moved from green to amber, resulting in an increase in amber ratings.

Green Plan key achievements

The revised SNEE Green Plan and Norfolk and Waveney Green Plan have been created to share the same strategic framework and approach to deliver sustainable value and outcomes. This has supported both entities clustering prior to our merger in April 2026.

The SNEE Green Plan contains in-depth case studies and summaries of the initiatives and achievements of our Green Plan. As such, this report shall refer to some key highlights only in this section to prevent duplication.

The key highlights in relation to our three up and three down outcomes are as below.

Reduce carbon emissions

- ICB annual recorded business mileage for 2025/26 is 222,431. This is 37.4 % lower than pre COVID levels (financial year 2019/20). This exceeds our 20% reduction target on pre COVID levels. This mileage represents an annual reduction of 36,377 miles in comparison to 2024/25. It is the ICB's lowest recorded business mileage since 2022/23.
- The carbon emissions from annual recorded business mileage in 2025/26 were 48,789kg CO2 (figures based on petrol, diesel and hybrid cars the mileage has been multiplied by the value of kg CO2e as reported 2023 UK government GHG conversion factors for company reporting).

- The inhaler switch programme continues a downward trend on carbon emissions. Based on the latest available data (November 2025), short-acting beta agonist (SABA) inhalers, also known as reliever inhalers, have an average modelled carbon footprint of 14.89 kg CO_2e per inhaler. This is down from 15.48 kg CO_2e in March 2025 and represents a significant reduction from the peak of 25.08 kg CO_2e recorded in January 2022.

- The modelled average emission per non-SABA inhalers (preventer inhalers) was 9.55 kg CO2e at the end of November 2025 compared to 10.09 inMarch 2025. This represents a comparable drop against the 11.62 high point in March 2022.
- Almost 1200 people have completed some form of 'gloves off' training (Oct 2025)

Several procurements have incorporated sustainable commissioning principles, helping to reduce both digital carbon impacts and travel and transport emissions.

- ICB scope one and scope two estates-related carbon emissions slashed through estate rationalisation.

Reduce air pollution

- ICB representatives have chaired the Essex Climate Anchors Air Quality Group, leading the development of an Essex-wide coordinated approach for the Essex Air Quality Strategy with alignment of all agencies working to maximise health benefits and deliver taxpayer value for money by preventing duplication.
- The ICB supported the East Suffolk Council Stepping Home and Warmer Homes initiatives. In partnership with Burlington General Practice, Ipswich, this work involved supporting home improvements that help patients live in warmer homes with improved indoor air quality.
- This project has delivered over 138 home visits, and 690 actions and interventions were made to support vulnerable people.
- The ICB supported the development of UK Government's National Warmer Homes Strategy.
- The ICB worked with partners to create training for GPs and primary care colleagues to help them signpost patients to local support aimed at improving indoor air quality in patients' homes. This was delivered in partnership with Mill Road General Practice, ESNEFT, the Suffolk County Council Public Health team and Colchester City Council.

Reduce waste

- The ICB launched a medicines waste project to highlight how our patients can support the NHS to reduce medicines waste.
- We launched diabetic pen recycling to reduce reliance on single use plastics.
- Provided training on waste reduction and cost efficiency to the Health Waste medicinesagers Association National conference attended by over 80 people.
- Sustainable commissioning implemented waste reduction measures in ophthalmology and endoscopy clinical procurements.
- Community Dental Services CIC switched to providing bamboo toothbrushes in the packs they give out to vulnerable community groups.

- Supported our trusts on numerous waste reduction initiatives, including the adoption of re-useable equipment, reduction of single use plastics and elimination of waste to landfill.

Increasing green spaces and supporting nature

- We supported our trusts and primary care partners to plants trees for the NHS Forest, with three new sites in 2025/26. The ICB introduced RSPB Nature Prescriptions: connecting to nature to boost health and wellbeing across all three SNEE health and wellbeing alliances.
- A quarter of ICB staff are involved in our RSPB Nature at Work Initiative. This has been successfully rolled out by three of our trusts. Attendance at lunch and learn events was 271 total attendees from across the system over 10 events.
- We continued to expand our Green Hubs at Kennedy Way Medical Centre (Clacton), Micheal Burke Centre (Eye) and Unity Centre (Ipswich).
- Our trusts continued to develop green spaces. WSFT created green space in partnership with the Green Light Trust to support stroke recovery at West Suffolk Hospital. ESNEFT continued its partnership with RHS. The ESNEFT and RHS health and wellbeing garden at Colchester Hospital was visited by Her Royal Highness The Princess of Wales.

Increasing our resilience to climate change

- Continued development of climate resilience BAF approach in line with UK Government 'Gold standards' as stipulated in HM Treasury Sustainability Reporting Guidance 2024-25.
- Adopted the NHS Climate Adaptation Capability Framework. Self-assessment RAG ratings (which are not a statutory requirement) show 11 green, 21 amber and 11 red ratings across the four maturity stages (starting, intermediate, advanced and mature). All red ratings are concentrated within the advanced and mature stages.

- Information about how to stay safe and well in hot weather was published to support the community during the heatwaves of 2025.

Increasing the social value we deliver

- Staff volunteering sessions included litter picking on Felixstowe beaches, landscaping at Suffolk Food Museum, gardening and landscaping at St Nicholas Hospice and supporting East Anglia's Children's Hospice (EACH) Tree Fest.
- Since introducing the sustainability impact assessment process, the ICB has registered 45 initiatives that demonstrate how social value is being embedded within commissioning and procurement.

- Environmental (social value) registered impacts include 32 carbon-reducing impacts, 36 air pollution-reducing impacts, 25 waste-reducing impacts, six green space benefits and nine climate resilience impacts.
- Social value impacts registered through the sustainability impact assessment process include: 20 relating to workforce and people; 17 to community engagement; 25 to supporting economic development and tackling economic

inequality; 24 to driving equal opportunities; 20 to improving wellbeing; 28 to health and community integration; and 12 to supporting communities in recovering from the impacts of COVID 19.

- The ICB transitioned to the Government's new Social Value Model during the year, resulting in the registration of additional social value impacts across a number of projects. These included: one relating to fair work; one to skills for growth; one to resilient suppliers; eight to environmental improvement; one to employment and training; one to reducing barriers to opportunity; and one to NHS staff health and wellbeing. Some are also included within the other figures.
- 10% social value weighting was included in all commissioning and procurement exercises.
- All tender and commissioning awards are now required to have a corporate Carbon Reduction Plan or Net Zero Commitment.
- The key highlights in relation to prevention and patient empowerment using sustainable care principles

- 80 people attended the SNEE ICB Sustainable Healthcare Conference with its objectives of 'Hope: Be optimistic. Believe: Know you can make a difference. Action: Do something'
- Digital health innovations, such as introducing sensor-based falls technology into care homes and online health access platforms such as Essex Frontline and Mental Health in Suffolk were introduced.
- One of or GPs launched 'Walk with a Doc' in Ipswich.
- Social prescribing was offered via the Suffolk Food Museum. Participants are supported through green therapies such as conservation and food-based activities.
- Continued the ICB and SCC social prescribing active travel programme, attracting £1.4m investment to SCC to encourage walking and cycling to improve health and climate outcomes. From September 2023 to July 2025 the initiative has facilitated 2782 participant sessions, supported sessions, supported 272 participants with a behaviour journey to improve health outcomes and received 596 referrals, of which 576 were self-referrals and 29 referrals were from GPs and social prescribers.
- A travel and transport workshop, co-hosted with Suffolk County Council, attracted over 60 attendees from healthcare, local authority, transport providers and voluntary, faith and community sector (VFCSE) organisations. Attendees learned about lots of areas that are linked to transport including patient access (to services), isolation, wider determinants of health, loneliness, and how crucial travel is for patients and staff modal shifts. The workshop has acted as a stimulus, providing impetus to work on patient access and tackle transport poverty and health inequalities across our system.

Green Plan risk to delivery

An overview of risk to green plan delivery is available to review in SNEE Green Plan 2025-28. In summary these are:

- capital and revenue funding and restrictions to support net zero amendment to estates and infrastructure
- resources and staff time regarding wider system pressures and competing

demands particularly in primary care.

- restructuring has slowed and impacted the ability of the ICB to deliver the green plan programme and
- reliance on third party deliverables.

Green Plan summary

Our Green Plan continues to yield some excellent results as we embed sustainability into our activities to reduce carbon and improve patient health outcomes. Across the system, our five partner trusts are collectively making very good progress with outstanding examples of good practice and projects. These include anaesthetic gas reductions, active travel and transport projects, switches to electric vehicles, waste reduction, renewable energy projects, embedding social value and sustainable procurement and investment to the NHS Forest to increase our green spaces. Despite this, there is a significant

journey and effort required to achieve net zero carbon emissions in line with NHS targets.

Andrew Urquhart SNEE ICB Sustainability Lead

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NHS England Report. Five years of a greener NHS: progress and forward look

Improve quality

The ICB has continued to develop its role in improving quality in collaboration with quality peers across the SNEE Integrated Care System, with an increased focus in several key areas.

Governance and reporting

We have continued to strengthen our quality governance and reporting frameworks to proactively manage quality and mitigate and escalate risks.

2025/26 has seen the introduction of the ICB Quality Oversight Meeting (QOM) which provides a single point of reference where all ICB Quality Leads, and wider ICB Medical and Nursing Directorate colleagues (including Patient Safety, IPC, Safeguarding, PALS and Complaints teams), come together to identify, notify and escalate quality risks, concerns and learning within their own portfolios. QOM has a key function in quality risk management within the ICB, helping to identify early warning signs, concerns and risks, the ICBs response to said risks, and overseeing implementation of any action plans.

Risks should be managed as close to the point of care as possible. However, it is recognised that where successful mitigation is not possible, then escalation and further support may be required.

We have utilised the NQB Guidance on Quality Risk Response and Escalation within the ICS to promote a robust and consistent approach. Several Rapid Quality Review meetings have taken place which have facilitated support from system partners and driven demonstrable improvements in quality and patient experience. These have included our non-emergency transport provider, a community neurorehabilitation provider, a primary medical care provider and a local trust. All have worked collaboratively with the process to support the development of action plans and subsequent improvement.

Clear reporting and governance arrangements include reporting into Regional Quality Groups, which has further strengthened the understanding and mitigation of risks.

To support our approach to quality management (quality planning, quality control and quality improvement) we have strengthened our Quality Impact Assessment tool. A Quality Impact Assessment policy has been developed and approved, which includes a panel for high-risk business cases and all cost improvement plans. This has strengthened the commissioning cycle, ensuring quality is central to decision making and will be progressed into 2026/27.

Quality visits have taken place across primary, community and acute care settings over the period. Living the principles of National Quality Board: Shared Commitment to Quality, we are increasingly encouraging peer-to-peer reviews with positive outcomes. Proactive Quality visits during 2025/26 have led to collaborative quality improvement. These visits included supporting trust with their internal assurance visits on wards

including elderly medicine, care of the elderly, general surgery, trauma and orthopaedics and oncology. There have also been supportive and proactive visits to local hospices, community hospitals, community leg ulcer clinics, community endoscopy and minor surgery providers. Reactive visits have been completed to support the Quality Risk Response and Escalation process for community neurorehabilitation and primary medical care. Quality Visits have taken place in all three of our acute hospital emergency departments with a focus on corridor care with particular attention given to the new guidance released by NHSE in December 2025 and the HSSIB report, published in January 2026, highlighting the patient safety implications.

We have been pleased to receive annual Quality Accounts from our system partners. The ICB reviews, scrutinises and signs off Quality Accounts from providers and ensures that quality improvement priorities align with system priorities. This year, a variety of work has taken place across the trusts to improve patient care and staff experience. Whether large or small, these change projects continue to be promoted, shared and discussed internally and externally to make sure best practice is adopted as widely as possible. Our system partners' improvement priorities for 2025/26 were discussed at Quality Committee to ensure system oversight. Our place-based health and wellbeing alliances also reviewed these improvements to ensure our providers quality priorities are reflected within their delivery plans.

A key focus for all of our acute providers remains to improve on their current CQC ratings. This remains challenging. However, we have seen some notable improvements in key areas. For example, following CQC inspections on both sites in April and March 2021, the ESNEFT maternity service was rated as 'inadequate' for the well led and safe domains on the Colchester site, and as 'requires improvement' for the responsive, well led and safe domains on the Ipswich site. Following the inspections, the service entered into the Maternity Safety Support Programme (MSSP). Whilst on the programme, the ICB and NHS England worked collaboratively with the trust to drive improvements.
Following a CQC inspection to the Colchester site in 2023, the service was rated at 'requires improvement' for the safe and well led domains. In July 2025, the service was deemed to have made significant improvements in order for it to exit the MSSP.

We also saw NSFT's Forensic and Secure wards receive a rating of 'good' in each domain when inspected by the CQC in October 2025.

Working together

We have developed our collective understanding of system-level risks, with notable maturity within the SNEE System Quality Group and ICB Quality Committee – moving us into the position of shared ownership of quality concerns and working together to ensure seamless pathways between commissioned services and across agencies to identify and manage quality issues.

Building on the National Quality Board's (NQB) Guidance on System Quality Groups (SQGs), SNEE's SQG effectively promotes strong working relationships, intelligence-sharing across organisations and shared ownership of risk.

The completion of minor surgery infection prevention control audits in primary medical care has provided an opportunity to work with practices to improve standards. The results of the audits have also helped focus commissioning moving forwards and highlighted areas of excellent practice that can be utilised further in the future.

A new Clinical Risk Review Panel has been meeting fortnightly over the winter period. Members are SNEE urgent and emergency care (UEC) partner medical and nursing directors and ICB clinical and operational leads. This forum is to provide clinical advice to support both strategic and operational decision-making across Suffolk and north east Essex ICB during periods of extreme operational pressure. The group works to identify, discuss and ensure appropriate mitigations are in place for the clinical risks of greatest concern across the SNEE UEC system, to provide visibility and shared understanding of these cross- organisational risks; and to provide a forum to discuss the balance of risk across the system.

Just culture

We continue to lead a just culture which is open, transparent and continuously improving; a core principle in SNEE ICB. This is demonstrably evident in the place-based leadership within our three Alliance Quality Groups where we continue to improve integration between health, social care and community partners. The groups display a good safety culture; one that includes value and respect for diversity, openness to learning, and a psychologically safe space and seen this space mature and support quality improvement.

Focused LeDeR (Learning from Lives and Deaths - People with Learning Disabilities and Autistic People) Review Panels are now embedded at place following the establishment through the Alliance Quality Groups across SNEE. Monthly LeDeR review panels see representation and engagement from a wide range of system stakeholders and key learning for learning disabilities and autism is shared with wider alliance partners. Additionally, key themes are identified and taken forwards to inform quality improvement across system partners and pathways.

The Ipswich and East Suffolk Alliance Quality group has worked with the Suffolk Safeguarding Partnership (SSP) to establish a System Learning Group to review a safeguarding incident. This was a novel alliance-based methodology for learning and improvement which identified key recommendations that the SSPs Adult Review Partnership have adopted and will integrate within the alliance.

The Covid-19 vaccination programme for autumn-winter 2025/6 commenced on 1 October 2025 and ended on 31 January 2026. SNEE ICB ranked in second position in the EoE (Norfolk and Waveney ICB were first) and fourteenth nationally. 114, 868 vaccinations were administered during the campaign. The SNEE uptake was 63%. The national average was 57% and EoE average 60%).

The flu vaccination programme for autumn-winter 2025/26 finishes on 31 March 2026. SNEE ICB had an uptake of 61% (national figure is 57%). This placed SNEE in second place regionally and 9th nationally. This is according to data accessed on 17 February 2026.

Dental commissioning has focused on improving patient access to urgent and unscheduled primary dental care in SNEE. Within SNEE, this is augmented by the Dental Priority Access and Stabilisation Service (DPASS). DPASS supports individuals with significant need or active disease. Primary care dental procurement is taking place focusing on areas within SNEE with limited access to NHS dentistry and populations with the most need.

Community pharmacies continue to enhance access within primary care across SNEE. Their contribution to preventative care has grown significantly, with considerably increased activity in hypertension case-finding and diagnosis, contraception provision, support for smoking cessation, and urgent care for minor illness through Pharmacy First. This has supported primary medical care and urgent care pathways. Community pharmacy teams have also demonstrated strong engagement with system priorities, contributing to winter resilience, antimicrobial stewardship, and support for people with long term conditions.

Community pharmacies have embedded safer prescribing and dispensing practices, engaging positively with the ICB's medicines optimisation agenda. Patient satisfaction with community pharmacy remains high in SNEE and has marginally increased year-on-year (88% in 2025, 2025 Ipsos/NHS England GP Patient Survey).

Patient safety

Mortality and safety

All providers with an NHS Standard Contract across England are required to implement the Patient Safety Incident Response Framework (PISRF), seeking agreement from their ICBs. The ICB has continued to support provider organisations during 2025-26 and oversee their implementation of PSIRF. 27 organisations have completed their requirements for PSIRF this year.

The ICB patient safety, medication safety and children and young person's collaboratives continued throughout the year sharing safety alerts, good practice, learning and actions taken following safety incidents. This has included improvements made to keep patients safe while waiting in emergency departments and the co-ordination of quality visits at our acute hospitals promoting sepsis recognition in children. A joint learning from deaths forum has been established with Norfolk and Waveney ICB in preparation for the forthcoming changes to ICB boundaries from 1 April 2026.

A Patient Safety Partner network (PSP) was established for all Patient Safety Partners working across Suffolk and north east Essex. Led by our ICB PSP, the group has been an opportunity for peer support and discussion of trends, themes and concerns. It is also a platform for our PSPs to learn and develop in their role.

PALS and Complaints

The PALS and Complaints Team received 4431 enquiries from 1 April 2025 to 31 March 2026. 3821 have been managed by the team as informal concerns/queries (patient advice and liaison service (PALS) queries).

The team has recorded 389 formal complaints, 183 MP enquiries and 38 compliments.

The team works together with patients and their families to identify the best route for a resolution or answer to their concern. The main theme of people's concerns has been 'access to services in primary and secondary care'.

The team has delivered training with the support of NHS England on managing formal complaints to GP practices across Suffolk and north east Essex.

In line with system partners, throughout 2025/26 the team has been approaching people who raise formal complaints to share their demographic data. This is in order to gain a better understanding of any wider determinants of health. Return on this data collection has been low. Going forward, the team will consider more effective ways in which this data could be captured, for example, via complaint response surveys at the end of the process.

The ICB PALS and Complaints Team has assisted in developing a complaints policy for the new organisation on 1 April 2026. This has been approved by the SNEE Quality Committee.

Clinical Services

The Clinical Services Department in the ICB delivers NHS Continuing Healthcare (NHS CHC) and Level 2b Neurological Rehabilitation. The ICB operates a mixed delivery model for NHS CHC, with assessment and case management functions managed in-house, and outsourcing for reviews, retrospective assessments and a proportion of appeals.

The team has delivered 1137 assessments of new referrals and has not conducted any NHS CHC assessments in the acute hospital setting, in line with national guidance. The ICB is currently commissioning care for 492 CHC eligible patients, 300 fast track patients and providing NHS-funded nursing care for 1153 patients. The ICB remains committed to the promotion of personalisation within NHS Continuing Healthcare and is currently delivering 262 Personal Health Budgets.

The ambition of the service is to deliver end-to-end NHS CHC in-house, and the team is planning to embark on recruitment to support delivery of this ambition. The team has continued its commitment to work collaboratively with partner organisations across Suffolk and north east Essex.

Several policies have been revised and updated, including the NHS CHC Equity and Choice Policy and the Enhanced Observations and Care policy.

Level 2b Neurorehabilitation for Suffolk has been fully integrated into the Clinical Services department. Following the closure of Brainkind's Neurological Care Centre, The Chantry, the ICB has commissioned three level 2b neuro-rehabilitation beds at The Marbrook Centre, and three beds at PJ Care Eagle Wood, replacing the six ICB commissioned beds at The Chantry. This has ensured continuity of access to bed-based level 2b neurorehabilitation for Suffolk patients.

Financial review

The following information reflects the expenditure in the 12-month accounting period for the ICB to 31 March 2026.

• The total expenditure for the period was £2,891m.
• This was split between Commissioning Health Services (£2,865m) and Running Costs (£26m).
The following table and chart provide a further breakdown by category of how the allocation was spent:

Area of spend	**Total Spend (£m) 25/26**	**Total Spend (£m) *24/25***	**Total Spend (%) 25/26**	**Total Spend (%) *24/25***
Acute Commissioning	1,411.3	1,295.0	48.8%	49.1%
Mental Health Services	250.0	225.3	8.6%	8.5%
Community Commissioning	230.1	224.6	8.0%	8.5%
Delegated Primary Care Commissioning (Primary Medical Services)	237.6	215.1	8.2%	8.1%
Delegated Dental, Ophthalmic and Pharmacy	94.0	93.8	3.2%	3.6%
Prescribing	203.8	203.1	7.0%	7.7%
Continuing Health Care	137.0	126.7	4.7%	4.8%
Delegated Specialised Commissioning	241.2	194.3	8.3%	7.4%
Other Commissioning	60.4	45.2	2.1%	1.7%
Running Costs	25.8	17.0	0.9%	0.6%
Total	**2,891.3**	**2,640.1**	**100%**	**100%**

The ICB delivered a £20,689k surplus in year, which was £97k above the initial plan. The surplus allowed the system (comprising of East Suffolk and North Essex Foundation Trust, West Suffolk Foundation Trust and the East of England Ambulance Service Trust) to meet their statutory breakeven target. The ICB also remained within their allocated running cost budget and therefore delivered on all financial duties as reported in the 'Financial Performance Targets' of the Accounts.

The ICB does not have its own capital resource limit, however, is allocated primary care capital which is to be utilised for capital projects/schemes of an estates or IT nature. The expenditure does not impact on the ICB's accounts or reporting and has been spent in full in 2025/26.

In March 2025, NHS England and the Department of Health and Social Care announced further cuts to ICB running cost budgets which would lead to the ICB's running costs to be equivalent to £19 per head of population from April 2026. This equated to the ICB reducing their pay budgets in the region of 50%. As of March 2026, the ICB is on track

to achieve these reductions. The increase in year-on-year running costs expenditure in 2025/26 has been due to the non-recurrent costs of restructuring.

