NHS
Norfolk and Suffolk
Integrated Care Board

A meeting of the NHS Norfolk and Suffolk Integrated Care Board

Wednesday 23 September 2026 10.00am

Council Chamber, Town Hall, Hall Plain, Great Yarmouth, Norfolk, NR30 2QF

Chair: Will Pope

Item	Time	Agenda Item	Purpose	Lead
1.	10.00	**Welcome, introductions and apologies**	N/A	**Chair**
2.	10.02	**Notification of Questions from the Public**	N/A	**Chair**
3.	10.05	**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests.	N/A	**Chair**
4.	10.10	**Minutes from previous meeting and matters arising**	Approval	**Chair**
5.	10.15	**Action Log**	Information	**Chair**
6.	10.20	**Chief Executive Update**	Information	**Ed Garratt** (Chief Executive)
7.	10.30	**Norfolk and Suffolk Population Health Management approach: a recent example in weight management**	Endorse	**Dr. Michael Smith** (Acting Executive Medical Director)
8.	10.55	**Norfolk and Suffolk Winter Plan 2026/27 – Board Assurance and Approval**	Approve	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)
9.	11.20	**Norfolk and Suffolk Health and Care Research Leadership Group**	Endorse	**Dr. Michael Smith** (Acting Executive Medical Director)
10.	11.35	**UCCH (Unscheduled care Co-ordination Hub) development and overnight provision across Norfolk and Suffolk**	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)

11.	11.45	**NHS Norfolk and Waveney ICB Annual Assessment Letter**	Information	**Ed Garratt** (Chief Executive)
12.	11.50	**NHS Suffolk and North East Essex ICB Annual Assessment Letter**	Information	**Ed Garratt** (Chief Executive)
13.	11.55	**Annual Report and Accounts for NHS Norfolk and Waveney ICB** (Published separately)	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning) **Howard Martin** (Executive Finance and Contracts Director)
14.	12.00	**Annual Report and Accounts for NHS Suffolk and North East Essex ICB** (Published separately)	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning) **Howard Martin** (Executive Finance and Contracts Director)
N/A	12.05	**Break**	N/A	N/A
15.	12.15	**Integrated Performance Report**	Information	**Richard Watson** (Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning)
16.	12.25	**Finance Report (Month 5)**	Information	**Howard Martin** (Executive Finance and Contracts Director)
17.	12.35	**Committee Highlight Reports**	Information	Committee Chairs
18.	12.40	**Amendments to Scheme of Reservations and Delegations**	Approval	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
19.	12.45	**Risk Management and Board Assurance Framework**	Information	**Amanda Lyes** (Executive Director of People, Governance, and Corporate Services)
20.	12.50	**Questions from the Public**	N/A	Chair
21.	13.00	**Any Other Business**	N/A	Chair

Date, time and venue of future Public Board Meetings:

- Wednesday 16 December 2026 – 2pm Online
- Wednesday 27 January 2027 – 10.00 am Diss Business Hub, Diss, IP22 4GT
- Wednesday 24 March 2027 – 10.00am King's Lynn Town Hall, Saturday Market Place, PE30 5DQ

The minutes of a meeting of the NHS Norfolk and Suffolk Integrated Care Board held on Wednesday, 15 July 2026 at 10.00am in the New Green Centre (Main Hall), Thurston, IP31 3TG.

Present
Members of the Board

Will Pope, Chair of the ICB
Kirsten Alderson, VCSE Member – Chair of the Suffolk VCFSE Assembly
Cath Byford, NHS Foundation Trust Partner Member – Chief Patient Experience Officer and Deputy Chief Executive Officer, Norfolk and Suffolk NHS Foundation Trust (deputy member)
Dr David Cargill, Primary Care Partner Member – Suffolk
Professor Lesley Dwyer, NHS Foundation Trust Partner Member – Chief Executive, Norfolk and Waveney University Hospitals Group.
Dr. Ewen Cameron, NHS Foundation Trust Partner Member – Chief Executive, West Suffolk NHS Foundation Trust
Tim Gardiner, VCSE Member – Chair of the Norfolk and Waveney VCSE Assembly
Dr. Ed Garratt, Chief Executive
Stuart Keeble, Local Authority Partner Member – Director of Public Health, Suffolk County Council
Amanda Lyes, Accountable Emergency Officer and Executive Director of People, Governance, and Corporate Services
Adrian Marr, NHS Foundation Trust Partner Member - Chief Executive, East Suffolk and North Essex NHS Foundation Trust
Howard Martin, Executive Finance and Contracts Director
Phanuel Mutumburi, Non-Executive Member
Lisa Nobes, Executive Director of Nursing
Elaine Noske, Non-Executive Member
Professor Frankie Swords, Executive Medical Director
Janet Wood, Non-Executive Director

Regular Attendees
Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk)
Adele Madin, Chief Executive, East Coast Community Healthcare CIC
Richard Watson, Executive Director of Strategy, Digital, and Commissioning

Also in attendance
Helen Bowles, Head of Health and Work for item 13
Michelle Grant-Richardson, Integrated Care Partnership Team for item 12
Tom McColgan, Corporate Governance Manager (minutes)
Neill Moloney, Chief Executive, East of England Ambulance Service NHS Trust for item 5
Andy Wall and Claudine Keelan, Clinical Specialist Occupational Therapist for item 4

1. Welcome, introductions and apologies

1.1. Apologies had been received from David Holt, Non-Executive Member; Caroline Donovan, NHS Foundation Trust Partner Member – Chief Executive, Norfolk and Suffolk NHS Foundation Trust; Ian Wake, Local Authority Partner Member - Executive Director of Adult Social Service, Norfolk County Council; Maddie Baker-Woods, Executive Director of Primary Care and Neighbourhood Health (Suffolk); and Dr Antonia Moussakou, Primary Care Partner Member – Norfolk

2. Notification of Questions from the Public

2.1. The Chair noted that questions received in advance of the meeting would be put to the Board under item 22 and that questions and responses would be published in full on the ICB's website.

2.2. The Chair invited Mr. Dooley to address the meeting. Mr. Dooley stated that he felt that the agenda should have included items on the NHS's contract with Palantir and the report of the independent

review of maternity services at the Shrewsbury and Telford Hospital NHS Trust as they were matter of public interest.

3. Declarations of interest

3.1. No members present declared an interest in any item on the agenda.

4. **Patient Story**

4.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services introduced the presentation and the 'Every Minute Matters' campaign.

4.2. Andy Wall spoke of his experience of suffering a cardiac arrest at a Norwich City football match, the help that he had received from stewards, paramedics, and staff at the Norfolk and Norwich Hospital. He spoke to the impact on his and his family's emotional and mental health and the invaluable support provided through the Cardiac Arrest Rehab Pathway which supported patients and their families particularly highlighting the support to build confidence around exercising which had been crucial to a full recovery.

4.3. Andy Wall had become an ambassador for the 'Every Minute Matters Campaign' which worked to encourage people to learn CPR through the Revivr tool by raising awareness at football matches. For the Championship play-off games the stands at Wembley Stadium had been renamed for survivors of cardiac arrest including Andy. The Campaign had exceeded its initial goal of getting 270,000 trained and was aiming to get even more people trained. Revivr was a free online tool provided by the British Heart Foundation.

4.4. Claudine Keelan, Clinical Specialist Occupational Therapist, Norfolk and Norwich University Hospital Trust spoke to the Cardiac Arrest Rehab Pathway which had been established as a pilot which had since concluded. Cardiac Arrest survival rates were increasing, which should be celebrated but did highlight the gap in recovery support which existed in England. The cost of the Pathway which had been piloted was around £60,000p.a. which would deliver several clinicians working for the pathway part time and administrative support.

4.5. The Chair thanked Andy Wall for sharing his story with the Board and Claudine Keelan for her presentation on the Recovery Pathway.

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

- Cardiovascular Disease was one of the ICB's priorities identified in the Population Health Improvement Plan and the National CVD Modern Service Framework was published jointly by the Department of Health & Social Care and NHS England in the last week. The ICB was developing a wider programme of investment in care for patients who suffered a cardiac arrest, which would be brought to a future Board meeting for consideration. The Board requested that an update on investment in the CVD pathway to meet the National CVD Modern Service Framework be reported to a future meeting.

- The Board recognised the impact of cardiac arrest as set out in the presentation and the need to ensure that follow up care was available to help recover and to prevent reoccurrence.

- The Board heard that the Quality Committee had also heard a patient story from an individual who had suffered a cardiac event. The Board supported the Committee's suggestion that all staff be encouraged to complete the 'Revivr' CPR training and that this could be made a part of mandatory training.

- The Board discussed the wider approach to pilot schemes in the system and the need to take a more systematic approach when considering whether to end a pilot programme and the support available to patients once a pilot concludes. The Board supported the ICB and providers reviewing

pilot schemes that had concluded to examine whether they should be incorporated into business as usual practice and ensuring that patients had not been left without support.

4.7. The Board **NOTED** the report.

Actions

- The Board requested that an update on investment in the CVD pathway to meet the National CVD Modern Service Framework be reported to a future meeting.

5. **East of England Ambulance Service NHS Trust (EEAST) Update**

5.1. Neill Moloney, Chief Executive, East of England Ambulance Service NHS Trust (EEAST) spoke to the presentation circulated with the agenda. He highlighted response time performance, hear and treat activity, hospital handover times, 111 activity, Unscheduled Care Coordination Hub activity, and the Independent Culture Review.

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

- The Board welcomed the presentation and the performance improvements particularly around category 1 and category 2 patients.
- The Board acknowledged the challenges presented by Norfolk and Suffolk's rurality and road infrastructure and considered how these could be addressed. The Board heard that in general increasing the availability of ambulances through improving hospital handover times and diverting demand to the community would help this. The Board also heard that there was an expectation of a significant growth in demand in rural areas and there was need to plan how to meet this.
- The Board noted that there were a number of business cases being developed by the ICB which would support an increase in community capacity which would in turn increase hand back rates. The Board noted that an Integrated Strategic Care plan would be reported to a future meeting.

5.3. The Board noted the report and endorsed the work of East of England Ambulance Service NHS Trust.

6. Minutes from previous meeting and matters arising

6.1. The Board approved the minutes of the previous meeting as a true and correct record.

7. **Action Log**

7.1. The Board noted the update to the actions.

7.2. Mark Burgis, Executive Director of Primary Care and Neighbourhood Health (Norfolk and Waveney) provided an update on further engagement with the Save Benjamin Court Campaign.

7.3. Lisa Nobes, Executive Director of Nursing providing an update on out of area placements and stated that the out of area placement panel was now in operation and had already met to review a placement.

8. Chief Executive Update

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

- The Board joined Ed Garratt in thanking the Team that had organised the first Norfolk and Suffolk Expo which had been held earlier in the month. The event had brought together over 1,500 people and organisations across Norfolk and Suffolk and had concluded with a healthcare awards event.
- The ICB had secured £8million from the Department of Science, Innovation and Technology to support Obesity and Weight Management work and hoped to work with UEA to deliver maximum value from that funding.

- The ICB had made a range of mental health investments in line with the Mental Health Strategic Plan including £20m to expand mental health teams in schools and had given provisional support to the Complex Emotional Needs Service and a further investment in Assertive Outreach was anticipated.
- The Board could expect to see further business cases soon around end of life care, neighbourhood health, and outpatient reform.

8.2. The Board **NOTED** the update.

9. Strategic Commissioning Policy and Toolkit

9.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning introduced the Strategic Commissioning Policy and Toolkit which sought to provide a consistent approach to how the ICB would develop business cases and commission services. The toolkit linked well with the national toolkit.

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

- The Board noted the feedback from the Strategic Commissioning Committee which had reviewed a number of business cases and had started to see the impact on the toolkit around providing consistent oversight, calculation of impact, finance, and consultation.
- The Board considered how it could assess whether the toolkit was having the expected impact. The Board noted that the immediate impact would be seen in the business cases which came through. The ICB was also undertaking a baseline assessment against the national toolkit. The Strategic Commissioning Committee would also be a key source of assurance for the Board.
- The Board welcomed the clear inclusion of clinical leadership featured in the toolkit.
- The Board noted the emphasis on evidence based commissioning and building robust evaluation metrics into business cases. The Board welcomed the suggestion that the ICB work closely with the Public Health Teams to gather the evidence which would inform business cases.
- The Board highlighted the need to ensure an equity of investment across the ICB area and noted that the Strategic Commissioning Committee had taken an action to review this in detail.
- The Board support using the toolkit to help providers understand the ask from the ICB and the approach to the business case to help with the maturity of the system.

9.3. The Board **ENDORSED** the Strategic Commissioning Policy and Toolkit.

10. Mental Health Strategic Plan

10.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning presented the Mental Health Strategic Plan which set out a clear long term vision for mental health services in Norfolk and Suffolk. He highlighted the perinatal and maternity mental health services in the plan as well as the focus on early interventions.

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

- The Board noted that the Strategic Commissioning Committee had considered and approved the plan at their last meeting. The Committee had robustly scrutinised the plan and had emphasised the need to have clear evaluation methodology approved.
- The Board welcomed the focus on health equity and the inequalities associated with a diagnosis of serious mental illness.
- The Board discussed the changing role of the ICB as a strategic commissioner and how this was reflected in the Strategic Plan which set out the population outcome but not a prescribed staffing model.

10.3. The Board **ENDORSED** the Mental Health Strategic Plan.

11. Community Stroke Services Business Case (Left Shift) 2026/27

11.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning presented the Community Stroke Services Business Case (Left Shift) 2026/27. The Business Case set out a recurrent investment which would deliver better patient outcomes through improved stroke rehab provision and was projected to release 7,000 acute bed days.

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

- The Board heard that the Strategic Commissioning Committee had approved the business case at their last meeting but had highlighted a risk around recruitment of staff to deliver the service.
- The Board welcomed the inclusive and collaborative approach that the ICB had taken to developing the business case.
- The Board recognised again that there was a need to review equity across the ICB area and noted that the business case was the start of broader work on the stroke pathway.
- The Board noted the recent visit from the NHSE leads for stroke to the Norfolk and Waveney University Hospital Group and the support they had given to the investment in stroke rehab.

11.3. The Board **ENDORSED** the business case

12. **Norfolk and Suffolk Health and Care Expo 2026**

12.1. Michelle Grant-Richardson, Integrated Care Partnership Team spoke to a presentation circulated with the agenda. 1,500 people had attended the first Norfolk and Suffolk Expo and there had been 160 exhibits and 12 workshops running on the day. The events focus was on rural health. The Expo had been followed by a health and care awards event where there had been 85 winners across 8 categories.

12.2. The Board noted the positive feedback received from attendees and thanked all those who organised and delivered the Expo for their work. The Board also thanked all those who had been nominated and won awards for their work.

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

13. East Coast Partnership & WorkWell

13.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services was joined by Helen Bowles, Head of Work & Health to present the report.

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

- The Board considered how the work set out in the report fit with the approach set out in the Young People and Work report authored by Rt Hon Alan Milburn.
- The Board recognised the potential opportunity to generate local employment from the three new hospitals programmes in the area; not just healthcare related employment but also around the construction of the new hospitals.
- The Board considered the toolkit which had been developed to help identify risk factors for a young person being not in employment, education, or training (NEET) at the age of 16. Schools could use the toolkit to help target wrap around support at those most at risk.
- The Board noted that the Apollo project mentioned in the report had been funded as a pilot and noted that recurrent funding for the programme had not been identified.
- The Board recognised that it was also important to look at the support provided to help individuals who were employed to maintain that employment. The Board heard that the Local Medical Committee was keen to support work around reasonable adjustments and asked that ICB Officers make contact.

13.3. The Board **NOTED** the report.

Actions

- The Board requested a further update in January 2027.

14. Lord Mann Review: Tackling Antisemitism and Racism in the NHS

14.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report.

14.2. The Board welcomed the fact that the ICB had accepted all of the recommendations but recognised that there was significant work to be done to implement them. The Board asked that the Remuneration Committee maintain oversight of the implementation of the recommendations. The Board also asked that the Committee seek assurance from the local NHS Trusts that they were also working to implement the recommendations. The Board heard that the implementation of the recommendations was being discussed by Chief People Officers at the local NHS organisations and best practice was being shared across the system.

14.3. The Board **ENDORSED** the report.

Action

- The Board requested that the Remuneration Committee maintain detailed oversight of the implementation of the recommendations and provide a further update to the Board. The Board also asked that the Remuneration Committee seek assurance from local NHS Providers that they were also progressing the implementation of the recommendations.

15. 2025 NHS Staff Survey Results

15.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report. She emphasised that participation in the staff survey had not been mandatory for ICBs in 2025 but that both historic ICBs had opted in. The feedback was being used to inform the organisational development programme for the ICB.

15.2. The Board welcomed the positive outcome of the survey but expressed disappointment at the gap between the two historic ICBs and the difference in staff experience that this represented. The Board recognised that culture change would not happen overnight and welcomed the organisational development programme as a positive way forward.

15.3. The Board **NOTED** the report.

16. Integrated Performance Report

16.1. Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital, and Commissioning presented the report highlighting the items for escalations and providing an overview of the new National Oversight Framework. He noted that the performance dashboard had been presented in a new format and that this would continue to develop over the coming months.

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

17. Finance Report

17.1. Howard Martin, Executive Finance and Contracts Director presented the report. He stated that the ICB's balanced financial plan of £4.9billion expenditure was contingent on achieving a £101m cost improvement programme. He spoke to the ICB's financial position, the delivery of its efficiency programme and the non-recurrent solutions that could be employed if the ICB failed to deliver the expected efficiency savings. He also highlighted the key risks to the delivery of the ICB's financial plan.

17.2. The Board **NOTED** the report.

18. Committee Highlight Reports

18.1. The Board **NOTED** the highlight reports.

19. **Governance Update and Amendments to Governance Handbook**

19.1. The Board **APPROVED** the amendments to the Governance Handbook.

20. Risk Management and Board Assurance Framework

20.1. Amanda Lyes, Executive Director of People, Governance, and Corporate Services presented the report.

20.2. The Board **NOTED** the report.

21. Questions from the Public

21.1. The Chair noted that a number of questions had been submitted in advance of the meeting and asked that summaries of the questions and answers be read out in turn with the full questions and answers to be published on the ICB website.

21.2. The Chair invited Mr Dooley to ask a question of the board from the public gallery.

21.3. Mr Dooley referred to a question he had previously raised regarding the reporting of data relating to incidents of corridor care to which the ICB responded that it had not previously reported this data but that it would do so in future. Mr Dooley sought assurances that this data would indeed be provided.

21.4. Mr Dooley noted that the ICB had previously reference seeking to improve the 'Safety and Quality of care provided in corridor spaces'. He stated that the response sounded like the ICB accepted that care would be delivered from corridors as a norm. He stated that this was unacceptable and that the ICB needed to think about the reasons that people were being treated in corridor spaces which he stated was the deliberate underfunding of the NHS over the past 15 years leading to a reduction in the number of beds. The public required proper investment to put an end to corridor care.

21.5. The Chair asked that written responses be provided to Mr Dooley's questions.

21.6. Mr Dooley also relayed his recent experience as a patient in the system. He had received an ECG at Ipswich Hospital. Following the examination the ECG Technician had indicated that they would provide the results through a report delivered via the Epic Electronic Patient Record system. When the report had not been delivered to the GP Surgery over a month later, Mr Dooley had returned to the Cardiology Department to chase the report. The staff at the Hospital had reported that the GP Surgery did not have access to the Epic system to review the report. The Cariology Department then sent the report via an email to the GP Surgery. Mr Dooley asked the Board to reflect on the failure interoperability between technology available in primary and secondary care and the lack of communication between the Hospital and GP Surgeries.

21.7. The Chair invited Adrian Marr, NHS Foundation Trust Partner Member – Chief Executive, ESNEFT to respond. Adrian Marr stated that GP surgeries were able to access Epic to read results and that access was being rolled out to all local GP practices and would be available.

Question 1

My recollection from statements made in the previous two meetings seem to contradict one another. I am referring to the question about which organisation is responsible for the disgraceful treatment of the Counsellors employed to offer talking therapies in the Lowestoft area. I believe that Faisal on behalf of NSFT told the March meeting that MIND was responsible. In the May meeting in response to a general

question the ICB stated that the organisation given the contract to provide the service was ultimately responsible, in this case NSFT. I have already raised this with the ICB after the May meeting with no response to date, hence, I guess, Amanda's invitation to me to submit a question.
Clearly, this preamble is essential to provide background and I would be unimpressed if it was considered as part of the current 10 minute allocation for the agenda item, questions from the public. This preamble can be made available in my view to the ICB members before the meeting so as not to take up precious time in the meeting.
Accordingly, my question is, which is the responsible organisation regarding the talking therapies contract, NSFT or MIND? I am expecting a simple answer.

Question 1 response

The ICB is the commissioner.
- NSFT is the contract holder.
- Norfolk and Waveney Mind is subcontracted to deliver elements of the talking therapies service provision and are the employers of the counsellors where there has been a dispute about pay.

Question 2

At the previous Board meeting, the officer responding to my public question advised that, in the interests of time, only a summary of my submitted question would be presented during the meeting and that the Board's full response would subsequently be published on the ICB website. However, the question presented at the meeting materially abridged the question that had actually been submitted, and the subsequently published response did not address all of the issues raised. Consequently, neither the Board nor members of the public were able to consider the question in the form in which it had actually been asked. I subsequently wrote to the Chair to highlight that the published response had not answered the questions submitted, but I did not receive a substantive response.
Could the Board therefore clarify its governance arrangements for public questions?
Specifically:
- Who determines whether a submitted public question is summarised or amended before it is presented to the Board?
- Are Board members provided with the full, unedited version of each public question before the meeting?
- Who determines whether the published response fully answers the question submitted?
- Are published responses approved by the Board itself or are they officer responses issued on the Board's behalf?
- If Board members neither consider the full question nor scrutinise the published response in public, how does the Board satisfy itself that the public question process provides meaningful accountability rather than simply an administrative exercise?
- Can the Board identify a recent example where a public question resulted in discussion, challenge or direction from Board members rather than simply an officer-prepared response
- Will the board ensure there is sufficient time allocated to public questions within the board to be able to challenge and question the board and for the board to discuss the questions posed?

Question 2 response

We recognise the important role that public questions play in supporting openness, transparency and accountability and we are sorry to hear that you felt your previous question and the response provided did not fully reflect the issues you had sought to raise.
Our intention is always to ensure that members of the public have a meaningful opportunity to engage with the Board and that questions are answered as fully and openly as possible. We welcome the opportunity to clarify our process.

- **Who determines whether a submitted public question is summarised or amended before it is presented to the Board?**

Public questions are reviewed by officers supporting the Board meeting process. Where a number of questions have been received, or where questions are particularly detailed, a summary may be presented during the meeting to assist with the management of the agenda and available time.
The intention of any summary is to capture the key substance of the question rather than alter its meaning. Questions are not amended to change the issues being raised.

- **Are Board members provided with the full, unedited version of each public question before the meeting?**

Board members are provided with the full, unedited version of each question that has been received by the ICB before each board meeting.

- **Who determines whether the published response fully answers the question submitted?**

Responses are prepared by the relevant executive lead or subject matter experts, supported by officers responsible for the administration of Board meetings. The expectation is that responses address the issues raised in the submitted question.
Where a question contains a number of detailed or complex points, it is possible that further clarification or correspondence may be required to provide a complete response. In addition, questions to the Board must relate to the agenda of the meeting.

- **Are published responses approved by the Board itself or are officer responses issued on the Board's behalf?**

Responses are generally prepared and approved by the relevant executive officers on behalf of the organisation rather than being individually approved by the Board in public session.
Board members are, however, accountable for the overall arrangements that govern public participation and engagement within Board meetings.

- **How does the Board satisfy itself that the public question process provides meaningful accountability rather than simply an administrative exercise?**

The Board views public questions as an important component of its wider commitment to transparency and public involvement. Questions raised by members of the public often highlight issues of concern, provide feedback on services and help inform future discussions. They also enable the Board to explain decision-making, policies and performance in a public forum. While not every question results in a detailed Board debate during the meeting itself, the issues raised are considered within the wider governance and decision-making processes of the organisation.

- **Can the Board identify an example where a public question has resulted in discussion, challenge or direction from Board members?**

Public questions frequently contribute to broader discussions by drawing attention to issues that Board members may wish to explore further. In some cases, questions have prompted additional information requests, follow-up discussions, or consideration through other governance forums. The Board would be willing to review recent examples and provide further information outside of the meeting where appropriate**.**

- **Will the Board ensure there is sufficient time allocated to public questions to allow challenge, discussion and consideration by the Board?**

The Board remains committed to ensuring that members of the public can raise questions and concerns. However, Board meetings are required to cover a wide range of statutory and governance business within limited time. We will continue to keep the operation of the public question process under review, including the balance between agenda management and providing sufficient opportunity for public participation. The feedback you have provided will form part of that ongoing consideration.

Questions 3 and 4 (grouped)

Question 3
Following the merger of the former Norfolk and Waveney and Suffolk and North East Essex Integrated Care Boards, different eligibility criteria continued to operate for specialist weight management services across different parts of the newly formed Integrated Care Board.
The practical consequence was that two patients with materially identical clinical circumstances could receive materially different access to the same commissioned specialist service solely because of where their GP practice was located.
A patient registered with a GP practice within the former Suffolk commissioning area could satisfy the local eligibility criteria and access the commissioned specialist service, whereas an otherwise clinically identical patient registered in Norfolk and Waveney could be refused access because the eligibility criteria were more restrictive.
Can the Board explain how it considered that position to be consistent with its statutory duty to reduce inequalities in access to NHS services?
Specifically:
- What assessment was undertaken of the impact of operating materially different eligibility criteria within one Integrated Care Board?
- What governance arrangements were in place to oversee those inequalities whilst services were being harmonised?
- What mitigating measures were implemented for patients disadvantaged solely because they lived within a different legacy commissioning area of the same ICB?

Question 4
The Board has publicly stated that weight management pathways across Norfolk and Suffolk are now being harmonised.
Can the Board explain what arrangements have been made for patients whose referrals were declined or prevented from progressing during the transition period since 1 April 2026 solely because different eligibility criteria operated across the ICB?
Specifically:
- Has the Board undertaken any review of patients affected by the differing criteria?
- Has the Board considered restoring those patients to the position they would have occupied had harmonised arrangements already existed?
- If no such review has been undertaken, how has the Board satisfied itself that the transition to a harmonised service has not perpetuated historic inequalities for patients affected during that period?

Questions 3 and 4 response

The Board acknowledges the importance of ensuring equitable access to services across Norfolk and Suffolk and recognises the concerns raised regarding the historical differences in eligibility criteria for specialist weight management services that existed prior to the formation of the Norfolk and Suffolk ICB. Since the establishment of the new ICB, there has been an active programme of work to harmonise clinical policies and commissioning arrangements across Norfolk and Suffolk. This includes specialist weight management services. We are fortunate to be working closely with the National Clinical Director for Diabetes and Obesity, whose expertise is supporting the development of a consistent and equitable approach across our geography.
The harmonisation of policies is a priority for the ICB. Bringing together two former organisations with different historical commissioning arrangements inevitably requires a
structured programme of review and alignment. Our aim is to ensure that patients across Norfolk and Suffolk are able to access services through a consistent set of clinical criteria, informed by clinical evidence, national guidance and local population need.
With regard to the specific questions raised:

- **What assessment was undertaken of the impact of operating materially different eligibility criteria within one Integrated Care Board?**

As part of our wider policy harmonisation programme, we have reviewed several areas where legacy commissioning policies differed across the two former ICB footprints, including weight management services. This work has included consideration of the impacts of those differences on clinical operations

and patients and has informed our priority to develop a single harmonised approach across Norfolk and Suffolk.

- **What governance arrangements were in place to oversee those inequalities whilst services were being harmonised?**

The harmonisation of clinical policies is overseen through the ICB's established commissioning and clinical governance arrangements with involvement from clinical and commissioning leaders from across the organisation. Policy reviews are undertaken through appropriate governance processes to ensure that future arrangements are clinically robust and support greater consistency across the system.

- **What mitigating measures were implemented for patients disadvantaged solely because they lived within a different legacy commissioning area of the same ICB?**

During the transition period, services continued to operate in accordance with the commissioning policies that were in place within the former organisations while harmonisation work was being undertaken. Clinicians retained the ability to consider individual patient circumstances and, where appropriate, requests could be considered through established clinical exceptionality processes. Our focus has been on progressing harmonisation as quickly and safely as possible to reduce variation and support more consistent access arrangements in the future.

- **Has the Board undertaken any review of patients affected by the differing criteria?**

The current focus of the programme has been on developing harmonised arrangements for the future. We have not undertaken a retrospective review of all patients who may have been affected by historical differences in eligibility criteria across the two legacy systems.

- **Has the Board considered restoring those patients to the position they would have occupied had harmonised arrangements already existed?**

At present, no programme of retrospective reassessment has been established. Our priority has been to develop and implement a consistent approach for patients accessing services going forward. Patients whose circumstances have changed, or who believe they may now meet revised criteria, should discuss this with their clinical team or GP, who can advise on the most appropriate next steps.

- **If no such review has been undertaken, how has the Board satisfied itself that the transition to a harmonised service has not perpetuated historic inequalities for patients affected during that period?**

The Board recognises that differences in legacy commissioning arrangements can create variation during periods of organisational transition. This is precisely why policy harmonisation has been identified as a priority area of work for the new ICB. By developing a single, clinically informed approach across Norfolk and Suffolk, we aim to reduce variation and support more equitable access to services for the population we serve.
While a retrospective review has not been undertaken, the harmonisation programme has been designed to address historical differences and establish greater consistency going forward. The involvement of national clinical expertise in this work provides additional assurance that future arrangements will be informed by the latest evidence and best practice.
In summary, the ICB fully recognises the importance of reducing inequalities in access to healthcare services. The harmonisation of weight management policies forms part of a broader programme to align clinical policies across Norfolk and Suffolk and ensure that patients receive consistent and clinically appropriate access to services, regardless of where they live within our geography.

Question 5

What is the Board’s current policy where a patient has exercised their NHS Right to Choose for a commissioned specialist provider, but the referral cannot proceed solely because of differing local commissioning criteria operating within the same Integrated Care Board?

Specifically:
- Does the Board consider that patients should retain the benefit of their original referral once those differing commissioning arrangements have been harmonised?
- If not, what is the Board's rationale for requiring patients to lose the benefit of an existing NHS referral because of historic commissioning arrangements that the ICB itself has subsequently changed?

Question 5 response

This issue is important to many patients and their families who may have experienced different access arrangements depending on where they lived within Norfolk and Suffolk. We acknowledge this can feel frustrating and unfair, particularly where a patient has already taken steps to access a service through the NHS Right to Choose process.
Norfolk and Suffolk ICB is committed to treating patients fairly and consistently. As you are aware, since the formation of the new ICB, we have been undertaking a programme of work to harmonise our commissioning policies across Norfolk and Suffolk, including for specialist weight management services. Where a patient has exercised their NHS Right to Choose, access to a service must still be in line with the commissioning criteria that are in place at the time the referral is considered. Historically, different arrangements existed in different parts of the two former ICBs, and referrals were assessed against the policies that applied in those areas at that time.
Our focus now is on creating a single, consistent approach across Norfolk and Suffolk so that patients have equitable access to services regardless of where they live.
At present, there is not an automatic process to reinstate referrals that were previously unable to proceed under former commissioning arrangements. However, as harmonised policies are implemented, patients who believe they may now meet the revised criteria should speak with their GP or healthcare professional, who can advise on the most appropriate next steps and whether a new referral is appropriate.
We are not removing access to services or leaving patients without support. Appropriate pathways continue to be available, and our aim is to ensure that future access arrangements are fair, consistent and based on the same criteria across Norfolk and Suffolk.
We appreciate that some patients may feel disadvantaged by historical differences in commissioning policies. That is one of the key reasons why policy harmonisation is a priority for the ICB, and why we are working with clinical experts to develop a more consistent approach for all patients across our area

Question 6

Can the Board explain how it assures itself that decisions relating to access to commissioned services remain consistent with the Board's statutory duties after organisational mergers or service redesigns?
Specifically:
- What reports are presented to the Board identifying inequalities in access to commissioned services?
- How does the Board monitor whether legacy commissioning arrangements create unequal access for clinically comparable patients?
- What role does the Board itself play in scrutinising and challenging executive decisions where such inequalities are identified?

Once the Board became aware that materially different eligibility criteria were operating across different parts of the Integrated Care Board, what action did it take to review, monitor or mitigate the impact of those arrangements in order to ensure equitable access to commissioned services across the Norfolk and Suffolk Integrated Care Board footprint?

Question 6 response

Patients rightly expect access to NHS services to be fair and consistent, regardless of where they live. We understand the concern that can arise when different arrangements exist following organisational changes such as the merger of two integrated care boards.
Reducing health inequalities is one of the ICB's key responsibilities and ensuring equitable access to services is an important part of this.

- **What reports are presented to the Board identifying inequalities in access to commissioned services?**

The Board receives regular reports on the quality, performance and delivery of services, including information that helps identify variation in access, outcomes and patient experience across Norfolk and Suffolk. In addition, specific service reviews and policy harmonisation programmes may highlight areas where historical differences in commissioning arrangements exist and require further consideration.

- **How does the Board monitor whether legacy commissioning arrangements create unequal access for clinically comparable patients?**

As part of bringing together the former NHS organisations across Norfolk and Suffolk, we have been reviewing commissioning policies and pathways to identify where differences exist. Where variation is identified, this is considered through our commissioning, clinical and governance processes. This helps us understand
whether different arrangements could lead to different experiences or levels of access for patients and whether harmonisation is required.

- **What role does the Board itself play in scrutinising and challenging executive decisions where such inequalities are identified?**

The Board provides oversight and assurance that the organisation is meeting its statutory responsibilities, including reducing health inequalities. Board members receive information about key risks, priorities and programmes of work and can seek assurance, ask questions and challenge where they feel further action is needed. The Board also approves the strategic direction and priorities that underpin programmes such as policy harmonisation.

- **What action was taken once the Board became aware that different eligibility criteria were operating across parts of the ICB?**

Once the new Norfolk and Suffolk ICB was established, work began to identify and review areas where different policies and commissioning arrangements existed across the two legacy organisations. This includes specialist weight management services.
An active programme of policy harmonisation is now underway, supported by clinical leaders and national expertise, including the National Clinical Director for Diabetes and Obesity. The aim of this work is to develop a consistent approach across Norfolk and Suffolk so that patients are assessed against the same criteria regardless of where they live.
We appreciate that patients may feel concerned where historical differences in access arrangements have existed. While bringing together policies and pathways across a large geography takes time, the purpose of this work is to reduce variation and support fairer, more consistent access to services in the future.
Our focus remains on ensuring services are commissioned in a way that is clinically appropriate, evidence-based and as equitable as possible for all the people we serve across Norfolk and Suffolk.

Question 7
The Board has acknowledged that, during the transition to a harmonised specialist weight management service, different eligibility criteria operated across different parts of the Norfolk and Suffolk Integrated Care Board, meaning that some patients were unable to access commissioned Tier 3 weight management services solely because they were registered with a GP practice within a different legacy commissioning area.
Now that those eligibility arrangements are being harmonised, what action is the Board taking to remedy the position of patients whose referrals were declined, delayed or prevented from progressing solely because of those historic differences in eligibility criteria?
Specifically:
- Will the Board undertake a review of all patients whose Tier 3 referrals were declined solely because of the former Norfolk and Waveney eligibility criteria?
- Where such patients are identified, will the Board seek to restore them, so far as reasonably practicable, to the position they would have occupied had harmonised eligibility criteria existed at the time of referral?