The Statement of Financial Position shows a reduction in total taxpayers' equity of £63.2m. This is largely explained by an increase in current trade and other payable liabilities, whereby an adverse movement in non-NHS accruals and NHS Payables - revenue of £27.3m and £6.6m respectively - has taken place year on year. In addition to this, total assets reduced by £13.8m, primarily driven by reductions in non-NHS prepayments and NHS receivables. Much of these movements are dictated by timing. Finally, the ICB's provision balance has increased by £12.9m. £4.9m of this is attributable to the ICB's reduction in PAY budgets through restructuring and legal provision. Further increases are seen in continuing healthcare, onerous contracts, and funding claw backs.

The ICB's 2025/26 savings performance against target was £25.9m (target of £20.4m).

Dr Ed Garratt OBE

Chief Executive (Accountable Officer)

16th June 2026

ACCOUNTABILITY REPORT

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration policies for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

The composition of the ICB Board

The Board is composed of the following 18 members:

a) Chair
b) Chief Executive
c) Three Partner Members - NHS and Foundation Trusts
d) Two Partner Members - Primary Medical Services
e) Two Partner Members - Local Authorities
f) Five Non-Executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) One Member for the VCFSE sector

They are also joined at Board meetings by other regular participants and observers.

Member profiles

Professor William Pope

Chair, NHS SNEE ICB Board

Will has a range of experience from his various roles within the NHS, academia and business, including at Chair and Chief Executive level. He has worked with several successful companies and started up many of his own, earning him the “Technology Fast 50” awards for the fastest growing companies four times.

As well as his role with the ICB, he is also Chairman and Pro-Chancellor of the University of Suffolk, Chairman of Yorkshire & Humber Academic Health Science Network, Chairman of the Society for the Environment, Chairman of the Environmental Policy Forum, Vice President of the Institution of Environmental Sciences and Director of East Midlands Ambulance Service NHS Trust.

Dr Ed Garratt OBE DL

Chief Executive, NHS SNEE ICB

Ed is Chief Executive of the NHS SNEE Integrated Care Board and has led the Integrated Care System since 2019. He is a Visiting Professor of Integrated Care at the University of Suffolk and an Honorary Professor at the University of Essex in the Institute of Public Health and Wellbeing. He is a Deputy Lieutenant (DL) of Suffolk. In 2023, he was awarded an OBE in The King's first Birthday Honours List for services to the Integrated Care System.

Ed has worked in the system for over a decade, including leading through the pandemic. He was Chief Executive of the NHS Ipswich and East Suffolk, North East Essex and West Suffolk clinical commissioning groups (CCGs), gaining 'outstanding' ratings in all three CCGs, before they were closed in 2022. Previously, he was Deputy Director of Commissioning and Head of Communications and Engagement at NHS East of England.

Ed supports various regional responsibilities such as chairing the East of England Mental Health Board and commissioning the East of England Ambulance Trust. He also sponsors the Essex Anchor Institutions' Network and the Care Tech campus being developed at the University of Essex.

He has worked on major national policy by supporting the development of the NHS Constitution (2009) and the Government's NHS White Paper (2021).

Ed has a published doctorate in English Literature from the University of Cambridge and a first-class degree in History from the University of Sussex.

Dr Freda Bhatti
Primary Care Essex Partner
Dr Bhatti qualified from University College Hospital medical school in 1991 and worked in various hospital posts in and around London before completing her GP training in 1997. She works full-time and has an interest in paediatrics.
Dr Bhatti enjoys socialising and spending time with her family and visiting Ireland regularly, particularly Dublin.

Dr Ewen Cameron

NHS Provider Partner, West Suffolk Foundation Trust

Dr Ewen Cameron is Chief Executive of West Suffolk NHS Foundation Trust.

Ewen joined the Trust in February 2023 from Cambridge University Hospitals NHS Foundation Trust (CUH) where he was the Director of Improvement and Transformation,

a role he had held since February 2018. He also held the role of Interim Chief Operating Officer for CUH from 2021 to 2022.

Dr David Cargill

Primary Care Suffolk Partner

Dr David Cargill is the SNEE Training Hub Clinical Lead and works as a GP at Stowhealth.

Gareth Everton

Partner Member, Suffolk County Council

Gareth Everton is the Director of Adult and Community Services for Suffolk County Council and has been working within the Integrated Care System since November 2024.

Caroline Donovan

NHS Partner Provider, Norfolk and Suffolk NHS Foundation Trust

Caroline Donovan is the Chief Executive of Norfolk and Suffolk NHS Foundation Trust.

Nick Hulme

NHS Partner Provider, East Suffolk and North Essex NHS Foundation Trust

Nick Hulme has worked in the NHS and social care for more than 35 years. He has worked in operational management and leadership roles in large, complex London acute trusts. His first management role was in sexual health services before being appointed to senior leadership roles in operational and general management.

Nick was appointed Chief Executive of Ipswich Hospital NHS Trust in January 2013 and in May 2016 also became Chief Executive of Colchester Hospital University NHS Foundation Trust. Following successful joint working, the two trusts merged on 1 July 2018 to form East Suffolk and North Essex NHS Foundation Trust, of which Nick is now Chief Executive.

The integrated acute and community trust runs Colchester Hospital, Ipswich Hospital, Aldeburgh Hospital, Felixstowe Hospital, Bluebird Lodge in Ipswich and community services at Clacton Hospital and Fryatt Hospital in Harwich.

Nick retired in January 2026 and Adrian Marr attended the Board as Interim CEO at ESNEFT from January to April 2026.

Dr Frankie Swords

Executive Medical Director

Dr Frankie Swords, who is also Chief Medical Director at Norfolk and Waveney ICB, is a former Medical Director at Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust.

She has also been a consultant physician, specialising in endocrinology, for over 10 years and continues to practice as consultant endocrinologist at Norfolk and Norwich University Hospitals NHS Foundation Trust.

Dr Swords is the ICB's lead for improving population health outcomes for local people and communities.

Dr Andrew Kelso held this post from April to September 2025.

Howard Martin

Executive Finance and Contracts Director

Howard joined the ICB in November 2022. He was previously Director for Population Health Management and Health Inequalities at NHS Norfolk and Waveney CCG where he also had responsibility for delivery of the COVID-19 vaccination programme.

He was the Chief Finance Officer for the NHS West Norfolk CCG before the five Norfolk and Waveney CCGs merged, after which he became the Locality Director for West Norfolk. Before going to Norfolk, Howard was the Deputy Director of Finance, Contracting and Performance at the NHS West Essex Clinical Commissioning Group.

In his role with the ICB, Howard is responsible for all matters relating to the financial leadership and financial performance of the ICB, ensuring that the ICB implements a robust financial strategy. He is also responsible for ensuring system resources are effectively deployed and used to provide the best possible care for local people and the communities we serve.

Moira McGrath
Partner Member, Essex County Council

Moira McGrath is the Director of Commissioning – Adult Social Care for Essex County Council and joined the Board in March 2024.

Phanuel Mutumburi
Non-Executive Member and Deputy Chair
Phanuel Mutumburi is the Director at the Ipswich and Suffolk Council for Racial Equality, a Suffolk human rights charity which has been campaigning for equal opportunities for all people for nearly 50 years.
Phanuel has a background in charity management and extensive experience in community engagement and development. He is passionate about raising the profile of equality, diversity and inclusion, providing advice, support and constructive challenge to leadership teams and organisations.
Phanuel holds an MBA and lives in Suffolk with his wife Shirley. He holds non-executive director and trustee roles in several health, education, and VCFSE organisations.

Kris Murali

Non-Executive Member
Kris joined the ICB Board from 1 April 2024. Kris is a finance professional and has held senior leadership roles with considerable financial, commercial and general management experience in both the private and not-for-profit sectors. Kris has been involved in managing and creating sustainable and profitable businesses and driving

efficiencies. He has worked in the private sector as well as membership and social care organisations.
Kris has considerable senior management experience, with the most recent Director of Finance and Resources at the Scout Association and prior to that as Deputy CEO of the disability charity, Sense.
At Sense, Kris managed the corporate support services including governance, as well as the trading portfolio of 115 charity shops, an shops and Sense International operating in eight countries and serving on their Board.
Kris has held Board positions in the UK and in the US and is currently a non-executive director at Youth Futures Foundation. He also serves as a trustee and Chair of Audit Committee of Diabetes UK.
In addition to his position as a Non-Executive Member of the Board, Kris is also Chair of the ICB's Audit Committee.

Lisa Nobes
Executive Director of Nursing
Lisa started her nursing career at West Suffolk Hospital 29 years ago and moved to Manchester to train and practise as a children's nurse at the Royal Manchester Children's Hospital before relocating back to Suffolk to work at the East Anglia Children's Hospice. She enjoyed working at both the hospice site and providing care to children at the end of their lives in their homes.
She left EACH to become a Lecturer in Children's Nursing and then a Senior Lecturer in Service Improvement, teaching service improvement methodologies to undergraduate and postgraduate health students. She has worked in the acute sector at both West Suffolk Hospital and Ipswich Hospital in senior nurse leadership posts, most recently as Director of Nursing at Ipswich Hospital before taking up the Chief Nursing Officer role in the Suffolk CCGs.
Her academic background is in psychology, interprofessional healthcare education and health psychology and she has recently been appointed as Senior Visiting Fellow at University of Suffolk.
She is interested in co-production of services with users and families and is keen to work with the wider Suffolk community to understand how services can be transformed to meet the needs of Suffolk residents. Nursing remains a career that she loves, and she is keen to work with senior nurse leaders across Suffolk to be the voice for nurses, midwives and allied health professionals.

Elaine Noske
Non-Executive Member
Elaine joined the ICB Board from 1 April 2024. She has extensive experience working on technology transformation within the communications industry. This has ranged from research and development of subsea optical communication systems, through to leading the development of new broadband, streaming TV, mobile and digital voice services.
She is passionate about managing change to have a positive impact on people's lives.
Elaine was previously a Non-Executive Member at ESNEFT where she focused on strategic innovation and patient quality. In addition to her position as a Non-Executive Member of the Board, Elaine is also Chair of the ICB's Quality and Safety Committee and the West Suffolk
Health and Wellbeing Alliance.

Janet Wood
Non-Executive Member and Senior Non-Executive Member

Janet is a chartered accountant, qualifying with Deloitte Edinburgh. Janet had an extensive career in NHS finance working for Redbridge Healthcare, South Essex Health Authority, and the Healthcare Financial Management Association (HFMA). Janet has held several Non-Executive Director positions in the last 20 years, primarily as Audit Committee Chair. Janet was the interim chair of the newly merged Essex Partnership Trust (EPUT) and has been the EPUT Non-Executive Director representative in the SNEE system since 2017.
Janet also volunteers in school governance. She is a member of an Academy Trust with schools across Essex, Chair of a Secondary School and a committee member of the Essex School Governors Association.

Kirsten Alderson
ICS VCFSE Assembly Chair
Kirsten Alderson is Chief Executive Officer at Suffolk Family Carers and joined the ICB Board as Voluntary, Community and Social Enterprise (VCFSE) Assembly Chair.
During 2023/24 a number of members have left the board: Geoff Dobson (interim Non-Executive Member), Steve Feast (Non-Executive Member), Steve Clarke (Non-Executive Member), Tanya Curry (Non-Executive Member), Sue Cook (Suffolk County Council Partner Member), Patrick Warren Higgs (Essex County Council Partner Member), Peter Devlin (Essex County Council Partner Member), Stuart Richardson (NHS Partner Provider – NSFT) and Dr Nick Rayner (Primary Care Suffolk Representative).
Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

There is one vacant Non-Executive Member role.

Committee(s), including Audit Committee

Audit and Risk
Committee:
- Kris Murali, Chair
- Phanuel Mutumburi
- Janet Wood
- Independent Person (vacant)

Remuneration and Human Resources Committee:
• Janet Wood, Chair
• Will Pope
• Non-Executive member (vacant)

Quality and Patient Safety Committee:

- Elaine Noske, Non-Executive Member (Chair)
- ICB Executive Director of Nursing
- ICB Executive Medical Director
- Local Authority Directors
- Alliance representatives
- Provider representatives

- Healthwatch Suffolk and Healthwatch Essex
- At least two lay members with lived experience (People and Communities Group and Patient Safety Partner)
- Other representatives where required

Finance, Performance, and Workforce Committee:

- Janet Wood, Independent Chair - the chair will be selected to ensure that the Audit Committee and the Finance Committee are chaired by different members
- Non-Executive Member (ICB appointed)
- Up to 2 Non-Executive Directors (nominated by provider partners)
- Primary Care ICB Board representative
- Suffolk and North East Essex ICB Director of Finance
- Suffolk and North East Essex ICB Director of Performance Improvement
- ESNEFT Director of Finance
- WSFT Director of Finance
- EEAST Director of Finance
- NSFT Director of Finance (non-voting member)*
- EPUT Director of Finance (non-voting member)*
- Section 151 Officer, Suffolk County Council (non-voting member)
- Section 151 Officer, Essex County Council (non-voting member)
- ICB Director of Operational Finance (non-voting member unless deputising for the Director of Finance)

  * Mental health representation and logistics to be agreed at the start of each meeting.

Strategic Commissioning Committee

- Phanuel Mutumburi, ICB Non-Executive Member (Chair)
- ICB Non-Executive Members for Finance and Quality
- ICB Chief Executive
- Regional Director Strategy and Transformation
- Nominated Executive, ESNEFT
- Nominated Executive, WSFT
- Nominated Executive, NSFT
- Nominated Executive, EPUT
- Nominated Executive, SCC
- Nominated Executive, ECC
- Nominated Executive, SNEE GP Collaborative
- ICB Deputy Chief Executive
- ICB Executive Director of Finance
- ICB Executive Medical Director
- ICB Executive Director of Nursing and Quality
- ICB Executive Director of People and Workforce
- Executive Lead, North East Essex Alliance
- Executive Lead, West Suffolk Alliance
- Executive Lead, Ipswich and East Suffolk Alliance

Other Committees Include:

- Ipswich and East Suffolk Alliance Committee

- West Suffolk Alliance Committee
- North East Essex Alliance Committee
- Executive Committee
- Integrated Care Partnership Committee

Register of Interests

The register of interest for all Board Members and regular attendees, is published on the ICB website.

Personal data related incidents

During the period of 2025/26, although minor incidents involving personal data have occurred, no data security incident met the requirement criteria to be reported to the Information Commissioners Office (ICO).

Modern Slavery Act

NHS Suffolk and North East Essex Integrated Care Board fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. While the ICB does not meet the requirements of the Act, we have chosen to produce and publish a statement on our website.

External Audit

The ICB's external auditor for 2025/26 is Ernst & Young LLP. In 2025/26, the total cost is expected to be in the region of £222,000 plus VAT.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Suffolk and North East Essex Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Suffolk and North East Essex Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Suffolk and North East Essex Integrated Care Board assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Suffolk and North East Essex Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information which the auditors are unaware of.

Dr Ed Garratt OBE

Chief Executive (Accountable Officer)

16th June 2025

Governance Statement

Introduction and context

NHS Suffolk and North East Essex Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The NHS Suffolk and North East Essex Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2025 and 31 March 2026, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Suffolk and North East Essex Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Suffolk and North East Essex Integrated Care Board's Accountable Officer Appointment Letter.

I am responsible for ensuring that the NHS Suffolk and North East Essex Integrated Care Board is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the

ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The Governance Framework of the ICB as set out in the Functions and Decisions Map is the system by which the ICB is directed and controlled in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for an ICB to achieve its clinical, quality, and financial objectives. The ICB's Governance Handbook sets out the governance structure.

All the ICB Board public papers are available on the ICB website.

The NHS Act 2006, together with the Health and Social Care Act 2012 and associated legislation, sets out the legal framework within which the ICB operates. It is a statutory requirement that the ICB Board specifies its terms of reference, schedule of reservation and delegation of powers, and the financial framework within which the organisation operates. These key documents comprise the ICB's corporate governance arrangements and include:

• The Constitution - as a framework for Board governance.

• The Functions and Decisions Map – a high-level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system.

• The Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs and as a framework for financial governance.

• The ICB Governance Handbook – which brings together all of the ICB's governance documents, so it is easy for interested people to navigate.

It is essential that the public and all employees are aware of these documents and that employees understand their responsibilities as set out within. They are therefore reviewed, updated, and approved each year at a meeting of the Board in public and made available on the ICB website and intranet.

The Membership of the Board and its statutory committees including the Audit Committee are included in the Member's report earlier in the document.

Board meetings focus on strategy, clinical and service development, finance, performance and scrutiny and governance and corporate business.

Some of the key items considered by the Board at meetings during 2025/26 included:

- Preparing for the establishment of a new NHS Norfolk and Suffolk Integrated Care Board including development of an ICB Population Health and Commissioning Strategy and Population Health Improvement Plan.
- Agreeing the Financial plan and budgets for NHS Norfolk and Suffolk ICB for 2026-27 together with the Norfolk and Waveney ICB Board and agreeing the financial plan and budgets for NHS Essex ICB for 2026-27 together with NHS Mid and South Essex ICB Board and NHS Hertfordshire and West Essex ICB.
- Maintaining continual oversight of performance in terms of activity, patient outcomes, and delivery against financial plans.
- Health inequalities and prevention.
- Assurance around the provision of Assertive Outreach following a national review.

Given the dynamic environment within which ICBs operate, even the most experienced Board Members benefit from on-going training and support. Any new Members would also need induction and training, allowing them to understand their role and the organisation's governance processes. As such, the ICB provides Board Members with regular training and development opportunities particularly through five Board Development sessions held during 2025/26.

Board development sessions are held on alternating months to Board meetings and generally cover a range of topics over several hours. The topics covered are identified by the Board and the agenda for each development session is set by the Chair. Topics may include changes to national policy, updates on local priorities, or a focus on an area where Board Members feel that they would benefit from increasing their knowledge.

Some of the key items considered by the Board at meetings during 2025/26 included:

- An NHS Confederation facilitated 'ICS Digital Leaders' session which covered the local implementation of the NHS's digital agenda.

- Fraud awareness session delivered by the local counter fraud expert particularly focused on the implications of new legislation.
- Development of the Population Health and Commissioning Strategy.
- Managing urgent and emergency care demand presented by the ambulance trust together with consultants working in the system.

The development sessions were held in common with NHS Norfolk and Waveney ICB to help develop working across the two Boards in advance of the establishment of the new NHS Norfolk and Suffolk ICB on 1 April 2026. The Board has set a programme of development sessions for 2026/27 which will focus on developing as strategic commissioners to support the new role of ICBs set out by the Department for Health and Social Care.

The table below shows Board member attendance at meetings during 2025-26.

Role	**Name**	25 April Special private meeting	20 May 2025	17 June 2025 Special private meeting	15 July 2025	23 September 2025	25 November 2025	16 December 2025 Special private meeting	27 January 2026	11 February 2026 special private meeting	25 March 2026
Chair	Will Pope	Present	Present	Present	Present	Present	Present	Apologies	Present	Present	Present
ICB Chief Executive	Ed Garratt	Present	Present	Present	Present	Present	Present	Present	Present	Present	Present
Partner Member – ESNEFT	Nick Hulme (Adrian Marr from January 2026)	Present	Present	Substitute (Adrian Marr)	Present	Apologies	Present	Substitute (Adrian Marr)	Substitute (Catherine Morgan)	Adrian Marr	Adrian Marr
Partner Member – NSFT	Caroline Donovan	Substitute (Cath Byford)	Substitute (Cath Byford)	Substitute (Cath Byford)	Substitute (Cath Byford)	Substitute (Cath Byford)	Substitute (Cath Byford)	Present	Substitute (Cath Byford)	Substitute (Cath Byford)	Substitute (Dr Faisil Sethi)
Partner Member - WSFT	Ewen Cameron	Apologies	Present	Present	Present	Present	Present	Present	Substitute (Nicola Cottington)	Present	Substitute (Nicola Cottington)
Partner Member- Primary Care Essex	Freda Bhatti	Present	Present	Apologies	Present	Present	Present	Present	Present	Apologies	Apologies
Partner Member – Primary Care Suffolk	David Cargill	Apologies	Present	Present	Present	Present	Present	Apologies	Present	Present	Present

Local Authority Partner member – Essex County Council	Moira McGrath	Present	Present	Present	Present	Apologies	Present	Apologies	Substitute (Pete Devlin)	Present	Apologies
Local Authority Partner member – Suffolk County Council	Gareth Everton	Present	Present	Present	Substitute (Clement Mawoyo)	Substitute (Louise Caesar)	Substitute (Clement Mawoyo)	Present	Present	Present	Apologies
Non-Executive Member – Audit	Janet Wood	Apologies	Present	Present	Present	Present	Present	Present	Present	Present	Present
Non-Executive Member – Finance	Kris Murali	Present	Present	Present	Present	Present	Present	Apologies	Apologies	Present	Present
Non-Executive Member – People and Communities	Phanuel Mutumburi	Present	Present	Present	Present	Apologies	Present	Present (in the Chair)	Present	Apologies	Present
Non-Executive Member – Quality	Elaine Noske	Present	Present	Present	Present	Present	Present	Present	Present	Present	Present

ICB Executive Finance and Contracts Director	Howard Martin	Present	Substitute (Chris Armitt)	Present	Present	Present	Present	Present	Present	Present	Present
ICB Executive Medical Director	Dr. Andrew Kelso/ Dr. Frankie Swords (from July)	Apologies	Present	Substitute (Ruth Bushaway)	Substitute (Ruth Bushaway)	Present	Present	Present	Present	Present	Present
ICB Executive Director of Nursing	Lisa Nobes	Substitute (Sarra Bargent)	Present	Present	Present	Present	Substitute (Sarra Bargent)	Apologies	Present	Substitute (Karen Watts)	Substitute (Karen Watts)
Member for the VCSE Sector	Kirsten Alderson	Present	Present	Present	Present	Apologies	Present	Present	Present	Apologies	Present

The Audit Committee

The purpose and key functions of the Audit Committee include the review and adequacy of:
(i) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
(ii) The mechanisms for identifying and managing key risks facing the organisation through the operational effectiveness of policies and procedures relating to internal control and risk management, including the Board Assurance Framework (BAF).
(iii) The policies and procedures for prevention, detection and management of work-related fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.
Highlights of the Committee's work included consideration and oversight of:
• The work plans and progress of the External Audit, Internal Audit and Counter Fraud programmes
• Review of the Board Assurance Framework (BAF)
• Information governance
• Approval of key policies
Internal Audit reported on a variety of items, which are discussed in the Head of Internal Audit opinion.

The Remuneration and Human Resources Committee

The purpose of the Remuneration and Human Resources Committee is to:
(i) Advise the board about the appropriate remuneration and terms of service for the ICB's Chief Executive Officer, directors, and senior managers
(ii) Under delegated powers from the board, make decisions on all aspects of the Chief Executive's, directors' and senior managers' remuneration (within the provisions of relevant national frameworks), provisions for other benefits and other contractual terms
(iii) Advise on all human resources policies, and procedures and issues that may impact the terms and conditions of employment for all staff
(iv) Advise on all matters of health and safety

Highlights of the Committee's work included:

- Agenda for Change and Very Senior Managers (VSM) pay awards
- Oversight of the Cost Reduction Programme including a complete organisational restructure
- Non-Executive diversity and capacity
- Gender pay gap
- Approval of key policies

Finance, Performance and Workforce Committee

The purpose of the Finance, Performance and Workforce Committee is to:

<u>Performance</u>

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

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

System financial management framework

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

- The Committee will develop the system financial planning processes to be used to make recommendations to the board on the system financial plan in line with strategy and national guidance
- The Committee will seek assurance that the system capital strategy and associated plan properly balances clinical, strategic and affordability drivers; ensure effective oversight of future prioritisation and capital funding bids; and gain assurance that short-, medium- and long-term commitments are built into the overall system capital plan

Resource allocation (revenue)

- To advise on the process regarding the deployment and monitoring the impact of system wide transformation funding

- To work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise

National framework

- to advise the ICB and ICS partners on any changes to NHS and non-NHS funding regimes

- to oversee national system level financial returns

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

Financial monitoring information

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

- to work with ICS partners towards common approaches across the system such as financial reporting, estimates and judgements

- to work with ICS partners, including their non-executive members, to seek assurance over the financial performance from system bodies

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

- to ensure the system develops an understanding of where costs sit across a system, including its cost drivers and the impact of service changes

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

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

Financial Performance

- to oversee the management of the system financial target

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

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

- to monitor and report to the ICB key service performance which should be considered when assessing the financial position

System efficiencies

- to ensure system efficiencies are identified and monitored across ICS partners, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged

- to ensure financial resources are used in an efficient way to deliver the objectives of the ICS

- to review exception reports on any material breaches of the delivery of the agreed efficiency plan including the adequacy of proposed remedial action plans

Communication

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

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

People

- to ensure an ICS wide finance staff development strategy is in place to ensure excellence by attracting and retaining the best finance talent

Capital

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

Internal ICB finances

- to ensure development of a reporting framework for the ICB (using the chart of accounts devised by NHS England and the integrated single financial environment (ISFE))
- to oversee the management of the ICB's own financial targets.
- to oversee the development of the ICB financial strategy and agree key outcomes to assess delivery
- to ensure that suitable financial policies and procedures are in place for the ICB to comply with relevant regulatory, legal and code of conduct requirements

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

We have reported on our corporate governance practice by adhering to best practice available and leveraging guidance from the UK Corporate Governance Code, specifically focusing on leadership, effectiveness, and accountability, as deemed pertinent to the ICB and best practice standards. Moreover, it's important to highlight that each director within the SNEE ICB has proactively ensured that any pertinent information, crucial for the auditors' audit report but previously unknown to them, has been promptly brought to their attention and addressed accordingly.

Discharge of Statutory Functions

NHS Suffolk and North East Essex Integrated Care Board have reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all the ICB's statutory duties.

Risk management arrangements and effectiveness

During 2025-26, the organisation's processes for effective risk management were organised in line with the ICB Risk Management Strategy and Organisational Framework and the Board Assurance Framework.

The Executive Director of People, Governance, and Corporate Services is the designated lead for overseeing the day-to-day coordination of risk management reporting arrangements, including training, and is a resource for all risk-related issues. The Governance and Risk Manager supports directors, heads of department and line managers, whilst also scrutinising all identified risk and incident data. As the designated lead, the Executive Director of People, Governance, and Corporate Services works in partnership with:

- The Risk Manager who acts as the ICB's 'Competent Person
- The Executive Director of Nursing with respect to risk management requirements set out in the Care Quality Commission standards
- The Associate Director of Data Security, Risk and Protection who is the ICB's operational lead for Information Governance and Data Protection and the Deputy Senior Information Risk Officer

Equality Impact Assessments were conducted at the outset of setting strategy and delivering services across the commissioning cycle, ensuring a control and assurance culture through risk, incident, and complaints management. This in turn ensured a clearly defined culture of equality across the ICB's activities.

Capacity to Handle Risk

The board considers the Board Assurance Framework at every meeting held in public. The Board Assurance Framework is regularly circulated to all the ICB's executives and senior officers outside of the board meeting to ensure that entries are kept up to date. The Board Assurance Framework identifies the key risks to delivery of the ICB's strategic objectives and areas of elevated operational risk.

Committees of the board review the relevant Board Assurance Framework entries and consider the risks relevant to their remit at every meeting. Every risk is owned by at least one executive director/s. They are responsible for regularly reviewing the entry and providing updates on additional mitigations, controls, or sources of assurance that have been identified. The Audit Committee has oversight of the risk management process and has established a Risk and Resilience Group to bring together operational leads for risk management from across the ICB to review the risk register and risk management processes.

Internal Audit undertook a review of risk management arrangements during 2025-26 and has identified further improvements which will help to inform the development of the

Board Assurance Framework and risk management system for the new Norfolk and Suffolk ICB.

The ICB's risk and control mechanism is described below:

- The ICB identifies risks in several ways, including through workstream risk assessments, regulatory inspections, audit reports, serious incidents, public and stakeholder engagement, and service delivery plans.
- When a significant risk is identified that may impact upon the ICB's ability to realise its strategic objectives, this is added to the Board Assurance Framework (BAF) which is owned by the Integrated Care Board.
- The board identifies ways that it can reduce the likelihood of the risk occurring, reduce the impact of the risk should it happen, and mechanisms for monitoring risk.
- Once these have been identified they are recorded on the BAF and monitored by the board, the Executive Committee, and the relevant committees of the board.

Risk Assessment

The Board Assurance Framework (BAF) provides the ICB with a simple but comprehensive method for the effective and focused management of risk. Through the BAF the Board gains assurance from the Executive Team that all risks are being appropriately managed throughout the organisation.

The BAF identifies which of the organisation's strategic goals may be at risk because of inadequacies in the operation of controls, or where the ICB has insufficient assurance. It encompasses the control of risk; provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the board to determine how to make the most efficient use of resources and address the issues identified, to continuously improve the quality and safety of healthcare commissioning.

The likelihood and consequences of all risks on the ICB Risk Register are scored against a 5x5 risk matrix, to ensure consistency in the risk assessment process. Risks of sufficient concern to the organisation inform the board's agenda and are assessed for escalation to the BAF. The management of risks differs according to their likelihood and consequence, and the risk matrix allows priorities to be assigned for remedial action and assessment of whether risks should be accepted. This system is also used to review how well the agreed controls are operating.

The subsequent red, amber, green (RAG) scores indicate the level at which identified risks will be managed within the organisation. They also assign priorities for remedial action.

In terms of evaluation of effectiveness, the confidence the ICB has in the assurances upon which it relies to assess whether controls are operating as expected:

Substantial: The scope of assurance noted on the current BAF demonstrates that the Controls are effectively managing the risk.

Adequate: There is a full range of assurances in place and no material issues have been identified with the effectiveness of controls. Assurances are reflecting the need to fully embed controls.

Limited: Either some of the assurances noted on the current BAF demonstrate that the controls in place are not effectively managing the risk and action is required to address and/or there are gaps in assurance.

None: The action that the ICB takes to respond to a risk is guided by its risk appetite. The ICB may choose to terminate the activity, transfer the risk, treat the risk, or it may decide that the risk is at an acceptable level and tolerate it.

The tables below provide a brief summary of the strategic risks affecting the ICB during 2025-26 which remain at the highest level of concern, the controls identified, gaps in those controls, assurance, and gaps in assurances. The full Board Assurance Framework (BAF) reported to every public meeting also includes a summary of management actions taken in the reporting period.

A key change to the BAF following establishment of the ICB has been to address risks on a system wide basis wherever possible rather than focusing upon issues arising with individual partners. This recognises that most risks are complex which can have an impact across the system and therefore require joint working to address.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR1	**System Accident & Emergency Services** The ICB continues to be under significant pressure. While it benchmarks well against other regional systems, it continues to fail several well-established standards.	Limited	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each Board meeting and to the relevant Board Committees.

Current Controls
1. System Coordination Centre (SCC) managing daily operational issues (proactive and reactive) inc. On Call
2. Integrated business planning and delivery oversight – strengthened and ongoing for 2025-26 (local, regional and national). Medium term planning from 26/27 has commenced in line with NHS England planning framework. In November 2026 there is a joint NHSE, ICB and ESNEFT deep dive focusing on assurance and improvement.
3. Organisational and integrated system improvement plans and delivery oversight (inc. SNEE UEC Forward Plan; UEC demand management (PA Consulting Phase 2; bespoke improvement initiatives (e.g. Ipswich Hospital's 'Time to Care'). Bespoke improvement support from NHS EOE Performance Team to ESNEFT. Initially focused on Ips Hosp, now extended to Colchester.
4. Digital support (e.g. Shrewd to support proactive management)
5. Seasonal variation planning (specific focus on winter 2025-26 preparedness aligned to NHS England's 2025-26 UEC Plan). By mid Nov, EEAST is expected to confirm additional non-recurrent resource funding to strengthen UCR.
6. Alliance governance and oversight – including BCF and the discharge funds process.
7. Refreshed and streamlined governance (performance oversight – collaboration with NHS EoE)

8. Change mgt (inc. Restructure transition management; NHSE Gateway Reviews (EPIC))
9. Clinical Advice Service available to EEAST crews to support use of alternative pathways
10.Handover in 45 mins processes in place across all sites, and Rapid Release process in place to support immediate release of ambulance crews as required
11.Clinical Risk Review Panel established – a forum for the senior clinical leads in the SNEE UEC system to collaboratively identify, review key clinical risks & proposed mitigations.
12.WSFT TES review group is embedded as a robust means of reviewing harm from TES.

Gaps in controls
1. Sustained unwarranted variation in practice and performance between providers that doesn't align to nationally recognised good practice (NHS England's Impact Programme). *Mitigation:* Heighten focus on compliance with national guidance (GIRFT/IMPACT)
2. Workforce constraints (culture to deliver pace and scale of change required; NHS restructure). *Mitigation*: Collaborative system working – prioritisation, planning, delivery and assurance with focus on delivering improvements and mitigation of risk.
3. Suboptimal focus on robustly evaluating the impact of investment/change and taking informed decisions thereafter. *Mitigation*: Enhanced working with ICS Intelligence Function (inc. 2024-25 Winter Debrief and 2025-26 preparedness; UEC Demand Mgt; UEC Forward Plan).
4. Capturing harm from delays – EEAST currently captures & reports incidents where system pressures have created delays in responding to C2 calls and have caused a patient safety incident of moderate harm or greater. There are, however, other instances of patient harm where system pressures have created delays and caused patient harm that we may not be routinely capturing. *Mitigation:* harm review group to review identified system delay incident & agree processes for capturing other incidents. TES audits planned across SNEE to provide assurance of safety & experience standards. Jan 2026 - Action from Clinical Risk Review Group to look deeper into how we capture harm from system delays.

Current Assurances
1. Information system that tracks live and historic demand against forecast to inform proactive and real time management of demand.
2. Provider, system and NHS England governance re planned versus actual delivery (performance, improvement and quality)
3. Regulator, SNEE ICB and NHS England quality and practice reviews (inc. CQC)
4. Active participation in NHS England improvement initiatives (e.g. LINs)

Gaps in Assurances
1. Infection outbreaks not predictable, however, there is greater focus on prevention (practice and capability)

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR3	**System Referral to Treatment (RTT) System failing** System failing to meet Constitutional Referral to Treatment Target of 18 weeks, meaning patients do not receive care within expected standards	Limited	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each Board meeting and to the relevant Board Committees.

Current Controls
1. Established trust-led elective change programme (ECPB) (inc. productivity, demand management and referral optimisation).
2. Detailed portfolio, specialty and diagnostic delivery plans with supporting organisational and system oversight - strengthened and ongoing for 25/26 (inc. NHSE-led tiering; NHSE GIRFT visits; fiscal monitoring).
3. Strengthened interface with dependent services (inc. alliance led 'Waiting Well' programmes; primary and secondary care (Advice & Guidance); referral optimisation; GIRFT Community MSK initiative; Healthwatch Suffolk patient insight (May 2025))
4. Mutual Aid arrangements to support delivery to trajectories (in and beyond SNEE ICB)
5. Strengthen commissioning and contract mgt within the ICB (inc. review of clinical policies; mgt aligned to NHS commissioning cycle; use of independent sector)
6. Plan to achieve full operating capability of ESEOC agreed at May ICB FPW Cttee. Delivery oversight in place.
7. System action plan developed in response to the Healthwatch Suffolk report into waiting for treatment. Actions 1-6 completed (detailed in Nov Planned Care Group Quality report). Three new actions added following a deep dive into elective care at the ICB's Quality Committee: system approach to harm from long waits reviews; review of pain provision in SNEE; further review of the resources available for people waiting for treatment by people with lived experience.

Gaps in controls
1. Workforce constraints (inc. culture to deliver pace and scale of change required; NHS restructure; and recruitment challenges impacting maximisation of diagnostic provision, part. Newmarket CDC). *Mitigation*: Collaborative system working – planning, delivery and assurance with focus on achieving improvements and mitigation of risk; WSFT Tier 1 (elective and diagnostics); attendance at regional events (LIN and Masterclasses).
2. Sustained unwarranted variation in practice and performance between providers that doesn't align to nationally recognised good practice (NHS England's Impact Programme). *Mitigation:* Heighten focus on compliance with national guidance (GIRFT) inc. participation in nat.

improvement schemes (e.g. MSK Community) where resource permits; ICB-led service reviews (e.g. gynae and derm) to evidence provision aligns to pop. need and good practice; attendance at regional events (LIN and Masterclasses).
3. Ring-fenced bed capacity is not available for some specialities (especially orthopaedics at WSFT). The risk has been reduced somewhat by the opening of the Elective Orthopaedic Centre (The Dame Clare Marx building) in Oct 2024.

Current Assurances
1. Oversight by the ICB's Planned Care Group in context of overall ICB governance model
2. Joint Elective Care Programme Board chaired by ESNEFT & WSFT
3. Monthly system performance reviews in collaboration with NHSE
4. Tiering oversight process (WSFT elective, diagnostics & cancer)
5. Regional Acute Planned Care Taskforce
6. Regional sitrep returns and national oversight (inc. GIRFT engagement)
7. Active participation in NHS England improvement initiatives (inc. LINs; GIRFT; Masterclasses)

Gaps in Assurances
1. A consistent & robust approach within SNEE to identify, understand and mitigate patient harm (physical & psychological) in the context of elective care was challenged at the Sept ICB Quality Cttee. This was particularly evident in relation to the dissonance between lived experience insight from HWS (May '25) and the stance and practice within trusts. *Mitigation:* Draft policy currently in review for the system to adopt – discussed at the Nov Patient Safety Collaborative with further work in progress.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR8	**System Mental Health Services** The inability to demonstrate appropriate safety and mortality standards throughout mental health services, presenting significant patient safety risks to the population of SNEE	Limited	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each board meeting and to the relevant board committees.

Current Controls

- NSFT Improvement Board
- EPUT SOF 3 Oversight action plan/Quality Together Meeting
- Essex Quality collaborative/single contract for
- EPUT Time to Care.
- EPUT International Fundamentals of Care programme.
- Pathways for inpatients with physical health issues is a risk identified by NSFT and is on their risk register with senior nurse oversight and support from ICB.
- NSFT OOA reduction programme.
- EPUT Learning from Death Oversight Group (LDOG).
- Focused ED MH visits project action plan, overseen by ICB.
- Right to choose accreditation scheme pending
- ICB Public Information page re ADHD and ADHD prescribing
- EPUT Assertive Outreach options paper due December 2025 followed by public board wrap-up statement/report.

Gaps in controls

- Strategic vision for quality improvement from NSFT.
- Detailed outcomes from quality strategy required from EPUT.
- Community transformation plans from EPUT and NSFT (awaited)
- Lead-time wait on ADHD accreditation framework
- Challenge in monitoring performance and quality outcomes for private providers
- Right to Choose will not effectively mitigate as independent provider lists may increase and people will have to wait longer than 18 weeks
- Long term funding commitment to mitigating services, such as the NSFT? Recovery College

Current Assurances

- Both NEE and Suffolk have improved their performance for SMI health checks for people in the community with support from VCSEs and other providers.
- Right to choose accreditation scheme pending
- ICB Public Information page re ADHD and ADHD prescribing
- Ardleigh Ward review underway and interim actions taken to improve local leadership
- Quality Handover to Essex ICB completed

Gaps in Assurances
• The Right to Choose will not effectively mitigate as independent provider lists may increase and people will have to wait longer than 18 weeks • Ongoing numerous complaints by people having poor experiences of ADHD pathway

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR10	**Access to Primary Care** Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).	Adequate	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each board meeting and to the relevant board committees.

Current Controls
1. Development of Primary Medical Care Forward Strategy and Plan towards new models of care to include safe working levels
2. Recruitment and retention programmes (clinical and non-clinical) including Additional Roles Reimbursement Scheme (ARRS) roles.
3. Workload management models
4. Development of PCN estates plan and delivery of new digital support
5. GP recovery plan and action plan
6. CBT and online consultation tools to increase access
7. SNEE General Practice Assurance Framework
8. Practice level support programmes such as SLF and MGP underway

Gaps in controls
1. GP recruitment and retention programmes do not yet meet full demand
2. Workload management models require OD support not yet funded or fully in place
3. National estates planning tools have not fully reflected local need and goals – local supplementary work in place

4. Operational delivery plan in place and actions identified

Current Assurances
1. Primary Care Commissioning Groups
2. Training Hub Operations Group (THOG)
3. Operational Support: (PM meetings / PCN CD and PCN Business Manager Meetings
4. ICB wide GP Executive
5. Monthly ICB and LMC meeting
6. Monthly SNEE PMC MDT
7. Joint Primary Care Strategy and Policy Group

Gaps in Assurances
1. Further work is required to align the given controls to provide collective and comprehensive assurance.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR11	**Cyber Security** Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc.	Adequate	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each board meeting and to the relevant board committees.

Current Controls
1. Microsoft MFA.
2. Ensuring backup and restore mechanisms are in place.
3. Next Generation Firewalls.
4. Monthly Penetration testing.
5. Immutable backups.
6. Anti-virus via MDE.

7. Encryption.
8. Machine based VPN.
9. Data housed in secure data centres.
10.Microsoft Entra for logins
11. SIEM monitoring.

Gaps in controls
1. Regularly tested cyber response.
2. Confidence in Primary Care cyber coverage (introduction of smart firewalls has helped).

Current Assurances
1. External and internal audit.
2. Monthly SLA provider meetings.
3. Monthly service review provider meetings.
4. Audit Committee review.
5. Cyber Essentials Plus accreditation
6. Secure Email accreditation (DCB1596)
7. DSPT – CAF 2024/25 standards met
8. AI Policy approved
9. Cyber, IT. IG, AI, EPRR drop-in sessions for staff

No Gaps in assurance were identified.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR12	**Workforce challenges across the system**	Adequate	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each Board meeting and to the relevant Board Committees.

Current Controls
1. The SNEE ICB Workforce Team has agreed programmes of work which set out a plan to deliver the three core areas of the NHS Long Term Workforce Plan and the Adult Social Care Workforce Plan – Train (grow), Retain and Reform.
2. The Finance, Workforce and Performance Committee has set a monthly rhythm now and includes DoFs, HRDs and DoO which allows for a triangulated conversation on the Operating Plan. Each provider submits a Highlight Report on the key workforce areas (bank/agency spend and use, establishment control, retention) with an opportunity for queries to be raised and asked. Risk escalations are presented to the Committee. • A Delivery Group consisting of deputies formulates/discusses any risks or details ahead of the committee • NHSE has also established monthly system review meetings to check and challenge the Operational Plan progress
3. Several workstreams associated with certain occupational groups: Healthcare Science, Allied Health Professionals (AHPs), Medical, Dental and Pharmacy. There is also an agreed programme with providers and the HEIs on Clinical Expansion, focusing on social and community.
4. Programmes to address specific challenges such as a Cancer and Diagnostic Workforce Plan. The Maternity and INTs Workforce Plans are currently being reviewed and refreshed. The EoL programme has led to additional capacity been provided to support delivery across the hospices.
5. Working alongside the ICA, the ICB will aim to increase the capability of workforce planning by running more courses in the Essentials of Workforce Planning, Cost Management and Intermediate courses in workforce planning.
6. Working with system partners to improve alignment between workforce metrics, finance and activity to identify both productivity metrics and areas of agreed focus for productivity improvements.

Gaps in controls
The People Plan needs to be refreshed and updated. This includes the NHS 10 Year Health Plan for England, Future Shift Aspirations, future demand/capacity work, and the revised Health Workforce Plan (due Spring 2026). There is uncertainty around the future of ICBs and the workforce function within the new model. The new ICB structure shows a smaller team which may decrease capacity at a system level.
As a new committee, format and flow is still being worked through.

West Suffolk Alliance has a workforce group focused on locality plans. NEE and IES Alliances are still in discussion. Lack of funding has hindered the development of these plans due to capacity constraints.
Lack of funding has hindered the development and progress of these plans due to lack of project capacity.
Although funding is available, this will now cease in December '25
Agreement on metrics is being measured.

Current Assurances
ICS Anchor Summary data is reported to the Integrated Care Partnership Committee and Anchors Board.
Workforce Dashboard is reported to the System Oversight and Assurance Committee and then to the ICB Board. The dashboard reports on key performance indicators associated with the Annual
SNEE Operational Planning, Workforce Delivery Group is to oversee delivery of High Impact Actions and align the workforce returns with the financial returns to demonstrate performance and any deviation from the Annual Plans from WSFT, ESNEFT and EEAST.

Gaps in Assurances
The underlying problem of staff supply across both the system & more widely across the national health and social care remains.
Budget constraints at system or provider level result in the workforce plan not being affordable.
With the newly clustered Norfolk and Suffolk ICB, decisions on how the infrastructure support groups will be facilitated in April onwards will need to be agreed.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR16	**EEAST Performance & Quality** EEAST is not achieving national	Limited	Severe	High	The risk remained elevated and was closely monitored throughout the year.

	performance targets, particularly C2 target of <30min mean for 2023-24 as a whole.				Performance was reported to each Board meeting and to the relevant Board Committees.