- If the Board does not intend to undertake such a review, how does it consider that approach to be consistent with its statutory duty to reduce inequalities in access to NHS services?
- What assurance can the Board give the public that patients affected by these historic inequalities will be identified and treated fairly and equitably across the Norfolk and Suffolk Integrated Care Board footprint?

Question 7 response

We understand that some patients may be concerned that different eligibility criteria were in place across Norfolk and Suffolk during the transition to a single Integrated Care Board. We recognise that patients expect access to NHS services to be fair and consistent, regardless of where they live.
Our priority is to commission a single, consistent weight management service for patients across Norfolk and Suffolk. This work is part of a wider programme to harmonise policies and reduce variation in access to services across the new ICB.

- **Will the Board undertake a review of all patients whose referrals were declined solely because of the former Norfolk and Waveney eligibility criteria?**

At present, our focus is on implementing a single, harmonised service and ensuring that patients across Norfolk and Suffolk are able to access services through the same eligibility criteria going forward. We have not established a programme to retrospectively review all previous referrals.

- **Will the Board seek to restore affected patients to the position they would have occupied had harmonised criteria existed at the time?**

There are currently no plans for a blanket retrospective reassessment of all previously declined referrals. However, patients whose circumstances have changed, or who believe they may now meet the harmonised criteria, should speak to their GP or healthcare professional, who can discuss the most appropriate next steps and whether a referral is appropriate under the current arrangements.

- **How is this approach consistent with the Board's duty to reduce inequalities?**

The Board takes its responsibility to reduce health inequalities seriously. The decision to develop a single weight management pathway across Norfolk and Suffolk is intended to address historical differences and ensure patients are assessed against a consistent set of criteria in the future. Our focus is on creating a fair and equitable service for all patients, regardless of where they live.

- **What assurance can the Board provide that patients will be treated fairly?**

The Board's commitment is that access to specialist weight management services will be based on a single, consistent approach across Norfolk and Suffolk. The harmonisation of policies is specifically designed to reduce variation and support equitable access to care. We will continue to work with clinical experts and service providers to ensure that services are delivered fairly, consistently and in line with national guidance and local population needs.
We appreciate that some patients may feel disadvantaged by previous differences in eligibility criteria. This is one of the reasons why establishing a single weight management service and harmonised policies across Norfolk and Suffolk remains an important priority for the ICB.

Question 8
Regarding the Board’s risk management of outsourced primary care, what specific quality assurance and contract compliance frameworks is this ICB utilising to oversee the Alternative Provider Medical Services (APMS) Special Allocation Service run by the Essex Partnership University NHS Foundation Trust (EPUT) in Ipswich? Given that EPUT is a core participant in the active Lampard Inquiry investigating systemic safety failures, and noting that certain CQC inspection records for elements of these services are significantly outdated, how is the Board ensuring these vulnerabilities do not read across into our local APMS contract?

Question 8 response

We are undertaking a quality review of the service. Although this service is a community one and not part of the Lampard inquiry (which focuses on inpatient mental health), we will ensure any recommendations or learning that comes out of the inquiry is acted upon.

Question 9
In terms of system performance, what explains the stark variance in Special Allocation Service (SAS) figures between neighbouring areas—specifically, 108 patients in Norfolk and Waveney versus 270 in Suffolk? If the Suffolk allocation includes patients from separate specialized or alternative primary care schemes alongside standard immediate-removal cases, what is the actual standalone headcount for the standard SAS cohort in Suffolk?
Furthermore, from a strict compliance perspective, can the Board formally confirm whether 100% of the mandatory patient reviews across all these respective cohorts are entirely up to date?

Question 9 response
The correct figure for SAS in Norfolk is 124 (as of 30/6/26) and 75 for Suffolk (as of 8/6/26).
There are multiple reasons why there are different numbers of patients on the schemes. We have undertaken a review of the patient review service. We continue to work with EPUT to ensure patients only stay on the scheme for the time they need to and to ensure they can be safely returned to mainstream practice.

Question 10
Background
I asked the previous SNEE ICB at the following question ICB Board meeting, 25 March 2025 - NHS Suffolk and North East Essex ICB
“I would like to ask the following question related to Board Assurance Framework Strategic Risk 3: *What is the statistical distribution of Referral To Treatment(RTT) times for patients diagnosed with Parkinson’s related conditions in 2023 and 2024? And how does this distribution compare to the target of 18 weeks set out in the Board Assurance Framework Jan 2025 Strategic Risk 3?*
I don’t think there was a reply to this question either at the meeting or subsequently.

Question 10 response
NHS Norfolk and Suffolk ICB does not routinely report Referral to Treatment (RTT) waiting times specifically for people with Parkinson's disease. RTT data is generally collected and reported by clinical specialty, such as Neurology, rather than by individual diagnosis.
The Board Assurance Framework refers to the NHS standard that patients should start treatment within 18 weeks of referral, with at least 92% of patients waiting no longer than 18 weeks on an incomplete RTT pathway.
We recognise that waiting for specialist assessment or treatment can be difficult and worrying for people living with Parkinson's and their families. While we cannot provide a Parkinson's-specific RTT distribution from published data, reducing waiting times and improving timely access to care remains a key priority for the ICB and our partner organisations.

Question 11
“Parkinson’s UK reported in Parkinson's prevalence in the UK | Parkinson's UK which *reports a drop in diagnosis rates(RTT) post-Covid and ethnic and gender biases.*
Are these figures consistent with the figures from the Risk Register/ Board Assurance Framework for RTT for Parkinson in Norfolk and Suffolk or its precursor organisations? Specifically have the diagnosis rates dropped post-covid and are the ethic and gender biases supported by Norfolk and Suffolk Statistics?
Question 11 response
We acknowledge the findings of the study referred to by Parkinson’s UK and note that it is based on UK-wide population data. We therefore assume that the conclusions drawn are very much relevant to the Norfolk and Suffolk population. As a consequence, we are going to commission our intelligence function to undertake an analysis of Parkinson’s diagnosis rates to confirm this or identify what the trends otherwise are. Alongside this, the Intelligence Function will work with the ICB's medical directorate to understand what the underlying causes are.

Question 12

In light of sickening racist violence in Belfast in which health workers were deliberately targeted, what measures are being put in place to ensure that racist abuse towards staff is dealt with and staff supported?
Will the board urge East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and other hospitals to put up posters by all entrances and along corridors saying that racist abuse to NHS staff will not be tolerated? Does it agree that this will immediately set an anti-racism framework?

Question 12 response
NHS Norfolk and Suffolk ICB is committed to ensuring that all NHS staff are treated with dignity and respect. Racism, discrimination and abuse towards healthcare workers are completely unacceptable, and staff should feel safe and supported at work.
We expect all NHS organisations within our system to have measures in place to prevent and address racist behaviour, support affected staff, and promote inclusive working environments.
Decisions about signage in hospitals, including posters stating that racist abuse will not be tolerated, are made by individual provider organisations such as ESNEFT. The ICB supports clear messages that promote respect and inclusion and recognises that visible anti-racism messaging can help reinforce expectations for patients and visitors. ESNEFT has a Violence and Aggression Reduction Group and is about to refresh its posters as well as working with the national NHS Alliance group to develop a consistent approach across the NHS.
Our priority is that all staff feel safe, valued and supported while providing care to our communities.

The meeting ended at 2.00pm

NHS Norfolk and Suffolk ICB
Action log for September 2026

July 2026

Agenda Item	Action	Lead	Update	Target Date
Item 4 Patient Story	The Board requested that an update on investment in the CVD pathway to meet the National CVD Modern Service Framework be reported to a future meeting.	Richard Watson	Strategic Commissioning Committee considered a draft CVD business case in September as reported under item 17. The full business case is expected to come to Committee in October and to the next Board meeting	December 2026
Item 13 East Coast Partnership & WorkWell	The Board requested a further update in January 2027.	Amanda Lyes		January 2027
Item 14 Lord Mann Review: Tackling Antisemitism and Racism in the NHS	The Board requested that the Remuneration Committee maintain detailed oversight of the implementation of the recommendations and provide a further update to the Board. The Board also asked that the Remuneration Committee seek assurance from local NHS Providers that they were also progressing the implementation of the recommendations.	Amanda Lyes	Closed – implementation updates are on the RemCom forward plan and	

May 2026

Agenda Item	Action	Lead	Update	Target Date

Norfolk and Waveney ICB Research and Innovation team annual report 2025-26	Explore the potential for the ICB and Providers to work together to deliver a Research and Innovation function.	Dr Clara Yates	Closed – on the agenda	September 2026
Lampard Inquiry Update	Next update on the work of the Inquiry include information on any interim findings or learning from the ICB as a result of ICB's evidence gathering and how these were being implemented.	Lisa Nobes		December 2026

March 2026

Norfolk & Waveney Green Plan	To consider a future development session to provide input into the Green Plan and ensure momentum is maintained on this essential work.	Amanda Lyes	Adoption of a Norfolk and Suffolk Green Plan is on the Board forward plan	December 2026
Performance Report for January 2026.	To arrange for a board development session on the use of AI tools in primary care triage	Maddie Baker-Woods	Session delivered. Closed	July 2026

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 7
Date: 23 September 2026

Title: Norfolk and Suffolk Population Health Management approach: a recent example in weight management

Lead Director: Dr Mike Smith, Interim Executive Medical Director

Authors: Lee Watson, Samantha Weston, Clara Yates

Purpose: To provide the Board with an overview and update of the Norfolk and Suffolk Population Health Management (PHM) approach, demonstrate its contribution to strategic priorities, showcase delivery through a weight management case study, and highlight emerging opportunities to support integrated obesity pathways through research.

Recommendation:

The Board is asked to:

1. Note the progress made in embedding Population Health Management across Norfolk and Suffolk.
2. Note the significant performance achieved through the NHS Digital Weight Management Programme and the contribution of PHM approaches to these outcomes.
3. Note the developing obesity transformation programme, including alignment between the Obesity Pathway Improvement Programme (OPIP) and the PROMISE CARE-I research programme.
4. Endorse continued system-wide adoption of PHM approaches to support prevention, proactive care and reduction of health inequalities.

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1. Background

1.1. Population Health seeks to improve health outcomes and wellbeing of whole populations while reducing inequalities. Population Health Management (PHM) supports this through the use of linked data, segmentation, risk stratification and proactive delivery models to identify populations that would benefit most from targeted interventions.

1.2. Within Norfolk and Suffolk, PHM supports delivery of several strategic priorities including:

- Prevention and earlier intervention, as set out within the NHS Long Term Plan
- The shift towards neighbourhood health and more proactive community-based care
- Delivery of the Population Health Improvement Plan and reduction of health inequalities

1.3 The model supports identification of target populations, proactive engagement, intervention delivery, monitoring and evaluation and has now been used to support a number of prevention and proactive care programmes.

1.4 The ICB is in the process of expanding the availability of its commissioned Population Health Management tool (Eclipse) to have synergy with the offer of support previously available in Norfolk and Waveney. This tool should be used alongside other data and intelligence products to inform system efforts around PHM.

2. Key Issues

2.1 Weight Management as a PHM Use Case

The NHS Digital Weight Management Programme provides a practical example of PHM delivery at scale. Using the Eclipse platform, eligible residents were identified and proactively contacted by the Virtual Support Team to offer referral and support into evidence-based weight management services in Norfolk and Waveney.

This approach delivered significant results during 2025/26 in Norfolk and Waveney:

- 4,458 referrals into the programme.
- Reached 187% of target, making Norfolk and Waveney the top performing ICB nationally.
- 92% of practices referred patients into the programme, representing the highest participation rate in the East of England.
- Referral quality reached 94%, the highest reported quality score in the East of England.

This example demonstrates how proactive identification and patient engagement can improve access, reduce unwarranted variation and support equitable uptake of preventative interventions. Whilst the focus of this example has been for Norfolk and Waveney there are emerging opportunities to implement across the ICB footprint.

2.2 Developing an Integrated Obesity Pathway with high-quality research

The weight management programme also illustrates how PHM can act as an enabling approach across a wider obesity pathway. This pathway increasingly includes:

- Early identification and engagement through PHM approaches.
- Service transformation through the £8 million Obesity Pathway Improvement Programme (OPIP).
- Long-term evidence generation through the PROMISE CARE-I research programme.

The PROMISE CARE-I programme has secured approximately £4.1 million of National Institute for Health and Care Research (NIHR) funding over six years and will evaluate a primary care-led long-term support hub for people receiving obesity treatments, including bariatric surgery and weight-loss medicines.

The programme is led by Dr Helen Parretti, supported by the ICB Research and Innovation Team and partners including UEA. It aims to determine whether structured long-term care can improve outcomes, prevent weight regain, reduce complications and provide value for money.

The programme will determine whether a primary care-led hub can improve long-term health, prevent avoidable complications and weight regain, strengthen GP support, and provide value for money. It will also generate evidence on the impact of privately funded treatment on NHS services and identify requirements for national adoption. This research closely aligns with the £8 million OPIP programme, which is expanding access to integrated weight management and complex obesity services, including community-based hubs, digital innovation and earlier support for people at greatest risk.

Together they provide an opportunity to create a more complete, locally integrated obesity pathway, from earlier identification and streamlined access through to lifelong follow-up, while using local service transformation to inform local and national practice.

3. Patient and Public Engagement

3.1. Within operational PHM programmes, the Virtual Support Team provides proactive outreach, patient engagement, education and referral support, helping individuals access services that they may not otherwise engage with.

Through the PROMISE CARE and PROMISE CARE-I programmes, the Research and Innovation Team worked with service users, commissioners, clinicians and national partners to shape the proposed model. The programme also utilised the University of East Anglia Citizens Academy to strengthen meaningful patient and public involvement in service and research design.

4. Committees and Groups

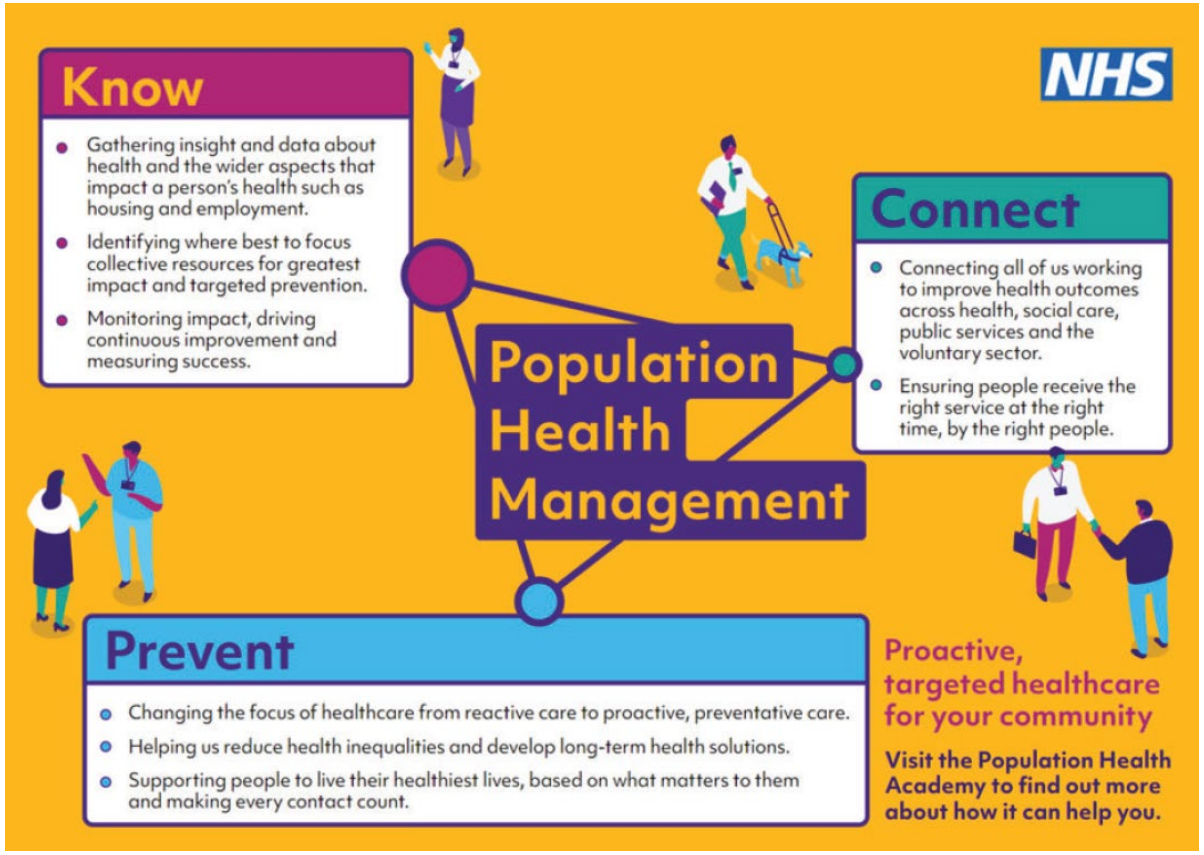
4.1 This report has been informed by work undertaken through the Population Health Management Programme and clinical steering group and Research and Innovation Team.

NHS
Norfolk and Suffolk
Integrated Care Board

Population Health and Population Health Management

Using our existing capability to deliver proactive, preventative and more equitable care across Norfolk and Suffolk

Norfolk & Suffolk ICB Board Meeting
September 2026



What is Population Health and Population Health Management?

Norfolk and Suffolk
Integrated Care Board

Population Health

"…is an approach aimed at improving the health of an entire population."

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population.

It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management

"…improves population health by data driven planning and delivery of proactive care to achieve maximum impact."

It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

Source: NHS Population Health Management Flatpack – definitions agreed with ALBs

Strategic context

Norfolk and Suffolk Integrated Care Board

Population Health Management supports national and system priorities

1

NHS Long Term Plan

Shift to prevention, earlier intervention and personalised care

2

10 Year Health Plan and Neighbourhoods

More joined-up, proactive and community-based care

3

Strategic Commissioning

Evidence-led investment in outcomes that matter

4

Population Health Improvement Plan (PHIP)

Tackling wider determinants and reducing inequalities

Our PHM delivery model

A repeatable approach to turn insight into action

Norfolk and Suffolk Integrated Care Board

1 **Define** — Identify the right population

2 **Understand** — Build the individual picture

3 **Engage** — Proactively engage and assess need

4 **Intervene** — Deliver targeted support

5 **Track** — Monitor delivery and outcomes

6 **Evaluate** — Measure impact and inform next steps

Eclipse + PHM Team + VST

Support to define, understand and engage

Eclipse: data, cohorts & pathways • PHM Team: clinical, operational & programme support • VST: proactive patient engagement

Eclipse + PHM Team

Support tracking, evaluation and learning

Real-time tracking, outcomes, reporting, evaluation and insight for scale

Provider

Engagement where provider-led • deliver and manage interventions

Worked example: Weight Management

Norfolk and Suffolk Integrated Care Board

1. IDENTIFY

We used Eclipse PHM to identify patients who were eligible for the NHS Digital Weight Management Programme across Norfolk and Waveney.

2. ENGAGE

Our Virtual Support Team (VST) proactively contacted patients on behalf of practices to inform them of the programme and offer support to refer.

3. REFER & SUPPORT

For those who wanted to take part, our VST supported a referral into the programme and ensured patients were signposted and supported throughout.

★ OUTSTANDING RESULTS IN 2025/26

Top referring ICB nationally

Achievement of **187%** against target

ICB	Total eligible GP referrals 2025/26	% target achieved
1. NHS Norfolk and Waveney ICB	4,458	187%
2. NHS North East London ICB	6,257	130%
3. NHS Frimley ICB	1,820	120%
4. NHS Staffordshire and Stoke-on-Trent ICB	3,078	110%
5. NHS Cheshire and Merseyside ICB	6,071	103%

The level of referrals achieved in 2025/26 already exceeds the new combined system target for 2026/27.

Highest % of practices referring in the East of England

92% NHSE have recorded 106 practices' (actual number of practices is 103) so performance is 97%.

General Practice Referral Summary (March 2026)

ICB	% practices referred	Eligible referral Target 2025/26
NHS Norfolk and Waveney ICB	92%	2,300
NHS Cambridgeshire & Peterborough ICB	88%	1,820
NHS Hertfordshire & West Essex ICB	88%	2,810
NHS Mid & South Essex ICB	86%	2,680
NHS Suffolk & North East Essex ICB	46%	2,240

Highest quality score in the East of England

94%

Accuracy of referrals sent through to providers.

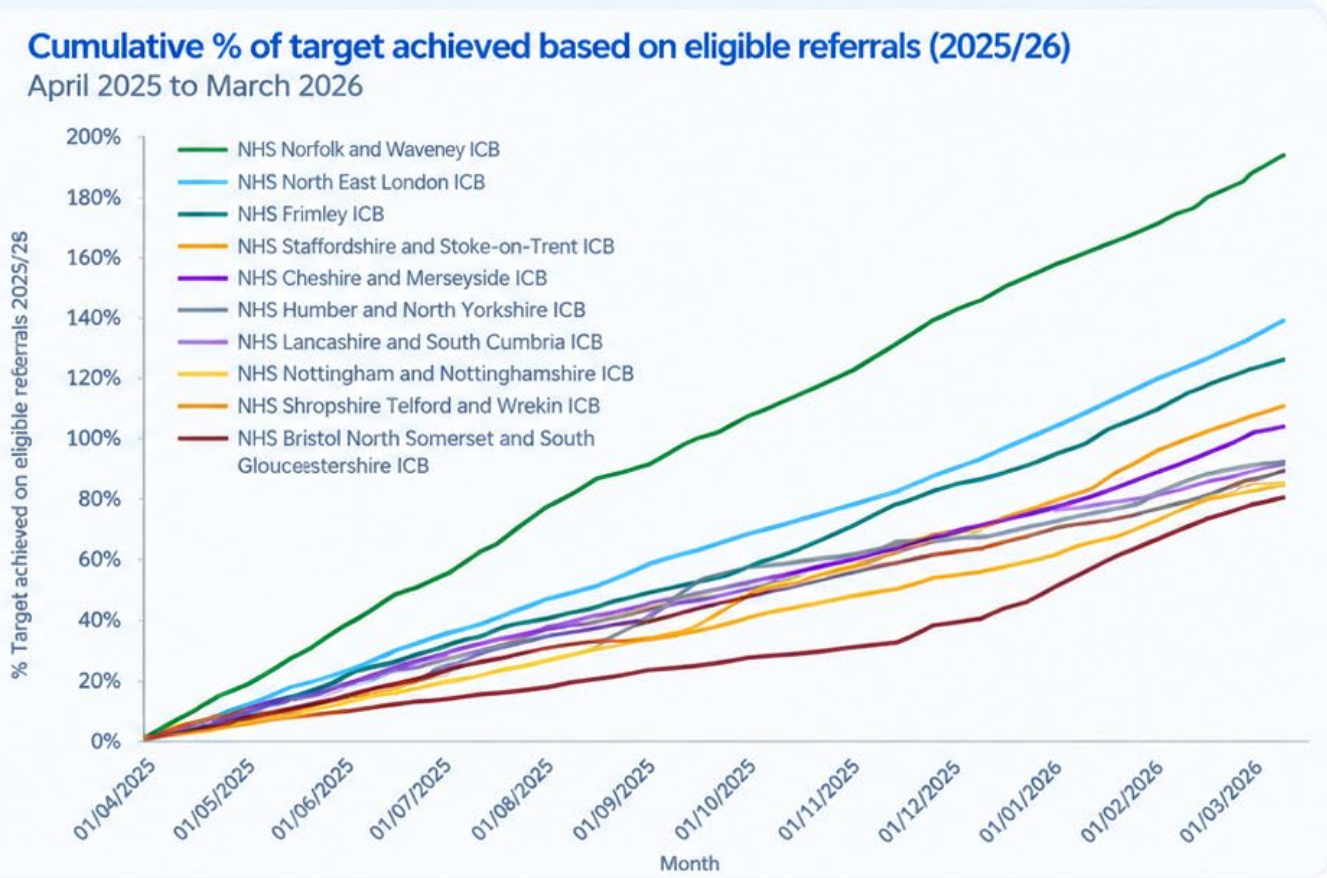
Quality of Referrals (March 2026)

ICB	% eligible referrals that were eligible
NHS Norfolk and Waveney ICB	94%
NHS Cambridgeshire & Peterborough ICB	90%
NHS Hertfordshire & West Essex ICB	90%
NHS Mid & South Essex ICB	84%
NHS Suffolk & North East Essex ICB	89%

Worked example: Weight Management

NHS
Norfolk and Suffolk
Integrated Care Board

Region	ICB	Total no. of eligible GP referrals in 2025/26	% Target achieved (using eligible referrals)
East of England	NHS Norfolk and Waveney ICB	4,458	187%
London	NHS North East London ICB	6,257	130%
South East	NHS Frimley ICB	1,820	120%
Midlands	NHS Staffordshire and Stoke-on-Trent ICB	3,078	110%
North West	NHS Cheshire and Merseyside ICB	6,071	103%
North East and Yorkshire	NHS Humber and North Yorkshire ICB	3,501	94%
North West	NHS Lancashire and South Cumbria ICB	3,744	94%
Midlands	NHS Nottingham and Nottinghamshire ICB	969	88%
Midlands	NHS Shropshire Telford and Wrekin ICB	1,742	87%
South West	NHS Bristol North Somerset and South Gloucestershire ICB	1,562	83%



From early identification to lifelong support: Obesity transformation and research

NHS
Norfolk and Suffolk
Integrated Care Board

1

Population Health and PHM

- Identify and prioritise eligible populations
- Proactive engagement (e.g. DWMP)
- Targeted, equitable access to support

2

OPIP – Service transformation

- £8 million programme
- Expanding integrated weight management and complex obesity services
- Community-based hubs, digital innovation and earlier support for people at greatest risk

3

PROMISE CARE-I Research programme

- £4.1 million NIHR grant (6 years from Sept 2026)
- Led by Dr Helen Parretti (UEA, GP and clinical academic)
- Testing a primary care-led long-term care Hub after weight-loss surgery and medicines

A more complete, locally integrated obesity pathway – from earlier identification and access through to lifelong follow-up, with evidence to inform national and local policy and practice.

Our offer to providers

Norfolk and Suffolk Integrated Care Board

Commissioned, available and at no additional cost

1

Eclipse platform

- Commissioned for providers across Norfolk and Suffolk
- Access to linked data, cohorts and digital pathways
- No additional cost

2

PHM Delivery Team

- Support to develop and deliver PHM programmes
- Help with cohort identification, pathway development and evaluation within the Eclipse tool.

3

Virtual Support Team (VST)

- Proactive patient engagement (SMS, letters, queries, calls, patient education)
- Can work on your behalf to support delivery at scale

4

Insights and evaluation

- Access to ICB data Hub & segmentation tool ‘Atlas’
- Tracking, reporting and evaluation support
- Evidence to demonstrate impact

If you have a proactive care, prevention or health inequalities idea, get in touch – we can explore how PHM can support you.

Let’s work together

Norfolk and Suffolk Integrated Care Board

Get in touch to discuss how PHM can support your priorities.

1

Lee Watson

Associate Director of Population Health Management

2

Dr Sarah-Jane Lang

Clinical Steward Population Health Management, Health Inequalities and Prevention

3

Samantha Weston

Senior Lead for Population Health Management, IFR & Clinical Policies

PHMI shared mailbox

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Any Questions….?

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 8
Date: 23 September 2026

Title: Norfolk and Suffolk Winter Plan 2026/27 – Board Assurance and Approval

Lead Director: Richard Watson

Author: Delroy Mountford, Lizzie Mapplebeck, Darren Maguire

Purpose: For approval and assurance

Recommendation: The Board is asked to:

- Approve the Norfolk and Suffolk Winter Plan 2026/27;
- Approve the accompanying Board Assurance Statement and supporting assurance narrative;
- Note that, following Board approval, the required assurance documentation will be submitted to NHS England in line with the national timetable.

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1. Executive Summary

The Norfolk and Suffolk Winter Plan provides a clear framework for managing winter pressures across Norfolk and Suffolk. It balances national imperatives with local priorities, ensuring that the system is equipped to maintain quality, safety, and equity of care during the most challenging period of the year.

2. Introduction

This paper presents the Norfolk and Suffolk Winter Plan 2026/27 and associated Board Assurance Statement for formal consideration and assurance by the Integrated Care Board. NHS England issued its national winter planning expectations on 17 July 2026, requiring each local system to have a robust, clinically led and deliverable winter plan, developed jointly with system partners, tested against surge and extreme surge scenarios and formally assured by the Board ahead of national submission.

In addition, the NHS Egland winter planning expectations prescribe, that as strategic commissioners, ICBs must lead prevention, including vaccination uptake (particularly maximising uptake in children to help reduce spread), and proactive support for people most at risk from winter viruses and cold weather and commission the right level of activity for winter so that people are treated closer to home wherever possible. That means sufficient commissioned capacity across:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector
- ICBs must also co-ordinate the winter response day-to-day through their co-ordination centre, operating 7 days a week and using the OPEL framework, with tested escalation, surge and mutual aid arrangements agreed by all partners.

The Winter Plan and supporting assurance position bring together evidence from across the Norfolk and Suffolk system to demonstrate how the national requirements will be met and how the system is preparing to manage anticipated winter pressures. The Board Assurance Statement provides the formal assurance framework, supported by a detailed narrative setting out the evidence underpinning each requirement and providing the Board with a clear view of system readiness, resilience and areas requiring continued focus.

The Norfolk and Suffolk system has adopted a coordinated, whole-system approach to managing winter pressures, ensuring that all partners contribute to maintaining patient safety, improving flow, and reducing avoidable demand on acute services. This approach spans urgent and emergency care, primary care, community services, mental health, ambulance services, and social care, underpinned by shared governance and escalation frameworks.

Overall, the assurance work undertaken to date indicates that appropriate arrangements are in place across the required areas of winter preparedness, with a small number of areas continuing to be refined through final review and exercise learning ahead of Board approval. This paper therefore sets out how the Winter Plan and assurance position have been developed, how the arrangements have been tested, the assurance position presented to the Board, and the process through which formal approval will enable submission to NHS England.

3. Developing the Plan

The Norfolk and Suffolk Winter Plan and associated assurance position for 2026/27 have been developed in response to the national winter planning expectations issued by NHS England on 17 July 2026. These requirements set out that each local system must have a robust, clinically led and deliverable winter plan, developed jointly across health and care partners and formally assured through the national Board Assurance Statement.

The Board Assurance Statement has been used to shape the development process from the outset. As the national template provides a structured framework for assessing assurance but limited opportunity to capture detailed supporting evidence, the Norfolk and

Suffolk ICB Resilience Team developed a supporting narrative slide set aligned to each individual assurance requirement. This enabled the evidence underpinning the assurance position to be captured in greater detail and presented alongside the formal Board Assurance Statement. Responsibility for each assurance area was allocated to the relevant subject-matter lead or team, ensuring that evidence was provided by those with direct responsibility for the services, functions and risks being assessed. Contributions were provided by Executive and Director-level leads and teams across Nursing and Quality, Urgent and Emergency Care and Mental Health, Strategic Planning, Workforce, Clinical Quality, Infection Prevention and Control, Vaccinations, Neighbourhoods, Primary Care Commissioning, Health Equity, Community Pharmacy, Communications and Engagement, and the System Operations Centre and Resilience Team.

Provider engagement has been integral to the development of the Winter Plan and reflects the NHS England expectation that winter planning is undertaken jointly across the health and care system. Planning commenced at provider and Place level, enabling organisations to consider anticipated demand, available capacity, workforce, operational pressures, local risks and service-specific mitigations before these were brought together into the wider Norfolk and Suffolk system position.

Development of the plan has also been supported through the Norfolk and Suffolk Urgent and Emergency Care Strategic Delivery Group from June 2026 onwards. This has provided an established forum for partners across acute, community, mental health, primary care, NHS 111, ambulance services, local authorities and social care to review planning assumptions, share emerging risks, consider demand and capacity requirements and contribute to the collective winter response. This provides assurance that the Winter Plan has been developed as a shared system response, informed by the organisations responsible for delivering services throughout winter.

Each assurance requirement was reviewed against the corresponding supporting evidence and summarised into the Board Assurance Statement, creating a clear line of sight from the national expectations, through the evidence provided by responsible leads, to the assurance position presented to the Board.

A Quality, Equality and Health Inequalities Impact Assessment (QEIA) was completed as part of the Winter Plan assurance process to consider the potential impact of the proposed arrangements on patient safety, clinical effectiveness, patient experience, equality and health inequalities. The assessment will now progress to QEAI panel to (by October) provided additional assurance that these considerations had been addressed alongside operational preparedness, with any identified actions or mitigations reflected within the final Winter Plan and assurance position.

This plan has been developed via a lessons-learned approach of previous winters along with planning for industrial action and recent learning from demand seen over summer. It has reviewed its tried-and-tested policies and procedures and is confident that there is resilience in planning for baseline, moderation and extreme pressures over winter, Christmas and the New Year. Learning from Winter 2025/26 has informed the development of the 2026/27 approach. The system debrief identified five principal areas for continued focus: earlier winter planning, more consistent use of system data, discharge and flow, patient transport and more focused system exercising. In the former Suffolk and North East Essex system, 17 incidents were formally declared from 1 November 2025, with only one escalating to a Level 2 system incident. A total of 49 care home outbreaks

were also managed during the winter period, reinforcing the importance of proportionate command and control, vaccination, infection prevention and early outbreak management.

These lessons have been reflected in the 2026/27 planning approach through earlier commencement of winter planning, prospective use of the Board Assurance Statement, greater emphasis on consistent operational intelligence and system co-ordination, and continued focus on discharge, flow and escalation arrangements. Previous feedback on winter exercising has also informed the approach to the 2026/27 exercise, with a greater focus on realistic scenarios and the interdependencies between organisations.

More recent summer assurance activity undertaken for NHS England provided an additional opportunity to consider system resilience during the seven-week school holiday period from 20 July to 7 September 2026, including specific assurance undertaken for the August Bank Holiday. This period enabled the system to review how existing escalation, command and co-ordination arrangements operated across sustained seasonal demand and known pressure points, and to identify where mitigations needed to be strengthened or carried forward into winter planning. The learning from these assurance processes has informed the 2026/27 Winter Plan, particularly in relation to maintaining operational oversight, ensuring continuity of services over holiday periods and preparing for fluctuations in demand, workforce and capacity. These considerations provided a further evidence base for strengthening winter preparedness for 2026/27.

The Board Assurance Statement and supporting narrative are substantially complete and will continue to be refined ahead of Board consideration to ensure that they reflect the latest system position, including any learning arising from winter exercise activity.

4. Testing the Plan

Testing the Winter Plan has formed a key part of the assurance process, moving beyond confirmation that plans and processes are in place to assess whether those arrangements operate effectively under realistic winter pressure. NHS England requires systems to test winter plans against surge and extreme surge scenarios so that assumptions can be challenged, interdependencies understood and any weaknesses identified before the winter period.

Norfolk and Suffolk ICB undertook a whole-system Winter Exercise Workshop on 8 September 2026 at the Charles Burrell Centre in Thetford, bringing together winter plan owners and representatives from acute, community, mental health, primary care, ambulance, NHS 111, local authorities, Public Health and Emergency Preparedness, Resilience and Response, with NHS England also represented. Realistic scenarios were used to test the collective arrangements described within the Winter Plan and Board Assurance Statement, including roles and responsibilities, escalation and command arrangements, system co-ordination, management of risk and capacity across organisational boundaries, and the use of operational intelligence, including SHREWD, to support live decision-making. Where the exercise identified gaps, unclear processes or areas requiring further strengthening, these were reviewed to inform refinement of the relevant plans, operational arrangements and assurance position ahead of winter. This provides the Board and NHS England with greater confidence that the Norfolk and Suffolk assurance position has been practically tested and challenged, rather than being based solely on written plans.