Current Controls
1. Governance, inc. monthly strategic oversight & assurance meeting against agreed business plan – Regulator & Lead Commissioner at Chief Executive level
2. Monthly deep dive on specific areas for assurance on improvements – Commissioners & Provider
3. Local monthly quality & performance meetings at ICS level (region-wide)
4. Weekly patient safety reports
5. Operational Improvement plan agreed by NHSE regional team and Commissioners for 2025/26 areas of focus
6. PA Consulting Phase 1 review completed – Change Programme initiated and reflected in the agreed '25/26 Business Plan. Phase 2 Report delivered – All opportunities accepted and being progressed within ICBs/EEAST, with regional-level governance led by the Lead Commissioner in place.
7. Winter preparedness measures are live within EEAST and in collaboration with EoE ICBs. NHSE assurance. - EEAST has a nominated director in each ICB. SOC now has a dedicated EEAST lead for support. Escalation processes have been reviewed. An EQIA has been completed to support winter planning.
8. A Clinical Risk Review Panel has been established for SNEE. This isa forum for the senior clinical leads in the SNEE UEC system to collaboratively identify and review key clinical risks & proposed mitigations.

Gaps in controls
1. Achieving PFSH target, OPIP targets, and handovers does not always lead to expected performance.This is not fully understood by EEAST, systems or region. Work is ongoing to understand why.
2. An escalation process between EEAST & ESNEFT for delays is fully embedded.However, activity does not align to ESNEFT's Arrival to Handover (A2H) plan.
3. An action was taken at the last Clinical Risk Review Panel to look deeper at capturing harms from system delays.

Current Assurances
1. Oversight of EEAST Operational Improvement & Workforce Plan and regular conversations about 25/26 delivery with Commissioners, regulator and partners (inc. EOE ICBs)
2. Updates and oversight at OSM of OPIP
3. Clinical review of safety incidents via EEAST's safety process, ICB and regulator governance
4. Oversight of local EEAST improvement plans now delivered at ICB system level
5. Escalation where necessary to Quality Committees

6. Clinically-led rapid review ongoing, focused on latest CQC report with regular assurance through ICB and consortium governance

No gaps in assurance were identified.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR19	**System Cancer Standards** System not meeting the cancer related standards within the NHS constitution, leading to worsening patient outcomes and quality of services	Limited	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each Board meeting and to the relevant Board Committees.

Current Controls
1. Annual Cancer Plan 25-26 and wider five-year Cancer Strategic Plan
2. Recovery Plans in place for both our major cancer providers (WSFT and ESNEFT)

Gaps in controls
1. It is not the case that the controls are not working however there are a combination of the following factors impacting performance: a. Demand b. Staff sickness c. Workforce gaps 1. Recruitment freeze e. System financial position f. Impact of recently announced ICB restructures g. Implementation of EPIC
WSFT is due to be removed from tier 1 for cancer due to improved cancer waiting time performance. However, ESNEFT has entered national tiering for cancer.

Current Assurances
1. Performance overview by monthly SNEE Cancer Ops Group
2. Weekly cancer focused reporting with ESNEFT & WSFT PTLs in place
3. Monthly joint performance meetings with ESNEFT & WSFT
4. Bi-monthly SNEE ICS Cancer Committee
5. Bi-weekly tiering meetings with ESNEFT

Gaps in Assurances
Assurances are appropriate, but risk is not being completely mitigated due to reasons set out in 'gaps in control' above.
There is regular monitoring of the risks to the current transformation programme and escalations, as required.
Monitoring of cancer waiting time performance lies with ESNEFT, the ICB and the National team.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR25	**Failure to meet statutory ICB financial targets** The inability to at least break even or ensure both capital and revenue resources do not exceed the limit set by NHSE or ensure expenditure on running costs does not exceed the limit set by NHSE	Adequate	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each Board meeting and to the relevant Board Committees.

Current Controls
1. Internal expenditure controls, including Vacancy Approval Panel etc
2. Contingency reserve
3. Projected underspends in Dental and Specialist Commissioning
4. Detailed Cost Improvement Plans
5. Double Lock Arrangements for WSFT
6. Production of the WSFT FRP and detailed review

Gaps in controls
1. System finance risk associated with WSFT not delivering a plan commensurate with a £1.3m run rate deficit etc
2. Payments limits policy being removed (not confirmed at point of writing)
3. Core plans for TIF (ESEOC and GSH) mitigation

Current Assurances
1. Internal Audit of key financial controls etc
2. Internal Audit against HFMA Financial Sustainability Checklist
3. Oversight by ICB Finance Committee & Financial Recovery & Sustainability Group
4. Monthly director budget scrutiny meetings
5. Alliance Committee scrutiny of delegated budgets
6. Vacancy Approval Process to remain in place
7. Double Lock approvals for WSFT pay and non-pay

Gaps in Assurances
1. Not currently assured on the WSFT delivering the recovery plan which forecasts a revised deficit of £28.5m etc
2. Current gap in system mitigations to offset the deterioration at WSFT

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR29	**Consequences of Climate Change** Risk to health and social care service delivery	Adequate	Severe	High	The risk remained elevated and was closely monitored throughout the year. The level of assurance did improve as the reporting on the implementation of the Green Plans across the ICB and providers developed.

Current Controls
1. ICB Green Plan Etc for all boxes like this

2. Multi-agency planning by LRFs
3. Trust S18 SC annual report returns received
4. Surface water flooding plan
5. Air Quality system-wide work
6. SIA Launch (commissioning)
7. Standard NHS T&Cs (procurement)
8. Mandatory net zero training (workforce)

Gaps in controls
1. Trusts Green Plan returns & governance
2. Primary care PCNs awareness & adoption

Current Assurances
1. ICS Board oversight & approval
2. LRF Executive Boards
3. Debriefs held after incidents
4. ICB Sustainability Steering Group meetings underway
5. Trust steering groups and Estates teams now commenced integrating approaches following ICB BAF driving system (requires further integration)

Gaps in Assurances
1. Trust green plan returns/governance have identified where additional work is necessary, including adaptation of premises to reduce risks associated with climate change/severe weather.
2. One trust return on NZ Technical Annex progress remains outstanding.
3. Unaware of the current position relating to PCN infrastructure strategies within social care and their climate adaptation & resilience planning.
4. S18 Standard Contract returns & NHS Quarterly returns are too ‘high level’. Data returns & links to EPRR and wider system approaches are required
Trusts’ Steering Groups are not always attended by theme leads (system pressures etc) and this leads to a gap/disconnect between theme leads ‘owning’ and managing a specific theme for reporting, scrutiny and integration.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR30	**Risk of Failing to Ensure Comprehensive FTSU arrangements** Recent Lucy Letby trial & conviction demonstrates the risk of not having robust FTSU arrangements in place within a listening organisation.	Risk closed	Risk closed	Risk closed	The ICB launched a new independent freedom to speak up service which is operating well. The Board de-escalated the risk and the operation of the service is overseen by the Remuneration and HR Committee.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR31	**Impact of the presence of RAAC on the Suffolk and North East Essex ICS** Reinforced Autoclaved Aerated Concrete (RAAC) has been identified at West Suffolk Hospital and at a few primary care sites across the ICB area meaning that the safe life of the buildings was significantly shorter than expected.	Substantial for NHS Estate (Limited in the wider	Moderate	High	SR31 was amended during 2025/26 to encompass the wider healthcare estate in SNEE rather than focus on the West Suffolk Hospital site as it had previously. The Board received positive assurance that required mitigation across the primary care estate and West Suffolk Hospital had been completed.

Current Controls
1. Local and regional plans are in place and aligned with regional oversight group established
2. WSFT has surveillance program/remedial plan to ensure safety of patients, visitors and staff
3. WSFT internal expert leadership team
4. The ICB has received assurance from all primary medical providers that they have not identified RAAC in their premises
5. Incidents or Events are routinely monitored through the EPRR Team

No gaps in controls were identified.

Current Assurances
1. Risk and assurance are reviewed through the Estates Committee
2. The outcome of Exercise Vesta held to review the SNEE and wider LRF response to an incident at WSFT
3. Regional exercises (Walker and Fox) were held to develop regional evacuation/shelter planning
4. Ongoing assurance is provided to the ICB from the WSFT risk meetings
5. An EPRR Forum is in place within the system which reviewed the SNEE RAAC Framework in 2023
6. A Quality Review was undertaken by the ICB Quality Team to ensure a safe patient environment
7. WSFT has shared its decision-making governance process with the ICB

Gaps in Assurances
1. The presence of RAAC in the wider health care estate is still unknown. Until the ICB is able to gain assurances about this, we will be exposed to an unknown level of risk.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR32	**System Children and Young People services (inc. SEND)** Children and Young People cannot access the appropriate health services in a timely way, including those children	Limited	Severe	High	The risk remained elevated and was closely monitored throughout the year. Performance was reported to each board meeting and to the relevant board committees.

	whose special educational needs are not being met sufficiently across SNEE.				

Current Controls
1. CYP - ICB Escalation and flow management in acute hospitals.
2. Regular system calls for CYP with involvement of all partners and ICB to manage clinical risk, share information and plan delivery of care.
3. NDD controls – monthly meeting with providers and the ICB and weekly recovery meeting in Suffolk with system colleagues to review recovery plans and any key challenges.
4. NDD SNEE – recovery plans and additional investment from ICB agreed and accelerated plan to access assessment agreed.
5. NEE North East Essex – feeding into the wider Essex SEND Joint Commissioning Group.
6. MH controls with NSFT for CYP waiting - SUTL and waiting list management protocols of clinical harm processes. CAMHS/YAMHS recovery plan in development with regular meetings between NSFT and the ICB.
7. MH Delivery Group in place across Suffolk with focus on improvements to the model and timely delivery of services.
8. Health providers across SNEE have SEND processes and monitoring in place for input to statutory processes.

Gaps in controls
1.Credible recovery plan for CAMHS/YAMHS at NSFT not yet in place and NSFT reporting for CYP MH waiting times for MH treatment in NSFT not improving. Data quality cited as a factor but needs to be better understood.
2. Final trajectories for NDD recovery. not in place yet for SNEE.

Current Assurances
1. Local protocol and processes and additional MH staffing in A and E for managing escalating need.
2. Weekly recovery calls with system partners. Update and agreement for decisions provided to Suffolk CYP Committee, Suffolk SEND Programme Board and Suffolk SEND Partnership Board and in NEE the NEE Alliance Cttee as needed, and the Essex SEND JCG and Partnership Boards.
3. Monthly meetings to review / challenge quality performance with providers.
4. MH - NSFT monthly meetings between ICB and NSFT on CAMHS/YAMHS recovery.
5. Regular reporting and escalation of issues through QC/ ICB CYP MDT/MH Steering group/CYP Board.
6. ICB Health and LAP quality audits of plans across SNEE.
7. Although final NDD trajectory plans are not finalised due to the variation in timeframes for procurement, WSFT ASD under 11 are already having assessments completed by their commissioned partner and waiting times are reducing.
8. Suffolk SEND Improvement board and SEND committee are both monitoring the priority action plan and there are 6 monthly deep dives by DfE and NHSE which are demonstrating improvements.

Gaps in Assurances
1. Gap in information provided re over 11s autism performance recording. Data now being received since May 2025.
2. NEE SEND LAP have identified a review of Partnership Board governance and risks required.
3. Waiting times for MH treatment in NSFT not improving. Data quality cited one possible factor but needs to be better understood.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR33	**BMA GP Collective Action** Following the referendum held by the British Medical Association (BMA) regarding the 2024/25 Contract, where the contract changes were rejected, general practice has voted to take collective action.	Substantial	Low	High	This risk was added in year and captured the potential impact on patients from the ongoing contractual dispute between GPs and NHS England.

Current Controls
1. ICB and Suffolk LMC worked transparently to share intelligence. Yet to be stood up for 26/27
2. Practice level analysis and tracking to understand impact and track risk. TBC
3. EPRR response and co-ordination (C3 structure –currently stood down).
4. Operational and system response groups (Primary care cell – currently stood down).
5. BI modelling data to inform decision may be required
6. Monthly MDT for primary care, includes all enablers.

Gaps in controls
1. Full individual practice-based intelligence of actions being implemented

Current Assurances
1.Monthly ICB and LMC meeting
2. Monthly SNEE PC MDT
3. Primary CA care cell
4. BI activity monitoring
5. LPC and ICB meetings
6. Weekly CA LMC/ICB meetings

Gaps in Assurances
1. Further work required to align the controls to provide collective and comprehensive assurance.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR34	**Organisational Change and Cost Reduction** This risk was added to the risk register in May 2025 following the	Substantial	Low	High	The risk score has consistently declined throughout the year and the assurance rating has improved. The transition programme

	announcement of the ICB reorganisation.				will be completed in the first quarter of 2026/27.

Current Controls
SNEE ICB and N&W ICB have appointed a Chief Executive, Chair and Director Team to enable clustering of services and the development of a single structure to deliver services effectively across both ICB areas. Interviews have commenced for the filling of all other posts.
SNEE ICB representation on regional and national planning groups.
Establishment of a staff reference group and promotion of staff networks
Engagement with staff and Trade Unions is in place to ensure clear communication and support.
Development of detailed plans and a regional due diligence checklist, a Transition Committee, and appointment of Transition Directors to lead the programme
Remuneration & HR Committee is meeting monthly to receive assurances on the HR processes underpinning the cost reduction programme.
Transition Committee is meeting on a fortnightly basis and is receiving updates on all 13 workstreams (this is a joint N&W and SNEE forum).
A full Equalities and Health Inequalities Impact Assessment (EHIIA) has been co-produced by the SNEE Staff Networks and Staff Reference Group, this includes a full action to mitigate the impacts.
High-level plans were submitted to national and regional teams in May 2025, October 2025, December 2025 and February 2026. No further future submission dates.
Executive Director collaboration regarding the final viable, costed structures.
Shared risk registers, plans and actions between N&W and SNEE ICBs accessible on a shared platform.

Regional Assurance Checkpoint took place in October, December 25 and February 26 (received high level of assurance),schedule of remaining checkpoints provided by Region have now completed.
The Transfer Schedule (legal instrument for transferring staff and property) has been completed, approved and signed by both NHS Essex ICB and NHS England.

Gaps in controls
Capacity of teams to complete the transfer (on-boarding and off-boarding) during a period of interviews and redundancies.

Actions being taken to improve assurance	**Implementation date**
Shared risk registers, plans and actions between N&W and SNEE ICBs	Complete
Collaborative working MoU approved	Complete
Attendance at all national and regional meetings	On-going
Adherence to all national and regional timeframes	On-going

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR35	**ISFE2 Implementation** A new Integrated Single Financial Environment (ISFE2) was launched across NHSE and all ICBs in October 2025. There were significant concerns about the functionality of the new system and the impact this would have both on immediate operations and end-of-year reporting.	Limited	High	Low	The entry was added in year following concerns raised by the Audit Committee. The risk remained high

Current Controls
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 and in a good place
Hypercare support available
Training provided to non-finance staff by the ICB has reduced invoice levels, but not to the levels seen before ISFE2.

Gaps in controls
NHSE has released cutover and local change plans but they have been significantly delayed. A training plan has been issued but is of poor quality, leading to ICBs encountering issues on use and NHSE/SBS having to find workarounds.
The team is inundated with requests meaning it takes longer to resolve issues as there is less opportunity to contact them.

Current Assurances
Assurance provided to the audit committee in respect of progress, concerns, issues etc.
Reporting to FRSG in respect of board progress
Project hub document completed by NHSE / SBS detailing tasks / progress
User Acceptance Testing has been reported to be positive and only a few issues identified
Previous finance system (ISFE 1) will remain open for a period of time.

Reporting on invoice levels to ensure suppliers aren't struggling due to delayed payments. NHSE has contacted suppliers in any cash distress to inform them directly.

Gaps in Assurances
NHSE falling behind on tasks – new document to be circulated so current version is out of date. Project closure checklist has not been completed and is delayed until further notice.
The ICB has no sight of this
Have not been made aware of how the old system will operate once ISFE2 goes live.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR36	**Impact of ESNEFT Epic EPR Implementation Across the ICS** The implementation of a new Electronic Patient Record at ESNEFT would have impacts across the system relating to interoperability.	Risk closed	Risk closed	Risk closed	This risk was added in year and then closed at the end of November following the successful launch of the new EPR at ESNEFT in October 2025.

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR37	**Finance Team Transition** There was a significant risk that the organisational change and implementation of the new	Substantial	High	Low	This risk was added in November 2025 following escalation by the Transition Committee.

	ledger system (ISFE2) would impede the Finance Team's ability to deliver the required transition tasks on time.				

Controls

- Proactive communication with NHSE to establish timelines
- Issues with new ISFE2 system raised
- Engagement with staff who are facing additional pressures due to issues created by the new ISFE2 system
- Support offered where possible to address low morale due to restructure and increased workload due to staff leaving

Ref.	Description of risk	End of year Aggregated Assurance Rating	End of year RAG rating	Risk Appetite	Changes over the year
SR38	**Timely Delivery of Transition Tasks** There was a risk that the required transition tasks would not be delivered in time to enable the safe transition	Substantial	Low	Low	The risk was positively reviewed throughout the year and drew assurance from the due diligence process overseen by NHS England.

Controls

- Proactive communication with NHSE regarding the delivery of guidance required
- Regular meetings with the regional NHSE colleagues to address concerns and escalate issues as a collective
- Engagement with workstream leads to highlight any

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Suffolk and North East Essex ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks; to evaluate the likelihood of those risks being realised and the impact should they be realised; and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest (COI) and to publish their own COI policy, which should be included in ICB's governance handbook. The ICB's Standards of Business Conduct and Conflicts of Interest Policy is published as part of the Governance Handbook and follows NHS England's suggested form. The ICB has moved from delivering local conflict of interest training and has introduced the nationally produced conflict of interest e-learning training. The training module is available through the ICB's electronic staff record system and is mandatory for all staff to complete annually. Compliance is generally excellent with over 90% of staff successfully completing the training on time. The ICB received a substantial assurance rating in respect of the COI audit undertaken as part of the 2025-26 internal audit programme.

Data Quality

The NHS Standard Contract (SC28) includes a specific requirement for the provider to use all reasonable endeavours to optimise its performance under NHS Digital's Data Quality Maturity Index (DQMI), where applicable, demonstrating its progress through implementation of a Data Quality Improvement Plans (DQIP) or other appropriate means. The DQMI currently covers the national datasets for admitted patient care, A&E, community services, diagnostic imaging, IAPT, mental health, maternity, and outpatients.

Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality, and flow of data to meet the requirements of the Information Schedule (6A) and to support both the commissioning and contract management processes, generally targeting areas of particular concern, or

in relation to new data capture because of service transformation. Completion of a DQIP is not mandatory for each contract. There are several recommended DQIPs depending on the nature of the service provided. These include providers of maternity 103 Accountability Report services (to improve the accuracy and completeness of maternity services data), providers of mental health and LD services (focusing on mental health clinically led reviews of standards), providers of inpatient services (to record diagnoses of LD and autism), and providers of community services (to improve the accuracy and completeness of Community Dataset submissions).

Commissioners can use DQIPs (where agreed) to address data quality issues highlighted through direct reporting or through the nationally available NHS Digital's DQMI.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

NHS England Data Security and Information Governance Framework set the processes and procedures by which Health and Care organisations handles information about patients and their employees, in particular personal identifiable information, and gives assurance against the 10 Data Security Standards. It is supported by a Data Security and Protection Toolkit (DSPT), and an annual submission provides assurance to the public and others that personal information is dealt with legally, securely, efficiently, and effectively.

The ICB placed high importance on ensuring there were robust information governance systems in place to protect patient and corporate information. All staff are required to undertake annual data security and awareness training, and an information governance management framework was established, as well as processes and procedures in line with the Data Security and Protection Toolkit. These included processes for incident reporting and investigation of serious incidents. The procedures embedded an information risk culture throughout the organisation. Data security and information

governance assurance is maintained and strengthened within the ICB and across the SNEE Integrated Care System (ICS).

Business Critical Models

An appropriate framework and environment are in place to provide quality assurance of business-critical models and to ensure the NHS quality assurance guidelines and checklist are applied.

Third party assurances

Provider and Services Delivered	Comment
NHS Business Services Authority Prescription Payments Process Report for the period 1 April 2025 to 31 March 2026	Reasonable Assurance
NHS Shared Business Services Finance and Accounting Report for the period 1 April 2025 to 31 March 2026	Reasonable Assurance
Capita – Primary Care Support England Services to NHS England and delegated ICBs for the period 1 April 2025 to 31 March 2026	Qualified Opinion
NHS Electronic Staff Record Programme - Provides NHS organisations with integrated payroll and HR service system for the period 1 April 2025 to 31 March 2026	Reasonable Assurance
National Calculating Quality Reporting Service is an approval and reporting calculation system for GP practices and supports the ICB's delegated functions for the period 1 April 2025 to 31 March 2026	Reasonable Assurance
NHS Business Services Authority Dental Payments Process Report for the period 1 April 2025 to 31 March 2026	Reasonable Assurance
GP Data Services Controls Assurance Report for the period 1 April 2025 to 31 March 2026	Qualified Opinion

Control Issues

The ICB is not aware of any current significant control issues that would potentially:

• Prejudice the achievement of priorities or undermine the integrity or reputation of the ICB and/or wider NHS

• Put delivery of the standards expected of the Accounting Officer at risk

• Make it harder to resist fraud or other misuse of resources or divert resources from another significant aspect of the business

• Have a material impact on the accounts

• Put national security of data integrity at risk

Review of economy, efficiency & effectiveness of the use of resources

The ICB has systems and processes for managing its resources including the following:

- Standing Orders
- Scheme of Reservation and Delegation.
- Financial Policies
- Strict controls on vacancy management, recruitment, and use of agency staff
- Devolved budget management throughout the ICB.
- CIP Delivery

The ICB governance handbook and constitution set out the controls and procedures.

Commissioning of delegated services (primary care services and specialised services)

SNEE ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025-26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025-26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

NHS Suffolk and North East Essex Integrated Care Board signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 2025-26 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2025-26 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

Where there were known compliance issues, the ICB leadership has, with other ICBs, collectively engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership can provide the necessary evidence of core commissioning requirements compliance should NHS England or a third party (e.g. external auditors) ask for such evidence.

Counter fraud arrangements

The ICB is required, under the terms of the Standard NHS Contract and in accordance with the NHS Counter Fraud Authority Standards for Commissioners: Fraud, Bribery and Corruption, to ensure that appropriate counter fraud measures are in place. There is therefore a robust program of counter fraud and anti-bribery activity, supported by the accredited Local Counter Fraud Specialist whose annual work plan is monitored by the Executive Director of Finance and Contracts and the Audit Committee.

Counter fraud material is disseminated to staff regularly through the ICB bulletins and emails. The Local Counter Fraud Specialist has contributed to the review of various policies including the Counter Fraud, Bribery and Corruption Policy to ensure that they are up to date and accurate. Policies are reviewed in line with current legislation, from a best practice and counter fraud perspective. Details of all policies, procedures and key documents reviewed are reported to the Audit Committee.

The Local Counter Fraud Specialist (LCFS) attends the ICB Audit Committee meetings regularly to provide progress reports and updates, as well as providing an annual NHS Counter Fraud Authority Self-Review Assessment against each of the Standards for Commissioners. The Counter Fraud Functional Standard Return (CFFSR) for 2025-26 was completed by the LCFS and reported to the Audit Committee in early 2026-27. It received an overall rating of 'Green' on submission. Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

Head of Internal Audit Opinion

For the year ending 31 March 2026, the Head of Internal Audit Opinion for NHS Suffolk and North East Essex Integrated Care Board is as follows:

The organisation has an adequate and effective framework for risk management, governance, and internal control.

However, our work has identified further enhancements to the framework of risk management, governance, and internal control to ensure it remains adequate and effective.

Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee. Our opinion is subject to inherent limitations, as detailed below:

- internal audit has not reviewed all risks and assurances relating to the organisation
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework, which is one component that the board takes into account in making its annual governance statement (AGS) to the board
- The opinion is based on the findings and conclusions of the agreed work which was limited to the area under review and agreed with the lead individual
- where strong levels of control have been identified, there are still instances where these may not always be effective, possibly due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention

During the period, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Financial Planning and Reporting	Substantial Assurance
Safeguarding Vulnerable Adults & Children	Substantial Assurance
Conflicts Of Interest	Substantial Assurance
Governance	Substantial Assurance
Risk Management	Reasonable Assurance
Continuing Healthcare - Adults	Reasonable Assurance
Key Financial Controls	Substantial Assurance

Follow Up of Management 24 management actions were raised (7 medium and 17 low) and agreed in our finalised reports.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

• The board

• The audit committee

• The quality committee

• Internal audit

• Other explicit review/assurance mechanisms.

The role and conclusions of each were: Internal Audit provided an independent, objective opinion on the degree to which governance and risk management supports the achievement of the organisation's objectives. The Head of Internal Audit, in accordance with NHS Internal Audit Standards, is required to provide an opinion of the overall adequacy and effectiveness of the organisation's system of internal control. The opinion stated that positive assurance could be given as a generally sound system of internal control is in place designed to meet the organisation's objectives. Controls are generally being applied consistently and effectively, with only minor areas for improvement identified.

Within the ICB, information risk management forms part of the wider information governance agenda. Ultimate responsibility rests with me as Chief Executive and I am supported by the Senior Information Risk Owner (SIRO), who is a member of the Board. The SIRO in turn is supported on a daily basis by the Information Governance and Risk Manager who has responsibility for following up on issues in this area.

An Information Governance Group, chaired by the SIRO and attended by staff from all areas, meets every quarter. This group discusses all information-related issues and makes recommendations of actions to address them. The group provides updates to the Audit Committee on a regular basis. To support this, the ICB approved a number of polices including an Information Governance Policy, IT Security Policy and a Data Protection Policy, which guides staff on their responsibilities.

Conclusion

The Governance Statement highlights the ICB's key governance issues for 1 April 2025 to March 31, 2026.

The ICB has continued to mature and bring together partners responsible for planning and delivering health and care across SNEE to ensure shared leadership and joint action to improve the health and wellbeing of the one million people who live locally. ICBs are central to the NHS Long Term Plan and have a key role in ensuring joint working across the NHS and Local Authorities to make shared commissioning decisions together with providers on how to use resources, design services and improve population health. The ICB enables communities to continue to shape priorities and release the assets which contribute to their wellbeing, care, and health, within a common set of standards which reduce unnecessary variations in performance and outcomes. By working with people in

our communities the ICB aims to develop trust and understanding with stakeholders about what matters.

The ICB has taken responsibility for the commissioning of additional services delegated from NHS England including Specialised commissioning.

The ICB's Alliances covering North East Essex, Ipswich and east Suffolk and west Suffolk have further developed. The Alliances focus on place-based service provision and, while the ICB brings the benefit of working at scale on a system-wide basis tackling strategic issues in health and care, the Alliances design and deliver changes in services to meet the distinctive needs and characteristics of our local populations. No significant internal control issues have been identified.

Dr Ed Garratt OBE

Chief Executive (Accountable Officer)

16th June 2026

REMUNERATION AND STAFF REPORT

Remuneration Committee

Name	Role
Janet Wood	Chair and Non-Executive Member
Will Pope	ICB Chair

Percentage change in remuneration of highest paid director (Subject to Audit)

Percentage Change – 2025/26 vs 2024/25	**Salary and allowances**	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	-26.51%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	7.68%	N/A

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in SNEE ICB the reporting period 1 April 2025 to 31 March 2026 was £150-£155k (2024-25 £205-£210K).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2025/26	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	37,810	50,288	63,536
Salary component of total remuneration (£)	37,807	50,288	63,536
Pay ratio information	4.0:1	3.0:1	2.4:1

2024/25	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	36,494	48,541	60,523
Salary component of total remuneration (£)	36,494	48,541	60,523
Pay ratio information	5.7:1	4.3:1	3.4:1

These ratios have been calculated taking into account the recharges associated with the joint management team following the clustering of SNEE and Norfolk & Waveney ICB.

During the reporting period 2025/26, 3 employees received remuneration in excess of the highest-paid director/member (2024/25: 1 employee). These 3 employees were part of the joint management structure and were therefore recharged to Norfolk and Waveney ICB at 50% during the periods they held joint office.

Remuneration excluding the impact of recharges in the joint management team ranged from £5k to £240k (2024/25 £5-£210k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

All ICB staff, including senior managers (up to and including Band 9), follow the national terms and conditions of service pertaining to notice periods. The maximum period of notice under Agenda for Change is three months. Directors are appointed in accordance with the VSM pay framework (Senior Salaries Review Body Recommendations) and have a six-month notice period built into their contracts of employment.

Remuneration of Very Senior Managers

Five Very Senior Managers (VSM) on the ICB payroll were remunerated more than the £150,000 in the 25/26 financial year. The ICB is satisfied the remuneration is reasonable as it has followed NHS England's pay directions for Chief Executives of

ICB’s of a specific size of population. The other four packages align with other organisations for the remuneration of a Very Senior Manager in a similar role.

Senior manager remuneration 2025/26 (including salary and pension entitlements) (Subject to Audit)

Name	Title	Note	Period in Office From	Period in Office To	Salary (bands of £5,000) **£000**	Expense Payments (taxable) to nearest £100) **£**	Performance Pay and Bonuses (bands of £5,000) **£000**	Long-term Performance Related Bonuses (bands of £5,000) **£000**	All Pension Related Benefits (bands of £2,500) * **£000**	Total (bands of £5,000) **£000**
Professor William Pope	Chair	1	01/04/2025	31/03/2026	50 - 55	0	0	0	0	50 - 55
Dr Ed Garratt	Chief Executive Officer	2	01/04/2025	31/03/2026	120 - 125	4,200	0	0	72.5 - 75	200 - 205
Ewen Cameron	NHS Partner Provider (WSFT)	N/A	01/04/2025	31/03/2026	0	0	0	0	0	0
Nick Hulme	NHS Partner Provider (ESNEFT)	N/A	01/04/2025	31/12/2025	0	0	0	0	0	0
Caroline Donovan	NHS Partner Provider (NSFT)	N/A	01/04/2025	31/03/2026	0	0	0	0	0	0

Dr Freda Bhatti	Primary Care Essex Partner	N/A	01/04/2025	31/03/2026	30 - 35	0	0	0	0	30 - 35
Dr David Cargill	Primary Care Suffolk Partner	3	01/04/2025	31/03/2026	110 - 115	0	0	0	15 – 17.5	125 - 130
Gareth Everton	Suffolk County Council Partner	N/A	01/04/2025	31/03/2026	0	0	0	0	0	0
Moira McGrath	Essex County Council Partner	N/A	01/04/2025	31/03/2026	0	0	0	0	0	0
Phanuel Mutumburi	Non-Executive Members	N/A	01/04/2025	31/03/2026	10 - 15	0	0	0	0	10 - 15
Janet Wood	Non-Executive Members	N/A	01/04/2025	31/03/2026	15 - 20	100	0	0	0	15 - 20
Kris Murali	Non-Executive Members	N/A	01/04/2025	31/03/2026	15 - 20	200	0	0	0	15 - 20
Elaine Noske	Non-Executive Members	N/A	01/04/2025	31/03/2026	15 - 20	0	0	0	0	15 - 20
Howard Martin	Executive Director of Finance and Contracts	4	01/04/2025	31/03/2026	100 - 105	1,000	0	0	42.5 - 45	145 - 150
Chris Armitt	Director of Operational Finance	N/A	01/04/2025	31/03/2026	115 - 120	1,700	0	0	20 – 22.5	135 - 140
Dr Andrew Kelso	Medical Director	5	01/04/2025	22/08/2025	85 - 90	900	0	0	37.5 - 40	130 - 135

Francesca Swords	Executive Medical Director	6	22/05/2025	31/03/2026	100 - 105	0	0	0	127.5 - 130	225 - 230
Lisa Nobes	Executive Director of Nursing	7	01/04/2025	31/03/2026	110 - 115	1,200	0	0	65 - 67.5	175 - 180
Kirsten Alderson	ICS VCSE Assembly Chair	N/A	01/04/2025	31/03/2026	30 - 35	0	0	0	7.5 - 10	40 - 45
Richard Watson	Executive Director of Strategy, Digital and Commissioning g	8	01/04/2025	31/03/2026	110 - 115	2,100	0	0	42.5 - 45	155 - 160
Amanda Lyes	Executive Director of People, Governance and Corporate Services	9	01/04/2025	31/03/2026	105 - 110	100	0	0	57.5 - 60	165 - 170
Mark Burgis	Executive Primary Care and neighbourhood Director (Norfolk and Waveney)	10	01/10/2025	31/03/2026	35 - 40	0	0	0	37.5 - 40	75 - 80

Maddie Baker-Woods	Executive Primary Care and neighbourhood Director (Suffolk)	11	01/04/2025	31/03/2026	105 - 110	200	0	0	125 - 127.5	230 - 235
Peter Wightman	Director of West Suffolk Alliance	N/A	01/04/2025	31/03/2026	150 - 155	200	0	0	45 – 47.5	195 - 200
Laura Taylor-Green	Director of North East Essex Alliance	N/A	01/04/2025	31/03/2026	130 - 135	0	0	0	32.5 - 35	165 - 170
Susannah Howard	Integrated Care Partnership Director	N/A	01/04/2025	31/03/2026	140 - 145	300	0	0	47.5 – 50	190 - 195
Elizabeth Moloney	Director of Operations for Urgent & Emergency Care (UEC)	12	01/04/2025	04/01/2026	80 - 85	100	0	0	120 – 122.5	205 - 210
Mark Cheeseman	Director of Optimisation and Pharmacy	13	01/04/2025	31/03/2026	75 - 80	1,800	0	0	102.5 - 105	180 - 185
Alexander Royan	Director of Strategy and Healthcare Intelligence	N/A	01/04/2025	31/03/2026	105 - 110	0	0	0	25 - 27.5	135 - 140

Nerinda Evans	Director of Strategic Programmes	14	01/04/2025	31/03/2026	105 - 110	100	0	0	60 - 62.5	170 - 175

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Notes:

1. William Pope's salary is partially funded by Norfolk and Waveney ICB as he was a joint appointment as Chair across both ICB's as of 01/05/2025

2. Ed Garratt's salary is partially funded by Norfolk and Waveney ICB as he was a joint appointment as Chief Executive Officer across both ICB's as of 01/05/2025. His benefit in kind (BIK) relates to a lease car and mileage claims.

3. David Cargill has 2 roles within the ICB, General Medical Practitioner and Primary Care Suffolk Partner. His pay is split in the following proportions, 69.02% and 30.98% respectively.

4. Howard Martin's salary is partially funded by Norfolk and Waveney ICB as he was a joint appointment as Director of Finance and Contracts across both ICB's as of 11/07/2025. His benefit in kind (BIK) relates to a lease car and mileage claims.

5. Dr Andrew Kelso left his role as Medical Director on 22/08/2025. His benefit in kind (BIK) relates to a lease car and mileage claims.

6. Francesca Swords' salary is partially funded as she was a joint appointment as Executive Medical Director across both ICB's as of 22/08/2025

7. Lisa Nobes's salary is partially funded by N&W ICB as she was a joint appointment as Executive Director of Nursing across both ICB's as of 01/10/2025. Her benefit in kind (BIK) relates to a lease car and mileage claims.

8. Richard Watson's salary is partially funded by N&W ICB as he was a joint appointment as Executive Director of Strategy, Digital and Commissioning across both ICB's as of 01/10/2025 His benefit in kind (BIK) relates to a lease car and mileage claims.

9. Amanda Lyes' salary is partially funded by N&W ICB as she was a joint appointment as Executive Director of People, Governance and Corporate Services across both ICB's as of 01/10/2025

10. Mark Burgis' salary is partially funded as he was a joint appointment as Executive Primary Care and Neighbourhood Director for Norfolk across both ICB's as of 01/10/2025.

11. Maddie Baker-Woods' is partially funded by N&W ICB as she was a joint appointment as Executive Primary Care and Neighbourhood Director for Suffolk across both ICB's as of 01/10/2025

12. Elizabeth Moloney left her role as Director of Operations for Urgent & Emergency Care on 04/01/2026

13. Mark Cheeseman's salary is partially funded by East Suffolk and North East Essex NHS Foundation Trust for the period 01/04/2025 - 28/02/2026. The gross salary prior to recharges was £115k - £120k. The 2024-25 disclosure did not account for any recharges to East Suffolk and North East Essex NHS Foundation Trust. Considering those recharges, the adjusted salary would have been disclosed as £10k-£15k in the prior year table (actual disclosure was £85k - £90k). The total salary, after considering pension related benefits, would have been disclosed as £90k-£95k (actual disclosure was £170k - £175k). These recharges were in respect of a secondment agreement effective 3rd June 2024 with East Suffolk and North Essex Foundation Trust. During the secondment period, Mark Cheeseman held the position of 'Chief Pharmacist' at East Suffolk and North Essex Foundation Trust.

14. Nerinda Evans agreed an exit package during 2025-26 as part of the ICB reorganisation. This was a voluntary redundancy exit and was between £150,000-£200,000 which was agreed in line with agenda for change guidance.

Taxable expense payments relate to travel and subsistence and lease cars. These are time apportioned based on the period held in office.

SNEE ICB clustered with Norfolk and Waveney ICB during the 2025/26 financial year. The below table outlines those individuals total gross salaries (i.e. before any recharges are accounted for):

Name	Total salaries – Band of £5,000 - £'000
Ed Garratt	230 - 235
Howard Martin	155 - 160
Francesca Swords	260 - 265
Mark Burgis	145 - 150

Lisa Nobes	150 - 155
Maddie Baker-Woods	145 - 150
Richard Watson	150 - 155
Amanda Lyes	145 - 150
Will Pope	90 - 95

All Pension Related Benefits

The amount included here is the annual increase in pension entitlement determined in accordance with the 'HMRC' method for defined benefit pension schemes. In summary, this is as follows:

Increase in pension entitlement = ((20 x PE) + LSE) – ((20 x PB) + LSB), where:

• PE is the annual rate of pension that would be payable to the officer if they became entitled to it at the end of the financial year;

• PB is the annual rate of pension, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.

• LSE is the amount of lump sum that would be payable to the officer if they became entitled to it at the end of the financial year; and,

• LSB is the amount of lump sum, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.

The amount included is not a sum paid to the officer by the ICB. It merely represents the increase in pension entitlement that occurred during the year and is derived from data received from NHS Pensions.

The all-pension related benefits table is an additional table to ensure transparency in relation to pension related benefits for members of the management delivery team whose costs are shared across multiple entities

Pension Related Benefits are time apportioned based on the period held in office.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

Senior manager remuneration 2024/25 (including salary and pension entitlements)

Name	Title	Note	Period in Office From	Period in Office To	Salary (bands of £5,000) **£000**	Expense Payments (taxable) to nearest £100) **£**	Performance Pay and Bonuses (bands of £5,000) **£000**	Long-term Performance Related Bonuses (bands of £5,000) **£000**	All Pension Related Benefits (bands of £2,500) * **£000**	Total (bands of £5,000) **£000**
Professor William Pope	Chair	1	01/04/2024	31/03/2025	160 - 165	0	0	0	0	160 - 165
Dr Ed Garratt	Chief Executive	2	01/04/2024	31/03/2025	195 - 200	12,100	0	0	22.5 - 25	230 - 235
Ewen Cameron	NHS Partner Provider (WSFT)	N/A	01/04/2024	31/03/2025	0	0	0	0	0	0

Nick Hulme	NHS Partner Provider (ESNEFT)	N/A	01/04/2024	31/03/2025	0	0	0	0	0	0
Caroline Donovan	NHS Partner Provider (NSFT)	N/A	01/04/2024	31/03/2025	0	0	0	0	0	0
Dr Freda Bhatti	Primary Care Essex Partner	N/A	01/04/2024	31/03/2025	25 - 30	0	0	0	0	25 - 30
Dr David Cargill	Primary Care Suffolk Partner	3	01/05/2024	31/03/2025	100 - 105	0	0	0	30 - 32.5	130 - 135
Georgia Chimbani	Suffolk County Council Partner	N/A	01/04/2024	31/07/2024	0	0	0	0	0	0
Moira McGrath	Essex County Council Partner	N/A	01/04/2024	31/03/2025	0	0	0	0	0	0
Phanuel Mutumburi	Non-Executive Members	N/A	01/04/2024	31/03/2025	15 - 20	0	0	0	0	15 - 20
Janet Wood	Non-Executive Members	N/A	01/04/2024	31/03/2025	15 - 20	100	0	0	0	15 - 20
Kris Murali	Non-Executive Members	N/A	01/04/2024	31/03/2025	15 - 20	200	0	0	0	15 - 20
Elaine Noske	Non-Executive Members	N/A	01/04/2024	31/03/2025	15 - 20	0	0	0	0	15 - 20
Howard Martin	Director of Finance	4	01/04/2024	31/03/2025	130 - 135	1,900	0	0	37.5 - 40	170 - 175

Chris Armitt	Director of Operational Finance	N/A	01/04/2024	31/03/2025	115 - 120	500	0	0	5 - 7.5	125 - 130
Dr Andrew Kelso	Medical Director	5	01/04/2024	31/03/2025	150 - 155	3,700	0	0	37.5 - 40	195 - 200
Lisa Nobes	Director of Nursing	6	01/04/2024	31/03/2025	130 - 135	1,700	0	0	0	135 - 140
Kirsten Alderson	ICS VCSE Assembly Chair	N/A	01/04/2024	31/03/2025	25 - 30	0	0	0	7.5 - 10	35 - 40
Richard Watson	Deputy Chief Executive and Director of Transformation & Strategy	7	01/04/2024	31/03/2025	130 - 135	3,400	0	0	25 - 27.5	160 - 165
Amanda Lyes	Director of Workforce and People	N/A	01/04/2024	31/03/2025	135 - 140	100	0	0	12.5 - 15	145 - 150
Paul Gibara	Director of Performance Improvement	8	01/04/2024	30/09/2024	225 - 230	0	0	0	72.5 - 75	300 - 305
Maddie Baker-Woods	Director of Ipswich and East Suffolk Alliance	N/A	01/04/2024	31/03/2025	135 - 140	100	0	0	0	135 - 140
Peter Wightman	Director of West Suffolk Alliance	N/A	01/04/2024	31/03/2025	145 - 150	200	0	0	52.5 - 55	200 - 205

Laura Taylor-Green	Director of North East Essex Alliance	N/A	01/04/2024	31/03/2025	130 - 135	0	0	0	32.5 - 35	160 - 165
Susannah Howard	Integrated Care Partnership Director	N/A	01/04/2024	31/03/2025	135 - 140	100	0	0	20 - 22.5	155 - 160
Elizabeth Moloney	Director of Operations for Urgent & Emergency Care (UEC)	9	19/07/2024	31/03/2025	75 - 80	0	0	0	20 - 22.5	95 - 100
Mark Cheeseman	Director of Optimisation and Pharmacy	10	03/06/2024	31/03/2025	85 - 90	1,100	0	0	80 - 82.5	170 - 175
Alexander Royan	Director of Strategy and Healthcare Intelligence	11	01/11/2024	31/03/2025	40 - 45	0	0	0	10 - 12.5	50 - 55
Nerinda Evans	Director of Strategic Programmes	12	01/11/2024	31/03/2025	40 - 45	100	0	0	10 - 12.5	55 - 60

Notes:

1. William Pope's salary includes an element of back pay relating to 22/23 (£40,000 - £45,000) & 23/24 (£50,000 - £55,000).
2. Dr Ed Garratt's salary includes a 23/24 salary sacrifice deduction for a lease car (£5,000 - £10,000). His benefit in kind (BIK) relates to a lease car and mileage claims. The BIK value includes a 23/24 adjustment (£5,000 - £10,000).

3. David Cargill started his role as Primary Care Suffolk Partner on 01/05/2024. He has 2 roles within the ICB, General Medical Practitioner and Primary Care Suffolk Partner. His pay is split in the following proportions, 69.02% and 30.98% respectively.
4. Howard Martin's salary includes a 23/24 salary sacrifice deduction for a lease car (£5,000 - £10,000). His benefit in kind (BIK) relates to a lease car and mileage claims. The BIK value includes a 23/24 adjustment (£0 - £5,000).
5. Dr Andrew Kelso's salary includes a 23/24 salary sacrifice deduction for a lease car (£5,000 - £10,000). His benefit in kind (BIK) relates to a lease car and mileage claims. The BIK value includes a 23/24 adjustment (£0 - £5,000).
6. Lisa Nobes's salary includes a 23/24 salary sacrifice deduction for a lease car (£5,000 - £10,000). Her benefit in kind (BIK) relates to a lease car and mileage claims. The BIK value includes a 23/24 adjustment (£0 - £5,000).
7. Richard Watson's salary includes a 23/24 salary sacrifice deduction for a lease car (£5,000 - £10,000). His benefit in kind (BIK) relates to a lease car and mileage claims. The BIK value includes a 23/24 adjustment (£0 - £5,000).
8. Paul Gibara left his role on 30/09/2024. His salary includes a voluntary redundancy payment (£160,000 - £165,000).
9. Elizabeth Moloney started her role as Director of Operations for UEC on 19/07/2024.
10. Mark Cheeseman started his role as Director of Optimisation and Pharmacy on 03/06/2024.
11. Alexander Royan started his role as Director of Strategy and Healthcare Intelligence on 01/11/2024.
12. Nerinda Evans started her role as Director of Strategic Programmes on 01/11/2024.