The programme also included input from the GIRFT team to explore system data and what this demonstrates about operational performance and pressure, alongside a session from VitalHub on the use of SHREWD to support live operational decision-making. The exercise therefore provided an opportunity to challenge both individual organisational arrangements and how these operate collectively as part of a single Norfolk and Suffolk response.

Norfolk and Suffolk ICB will also participate in the UK Health Security Agency and NHS England East of England Regional Emergency Preparedness, Resilience and Response Exercise and Urgent and Emergency Care Strategic Winter Preparedness Event on 1 October 2026 at the Imperial War Museum, Duxford. The event will provide an opportunity to consider Norfolk and Suffolk's arrangements within the wider East of England context and identify any further regional learning or opportunities to strengthen preparedness. Where the Regional Winter event highlights gaps or opportunities to strengthen preparedness, these findings will be reviewed and used to further develop plans, operational arrangements and the overall assurance position ahead of winter.

5. Next Steps and Approvals

Upon reviewing the evidence against the national assurance requirements, the Board are asked to confirm they are sufficiently assured that appropriate arrangements are in place to support winter preparedness across Norfolk and Suffolk.

Formal approval from the ICB Board of the Winter Plan and associated assurance position provides the required organisational assurance that Norfolk and Suffolk have a robust, clinically led and deliverable plan in place for winter 2026/27. NHS England requires this assurance to be demonstrated through Board consideration of the national Board Assurance Statement.

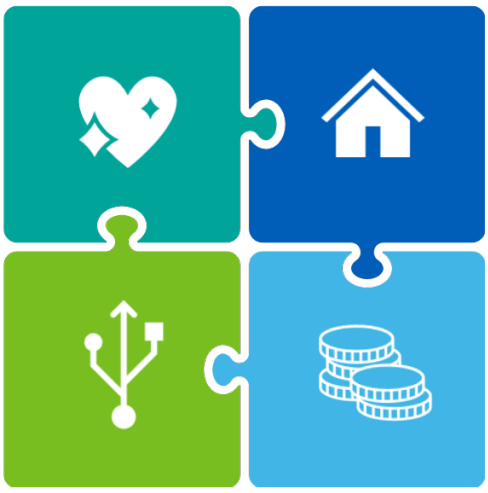
Following Board approval, the Board Assurance Statement and supporting narrative will be formally signed by the ICB Chair and Chief Executive and provided to NHS England by the national deadline of 30 September 2026. This will complete the local approval and assurance process and confirmed organisational ownership of the position submitted to NHS England.

6. Appendices

Appendix One Norfolk and Suffolk Winter Plan
Appendix Two Norfolk and Suffolk ICB Board Assurance Statement
To follow:
Appendix Three Norfolk Group Board Assurance Statement
Appendix Four East Suffolk and North East Essex Board Assurance Statement
Appendix Five West Suffolk Foundation Trust Board Assurance Statement
Appendix Six East of England Ambulance Trust Board Assurance Statement

NHS
Norfolk and Suffolk
Integrated Care Board

Norfolk and Suffolk Winter Plan 2026/27



September 2026 v0.5

1. Document Control

Important status note

This plan reflects the position of our system preparedness on 23 September 2026. The Board consideration planned for 30 September and the regional exercise planned for 01 October are future milestones. Statements dependent on those events are therefore presented as planned actions or assurance to be completed, rather than as completed activity.

Field	Detail
Title	Norfolk and Suffolk Winter Plan 2026/27
Purpose	To set out how the ICB and system partners are preparing for winter and provide a clear line of sight to Board assurance.
Scope	Norfolk and Suffolk health and care system.
Executive Winter Sponsor	Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning.
Coordinating team	Norfolk and Suffolk ICB System Operations Centre Team.

The plan should be read alongside the completed Board Assurance Statement, Quality, Equality and Health Inequalities Impact Assessment, Operational Risk Management Framework, Incident Response Plan and relevant provider and place plans.

2. Contents

3. Executive summary

The Winter Plan provides a single narrative connecting the pressures already experienced, the lessons learned, the work undertaken and the arrangements that will operate through winter 2026/27.

Norfolk and Suffolk enter winter 2026/27 after a sustained period of pressure across health and care. Summer 2026 saw higher urgent and emergency care demand, with Emergency Department attendances increasing by 6.2%, ambulance calls by 3.4% and NHS 111 activity by 7.7% across the comparable data available. Despite this, four-hour Emergency Department performance improved from 61.7% to 66.5%, breaches reduced by 7.3%, and the ambulance conveyance rate reduced from approximately 58.8% to 56.9%. The continuing constraint was admitted patient flow, with high occupancy reinforcing the need to prioritise discharge, community capacity, alternatives to admission and whole-system co-ordination.

Preparation has therefore focused on four connected aims: preventing avoidable deterioration and demand; maximising access to care closer to home; improving flow and discharge; and maintaining strong operational oversight so that risks can be shared and managed across organisational boundaries. The plan brings together action across vaccination, population health management, primary care, NHS 111, community pharmacy, urgent dental and eye care, urgent community response, virtual wards, mental health, social care, ambulance services and acute providers.

The plan has been developed through provider and place planning, ICB subject-matter leadership, the Urgent and Emergency Care Strategic Delivery Group and a structured assurance process aligned to the NHS England Board Assurance Statement. A whole-system exercise took place on 08 September 2026 and participation in the East of England regional exercise is planned for 1 October 2026. Learning and actions from the system exercise have been incorporated, learning from the regional exercise will be reviewed and embedded in the plan through established governance before and during winter.

Operationally, the System Operations Centre will provide co-ordination from 08:00 to 18:00, seven days a week, with the ability to extend during extreme pressure. The centre will lead daily system calls, maintain the common operating picture, oversee OPEL reporting through SHREWD, co-ordinate proactive action and connect to 24/7 Tactical and Strategic on-call arrangements. The Operational Risk Management Framework and Incident Response Plan provide the route from operational escalation into business continuity, critical incident or major incident arrangements where required.

Overall assurance position

The evidence demonstrates a comprehensive and jointly owned approach to winter preparation. Some elements remain subject to completion or final assurance, including the QEIA, the regional exercise actions, final festive occupancy plans, some community capacity decisions and staffing mitigations for the System Operations Centre. These are tracked transparently within the plan rather than treated as complete.

Section One: Preparing The Winter Plan 2026/27

4. Purpose, scope and national context

4.1. Purpose

This plan explains how Norfolk and Suffolk will manage winter pressures while protecting patient safety, clinical effectiveness, patient experience, equality and health outcomes. It is intended to provide the ICB Board, system partners and NHS England with a coherent account of readiness, delivery arrangements, risks and assurance.

4.2. National expectations

NHS England issued winter planning expectations on 17 July 2026. Local systems are required to have a robust, clinically led and deliverable plan, developed jointly with system partners, tested against surge and extreme surge scenarios, supported by a named Executive Winter Sponsor and formally assured by the Board.

For the ICB as strategic commissioner, the expectations require leadership of prevention and vaccination; proactive support for people most at risk; sufficient commissioned capacity across primary care, community services, mental health, social care and intermediate care; safe infection prevention and control arrangements; and daily system co-ordination using the OPEL framework, supported by tested escalation, surge and mutual aid arrangements.

4.3. Local scope

The plan covers the connected pathway from self-care and prevention through primary, urgent, community, mental health and acute care to discharge and recovery. It includes the services, enabling functions and system governance required to maintain safe care across Norfolk and Suffolk, while recognising that delivery is led through providers, places, local authorities, neighbourhoods and integrated teams.

5. The story of our preparation

The system started earlier; learning from winter 2025/26 led to earlier planning, prospective use of the Board Assurance Statement and earlier engagement through provider, place and system forums.

Planning was grounded in live pressure. Summer 2026 was effectively managed using a winter-style approach, showing both improved front-door performance and the continuing challenge of admitted flow and occupancy.

The response was built across the whole pathway. Prevention, vaccination, proactive care, admission avoidance, community capacity, discharge, festive planning and operational co-ordination were developed as interdependent components rather than isolated schemes.

Accountability was made explicit. A named Executive Winter Sponsor, subject-matter owners, the Urgent and Emergency Care Strategic Delivery Group, System Operations Centre arrangements and Board assurance create a line from strategy to daily delivery.

The system moved from written assurance to practical testing. A whole-system workshop and a regional exercise are intended to test realistic scenarios, organisational interdependencies, command arrangements and the use of operational intelligence.

The plan will remain live. Daily operational review, OPEL reporting, risk escalation and governance oversight will be used to adapt plans as demand, workforce, outbreaks, weather and capacity change.

6. What we learned and what it means for winter

6.1. Learning from winter 2025/26

Winter 2025/26 represented a significant period for both Norfolk and Waveney ICB and Suffolk and North East Essex ICB, requiring coordinated efforts across provider organisations. The challenges faced during this period highlighted areas for improvement and provided the basis for evaluating the effectiveness of process and strategies, these were captured in full de-brief documents which were presented in system wide debriefing sessions, of which, the outcomes have shaped our planning for winter 2026/27.

Identifying lessons is an essential component of ongoing improvement within our system, capturing comprehensive details about the experiences and perspectives of everyone involved is crucial, as it allows organisations to build a more accurate and nuanced understanding of what occurred. Debriefing sessions are widely recognised as best practice for this purpose, enabling structured reflection and collaborative learning.

Both systems entered winter 2025/26 with stronger foundations than in previous years, with partners reporting that learning from earlier winters had informed preparedness, service design and operational delivery. Both debriefs identified significant strengths across the system, particularly in partnership working, communication, discharge improvement, same day emergency care, frailty services, community integration and vaccination programmes. Organisations consistently highlighted stronger relationships, increased collaboration and more effective system working as key contributors to managing winter pressures.

The winter debrief identified five principal areas for continued focus: earlier planning, more consistent use of system data, discharge and flow, patient transport and more focused system exercises, all of which have been embedded or addressed in this years planning.

6.1.1. Suffolk and North East Essex learnings

The Suffolk and North East Essex debrief noted that there was good engagement with the planning exercise and strong collaborative culture and system partnerships that led to an effective and efficient system coordination structures.

From 1 November onwards, 17 incidents were formally declared across the SNEE system, predominantly at Level 1. Only one Level 2 system incident was declared. Enhanced command and control arrangements enabled incidents to be managed efficiently at organisational level. Prolonged operational pressures were experienced at ESNEFT, largely associated (but not directly caused by) with EPIC implementation impacts. Overall system impact was mitigated by relatively mild winter weather conditions.

Winter planning was described as structured and proactive, with learning taken forward from previous years. The winter exercise represented a step change in quality and directly informed the strengthening of command and control. Quality and equality impact assessments were highlighted as good practice. However, late national guidance shortly

before the exercise disrupted local planning and reduced the opportunity to capture richer discussion and feedback.

Key learning included the need to confirm primary care winter schemes and funding earlier, ideally by late August or early September. Engagement of the GP Collaborative earlier in planning was identified as a key improvement. Late confirmation of funding limited the ability of practices to plan capacity effectively. It was noted that some winter funding was repurposed from existing budgets, reinforcing the need for earlier internal decision-making.

Fit testing in primary care remained a recurring challenge and a health and safety risk, requiring earlier communication and alternative delivery models. Care home vaccination uptake was high, contributing to fewer cases of flu, COVID-19 and RSV. A total of 49 care home outbreaks were managed effectively. Challenges remain in early outbreak recognition and notification, with GPs playing a critical role in identifying emerging patterns. Information flow from acute trusts was generally effective, although delays were experienced at Ipswich Hospital.

Command and control arrangements enabled proportionate escalation and avoided unnecessary system-level incidents. System calls were pre-planned, time-limited and flexed according to pressure. Staff vaccination programmes were well organised and achieved higher uptake than in previous years. Communications to primary care were clear and timely.

System modelling undertaken during the summer provided valuable insight into capacity pressures, particularly bed shortages in Colchester. Participants agreed modelling should be embedded as business as usual rather than winter specific.

6.1.2. Norfolk and Waveney learnings

A recurring theme throughout the debrief was the benefit of a whole-system approach to patient flow. Acute, community, mental health, local authority and social care partners all identified examples of improved integration supporting discharge and admission avoidance. These included stronger links between acute trusts and community providers, the development of frailty pathways, increased use of virtual wards, expanded discharge arrangements, seven-day services, community-based alternatives to admission and early engagement of Adult Social Care in planning activities. Participants reported that these approaches contributed positively to patient flow, discharge performance and system resilience.

The debrief also demonstrated the value of operational innovation and service redesign. Examples included GP front-door services, virtual wards, frailty Same Day Emergency Care (SDEC), community diagnostic initiatives, consultant-led decision-making at hospital front doors, enhanced discharge support and the use of patient-level intelligence and bed modelling tools to inform operational decisions.

Several organisations reported that these initiatives had improved decision-making, reduced delays and enabled more patients to receive care in the most appropriate setting. Whilst many improvements were identified, the debrief highlighted several enduring challenges that continue to affect system performance during periods of sustained pressure. Patient transport emerged as a constraint across multiple organisations, affecting discharge processes, admission avoidance and patient flow.

Partners also identified challenges relating to mental health capacity, increasing patient complexity, discharge arrangements for patients with complex needs, limited step-down

capacity, variation in community service availability and difficulties associated with pathway 3 and care home capacity.

Discharge and flow remained a central focus of system learning. Whilst notable progress had been achieved through strengthened discharge processes and closer partnership working, opportunities were identified to increase earlier discharges, improve planning for complex patients, enhance community capacity and strengthen arrangements for those whose needs do not align neatly with existing pathways. Participants recognised the importance of continuing to develop joint approaches across health and social care to support timely discharge and reduce unnecessary delays.

The debrief also identified the importance of improving system-wide situational awareness and coordination. Areas highlighted included access to operational intelligence, consistency of escalation processes, clarity of roles and responsibilities, participation in system coordination groups and the need to maintain effective senior leadership engagement during periods of escalation. Partners recognised that strong communication and coordinated decision-making remain critical to effective winter management.

Several recommendations were agreed to strengthen preparedness for future winters. These included reviewing patient transport arrangements, enhancing discharge processes, strengthening mental health planning, reviewing virtual ward arrangements, maintaining early Adult Social Care involvement, developing a more coordinated system approach to seasonal pressures, improving escalation communications and continuing to build community capacity. The debrief also highlighted the need to maintain focus on workforce wellbeing and resilience, recognising the cumulative impact of prolonged winter pressures on staff across the health and care system.

6.1.3. System winter learning summary

The learning from Winter 2025/26 demonstrates that collaborative planning, integrated working, operational innovation and strong relationships across organisations are critical enablers of resilience. The findings of the debrief have informed the development of the 2026/27 Winter Plan, which seeks to build upon successful initiatives, address areas of system constraint and further strengthen the ability of partners to respond collectively to periods of increased demand.

Learning	Response in 2026/27
Start planning earlier	Planning was initiated through provider and place processes and supported by the UEC Strategic Delivery Group from June 2026.
Use consistent operational intelligence	The System Operations Centre will use SHREWD, OPEL submissions, provider updates and daily system calls to maintain a common operating picture.
Strengthen discharge and flow	The plan prioritises Transfer of Care Hubs, integrated discharge, Home First, Discharge to Assess, intermediate care and coordinated festive occupancy reduction.

Learning	Response in 2026/27
Address patient transport dependencies	Patient transport remains a cross-system dependency to be managed through operational planning and escalation. A review was jointly commissioned by Norfolk and Suffolk ICB and HTG-UK to provide a shared understanding of how the current non-emergency patient transport service (NEPTS) is operating across Norfolk and where opportunities for improvement exist and how the service can continue to evolve to meet future requirements. Summary of key high-level actions/recommendations from the NEPTS review which are currently being actioned: • Introduce a system-wide patient prioritisation framework to ensure transport capacity is directed towards the patients and pathways with the greatest clinical and operational need. • Move from a reactive to a planned scheduling model, supported by improved demand forecasting and collaborative scheduling. • Implement a revised KPI and performance framework focused on patient outcomes, pathway priorities and operational effectiveness. • Strengthen communication, visibility and escalation arrangements through standardised processes and proactive operational updates. • Improve integration between transport services and patient flow processes, embedding transport planning into discharge and operational flow management. • Simplify and standardise booking processes through a single booking route, clearer responsibilities and improved user training. • Adopt demand-led capacity planning that reflects seasonal pressures and pathway-specific demand rather than average activity. • Strengthen governance and partnership working across providers and commissioners to support consistent decision-making and accountability.
Use realistic exercises	The 08 September workshop utilised scenarios using NHS England's Ex Aegis 2026 and 01 October regional event is intended to test scenarios, interdependencies and command arrangements utilising a realistic situation.

6.2. Learning from summer 2026

Summer 2026 has provided an important opportunity to test system resilience ahead of winter. The period was characterised by sustained operational pressure, including significant demand across urgent and emergency care services, multiple heat waves, workforce challenges, high bed occupancy, discharge challenges and the impact of prolonged hot weather on infrastructure. As one of the hottest and busiest summers experienced in recent years, it placed many of the same pressures on health and care services that are traditionally associated with winter, providing valuable insight into how the system responds under sustained demand.

The experience has highlighted both areas of strength and opportunities for improvement across patient flow, demand management, community capacity, discharge arrangements, escalation processes and whole-system coordination. Learning from these pressures is being used to refine winter plans, strengthen operational arrangements and ensure that services are better prepared to respond effectively to periods of increased demand. By applying the lessons identified during summer 2026, the system aims to enter winter from a stronger position, with improved resilience, greater integration and enhanced capacity to maintain safe, timely and effective care for local populations.

The table below highlights the increase seen across a number of different measures alongside how the system performed considering these challenges. All data shown is from months May, June and July.

Measure	Comparable position (Month May to July)
Emergency Department attendances	183,780 in 2025 and 195,241 in 2026: **increase** of 11,461 or 6.2%.
ED four-hour performance	**Improved** from 61.7% to 66.5%, a 4.8 percentage point improvement.
ED four-hour breaches	**Reduced** from 70,446 to 65,321: reduction of 5,125 or 7.3%.
Ambulance calls	76,259 in 2025 and 78,867 in 2026: **increase** of 2,608 or 3.4%.
Ambulance conveyances	44,848 to 44,902: **increase** of 54 or 0.1%.
Conveyance rate	**Reduced** from approximately 58.8% to 56.9%.
NHS 111 activity	**Increase** of 7.7% across the comparable available period.

Planning implication

The central winter challenge is not only managing the front door. It is maintaining flow through admitted care and back into home and community settings. Alternatives to admission, timely discharge, community capacity and coordinated operational action are therefore the organising priorities of this plan.

7. How the plan was developed and tested

7.1. Collaborative development

Planning commenced at provider and place level, enabling organisations to assess anticipated demand, capacity, workforce, local risks and service-specific mitigations. These plans were then connected into a single Norfolk and Suffolk position. The UEC Strategic Delivery Group has supported development from June 2026, bringing together acute, community, mental health, primary care, NHS 111, ambulance, local authority and social care partners.

The Board Assurance Statement was used prospectively as the organising framework. The ICB Resilience Team developed supporting narrative against each assurance requirement and allocated ownership to the relevant subject-matter lead. Evidence was provided across Nursing and Quality; UEC and Mental Health; Strategic Planning; Workforce; Clinical Quality; IPC; Vaccinations; Neighbourhoods; Primary Care Commissioning; Health Equity; Community Pharmacy; Communications and Engagement; and the System Operations Centre and Resilience Team.

7.2. Quality and equality assurance

A Quality, Equality and Health Inequalities Impact Assessment is being completed to examine patient safety, clinical effectiveness, patient experience, equality and health inequalities. It will be updated to reflect exercise findings and any changes to the plan. Until final review is complete, this remains an open assurance action.

7.3. Exercising and stress testing

A whole-system Winter Exercise Workshop took place on 08 September 2026 at the Charles Burrell Centre in Thetford. It was designed to bring together plan owners and representatives from acute, community, mental health, primary care, ambulance, NHS 111, local authorities, Public Health and EPRR, with NHS England represented. The following scenario was used to test roles, escalation, command, system co-ordination, capacity and risk management across organisational boundaries, and the use of SHREWD for live decision-making.

The scenario

The system is experiencing sustained extreme winter pressures. All planned surge capacity has been opened and utilised across acute, community, primary care, mental health and ambulance services. Demand continues to exceed forecast

assumptions, and the system is now operating beyond normal contingency arrangements.

The system has been operating at elevated escalation levels for several weeks. Despite implementation of winter plans and full deployment of surge capacity, demand continues to outstrip available capacity and operational resilience is deteriorating.

Participants should consider not only the current response, but also the point at which the system moved from business-as-usual escalation into formal incident management arrangements. Responses should describe how emerging pressures were recognised, how local escalation plans were activated, how command and governance arrangements were established, and how business-as-usual functions were separated from incident management activity.

All available winter capacity has already been opened including:

- Additional escalation beds
- Virtual ward expansion
- Additional discharge pathways
- Ambulance surge measures
- Workforce bank and agency capacity
- Mutual aid agreements

Demand continues to exceed available capacity despite these interventions.

- ED attendances are up 25-30% above forecast levels, with sustained increases in respiratory illness, frailty, mental health crises and paediatric presentations. NHS 111 demand has risen significantly over recent weeks, with increasing call volumes, longer waits for assessment and growing pressure on urgent care navigation services.
- All available escalation beds have been opened across the system. Acute bed occupancy has remained above 99% for seven consecutive days, with no site below 95% occupancy.
- More than 15% of patients in ED have waited over 12 hours from decision to admit, with several patients waiting more than 24 hours for an inpatient bed.
- Ambulance handover delays exceed 60 minutes for over 60% of arrivals. At peak periods, ambulance queues are preventing regional ambulance resources from responding to new incidents.
- Adult critical care, paediatric critical care and specialist neonatal services are operating at maximum occupancy, with regional mutual aid and patient transfer arrangements already being utilised.
- All planned elective reductions have been implemented, and further reductions are being actively considered.
- Staff absence exceeds 20%, while fatigue and wellbeing concerns are increasing amongst frontline and operational leadership teams.
- IPC restrictions, infrastructure limitations and staffing shortages have reduced effective bed capacity despite all escalation areas being operational.
- Mental health demand has increased significantly, with patients awaiting inpatient beds occupying emergency department capacity and creating additional operational risk.

- Virtual wards, urgent community response services and intermediate care capacity are operating at or near maximum utilisation, with discharge demand continuing to exceed available community capacity.
- Pathway 2 and Pathway 3 discharge capacity is constrained, resulting in prolonged lengths of stay and worsening system flow.
- System partners have exhausted all planned winter surge interventions and are considering extraordinary measures to maintain patient safety and service continuity.
- All planned winter surge capacity has already been deployed. The executive team must now consider what additional actions are available when the system has exhausted its planned resilience measures.

The programme includes input from GIRFT on system data and from VitalHub on SHREWD.

The exercise identified some gaps and areas that required further strengthening, these were reviewed to inform refinement of this relevant plan, the operational arrangements and assurance position ahead of winter.

This provides the Board and NHS England with greater confidence that the Norfolk and Suffolk assurance position has been practically tested and challenged, rather than being based solely on written plans.

The ICB also plans to participate in the UK Health Security Agency and NHS England East of England regional EPRR exercise and UEC Strategic Winter Preparedness Event on 01 October 2026 at the Imperial War Museum, Duxford. Both exercises will be followed by structured debrief, action ownership and governance review.

8. Governance, accountability and assurance

8.1. Executive accountability

Richard Watson, Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning, is the Executive Winter Sponsor. The role provides executive leadership and accountability for readiness, delivery, escalation, demand and capacity, risk management and whole-system oversight. During winter, the sponsor will oversee system performance and resilience and ensure that risks and escalation are acted upon.

8.2. Governance route

Level	Primary role
ICB Board	Formal assurance of the plan, supporting evidence, QEIA and readiness position.
Executive Winter Sponsor	Executive accountability, strategic oversight and escalation.

Level	Primary role
UEC Strategic Delivery Group	System partner engagement, planning review, shared risks and delivery oversight.
System Operations Centre	Daily co-ordination, OPEL oversight, common operating picture and proactive operational action.
Tactical and Strategic on-call	24/7 decision-making and escalation outside normal operating arrangements.
Provider and place governance	Delivery of local plans, risk management, workforce and capacity action.

8.3. Board assurance

Board consideration is planned for 30 September 2026. The Board will be asked to review the completed Board Assurance Statement, full narrative plan, QEIA, exercise outcomes, risks and mitigations. The evidence should enable the Board to determine whether the plan is robust, clinically led, deliverable and aligned to national requirements.

Section Two: The Winter Plan 2026/27

9. Risk and escalation framework

The Operational Risk Management Framework sets out escalation triggers, governance and response actions. It is supported by strategic, tactical and operational leadership arrangements seven days a week and aligned to OPEL. Defined thresholds connect operational pressure to EPRR arrangements and allow business continuity, critical incident or major incident structures to be activated where required.

The framework outlines the oversight and coordination of operational urgent and emergency care activity and demand across the system to:

- Ensure patient safety is maintained across the system
- Plan mitigating actions to support core business (risk identification & mitigation)
- Anticipate and proactively manage and respond to increasing activity and demand
- Maintain delivery of prioritised activities
- Return to ‘acceptable’ levels (resumption and recovery)

The key objectives and priorities are to ensure plans are in place within the organisation to allow it to:

- Deliver safe and appropriate care to patients affected by concurrent incidents
- Support incident level escalation and de-escalation
- Mitigate the impacts on business as usual
- Facilitate the resumption and recovery of activities

The framework provides the agreed Norfolk and Suffolk Operational Escalation Threshold which is a tool used to measure system pressure via a combination of agreed metrics across system partners, incorporating a multi-disciplinary view to ensure a rounded perspective of system pressure. It will allow for a proactive and consistent approach to managing UEC flow effectively. There are suggested actions and prompts in relation to the triggers identified and OPEL framework, with links to our command, control and co-ordination actions.

System Escalation Framework

Metric	0	1	2	3
OPEL score	0-45	46-60	61-70	71+
Social care LAPEL	4	6	8	8 for 48 hours
% of patients with LoS >12 hours in ED since arrival	<2%	2.01-5%	5.01-10%	>10%
Average A2H	<30 mins	30:01-45 mins	45:01-90 mins	>90mins
C2 mean	<18 mins	18:01-30 mins	30:01-60 mins	>60:01 mins
111 - number of calls referred to 999/ED	0-10	11-15	16-20	21+
Primary care activity	BAU	Increased demand	Increased demand >3 days	Increased demand >5 days
NCTR - percentage of inpatients that do not have criteria to reside (acute)	<10%	10.01-15%	15.01-20%	>20%
Number of patients >7 days LoS	0-500	501-600	601-700	701+
Number of patients in corridor care on general & acute wards	0-25	26-40	41-60	61+
Mental health - number of patients MOFD	0-10	11-15	16-30	31+
Mental health - number of waits for admission	0-13	14-19	20-24	>25
Local Escalation Level	Green	Amber	Red	Black
	0-12 BAU	13-22 Moderate pressure	23-30 Significant pressure	31+ Consider incident declaration?

Escalation levels (OPEL Scores) and locally agreed escalation thresholds are monitored within the SOC 7 days per week with system calls capturing key tactical narrative from providers on challenges, concerns and risks. The SOC completes a risk profile and considers any concurrent risks or impacts.

N&S EPRR team attend daily system call and provide soft intelligence at system level, as well as provide updates from a wider perspective. Using the franeworkm if a score is greater than 22 it will be escalated to Strategic on call (Head of UEC Operations or Associate Director of Strategic planning, resilience & change in absence) for discussion. At this point consideration will be given whether there are sufficient plans in place to mitigate system risks.

If the score is greater than 31, a Joint call with N&S Director of UEC and Head of UEC, Operations and Resilience will take place to discuss whether there are sufficient plans in place to mitigate risks. Consideration of escalation into System Critical Incident.

Agreement of an action plan including timeframes to review the risk matrix to ensure deescalation of risk and/or no further escalation.

At any time, the System Operations Centre, if concerned, can complete the risk matrix and/or discuss concerns in the first instance with the Head of UEC Operations and Resilience.

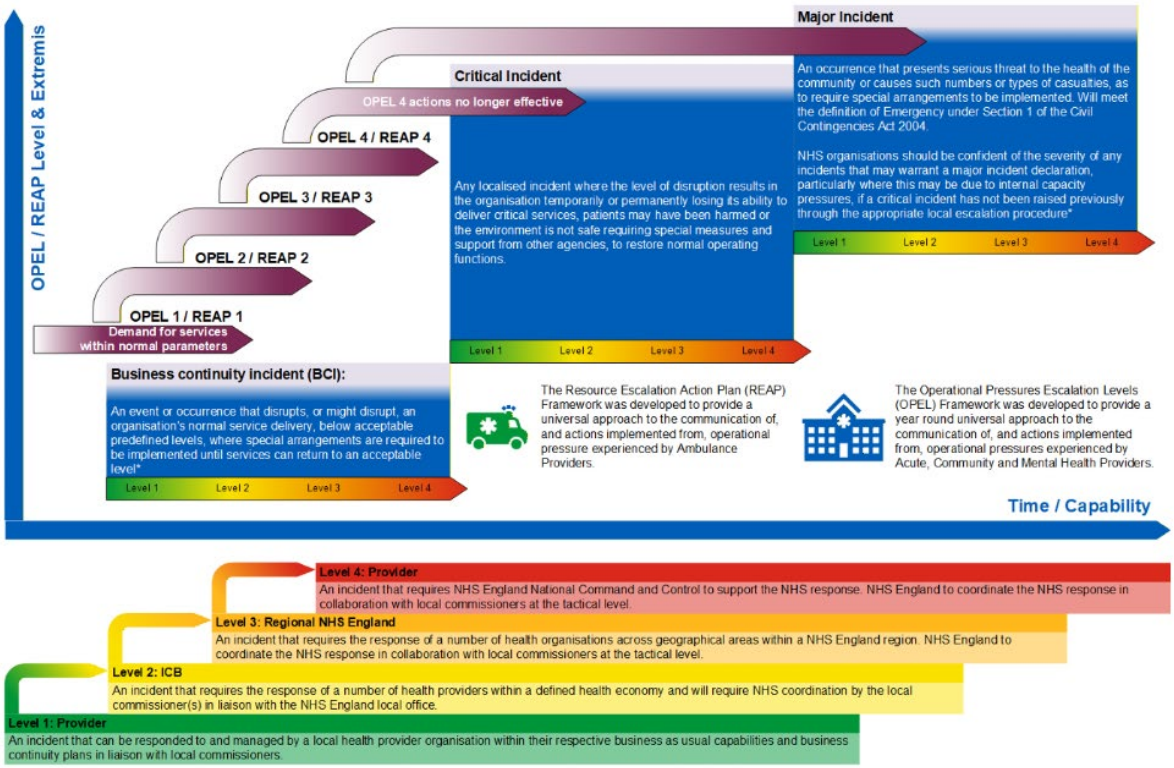
Any incident (Business continuity, Critical or Major) can be declared independently of operational pressures and should be managed in line with system/ provider plans.

Should the risk assessment metrics confirm that the risk has reached “elevated” levels, collaboration between the UEC and EPRR Teams is imperative. The SOC Team remain lead for the escalation with the required support from EPRR. Authority to activate the N&S Incident Response Plan lies with any of the following;

- Head of UEC Operations and Resilience (or their designate in their absence)
- The Accountable Emergency Officer (or their designate in their absence)
- ICB On Call Strategic Director

During the response, the EPRR team provide an advisory role on decision making, contingencies and response plan options.

Bridging OPEL and EPRR Framework



10. Prevention, vaccination and vulnerable cohorts

10.1. Vaccination

Robust arrangements are in place to ensure eligible populations have access to the priority vaccination programmes for Winter 2026/27, with a comprehensive network of delivery sites across Norfolk and Suffolk. This includes the Respiratory Syncytial Virus (RSV) vaccination programme, the annual Flu and COVID-19 vaccination programmes, Meningitis B (MenB) programme and the Pneumococcal vaccination programme delivered through General Practice for eligible adults and clinical risk groups. These programmes are aligned to national priorities and ambitions.

Robust governance, oversight and provider engagement arrangements are in place to support programme delivery, monitor performance and maximise vaccine uptake across Norfolk and Suffolk.

A targeted communications and engagement campaign is being developed to support both the flu and COVID-19 programmes, using deprivation, vaccine uptake and population insight data to focus activity on communities where uptake has historically been lower. This approach aims to reduce health inequalities, maximise uptake across all eligible cohorts and support achievement of national vaccination ambitions.

Provider sign-up levels for Winter 2026/27 are positive, demonstrating strong engagement across both General Practice and Community Pharmacy settings. For the Flu programme, 156 GP practices (97.5%) and 219 community pharmacies (80.5%) have signed up to participate. For the COVID-19 programme, 152 GP practices (95%) and 173 community

pharmacies (63.6%) have signed up. Community pharmacy engagement with the MenB programme is also strong, with 228 pharmacies (83.8%) signed up to deliver the programme. Overall, the level of provider participation gives confidence that there is sufficient geographical coverage to support access across neighbourhoods, whilst continuing engagement will seek to increase participation in areas where coverage remains lower.

Programme	Provider participation reported
Flu	156 GP practices (97.5%) and 219 community pharmacies (80.5%).
COVID-19	152 GP practices (95%) and 173 community pharmacies (63.6%).
MenB	228 community pharmacies (83.8%).

Current provider sign-up levels alongside established governance arrangements and strong historical performance, particularly for Flu, Covid-19 and RSV, provide reasonable assurance that Norfolk and Suffolk are well positioned to deliver the Winter 2026/27 vaccination programmes and maintain equitable access across its population. Continued focus will be required to maximise COVID-19 uptake and address inequalities in vaccine coverage.

Last year Norfolk and Suffolk administered 623,555 Flu Vaccines, this was 10.2% above the national average. this year the target is 628,376. The table below presents the 3-year Flu Ambitions versus previous Autumn / Winter (AW) 2025.

Cohort	AW25 Uptake	AW26 Ambition	AW27 Ambition	AW28 Ambition
Age 65+	79.24%	79.24%	79.24%	79.24%
Care Home Resident	80.08%	80.08%	80.08%	80.08%
Children aged 2 and 3	54.00%	54.00%	54.00%	54.00%
Clinical Risk Group	49.07%	50.05%	51.02%	52.00%
House Contact of immunosuppressed	7.50%	7.50%	7.50%	7.50%
Pregnant	38.75%	38.75%	38.75%	38.75%

Cohort	AW25 Uptake	AW26 Ambition	AW27 Ambition	AW28 Ambition
Primary School Children	66.26%	66.26%	66.26%	66.26%
Secondary School Children	59.16%	59.16%	59.16%	59.16%

Last year Norfolk and Suffolk administered 188,482 COVID-19 Vaccines which was 9.4% above the national average, this year the target is 196,396

Nationally, no formal ambitions have been set for COVID this year. Therefore, for performance assumes the same uptake as AW25 will be maintained for Norfolk & Suffolk.

Cohort	AW25 Uptake	AW26 Ambition
Age 75+	73.01%	73.01%
Clinical Risk Group	36.37%	36.37%
Other Adult Care Home Residents	75.61%	75.61%

As at 09/09/26 the MenB uptake figures show there has been 5,797 first doses provided and 2,634 second doses.