Taxable expense payments relate to travel and subsistence and lease cars. These are time apportioned based on the period held in office.

All Pension Related Benefits

The amount included here is the annual increase in pension entitlement determined in accordance with the 'HMRC' method for defined benefit pension schemes. In summary, this is as follows:
Increase in pension entitlement = ((20 x PE) + LSE) – ((20 x PB) + LSB), where:

• PE is the annual rate of pension that would be payable to the officer if they became entitled to it at the end of the financial year;
• PB is the annual rate of pension, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.

• LSE is the amount of lump sum that would be payable to the officer if they became entitled to it at the end of the financial year; and,
• LSB is the amount of lump sum, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.

The amount included is not a sum paid to the officer by the ICB. It merely represents the increase in pension entitlement that occurred during the year and is derived from data received from NHS Pensions.

The all-pension related benefits table is an additional table to ensure transparency in relation to pension related benefits for members of the management delivery team whose costs are shared across multiple entities

Pension Related Benefits are time apportioned based on the period held in office.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the potential benefit of being a member of the pension scheme.

Pension benefits of Senior Managers in 2025/26 (Subject to audit)

Name	Title	Note	Period in Office From	Period in Office To	Real increase / decrease in pension at	Real increase / decrease in pension lum	Total accrued pension at age 60 at 31/03/2026 (band	Lump sum at age 60 related to accrued pensi	Cash Equivalent Transfer Value at 01/04/2025 £000	Cash Equivalent Transfer Value at 31/03/2026 £000	Real increase/ decrease in Cash Equivalent	Employer's contribution to stakeholder pensi

					age 60 (bands of £2,500) £000	p sum at aged 60 (bands of £2,500) £000	s of £5,000) £000	on at 31/03/2026 (bands of £5,000) £000			Transfer Value £000	on £000
Dr Ed Garratt	Chief Executive Officer	N/A	01/04/2025	31/03/2026	2.5 - 5	0 - 2.5	60 - 65	135 - 140	1,130	1,244	68	0
Dr David Cargill	Primary Care Suffolk Partner	N/A	01/04/2025	31/03/2026	0 - 2.5	0 - 2.5	10 - 15	15 - 20	159	190	9	0
Howard Martin	Executive Director of Finance and Contracts	N/A	01/04/2025	31/03/2026	2.5 - 5	0	30 - 35	20 - 25	507	576	41	0
Chris Armitt	Director of Operational Finance	N/A	01/04/2025	31/03/2026	0 - 2.5	0	30 - 35	70 - 75	592	630	14	0
Dr Andrew Kelso	Medical Director	N/A	01/04/2025	22/08/2025	0 - 2.5	2.5 - 5	30 - 35	65 - 70	556	684	38	0
Francesca Swords	Executive Medical Director	N/A	22/05/2025	31/03/2026	5 - 7.5	10 - 12.5	90 - 95	230 - 235	1,823	2,111	136	0
Lisa Nobes	Executive Director of Nursing	N/A	01/04/2025	31/03/2026	2.5 - 5	0 - 2.5	95 - 100	0 - 5	1,532	1,650	73	0
Kirsten Alderson	ICS VCSE Assembly Chair	N/A	01/04/2025	31/03/2026	0 - 2.5	0 - 2.5	0 - 5	0 - 5	21	32	7	0
Richard Watson	Executive Director of Strategy, Digital and Commissioning	N/A	01/04/2025	31/03/2026	2.5 - 5	0 - 2.5	40 - 45	0 - 5	554	611	30	0
Amanda Lyes	Executive Director of People, Governance and Corporate Services	N/A	01/04/2025	31/03/2026	2.5 - 5	2.5 - 5	70 - 75	180 - 185	1,557	1,674	72	0

Mark Burgis	Executive Primary Care and neighbourhood Director (Norfolk and Waveney)	N/A	01/10/2025	31/03/2026	0 - 2.5	0 - 2.5	40 - 45	0 - 5	563	653	31	0
Maddie Baker-Woods	Executive Primary Care and neighbourhood Director (Suffolk)	N/A	01/04/2025	31/03/2026	10 - 12.5	0	35 - 40	0 - 5	620	656	13	0
Peter Wightman	Director of West Suffolk Alliance	N/A	01/04/2025	31/03/2026	2.5 - 5	0 - 2.5	65 - 70	95 - 100	1,246	1,339	53	0
Laura Taylor-Green	Director of North East Essex Alliance	N/A	01/04/2025	31/03/2026	2.5 - 5	0 - 2.5	10 - 15	5 - 10	129	165	18	0
Susannah Howard	Integrated Care Partnership Director	N/A	01/04/2025	31/03/2026	2.5 - 5	0 - 2.5	45 - 50	105 - 110	985	1,073	54	0
Elizabeth Moloney	Director of Operations for Urgent & Emergency Care (UEC)	N/A	01/04/2025	04/01/2026	5 - 7.5	0 - 2.5	25 - 30	0 - 5	269	435	113	0
Mark Cheeseman	Director of Optimisation and Pharmacy	N/A	01/04/2025	31/03/2026	5 - 7.5	7.5 - 10	40 - 45	95 - 100	696	816	94	0
Alexander Royan	Director of Strategy and Healthcare Intelligence	N/A	01/04/2025	31/03/2026	0 - 2.5	0 - 2.5	10 - 15	0 - 5	93	119	11	0
Nerinda Evans	Director of Strategic Programmes	N/A	01/04/2025	31/03/2026	2.5 - 5	2.5 - 5	45 - 50	110 - 115	963	1,064	71	0

Notes

1. No lump sum will be shown for senior managers who only have membership in the 2015 Scheme or 2008 Section, unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise. Where the calculation of real increase produced a negative result, this is indicated by a " - " in the table.

2. No Cash Equivalent Transfer Value (CETV) is shown for senior managers over normal pension age. The normal pension age is 60 in the 1995 section, 65 in the 2008 Section and State Pension Age, or 65 (whichever is the later) in the 2015 Scheme.

3. Members of the Board who have not made pension contributions or accrued pension benefits within the NHS Pension Scheme while in office at the ICB are listed in the table below:

Name	Title
Professor William Pope	Chair
Ewen Cameron	NHS Partner Provider (WSFT)
Nick Hulme	NHS Partner Provider (ESNEFT)
Caroline Donovan	NHS Partner Provider (NSFT)
Dr Freda Bhatti	Primary Care Essex Partner
Gareth Everton	Suffolk County Council Partner
Moira McGrath	Essex County Council Partner
Phanuel Mutumburi	Non-Executive Members
Janet Wood	Non-Executive Members
Kris Murali	Non-Executive Members
Elaine Noske	Non-Executive Members

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Pension benefits of Senior Managers in 2024/25

Name	Title	Note	Period in Office From	Period in Office To	Real increase / decrease in pension at age 60 (bands of £2,500) £000	Real increase / decrease in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31/03/2025 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31/03/2025 (bands of £5,000) £000	Cash Equivalent Transfer Value at 01/04/2024 £000	Cash Equivalent Transfer Value at 31/03/2025 £000	Real increase/ decrease in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000

Dr Ed Garratt	Chief Executive	N/A	01/04/2024	31/03/2025	2.5 - 5	0	55 - 60	130 - 135	1018	1130	18	0
Dr David Cargill	Primary Care Suffolk Partner	N/A	01/05/2024	31/03/2025	0 - 2.5	0 - 2.5	5 - 10	15 - 20	108	159	20	0
Howard Martin	Director of Finance	N/A	01/04/2024	31/03/2025	2.5 - 5	0 - 2.5	25 - 30	20 - 25	427	507	35	0
Chris Armitt	Director of Finance	N/A	01/04/2024	31/03/2025	0 - 2.5	0	30 - 35	70 - 75	540	592	1	0
Dr Andrew Kelso	Medical Director	N/A	01/04/2024	31/03/2025	0 - 2.5	2.5 - 5	25 - 30	55 - 60	473	556	37	0
Lisa Nobes	Director of Nursing	N/A	01/04/2024	31/03/2025	0	0 - 2.5	90 - 95	0 - 5	1425	1532	0	0
Kirsten Alderson	ICS VCSE Assembly Chair	N/A	01/04/2024	31/03/2025	0 - 2.5	0 - 2.5	0 - 5	0 - 5	12	21	6	0
Richard Watson	Deputy Chief Executive and Director of Transformation and Strategy	N/A	01/04/2024	31/03/2025	0 - 2.5	0 - 2.5	35 - 40	0 - 5	488	554	16	0

Amanda Lyes	Director of Workforce and People	N/A	01/04/2024	31/03/2025	0 - 2.5	0	65 - 70	175 - 180	1421	1557	24	0
Paul Gibara	Director of Performance Improvement	N/A	01/04/2024	30/09/2024	2.5 - 5	7.5 - 10	55 - 60	165 - 170	1198	0	0	0
Maddie Baker-Woods	Director of Ipswich and East Suffolk Alliance	N/A	01/04/2024	31/03/2025	0	60 - 62.5	25 - 30	60 - 65	512	620	60	0
Peter Wightman	Director of West Suffolk Alliance	N/A	01/04/2024	31/03/2025	2.5 - 5	0 - 2.5	60 - 65	90 - 95	1096	1246	58	0
Laura Taylor-Green	Director of North East Essex Alliance	N/A	01/04/2024	31/03/2025	0 - 2.5	0	5 - 10	5 - 10	90	129	16	0
Susannah Howard	Integrated Care Partnership Director	N/A	01/04/2024	31/03/2025	0 - 2.5	0	40 - 45	105 - 110	884	985	24	0
Elizabeth Moloney	Director of Operations for UEC	N/A	19/07/2024	31/03/2025	0 - 2.5	0 - 2.5	15 - 20	0 - 5	217	269	16	0

Mark Cheeseman	Director of Optimisation and Pharmacy	N/A	03/06/2024	31/03/2025	2.5 - 5	7.5 - 10	30 - 35	85 - 90	557	696	73	0
Alexander Royan	Director of Strategy and Healthcare Intelligence	N/A	01/11/2024	31/03/2025	0 - 2.5	0 - 2.5	5 - 10	0 - 5	65	93	5	0
Nerinda Evans	Director of Strategic Programmes	N/A	01/11/2024	31/03/2025	0 - 2.5	0 - 2.5	40 - 45	105 - 110	857	963	15	0

**For pension related benefits, an N/A indicates NIL but 0 indicates a negative balance but is stated as 0 in line with the relevant guidance.*

Notes:

1. NHS Pensions confirmed there is no CETV at 31/03/2025 for Paul Gibara as he is now claiming his pension.

2. No lump sum will be shown for senior managers who only have membership in the 2015 Scheme or 2008 Section, unless they chose to move their 1995 Section benefits to the 2008 Section under the Choice exercise. Where the calculation of real increase produced a negative result this is indicated by a " - " in the table.

3. No Cash Equivalent Transfer Value (CETV) is shown for pensioners or senior managers over normal pension age. This is age 60 in the 1995 section, age 65 in the 2008 Section and State Pension Age, or age 65 (whichever is the later) in the 2015 Scheme.

4. The pension benefits of senior managers on secondment from other NHS bodies are disclosed where appropriate in the employing organisations' Remuneration Report.

5. Members of the Board who have not made pension contributions or accrued pension benefits within the NHS Pension Scheme while in office at the ICB are not disclosed in the above table as their remuneration is non-pensionable.

Name	**Title**
Professor William Pope	Chair
Ewen Cameron	NHS Partner Provider (WSFT)
Nick Hulme	NHS Partner Provider (ESNEFT)
Caroline Donovan	NHS Partner Provider (NSFT)
Dr Freda Bhatti	Primary Care Essex Partner
Georgia Chimbani	Suffolk County Council Partner
Moira McGrath	Essex County Council Partner
Phanuel Mutumburi	Non-Executive Members
Janet Wood	Non-Executive Members
Kris Murali	Non-Executive Members
Elaine Noske	Non-Executive Members

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The benefits and corresponding CETV do allow for any potential adjustments in relation to the McCloud judgement.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office (Subject to Audit)

The ICB made no payments of compensation on early retirement or for loss of office during the period.

Payments to past directors (Subject to Audit)

The ICB made no payments to past members during the period.

Staff Report

Introduction

As of 31 March 2026, Suffolk and North East Essex ICB employed a total of 505 people (462.17 full time equivalents) on average during the year. The sections within this staff report provide further information on the composition of the people employed by the ICB, policies implemented, and engagement and partnership initiatives developed during the reporting period.

[AB note - sentence repeated above]

Staff Numbers and Costs (Subject to Audit) 2025-26

Employee benefits	Admin Permanent Employees £'000	Admin Other £'000	Admin Total £'000	Programme Permanent Employees £'000	Programme Other £'000	Programme Total £'000	Total Permanent Employees £'000	Total Other £'000	2025-26 Total £'000
Salaries and wages	10,476	83	**10,559**	15,646	346	**15,992**	26,122	429	**26,551**
Social security costs	1,422	6	**1,428**	2,108	0	**2,108**	3,529	6	**3,535**
Employer contributions to the NHS Pension Scheme	3,716	6	**3,722**	2,034	0	**2,034**	5,749	6	**5,756**
Apprenticeship Levy	118	0	**118**	0	0	**0**	118	0	**118**
Termination benefits	4,970	0	**4,970**	6,667	0	**6,667**	11,637	0	**11,637**

Gross employee benefits expenditure	**20,702**	**96**	**20,797**	**26,454**	**346**	**26,800**	**47,156**	**441**	**47,597**
Less recoveries in respect of employee benefits	-431	0	**-431**	-401	0	-401	-831	0	**-831**
Total - Net admin employee benefits including capitalised costs	**20,702**	**96**	**20,797**	**26,454**	**346**	**26,800**	**47,156**	**441**	**47,597**

Staff Costs (Subject to Audit) 2024-25

Employee benefits	Admin Permanent Employees £'000	Admin Other £'000	Admin Total £'000	Programme Permanent Employees £'000	Programme Other £'000	Programme Total £'000	Total Permanent Employees £'000	Total Other £'000	2024-25 Total £'000
Salaries and wages	10,446	230	**10,676**	13,840	553	**14,393**	24,286	783	**25,069**
Social security costs	1,173	0	**1,173**	1,567	0	**1,567**	2,740	0	**2,740**

Employer contributions to the NHS Pension Scheme	3,462	0	**3,462**	1,846	0	**1,846**	5,308	0	**5,308**
Apprenticeship Levy	109	0	**109**	0	0	**0**	109	0	**109**
Termination benefits	35	0	**35**	191	8	**199**	226	8	**234**
Gross employee benefits expenditure	**15,225**	**230**	**15,455**	**17,444**	**561**	**18,005**	**32,669**	**791**	**33,460**
Less recoveries in respect of employee benefits	-264	0	**-264**	-403	0	**-403**	-667	0	**-667**
Total - Net admin employee benefits including capitalised costs	**14,961**	**230**	**15,191**	**17,041**	**561**	**17,602**	**32,002**	**791**	**32,793**

Number of senior managers

The below table shows the headcount number of senior managers employed by the ICB as at 31 March 2026:

Band/Payscale	Number of senior Managers
Band 8 - Range A	79
Band 8 - Range B	53
Band 8 - Range C	30
Band 8 - Range D	22
Band 9	5
VSM	9
Grand Total	**198**

Of the 9 individuals who are within the reporting group of 'Very Senior Manager', four are male and five are female.

The below table shows the average full time equivalent staff numbers for the 2025/26 financial year.

Staff Group	Permanently Employed	Other	Total
Add Prof Scientific and Technic	23.78	4.44	28.22
Additional Clinical Services	5.00	0.00	5.00
Administrative and Clerical	305.14	36.96	342.10
Medical and Dental	2.04	0.00	2.04
Nursing and Midwifery Registered	82.98	1.60	84.58
Chair	0.00	0.23	0.23
Total	**418.94**	**43.23**	**462.17**

(2024/25 figures were: Permanent 401.71; Other 47.21; Total 448.92)

Staff composition

The below table shows the composition of the ICB Board (headcount):

Composition	Female	Male
Board Member	8	9
Other Attendees	3	4
Observers	n/a	n/a
Total	**11**	**13**

The below table shows the composition of the ICB excluding Board members as at March 2026 (headcount):

Band/Payscale	Female	Male	Grand Total
Band 2	1	0	1
Band 3	13	4	17
Band 4	30	7	37
Band 5	42	4	46
Band 6	80	11	91
Band 7	65	18	83
Band 8 - Range A	56	23	79
Band 8 - Range B	39	14	53
Band 8 - Range C	18	12	30
Band 8 - Range D	16	6	22
Band 9	2	3	5
Other	18	14	32
VSM	5	4	9
Grand Total	**385**	**120**	**505**

Sickness absence data

Under guidance issued by NHS England, we are required to report sickness absence on a calendar year basis. The data in this report therefore reflects a full twelve-month period from 1st January 2025 to 31st December 2025.

In total, 4,650 full time equivalent days were lost to sickness absence which equates to 2.73% of contracted time.

On average 6.1 days per full-time equivalent was lost in the year. It should be noted that the days lost were attributed to both long-term and short- term illnesses.

Supporting our staff wellbeing is a priority for us. We have supported employees' health and wellbeing through access to an Occupational Health Service, Employee Assistance Programme, absence management process, as well as wellbeing initiatives throughout the year including support for financial wellbeing.

We ensure that all staff complete a wellbeing conversation as part of their annual appraisal process. We have reviewed and provisioned a new Freedom to Speak Up

Guardian service to provide a safe space for when staff need to raise any matters of concern.

Staff turnover percentages

Between 1st April 2025 and 31st March 2026, the ICB had a total of 83.83 FTE staff left the organisation.

This is a turnover rate in the period of 18.49%. 37% of leavers left on a voluntary basis with the highest known voluntary reason due to finding promotion opportunities elsewhere (10 out of 39 voluntary leavers). In 2025/26 the organisation went through a period of changes which has influenced the reduced rate of people leaving on a voluntary basis. On 31st March 2026 the organisation at 36.63 FTE staff transfer to the new Essex ICB and 4.42 FTW staff left on voluntary redundancy agreements.

To support better retention and to better support staff in their next career steps, we help develop their skills by promoting learning and secondment opportunities. All our roles are advertised internally in the first instance and we also promote vacancies within our system partner organisations.

We recognise the importance of keeping talented individuals working within the health and care system.

We conduct exit interviews both online and face-to-face, so that we can gather more information around the reason for leaving and can, therefore, take steps to address any concerns raised.

Staff turnover is reported to the Joint Staff Partnership and the Renumeration Committee. All data is collected from the ESR Business Intelligence Reporting Up-to-date information on our staff turnover figures can be found via the NHS England publication series on NHS staff turnover rates. The series is an official statistics publication complying with the UK Statistics Authority's Code of Practice. Data is provided for a number of staff groups.

Staff engagement percentages

The staff engagement score for the ICB taken from the NHS Staff Survey 2025 was 6.83 (out of 10), the highest score recorded by an ICB in the survey. Our response rate to the National NHS Staff Survey was 65%, and in line with the national average. We are committed to improving this further going forward.

The ICB achieved above very high scores in all seven People Promise elements and across the staff engagement and morale theme scores, compared with other ICB's.

We continue to achieve high engagement scores and are ranked 1st in the country on the overall staff engagement theme which included the following questions:

- 55.05% of staff would recommend the ICB as a place to work, compared to a national average of 36.87%
- 76.76% of staff reported care of patients/service users are the organisation's top priority, compared to a national average of 60.96%

NHS People Promise Element or Theme	ICB Score	Comparator Group Average
Response Rate	65%	65%
We are compassionate and inclusive	7.76	7.4
We are recognised and rewarded	6.95	6.49
We each have a voice that counts	7.03	6.55
We are safe and healthy	6.75	6.36
We are always learning	5.6	4.98
We work flexibly	7.83	7.27
We are a team	7.42	7
Staff engagement	6.83	6.28
Morale	5.97	5.58

Staff policies

The ICB promotes a working environment in which all policies and procedures relating to our workforce and staffing are free from unfair discrimination, ensuring that no employee or

prospective employee is discriminated against, whether directly or indirectly on the grounds of

age; disability; gender reassignment; pregnancy and maternity; race including ethnic or national

origins, nationality; religion belief; sex (gender); sexual orientation; marriage and civil

partnership; trade union membership; responsibility for dependents or any other condition or

requirement which cannot be shown to be justifiable.

As a statutory body, we prioritise robust employment policies that align with current legislation,

best practices, and our organisational culture and values. Throughout the year, we continually
review and update our policies in collaboration with trade union representatives, who play an
active role in this process. Before implementation, all new policies undergo thorough scrutiny by
relevant partnership and engagement groups and relevant board committees. All our policies
are available to all staff via our intranet pages.

Other employee matters

Health and wellbeing support

Our staff Health and Wellbeing support is well developed. Resources and information available for staff and managers include:

- An Employee Assistance Programme
- Mental Health First Aiders
- Free app-based support for mindfulness sessions
- Cost of Living Support
- Domestic Violence Awareness
- Online fitness classes and videos and tips for staying active
- Regular ICS Health and Wellbeing Newsletter publication contact details
- Finance Wellbeing

We encourage managers and staff to talk about reasonable adjustments and working practices and promote the 'health passport' that allows individuals to easily record information about the individual barriers they face, and any workplace adjustments they may already have in place.

The passport helps to ensure there is a clear record and can be used with new line managers to explain what is needed in the workplace to help them carry out their role.

Training and awareness sessions have been provided for staff on health and well-being topics such as resilient and emotional wellbeing.

The ICB uses the annual and quarterly Staff Surveys outcomes to implement various health and wellbeing campaigns and provide relevant training and awareness sessions for all staff.

Our annual appraisal paperwork includes questions relating to wellbeing and identity.

Our 2025 staff survey results tell us that our staff feel safe and healthy at work. The ICB scores above average at 6.75 (out of ten), the highest score achieved by an ICB in the survey, with the average being 6.36.

Developing our workforce

All staff within SNEE ICB have a competency framework that sets out both mandatory and statutory training requirements for their roles.

The ICB has worked to deliver two training plans during 2025/26. The first training programme, launched during winter and spring 2025, supported staff to develop skills and receive appropriate training in line with one of our core values - 'enabling excellence' for our staff.

Much of our development programme in 2025.26 was focused on managing and coping with change.

We encourage all staff to complete an annual appraisal with their line manager. The ICB has a cohort of trained coaches that are available to coach our staff. Coaching sessions are free, and we encourage our staff to take up apprenticeship opportunities, using the apprenticeship levy funding.

Within the 2025 NHS Staff Survey, 67.28% of staff felt that they had opportunities to improve their knowledge and skills, which was the highest score across all ICBs.

Induction, Onboarding and development .

Our induction, onboarding and development plan is designed to help new employees feel welcome and supported, get up to speed quickly and effectively, and give them the tools and knowledge they need to succeed in their roles.

The program covers a wide range of topics including: Introduction to the ICB, Alliances, ICP and ICS; Organisational Values; Who's Who, and Practical Advice and Support.

These topics cover content from Freedom to Speak Up; EDI and Staff Networks; Introduction to Information Governance; Health and Safety and Fire Update; and Sustainability Update.

Developing a diverse workforce

Our staff networks are long standing and regularly attended and well supported. There are five Staff Networks in the ICB:

- Race, Equality and Cultural Heritage (REACH) Staff Network (previously known as BAME Staff Network) – Launched March 2021
- LGBTQ+ Staff Network – Launched March 2022
- Disability Staff Network – Launched March 2022
- Neuro-diversity Network – Launched February 2025
- Carers Network – Launched February 2025
- Woman's Network – Launched April 2025

Each network has an executive sponsor that attends each meeting. The ICB supports each network by an agreement that each chair/co-chair will be assigned ring-fenced hours (0.5 days) each week to undertake chair duties to each network group and perform associated work.

The aim of each network is to provide staff with a safe and secure platform to share experiences and ensure that equality, diversity and inclusion are promoted and embedded in every strand of the organisation.

The ICB's staff networks are active, accessible and led by staff.

The ICB HR Team revised the key HR policies such from an ED&I lens and policies and project have an Equality Impact Assessment provided

Our 2025 NHS Staff Survey results show that people consider SNEE ICB to have a compassionate culture, putting high importance on diversity, equality and inclusion. All factors in the staff survey under the 'compassionate and inclusive' element scored above average and achieved results in the upper quartile. We are committed to providing a safe and thriving environment for all of our colleagues.

Disabled employees

Our policy on disabled persons ensures that:

- full and fair consideration is given to applications for employment made by disabled persons.
- we provide training, career development and promotion of disabled people that we employ.
- We encourage the deployment of adjustments to remove or reduce a disadvantage
- related to someone's disability.

The types of adjustments may include adjustments to work base, working hours, redeploying the employee to another suitable position, and providing any necessary equipment to assist the employee to perform their role.

Our Sickness Absence Policy confirms that where an employee becomes disabled during their employment, we will make any necessary reasonable adjustments required in accordance with the Equality Act to enable the employee to return and remain at work.

Of our staff 10.28% have declared a disability. It is not mandatory for staff to declare disabilities. All staff complete online DSE Training and assessments on an annual basis and new joiners complete these as part of their induction. Staff are supported to purchase any DSE equipment needed and support is in place for staff with disabilities who may require specialist equipment.

Our 2025 staff survey results show that 91% of staff with an illness or LTC reported they had the reasonable adjustment(s) required to perform their duties. This has increased from 80% in the last year and is higher than the average at 81%.

Expenditure on consultancy

The ICB spent £906k on consultancy services during 25/26 (£860k during 24/25). Significant spend in 25/26 related to Outsourced Continuing Healthcare Review Work of £497k (24/25 £312k) and Digital / IT solution planning in readiness for the new organisation from 1st April 2026 (£141k).

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2026, for more than £245* per day:

Existing Arrangements	Number
Number of existing engagements as of 31 March 2026	3
for less than one year at the time of reporting	NIL
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	NIL
for between 3 and 4 years at the time of reporting	NIL
for 4 or more years at the time of reporting	1

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB has robust contractual arrangement with all of its off-payroll engagements that minimises any risk to the ICB

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245(1) per day:

Category	Number
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	5
No. not subject to off-payroll legislation(2)	3
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	NIL
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	1
the number of engagements reassessed for compliance or assurance purposes during the year	1
Of which: no. of engagements that saw a change to IR35 status following review	NIL

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the

Departments must undertake an assessment to determine whether that worker is in- scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

Category	**Number**
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the reporting period.	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	25

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages (Subject to Audit)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies (Number)	Cost of compulsory redundancies (£)	Number of other departures Agreed (Number)	Cost of other departures agreed (£)	Total number of exit packages (Number)	Total cost of exit packages (£)	Number of departures where special payments have been Made (Number)	Cost of special payment element included in exit packages (£)
Less than £10,000	NIL	NIL	6	47,780	6	47,780	NIL	NIL
£10,000 - £25,000	NIL	NIL	7	116,157	7	116,157	NIL	NIL
£25,001 - £50,000	NIL	NIL	20	746,095	20	746,095	NIL	NIL
£50,001 - £100,000	NIL	NIL	25	1,812,796	25	1,812,796	NIL	NIL
£100,001 - £150,000	NIL	NIL	8	957,984	8	957,984	NIL	NIL
£150,001 – £200,000	NIL	NIL	4	629,565	4	629,565	NIL	NIL
>£200,000	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
TOTALS	NIL	NIL	70	4,310,377	70	4,310,377	NIL	NIL

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS pension scheme. Exit costs in this note are accounted for in full in the year of departure. Where NHS Suffolk and North East Essex ICB have agreed early retirements, the additional costs are met by the ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

Type of Departure	Agreements (Number)	Total Value of agreements (£)
Voluntary redundancies including early retirement contractual costs	**72**	**4,310,377**
Mutually agreed resignations (MARS) contractual costs	**NIL**	**NIL**
Early retirements in the efficiency of the service contractual costs	**NIL**	**NIL**
Contractual payments in lieu of notice*	**NIL**	**NIL**
Exit payments following Employment Tribunals or court orders	**NIL**	**NIL**
Non-contractual payments requiring HMT approval**	**NIL**	**NIL**
TOTAL	**72**	**4,310,377**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4.3 which will be the number of individuals.

*Any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, including any cases relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report if relevant.

There were significant number of exit packages agreed and paid in 2025/26 due to the 50% running cost reductions imposed on ICBs by the Department of Health & Social Care and NHS England.

Parliamentary Accountability and Audit Report

Suffolk and North East Essex ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report if relevant. An audit report is also included in this Annual Report.

Dr Ed Garratt OBE

Chief Executive (Accountable Officer)

16th June 2026

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

Category	Note	31 March 2026 £'000	31 March 2025 £'000
Income from sale of goods and services	2	(39,726)	(40,458)
Other operating income	2	(591)	(991)
Total operating income	N/A	**(40,317)**	**(41,449)**
Staff costs	4	47,517	33,417
Purchase of goods and services	5	2,866,391	2,644,792
Depreciation and impairment charges	5	114	148
Provision expense	5	14,567	2,316
Other operating expenditure	5	3,011	1,041
Total operating expenditure	N/A	**2,931,600**	**2,681,714**
Net Operating Expenditure	N/A	**2,891,283**	**2,640,265**
Finance expense	N/A	3	6
Other Gains & Losses	N/A	NIL	(180)
Net expenditure for the Year	N/A	**2,891,286**	**2,640,091**

Statement of Financial Position as at
31 March 2026

Non-current assets:	Note	31 March 2026 £'000	31 March 2025 £'000
Right-of-use assets	7	147	261
Total non-current assets	N/A	**147**	261
Current assets:	N/A	N/A	N/A
Trade and other receivables	8	11,034	23,957
Cash and cash equivalents	9	475	1,229
Total current assets	N/A	**11,509**	25,186
Total assets	N/A	**11,656**	25,447
Current liabilities	N/A	N/A	N/A
Trade and other payables	10	(137,329)	(100,710)
Lease liabilities	7	(94)	(116)
Provisions	11	(20,231)	(7,236)
Total current liabilities	N/A	**(157,654)**	(108,062)
Non-Current Assets plus/less Net Current Assets/Liabilities	N/A	**(145,998)**	(82,615)
Non-current liabilities	N/A	N/A	N/A
Lease liabilities	7	(45)	(139)
Provisions	11	(4,632)	(4,700)
Total non-current liabilities	**N/A**	**(4,677)**	(4,839)
Assets less Liabilities	N/A	**(150,675)**	(87,454)
Financed by Taxpayers' Equity	N/A	N/A	N/A
General fund	N/A	(150,675)	(87,454)
Total taxpayers' equity:	N/A	**(150,675)**	(87,454)

The notes on pages 183 to 203 form part of this statement

The financial statements on pages 171 to 203 were approved by the Board on 15th June 2026 and signed on its behalf by:

Dr Ed Garratt OBE
Chief Executive (Accountable Officer)
16th June 2026

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

Changes in taxpayers' equity for 31 March 2026	31 March 2026 General Fund £'000
Balance at 01 April 2025	(82,352)
Changes in NHS Integrated Care Board taxpayers' equity for 31 March 2026	N/A
Net operating expenditure for the financial year	(2,640,091)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(2,640,091)**
Net funding	2,634,989
Balance at 31 March 2026	**(87,454)**

Changes in taxpayers' equity for 31 March 2025	31 March 2025 General Fund £'000
Balance at 01 April 2024	(82,352)
Changes in NHS Integrated Care Board taxpayers' equity for 31 March 2025	N/A
Net operating costs for the financial year	(2,640,091)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(2,640,091)**
Net funding	2,634,989
Balance at 31 March 202	**(87,454)**

The notes on pages 183 to 203 form part of this statement

Statement of Cash Flows for the year ended
31 March 2026

Cash Flows from Operating Activities	**Note**	**31 March 2026 £'000**	**31 March 2025 £'000**
Net operating expenditure for the financial year	N/A	(2,891,286)	(2,640,091)
Depreciation and amortisation	5	114	148
Interest paid / received	N/A	3	6
Other Gains & Losses	N/A	NIL	(180)
Finance Costs	11	(17)	(31)
(Increase)/decrease in trade & other receivables	8	12,923	858
Increase/(decrease) in trade & other payables	10	36,620	5,120
Provisions utilised	11	(1,640)	(1,865)
Increase/(decrease) in provisions	11	14,583	2,413
Net Cash Inflow (Outflow) from Operating Activities	N/A	**(2,828,700)**	(2,633,622)
Net Cash Inflow (Outflow) before Financing	N/A	**(2,828,700)**	(2,633,622)
Cash Flows from Financing Activities	N/A	N/A	N/A
Net Funding Received	N/A	2,828,064	2,634,987
Repayment of lease liabilities	N/A	(118)	(315)
Net Cash Inflow (Outflow) from Financing Activities	N/A	**2,827,946**	2,634,672
Net Increase (Decrease) in Cash & Cash Equivalents	9	**(754)**	1,050
Cash & Cash Equivalents at the Beginning of the Financial Year	N/A	**1,229**	179
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	N/A	NIL	NIL
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	N/A	**475**	1,229

The notes on pages 183 to 203 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the circumstances of the ICB for the purpose of giving a true and fair view has been selected. The policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis in accordance with the definition as set out in Section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual 2025/26, which outlines the interpretation of IAS1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents'.

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision (funding allocation) for that service in published documents, is normally sufficient evidence of going concern.

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

In carrying out its assessment, the Board has considered the following key considerations:

2026/27 Financial Plan

With effect from 1 April 2026, NHS Suffolk and North East Essex ICB disaggregated with Suffolk merging to form a new organisation, NHS Norfolk and Suffolk ICB. North East Essex merged to form a new organisation, NHS Essex ICB. Financial plans were developed and submitted to NHS England based on these new organisational boundaries.

The newly formed NHS Norfolk and Suffolk ICB will continue to operate as a Going Concern with no changes to its funding stream, and with an approved allocation for 2026-27 of £4.949 billion, ensuring healthcare service provision, throughout Norfolk and Suffolk remains unaffected.

The North East Essex element of Suffolk and North East Essex will continue as a going concern following an approved plan allocation of £5.282 billion submitted by NHS Essex ICB. This ensures the provision of healthcare services throughout Essex continues.

As in previous years, the ICB will be permitted to draw down sufficient cash from NHS England to meet expenditure levels even if these exceed the resource allocation issued.

Conclusion

Our considerations cover the period through to 30 June 2027, being 12 months beyond the date of authorisation of these financial statements. Considering these factors, the Board has a reasonable expectation that the ICB will have adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing these financial statements.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Joint Operations – Pooled Budgets

The ICB has entered a pooled budget arrangement with Suffolk County Council, in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled in the Better Care Fund and the Mental Health Pooled Fund. The former seeks to join up health and care services and the latter is used to jointly purchase mental health services.

The pools are both hosted by Suffolk County Council. The ICB accounts for its share of the assets, liabilities, income, and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.4 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.5 Revenue

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

IFRS 15 is applicable to revenue in respect of dental and prescription charges in line with the adaptation in IFRS 15 which states that the definition of a contract includes revenue received under legislation and regulations. Revenue for these charges is recognised when the performance event occurs, such as the issue of a prescription or payment for dental treatment.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.1 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services.

1.8 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise

from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.9.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

For the 2026 calendar year, HM Treasury confirmed the incremental borrowing rate as 5.32%. This will be relevant for newly commenced leases, relevant lease modifications and relevant lease remeasurement scenarios, occurring in 2026.

Lease payments included in the measurement of the lease liability comprise:

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.10 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.11 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.22% (2024-25: 4.07%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 5.32% (2024-25: 4.81%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received, and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.12 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.13 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. The ICB's financial assets are recognised at amortised cost less any impairment for expected credit losses.

1.15 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired. The ICB's financial liabilities are recognised at amortised cost.

1.16 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated recognising when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accrual's basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.18 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.18.1 Critical accounting judgements in applying accounting policies.

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Better Care Fund:

The ICB has entered into a pooled budget arrangement with Suffolk County Council (SCC) in respect of the Better Care Fund. This is a national policy initiative, and the funds involved are material in the ICB accounts. The operation is jointly led, with day to day running of the operation led either by SCC or the ICB. Having reviewed the terms of the agreement, the Department of Health and Social Care manual for accounts and the appropriate financial reporting standards, the ICB has determined that there are two elements to the Better Care Fund, and they are accounted for as follows:

- The first part is within Suffolk County Council's remit and commissions services from various non-NHS providers. Whilst the services are determined in partnership, the risks and rewards of the contracts remain wholly with the Council. The ICB accounts for its share of these costs as healthcare expenditure with the local authority.
- The second part is within the ICB's remit and involves the commissioning of various services from NHS and non-NHS providers. The risks and rewards of these contracts are the responsibility of the ICB. The ICB accounts for these costs as healthcare purchased from NHS and non-NHS providers. Otherwise, there were no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the

ICB's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.18.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Prescription Services and Prescribing Liabilities: The ICB receives financial information from NHS Business Services Authority relating to the cost of drugs prescribed by independent GPs, ICB run practices and other ICB services. The total expenditure for the period includes an estimate for February and March 2026, based on the estimated profile of spend. The estimates for February and March 2026 totalled £35.612m. The Prescription Pricing Authority currently have a two-month lag regarding the distribution of the reporting data, and in addition there is a time lag on the cash advance for the payment of prescribed drugs. However, the figures included are not believed to represent a significant level of uncertainty but are included due to the volatile nature of prescribing data.

1.19 New and revised IFRS Standards in issue but not yet effective

- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2 Other Operating Revenue

Income from sale of goods and services (contracts)	31 March 2026 £'000	31 March 2025 £'000
Non-patient care services to other bodies	**7,116**	**9,196**
Prescription fees and charges	**14,875**	**15,443**
Dental fees and charges	**16,304**	**14,662**
Other Contract income	**599**	**490**
Recoveries in respect of employee benefits	**832**	**667**
Total Income from sale of goods and services	**39,726**	**40,458**
Other operating income	**N/A**	**N/A**
Receipt of Government grants for capital acquisitions	**NIL**	**NIL**
Other non contract revenue	**591**	**991**
Total Other operating income	**591**	**991**
Total Operating Income	**40,317**	**41,449**

3.1 Disaggregation of Income - Income from sale of good and services (contracts) 2025/26

Source of Revenue	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
NHS	1,876	NIL	NIL	NIL	738
Non NHS	5,240	14,875	16,305	599	94
Total	**7,116**	**14,875**	**16,305**	**599**	**832**

Timing of Revenue	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Point in time	NIL	NIL	NIL	NIL	NIL
Over time	7,116	14,875	16,305	599	832
Total	**7,116**	**14,875**	**16,305**	**599**	**832**

Disaggregation of Income - Income from sale of good and services (contracts) 2024/25

Source of Revenue	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
NHS	701	NIL	NIL	NIL	548
Non NHS	8,495	15,443	14,662	490	119
Total	**9,196**	**15,443**	**14,662**	**490**	**667**

Timing of Revenue	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Point in time	NIL	NIL	NIL	NIL	NIL
Over time	9,196	15,443	14,662	490	667
Total	**9,196**	**15,443**	**14,662**	**490**	**667**

4. Employee benefits and staff numbers

4.1.1 Employee Benefits

Category	Total Permanent Employees £'000	Total Other £'000	2025-26 Total £'000
Salaries and wages	26,122	429	**26,551**
Social security costs	3,529	6	**3,535**
Employer Contributions to NHS Pension scheme	5,708	6	**5,714**
Apprenticeship Levy	118	NIL	**118**
Termination benefits	11,599	NIL	**11,599**
Gross employee benefits expenditure	**47,076**	**441**	**47,517**
Less recoveries in respect of employee benefits (note 4.1.2)	(832)	NIL	**(832)**
Total - Net admin employee benefits including capitalised costs	**46,244**	**441**	**46,685**

Category	Total Permanent Employees £'000	Total Other £'000	2024-25 Total £'000
Salaries and wages	24,243	783	**25,026**
Social security costs	2,740	NIL	**2,740**
Employer Contributions to NHS Pension scheme	5,308	NIL	**5,308**
Apprenticeship Levy	109	NIL	**109**
Termination benefits	234	NIL	**234**
Gross employee benefits expenditure	**32,634**	**783**	**33,417**
Less recoveries in respect of employee benefits (note 4.1.2)	(667)	NIL	**(667)**
Total - Net admin employee benefits including capitalised costs	**31,967**	**783**	**32,750**

4.1.2 Recoveries in respect of employee benefits

Category	Total Permanent Employees £'000	Total Other £'000	2025-26 Total £'000	2024-25 Total £'000
Salaries and wages	(718)	NIL	**(718)**	(567)
Social security costs	(60)	NIL	**(60)**	(46)
Employer contributions to the NHS Pension Scheme	(54)	NIL	**(54)**	(54)
Total recoveries in respect of employee benefits	**(832)**	**NIL**	**(832)**	**(667)**

4.2 Average number of people employed

Category	Permanently employed Number	Other Number	31 March 2026 Total Number	Permanently employed Number	Other Number	31 March 2025 Total Number
Total	**401.38**	**47.44**	**448.82**	**401.38**	**47.44**	**448.82**

4.3 Exit packages agreed in the 2025-26 financial year

Payment Bracket	Compulsory redundancies Number	Compulsory redundancies £	Other agreed departures Number	Other agreed departures £	2025-26 Total Number	2025-26 Total £
Less than £10,000	NIL	NIL	6	47,780	6	47,780
£10,001 to £25,000	NIL	NIL	7	116,157	7	116,157
£25,001 to £50,000	NIL	NIL	20	746,095	20	746,095
£50,001 to £100,000	NIL	NIL	25	1,812,796	25	1,812,796
£100,001 to £150,000	NIL	NIL	8	957,984	8	957,984
£150,001 to £200,000	NIL	NIL	4	629,565	4	629,565
Total	NIL	NIL	**70**	**4,310,377**	**70**	**4,310,377**

4.3 Exit packages agreed in the 2024-25 financial year

Payment Bracket	Compulsory redundancies Number	Compulsory redundancies £	Other agreed departures Number	Other agreed departures £	2024-25 Total Number	2024-25 Total £
Less than £10,000	NIL	NIL	2	14,261	2	14,261
£10,001 to £25,000	NIL	NIL	NIL	NIL	NIL	NIL
£25,001 to £50,000	2	65,190	1	29,643	3	94,833
£50,001 to £100,000	2	144,468	NIL	NIL	2	144,468
£100,001 to £150,000	NIL	NIL	NIL	NIL	NIL	NIL
£150,001 to £200,000	1	160,000	NIL	NIL	1	160,000
Total	**5**	**369,658**	**3**	**43,904**	**8**	**413,562**

Analysis of Other Agreed Departures	31 March 2026 Other agreed departures Number	31 March 2026 Other agreed departures £	31 March 2025 Other agreed departures Number	31 March 2025 Other agreed departures £
Voluntary redundancies including early retirement contractual costs	72	4,310,377	NIL	NIL
Contractual payments in lieu of notice	NIL	NIL	4	43,904
Total	**72**	**4,310,377**	**4**	**43,904**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions and conditions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and in full at the year of agreement.

On 13 March 2025 the government announced that ICB's are expected to make 50% cuts by December 2025, performing the role of a strategic commissioner.

This direction precipitated a restructure process within the ICB, which resulted in the majority of exit packages noted above in 2025-26. Disclosed in note 4.3 are those individuals who have signed their voluntary redundancy settlement agreements. There will be a significant number of exit packages disclosed in the Norfolk and Suffolk ICB accounts for the financial year 2026/27.

4.3 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

4.3.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.3.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

The ICB also offers an additional defined contribution workplace pension schemes, the National Employment Savings Scheme (NEST). The ICB has recognised £3,241 as an expense for this scheme within the 2025-26 financial statements.