UKHSA published on 13/08/26 the Respiratory Syncytial Virus (RSV) annual report which shows around 50% fewer infants under 6 months being admitted to intensive care with RSV disease in England. The data demonstrates the annual impact of the NHS RSV maternal vaccination programme for the first time. The Norfolk and Suffolk uptake rate is detailed below with comparison to the national uptake, Norfolk and Suffolk are high in all cohorts than the national average.

Cohort	Norfolk and Suffolk Uptake	National Uptake
Older Adults Catchup	77.85%	71.96%
Older Adults Routine	52.42%	46.54%
Maternity	51.16%	46.40%
Newly Eligible 80+	46.93%	39.14%

Cohort	Norfolk and Suffolk Uptake	National Uptake
Older Adult Care Home Residents	51.19%	40.22%

All vaccination sources are via the Federated Data Platform (FDP)

10.2. Proactive and risk-stratified care

In Norfolk and Waveney, population health management and risk stratification are being used to identify people at greatest risk of avoidable admission, with work spanning respiratory diagnosis and management, care planning and wider health and wellbeing needs.

All providers have access to a range of case finding and risk stratification tools to identify the patients with greatest risk of winter-related deterioration or admission. This includes GP case finding tools and population health management platforms for integrated neighbourhood teams and system planning.

Through the Eclipse population health platform and linked system data, proactive care programmes are targeting people living with frailty, multiple long-term conditions and rising-risk profiles to provide earlier intervention, personalised care planning and coordinated support through primary care and Integrated Neighbourhood Teams. These programmes aim to improve self-management, reduce health inequalities, prevent avoidable escalation of need and support a reduction in emergency attendances, admissions and length of stay during periods of increased winter pressure.

In Suffolk, virtual ward development continues alongside the rollout of the Care Management Service across all 14 Integrated Neighbourhood Teams during 2026/27.

The Care Management Service was developed following a sustainability review (led by McKinsey) which examined how to deliver clinically and financially sustainable care amid rising demand, workforce challenges, and ageing demographics. It was identified that while overall health outcomes are broadly in line with national averages, there are stark inequalities and growing pressure on acute services, the review found that 1% of the population in our local geography used 60-70% of unplanned hospital bed days. The Care Management Service aims to bring services working together across Suffolk to reduce hospital admissions for people in most need.

Operationalisation commenced in October 2025 in West Ipswich which is the neighbourhood with the largest number of people in the “1%” cohort. Mildenhall and Brandon INT, Woodbridge INT, Central Suffolk and Newmarket INT are also now live. Two further INTs are due to go live in the next 4 weeks with the remaining INTs going live before the end of the 2026/27 financial year.

Once the Care Management Service is fully operational across Suffolk, the ICB aims to achieve a reduction in bed days for the cohort of people supported of 18,603 (a 10% reduction) across Suffolk and an overall reduction in UEC activity at ESNEFT and WSFT.

The key performance metrics, for the target cohort, to achieve this, measured across a 12-month rolling period are:

- Mean admissions per patient – 2.26 (v current mean admissions of 2.52)
- Mean bed days per admission – 12.31 (v current mean of 13.7)
- Mean bed days per patient 30.94 (v current mean of 34.6)

Local planning considers Core20PLUS5, underserved populations, wider determinants of health and partnership opportunities with local government, housing, adult social care, voluntary, community and social enterprise organisations and anchor partners. Practical priorities include prevention, safe and warm discharge, outreach, housing and welfare support and community resilience.

11. Primary care, NHS 111 and admission avoidance

11.1. General practice capacity and access

Seasonal demand will be assessed against general practice capacity, Out of Hours and Enhanced Access provision. Practices are expected to adapt appointments to demand, including same-day access. Enhanced Access will be available on 24 December, normal opening is planned for 31 December, and Out of Hours services are commissioned across weekends and bank holidays.

An OPEL framework for general practice is being developed. Place and Primary Care teams monitor and escalate workforce shortages, adverse weather and other pressures, with severe issues managed through ICB resilience arrangements. Daily System Operations Centre calls support mitigation and changes to the Directory of Services.

Access area	Position and action
Core opening hours	All Suffolk practices reported as compliant. In Norfolk, 15 of 103 practices require follow-up, with compliance or action plans confirmed.
Online consultation	All practices meet requirements. Nine with low usage are being monitored and offered support.
Urgent same-day access	Baseline variation remains: 80 practices rated amber and 28 red against the 90% target. The ICB is working with those practices to develop (and assure) action plans and this continues to be monitored.
NHS 111 booking	Practices will be reminded of the contractual requirement to provide one appointment per 3,000 patients.
PCN Enhanced Access	A one-off audit beginning in September 2026 will seek assurance that unused slots are made available to NHS 111.

11.2. Clinically led admission avoidance

NHS 111, the Clinical Assessment Service and the Urgent Care Co-ordination Hub provide early clinical assessment, conveyance avoidance, referral to community alternatives and support to reduce Emergency Department attendance

A business case approved by the Strategic Commissioning Committee in September supports the expansion of UCCH and CAS operational hours across Norfolk and Suffolk for winter 2026/27. This will increase the availability of clinically led assessment and coordination services, enabling more patients to receive timely advice, triage and referral to appropriate community and urgent care pathways outside traditional service hours.

The expansion is intended to strengthen admission avoidance, reduce unnecessary Emergency Department attendance and ambulance conveyance, improve patient flow and provide additional resilience within the wider urgent and emergency care system during periods of increased winter demand. Pilot schemes have already demonstrated improvements in hear-and-treat rates, conveyance avoidance and overall pathway performance.

Measure	Estimate annual impact
Reduced ambulance conveyances	2,063
Reduced emergency department attendances	1,224
Reduced same day non-elective activity	2,204

11.3. Urgent dental and eye care

From April 2026, eligible dental contracts are required to deliver 8.2% of contract value as urgent and unscheduled care, equating to around 86,000 courses of treatment across Norfolk and Suffolk. Activity and capacity are monitored through established commissioning arrangements, with NHS 111 acting as the primary access route to ensure patients are directed to the most appropriate service in a timely manner.

A dedicated Dental Trauma Service and out-of-hours provision provide additional resilience and support access to urgent treatment during evenings, weekends and bank holidays. In Suffolk, the Dental Priority Access and Stabilisation Service (DPASS), which provides urgent assessment, treatment and stabilisation for patients unable to access routine NHS dental care, has been extended until September 2027.

In Norfolk, where demand for urgent dental care remains high, an additional 10,000 urgent dental appointments are being commissioned between September 2026 and March 2027 while longer-term sustainable service models are developed.

NHS 111 dental pathways are also being aligned across Norfolk and Suffolk, supported by a communications programme to improve public awareness of available services and reduce inappropriate attendance at Emergency Departments.

Urgent eye care is available through local optometrists and the Community Urgent Eye Care Service (CUES), providing timely assessment and management of a wide range of eye conditions within community settings.

Together, these services help ensure patients receive care in the most appropriate setting, reducing pressure on general practice, urgent treatment centres and Emergency Departments during periods of increased winter demand

11.4. Community pharmacy

Norfolk and Suffolk have 274 community pharmacies, with 99% commissioned to deliver the Pharmacy First service, providing significant accessible primary care capacity across the system. Community pharmacies play an important role in managing winter demand by offering advice, assessment and treatment for a range of common conditions, supporting self-care and reducing pressure on general practice, urgent treatment centres and Emergency Departments. Pharmacy First provides patients with timely access to clinical advice and treatment without the need for a GP appointment, helping to ensure individuals are managed in the most appropriate setting.

To support resilience over the festive period, 19 pharmacies are planned to open on Christmas Day, 28 December and New Year's Day between 10:00 and 18:00, with assurance work continuing to confirm arrangements for 26 December. Festive provision will include Pharmacy First consultations, oral contraception services, dispensing, repeat medicines support and the Discharge Medicines Service, helping to maintain continuity of care and reduce avoidable attendances elsewhere in the system. Particular attention is being given to ensuring access to palliative and end-of-life medicines, recognising the importance of timely availability for patients and families during periods of increased winter pressure.

Community pharmacies also contribute to system flow by supporting medicines optimisation, facilitating safe discharge from hospital through the Discharge Medicines Service and providing convenient access to healthcare advice within local communities. Collectively, the pharmacy network provides a resilient and accessible source of clinical support throughout winter, helping to manage demand across urgent and emergency care pathways and improve patient experience.

11.5. Directory of Services

The NHS 111 Directory of Services (DoS) is regularly reviewed and maintained by the Directory of Services Manager to ensure service information remains accurate, current and reflective of available capacity across Norfolk and Suffolk. This supports NHS 111 clinicians and call handlers to direct patients to the most appropriate service first time, helping to reduce unnecessary attendance at Emergency Departments and ensuring available capacity across primary, community and urgent care services is effectively utilised.

Robust escalation arrangements are in place to manage situations where services become overwhelmed, experience capacity constraints or activate business continuity plans. During operational hours, issues are managed through the System Operations Centre (SOC), enabling service pressures to be considered within the context of the wider system position and facilitating coordinated responses where actions are required across multiple organisations. This supports timely escalation, service reconfiguration where necessary and clear communication of changes in service availability.

Provider referral patterns from NHS 111 are monitored through established commissioning and contract management arrangements to ensure patients are being directed to the agreed pathways and that commissioned services are receiving appropriate utilisation. Performance, referral volumes and service availability are regularly reviewed to identify opportunities to improve pathway effectiveness and patient access. During periods of increased winter pressure, the Directory of Services provides an important mechanism for managing demand across the system by enabling rapid updates to service availability, supporting admission avoidance pathways and ensuring patients continue to be directed to the right care, in the right place, at the right time.

12. Community health capacity and out-of-hospital care

Community capacity is central to both admission avoidance and timely discharge and forms a key component of the Norfolk and Suffolk winter resilience approach. The system's model brings together urgent community response, virtual wards, Hospital at Home services, front-door clinical assessment, frailty pathways, intermediate care, Home First services and integrated discharge functions to ensure patients can receive care in the most appropriate setting and avoid unnecessary hospital admission where clinically safe to do so.

These services provide alternatives to admission for people who can be safely supported at home, including those with frailty, long-term conditions, respiratory illness and other conditions commonly associated with increased winter demand. Community teams work closely with acute services, primary care, mental health providers and social care to identify patients who may benefit from rapid assessment, ongoing monitoring or enhanced support outside of hospital. Virtual wards and Hospital at Home services enable patients to receive acute-level care in their usual place of residence, whilst urgent community response services provide rapid intervention aimed at preventing avoidable deterioration and escalation to emergency care.

The system has also continued to strengthen front-door models and frailty pathways, supporting earlier senior clinical decision-making and facilitating direct referral to community-based alternatives where appropriate. Intermediate care and Home First services play a critical role in supporting discharge, enabling patients to recover in their own homes wherever possible and reducing reliance on long-term hospital stays. These arrangements are supported by integrated discharge teams working across organisational boundaries to ensure care, support and equipment are in place to facilitate safe and timely discharge.

Learning from winter 2025/26 highlighted the value of stronger integration between acute, community, mental health, local authority and social care partners, including the use of frailty pathways, virtual wards, enhanced discharge arrangements, seven-day services and community-based alternatives to admission. These approaches will continue to underpin the system response during winter 2026/27, helping to improve patient flow, reduce delays and maintain capacity across urgent and emergency care services.

12.1. Norfolk and Waveney

Plans are progressing to increase Urgent Community Response (UCR) capacity across Great Yarmouth and Waveney, West Norfolk and Central Norfolk, alongside enhanced front-door assessment, frailty, Hospital at Home and community-based admission avoidance pathways. This forms part of a broader whole-system approach to reduce avoidable conveyance and admission, support same-day urgent care in the community and improve patient flow throughout periods of increased winter demand. Community providers are

developing detailed winter capacity plans that align workforce, estates, operational escalation arrangements and community service capacity with anticipated demand, supported by close integration with primary care, NHS 111, ambulance services, acute providers and local authority partners.

Further pathway development is under way across respiratory care, lower leg wound management and diabetes services to support earlier intervention, proactive management of long-term conditions and delivery of care closer to home. These pathways are intended to reduce avoidable deterioration and non-elective admissions during winter while improving patient experience and outcomes. Alongside UCR expansion, continued investment in intermediate care, Home First services, integrated discharge arrangements and home-based support will provide additional resilience across community services and support timely discharge from hospital.

Whilst delivery remains on track, some elements of the planned UCR expansion are dependent on workforce recruitment and implementation timelines and may not be fully operational until later in winter 2026/27. This remains a recognised delivery dependency within the winter plan and will continue to be monitored through established governance and escalation arrangements to ensure any risks to capacity, patient flow or admission avoidance are identified and mitigated at the earliest opportunity

12.2. Suffolk

Ipswich and East Suffolk

In Ipswich and East Suffolk, approval has been secured to expand the REACT (Rapid Emergency Assessment and Care Team) and Urgent Community Response service across all eight Integrated Neighbourhood Teams. The expansion will extend operating hours, strengthen proactive hospital in-reach arrangements and further enhance the Virtual Ward offer, increasing the system's ability to identify and support patients who can be safely managed outside of hospital. The investment is intended to improve admission avoidance, provide more rapid community-based assessment and intervention, support earlier discharge and reduce reliance on acute services during periods of increased winter pressure.

Together with the continued rollout of neighbourhood-based care models, the enhanced REACT service will strengthen community capacity and improve the integration of urgent, proactive and discharge services across Ipswich and East Suffolk. The wider Suffolk approach also includes the rollout of the Care Management Service across all 14 Integrated Neighbourhood Teams, helping to connect prevention, admission avoidance and discharge pathways which is referenced in Section 12.

West Suffolk

In West Suffolk, recruitment to additional District Nursing and Early Intervention Team capacity is expected to be completed by October 2026, increasing the availability of community-based clinical support and strengthening the system's ability to identify, assess and intervene early for patients at risk of deterioration, hospital admission or delayed discharge. The enhanced workforce will support more responsive care in people's homes, facilitate timely clinical reviews, and enable closer coordination with primary care, urgent community response services and acute providers to prevent avoidable admissions wherever clinically appropriate.

To further support discharge pathways and patient flow, West Suffolk Council has commissioned increased assessor capacity, seven-day brokerage arrangements and additional external reablement services. These measures will improve the timeliness of discharge assessments, ensure care and support packages can be arranged consistently throughout the week, including weekends, and provide greater flexibility and resilience within the local care market during periods of peak winter demand. The expanded reablement offer will help more individuals regain independence following a hospital stay, reducing reliance on ongoing care services and supporting sustainable discharge outcomes.

Collectively, these interventions are designed to improve flow across the health and care system by reducing delays in transferring care, increasing the availability of community support, maximising the use of home-based care pathways and ensuring patients are discharged to the most appropriate setting without unnecessary delay. By strengthening both clinical and social care capacity, the approach will support people to return home safely as soon as they are clinically ready, improve patient experience and outcomes, and create additional capacity within acute hospitals during periods of sustained winter pressure.

12.3. Whole-system integration

Across Norfolk and Suffolk, partners are delivering an integrated, place-based approach that aligns health, social care, community, voluntary sector and housing services around a shared objective of preventing unnecessary admissions, supporting timely discharge and maximising independence. Services are designed to operate as a single, coordinated pathway, ensuring individuals receive the right care, in the right place, at the right time, with seamless transitions between acute, community and primary care settings.

In Norfolk and Waveney, proactive care, urgent community response, virtual wards, integrated front-door and discharge services, Home First and intermediate care work together to provide a coordinated response across the patient journey, from prevention and early intervention through to recovery and rehabilitation. In Suffolk, the rollout of the Care Management Service across all 14 Integrated Neighbourhood Teams, alongside the continued development of REACT, virtual wards and strengthened Transfer of Care arrangements, creates a connected model that brings together prevention, admission avoidance, discharge planning and ongoing support in the community.

These arrangements are supported by shared operational oversight, multi-agency decision making, integrated escalation processes and system-wide performance monitoring, enabling organisations to respond collectively to emerging pressures and maintain patient flow during periods of increased winter demand. The approach strengthens resilience across the whole system, maximises the use of community capacity, reduces fragmentation between services and improves outcomes and experiences for people requiring urgent and ongoing care.

13. Flow, occupancy and discharge

13.1. Seven-day flow

The system has established operational plans and daily processes to reduce avoidable bed occupancy, support timely discharge and maintain seven-day flow. Demand and capacity reviews are undertaken across partners and the NHS England Model Discharge Pathway informs operational planning. The seven principles of the Model Discharge Pathways have been built into provider assessments which are monitored via the System Delivery Group.

Norfolk and Waveney are strengthening intermediate care, home-based support, urgent community response, integrated discharge services and preventative pathways.

In Suffolk, Ipswich and West Suffolk Hospitals operate daily discharge processes supported by Transfer of Care Hubs and social care, community and voluntary sector partners.

Further developments include expansion of the West Suffolk Early Intervention Team and the proposed REACT/Urgent Community Response service across all Integrated Neighbourhood Teams, increasing the system's ability to provide rapid assessment, intervention and admission avoidance support in patients' homes. In addition, greater integration across Integrated Neighbourhood Teams, enhanced proactive hospital in-reach and strengthened virtual ward provision will increase community capacity to support timely discharge, reduce avoidable admissions and improve patient flow during periods of sustained winter pressure.

Further developments include the West Suffolk Early Intervention Team and proposed REACT/Urgent Community Response expansion, greater Integrated Neighbourhood Team integration, proactive hospital in-reach and enhanced virtual ward provision.

13.2. Eliminating corridor care

System partners are committed to eliminating corridor care and ensuring that all patients are cared for in environments that are safe, clinically appropriate and preserve dignity, privacy and patient experience. Patient safety remains the overriding priority and all organisations will continue to take action to reduce overcrowding, improve patient flow and minimise the risk factors that can lead to patients receiving care in non-designated clinical areas.

A whole-system approach is being used to address the underlying causes of corridor care, with operational command arrangements providing oversight of system pressures and enabling rapid escalation and coordinated decision-making. Transfer of Care Hubs, integrated discharge services and Home First approaches support timely discharge planning from the earliest point of admission, helping to reduce unnecessary length of stay and improve bed availability across acute sites.

Community admission avoidance services, including Urgent Community Response, Same Day Emergency Care, Virtual Wards, care coordination and enhanced community support, are being utilised to provide alternatives to hospital attendance and admission wherever clinically appropriate. These services enable patients to receive assessment, treatment, monitoring and ongoing support closer to home, reducing demand on emergency departments and inpatient capacity while maintaining high-quality care.

The system is also maximising the use of intermediate care, rehabilitation, reablement and community-based recovery services to support patients to leave hospital as soon as they are clinically ready. Through strengthened partnerships between acute providers, primary care, community services, local authorities and the voluntary sector, pathways are being coordinated to ensure patients experience seamless transitions between services and avoid delays that contribute to hospital congestion.

The GIRFT Corridor Care Clinical Operational Standards are being used as a key improvement framework to support local planning, operational readiness and continuous improvement. Providers are reviewing practices against these standards, strengthening escalation processes, improving visibility of patient flow risks and ensuring that capacity, workforce and operational responses remain focused on reducing overcrowding and maintaining safe care throughout periods of sustained winter demand. Together, these measures will support the system's ambition to improve flow, prevent avoidable harm, enhance patient experience and eliminate the need for corridor care wherever possible.

13.3. Joint discharge planning

Transfer of Care Hubs bring together acute, community, social care, mental health and district or borough council partners. Shared processes, daily multi-agency meetings and joint use of the Optimised Patient Tracking and Intelligent Choices Application support timely, safe and person-centred discharge decisions.

13.4. Model discharge pathway baseline

Providers have reviewed discharge arrangements against the national Model Discharge Pathway. In Suffolk, ESNEFT and West Suffolk Hospital included this baseline in seasonal plans discussed at their boards in August 2026, with monitoring through four-hour performance, acute length of stay and daily stand-up meetings. In Norfolk and Waveney, the baseline informs Transfer of Care Hub arrangements, Home First, Discharge to Assess, demand and capacity modelling and pathway transformation.

14. Mental Health

NSFT have implemented operational oversight and escalation arrangements across the Trust. Daily safety and capacity reviews give a real-time view of pressures across services, allowing them to identify risks early and respond before they escalate. Consistent senior clinical and operational oversight, supported by consultant psychiatrists, resident doctors, duty senior nurses and senior managers is in place. Alongside this, business continuity, adverse weather, industrial action, and mutual aid plans have all been reviewed and tested, giving confidence that they can continue to deliver safe care and respond effectively when pressures increase.

NSFT aim for patients to receive care in the most appropriate setting for their needs, with our Crisis Resolution and Home Treatment Teams providing a vital alternative to admission where safe to do so, while also supporting timely discharge from inpatient care. Alongside this, the transition of the NHS 111 Mental Health service to an enhanced Integrated Response Service (IRS) model will strengthen the resilience and consistency of our urgent mental health offer, helping people access timely support at the earliest opportunity. With crisis, liaison psychiatry and Section 136 services in place, supported by senior clinical decision-makers and out-of-hours escalation arrangements, NSFT are confident that we will be able to maintain flow across our mental health pathways throughout the winter period.

NSFT focus is on supporting older and more vulnerable patients through the winter period by promoting vaccination, maintaining strong infection prevention measures and working closely with partners to identify and support those most at risk. By responding early to changes in need and maintaining continuity of care, we aim to help people stay well and avoid unnecessary hospital admission wherever possible.

NSFT are taking a proactive approach to managing bed pressures through close daily oversight of capacity, demand and staffing. Patient flow is reviewed with partners across the system each day, enabling barriers to admission and discharge to be identified and addressed quickly. Over the winter and festive period, there will be a continued focus on maximising safe discharge opportunities and supporting appropriate home leave arrangements, helping to ensure inpatient capacity remains available for those who need it most.

15. Demand, capacity, surge and mutual aid

15.1. Demand and capacity approach

Providers undertake demand and capacity modelling through the year. The ICB System Operations Centre and EPRR arrangements monitor pressures and co-ordinate response. Winter plans are informed by data analysis, local plans and system planning events. Escalation routes enable response arrangements to be implemented at pace.

Winter demand and capacity planning has been informed through a system-wide modelling approach using historical winter activity, recent demand trends, operational intelligence and learning from both winter 2025/26 and summer 2026. Forecast demand assumptions reflect anticipated increases in urgent and emergency care activity, ambulance demand, NHS 111 contacts and pressures associated with seasonal illnesses, alongside the assumption that the system may enter winter under sustained operational pressure. Capacity assumptions were based on provider baseline capacity plans, workforce availability, discharge performance expectations and commissioned winter schemes.

Providers were required to assess and demonstrate how their local plans would meet forecast demand, with assumptions reviewed collectively through system planning and the system wide Strategic Delivery Group governance processes to identify gaps, risks and mitigating actions. Where modelling identified potential shortfalls between forecast demand and available capacity, these informed the development of escalation, surge and extreme surge arrangements, ensuring additional capacity, mutual aid and command and control processes can be activated in a timely and co-ordinated manner

15.2. Surge and extreme surge

The plan is designed to operate across baseline, moderate, surge and extreme surge conditions. Testing focuses on whether services and command arrangements can respond collectively, not simply whether individual plans exist. The response combines additional service capacity, operational prioritisation, admission avoidance, mutual aid and incident structures where thresholds are met.

15.3. NHS 111 and workforce resilience

Integrated Urgent Care providers IC24 and Practice Plus Group model call adviser and clinical staffing requirements through the year and use predictive modelling for seasonal periods. Performance and capacity are monitored through ICB oversight meetings. Provider escalation plans include virtual working, and national contingency arrangements can route NHS 111 calls across providers subject to national approval.

15.4. Mutual aid and business continuity

The System Operations Centre will co-ordinate support between providers where practical, agree plans into the evening and support escalation of provider business continuity arrangements. Severe weather and rising-tide events, including industrial action, will be managed with Local Resilience Forum partners and through normal command, control and co-ordination arrangements.

16. Infection prevention, health protection and outbreak response

16.1. Infection prevention and control readiness

Assurance on fit testing, PPE, wider IPC mitigations and staff vaccination is sought from acute providers through Infection Control Committees attended by the ICB IPC team. An options paper is being developed on the approach and cost of fit testing for primary care, with an intention to fund. The Norfolk primary care IPC ICAT audit programme continues.

Commissioned support includes ECCH IPC support for primary care and care homes in Great Yarmouth and Waveney, Commisceo outbreak screening advice in Suffolk and EEC support for care homes in Norfolk. Screening and antiviral pathways are planned for review before winter.

Winter messaging is shared with primary care and the social care sector, and an outbreak management chart is being developed for out-of-hours ICB on-call staff.

16.2. Health protection governance

A Norfolk and Suffolk system call involving the ICB IPC team, acute IPC leads, UKHSA, community providers and local authorities meets twice weekly to share intelligence and good practice, with the ability to increase frequency as pressures require. Teams channels support outbreak notification and intelligence sharing for care homes and the wider care sector.

17. Leadership, operational grip and system co-ordination

17.1. System Operations Centre operating model

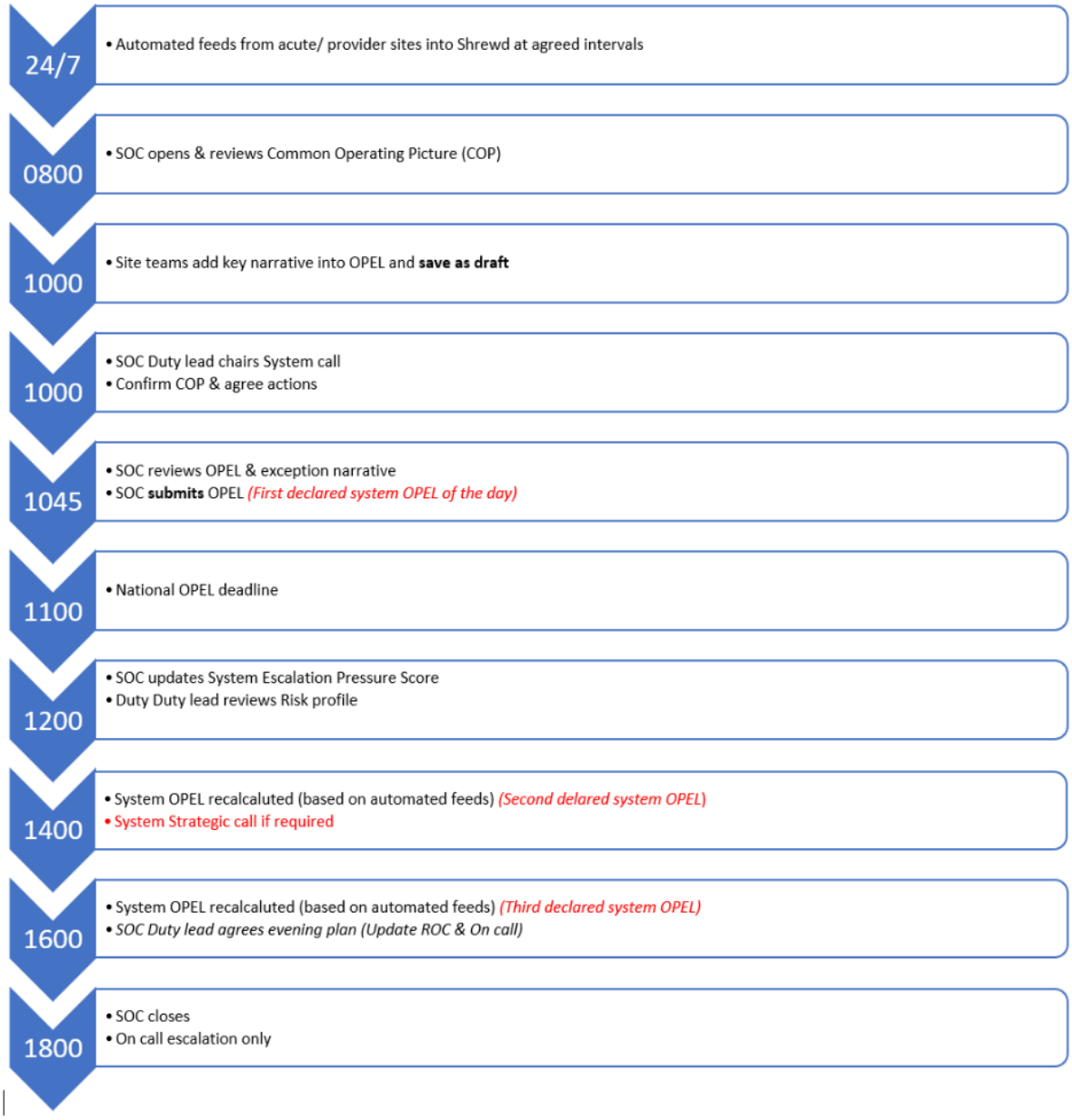
The System Operations Centre (SOC) will operate from 08:00 to 18:00, seven days a week, staffed by UEC Operations Managers and Operations Support Officers. It will lead a daily system call, review the common operating picture, oversee OPEL submissions and agree proactive action to support flow. The service can flex or extend hours during extreme pressure.

Key responsibilities:

- Attendance at all regional Tactical and Strategic Command meeting by senior system manager and system executive.
- Lead system sitrep coordination
- On-site liaison several times a week to support acutes
- Clinical risk oversight
- Strengthened tactical leadership of the SOC for key periods
- Lead on system surge plan & actions
- Governance for contingent funding arrangements (if required)

The SOC provides a coordinated, system-wide approach to managing operational pressures, maintaining situational awareness and supporting timely decision-making throughout the day. Through a combination of real-time data, shared intelligence and structured escalation arrangements, the SOC develops and maintains a common operating picture across health and care partners, enabling risks to be identified early and actions agreed collectively.

The daily operating rhythm set out below ensures that system pressures, patient flow, discharge performance and emerging risks are reviewed at regular intervals, with operational and strategic responses escalated as required. This structured approach supports proactive management of demand, effective use of available capacity and a coordinated response to maintain safe and timely care during periods of increased winter pressure.



Operational resilience action

Temporary staffing gaps caused by sickness absence are being monitored. Recruitment to fixed-term posts began in early September. If absence continues into winter, additional cover and rota mitigations will be required to maintain seven-day coverage.

17.2. Command and on-call

A 24/7 two-tier on-call structure provides one Tactical level across Norfolk and Suffolk supported by one Strategic Commander. In hours, the System Operations Centre covers tactical and strategic functions and can access nursing, medical, communications, commissioning and wider ICB support. Tactical and Strategic Commanders work to an On-call Standard Operating Procedure, Incident Response Plan, action cards and supporting guidance.

A full complement of on-call staff is in place, both at Tactical and Strategic Level. The Tactical on-call provides coverage for one county, therefore at any given time, two Tactical are on-call to ensure full Norfolk and Suffolk coverage.

Additional training has been provided to all on-call staff which enables them to

- identify where to find on-call information and guidance
- Understand how to log incidents and decisions correctly
- Understand the ICB role within the wider health and emergency system
- Recognise how to operate safely within on-call escalation and communication pathways

The training prepares staff to function safely and consistently in an on-call emergency coordination role within the Norfolk and Suffolk ICB system.

17.3. Operational intelligence

OPEL reporting through SHREWD provides a near real-time view of operational pressure across acute, community, mental health, ambulance, primary care and social care services, supported by automated business intelligence feeds and provider updates throughout the day. SHREWD brings together key system metrics into a single Common Operating Picture, enabling the System Operations Centre and partner organisations to identify emerging pressures, monitor patient flow, track capacity constraints and assess system risk at both place and system level.

Automated data feeds ensure that core performance indicators are refreshed regularly, whilst provider narrative updates add local intelligence and context to support decision-making.

The platform calculates OPEL status using agreed metrics and supports structured escalation processes, allowing operational and strategic leaders to take proactive action, coordinate resources and maintain safe patient flow during periods of sustained demand. Daily system calls and ongoing monitoring of the SHREWD dashboard enable risks to be shared, mitigated and escalated appropriately across the Norfolk and Suffolk system.

The System Operations Centre is contactable through Teams, telephone and email and provides the route to executive escalation where required.

17.4. Regional engagement

Regional engagement is supported through an established Teams chat across East of England UEC teams and System Co-ordination Centres, regional tactical calls as required, monitoring of the ICB single point of contact inbox, co-ordination of assurance returns and monthly System Co-ordination Centre lead meetings.

18. Workforce resilience and staff welfare

Workforce resilience is both a capacity risk and a quality and safety issue. In May 2026, secondary care provider sickness absence was reported at 5.5%, compared with a 4.9% plan and an England rate of 5.5%. EEAST was at 7.8%; ECCH at 6.4%; East of England Community Health and Care at 5.7%; NSFT at 6.1%; JPUH at 5.6%; and QEH King's Lynn at 5.4%. Bank and agency use in June 2026 was above plan for all acute providers, EEAST and the mental health provider.

Provider support includes occupational health, Employee Assistance Programmes, psychological wellbeing services, wellbeing hubs and rest spaces, vaccination, flexible working, manager support, proactive management of long-term absence, staff networks and retention programmes. Health and social care staff can access the confidential 24/7 SHOUT service by SMS.

In April 2026, Norfolk and Suffolk partners secured £250,000 of NHS Workforce Wellbeing Programme funding. The programme is being delivered jointly by NSFT, primary care organisations and the ICB and is intended to provide accessible, stigma-free wellbeing and postvention support, particularly following traumatic incidents, sudden death or suicide.

19. Communications and public engagement

The annual Warm and Well campaign will support residents to protect their health, understand available services and use the right care at the right time. Planning includes primary care, NHS 111, community pharmacy and admission avoidance services.

Previous activity has used social media, media advertising, digital and Google pay-per-click advertising, outdoor digital screens and printed material distributed through GP practices, pharmacies, community groups, food banks, libraries and directly to households. For 2026/27, communications should align service availability with targeted population insight and vaccination campaigns, and remain responsive to live operational pressures and outbreaks.

Communication objective	Planned emphasis
Prevent avoidable deterioration	Vaccination, self-care, keeping warm, respiratory health and early help.
Guide access	NHS 111, Pharmacy First, general practice, urgent dental and eye care, and community alternatives.
Support equity	Target communities with lower uptake or access barriers using deprivation and population insight.
Support operational response	Provide timely messages when services, weather, outbreaks or access arrangements change.

During winter, demand for services tends to increase significantly with the onset of cold weather and respiratory and seasonal illnesses, including COVID-19, flu and respiratory syncytial virus (RSV). Combined with ongoing cost-of-living pressures and vaccine hesitancy among some eligible groups, wider determinants of health may have a major impact on the health and wellbeing of people across Norfolk and Suffolk and increase demand on health, care and support services across the system.

The Warm and Well joint campaign led by Norfolk County Council, Suffolk County Council and NHS Norfolk and Suffolk Integrated Care Board will bring health, wellbeing and practical support messages together under one clear identity.

- Activity will be focused around three connected themes:
- Prevention, including awareness of and access to vaccinations
- Hardship support, particularly where take-up of available support is low
- Keeping warm, with additional activity when temperatures fall

A fresh campaign identity and coordinated set of assets will be developed for launch across Norfolk and Suffolk.

Creative will be designed for use across paid, partner and community channels, with flexibility to tailor messages by audience, location and weather conditions. Performance will be reviewed throughout the campaign so content can be refined and refreshed where needed.

Based on recommendations from the previous year, assets with a refreshed visual identity will be used from January onwards to help tackle message fatigue.

The campaign will be presented as Warm and Well Norfolk and Suffolk. A single campaign landing page, hosted by the ICB, should provide shared health information and direct people to the correct county or local support service.

19.1. Objectives

- Support people to stay well, warm and independent throughout winter.
- Promote vaccination, prevention and self-care to reduce avoidable illness.
- Help residents choose the right NHS service when they need care.
- Increase awareness of local financial, community and wellbeing support.
- Reach residents across Norfolk and Suffolk through a coordinated partnership campaign.

19.2. Audiences

- Residents aged 18 to 65 living in areas experiencing higher levels of deprivation across Norfolk and Suffolk. Priority locations may include Norwich, Great Yarmouth, King's Lynn, Thetford, Lowestoft, Ipswich, Felixstowe, Stowmarket, Beccles and Haverhill.
- Vulnerable residents aged 65 and over.
- People eligible for flu, COVID-19 or RSV vaccination, including pregnant women where relevant.
- Carers, relatives, friends and neighbours of vulnerable residents.
- People affected by financial hardship, fuel poverty or social isolation.
- People who are digitally excluded or less likely to engage with online information.

19.3. Measures of success

The figures below have been calculated by applying approximately a 77% increase to the results achieved by the 2025-26 Warm and Well campaign delivered in Norfolk and Waveney. This uplift reflects the estimated growth in the target audience reached by the campaign following the expansion from a Norfolk and Waveney focus to a Norfolk and Suffolk footprint. These draft figures may be adjusted once budgets have been confirmed.

Measure	Target	Deadline
Visits to the campaign website	13,000	31 March 2027
Social media ad reach	112,650	31 March 2027
Social media ad clicks	250	31 March 2027

19.4. Channel and activity plan

Channel	Approach
Campaign landing page	A single Norfolk and Suffolk landing page with shared health information and clear county-specific routes to hardship, warm space and community support.
Earned media	Joint launch press release and local media pitches across Norfolk and Suffolk.
Paid social media	Geographically targeted activity across both counties, coordinated by the core partners.
Digital display PPC	Location and postcode targeting, with creative and landing pages matched to user need where possible.
Print advertising	A mix of Norfolk and Suffolk local titles to reach digitally excluded audiences. Final titles to be agreed against audience and value.
Council publications and newsletters	Use Norfolk County Council, Suffolk County Council and other partner publications and resident newsletters where available.
Outdoor digital screens	Paid and partner-owned screens across both counties, including appropriate travel locations.

Channel	Approach
Health and care screens	Waiting-room screens in GP practices, pharmacies and other health and care settings.
Libraries and community venues	Distribution through Norfolk and Suffolk libraries, community hubs, family hubs and other trusted local venues.
Transport channels	Norfolk and Suffolk bus, travel hub and related advertising opportunities, subject to availability.
Audio	Radio and audio streaming activity with geographic targeting across both counties.
Printed materials	Posters and other materials for community groups, food banks, libraries, GP practices, pharmacies and partner venues.
Internal communications	Staff channels, partner bulletins and optional email signature assets.
Stakeholder toolkit	Approved copy, creative, links and guidance that partners can use to extend campaign reach.

19.5. Suggested partner networks

- Norfolk and Suffolk district and borough councils
- NHS provider organisations and primary care networks
- Pharmacies and GP practices
- Voluntary, community and social enterprise organisations, including Community Action Suffolk and equivalent Norfolk networks
- Housing, welfare, food support and community organisations
- Town and parish councils
- Libraries, family hubs and community hubs

19.6. County-specific signposting

Health messages can be shared across the campaign area, but support services may differ between Norfolk and Suffolk and between local authority districts. Campaign materials should therefore:

- Use shared core language where advice is the same across both counties.
- Provide separate Norfolk and Suffolk links for hardship, household support, warm spaces, welfare advice and community services.
- Avoid naming a local scheme in shared creative unless it is available to everyone in the target geography.

- Use location-specific paid advertising or Nextdoor organic content where a service is only available in one area.
- Keep information under review so expired schemes or changed eligibility criteria are removed promptly.

19.7. Campaign delivery principles

- Use a coordinated mix of paid digital, search, social, print and partner channels to build reach across both counties.
- Design platform-appropriate creative for priority audiences, with clear calls to action and location-relevant landing pages.
- Make partner involvement a core part of the campaign from the outset, supported by a simple toolkit, clear responsibilities and an agreed reporting approach.
- Coordinate social media activity across Norfolk County Council, Suffolk County Council and NHS Norfolk and Suffolk ICB to maintain consistent messages and reduce duplication.
- Use shared performance measures, county-level insight and regular review points to optimise delivery throughout the campaign.

19.8. Core channel recommendations

- Use an upweighted digital campaign with postcode and audience targeting across Norfolk and Suffolk to tackle known health inequalities.
- Use outdoor digital advertising to promote vaccination, prevention and household support messages.
- Maintain a mix of press, print and digital channels to reach people who are digitally excluded.
- Upweight activity early in the campaign period to build awareness before the peak winter period.
- Reserve flexible budget for weather-triggered activity and locally targeted support messages.
- Track delivery and performance separately for Norfolk and Suffolk where possible, while maintaining an overall campaign view.

19.9. Roles and governance

Partner	Indicative role
Norfolk County Council	Lead and support Norfolk-specific content, channels, local services and partner distribution. Contribute to joint planning, approvals and evaluation.
Suffolk County Council	Lead and support Suffolk-specific content, channels, local services and partner distribution. Contribute to joint planning, approvals and evaluation.

NHS Norfolk and Suffolk ICB	Lead and assure NHS content, coordinate health partner involvement and contribute to paid and organic delivery across both counties.
Wider partners	Use approved campaign assets, provide accurate local signposting, share activity through trusted channels and report available results.

19.10. Campaign steering group

A communications and engagement steering group should oversee the campaign, with representatives from Norfolk County Council, Suffolk County Council and NHS Norfolk and Suffolk ICB. Wider NHS and voluntary, community and social enterprise partners can be involved where their input is required.

- Agree the campaign proposition, priority audiences and geographic targeting.
- Approve shared assets and county-specific signposting.
- Coordinate paid and organic activity.
- Manage the content review and approval process.
- Monitor performance and agree any changes during the campaign.
- Complete a shared evaluation after the campaign.

19.11. Timeline

Stage	Timing	Focus
Phase 1: prevention and preparation	Week commencing 20 October 2025	Early prevention, vaccination, self-care and winter preparation messages.
Phase 2: full campaign	3 November 2025	All campaign themes, including NHS service use and hardship support.
Cold weather activity	Dynamic	Keeping warm and local support messages activated according to weather and partner decisions.
Review points	To be agreed	Regular performance and content review by the campaign steering group.

19.12. Social media copy

The copy below has been adapted for a Norfolk and Suffolk campaign. County-specific links should be used where a post promotes local support that differs between Norfolk and Suffolk.

Be prepared

Be prepared for winter by making sure you can care for yourself and your family.

Stocking your medicine cabinet with painkillers, cough medicines and treatments for diarrhoea is a good place to start.

Ask your local pharmacist for advice or visit [campaign link]

#WarmAndWell

Carer support

If you care for someone, creating an emergency carer plan can help you prepare for unexpected circumstances this winter.

Find advice and support across Norfolk and Suffolk: [campaign link]

#WarmAndWell

Winter strong

Booking your winter vaccines as early as possible gives you the best protection.

The NHS will contact you if you are eligible.

Find out more: [campaign link]

#WarmAndWell

Do not let bugs stop you

If you catch a winter virus, you are more likely to have milder symptoms and recover more quickly if you have had the vaccinations you are eligible for.

Book your free flu, COVID-19 or RSV vaccination when invited.

Find out more: [campaign link]

#WarmAndWell

Maternal RSV

Help protect your baby's health.

The RSV vaccine during pregnancy helps protect your baby after they are born. Speak to your midwife or GP practice team.

Find out more: [campaign link]

#WarmAndWell

Protect your health and income

Illness can mean time away from work and family life. If you are offered a free NHS winter vaccination, taking it up can help protect your health.

Find out more: [campaign link]

#WarmAndWell

Help stop viruses spreading

If you feel unwell and think you may have a virus, stay at home where possible to help reduce the risk of passing it to others.

If you need advice, NHS 111 can tell you what to do next.

[campaign link]

#WarmAndWell

Sore throats

Sore throats are common at this time of year.

Warm salty water, throat sprays, lozenges, painkillers and plenty of fluids may help. Your pharmacist can also provide advice.

For more self-care tips, visit [campaign link]

#WarmAndWell

Winter wellbeing

Winter can be tough. Take care of your wellbeing and ask for help if you need it.

If you need urgent mental health help, use the NHS support information linked from our campaign page.

Support across Norfolk and Suffolk: [campaign link]

#WarmAndWell

Look out for others

Please check in on friends, family and neighbours who may need extra support this winter.

Find tips for staying warm, well and connected across Norfolk and Suffolk: [campaign link]

#WarmAndWell

Choose NHS 111

If you need urgent health advice this winter, visit 111.nhs.uk or call NHS 111. They can advise you what to do next. 📱

#WarmAndWell

Pharmacy First

Your local pharmacy can help with a range of common conditions, often without the need for a GP appointment. 💊

Find out more about Pharmacy First: [campaign link]

#WarmAndWell

Warm spaces

Cold weather message only

Warm spaces offer a welcoming place to spend time during cold weather. Availability varies locally.

Find support in Norfolk or Suffolk: [campaign link]

#WarmAndWell

Warm home

Cold weather message only

Keeping your home warm can help protect your health during cold weather, particularly if you have a long-term condition.

Find practical advice and local support in Norfolk and Suffolk: [campaign link]

#WarmAndWell

20. Festive period arrangements

The festive period presents predictable risks from reduced service availability, workforce pressure, bank holidays and accumulated occupancy. Partners will agree a coordinated occupancy reduction plan covering Saturday 19 December 2026 to Sunday 3 January 2027, the Strategic Delivery Group will have sight of these in October 2026.

- Maximise clinically appropriate discharge before and throughout the period.
- Confirm acute, community, mental health, social care and wider discharge pathway capacity.
- Identify reductions in normal service availability across weekends and bank holidays and put mitigations in place.
- Maintain Out of Hours general practice, Enhanced Access, NHS 111, community pharmacy and urgent care routes.
- Track risks and gaps through system oversight and escalate them promptly.

- Align to any additional NHS England Christmas and New Year assurance requirements.

21. Delivery, monitoring, risks and continuous improvement

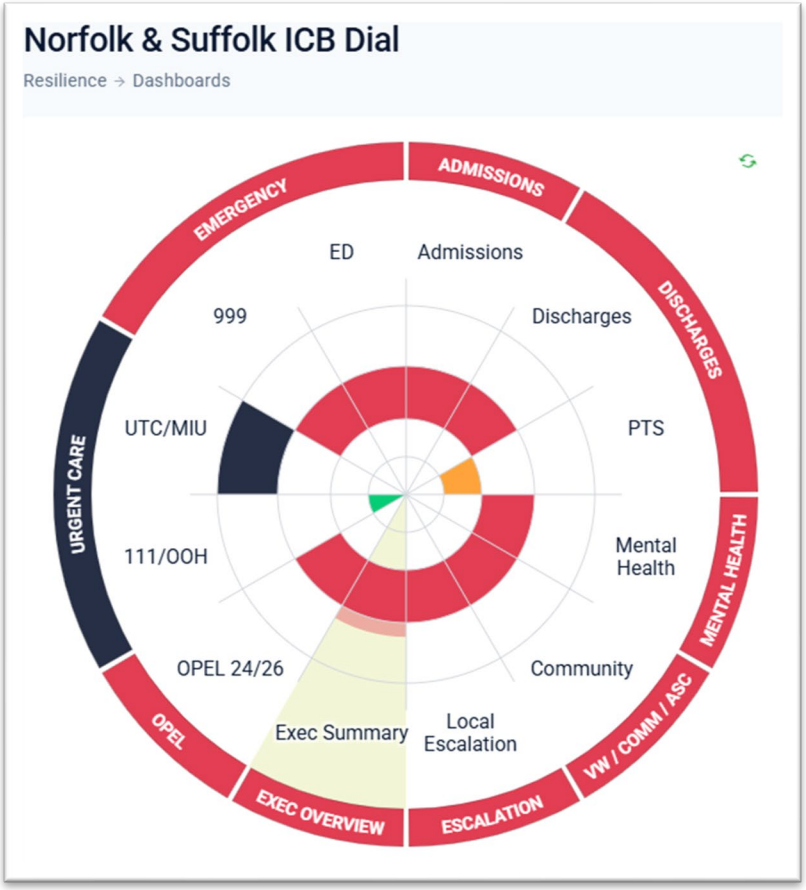
21.1. Delivery model

The plan will be delivered through provider and place operational plans, coordinated through the System Operations Centre and overseen by established governance. Assurance will be maintained through daily operational intelligence, OPEL reporting, performance review, risk escalation and formal review of actions arising from exercises and live incidents.

21.2. Priority measures

Domain	What will be watched
Demand and access	ED attendances, NHS 111 activity, ambulance calls, same-day primary care access and service availability.
Flow and discharge	Occupancy, length of stay, discharge performance, pathway delays and corridor care indicators.
Admission avoidance	Hear and treat, conveyance, community referrals, UCR, virtual ward and alternative pathway utilisation.
Prevention	Vaccination access and uptake, targeted engagement and outbreak intelligence.
Operational resilience	OPEL, staffing, business continuity, incidents, severe weather and mutual aid.
Quality and equity	Patient safety, experience, clinical effectiveness and health inequality impacts.

Delivery and impact of these measures will be monitored through SHREWD's real-time operational dashboards, examples of which are shown below. This provides a live view of demand, capacity, flow and escalation indicators, enabling the system to identify pressures early and take timely corrective action.


Norfolk & Suffolk ICB Dial
Resilience → Dashboards
EMERGENCY
ADMISSIONS
DISCHARGES
MENTAL HEALTH
VW / COMM / ASC
ESCALATION
EXEC OVERVIEW
OPEL
URGENT CARE
ED
Admissions
Discharges
PTS
Mental Health
Community
Local Escalation
Exec Summary
OPEL 24/26
111/OOH
UTC/MIU
999

OPEL Status - Norfolk & Waveney	Integrated	Acute	Community	Mental Health	111
OPEL Score	52	55	62	38	17

OPEL Status - Suffolk & North East Essex	Integrated	Acute	Community	Mental Health	111
OPEL Score	43	54	38	38	0

Acute OPEL Status - Trust Level	JPUH	NNUH	QEHKL	WSFT	ESNEFT
OPEL Score	70	53	43	53	55

Acute OPEL Status - Site Level	James Paget University Hospital	Norfolk & Norwich University Hospital	Queen Elizabeth Hospital Kings Lynn	West Suffolk Hospital	Ipswich Hospital
OPEL Score	70	53	43	53	52

Provider Level OPEL	EECH&CT - Community	ECCH - Community	WSFT - Community
OPEL Score	57	56	24

999 Handovers	James Paget University Hospital	Norfolk & Norwich University Hospital	Queen Elizabeth Hospital Kings Lynn	West Suffolk Hospital	Ipswich Hospital
Ambulances en Route	2	4	2	1	4
Ambulances Awaiting Handover	1	5	2	0	1
Current Longest Arrival to Handover Delay (mins)	1h 29m	43m	15m	0s	37m
Ambulance Average Arrival to Handover Time (Since Midnight)	1h 14m	29m	14m	19m	26m

999 Performance	EEAST	Waveney	Norfolk East	Norfolk West	Suffolk West	Suffolk East
Current REAP Level	2					
Current CSP Level	3					
Performance C2 Mean (Hours/Mins)		49m	33m	31m	28m	25m

ED	James Paget University Hospital	Norfolk & Norwich University Hospital	Queen Elizabeth Hospital Kings Lynn	West Suffolk Hospital	Ipswich Hospital
Patients in Department	67	103	44	68	37
Patients with a Decision to Admit (DTA)	10	26	4	14	11
Unvalidated 4hr % Performance (ED all-type)	71.22%	70.8%	65.03%	65.87%	80.23%
Patients with LoS > 12hrs from Arrival in ED	13	9	0	8	4
Expected Ambulance Conveyances	5	6	3	1	3
Total patients in corridor care in ED	1	1	1	1	1

Operations	James Paget University Hospital	Norfolk & Norwich University Hospital	Queen Elizabeth Hospital Kings Lynn	West Suffolk Hospital	Ipswich Hospital
% Bed Occupancy (G&A + Escalation)	99.02%	97.7%	99.33%	94.25%	88.81%
% of open beds that are escalation beds	5.88%	4.1%	0.85%	1.38%	4.01%
Total patients in corridor care across G&A wards	0	6	0	0	0
% Beds with Not Meeting Criteria to Reside	31.72%	20.9%	6.06%	14.39%	17.53%

Mental Health	NSFT
Patients Awaiting Admission - Adults	14
Patients Awaiting Admission - Older Adults	13
Patients Fit for Discharge - Adults	23

21.3. Principal open risks and dependencies

Risk or dependency	Mitigation or required action	Status
High baseline occupancy and admitted flow pressure	Prioritise discharge, community capacity, front-door streaming and daily system co-ordination.	Active
Variation in same-day urgent access	Practice action plans, ICB monitoring and improved visibility of capacity.	Active
Some community capacity subject to approval, recruitment or later delivery	Track through place and system governance; maintain contingency arrangements.	Open
SOC temporary staffing gaps	Complete recruitment and activate rota mitigations if absence continues.	Open
Corridor care safety thresholds not yet specified	Complete clinical review and embed thresholds in escalation arrangements.	Open
QEIA not finalised	Complete, review and update following exercise findings.	Open
Exercise and regional learning pending	Debrief, assign actions and update the plan and assurance statement.	Planned
Festive occupancy plan not yet complete	Agree partner plans, capacity and daily oversight arrangements.	Open
COVID-19 uptake and inequalities	Target communications and engagement using population insight.	Active

21.4. Continuous improvement

The plan will be treated as a live framework. The system will use exercise findings, operational data, incident debriefs, outbreak learning, partner feedback and patient safety intelligence to refine arrangements. Material changes will be documented, risk assessed and reported through the agreed governance route.

22. Conclusion

Norfolk and Suffolk have developed a whole-system winter response that connects prevention, access, admission avoidance, flow, discharge, community capacity, workforce resilience and daily operational co-ordination. The plan is grounded in learning from previous winter and the sustained pressures experienced during summer 2026, and it provides a clear structure for how partners will work together as demand escalates.

The evidence shows substantial preparation and collective ownership. It also identifies areas where assurance is not yet complete. The strength of the final plan will depend on closing those actions transparently, particularly the QEIA, exercise learning, corridor care safety thresholds, final festive plans, community capacity dependencies and System Operations Centre staffing resilience.

Recommendation to the Board

Subject to review of the final supporting evidence and closure or explicit acceptance of outstanding actions, the Board is invited to assure the Norfolk and Suffolk Winter Plan 2026/27 and endorse the governance and operational arrangements through which it will be delivered and kept under review.

Winter Planning 26/27
Board Assurance Statement (BAS)
Integrated Care Board (ICB)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Integrated Care Board's (ICB) name at the top of the tab.
This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to
the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

Winter Planning 26/27

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

Section B: 26/27 Winter Plan checklist			Please complete these sections Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention and vulnerable cohorts					
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes	Winter vaccination arrangements cover RSV, flu, COVID-19, MenB and pneumococcal programmes, supported by established governance and strong GP/community pharmacy participation. Current provider sign-up levels, established governance arrangements and strong historical performance, particularly for Flu, Covid-19 and RSV, provide reasonable assurance that Norfolk and Suffolk are well positioned to deliver the Winter 2026/27 vaccination programmes and maintain equitable access across its	
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes	Population health management and risk stratification are being used across Norfolk and Suffolk to identify people at greatest risk of deterioration or avoidable admission and provide proactive support through improved respiratory diagnois and management, care planning and support for the wider health and wellbing needs and to identify people at greatest risk and provide proactive support to reduce avoidable urgent care and hospital admissions. Care management and virtual wards services continue to be rolled out across all Integrated Neighbourhood Teams continues during 2026/27. All providers have access to a range of case finding and risk stratification tools to identify the patients with greatest risk of winter-related deterioration or admission. This includes GP case finding tools and population health management platforms for integrated neighbourhood teams and system planning.	
Flow, occupancy and discharge					
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	Yes	Seven-day flow and discharge arrangements are supported our whole-system approach to strengthening winter resilience through investment in intermediate care, home-based support, urgent community response, integrated discharge services and preventative pathways, Transfer of Care Hubs, social care and community and voluntary sector partners. Additional capacity is being developed through Early Intervention Team and proposed expansion of REACT/Urgent Community Response, including creating UNIT interaction operative hospital in reach	
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	Yes	A coordinated system-wide approach is in place to reduce corridor care through operational command, Transfer of Care Hubs, integrated discharge, admission avoidance, Virtual Wards, Urgent Community Response and Home First, with escalation supported by the GIRFT Corridor Care Improvement guide. Corridor care is monitored in real-time through situational reporting so we	
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes	Transfer of Care Hubs bring together acute, community, mental health, local authority and social care partners through shared processes, daily multi-agency meetings and joint use of Optimised Patient Tracking & Intelligent Choices Application to coordinate safe and timely discharge. Discharge planning is undertaken through established joint working arrangements between health, local authority and adult social care partners.	
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes	Providers have reviewed discharge arrangements against the NHS England Model Discharge Pathway, establishing system baselines and improvement priorities, with ongoing performance monitoring and pathway review across Norfolk and Suffolk. Providers have included this baseline in seasonal plans discussed at their boards in August 2026.	
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes	A system-wide festive occupancy reduction plan will cover 19 December 2026–3 January 2027, focusing on discharge, avoidable occupancy, service resilience and bank holiday capacity across all providers. The plan will align with any additional	
Demand, capacity, and surge management					
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	Yes	Winter demand and capacity planning has been informed through a system-wide modelling approach using historical winter activity, recent demand trends, operational intelligence and learning from both winter 2025/26 and summer 2026. Forecast demand assumptions reflect anticipated increases in urgent and	
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes	IC24 and Practice Plus Group model 111 demand, workforce and seasonal surges throughout the year, with performance monitored through ICB oversight and provider escalation. Both providers utilise predicative modelling for the seasonal	

	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes	Provider plans open planned escalation capacity aligned to their modelling with some flexibility to change these dates if required. A UCCH service development business case was approved by the Strategic Commissioning Committee in	
Primary Care, NHS 111 and admission avoidance					
4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.	Yes	NHS 111, CAS and UCCH support admission avoidance and general practice resilience through early clinical assessment, community referral and reduced ED attendance, with evidence of improved hear-and-treat and conveyance performance. Practices will adapt appointment capacity to seasonal demand, including increased same-day access. Enhanced Access will be available on 24 December, with normal opening on 31 December. Out of Hours services are commissioned across all weekends and bank holidays.	
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.	Yes	Opening hours: All Suffolk practices are compliant with core opening hours. In Norfolk, 15/103 practices undergoing follow-up, with compliance or action plans confirmed. Online consultations: All Norfolk and Suffolk practices meet requirements. Same-day access: Baseline assessment has identified variation against the 90% same-day urgent access target, with 80 practices rated amber and	
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.	Yes	PCNs are being supported to maximise Enhanced Access capacity, comply with DES requirements and make appropriate appointment capacity available to NHS 111. The ICB has completed a one-off ad hoc audit (in September 2026), requesting PCN assurance that unused slots are being made available to 111.	
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.	Yes	Urgent and unscheduled dental provision is commissioned and monitored across Norfolk and Suffolk, including approximately 86,000 courses of treatment, dedicated urgent services and NHS 111 access pathways. In Suffolk, Dental Priority	
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.	Yes	Norfolk and Suffolk has 274 community pharmacies, with 99% commissioned for Pharmacy First and identified festive pharmacy provision supporting access over Christmas and New Year.	
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.	Yes	The Directory of Services is routinely reviewed by the DoS Manager, with escalation arrangements for capacity or business continuity issues and in-hours system impacts managed through the SOC. 111 referral performance is monitored through commissioning oversight.	
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.	Yes	The annual Warm and Well campaign provides coordinated winter communications promoting primary care, NHS 111 and admission avoidance services through digital, media and community channels helping to reduce pressure on NHS services over	
Community Health Capacity					
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.	Yes	Plans across Norfolk and Suffolk are increasing Urgent Community Response, Virtual Ward, community and discharge capacity, supported by additional commissioning, pathway development and workforce recruitment across seven days with extended operating hours to strengthen the offer	
Whole System Response					
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes	Norfolk and Suffolk have coordinated out-of-hospital and admission-avoidance arrangements including proactive and preventative care, urgent community response, virtual wards/Hospital at Home, integrated front-door and discharge services, Home First and intermediate care. Further work is focused on strengthening seven-day community capacity, frailty pathways and primary care	
Leadership, operational grip and resilience					
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.	Yes	A 24/7 on-call model is in place with one Strategic and two Tactical commanders, supported in hours by the SOC and with access to clinical and medical advice. Reasonable scenarios have been tested during our winter workshop on the 8th Sept.	Current SOC staffing gaps are being supported through recruitment which is yet to conclude.
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	Darren The SOC provides daily system coordination, OPEL oversight and escalation, supported by integrated EPRR arrangements, wider ICB teams and clear escalation routes through to Executive level. Daily operational system calls enable the sharing	
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.	Yes	Live OPEL reporting through SHREWD is linked to defined EPRR escalation thresholds, supported by 24/7 Tactical and Strategic command arrangements, formal SOPs and incident plans. Command arrangements are supported and tested	
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.	Yes	Business continuity, severe weather, mutual aid and industrial action responses are coordinated through the SOC, with provider BCP arrangements and Local Resilience Forum links supporting system escalation and response.	
	7.5	The Board is assured thatplans are in place to support staff welfare through periods of high demand.	Yes	Providers have established staff wellbeing arrangements including occupational health, EAPs, psychological support, wellbeing hubs, flexible working and retention support, supplemented by £250k system Workforce Wellbeing Programme funding.	

System Co-ordination Centres					
8	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.	Yes	The SOC operates 08:00–18:00 daily with UEC operational leadership and support, using the Common Operating Picture and agreed escalation triggers to coordinate provider actions. Out-of-hours resilience is provided through 24/7 Tactical and Strategic on-call arrangements.	
	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.	Yes	The winter SOC rota is populated for 08:00–18:00, 7-day coverage, with contingency arrangements to extend hours during extreme pressure.	
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.	Yes	Regional engagement is maintained through the East of England SCC Teams channel, Tactical calls, the ICB single point of contact, coordinated assurance returns and monthly SCC leads meetings.	

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Integrated Care Board (ICB):	Norfolk and Suffolk
If Other, write ICB Name here:	
Contact details (email, phone number):	Darren Maguire, darren.maguire2@nhs.net 07931 862574
Date:	25/09/2026

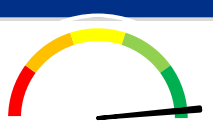
Please complete these sections

		Assurance statement	Is this in place? (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance					
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.	Yes	Board has assured (on 30 September 2026) the ICBs winter plan including	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	The Nursing directorate has assessed the Winter Plan against patient safety, clinical effectiveness, patient experience, equality and health inequalities, with findings used to identify and address gaps before	
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	Coordinated through the System Delivery Group Winter planning has been developed collaboratively across system partners through place/provider planning, whole system winter planning workshop with UEC Strategic Delivery Group oversight.	
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.	Yes	Richard Watson is the named Executive Winter Sponsor, providing executive accountability for winter preparedness, delivery, escalation and whole-system oversight.	
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	No	Norfolk and Suffolk will participate in the regional winter exercise to test resilience, command and control, escalation and system interdependencies, with learning incorporated into winter arrangements	Planned event 1st October, no issues expected
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.	Yes	The Operational Risk Management Framework provides defined escalation triggers and response actions, supported by strategic, tactical and operational leadership arrangements 7 days a week aligned to OPEL.	
	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.	Yes	IPC assurance is maintained through NHS provider Infection Control Committees, primary care audit/support arrangements and winter outbreak planning across Norfolk and Suffolk. New ICB IPC Operating Model shared with UKHSA consultants in July 2026.	IPC nurses and care home support reduction following ICB restructure could impact the care home market ability to accpet discharges
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/	Yes	Twice-weekly Norfolk and Suffolk system IPC calls bring together the ICB, providers, UKHSA and local authorities to share outbreak intelligence and coordinate response, with frequency increased as required. Dedicated Teams channels support rapid sharing of outbreak notifications across acute and social care.	

BAS Self-Assessment Dashboard

ICB

Overall Assessment Rating: 5 - Full assurance



		Rating
Section A	Governance	5 - Full assurance
Section B	Prevention and vulnerable cohorts	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Demand, capacity, and surge management	5 - Full assurance
	Primary Care, NHS 111 and admission avoidance	5 - Full assurance
	Community Health Capacity	5 - Full assurance
	Whole System Response	5 - Full assurance
	Leadership, operational grip and resilience	5 - Full assurance

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

Integrated Care Board (ICB) name:	Norfolk & Suffolk
ICB CEO/AO name:	Ed Garratt
Date reviewed:	23/09/2026
ICB Chair name:	Will Pope
Date reviewed:	23/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Richard Watson

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Yes

Please confirm date reviewed
23/09/2026

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 9
Date: 23 September 2026

Title: Norfolk and Suffolk Health and Care Research Leadership Group

Lead Director: Dr Mike Smith, Interim Executive Medical Director

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

Purpose: To provide the Board with an update on the refresh of the Norfolk and Suffolk Health and Care Research Leadership Group.

Recommendation: The Board is asked to ratify the refreshed Norfolk and Suffolk Health and Care Research Leadership Group and note the proposed Terms of Reference attached at Appendix 1.

1. Background and context

1.1. Integrated Care Boards have a statutory responsibility to promote and facilitate research. This responsibility is reinforced by NHS England guidance, *Maximising the benefits of research*[1], published in 2023, which sets out the expectation that research should be embedded across health and care systems and used to improve outcomes, reduce inequalities and support evidence-informed decision-making.

1.2. Norfolk and Waveney previously developed a Research and Innovation Strategy and established an ICS Research Leadership Group to support implementation. The group was chaired by the ICB Associate Director of Research and Innovation, with deputy chairing from the Head of Research at Norfolk and Suffolk NHS Foundation Trust.

1.3. The original group focused deliberately on building connections, relationships and shared purpose across the system. It provided a forum for senior research leaders to share intelligence, identify opportunities and strengthen collaboration across health, care, academic and research infrastructure partners.

[1] https://www.england.nhs.uk/long-read/maximising-the-benefits-of-research/

1.4. The group operated without dedicated financial arrangements and was designed to maximise alignment and coordination rather than create additional infrastructure.

1.5. Achievements supported through this system-wide approach include ICB representation on the Health UEA Steering Group, a successful Primary Care Commercial Research Delivery Centre application, a successful East of England NIHR Health and Care Internship application, and the establishment and development of the NHS England-funded Research Engagement Network programme. This work has also strengthened links with the UEA Citizens Academy and culminated in a research celebration event in March 2026.

1.6. Following the ICB restructure and the creation of the Norfolk and Suffolk ICB footprint, the group now requires refresh to reflect the wider geography and the broader range of health and care providers, universities, public health partners, NIHR infrastructure and research assets across Norfolk and Suffolk.

2. Proposed refreshed role of the group

2.1. The refreshed Norfolk and Suffolk Health and Care Research Leadership Group will provide a system-level coordination forum for research leadership across the new ICS. Its purpose is to strengthen alignment, visibility and relationship-building, rather than to create a new research strategy or duplicate existing organisational governance. The group will also help ensure that research activity across Norfolk and Suffolk is aligned with national NHS 10 Year Health Plan ambitions, particularly the shift from hospital to community.

2.2. The group will support alignment across partners, including providers, universities, public health, NIHR infrastructure and Norwich Research Park, and will provide a forum for programmes such as the Research Engagement Network and Research Capability Funding to be coordinated across the system.

2.3. The group will share intelligence on research pipelines, funding opportunities and emerging system priorities; identify areas where partners can work together; and provide an escalation route for system barriers that require collective action or senior leadership support. It will also support partners to identify gaps in knowledge and evidence, particularly where further research could strengthen neighbourhood health, integrated care, prevention, community-based services and models that enable people to receive high-quality care closer to home.

3. Activity to date

3.1. Stakeholder engagement has taken place with health and care leaders across Norfolk and Suffolk through Research Leadership in each organisation in July and August 2026. Draft Terms of Reference were shared and support requested for the new group to test and own shared research principles and areas of work across the new footprint.

3.2. Membership has been considered in line with the draft Terms of Reference and will include senior representation from higher education institutions, public health, primary care, community, acute and mental health providers, alongside relevant research infrastructure and system partners.

3.3. Confirmation will be sought from the group at the first meeting that principles developed through the Norfolk and Waveney Research and Innovation Strategy will be adopted: research should be focused on communities, supported by a confident and capable workforce, coordinated and

collaborative across partners, and embedded in day-to-day health and care work. These principles will be applied in the context of the wider Norfolk and Suffolk footprint, with a particular emphasis on research that supports neighbourhood health, integrated care, prevention and the delivery of services closer to where people live.

4. Key issues and risks

4.1. There are currently no risks relating to this proposal on the ICB Board Assurance Framework. The ICB Research and Innovation team maintains a risk register in line with corporate governance requirements and research governance standards.

4.2. The principal risk is that, across the wider Norfolk and Suffolk footprint, the group could become too large or unfocused. This will be mitigated through clear Terms of Reference, senior membership, focused agendas, and prioritisation of items that require system-level coordination.

5. Patient and public engagement

5.1. The Research Engagement Network is the main mechanism through which the ICB Research and Innovation team supports engagement with local communities around research. It provides a route to strengthen public awareness, involvement and influence in the development of research priorities and activity.

5.2. It is a condition of relevant ICB-supported or ICB-funded research activity that academic and system partners demonstrate robust community engagement and patient and public involvement. The refreshed group will help maintain visibility of this requirement and support alignment with wider system work on inclusion, inequalities and community engagement.

6. Governance route

6.1. This proposal was approved by the Norfolk and Suffolk ICB Quality Committee on 3rd September 2026.

7. Conclusion

7.1. The refreshed Norfolk and Suffolk Health and Care Research Leadership Group will provide a practical and proportionate forum for senior research leaders to coordinate activity across the new ICS footprint. It will support the ICB in meeting its statutory responsibility to promote and facilitate research, strengthen system alignment, and ensure that research activity remains connected to local communities, workforce development and service priorities.

8. Recommendation

8.1. The Board is asked to ratify the refreshed group and note the Terms of Reference at Appendix 1.

Norfolk and Suffolk ICS Health and Care Research Leadership Group Terms of Reference

Norfolk and Suffolk Health and Care Research Leadership Group

1. **Background**

Integrated Care Boards have a statutory duty to promote and facilitate research. The group builds on the previous Norfolk and Waveney ICS research arrangements and refreshes them for the Norfolk and Suffolk footprint, retaining the core principles that research should be focused on communities, driven by a confident and capable workforce, collaborative and coordinated, and embedded in day-to-day health and care work.

2. **Role, scope and functions**

The Norfolk and Suffolk Health and Care Research Leadership Group provides a system-level forum for senior research leaders to coordinate, align and strengthen research activity across the Norfolk and Suffolk Integrated Care System footprint. It enables partners to maximise the benefits of research for patients, communities, staff and services.

The group will use a broad definition of research across health and wider care settings, public health, primary care, community and social care interfaces, and the voluntary, community and social enterprise sector. The focus is system-level coordination, shared intelligence and collaboration, rather than operational management of individual studies, organisational research governance or creation of a separate research strategy.