5. Operating expenses

Purchase of goods and services	31 March 2026 £'000	31 March 2025 £'000
Services from other ICBs and NHS England	3,666	3,319
Services from foundation trusts	1,828,306	1,679,874
Services from other NHS trusts	137,448	116,616
Services from Other WGA bodies	NIL	1
Purchase of healthcare from non-NHS bodies	259,910	237,004
General Dental services and personal dental services	59,657	57,788
Prescribing costs	203,822	203,113
Pharmaceutical services	41,030	40,216
General Ophthalmic services	10,228	9,876
GPMS/APMS and PCTMS	240,105	220,899
Supplies and services – Clinical	194	NIL
Supplies and services – general	68,814	64,721
Consultancy services	906	860
Establishment	5,894	5,602
Transport	4	1
Premises	2,723	3,056
Audit fees	222	203
Internal Audit Expenditure	97	140
Other Auditor's Remuneration	43	73
Other professional fees	1,410	122
Legal fees	677	358
Education, training and conferences	1,235	950
Total Purchase of goods and services	**2,866,931**	2,644,792
Depreciation and impairment charges	**N/A**	N/A
Depreciation	114	148
Impairments and reversals of right-of-use assets	NIL	NIL
Total Depreciation and impairment charges	**114**	148
Provision expense	**N/A**	N/A
Change in discount rate	(17)	(31)
Provisions	14,584	2,347
Total Provision expense	**14,567**	2,316
Other Operating Expenditure	**N/A**	N/A
Chair and Non Executive Members	211	279
Grants to Other bodies	2,736	503
Clinical negligence	9	19
Research and development (excluding staff costs)	58	102
Expected credit loss on receivables	(3)	6
Other expenditure	NIL	132
Total Other Operating Expenditure	**3,011**	1,041
Total operating expenditure	**2,884,082**	2,648,297

5.1 Limitation on Auditor's Liability

The limitation on auditor's liability for external work is £2m in each contract year.

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance - Non-NHS	31 March 2026 Number	31 March 2026 £'000	31 March 2025 Number	31 March 2025 £'000
Total Non-NHS Trade invoices paid in the Year	70,169	610,957	67,629	546,146
Total Non-NHS Trade Invoices paid within target	67,404	602,138	66,312	529,618
Percentage of Non-NHS Trade invoices paid within target	**96.06%**	**98.56%**	**98.05%**	**96.97%**

Measure of compliance - NHS	31 March 2026 Number	31 March 2026 £'000	31 March 2025 Number	31 March 2025 £'000
Total NHS Trade Invoices Paid in the Year	2,520	1,948,995	2,771	1,798,542
Total NHS Trade Invoices Paid within target	2,475	1,947,497	2,721	1,793,027
Percentage of NHS Trade Invoices paid within target	**98.21%**	**99.92%**	**98.20%**	**99.69%**

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice. Target performance against these categories is at 95%.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no late payments of Commercial Debts by the ICB in the 2025/26 financial year (£NIL 2024/25)

7 Leases

7.1 Right-of-use assets

Sums for	Buildings excluding dwellings £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2025	199	14	213
Additions	NIL	NIL	NIL
Derecognition for early terminations	NIL	NIL	NIL
Cost/Valuation at 31 March 2026	**199**	**14**	**213**
Depreciation 01 April 2025	(62)	14	48
Charged during the year	114	NIL	114
Depreciation at 31 March 2026	**52**	**14**	**66**
Net Book Value at 31 March 2026	**147**	**NIL**	**147**

7 Leases cont'd

7.2 Lease liabilities

Sums for	31 March 2026 £'000	31 March 2025 £'000
Lease liabilities at 01 April 2024	(256)	(762)
Additions purchased	NIL	(51)
Interest expense relating to lease liabilities	(3)	(6)
Repayment of lease liabilities (including interest)	120	315
Derecognition for early terminations	NIL	248
Lease liabilities at 31 March 2025	**(139)**	(256)

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

Sums for	31 March 2026 £'000	31 March 2025 £'000
Within one year	(94)	(116)
Between one and five years	(57)	(94)
After five years	NIL	(45)
Balance at 31 March 2026	**(151)**	**(255)**
Effect of Discounting	**12**	**(1)**
(I) Current lease liabilities	**(94)**	**(116)**
(II) Non-current lease liabilities	**(45)**	**(139)**
Total	**(139)**	**(256)**

7 Leases cont'd

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

Sums for	31 March 2026 £'000	31 March 2025 £'000
Depreciation expense on right-of-use assets	114	148
Interest expense on lease liabilities	3	6

7.5 Amounts recognised in Statement of Cash Flows

Sums for	31 March 2026 £'000	31 March 2025 £'000
Total cash outflow on leases under IFRS 16	118	315

8.1 Trade and other receivables

Receivable Category	Current 31 March 2026 £'000	Current 31 March 2025 £'000
NHS receivables: Revenue	1,069	4,683
NHS prepayments	106	24
NHS accrued income	366	1,274
NHS Contract Receivable not yet invoiced/non-invoiced	479	NIL
Non-NHS and Other WGA receivables: Revenue	1,030	865
Non-NHS and Other WGA prepayments	2,123	7,432
Non-NHS and Other WGA accrued income	300	413
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	4,974	7,634
Expected credit loss allowance-receivables	(6)	(9)
VAT	536	1,586
Other receivables and accruals	55	55
Total Trade & other receivables	**11,034**	23,957
Total current	**11,034**	23,957

8.2 Receivables past their due date but not impaired

Period	31 March 2026 DHSC Group Bodies £'000	31 March 2026 Non-DHSC Group Bodies £'000	31 March 2025 DHSC Group Bodies £'000	31 March 2025 Non-DHSC Group Bodies £'000
By up to three months	252	NIL	115	NIL
By three to six months	NIL	NIL	3	NIL
By more than six months	8	NIL	79	NIL
Total	**260**	**NIL**	**197**	**NIL**

8.3 Loss allowance on asset classes

Sums for	Trade and other receivables - Non DHSC Group Bodies £'000	Other Financial Assets £'000	Total £'000
Balance at 01 April 2025	**(9)**	**NIL**	**(9)**
Lifetime expected credit losses on trade and other receivables-Stage 2	3	NIL	**3**
Total	**(6)**	**NIL**	**(6)**

9 Cash and cash equivalents

Sums for	31 March 2026 £'000	31 March 2025 £'000
Balance at 01 April 2025	1,229	179
Net change in year	(754)	1,050
Balance at 31 March 2026	**475**	1,229
Made up of:	N/A	N/A
Cash with the Government Banking Service	475	1,229
Balance at 31 March 2026	**475**	1,229

10 Trade and other payables

Payable Category	Current 31 March 2026 £'000	Current 31 March 2025 £'000
NHS payables: Revenue	8,491	1,860
NHS accruals	8,042	7,801
NHS deferred income	45	431
Non-NHS and Other WGA payables: Revenue	14,427	11,948
Non-NHS and Other WGA accruals	87,786	60,514
Non-NHS and Other WGA deferred income	822	538
Social security costs	387	342
Tax	371	370
Other payables and accruals	16,958	16,906
Total Trade & Other Payables	**137,329**	100,710
Total current and non-current	**137,329**	100,710

Other payables include £1,732k outstanding pension contributions at 31 March 2026 (£1,555k at 31 March 25)

11 Provisions

Provision Category	Current 31 March 2026 £'000	Non-Current 31 March 2026 £'000	Current 31 March 2025 £'000	Non-Current 31 March 2025 £'000
Restructuring	3,382	NIL	NIL	NIL
Redundancy	93	NIL	110	NIL
Legal claims	2,748	NIL	85	65
Continuing care	5,035	NIL	4,044	NIL
Other	8,973	4,632	2,997	4,635
Total	**20,231**	**4,632**	**7,236**	**4,700**

The balance of total current and non-current provisions as at 31 March 2026 is £24,863k (31 March 2025 £11,936k)

Sums for	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2025	**NIL**	**110**	**150**	**4,044**	**7,633**	**11,936**
Arising during the year	3,382	NIL	2,830	4,534	9,235	**19,891**
Utilised during the year	NIL	(17)	(161)	(185)	(1,277)	**(1,640)**
Reversed unused	NIL	NIL	(71)	(3,358)	(1,969)	**(5,398)**
Change in discount rate	NIL	NIL	NIL	NIL	(17)	**(17)**
Balance at 31 March 2026	**3,382**	**93**	**2,748**	**5,035**	**13,605**	**24,863**
Expected timing of cash flows:	N/A	N/A	N/A	N/A	N/A	N/A
Within one year	3,382	93	2,748	5,035	8,973	**20,231**
Between one and five years	NIL	NIL	NIL	NIL	3,437	**3,437**
After five years	NIL	NIL	NIL	NIL	1,195	**1,195**
Balance at 31 March 2026	**3,382**	**93**	**2,748**	**5,035**	**13,605**	**24,863**

The restructuring provision held consists of the costs associated with the ICB reducing its running costs to £19 per head of population as per the NHSE and DHSC national directive for ICBs. Legal claims is calculated as the expected expenditure associated with the restructuring of the organisation plus other ongoing legal cases.

The continuing care provision consists of the likely costs associated with appeals as at 31 March 2026 and the likely costs associated with a backlog of cases that relate to retrospective periods of care. The provision has been calculated on a case-by-case basis using both average weekly costs and conversion rates.

Provisions that make up "Other" include onerous contract provisions in respect of NHSPS / CHP premises where SNEE as geographical commissioner is liable for the void costs (£5.5m) and provisions in respect of funding clawbacks (£6.5m).

Clinical Negligence Balances

The value of provisions carried in the books of NHS Resolution in regard to CNST claims as at 31 March 2026 is £94,674 (£166,895 as at 31 March 2025)

12 Financial instruments

12.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the NHS integrated care board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS integrated care board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS integrated care board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS integrated care board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS integrated care board and internal auditors.

12.1.1 Currency risk

The NHS integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS integrated care board has no overseas operations and therefore has low exposure to currency rate fluctuations.

12.1.2 Credit risk

Because the majority of the NHS integrated care board revenue comes from parliamentary funding, the NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.3 Liquidity risk

The NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

12.1.4 Financial Instruments

As the cash requirements of the NHS integrated care board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the NHS integrated care board's expected purchase and usage requirements and the NHS integrated care board is therefore exposed to little credit, liquidity or market risk.

12 Financial instruments cont'd

12.2 Financial assets

Financial Asset Category	Financial Assets measured at amortised cost 31 March 2026 £'000	Financial Assets measured at amortised cost 31 March 2025 £'000
Trade and other receivables with NHSE bodies	603	5,746
Trade and other receivables with other DHSC group bodies	1,312	210
Trade and other receivables with external bodies	6,360	8,967
Cash and cash equivalents	475	1,229
Total at 31 March 2025	**8,750**	16,152

12.3 Financial liabilities

Financial Liability Category	Financial Liabilities measured at amortised cost 31 March 2026 £'000	Financial Liabilities measured at amortised cost 31 March 2025 £'000
Trade and other payables with NHSE bodies	714	742
Trade and other payables with other DHSC group bodies	15,819	9,019
Trade and other payables with external bodies	119,171	89,269
Private Finance Initiative and finance lease obligations	139	256
Total at 31 March 2024	**135,843**	99,286

13 Mental Health expenditure

13 Mental Health expenditure	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	197,032	173,157
Eligible mental health expenditure	197,211	173,285
Mental health expenditure above/(below) minimum investment required	179	128
Mental health expenditure as a proportion of total expenditure	6.82%	6.56%

14 IFRS 17 Insurance Contracts Reconciliation to movements

The primary objective of an ICB is to commission health services for the local population free at the point of use. An assessment of the ICB's contracts has been carried out and none were found to be within the scope of IFRS 17.

15 Operating Segments

The ICB consider they only have one segment : Commissioning of Healthcare Services

16 Joint arrangements - interests in joint operations

ICBs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

16.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	31 March 2026 Assets £'000	31 March 2026 Liabilities £'000	31 March 2026 Income £'000	31 March 2026 Expenditure £'000
Mental Health Pooled Fund	Suffolk County Council	Purchase of mental health services	NIL	NIL	NIL	1,239
Better Care Fund	Suffolk County Council	Jointly commission or deliver health and social care services	NIL	NIL	NIL	57,358

N

Name of arrangement	Parties to the arrangement	Description of principal activities	31 March 2025 Assets £'000	31 March 2025 Liabilities £'000	31 March 2025 Income £'000	31 March 2025 Expenditure £'000
Mental Health Pooled Fund	Suffolk County Council	Purchase of mental health services	NIL	NIL	NIL	1,118
Better Care Fund	Suffolk County Council	Jointly commission or deliver health and social care services	NIL	NIL	NIL	56,396

The amounts disclosed above represent the values recognised in SNEE ICB's books ONLY.

17 Related party transactions 2025-26

Details of related party transactions with individuals are as follows:

Board member	Title	Related party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party in respect of Primary Care Provision £'000
Freda Bhatti	Primary Care Essex Partner	Salaried GP with Suffolk Primary Care	NIL	NIL	2	NIL	41
Ewen Cameron	Provider Partner – Community, WSFT	CEO at West Suffolk NHS Foundation Trust	333,597	94	222	24	NIL
David Cargill	Primary Care Suffolk Partner	Suffolk LMC member	348	NIL	NIL	NIL	NIL
Caroline Donovan	Provider Partner – Mental Health, NSFT	Board member at Norfolk and Suffolk NHS Foundation Trust	122,369	165	2,889	154	NIL
Nick Hulme	Provider Partner - Acute	CEO of East Suffolk and North Essex NHS Foundation Trust	1,028,067	1,853	2,466	556	NIL
Gareth Everton	Suffolk County Council Partner	Executive Director Adult Social Care	50,650	5,698	3,793	319	NIL
Steve Wiles	Suffolk County Council Partner	Cabinet Member Public Health Suffolk County Council	50,650	5,698	3,793	319	NIL
Moira McGrath	Essex County Council Partner	Director of Commissioning – Adult Social Care for Essex County Council	39,965	490	9,846	254	NIL
Maddie Baker-Woods	Ipswich and East Suffolk Alliance Executive Director	Trustee of Suffolk ArtLink	17	NIL	NIL	NIL	NIL
John Spence	ICP Co-Chair Essex	Life Vice President of Essex Community Foundation	90	NIL	NIL	NIL	NIL
John Spence	ICP Co-Chair Essex	County Councillor for Essex County Council	39,965	490	9,846	254	NIL
Elizabeth Moloney	Director of Operations (UEC)	Husband is CEO at East of England Ambulance Service NHS Trust	106,166	NIL	14	NIL	NIL

Richard Watson (Deputy Chief Executive and Executive Director of Strategy and Transformation), held the position of National Programme Director for Strategic Commissioning at NHS England during 2025/26. The transactions with NHS England however have not been disclosed within the table above as NHS England fall within the Department of Health Social Care organisational boundary.

2025/26 Entities with whom the value of transactions exceeded £250k

The Department of Health and Social Care, as the parent of NHS England, is regarded as a related party. The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group. The ICB were provided with a list of the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2026.

The entities listed below have transactionised with the ICB during the year ended 31 March 2026.

DHSC Related party
Accurx Ltd
NHS Confederation
NHS England

Barking, Havering & Redbridge University Hospitals NHS Trust
Barts Health NHS Trust
Bedfordshire Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire & Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Chelsea & Westminster Hospital NHS Foundation Trust
Community Health Partnerships
East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
East Suffolk & North Essex NHS Foundation Trust
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's & St Thomas' NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Homerton Healthcare NHS Foundation Trust
Imperial College Healthcare NHS Trust
James Paget University Hospitals NHS Foundation Trust
King's College Hospital NHS Foundation Trust
London North West University Healthcare NHS Trust
Mid & South Essex NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
NHS ARDEN & GREATER EAST MIDLANDS CSU
NHS Cambridgeshire and Peterborough ICB
NHS Hertfordshire and West Essex ICB
NHS Mid and South Essex ICB
NHS NORTH OF ENGLAND CSU
NHS Property Services
Norfolk & Norwich University Hospitals NHS Foundation Trust
Norfolk & Suffolk NHS Foundation Trust
Norfolk Community Health And Care NHS Trust
North East London NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Royal Free London NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
Royal Papworth Hospital NHS Foundation Trust
South London & Maudsley NHS Foundation Trust
St George's University Hospitals NHS Foundation Trust
The Princess Alexandra Hospital NHS Trust
The Royal Marsden NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
West Suffolk NHS Foundation Trust

In addition, NHS Suffolk & North East Essex ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Suffolk County Council & Essex County Council.

There were transactions with NHS Norfolk and Waveney ICB, however these were mainly related to recharges between the organisations, as part of the sharing of staff.

- Francesca Swords
- Ed Garratt
- Howard Martin
- Amanda Lyes
- Lisa Nobes
- Richard Watson
- Will Pope
- Maddie Baker-Woods
- Mark Burgis

17 Related party transactions 2024-25

Details of related party transactions with individuals are as follows:

Board member	Title	Related party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party in respect of Primary Care Provision £'000
Dr Freda Bhatti	Primary Care Essex Partner	GP partner at Great Bentley Surgery	15	NIL	NIL	NIL	1,587
Dr Nick Rayner	Primary Care Suffolk Partner	Non-executive director at Suffolk GP Federation CIC	5,883	34	179	NIL	NIL
Steve Clarke	Non-Executive Member Finance and Audit	Independent Board Director at University of Suffolk	1,003	92	NIL	141	NIL
Ewen Cameron	NHS Partner Provider (WSFT)	Chief Executive at West Suffolk NHS Foundation Trust	291,081	10	422	13	NIL
Nick Hulme	NHS Partner Provider (ESNEFT)	Board member at East Suffolk and North Essex NHS Foundation Trust	793,013	1,984	99	14	NIL
Nick Hulme	NHS Partner Provider (ESNEFT)	CEO of Norfolk & Norwich University Hospitals NHS FT	8,012	4	1	NIL	NIL
Stuart Richardson / Caroline Donovan	NHS Partner Provider (NSFT)	Board member at Norfolk and Suffolk NHS Foundation Trust	106,432	299	134	15	NIL
Sue Cook / Georgia Chimbani / Stuart Keeble	Suffolk County Council Partner	Board member Suffolk County Council	65,014	9,371	4,287	716	NIL
John Spence	ICP Co-Chair Essex - Essex County Council representative	Life Vice President of Essex Community Foundation	24	NIL	NIL	NIL	NIL
Maddie Baker-Woods	Director Ipswich and East Suffolk Alliance	Trustee of Suffolk ArtLink	20	NIL	NIL	NIL	NIL
Geoff Dobson	Non Executive - Finance and Audit - Interim	Non-Executive Director on the Audit and Risk Committee of Suffolk Group Holdings;	NIL	NIL	NIL	NIL	NIL
Geoff Dobson	Non Executive - Finance and Audit - Interim	Vertas Group Limited	2	NIL	NIL	NIL	NIL
Geoff Dobson	Non Executive - Finance and Audit - Interim	Concertus Design and Property Consultants Ltd	9	NIL	2	NIL	NIL

Details of related party transactions with entities controlled or influenced by Department of Health and Social Care Ministers or their close families

The Department of Health and Social Care, as the parent of NHS England, is regarded as a related party. The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party

DHSC Related party
Accurx Ltd
Cera Care Ltd
NHS Confederation
NHS England

2024/25 Entities with whom the value of transactions exceeded £250k

The Department of Health is regarded as a related party. During the year Suffolk and North East Essex ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The main entities

Barking, Havering & Redbridge University Hospitals NHS Trust
Barts Health NHS Trust
Bedfordshire Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire & Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Community Health Partnerships
East of England Ambulance Service NHS Trust
East Suffolk and North Essex NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's & St Thomas' NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Homerton Healthcare NHS Foundation Trust
Imperial College Healthcare NHS Trust
James Paget University Hospitals NHS Foundation Trust
King's College Hospital NHS Foundation Trust
London North West University Healthcare NHS Trust
Mid and South Essex NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
NHS Arden & Greater East Midlands CSU
NHS Cambridgeshire and Peterborough ICB
NHS England - CORE
NHS England - East of England Regional Office
NHS Hertfordshire and West Essex ICB
NHS Mid and South Essex ICB
NHS North of England CSU
NHS Property Services
Norfolk & Norwich University Hospitals NHS Foundation Trust
Norfolk & Suffolk NHS Foundation Trust
North East London NHS Foundation Trust
Royal Free London NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
Royal Papworth Hospital NHS Foundation Trust
South London & Maudsley NHS Foundation Trust
The Princess Alexandra Hospital NHS Trust
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
West Suffolk NHS Foundation Trust

In addition, NHS Suffolk & North East Essex ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Suffolk County Council & Essex County Council.

18 Events after the end of the reporting period

NHS Norfolk and Suffolk ICB was established with effect from 1 April 2026. As part of this reorganisation of ICBs, NHS Norfolk & Waveney ICB and NHS Suffolk and North East Essex ICB have been abolished. NHS Suffolk and North East Essex ICB services were disaggregated, with the responsibilities and associated assets and liabilities for the Suffolk footprint transferred to NHS Norfolk and Suffolk ICB and for the North East Essex footprint to NHS Essex ICB.

This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

19 Financial performance targets

NHS Integrated Care Boards have a number of financial duties under the

NHS Act 2006 (as amended). NHS Integrated Care Board performance

against those duties was as follows:

Performance Target	NHS Act Section	Duty Achieved?	31 March 2026 Target £'000	31 March 2026 Performance £'000	31 March 2025 Target £'000	31 March 2025 Performance £'000
Expenditure not to exceed income	223H(1)	Yes	2,952,291	2,931,602	2,701,446	2,681,539
Revenue resource use does not exceed the amount specified in Directions	223I(3)	Yes	2,911,974	2,891,285	2,659,996	2,640,089
Revenue administration resource use does not exceed the amount specified in Directions	223J(3)	Yes	26,087	25,761	19,097	16,950

20 Special Payments and Losses

The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

Losses	Total Cases 31 March 2026 Number	Total Cases 31 March 2026 £'000	Total Cases 31 March 2025 Number	Total Cases 31 March 2025 £'000
Administrative write-offs	NIL	NIL	1	0
Total	**NIL**	**NIL**	**1**	**0**

Special payments	Total Cases 31 March 2026 Number	Total Cases 31 March 2026 £'000	Total Cases 31 March 2025 Number	Total Cases 31 March 2025 £'000
Extra Contractual Payments	NIL	NIL	2	133
Total	**NIL**	**NIL**	**2**	**133**

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The ICB incurred 1 loss during 24/25 of £35.40. The ICB made 2 termination payments during 24/25 in respect of leases for the corporate estate. Each payment was approved in line with the ICB's financial governance process for such transactions and reported to the audit committee via the ICB's Special Payments and Losses register.