The group will:

- Strengthen senior research leadership relationships across health and care providers, universities, public health, NIHR infrastructure, Norwich Research Park and wider system partners.
- Align research activity with national NHS ambitions, local system priorities and emerging evidence needs, including neighbourhood health, integrated care, prevention, reducing inequalities and care closer to home.
- Share intelligence on research pipelines, funding opportunities, national policy, system priorities, areas of research strength, gaps and opportunities.
- Identify opportunities for collaboration on research priorities, funding, infrastructure development, delivery, and evidence informed practice and commissioning
- Champion patient, public and community involvement and engagement in research
- Support a research culture that is community-focused, workforce-enabled, coordinated and embedded in day-to-day health and care work.

- Support workforce development by identifying opportunities to build research confidence, capability and participation across professional groups and care settings.
- Escalate system barriers, risks, issues or opportunities where collective leadership action is required, including relating to the NHS National Oversight Framework.

3. Membership

Membership will comprise senior representatives with responsibility for research leadership, who are knowledgeable about their organisation's strategy, delivery, engagement and infrastructure across Norfolk and Suffolk. Membership will be invited from organisations listed in Appendix 1.

Other individuals may be invited to attend meetings when the group is discussing items that fall within their areas of responsibility or where their expertise would support delivery of the group's objectives. Membership will be reviewed annually to ensure appropriate representation across the Norfolk and Suffolk footprint.

4. Chairing arrangements

The group will be chaired by the ICB Associate Director of Research and Innovation or nominated senior deputy. A deputy chair will be agreed from within the membership to support continuity and shared system ownership.

5. Frequency and administration

The group will meet every 6 months with additional meetings or task-and-finish discussions convened where required. Agenda items will be agreed by the Chair and will focus on matters requiring system coordination, shared intelligence, alignment or escalation. Escalation can occur in between meetings via the Chair. Administrative support will be provided by the ICB Research and Innovation team.

Agendas and papers will normally be circulated 5 working days in advance of meetings. Minutes and actions will be recorded and shared with members following each meeting.

6. Quoracy

The group will be considered quorate when the Chair or deputy chair is present, alongside representation from at least three partner organisations or sectors. The group is advisory and coordinating in nature; where formal decisions are required, these will be taken through the relevant organisational governance route.

7. Review

These Terms of Reference will be reviewed annually, or sooner if required to reflect changes in national policy, ICB governance, system priorities or membership arrangements.

Appendix 1: Membership organisations

Anglia Ruskin University (ARU)

Community Pharmacy Norfolk and Suffolk

Health Innovation East (HIE)

East of England Ambulance Trust (EEAST)

East of England Community Health and Care NHS Trust (EEC)

East Coast Community Health Care CIC (ECCH)

East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

NIHR Applied Research Collaboration East of England (ARC EoE)

NIHR Breckland and Norfolk Region Primary Care Commercial Research Delivery Centre (CRDC)

NIHR Norfolk Clinical Research Facility (CRF)

NIHR Regional Research Delivery Network East of England (RRDN EoE)

Norfolk County Council (NCC)

Norfolk and Waveney University Hospitals Group to include James Paget University Hospitals NHS Foundation Trust (JPUH), Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and The Queen Elizabeth Hospital NHS Foundation Trust (QEHKL)

Norfolk and Suffolk NHS Foundation Trust (NSFT)

NHS Norfolk and Suffolk Integrated Care Board (NSICB)

Norfolk and Waveney Primary Care Collaborative

Norwich Research Park/ The Quadram Institute

Norwich University of the Arts

Norfolk VCSE Assembly

Suffolk Primary Care Collaborative

Suffolk VCFSE Assembly

Secure Data Environment East of England (SDE EoE)

Suffolk County Council (SCC)

University of East Anglia (UEA)

University of Suffolk (UoS)

West Suffolk NHS Foundation Trust (WSFT)

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 10

Date: 23 September 2026

Title: UCCH (Unscheduled care Co-ordination Hub) development and overnight provision across Norfolk and Suffolk

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

Author: Kathryn Ramsey – UEC Senior Commissioning Manager

Purpose: To update the Board on the decision to commission and sustain Unscheduled Care Co-ordination Hub (UCCH) model developments across the two hubs in Norfolk and Suffolk.

Recommendation to the Board

The Board is asked to note and welcome the approved commissioning of the Unscheduled Care Coordination Hub (UCCH) Development and Overnight Business Case, recognise the anticipated benefits for patients and system performance, and encourage the required oversight of mobilisation, delivery and benefits realisation.

Executive Summary

The ICB has commissioned four complementary UCCH developments, creating a more resilient and clinically led 24/7 urgent care pathway offer across Norfolk and Suffolk. This is a positive step towards more patients receiving timely and appropriate care closer to home, while supporting ambulance performance, community pathway use and system flow.

Approval was given by the Strategic Commissioning Committee for recurrent investment of £1,381,532 per annum to implement the preferred option described within the business case, comprising four complementary service developments across Norfolk and Suffolk.

Background

Urgent and emergency care services continue to experience sustained demand from lower-acuity ambulance calls, frailty and urgent needs that can often be managed safely outside hospital. Previous delivery demonstrated that adequately resourced UCCH arrangements support better clinical co-ordination, increased hear-and-treat activity, safer use of community alternatives and reduced unnecessary conveyance. The commissioned developments address overnight, capacity and pathway gaps that have previously constrained flow.

Together, the commissioned developments are expected to deliver benefits for patients and across ambulance, urgent care, community and acute pathways:

Proposed Service Developments

- Proposal 1 – (PPG led 111 service) 24/7 overnight Clinical Assessment Service capacity for appropriate C3/C4 ambulance cases when UCCH is closed, supported by digital ITK referral - £390,414
- Proposal 2 – (PPG led 111 service) Capacity build, expand centralised UCCH triage and the Trusted Assessor approach to improve referral appropriateness and use of Urgent Community Response services - £31,395
- Proposal 3 – (PPG led 111 service) Expanded Enhanced Conveyance Avoidance Helpline capacity to support faster clinical advice for ambulance crews and progress towards the 10-minute callback standard - £103,435
- Proposal 4 - (IC24 led 111 service) Enhanced overnight UCCH model. Reinstated overnight UCCH provision in Norfolk and Waveney, including senior GP-led decision-making, case holding and multidisciplinary co-ordination - £856,288

Total cost: **£1,381,532.00**

Outcomes

The combined proposals are expected to deliver benefits across ambulance, urgent care, community and acute pathways. The financial appraisal estimates reductions of approximately 2,063 ambulance conveyances, 1,224 Emergency Department attendances and 2,204 same-day non-elective episodes per annum, supporting delivery of a Benefit-Cost Ratio of approximately 1.60:1.

- More patients managed safely at home or through community alternatives.
- Reduced avoidable ambulance conveyance and Emergency Department attendance.
- Improved hear-and-treat activity and faster clinical support for ambulance crews.
- More appropriate community referrals and improved use of UCR, Virtual Ward, frailty and SDEC pathways.
- Improved patient experience, system resilience and access to care closer to home.

Key Issues and Risks

The main delivery considerations are workforce availability and rota resilience, community and downstream pathway capacity, digital interoperability, and demand varying from commissioned assumptions. These risks are understood and will be managed through mobilisation planning, established clinical and contract governance, routine performance monitoring and agreed escalation arrangements.

Finance and Performance

The developments have been commissioned through recurrent annual investment of £1,381,532. Benefits will be monitored through existing contractual and UEC governance arrangements, with a focus on activity, quality, workforce, patient outcomes, system flow and value for money. The financial benefits are expected to arise predominantly through avoided

demand, released capacity and improved productivity rather than immediate cash-releasing savings.

Patient and Public Engagement

The developments enhance established services rather than materially changing how patients access care. Existing patient insight and experience information will continue to inform implementation, monitoring and evaluation, including feedback, complaints, compliments and quality themes.

Committees and Groups

The following ICB teams were consulted on and participated in the development of this business case. Contracts and procurement, Digital, Estates, Intelligence Function, Innovation, People and Communities, Strategic planning and change, Quality, Workforce

The Business case was presented to and approved by the Strategic Commissioning Committee on 08/09/2026

NHS
Norfolk and Suffolk
Integrated Care Board

Unscheduled Care Co-ordination Hub development and overnight provision business case.

September 2026
UEC Commissioning Team

Background

UEC demand remains high across Norfolk & Suffolk with sustained pressure on ambulance services, emergency departments, and urgent care pathways

Sustained pressure

Lower-acuity ambulance calls (C3 - C5), a growing population living with frailty and urgent needs that could be managed outside hospital, continue to place pressure on services across Norfolk and Suffolk.

Coordination works

When adequately resourced, the UCCH model demonstrates the benefits of integrated care co-ordination through enhanced MDT working, improved patient navigation, increased access to urgent community-based support, reduced unnecessary hospital attendances and conveyance, increased hear and treat rates, and more effective use of system resources.

Current gaps constrain flow

Overnight and geographical gaps, limited capacity and manual processes fragment pathways across Norfolk and Suffolk, contributing to avoidable conveyance, Emergency Department attendance and operational inefficiency.

Evidence of need

Pilot results from winter 2025/2026 demonstrated sustained overnight demand and materially better performance when capacity is available.

5–6 percentage points
sustained reduction in conveyance during winter 2025/26

+71%
year-on-year increase in hear-and-treat activity

79%
1,283 of 1,625 overnight cases resolved via alternatives to conveyance

40%
conveyance rate increasedto 40% following withdrawal of overnight providion

Overnight demand was sustained

29
Average

C3/C4 cases per night required overnight clinical assessment in Suffolk and North East Essex.

CAH performance remains below the 10-minute callback aspiration—contributing to longer ambulance on-scene times and potentially delaying ambulance availability for others.

What the evidence showed

- Demand is consistent, including overnight.
- UCCH and CAH capacity materially improves system performance.
- Short-term or partial provision creates instability—not resilience.

Stable overnight capacity enables more patients to receive safe alternatives to hospital conveyance.

The Proposals

The Norfolk and Suffolk UCCH Development and Overnight Provision Business case comprises four complementary proposals:

1. **Overnight CAS – PPG**

   Provide 24/7 pathway coverage for C3/C4 ambulance cases by expanding overnight capacity within the Integrated Urgent Care Clinical Assessment Service (IUC CAS) capacity overnight, enabling the interoperability toolkit (ITK) referral when UCCH is closed

2. **UCR triage - PPG**

   Further expansion of centralised UCCH coverage for Urgent Community Response (UCR) services, extending the Trusted Assessor (REACT) model.

3. **CAH capacity - PPG**

   Increase capacity within the Conveyance Avoidance Helpline (CAH) to support consistent achievement of the 10-minute call-back standard for ambulance crews at scene.

4. **Overnight UCCH – IC24**

   Reinstatement of enhanced overnight UCCH clinical provision, delivering senior GP-led decision-making, case holding, and multidisciplinary coordination overnight.

Together, these proposals establish a consistent, resilient, and clinically led 24/7 urgent care coordination model, improving patient outcomes, ambulance performance, and system flow.

Outcomes

Each proposal strengthens avoidance, access and safe community-based care.

1 Overnight CAS

- Fewer C3–C5 conveyances and ED attendances
- Potential reduction in avoidable admissions and reattendances
- Better use of UCR, Virtual Ward, Frailty and SDEC

2 UCR triage

- More appropriate referrals to UCR teams
- Fewer inappropriate UCR referrals and lower referral rejection rates

3 CAH capacity

- Faster clinical advice to ambulance crews
- Improved achievement of the 10-minute callback standard.

4 Overnight UCCH

- More hear-and-treat and community management
- More patients managed safely in community
- Safe non-conveyance supported by monitoring of recontact and subsequent escalation

Combined ambition: reduce avoidable conveyance and ED attendance, improve ambulance response, provide year-round access and increase the number of patients safely managed in the community.

Strategic alignment

The four proposals shift urgent care from reactive, hospital-based response to coordinated 24/7 care closer to home.

From hospital to community

Consistent clinical assessment and stronger use of UCR, Virtual Wards, Frailty and SDEC pathways help patients receive the right care first time—reducing avoidable conveyance, attendance and admission.

From analogue to digital

ITK-enabled referrals replace manual overnight processes and connect ambulance services, CAS, UCCH and community providers—supporting faster decisions, reliable handovers and better use of resources.

From sickness to prevention

Earlier senior clinical input, trusted assessment and rapid advice and onward referral, prevents deterioration and escalation—particularly for frail people, those with multiple conditions and frequent urgent-care users.

Strategic contribution: improved outcomes • reduced inequalities • improved ambulance responsiveness • high-quality care closer to home • stronger neighbourhood delivery

ICB clinical priorities

The business case supports the ICB's Population Health Improvement Plan through earlier, coordinated care across the life course.

Start Well	Co-ordinated clinical assessment and advice support earlier intervention and appropriate care navigation for children, young people and families.
Be Well	Earlier intervention for those with long-term conditions. Integrated community support for people with a learning disability and autism, promoting independence and avoiding unnecessary admissions.
Feel Well	Coordinated 24/7 clinical decision-making and MDT support helping prevent crisis escalation and manage complex needs.
Stay Well	Timely triage, rapid clinical advice, hear-and-treat and conveyance avoidance provide earlier care through consistent pathways outside hospital.
Age Well	Rapid access to community, frailty and Virtual Ward services helps older people and those with dementia remain safely at home, reduces avoidable hospital and care-home admissions.
Die Well	Better coordination reduces avoidable end-of-life admissions and supports each person's preferred place of care and death.

North East Essex – cross-boundary benefits

The proposed investment will also benefit North East Essex residents, who sit outside the ICB boundary but within the PPG 111 service footprint.

Why North Essex is included

PPG 111 operates as one integrated service across Suffolk and North East Essex, while its provider footprint does not align with ICB boundaries.

The proposals enhance this existing service rather than create separate provision for each geography.

What this means for North East Essex

North East Essex residents will share the improvements: greater clinical capacity, stronger hear-and-treat and more conveyance avoidance.

This is a cross-boundary benefit of the existing provider model—not a separately commissioned investment.

The commissioning consideration

Some benefits will accrue outside the ICB footprint. Geographical separation would require a different operating model and weaken service efficiency and resilience. The full cost of service enhancements is included within the business case as PPG operates a single integrated NHS 111 service across Suffolk and North East Essex. The financial appraisal has adopted a prudent approach and includes only benefits attributable to the Norfolk and Suffolk system. Benefits arising within North East Essex have not been monetised within the value for money assessment.

Recommendation: retain a single service model across the PPG footprint and formally agree the associated cross-boundary funding, benefit, and governance arrangements.

Key Issues & Risks

Delivery risks are identifiable and manageable through proposed controls; continued instability or withdrawal of provision presents a material system risk.

KEY RISK	MITIGATION / CONTROL
Workforce capacity & retention	Use existing pilot and UCCH/CAS/CAH staff pools, blended MDTs, recurrent funding and flexible substantive/fixed-term staffing; monitor rota incentive costs.
Skills & onboarding	Use established professional roles; role-appropriate induction covering local pathways, digital systems, information governance, safeguarding and clinical escalation.
Inflation & cost escalation	Recurrent costs and applicable contractual uplifts are reflected in the financial model. Future inflationary pressures, expenditure and staffing premiums will be monitored.
Demand above forecast	Base capacity assumptions on observed activity. Monitor demand, acuity, referral volumes and clinical productivity through mobilisation, with escalation arrangements if demand exceeds planned capacity.
Community capacity	Improve suitability through Trusted Assessor and UCCH triage; strengthen SDEC, frailty, Virtual Ward and UCR routes alongside the Community UEC case.
Fragmentation & default conveyance	Implement the package under joint governance; retain overnight GP-led UCCH, expanded CAH and CAS fallback, tracking conveyance and hear-and-treat.

Financial & Economic Appraisal

£1.38m recurrent investment delivers 1.6–2.2:1 whole-system value—primarily through released capacity.

£1.38m

Recurrent annual investment

Future years uplifted under current contracted terms.

£2.21

Norfolk and Suffolk ICB Finance Template

Green Book economic value

BCR 1.6–2.2:1 • whole-system capacity value

1.49:1 - 1.60:1 BCR

Prudent NHS finance position

Risk-adjusted, deliverable value case

Annual investment breakdown

1. C3/4 overnight CAS capacity	**£390,414**
2. UCR triage expansion	**£31,395**
3. CAH capacity	**£103,435**
4. Overnight UCCH provision	**£856,288**

Expected annual system impact

1,224 ED attendances avoided

2,200–2,700 acute bed days released

Value is mainly non-cash-releasing: realising and representing avoided demand, productivity improvement and released system capacity.

Conservative baseline; carbon reduction, staff wellbeing and wider system resilience provide additional upside.

Options

Only the full model delivers a consistent 24/7 offer and sustains the clinical, operational and financial benefits across both counties.

OPTION 1

Do nothing

£0 additional

Continue the current service configuration without recurrent investment in the proposed enhancements.

EXPECTED IMPACT

Sub-optimal performance persists; conveyance, ED demand and overnight risk remain.

STRENGTH

No new funding or mobilisation.

KEY LIMIT

False economy: pilot gains are lost and downstream pressure grows.

OPTION 2

Partial enhancement

Variable by subset

Fund selected proposals only/IC24 proposal only; components cost £31k–£856k each.

EXPECTED IMPACT

Some gains in triage and access, but benefits remain inconsistent and inequitable.

STRENGTH

Lower cost and simpler near-term delivery. Allows funding IC24 proposal only if Essex funding is declined.

KEY LIMIT

Inconsistent provider delivery, inequity; lower impact and value for money.

OPTION 3 — RECOMMENDED

Full model

£1.38m recurrent

Implement all four proposals as one integrated 24/7 model.

EXPECTED IMPACT

Strongest gains: lower conveyance and ED demand, better flow and care closer to home.

STRENGTH

Sustains pilot gains, supports workforce stability and offers strongest potential for whole-system value.

KEY LIMIT

Higher recurrent cost; coordinated recruitment and provider delivery.

Recommendation: approve Option 3 with recurrent funding—the best balance of cost, delivery risk and system impact.

Classification: Official-Sensitive

EoE Ref: 26-189

Item 11

NHS England – East of England
Victoria House
Camlife
Fulbourn
Cambridge
CB21 5XB

Professor Will Pope
Chair
Norfolk and Suffolk ICB

31 July 2026

Dear Will,

Annual assessment of Norfolk and Waveney (N&W) Integrated Care Board's (ICB) performance in 2025-26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and organisational change. In parallel, ICBs have been required to adapt to an evolving operating model while maintaining a clear focus on statutory duties, system leadership and delivery for local populations. In the East of England, this has included the additional complexity of managing the merger of all six predecessor ICBs in-year.

Against this backdrop, I recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden of maintaining stability, continuity, and delivery through a period of significant structural transition.

In reaching this assessment, I have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners where received, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

Clare Panniker
Regional Director
NHS England - East of England

Cc Ed Garratt, Chief Executive Officer, Norfolk and Suffolk ICB
Adam Cayley, Executive System Lead & Chief Operating Officer, NHS England - East of England

Section 1: ICB performance assessment

During 2025/26, Norfolk and Waveney (N&W) ICB operated through a period of significant organisational change, maintaining focus on its statutory duties, system leadership and delivery for its population. This assessment reflects performance against these duties, including reducing inequalities, improving quality, meeting financial requirements, supporting research, and having regard to local strategies. It also considers the wider effect of decisions across the system, consistent with the triple aim of improving population health, quality of care and value for money, and supporting the long-term sustainability of services for local communities.

Population Health and Inequalities

N&W ICB showed strengths in population health and prevention over the year, with population health finishing in the highest performing quartile. There was particularly strong performance in serious mental illness health checks, where coverage reached 65%, above the national average. The ICB also made progress in screening, immunisation and prevention, including strong measles, mumps and rubella (MMR) vaccination coverage and an improving position on stage 1 and 2 cancer diagnosis. System discussions highlighted focused leadership on cardiovascular disease prevention and wider ambitions around neighbourhood health and early intervention. The ICB continued to be the top performer or above average nationally for Digital Weight Management Programme services (DWMP) and for people starting the Diabetes Prevention Programme, although performance has declined in-year.

However, further improvement is needed in some areas. Breast screening coverage reduced from its peak during the year, and while learning disability annual health checks improved significantly to 76.4% by Q4, delivery across the year remained variable. More broadly, variation in place maturity, neighbourhood development and local authority alignment may affect the consistency and pace of population health delivery across the geography.

Quality and Safety of Services

The ICB maintained active oversight of quality and safety concerns across the system during a challenging year. There was sustained engagement with provider quality issues, including ongoing pressures at James Paget University Hospital (JPUH), particularly in maternity services, and a number of quality and safety challenges at Queen Elizabeth Hospital (QEH), including concerns relating to surgical care and governance. These issues were compounded by wider operational and estate pressures, alongside work with local authority partners on care market sustainability. There is evidence of strengthened system-level quality governance, with system-wide quality meetings aligned with NHS England and action taken where concerns required escalation. This demonstrates that the ICB remained sighted on its quality responsibilities despite the wider organisational transition.

However, the safety picture remained mixed, with the National Outcomes Framework safety domain rated below average. While some indicators improved, including neonatal deaths and stillbirths, wider system intelligence points to continuing provider-level concerns, particularly at JPUH and QEH. JPUH remained one of the most challenged trusts nationally, while QEH was subject to rapid quality review activity and ongoing concern about its capacity to address identified issues. This suggests that, although the ICB was engaged and responsive, material quality and safety risks remained within parts of the provider landscape during the year.

Access and Experience

There was a mixed picture for access and experience during the review period. N&W remained below national targets on key operational measures, including accident and emergency (A&E) four-hour performance at 75.10%, 18-week referral to treatment (RTT) at 61.65%, and 62-day cancer at 66.03% at year end, however each showed improved performance compared with

2024/25. The ICB also performed strongly in some primary care experience measures, with GP satisfaction at 78.10%, above the national average and improved from the previous year, alongside high levels of continuity of care, with 81.9% of patients able to see their preferred GP professional.

Review discussions also highlighted progress in urgent and emergency care pathways, including the Unscheduled Care Coordination Hub as a strong model for avoiding conveyance and supporting demand management in the community.

However, access remained a significant challenge across several areas. There were persistent pressures in urgent and emergency care, ambulance handovers, elective recovery and cancer pathways, particularly at JPUH and QEH. GP booking satisfaction declined during the year, with only partial recovery by quarter four. Taken together, this indicates that while the ICB supported improvement activity and some trajectories were positive, residents continued to experience uneven access and variable performance across key services.

Financial Duties

N&W ICB met its statutory financial duties in 2025/26, delivering a break-even position and maintaining financial control in a challenging context, with performance broadly in line with plan across the year.

However, this was not achieved without risk. Discussions throughout the year highlighted a high-risk efficiency requirement, continued provider fragility, and underlying financial pressure across the system. Concerns were raised about the scale of unidentified efficiencies, the deliverability of some cost improvement plans, and the position of individual providers, particularly JPUH and QEH. While the ICB delivered its financial duties overall, this required continued grip and active management, with productivity and efficiency challenges remaining within the system.

Research and Local Strategies

The ICB maintained focus on its longer-term strategic priorities during 2025/26, despite significant organisational change and operational pressure. This included continued delivery of the Joint Forward Plan and alignment with the Integrated Care Strategy, with ongoing emphasis on prevention, reducing inequalities, improving integration and strengthening neighbourhood-based working. There was also evidence of progress in areas such as digital transformation, primary care infrastructure and research, indicating continued attention to local strategic priorities alongside immediate delivery pressures.

However, some elements of longer-term transformation remained at an earlier stage of development. Review discussions highlighted ongoing complexity around place maturity, governance alignment, provider group arrangements and wider system reform. The ICB also continued to develop its approach to environmental sustainability and greener working. Taken together, this suggests that while the ICB maintained strategic direction during the year, some aspects of longer-term system development and alignment were still maturing.

Section 2: ICB Capability assessment

During 2025/26, N&W ICB demonstrated organisational capability during a period of significant transition, while continuing to discharge its commissioning, governance and partnership responsibilities. This assessment considers the ICBs ability to commission services, obtain appropriate advice, maintain effective governance and leadership, and involve the public, alongside its capacity to sustain delivery through organisational change.

Commissioning and Delegated Services

The ICB demonstrated capability in several core commissioning functions during the year. It continued to deliver delegated responsibilities across primary care and specialised services, alongside progress in areas including digital transformation, estates, research and prevention. The ICB retained commissioning capability during a demanding year, including in areas requiring longer-term planning and system coordination.

However, some elements of commissioning capability remained less mature. Review discussions highlighted challenges around place development, neighbourhood working and the need to strengthen strategic commissioning capability in the context of the new cluster arrangements. There was also continued pressure in areas such as primary care resilience, continuing healthcare timeliness and specialised commissioning complexity. While the ICB maintained delivery of its commissioning responsibilities, aspects of strategic commissioning maturity and consistency were still developing.

Governance and Decision-Making

The ICB maintained formal governance arrangements and decision-making structures through a period of significant organisational change. There was an established governance framework, regular Board and committee oversight, and continued management of key risks through the Board Assurance Framework and committee structure. Review discussions also evidenced governance arrangements to support financial oversight, quality governance, transition planning and system performance management, indicating that the ICB retained governance grip during a challenging year.

However, these arrangements operated in a complex and evolving context. The scale of organisational change, transition to the new Norfolk and Suffolk ICB, and the challenge of maintaining continuity while redesigning structures and ways of working were evident throughout the year. There was also continuing ambiguity in some areas, including provider group arrangements, place leadership and the alignment of responsibilities across the evolving system. While core governance remained in place, some aspects of decision-making and accountability were still maturing.

Workforce and Culture

Within the NOF workforce domain, N&W ICB performed below average overall. Staff experience was affected by the scale of change and uncertainty during 2025/26, with staff survey scores declining across a number of areas, including engagement and learning. This reflects the impact of restructuring and merger activity during the year. Sickness absence also increased, indicating additional pressure on the workforce.

However, there was evidence of some workforce resilience. The ICB made progress in areas such as GP retention, with reduced leaver rates, alongside continued focus on recruitment, training practice status, staff wellbeing, equality and inclusion. Review discussions also indicated that the ICB worked proactively to maintain key capability and manage transition through significant organisational change. Discussions also identified capability gaps in some specialist areas, including analytics, healthcare economics and aspects of strategic commissioning. Taken together, this suggests that while workforce capacity was maintained, organisational change created pressure on culture, morale and some areas of specialist capability.

Public Involvement and Consultation

The ICB continued to involve patients, communities and partners in its work during 2025/26. This included ongoing engagement through community voices activity, patient participation mechanisms, consultation activity, and partnership working through the Integrated Care

Partnership and Health and Wellbeing Boards. Community insight informed service design and the ICB maintained a commitment to reducing inequalities and reflecting local priorities in its planning and delivery. Public involvement and partnership working remained an active part of the ICB's approach.

However, there is less evidence of how consistently this translated into mature place-based leadership and delivery across the system. Review discussions highlighted variation in place development and the ongoing work required to align local government, provider and neighbourhood arrangements more effectively. While involvement activity remained in place, the maturity of place-based structures and local system alignment was still variable during the year.

Section 3: Support and intervention

This section considers the nature of oversight during the year, progress against improvement priorities, and the ICB's capacity to sustain improvement.

Support and Oversight

The ICB continued to receive regular regional oversight during the year across financial, operational, quality and organisational priorities. This included quarterly review meetings, performance discussions, and system-level engagement on key risks including urgent and emergency care, elective recovery, provider quality concerns and financial delivery. This reflects a sustained and active approach to oversight during a demanding period.

However, the level of oversight also reflects the scale of challenge within parts of the system. Review discussions highlighted continuing concerns around JPUH and QEH, urgent and emergency care performance, ambulance handovers, financial delivery and quality risk, including the monitoring of delivery of the QEH enforcement undertakings prior to their discontinuation. While oversight arrangements were active and constructive, they were required in response to material and continuing system pressures.

Progress Against Improvement Objectives

There was evidence of progress against several priorities during the year, with improvement in a number of headline areas compared with 2024/25, including A&E four-hour performance, referral to treatment, 62-day cancer and GP satisfaction. Review discussions also highlighted progress in areas such as cardiovascular disease prevention, primary care access, urgent dental provision and aspects of urgent and emergency care pathway development. This demonstrates that the ICB was able to make progress in several areas despite the wider operating context.

However, progress was variable, with partial delivery across some priorities and ongoing challenges in access, safety and provider performance at JPUH and QEH. Some areas remained fragile or showed limited progress, including obesity-related measures, GP booking satisfaction, aspects of elective and cancer recovery, and elements of the safety domain. Despite improvements in places, overall delivery remained mixed, and some longstanding issues persist.

Capacity to Sustain Improvement

The ICB demonstrated strengths that should support future improvement. These included continued delivery of statutory functions, evidence of strategic direction through the Joint Forward Plan and wider system strategies, and active engagement with partners, communities and regional teams. There was also continued investment in enabling capability, including digital infrastructure, primary care development, research, estates and neighbourhood-based working. This provides a foundation on which the new Norfolk and Suffolk ICB can build.

However, the capacity to sustain improvement will depend on how effectively the new organisation consolidates these strengths while addressing areas that remain less mature. Organisational change, place variation, provider fragility, capability gaps in some specialist functions, and the continued need for grip on quality, access and financial performance all present ongoing risks. Sustained improvement will require continued focus on organisational stability, commissioning maturity and consistent delivery across the system.

Conclusion

In forming this assessment, I have taken a balanced and proportionate view of your performance in a complex operating environment. I am encouraged by progress towards more mature, integrated care shaped by the needs of local people and communities.

This assessment reflects the statutory body in place during the period assessed (2025/26). NHS England remains committed to supporting continuity, learning and improvement as the new ICB embeds its responsibilities.

Please share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. NHS England will also publish a summary of all ICB annual assessment outcomes.

Classification: Official-Sensitive

EoE Ref: 26-190

Item 12

NHS England – East of England
Victoria House
Camlife
Fulbourn
Cambridge
CB21 5XB

Professor Will Pope
Chair
Norfolk and Suffolk ICB

31 July 2026

Dear Will,

Annual assessment of Suffolk and North East Essex (SNEE) Integrated Care Board's (ICB) performance in 2025-26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and organisational change. In parallel, ICBs have been required to adapt to an evolving operating model while maintaining a clear focus on statutory duties, system leadership and delivery for local populations. In the East of England, this has included the additional complexity of managing the merger of all six predecessor ICBs in-year.

Against this backdrop, I recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden of maintaining stability, continuity and delivery through a period of significant structural transition.

In reaching this assessment, I have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners where received, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

Clare Panniker
Regional Director
NHS England - East of England

Cc Ed Garratt, Chief Executive Officer, Norfolk and Suffolk ICB
Tom Abell, Chief Executive Officer, Essex ICB
Adam Cayley, Executive System Lead & Chief Operating Officer, NHS England – East of England
Simon Wood, Executive System Lead & Regional Director of Strategy and Integration, NHS England – East of England

Section 1: ICB performance assessment

During 2025/26, Suffolk and North East Essex (SNEE) ICB operated through a period of significant organisational change, maintaining focus on its statutory duties, system leadership and delivery for its population. This assessment reflects performance against these duties, including reducing inequalities, improving quality, meeting financial requirements, supporting research, and having regard to local strategies. It also considers the wider effect of decisions across the system, consistent with the triple aim of improving population health, quality of care and value for money, and supporting the long-term sustainability of services for local communities.

Population Health and Inequalities

The ICB demonstrated strong performance in population health and prevention during 2025/26, with the system in the highest performing quartile for population health. There was particularly strong performance in serious mental illness health checks, alongside evidence of well-developed prevention and inequalities programmes. This includes neighbourhood health implementation, cardiovascular prevention, vaccinations, integrated weight management, social prescribing, targeted dental access and partnership-based work to address inequalities in coastal and more deprived communities.

While overall performance in population health is strong, there remain areas where outcomes and access vary across the SNEE population. This includes variation in elective waits, emergency admissions for children, Mental Health Act detentions and early cancer diagnosis. These patterns indicate that, alongside strong system-wide performance, further sustained action will be required to reduce unwarranted variation and improve outcomes for specific population groups.

Quality and Safety of Services

The ICB maintained active oversight of quality and safety during the year, supported by strengthened governance arrangements, system quality forums and responsive review processes. SNEE ICB performed above average for safety and demonstrated a mature approach to quality management, collaborative oversight and proactive intervention where risks emerged.

However, the quality picture remained mixed across the provider landscape. In particular, there were concerns at East Suffolk and North Essex NHS Foundation Trust during the year, including regulatory findings, operational pressures and variation in delivery. While the ICB remained engaged and responsive, these provider-level risks persisted and required ongoing system oversight and improvement.

Access and Experience

Performance on access and experience was comparatively strong over the course of 2025/26, with the ICB performing above average overall. There was particularly positive performance in primary care experience, including GP satisfaction, alongside continued delivery in areas such as pharmacy first and community-based alternatives to hospital care.

However, despite this relative strength, delivery against key constitutional standards remained below national ambition in a number of areas, including urgent and emergency care, elective care and the 62-day cancer standard, with both accident and emergency four-hour performance and 62-day cancer performance showing a deterioration on the previous year. In addition, there were ongoing pressures in flow and discharge, and in some community-based pathways, contributing to variation in experience across the system. As a result, while the system demonstrates comparative strength in access and experience overall, residents

continue to experience pressure and variation across core services, and further coordinated action will be required to deliver sustained improvement.

Financial Duties

SNEE ICB met its statutory financial duties in 2025/26 and demonstrated strong financial control in a challenging environment. The ICB was in the highest performing quartile for system finance, delivered a surplus position, and played a key role in enabling the wider system to achieve financial balance and meet its statutory financial duties.

This position was achieved despite continued provider fragility and underlying financial risk within parts of the system, and without any external support. The ICB took a proactive approach, including effective use of the Commissioning Management System, targeted review of diagnostics activity and robust system level financial oversight and scrutiny. While the financial performance in 2025/26 was strong, ongoing challenges remain in relation to efficiency, productivity and the delivery of recurrent financial sustainability.

Research and Local Strategies

During 2025/26, the ICB continued to have regard to relevant local strategies, including the Joint Forward Plan and wider system strategies structured around the Live Well framework. There is strong evidence that SNEE maintained a strategic focus on neighbourhood health, prevention, integration and partnership working, while also supporting research, innovation, sustainability and wider social value. This included development of the Research Engagement Network, extensive community and co-production infrastructure, work with anchor institutions, and a broad range of initiatives linking health improvement with employment, housing, digital inclusion and environmental sustainability. The ICB's three-year Green Plan sets out strategic objectives and key activities across the system. Progress includes reductions in carbon emissions, sustainable commissioning, and partnership work supporting the Greener NHS programme

It is evident that the ICB not only maintained strategic direction during a difficult year but also continued to contribute to the wider social and economic fabric of its system. The breadth of partnership and co-production work is a notable strength and provides a strong foundation for future strategic commissioning and neighbourhood-based delivery.

Section 2: ICB Capability assessment

During 2025/26, SNEE ICB demonstrated effective organisational capability through a demanding period of transition, while continuing to discharge its commissioning, governance and partnership responsibilities. This assessment considers the ICBs ability to commission services, obtain appropriate advice, maintain effective governance and leadership, and involve the public, alongside its capacity to sustain delivery through organisational change.

Commissioning and Delegated Services

The ICB maintained its commissioning responsibilities across a broad range of services, including delegated primary care, community, dental, pharmacy, specialised and strategic commissioning functions. There is evidence of increasingly mature commissioning arrangements across areas such as dentistry, community services redesign, urgent care, neighbourhood delivery and strategic transformation programmes. Delegated services were commissioned in line with national requirements and the ICB was able to evidence compliance with delegation arrangements.

Governance and Decision-Making

The ICB maintained effective governance and decision-making arrangements throughout the year, with clear board and committee structures supporting oversight of finance, performance, quality, risk and transformation. The ICB demonstrated well-developed governance arrangements, active board assurance processes and strong committee architecture. Review discussions during the year also reflected confidence in the board's leadership, governance discipline and ability to maintain strategic oversight while progressing operational priorities.

Given the scale of organisational change, governance will remain an area requiring continued focus in the successor arrangements, however, SNEE retained sufficient governance oversight and decision-making maturity during the period assessed.

Workforce and Culture

SNEE ICB demonstrated a strong workforce position during 2025/26, with performance in the highest quartile and a positive picture in relation to staff engagement, inclusion and organisational wellbeing. Staff experience indicators were strong overall, reflecting a resilient workforce and a positive internal culture through a demanding period of change.

However, as with all organisations undergoing major transition, there are risks relating to capacity, retention and the continuity of specialist expertise. Maintaining workforce stability and sufficient capability to support strategic commissioning, planning, intelligence and improvement will therefore remain important as the successor organisation embeds its operating model.

Public Involvement and Consultation

This is a clear area of strength for SNEE. The ICB demonstrated mature and meaningful public involvement and partnership working, including structured engagement with Healthwatch, the voluntary sector and wider community groups, alongside effective mechanisms for incorporating insight into planning and commissioning decisions. There is clear evidence of involvement of people and communities in service redesign and strategic development, providing a strong foundation for future neighbourhood health and strategic commissioning work.

Section 3: Support and intervention

This section considers the nature of oversight during the year, progress against improvement priorities, and the ICB's capacity to sustain improvement.

Support and Oversight

During 2025/26, SNEE ICB was not subject to formal regulatory intervention. However, the ICB did operate under regular and, in some areas, close regional oversight during the year. This included formal review meetings, performance discussions and targeted regional engagement in response to provider-level quality, operational and financial risks. In particular, there was sustained oversight in relation to ESNEFT, mental health flow, urgent and emergency care, and provider financial delivery. Whilst proportionate and constructive, these arrangements reflect material and continuing pressures within parts of the system.

Progress Against Improvement Objectives

Over the course of the year, the ICB demonstrated progress across a number of priority areas including financial control, prevention, primary care and dental access, neighbourhood development and aspects of access and experience. This included supporting improvement trajectories at West Suffolk NHS Foundation Trust, progress in addressing challenges across ambulance and mental health services, and delivering a significant expansion in access to

NHS dentistry. There was evidence of increasing strategic maturity and several areas of strong delivery, particularly in population health, workforce and financial management.

Nevertheless, progress was variable. While overall performance improved and the ICB performed comparatively strongly in several domains, delivery against key constitutional standards in urgent care, elective care and cancer remained below national ambition. In addition, provider fragility, particularly in relation to ESNEFT and aspects of mental health flow and operational delivery, continued to constrain overall system performance. These areas will require continued focus and coordinated action.

Capacity to Sustain Improvement

On balance, SNEE enters the next phase with a number of significant strengths that should support continued improvement. These include strong strategic leadership, good financial grip, a resilient workforce, comparatively mature public and partnership infrastructure, and well-established prevention and neighbourhood programmes.

However, the capacity to sustain improvement will depend on how effectively successor arrangements maintain grip on access recovery, provider quality and operational resilience, while preserving strategic commissioning capability and organisational stability during transition. Continued focus on governance, workforce capability, commissioning maturity and system collaboration will be essential.

Conclusion

In forming this assessment, I have taken a balanced and proportionate view of your performance in a complex operating environment. I am encouraged by progress towards more mature, integrated care shaped by the needs of local people and communities.

This assessment reflects the statutory body in place during the period assessed (2025/26). NHS England remains committed to supporting continuity, learning and improvement as the new ICB embeds its responsibilities.

Please share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. NHS England will also publish a summary of all ICB annual assessment outcomes.

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NHS
Norfolk and Suffolk
Integrated Care Board

NSICB Board Performance Report

September 2026

Item 15

Integrated Performance Report

Performance summary - COMMISSIONER VIEW

NHS Norfolk and Suffolk Integrated Care Board

Medium Term Planning Framework Metrics (2026/27 targets)

Theme	Metric	Success Measure	Reporting Date	Achievement	NHSE Plan Target	2026/27 Target	Variation	Assurance
Elective, cancer & diagnostics	18-week RTT	Improve the percentage of patients waiting no longer than 18 weeks for treatment	Jul-26	63.6%	57.4%	68.4%	H	F
	6 week waits	Improve performance against the DM01 diagnostics 6-week wait standard	Jul-26	29.9%	23.3%	14%		F
	28-day FDS	Improve performance against cancer constitutional standards	Jul-26	77.1%	74.9%	80%		?
	31-day standard	Improve performance against cancer constitutional standards	Jul-26	92.3%	92.5%	94%		F
	62-day standard	Improve performance against cancer constitutional standards	Jul-26	69.7%	71.5%	80%		F
Mental health, learning disabilities & autism	Individual placement and support access	Meet the existing commitments to expand Individual Placement and Support	Jul-26	1,310	1,590	1,610	L	
	NHS Talking Therapies - reliable recovery rate	Meet the existing commitments to expand NHS Talking Therapies	Jul-26	49.8%	62.4%	51%		?
	NHS Talking Therapies - reliable improvement rate	Meet the existing commitments to expand NHS Talking Therapies	Jul-26	71.8%	68.6%	69%	H	P
	Out of area placements	Eliminating inappropriate out-of-area placements	Jul-26	0	0	0	L	?
Primary care & community services	Clinically urgent patients seen on same day	Same day appointments for all clinically urgent patients (face to face, phone or online)	Jul-26	78.1%	72.9%	90%	H	F
	Additional urgent dental appts per year	Deliver 700,000 additional urgent dental appointments against the July 2023 to June 2024 baseline period	Mar-26	9,368		9,933		
	Community health service activity within 18 weeks	Address long waiting times for community health services	Jul-26	83.2%	87.8%	78%	H	?
	Pharmacy first and roll out new services	Embed pharmacy-first approaches, ensuring that local commissioning discussions utilise pharmacy capacity to support primary care pressures	May-26	17,076	13,422	15,995		
Urgent & emergency care	A&E 4 hour waits	4-hour A&E performance	Aug-26	75.8%	78.0%	82%		F
	Reduce number who wait over 12 hours	12-hour A&E performance	Aug-26	4,315	4,060	3,996		

Assurance against target is measured against submitted NHSE plan trajectories not the final medium term plan 26/27 target

Performance Assurance Summary

Domain	Summary	Assurance Level & Board Focus
Elective Care and Diagnostics	Elective recovery continues to improve, with RTT 18-week performance ahead of trajectory and long waits reducing overall. However, diagnostics remains materially behind trajectory and is the principal constraint on elective and cancer recovery. Capacity, workforce and productivity pressures vary between providers. At ESNEFT, waiting-list validation identified additional patients, increasing reported 52- and 65-week waits. The ICB is seeking further assurance on the impact and exploring mitigation through the £20m waiting-list investment fund.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Insufficient improvement in diagnostic capacity and productivity may prevent delivery of the elective and diagnostic year-end standards.
Cancer	Cancer performance remains mixed. Faster Diagnosis performance is improving and the 31-day standard remains close to target, but the 62-day standard is the principal concern at 69.7%, below both the 71.5% trajectory and 80% year-end standard. The Cancer Alliance is providing targeted support to QEH and JPUH, alongside regular performance oversight and work to address constrained pathways. Recovery remains dependent on diagnostic and treatment capacity, particularly imaging, histopathology and specialist workforce capacity.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Diagnostic and treatment constraints may prevent recovery of the 62-day standard and continue to delay diagnosis and treatment.
Urgent and Emergency Care	UEC performance remains below plan, with the main pressure concentrated at QEH and JPUH. WSFT delivered above plan in August, while NHS England is providing focused support and performance management to the two challenged providers. Ambulance Category 2 response times remain above the 30-minute standard in both Norfolk and Suffolk. The Winter Readiness Event has taken place and the Urgent Community Coordination Hub business cases have been approved, with implementation commencing to strengthen admission avoidance and capacity. Improvement is not yet consistent enough to provide confidence ahead of winter.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Continued underperformance at QEH and JPUH, together with delayed handovers, may weaken system resilience during winter.

Performance Assurance Summary

	Summary	Assurance Level & Board Focus
Mental Health	Mental health performance is mixed. No inappropriate out-of-area placements have been recorded for more than a year and Talking Therapies reliable improvement is above target at 71.8%. However, reliable recovery remains below target at 49.8%, and IPS access remains below trajectory. Provider recovery plans, mobilisation of the new IPS service and strengthened ICB oversight are in place. Delivery confidence remains moderate because workforce gaps, increasing demand and provider variation continue to affect improvement.	**Assurance to the Board:** Partial assurance. **Key residual risk:** Workforce pressures and provider variation may limit improvement in Talking Therapies outcomes and IPS access.
Primary Care, Community and Wider Access	Same-day access for clinically urgent GP patients is ahead of trajectory at 78.1% against 72.9%, but remains below the 90% year-end ambition. Practices have been RAG rated, with improvement plans and targeted support where required. Dental activity is not considered a significant concern, though additional urgent capacity has been commissioned. Community performance is above the 78% target overall at 83.2%, although the headline position masks variation between services, including lower performance in children's pathways. Reporting delays and appointment-mapping issues also limit confidence in the GP access data and work is underway to address these	**Assurance to the Board:** Limited to partial assurance. **Key residual risk:** Service-level variation and limitations in GP access data may obscure underperformance and weaken confidence in delivery of the year-end ambitions. No additional Board escalation is proposed.
Overall Performance Assurance	The Committee provides the Board with partial assurance on delivery of the 2026/27 performance plan. Elective performance is ahead of trajectory, mental health out-of-area placements remain well controlled, and primary care and community performance are ahead of their current trajectories. Recovery actions and enhanced oversight are in place where performance is below plan. The principal threats to year-end delivery are diagnostic performance and its impact on elective and cancer recovery, the 62-day cancer pathway, and UEC performance at QEH and JPUH as the system enters winter. Mental health, primary care and community exceptions should remain under Committee oversight and do not currently require separate Board escalation.	**Overall assurance:** Partial assurance. **Board focus:** Diagnostic recovery; the 62-day cancer standard; and UEC performance and winter resilience.

NHS
Norfolk and Suffolk
Integrated Care Board

Finance Report Month 05 2026/27

Finance, Performance and Workforce Committee
September 2026

Contents

Key Financial Metrics

	Month 05	Forecast	
Surplus/Deficit	G	G	The ICB reported on plan at Month 05 with break even year to date and breakeven forecast. Some areas of risk are now reflected in the forecast but are being offset by other underspending budgets.
Efficiency Delivery	A	A	Reported year to date delivery is at 95% and the forecast delivery is 98% of the £102m target.
Running Costs Limit	G	G	The forecast is on plan to remain within the £27.5m limit. (note: this is the statutory limit which is a subset of the national £19ph target)
Mental Health Investment Standard	G	G	The forecast is for achievement of the £376m target for core ICB and £43m for delegated Specialised Commissioning.
Net Risk	G	G	There has been no change to the reported net risk position this stage.

G On Plan

A Adverse variance to plan within manageable tolerance

R Adverse variance to plan above manageable tolerance / risk to financial duties

Finance Summary M05

The ICB reported on plan at Month 05 with break even year to date and breakeven forecast. Key variances and further areas of potential risk are:

Prescribing – The reported forecast overspend remains unchanged at £7.1m, however the risk of further deterioration has increased with price concessions continuing at £1m per month higher than 25/26 which are now also impacting on delivery of efficiency programmes. The publication of national forecast profiles has been delayed but is expected before month 06 reporting to inform any further changes to the forecast.

Acute – Elective underperformance with system providers is driving a £5m underspend year to date particularly at WSFT (£2.3m) and NNUH (£3.5m). Initial recovery plans have been provided by both Trusts and the Forecast remains on plan assuming activity will be recovered. The contract dispute with CUHFT for 2026/27 is in further escalations with NHS England.

Mental Health – The forecast overspends on ADHD and ASD diagnosis and treatment costs remains stable from last month at £1.1m post enactment of agreed recovery actions. Underspends on MH and LDA individual packages of care are the main driver of the overall forecast underspend in Mental Health.

Continuing Care – The year to date position worsened in month as the expenditure run rate increased but is still underspent by £0.6m. Reviews are underway to identify the drivers of the increase, the potential impact on full year budget delivery and any available mitigations.

Category	1 Apr 26 to 31 Aug 26			Forecast to 31 Mar 27		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Revenue Resource Limit (in year)	(2,103.9)	(2,103.9)	0.0	(5,005.5)	(5,005.5)	0.0
TOTAL REVENUE RESOURCE LIMIT	**(2,103.9)**	**(2,103.9)**	**0.0**	**(5,005.5)**	**(5,005.5)**	**0.0**
Acute Services	963.9	959.0	5.0	2,295.4	2,295.7	(0.3)
Mental Health Services	196.1	195.1	1.0	471.9	469.6	2.3
Community Health Services	178.0	176.0	2.0	426.6	423.3	3.4
Continuing Care Services	106.6	106.0	0.6	251.9	251.9	0.0
Primary Care - Prescribing	150.7	153.5	(2.9)	350.3	357.4	(7.0)
Primary Care - Other	24.9	24.6	0.3	59.9	59.6	0.3
Delegated GP	174.1	172.9	1.2	418.0	417.9	0.1
Delegated Pharmacy, Optom, Dental	77.0	76.1	0.9	184.3	184.2	0.1
Delegated Specialised Commissioning	193.7	193.7	(0.0)	453.5	453.5	0.0
Other Commissioned Services	10.2	10.1	0.2	25.4	25.3	0.0
Other Programme	4.4	1.3	3.1	7.0	3.7	3.2
Programme Reserve & Contingency	12.8	25.1	(12.3)	34.1	37.1	(3.0)
Running Costs	11.4	10.4	0.9	27.3	26.4	0.9
TOTAL EXPENDITURE	**2,103.9**	**2,103.9**	**0.0**	**5,005.5**	**5,005.5**	**0.0**
IN YEAR SURPLUS/ (DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Community– Year to date and forecast underspends are due to work undertaken to reduce the volume of additional spot purchased Neuro placements across Norfolk and Suffolk.

Acute

	1 Apr 26 to 31 Aug 26			Forecast to 31 Mar 27		
	Budget £'000	Forecast £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Acute - Reserve	19,158	19,158	(0)	49,658	49,658	0
Acute - Contract - NNUH	275,635	272,175	3,460	661,524	661,524	0
Acute - Contract - JPUH	115,778	116,058	(280)	277,867	277,867	0
Acute - Contract - QEH	85,879	85,908	(29)	206,109	206,109	0
Acute - Contract - WSH	128,898	126,634	2,264	309,354	309,354	0
Acute - Contract - ESNEFT	166,069	166,069	0	398,565	398,565	0
Acute - Contract - CUH	29,691	29,691	0	71,260	71,260	0
Acute - Contract - Associates	13,672	13,565	107	32,812	32,812	0
Acute - Contract - Independent	29,651	30,526	(875)	68,956	69,518	(562)
Ambulance - Contract - EEAST	66,387	66,387	0	159,329	159,329	0
Acute - LVA	10,282	10,282	0	10,282	10,282	0
Acute - NCA	1,484	1,484	0	3,561	3,561	0
Patient Transport Services	9,960	9,623	337	23,903	23,566	337
High Costs Drugs	857	857	0	2,057	2,057	0
Non Tariff Devices	3,415	3,415	0	8,196	8,196	0
Cancer Alliance	4,738	4,738	0	5,302	5,302	0
Protect NOW	85	85	0	205	205	0
Local Maternity Neonatal Services	232	232	(0)	653	653	0
Acute Projects - Planned Care	1,387	1,387	0	3,329	3,329	0
Acute Projects - CYP	26	26	0	62	62	0
Acute Non Recurrent	233	233	(0)	1,345	1,345	0
Acute Pay Costs	424	423	1	1,097	1,097	0
Acute Total	**963,939**	**958,955**	**4,984**	**2,295,425**	**2,295,650**	**(225)**

There are year to date net underspends totalling -£5.4m at NNUH, JPUH, QEH and WSH within the elective variable area of the contract. This is a small increase on the M4 position of -£5.2m under performance. Forecast remains on plan with the assumption that either activity is recovered or under performance is clawed back and reinvested in alternative capacity. Recovery plans have been received from NNUH and WSH following the ICB issuing Activity Query Notices (AQNs) for elective underperformance. JPUH have now issued an AQN to the ICB in respect of A&E over performance of c5%.

Joint work is ongoing with ESNEFT to gain assurance on data recording following their EPR implementation ahead of 27/28 planning. CUH is reported on plan at M5 however there remains a contract dispute risk of c£5m.

Within Associate NHS contracts there is a net -£0.1m underspend made up of a number of immaterial variances. The working assumption is these contracts will achieve plan by year end.

Independent Sector Providers have various YTD over and underspends against IAP due to timing and activity phasing which are forecast to be within full year plan. The forecast variance relates to weight management provider Oviva who operate on a NCA basis. Patient Transport includes a small YTD underspend due to less cost and volume journeys in months 1 to 3 under the Norfolk contract.

Acute Reserves include a £3m contingency set aside to support any in year pressures across NHS contracts and a further £3.9m to manage any ISP risk.

Mental Health

The reported position in Mental Health is a year-to-date underspend of **£0.983m**, primarily driven by reductions in expenditure across **Learning Disabilities and Autism (LDA) packages** and certain Mental Health placements. Given the early stage of the financial year, only the year-to-date underspend on packages has been incorporated into the full-year forecast and a proportion of the full year predicted variance, as the sustainability of these reductions remains still uncertain.

This is partially offset by higher-than-planned **Right to Choose (RTC)** expenditure. Provider returns have been received and validated for April, May, June and July with August activity and costs currently being finalised.

The full-year forecast reflects the identified RTC pressure following detailed provider-level analysis. This is lower than the year-to-date pressure, as the forecast reflects engagement work with some providers who will be bringing activity down in the rest of the year to offset the year-to-date pressures. Further detail regarding the RTC analysis is provided in the section below.

Mental Health M05 Summary Position

	1 Apr to 31 Aug 26			Forecast to 31 Mar 27		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
NSFT Contract Value	134,135	134,135	-	321,924	321,924	-
Other Contract Value	8,463	8,432	30	20,311	20,237	73
MH Act S12	12,722	12,455	267	30,533	30,538	- 4
MH CYP	5,257	5,023	234	12,618	12,304	314
Right to Chose Adult	5,579	7,358	- 1,778	13,391	14,501	- 1,110
Right to Chose CYP	3,572	3,750	- 179	8,572	8,556	16
LDA	12,603	10,998	1,605	30,329	28,538	1,791
MH Other	13,781	12,977	804	34,263	33,053	1,210
MENTAL HEALTH	**196,112**	**195,129**	**983**	**471,939**	**469,650**	**2,289**

Right to Choose (RTC)

The year-to-date overspend within the **Right to Choose (RTC)** portfolio is attributable to activity levels exceeding planned assumptions across several providers. Analysis of April to July submissions indicates that **11 providers have exceeded their Indicative Activity Plans (IAPs)**, with five **providers reporting expenditure more than £100k above plan**. The largest individual variance is currently **£837k** above the agreed activity plan.

Finance and Contracting teams have engaged with the five highest-variance providers. Formal contract management processes have been initiated to understand the drivers of the increased activity, validate expenditure, and identify opportunities to mitigate the financial impact for the remainder of the year. The position will continue to be monitored closely through the monthly reporting process. An AQP and AMP have been raised & requested against the provider with the largest variance

Community

Cost Centre	1 Apr 26 to 31 Aug 26 Budget £'000	Actual £'000	Variance £'000	Forecast to 31 Mar 27 Budget £'000	Forecast £'000	Variance £'000
Community - Reserve	4,015	4,015	0	9,635	9,635	0
Community - Contract - NCHC	57,776	57,770	6	138,962	138,962	0
Community - Contract - ECCH	18,276	18,269	7	43,863	43,863	0
Community - Contract - WSFT	18,516	18,516	0	44,439	44,439	0
Community - Contract - ESNEFT	26,479	26,479	0	63,549	63,549	0
Community - Contract - Other - Suffolk	810	805	5	1,944	1,943	1
Community Services - Norfolk	5,367	5,342	26	12,882	12,840	42
Community Services - Suffolk	370	343	27	888	835	53
Community Other - Norfolk	726	438	288	1,743	1,435	308
Community Other - Suffolk	444	348	96	1,066	1,066	0
Better Care Fund - Norfolk	17,465	17,465	0	41,917	41,917	0
Better Care Fund - Suffolk	9,618	9,618	0	23,084	23,084	0
Better Care Fund - Discharge Fund - Norfolk	3,030	3,030	0	7,271	7,271	0
Better Care Fund - Discharge Fund - Suffolk	2,328	2,328	0	5,588	5,588	0
Health Inequalities - Norfolk	20	8	12	48	48	0
Health Inequalities - Suffolk	69	69	0	165	165	0
Community LVA - ICB	298	298	0	298	298	0
Carers - Suffolk	108	106	2	260	260	0
CYP Services - Norfolk	1,469	1,464	5	3,526	3,499	27
CYP Services - Suffolk	1,102	1,104	-2	2,344	2,352	-8
CYP Transformation - Suffolk	0	0	0	0	0	0
Community Equipment - Norfolk	2,143	2,141	2	5,144	5,142	2
CYP Palliative Care - Norfolk	141	141	0	339	339	0
CYP Palliative Care - Suffolk	215	215	0	515	515	0
Palliative Care - Norfolk	774	774	0	1,857	1,857	0
Palliative Care - Suffolk	0	0	0	0	0	0
Hospices - Suffolk	2,987	2,987	0	7,170	7,170	0
Neurorehabilitation - Norfolk	1,978	992	986	4,746	2,510	2,237
Neurorehabilitation - Suffolk	614	556	58	1,474	1,428	46
Neuro Psych - Norfolk	316	248	68	731	532	199
Neuro Psych - Suffolk	498	98	401	1,196	711	485
COMMUNITY TOTAL	**177,955**	**175,968**	**1,986**	**426,646**	**423,253**	**3,392**

Community

The year-to-date underspend of £2.0m is primarily attributable to variable contract activity within the Neuro Rehabilitation and Neuro Psychology services. Following a detailed review of spot-purchased beds within Neuro Rehabilitation to ensure placements are aligned to patient needs, the service is now forecasting a full-year underspend of £2.2m. In addition, lower-than-anticipated levels of non-required observations within the Neuro Psychology service have contributed to the year-to-date underspend.

Community Other - Norfolk YTD is now showing underspend, primarily due to non-recurrent slippage caused by delayed start dates for Community Transformation schemes in North and South localities, as well as Planned Care diabetes initiatives.

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All other Community service areas are commissioned through fixed-contract arrangements and are currently forecast to operate in line with agreed contract values.

Better Care Fund (BCF) expenditure is forecast to achieve the required committed threshold spend.

Continuing Healthcare

At month 05 Continuing Healthcare is underspent by £0.6m year to date and forecast on plan.

Budget realignment work is ongoing. Expenditure data currently shows a higher level of spend within Personal Health Budgets compared to CHC Fully Funded packages. As more accurate data becomes available throughout the year, budget alignment will be further refined to better reflect the distribution of care package types.

At M05, CHC Fully Funded (including PHB) is reporting an overspend of £1.6m. Referral activity and caseload for this cohort of patients is currently stable and whilst referrals are volatile month on month, they are broadly the same as this time last year. CHC Fully Funded has shown an increase in expenditure of approximately £1.4m each month over the last two months, this is due to packages of care increasing in costs as the caseload has remained stable over the same period. Finance will be working closely with the CHC team to ensure this trend doesn't create a risk in delivering within budget.

At M05, CHC Fast Track is reporting a year-to-date underspend of £1.48m. Patient numbers change quickly with Fast Tracks and Finance continue to flag patients that have remained Fast Track eligible for over 12 weeks. The opportunities within the Fast Track underspend are helping offset the overspends within CHC Fully Funded. Referrals whilst incredibly volatile week on week have remained in line with referrals this time last year, stable Fast Track referral levels have helped manage the risk of unanticipated growth in high-cost care packages.

Cost Centre	1 Apr 26 to 31 Aug 26			Forecast to 31 Mar 27		
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Forecast £000s	Variance £000s
CHC Adult - Fully Funded - Standard	37,004	35,724	1,280	84,134	82,088	2,046
CHC Adult - Fully Funded Personal Health Budgets - Standard	38,370	41,208	(2,838)	90,803	98,866	(8,062)
CHC Adult - Fully Funded - Fast Track	10,665	9,188	1,477	25,596	22,365	3,231
CHC Adult - Joint Funded	1,596	1,525	71	3,830	3,444	387
CHC Adult - Joint Funded Personal Health Budgets	1,282	978	304	3,077	2,334	742
Childrens Continuing Care	1,056	2,499	(1,443)	2,534	4,053	(1,519)
Childrens Continuing Care Personal Health Budgets	2,497	1,085	1,412	5,993	3,572	2,420
Funded Nursing Care	10,548	10,557	(9)	25,315	24,560	755
Continuing Care Assessment and Support	1,400	1,004	396	3,361	3,361	0
CHC Pay Costs	2,195	2,196	(1)	7,208	7,208	0
CONTINUING CARE	**106,612**	**105,965**	**648**	**251,851**	**251,851**	**0**

Funded Nursing Care and Joint Funded packages remain stable resulting in an underspend year to date of £0.4m. All FNC packages have been fully uplifted, and the Joint Funded packages are driven by the council, and we are uplifting when we are notified by them of changes.

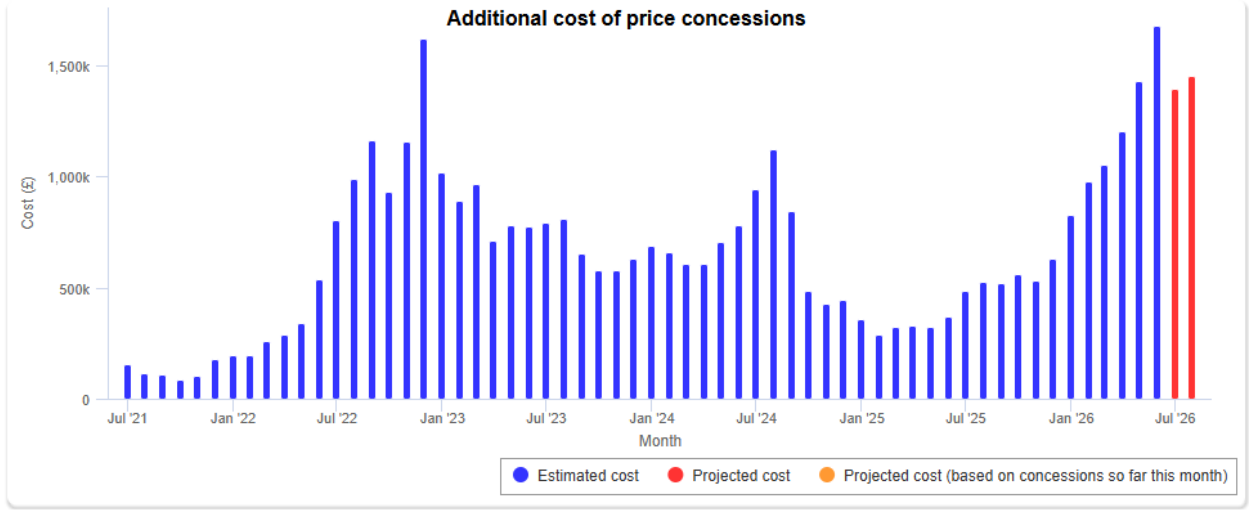
At M05 Children's Continuing Care is showing an overspend of £31k, more analysis needs to be completed to understand areas of concern and if there are any opportunities with better Social and education engagement to help any jointly funded packages.

Primary Care Prescribing & Other

Prescribing

The M05 finance position maintains the forecast overspend of **£7.1m.** With historic seasonal profiles varying significantly between financial years the national NHSBSA forecasting projections would be used to calculate full year spend. However, these have been delayed nationally and will not be available until M04 data is released. As a result, the forecast overspend has been held as at M04 but the prescribing risk on the ICB register has been increased by a further £2m as June prescribing was higher than in both April and May and due to continuing price concessions.

The cost increase of published price concessions for M01-5 for the ICB were £7m with August forecasting £1.5m which is on average £1m per month higher than 25/26. These are contained in the year to date actuals at M03 and form part of the forecast but the chart to the right shows the increase in concessions since the start of the year.



Best Value Medicines schemes are underway and are on plan for M01-3. However, there is high risk around the Edoxaban and Cat M schemes with products remaining on the price concession and the impact of Category M agreements on base prices resulting in cost pressures. This is forecast to result in slippage in delivery of £2.4m at M05 which has contributed to the increased risk. This impact was calculated after the ledger forecast was finalised and a triangulation exercise between ledger, risk and efficiency delivery will take place for M06.

Primary Care Other

The year-to-date underspend of £0.3m is driven by some Local Enhanced Services which contain year end top up payments but the budget is phased in 12ths.

Local Enhanced Service forecasts include the agreed 3.5% rate uplift; there remains a risk if activity increases on the cost and volume schemes above and beyond the assumed list size growth of 1%. Quarterly claim data from CQRS Local has been used to extrapolate spend into the forecast.

The forecast underspend is driven by the ceasing of the AGEM NMSS (Norfolk Medicines Support Service) contract.

Primary Care Delegated GP

Delegated GP	1 Apr 26 to 31 Aug 26			Forecast to 31 Mar 27		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Enhanced services	3,424	3,391	33	8,219	8,265	(47)
General Practice - GMS	58,945	57,874	1,071	141,468	140,627	841
General Practice - PMS	7,454	7,628	(174)	17,890	18,244	(354)
Other - GP Services	407	394	13	977	939	38
Other List-Based Services (APMS incl.)	2,890	2,942	(51)	6,937	7,020	(84)
Pension/Levy	0	0	0	0	0	0
Premises cost reimbursements	7,339	7,467	(128)	17,613	17,724	(111)
Primary Care Network	20,628	20,742	(113)	49,508	49,509	(1)
QOF	6,662	6,662	(0)	15,988	16,381	(393)
Delegated GP - Norfolk	**107,750**	**107,099**	**650**	**258,599**	**258,710**	**(111)**
Enhanced services	1,860	1,861	(1)	4,464	4,465	(1)
General Practice - GMS	12,636	12,444	192	30,327	30,282	46
General Practice - PMS	31,351	31,126	225	75,242	74,770	471
Other - GP Services	241	241	0	579	579	0
Other List-Based Services (APMS incl.)	141	328	(186)	339	329	10
Pension/Levy	0	0	0	0	0	0
Premises cost reimbursements	3,435	3,417	17	8,244	8,286	(43)
Primary Care Network	12,741	12,442	299	30,578	30,581	(4)
QOF	3,991	3,991	(0)	9,579	9,889	(310)
Delegated GP - Suffolk	**66,397**	**65,850**	**546**	**159,352**	**159,182**	**170**
DELEGATED GP	**174,146**	**172,949**	**1,197**	**417,951**	**417,892**	**59**

Year to date underspends are due to timing of expenditure compared to budget phasing so this is expected to return to budget by the end of the year. In Norfolk this is driven by Enhanced services and the new GP Reimbursement scheme.

The year-to-date underspend in Suffolk is driven by timing of ARRS claims and some missing claims from one PCN. The PCN Test Site Pilot costs are included in the expenditure, and these will be funded by a separate allocation from NHSE.

There has been a nationally led practice list size cleanse which has reduced lists sizes, and this has resulted in lower than planned contractual payments as seen in the forecast on the GMS and PMS budget lines.

Both forecasts include achieving QOF in full as well as fully utilising the ARRS and practice level reimbursement scheme. The impact of the reduced list sizes seen as at July 1st is also factored in.

Primary Care Delegated POD

Delegated Pharmacy, Optometry and Dental

Delegated Pharmacy, Optom, Dental	1 Apr 26 to 31 Aug 26			Forecast to 31 Mar 27		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Delegated Community Dental	2,614	2,598	16	6,273	6,273	0
Delegated Ophthalmic	7,653	7,223	430	18,367	18,219	148
Delegated Pharmacy	21,982	21,820	161	52,756	52,772	(16)
Delegated Primary Care IT	0	0	0	0	0	0
Delegated Primary Dental	34,609	34,987	(378)	83,062	83,062	0
Delegated Property Costs	0	0	0	0	0	0
Delegated Secondary Dental - ICB	10,143	9,473	671	23,836	23,836	(0)
OTHER DELEGATED	**77,001**	**76,101**	**900**	**184,294**	**184,162**	**132**

Pharmacy
The year-to-date underspend relates the Pharmacy Quality Scheme which is not paid out until later in the year but the budget is currently split in equal 12ths.

The Pharmacy First allocation has been provided up front this year as part of the agreed changes based on the share of 25/26 Pharmacy First allocation.

Forecast is in line with budget based on the 3 months actual data and forecast using seasonal trends.

Optom
The year-to-date position reflects M04 actuals with accruals and forecast based on seasonal trends which sees increased spend in the second half of the year. There is one large provider with missing claims for which a £0.4m forecast has been included within the Miscellaneous Expenditure line.

Dental
Dental forecast is in line with budget and the dental ringfence. The national contract changes relating to urgent care, complex care pathways and appraisals are likely to increase UDA delivery across most contracts and have a material impact on the performance clawback as activity for all changes are converted into UDAs. Patient Charge revenue continues to be higher than last year, August receipt was lower than the year to date average but matches prior year seasonality.

The underspend year to date on dental is driven by timing of spend against plan for the LVA payments in Secondary Care. Within secondary care the commissioning team are engaging in activity monitoring and tracking.

Efficiency Delivery Overview M05

Programme	SRO	Scheme Value (£000s)	Actuals at Month 4 (£000s)	YTD Plan at Month 4 (£000s)	Variance (£000s)	FOT (£000s)	Variance (£000s)	% Delivery (FOT/Scheme Value)	Delivery RAG
Complex Care	Lisa Nobes	£18,991	£6,971	£5,430	£1,541	£18,991	£0	100%	
Neuro Rehab	Lisa Nobes	£0	£1,299	£0	£1,299	£3,260	£3,260		
Best Value Medicines	Mike Smith	£27,500	£5,655	£8,055	-£2,400	£21,700	-£5,800	79%	
Clinical Policies	David Brandon	£1,000	£0	£415	-£415	£0	-£1,000	0%	
GP IT Costs	Richard Watson	£1,780	£445	£445	£0	£1,780	£0	100%	
Contract and Service Reviews incl. Strategic Commissioning	Howard Martin & Richard Watson	£7,000	£41	£2,915	-£2,874	£325	-£6,675	5%	
Contract Management (Acute IAPs)	Howard Martin	£1,000	£415	£415	£0	£1,000	£0	100%	
Contracting Out of Area	Howard Martin	£1,000	£415	£415	£0	£1,000	£0	100%	
Finance	Howard Martin	£6,421	£4,146	£2,970	£1,176	£14,214	£7,793	221%	
Corporate	Amanda Lyes	£36,306	£15,125	£15,125	£0	£36,306	£0	100%	
Estates	Amanda Lyes	£807	£302	£336	-£34	£807	£0	100%	
Demand Management (Left Shift)	Maddie Baker-Woods & Mark Burgis	£0	£0	£0	£0	£0	£0		
LES Review	Maddie Baker-Woods & Mark Burgis	£0	£0	£0	£0	£0	£0		
		£101,805	**£34,814**	**£36,521**	**-£1,708**	**£99,383**	**-£2,422**	**98%**	

Delivery Rag Key
<80%
80%<>99%
100% +

- At month 5 we have reported delivery of £34.8m which is £1.7m below plan. The forecast is now under delivery of £2.4m for the year.
- Overall delivery is rated Amber, reflecting the adverse variance to plan now reported in the forecast.

- Best Value Medicines - The impacts of national stock shortages and price concessions and resultant changes to baseline Cat M prices are reflected in the adverse forecast movement this month of £5.8m.
- Contact and Service reviews and Clinical Policies – Remains unchanged from the previous month with limited delivery forecast in 26/27.
- Finance – The progress on additional schemes including enhanced budgetary control are mitigating the majority of forecast under delivery so far.

Risks and Mitigations

Risks	Likelihood (High / Medium / Low)	Forecast £m	Narrative
Contract Risk	High	5.0	There is an ongoing contract dispute with CUHFT relating to activity volumes, pricing and growth which remains unresolved at this stage and is in advanced escalation with NHS England. Risk has increased
Contract Performance	High	5.5	Risk of acute activity levels exceeding the plan driven by increase in demand.
ADHD/ASD Assessments	High	4.0	Continued increase in Right to Choose (RtC) activity, primarily within neurodevelopmental pathways, driven by ongoing demand and patient choice.
Prescribing Costs	High	7.0	Prescribing costs continue to present a risk to the financial position, driven by increased demand and higher prescribing volumes, national stock shortages and pricing concessions.
Continuing Care	Medium	5.0	Ongoing pressure within Continuing Care, driven by increases in demand and the complexity and cost of care packages.
Non recurrent Investments	Low	2.0	Non recurrent investments in the previous year which have no identified funding source and may create a potential financial pressure should these services be required to continue.
Individual Placements	Medium	2.0	Risk in relation to individual mental health placements, driven by the demand for high-cost, complex packages of care.
Total		**30.5**	

Mitigations	Likelihood (High / Medium / Low)	Forecast £m	Narrative
Contingency	Medium	(3.0)	Contingency has been set aside to support the anticipated increase in elective activity and associated contract costs.
Contingency	Medium	(27.5)	The plan includes a level of contingency to manage in-year risks; however, this is expected to be utilised across a number of pressures.
Total		**(30.5)**	

Net Risk		**0.0**	

Underlying Position

Adjustment	Recurrent / Non-Recurrent	Allocation £m	Expenditure £m	Surplus / (Deficit) £m
Underlying Position Y/E 25/26		(4,672)	4,726	(54)
Planning & YTD Adjustments		(305)	250	54
Plan 26/27	-	(4,977)	4,977	0
Non-recurrent allocations	NR	0	0	0
Non-recurrent flexibilities	NR	0	44	(44)
Non-recurrent efficiency schemes	NR	0	13	(13)
Redundancy / change programme costs	NR	0	(4)	4
Full Year Effect of recurrent efficiencies	R	0	(8)	8
Cost pressures not reflected in forecast as per risks	R	0	29	(29)
Contingency released as per mitigations	R	0	(32)	32
Other adjustments	R	0	0	0
Underlying Position Y/E 26/27		**(4,977)**	**5,018**	**(41)**

The ICB is planning to achieve a break-even position in 2026/27. However, the reported position includes a number of non-recurrent benefits and temporary measures. After adjusting for non-recurrent flexibilities, one-off efficiencies, other non-recurrent items and incorporating known recurrent cost pressures

At month 5 the underlying recurrent position is estimated to be a deficit of £41m. This is an adverse movement of £4m from month 4 and the change has been driven by the reduced estimate of recurrent efficiency savings.

Further movement in the reported position is expected in month 6 as final uplift guidance for 2026/27 has now been issued for the year by NHS England along with associated with recurrent allocations. The difference in the recurrent cost compared to allocation will impact on the underlying position.

Capital

Current forecasts indicate an underspend of £1.100m (10.0%). This represents an adverse movement of £0.227m (2.06%) movement to M04. This is primarily driven by a reduction in the forecasted spend on the Strategic schemes, however this movement is expected to be largely offset against the cost of appointing a new consultant in respect of the Cardinal scheme.

Most of the underspend sits in the strategic capital pot. This funding could also be used for IT or passed back to providers but early indications from the digital team are that this could be used on networking costs.

Although the ICB is forecasting an underspend overall currently, there are several estates and IT (e.g. Suffolk WIFI) schemes which could be brought forward to mitigate against that risk. These are currently being prioritised and will then be aligned with the appropriate governance routes once the practices have been liaised with.

The system has also been awarded bonus capital because of SNEE's revenue performance during 2025/26. No decision has yet been made around the use of these funds.

The ICB is required to provide a forecast to the national team for 21st Sep. Discussions are being had with the relevant teams and although there is a forecasted underspend based on the planned schemes for the year, there is still high confidence that the full allocation can be spent in year.

Scheme Reference & Capital Category	Scheme Name	Scheme Description	Plan £'000	Forecast £'000	Variance £'000	Comments
BAU GPIT 1	GPIT PC's & Laptops	GPIT PC's Laptops & peripherals annual refresh	2,000.0	2,000.0	0.0	No submission as yet, but no concerns over delivery
BAU GPIT 2	Hardware Expansion	Additional servers for expansion of RPA in N&S GPs	90.0	90.0	0.0	No submission as yet, but no concerns over delivery
BAU GPIT 3	LG Notes Digitisation	LG Notes Digitisation	940.0	940.0	0.0	No submission as yet, but no concerns over delivery
BAU Estate 1	Brundall	Expansion of Existing Primary Care Facility	101.0	101.0	0.0	Fully approved. Legals including Grant Agreement required prior to delivery
BAU Estate 2	Lighthouse	Expansion of Existing Primary Care Facility	76.0	76.0	0.0	Fully approved. Legals including Grant Agreement required prior to delivery
BAU Estate 3	Embrace	Expansion of Existing Primary Care Facility	80.0	80.0	0.0	In delivery - on track to complete this FY
BAU Estate 4	Hingham	Expansion of Existing Primary Care Facility	379.0	285.0	94.0	Currently at the grant agreement & legals stage
Strategic 1	SPCC - East Harling & Kenning Hall. Extension.	Expansion of Existing Primary Care Facility	500.0	500.0	0.0	Tendering / Procurement underway. Early drawdown of fees requested by practice. POW draft shared with all parties. Legals / grant agreement to follow
Strategic 2	SPCC - Aylsham Extension	Expansion of Existing Primary Care Facility	850.0	850.0	0.0	Initial Quotes received via PID were overbudget - revised submission requested from the practice
Strategic 3	SPCC - Acle Extension	Expansion of Existing Primary Care Facility	850.0	850.0	0.0	Initial Quotes received via QS higher than initially planned. Revised submission received and under review
Strategic 4	Refurbishment and rent/purchase of the Inkerman Public House located next to the existing Norwich Road building for Cardinal Medical Practice	Expansion of Existing Primary Care Facility	3,600.0	2,750.0	850.0	In delivery - however, the consultant involved with the scheme has gone into administration. No additional cost is yet factored into the forecast, but this could be as much as £0.5m. This will likely delay the project as the new provider will look to review the original designs. The estates team are in frequent dialogue with all parties and requesting revised timelines & querying any additional process that is required internally and with NHSE
Strategic 8	Additional future capacity requirements	Expansion of Existing Primary Care Facility	60.0	0.0	60.0	Further scheme to be developed
UMF 1	Magdalen - UMF. Refurbishment.	Refurbishment of Existing Primary Care Facility	336.0	336.0	0.0	In progress - no concerns over delivery
UMF 2	Lawson Road - UMF. Refurbishment.	Expansion of Existing Primary Care Facility	482.0	360.0	122.0	Legals currently with NHSE for approval - no real concerns over delivery providing NHSE undertake assessment in good time
UMF 5	Derby Road extension and internal alterations	Expansion of Existing Primary Care Facility	100.0	0.0	100.0	Practice withdrawn. Capital reallocated to Barrack Lane.
UMF 6	Barrack Lane Surgery extension and internal alterations	Expansion of Existing Primary Care Facility	382.0	663.0	(281.0)	Increased capital allocated from slippage
UMF 7	Wickham Market extension and internal alterations	Expansion of Existing Primary Care Facility	200.0	45.0	155.0	CIL bid to fund residual – recommended for approval. Residual capital reallocated to Barrack Lane
		TOTAL CAPITAL EXPENDITURE	**11,026.0**	**9,926.0**	**1,100.0**	

				M04 Position	Variance M05 v M04
Business As Usual	3,666.0	3,572.0	94.0	174.0	80.0
Strategic Capital	5,860.0	4,950.0	910.0	670.0	(240.0)
Utilisation & Modernisation Funding	1,500.0	1,404.0	96.0	28.6	(67.4)
IN YEAR SURPLUS/ (DEFICIT)	**11,026.0**	**9,926.0**	**1,100.0**	**872.6**	**(227.4)**

Working Capital and Cash Management

Cash Flow Forecast / Drawdown Rates
The ICB is awarded an annual Cash Drawdown Requirement (CDR) based on Revenue allocations the ICB receives adjusted for non-cash items such as Depreciation. Whilst the CDR can be subject to in-year changes, it should not be breached without prior approval to align to the national levels of cash requirements set by the Department of Health; the **ICBs current forecast 2026/27 CDR is £5.00 billion**.

As of 31 August 2026, the ICB has under drawn cash against it's CDR on a straight-line year-to-date basis, with a forecast to bring this back in line with total CDR for 2026/27.

The ICB held high levels of cash for the early months. This cash was drawn to cover expected costs of in the first four months; however, the restructure and ISFE2 system migration issues have caused delays in invoice processing activity. At month 5, we are back in line with CDR, as we now have a better understanding of the ICB's forecast spending patterns.

NHS NORFOLK & SUFFOLK ICB Cash Expended vs CDR Limit	Actual Apr-26 £000s	Actual May-26 £000s	Actual Jun-26 £000s	Actual Jul-26 £000s	Actual Aug-26 £000s	Forecast Sep-26 £000s	Forecast Oct-26 £000s	Forecast Nov-26 £000s	Forecast Dec-26 £000s	Forecast Jan-27 £000s	Forecast Feb-27 £000s	Forecast Mar-27 £000s
CDR to date based on equal monthly allocation	412,176	820,638	1,241,138	1,657,806	2,084,283	2,501,140	2,917,997	3,334,854	3,751,710	4,168,567	4,585,424	5,002,280
Drawdown/Cash expended on ICB's behalf to date	443,227	888,102	1,256,577	1,680,077	2,071,929	2,497,759	2,930,149	3,337,575	3,759,901	4,173,628	4,579,254	5,002,280
ICB (over)/under draw position (Cummulative)	(31,051)	(67,464)	(15,439)	(22,272)	12,355	3,381	(12,152)	(2,722)	(8,191)	(5,061)	6,170	0
ICB (over)/under draw position (Monthly)	(31,051)	(36,413)	52,025	(6,833)	34,626	(8,973)	(15,533)	9,430	(5,470)	3,130	11,230	(6,170)
Percentage of CDR utilised (CFF - Actual/Forecast)	9.0%	18.0%	25.3%	33.8%	41.4%	49.9%	58.6%	66.7%	75.2%	83.4%	91.5%	100.0%
Percentage of months completed (CFF - Plan)	8.3%	16.7%	25.0%	33.3%	41.7%	50.0%	58.3%	66.7%	75.0%	83.3%	91.7%	100.0%
Bank Balance at the end of the month	50,665	74,374	40,389	21,273	5,986	0	0	0	0	0	0	0

Debtors
The M05 total trade debtors balance (graph 1) includes 95 invoices; the high value organisations include £493k with Norfolk County Council (17 invoices), £452k with Norfolk & Norwich University Hospitals (4 invoices) and £58k with Norfolk & Suffolk FT (7 invoices).

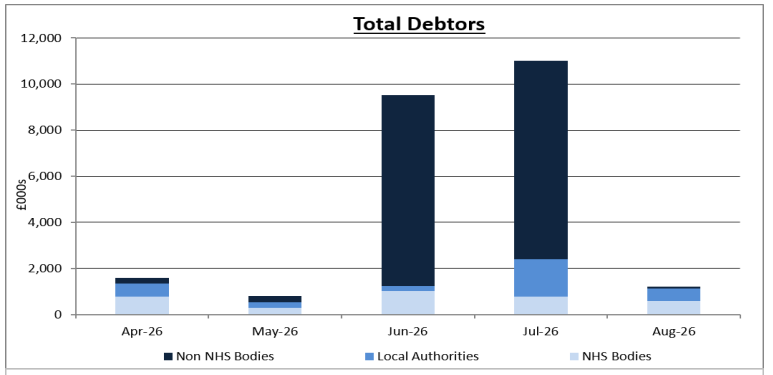
The M05 trade debt aging (graph 2) shows 34 invoices overdue 90+ days, a decrease of 6 invoices against M04. The overdue debt principally remains with Local Authorities, NHS Bodies and staff debt for which the ICB is continuing to seek full recovery of but does provide for the chance of risk of non-receipt. The debt over 90 days has decreased July to August by £57k.

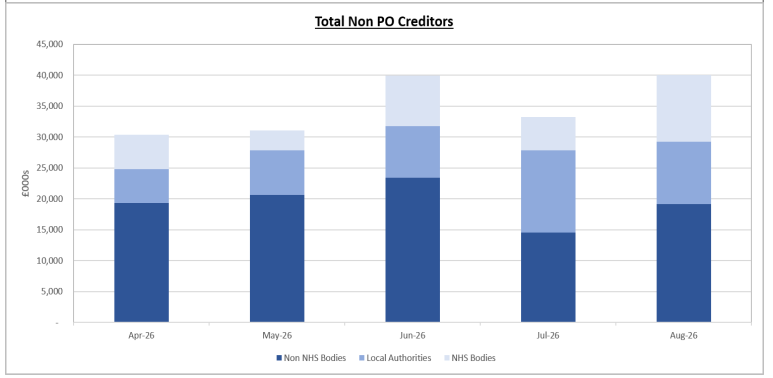
The total debt has reduced July to August by £9.8m, a major factor in this reduction was payment in August of the £8.2m with East Coast Community Healthcare CIC invoice.

Non-PO Creditors
At the end of M05, there are 4,548 unapproved invoices in the system (graph 1), of which 3,386 invoices are of a value below £5k. Total invoices comprise: £19.1m relating to Non-NHS Bodies (2,632 invoices), £10.1m relating to Local Authorities (1,688 invoices) and £10.7m relating to NHS Bodies (228 invoices). This compares with circa 2,500 at year-end against Suffolk & North East / Norfolk & Waveney combined.

The aging profile (graph 2) indicates 2,685 invoices are outside of payments terms based on the invoice date. At this point in time, we have managed to stabilise and maintain the level of outstanding invoices on a week-by-week basis, but to achieve this, it has resulted in an increase in manual payments to meet payment terms and sustain good relationships with suppliers. The total number of manual payments to the end of August is 197.

The overall elevated level of unapproved invoices primarily reflects processing delays by SBS associated with the ICB system migration and the impact of the restructure. We are working closely with SBS to accelerate approval of valid invoices and reduce outstanding balances. This includes moving to system payment schedules and considering decreasing the billing frequency where possible (e.g. weekly to monthly) to bring invoice volumes and administrative burden down. The ICB has agreed with NCC to move to a payment on a/c arrangement with a quarterly reconciliation process from 1st October, this is expected to reduce the invoice volume by circa 700 invoices per month.





Statement of Financial Position (SoFP)

Statement of Financial Position

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31 August 2026.

The opening SoFP position at 1 April 2026 reflects the transfer by absorption following the merger of NHS Suffolk and North East Essex ICB and NHS Norfolk and Waveney ICB. These balances have been reconciled to the respective legacy organisations' closing ledger positions. Work continues with the support of NHS SBS to fully reconcile the in-year position following the transfer.

Non-Current assets
The non-current assets balance includes the right-of-use assets relating to leased premises at Endeavour House, King's Lynn and Norfolk County Council, following implementation of IFRS16 in April 2022. Corresponding lease liabilities are recognised within both current and non-current liabilities.

Current assets
Total current assets have increased by £7m since March 2026 (£28m decrease against July 2026), principally driven by an increase in prepayments and cash balances, arising from delays in invoice payment processing as explained on the previous slide.

The trade and other receivables balance of £29m comprises: Trade debtors of £1m, prepayments & accrued income of £17m, dental under-delivery balances of £13m and a bad debt provision of £2m against aged debtors and dental under-delivery balances. The movement can be explained primarily through timing of the collection of debts as well as higher prepayments during the year as apposed to year end.

Trade debtors are subject to a quarterly review to assess the requirement for bad debt provisions or write-offs, with the outcomes reported to the Audit Committee.

Current liabilities
Total current liabilities have increased by £39m since March 2026 (£36m increase against July 2026), primarily due to the timing of ICB and system invoice accruals.

The trade and other payables balance of £350m comprises: Trade creditors of £5m, Prescription Pricing Authority and dental accruals of £37m, payroll and GP pensions liabilities of £5m, deferred income of £2m, and ICB and system invoice accruals of £301m.

Provisions
A further analysis of provisions is included on the next slide.

Long Term liabilities
The non-current lease liabilities relate to right-of-use liabilities associated with leased premises at Endeavour House, King's Lynn, and Norfolk County Council, recognised following the implementation of IFRS 16 in April 2022.

General Fund
The ICB is funded directly by NHS England through monthly cash allocations. Any short-term General Fund deficit is supported through subsequent monthly cash drawdowns from NHS England. Consequently, the General Fund balance is expected to remain in a deficit position, reflecting NHS England's funding principle that cash should only be drawn to meet forecast expenditure requirements for the forthcoming month.

NHS NORFOLK & SUFFOLK ICB STATEMENT OF FINANCIAL POSITION (SoFP)	Position as at 31/03/26	Position as at 31/07/26	Position as at 31/08/26
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	402	312	290
Total non-current assets	402	312	290
Current assets			
Trade and Other Receivables	23,293	43,551	28,790
Cash and Cash Equivalents	3,650	18,632	4,861
Total current assets	26,943	62,183	33,651
Current liabilities			
Trade and Other Payables	(311,307)	(314,727)	(350,684)
Lease Liabilities	(305)	(271)	(231)
Provisions	(39,244)	(38,259)	(38,574)
Total current liabilities	(350,856)	(353,257)	(389,489)
Long Term liabilities			
Non-Current Lease Liabilities	(120)	(43)	(25)
Provisions	(4,432)	(4,432)	(4,432)
Total non-current liabilities	(4,552)	(4,475)	(4,457)
Net assets employed	(328,063)	(295,237)	(360,005)
FINANCED BY TAXPAYERS EQUITY			
General fund	(328,063)	(295,237)	(360,005)
Total taxpayers equity	(328,063)	(295,237)	(360,005)

Provisions, Accruals & BPPC

Provisions
Provisions are held in respect of legal claims, restructuring costs, estate-related liabilities, Continuing Healthcare (CHC) reimbursement claims, onerous contracts and dental clawback arrangements. During the year, these provisions have been partially utilised as the related expenditure has been incurred. Now we are approaching the tail end of the restructuring process we expect to see an increase in the utilisation of staff exit packages as the staff of left early in the year via voluntary redundancy were accrued given the certainty of their departure.

Provisions movements remain low during the year, this is primary related to the completion of the opening balances work, provisions continues to be reviewed monthly.

NHS NORFOLK & SUFFOLK ICB - PROVISIONS	Restructuring £'000	Legal Claims £'000	Continuing Care £'000	Other* £'000	Total £'000
Balance at 01 April 2026 (Transfer by absorption)	**(6,857)**	**(5,627)**	**(8,810)**	**(22,382)**	**(43,676)**
Utilised during the year	278	52	147	193	670
Balance at 31 August 2026	**(6,579)**	**(5,575)**	**(8,663)**	**(22,189)**	**(43,006)**
Expected timing of cash flows:					
Within one year	(6,579)	(5,575)	(8,663)	(17,757)	(38,574)
Between one and five years	-	-	-	(3,237)	(3,237)
After five years	-	-	-	(1,195)	(1,195)
Balance at 31 August 2026	**(6,579)**	**(5,575)**	**(8,663)**	**(22,189)**	**(43,006)**

* Other Provisions include Dental under-performance, estate related liabilitis and onerous contracts.

Accruals-to-expenditure
Accruals have been analysed as a percentage of total expenditure for each team to assess the relative level of outstanding costs recorded at month-end and to support consistency in forecasting and financial reporting.

Reserves have been excluded from this analysis on the basis that there is no budget.

Areas with a higher % of accruals correlate with those areas of high volumes of invoices, with the majority of acute & community expenditure being recognised via the invoice payment file method of payment hence the lower %. A lower % of accrual recognition should result in a lower level of audit field work scrutiny in an area which will be flagged as containing a higher level of audit risk.

NHS NORFOLK & SUFFOLK ICB % Accruals to Expenditure by Category	Expenditure £'000	Accruals £'000	% Accruals to Expenditure by Category
Acute	958,955	39,855	4.16%
Continuing Care	105,965	28,031	26.45%
Community	175,968	14,200	8.07%
Corporate	10,447	5,402	51.71%
Mental Health	195,129	38,297	19.63%
Other Commissioned Services	10,079	954	9.46%
Primary Care	427,214	86,733	20.30%
Spec Comm	193,693	41,485	21.42%
Total	**2,077,450**	**254,956**	12.27%

Better Payment Practice Code
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%.

At the time of reporting this information is currently unavailable in ISFE2. This issue continues to be raised with SBS/NHSE on a regular basis and is listed on the global issues report.

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 17.
Date: 23 September 2026

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

a) Quality Committee
b) Strategic Commissioning Committee
c) Norfolk and Waveney Primary Care and Neighbourhood Committee
d) Suffolk Primary Care and Neighbourhood Committee
e) Remuneration Committee
f) Finance, Performance, and Workforce Committee

Recommendation: To note.

Quality COMMITTEE

Date: 06 August 2026

Chair: Elaine Noske, Non-Executive Member

Item Status	Update
Assure	**Norfolk and Suffolk's Safeguarding Children's Policy:** The committee approved the merged and updated policy. **Research and Innovation update:** an update was provided to committee on the ICB's statutory duty to facilitate or promote the use of evidence obtained from research. The previous evidence and evaluation team has moved to the Strategic Commissioning Directorate and is now smaller, with a current focus on evaluation support. The Research and Innovation Team receives external Applied Research Collaborative funding to support evidence use within the ICB. Four evidence briefs have been completed since April, covering; 'See the Signs' as a cancer support tool in primary care, local enhanced services in primary care, fracture liaison services and BMI thresholds for hip and knee replacement referrals. A further brief on outcomes-based commissioning is in development.
Advise	**Quality Dashboard/Regional Scorecard:** The committee noted Care Quality Commission ratings (CQC), Summary Hospital -level Mortality Indicator (SHMI), corridor care reporting, births and regional and national outcome framework metrics. The dashboard highlighted significant concerns for some providers, including QEHKL and JPUH in national outcome framework rankings, and EEAST. Patient safety event data did not show a significant increase in fatal or significant incidents compared with previous months. A detailed summary of healthcare associated infection data was shared. A deep dive of QEHKL and JPUH was agreed to be brought to September committee. **Quality Oversight Meeting Escalation Paper:** The committee noted key escalations from the meeting relating to Histopathology, diagnostic recovery and the outcome ESNEFT's rapid quality review, and EEAST's ongoing culture and sexual safety work. **Outcomes and experience of annual health checks for people with learning disabilities:** The committee received a presentation on annual health checks for people with learning disabilities and noted that annual health checks are a key mechanism for identifying unmet health needs and reducing health inequalities. Experience remained inconsistent, particularly around reasonable adjustments and implementation/sharing of health action plans. Key points included the need to improve delivery and receipt of health action plans, use peer educators to raise awareness, focus on those aged 14 years and above, explore GP friendly kite mark rollout and maintain targeted support for practices. Future metrics would include 82% annual health check delivery, 100% health action plan delivery for those receiving checks, vaccination uptake and screening uptake. The future approach would use population health data to identify hotspots and target practices requiring support. Oliver McGowan mandatory training uptake remained strong in Norfolk and had historically been low in Suffolk, although 16 Suffolk practices were now receiving or booking training. GP practice engagement was discussed and whether learning could be replicated. It was emphasised that involving people with learning disabilities and peer educators is central to effective engagement. There is a proposal to embed inclusion of annual health check, health action plan, vaccination and screening metrics in the GP Quality Assurance Framework. Deadline: developing framework / from April 2027 full model.

Item Status	Update
	Update on the Children, Young People Neurodevelopmental (CYPND) pathway: The committee received an all-age update on the CYPND pathway, noting that new ICB arrangements had moved to an all-age ND Clinical Oversight Group covering attention deficit hyperactivity disorder (ADHD) and autism assessment, Right to Choose and NHS provider oversight. Initial work had focused on housekeeping, budgets, forecasts and Individual Accreditation Process discussions with Right to Choose providers. A communications plan is being developed to improve information for families, young people, patients and professionals, including website FAQs and updated professional content. Complaints, FOIs and quality concerns had increased, mainly relating to NHS pathway waiting times and Right to Choose issues such as access to titration medication following assessment. The ICB was triangulating this intelligence to identify quality themes and provider-specific risks. A Norfolk and Suffolk quality assured/accredited provider framework was being developed, with specifications ready. The NHS one-provider selection exercise was underway, with a planned go-live of April 2027. Emergency shared care commissioning arrangements would be recommissioned for 2026/27. Data limitations were noted, but this was being refreshed. The Committee noted the need for a regular assured dataset showing the patient journey, all waits and waits after assessment for ADHD treatment. NHSE 52-week-plus waiting list initiative funding had delivered additional assessments, but further work was needed to understand the impact on subsequent treatment waits. It was outlined the ambition to recover NHS pathways to an 18-week referral-to-treatment timeframe, with principles including early support, consideration of vulnerability factors, pre- and post-diagnostic support, family experience, a clear dataset and a local oversight group involving parent carer voice and providers. SEND reforms, including the Experts at Hand model and team around the school approach, were noted as potential opportunities for earlier support. **NHS Continuing Healthcare (CHC) and Neuro Rehab Update inc. update on current position of 28-day standard:** A presentation was received by committee NHS Continuing Healthcare and Neuro Rehab update. The ICB was achieving 43% against the NHS England quality premium target to assess 80% of people within 28 days of referral. The shortfall was mainly due to clinical workforce vacancies. Senior nurse triage was in place to prioritise urgent referrals and mitigate clinical risk. The issue is recorded on the corporate issue register, with a related risk on slow recovery. Recruitment was ongoing, including targeted recruitment for mental health nurses and Norfolk-based assessors. Operational alignment across Norfolk and Suffolk is progressing, with case management teams expected to operate as one team from 1st September 2026. A small Artificial Intelligence (AI) pilot for CHC assessments had been successful, saving report-writing time and attracting positive feedback from participating nurses, with no complaints from families or patients. A business case is being developed to expand the pilot into appeals and retrospective assessments. A plan to address the Norfolk backlog of more than 100 appeals and more than 100 retrospective assessments is being developed for the next Clinical Oversight Group. The Committee discussed quality impact where assessment standards are not met. The Committee noted decisions to move away from underutilised block contracts.

Guidance

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Quality COMMITTEE

Date: 03 September 2026

Chair: Elaine Noske, Non-Executive Member

Item Status	Update
Advise	**Learning from deaths - suicides:** The Committee was advised that seven suicides have been reported during 2026. These cases will be considered through the Learning from Deaths Group to support systematic review, thematic learning and coordinated improvement. A further report will return to the Quality Committee so that it can assess the learning, actions and assurance required. **Research into women's health:** The Committee received an update on research addressing women's health issues by Knowing Works (prev. Healthwatch Suffolk). Members welcomed and applauded this important work, recognising its potential to strengthen the evidence base and improve women's experiences and outcomes. The Committee asked that learning and opportunities for wider system application continue to be shared.
Alert	**NHS provider staff surveys:** The 2025 staff survey results were highlighted as leading indicators of quality, safety and culture and provided only partial assurance overall. Particular concern remains where poor staff experience converges with operational and regulatory pressures: QEHKL, JPUH and EEAST require targeted oversight. QEHKL was identified as the provider of greatest immediate concern; focused assurance is also required from EEAST on the Norfolk and Waveney workforce culture. The Committee supported routine triangulation with patient experience, incidents, complaints, safe staffing, Freedom to Speak Up and NHS Oversight Framework intelligence. **Learning from deaths:** The Committee noted continuing gaps and pressures within mortality and learning-from-deaths arrangements, including workforce capacity, variable quality of GP referrals for Medical Certificates of Cause of Death, complex community deaths, and inconsistent advance care planning and communication. Provider deep dives, mortality reviews and coroner updates will continue. The Committee requires clearer thematic learning, evidence of completed improvement actions and assurance that lessons are shared across the system. **Acute provider deep dive - QEHKL and JPUH:** The deep dive identified continuing fragility and only partial assurance across both acute providers. QEHKL remains the most immediate concern, with a Requires Improvement CQC profile, a national performance ranking of 133/134, four Section 29A warning notices following the April 2026 inspection, a Royal College of Surgeons review, paused undergraduate medical student placements, and continued challenge in services including paediatric audiology, colposcopy and histopathology. JPUH is also in NHS Oversight Framework segment 4 (ranked 131/134), with material access, elective recovery, mortality, maternity and workforce-culture pressures. The Committee supported sharing the deep dive with the Finance, Performance and Workforce Committees to strengthen triangulated oversight and maintain close surveillance of service sustainability and patient risk.

Item Status	Update
Assure	**Norfolk and Suffolk Health and Care Research Leadership Group:** The Committee approved the refreshed system-wide research coordination proposal for onward ratification by the ICB Board. Members welcomed the strong interest from external partners and the breadth of prospective participation across health and care providers, universities, public health, primary care, NIHR infrastructure and other research partners. The group will improve alignment, visibility and collaboration, coordinate funding and research opportunities, and help the ICB meet its statutory duty to promote and facilitate research without duplicating existing governance. **Subject matter expert highlight reports:** The Committee approved the inclusion of two or three subject matter expert highlight reports at each meeting from October 2026 as an adjunct to the Quality Dashboard. The concise, narrative-led reports will explain what the data mean for patients and staff, triangulate metrics with patient and staff feedback, complaints and incidents, and identify improvement, residual risk and any need for escalation. A forward planner will support preparation while retaining flexibility to respond to emerging concerns.

Guidance

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Strategic Commissioning Committee

Date: 8 September 2026

Chair: Phanuel Mutumburi

Item Status	Update
Assure	**Unscheduled Care Co-ordination Hub (UCCH) development and overnight provision** The Committee approved recurrent funding for four complementary proposals including an Overnight Clinical Assessment Service, expansion of the Urgent Community Response triage, increasing capacity within the Conveyance Avoidance helpline, and enhanced overnight UCCH clinical provision.
Assure	**Cardiovascular Disease (CVD) Prevention and Optimisation Programme** The Committee considered the options for investment in a CVD programme which would deliver the national direction which is described in the CVD Modern Service Framework. The Committee supported the proposed options and expected the final business case to come forward in October.
Assure	**Norfolk and Waveney Dementia Support Service** The Committee approved a recurrent investment in a community based dementia support service to cover patients across Norfolk and Waveney.
Assure	**Vasectomy Business Case** The Committee approved the procurement of community vasectomy services across the ICB area with five contracts aligned to each ICB area.

Guidance

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

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Norfolk and Waveney Primary Care and Neighbourhood Committee

Date: 9 September 2026

Chair: Elaine Noske

Item Status	Update
Assure	**Active NoW Proposition Mandate** The Committee endorsed the Active NoW Proposition Mandate, including a proposed 12-month funding extension. The programme provides a secondary prevention pathway for people with long-term conditions and is currently supporting around 420 referrals per month, with positive outcomes in supporting people to become and remain physically active. The Committee supported a wider review across Norfolk and Suffolk to develop a more consistent and sustainable approach, with further work requested on outcomes, value for money and alignment with Public Health, place and neighbourhood priorities.
Assure	**Urgent Community Response (UCR) Proposition Mandate** The Committee endorsed the proposition mandate to progress the development of a business case for investment in Urgent Community Response (UCR) across Norfolk and Waveney. The investment aims to address existing inequalities in service capacity and capability, increase capacity to meet unmet demand, and strengthen the community response to reduce avoidable hospital attendances, particularly for older people and those living with frailty. A £3.8m funding allocation is available, with the business case to be developed further and brought back to the Committee for approval.
Assure	**Central Norfolk CTF Spend Mandates** The Committee endorsed progression of two Community Transformation Fund mandates to the next stage. These included an 18-month test-and-learn programme for proactive care management for people with complex and rising health needs, building on existing services and integrated neighbourhood teams to improve coordination, outcomes and independence. The Committee also supported progressing the capsule sponge initiative to explore earlier detection of oesophageal cancer, with further work required on evaluation, recurrent funding and alignment with the wider cancer pathway.
Advise	**The process and progress in the development of the Community Services Strategic Plan and Recommissioning Process** The Committee received an update on the Community Services Strategic Plan and recommissioning programme, including the proposed extension of existing contracts to April 2029. The Committee noted the opportunity to use this period to develop a strategic approach to community services and reduce unwarranted variation. Further engagement and service planning will inform the draft strategic plan and subsequent procurement decisions.
Advise	**Performance Dashboard** The Committee received a verbal update on Norfolk and Waveney performance, noting that a holistic performance dashboard aligned to the

	Committee's remit is being developed. Performance at East Coast Community Healthcare remains positive, while data validation and reporting following the East of England Community Health and Care merger remain in progress. Long waits for wheelchairs were highlighted as an area requiring continued focus.
Assure	**Research and Innovation in Primary Care and Community Services** The Committee received an update on the ICB's support for research in primary care across Norfolk and Suffolk, including research governance, delivery and workforce development. The Committee welcomed the developing infrastructure and opportunities to increase participation in research, particularly in underserved communities and through commercial research.

Guidance

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Suffolk Primary Care and Neighbourhood Committee

Date: 9 September 2026

Chair: Elaine Noske

Item Status	Update
Advise	**Expansion of Rapid Emergency Assessment and Community Team (REACT) Business Case** The Committee approved the proposal to expand the REACT Urgent Community Response service across Ipswich and East Suffolk to meet growing demand safely, subject to a Chair's Action to further review the return on investment and agree the financial arrangements.
Advise	**The process and progress in the development of the Community Services Strategic Plan and Recommissioning Process** The Committee received an update on the Community Services Strategic Plan and recommissioning programme, including the proposed extension of existing contracts to April 2029. The Committee noted the opportunity to use this period to develop a strategic approach to community services and reduce unwarranted variation. Further engagement and service planning will inform the draft strategic plan and subsequent procurement decisions.
Advise	**Performance Dashboard** The Committee received a verbal update on Suffolk performance, noting that a holistic performance dashboard aligned to the Committee's remit is being developed. Partial assurance was provided on community services across East and West Suffolk, with performance and demand broadly stable, while areas of focus include children's wheelchair services, the Care Co-ordination Centre, bowel and bladder services, staffing and data availability following the transition to Epic.
Assure	**Research and Innovation in Primary Care and Community Services** The Committee received an update on the ICB's support for research in primary care across Norfolk and Suffolk, including research governance, delivery and workforce development. The Committee welcomed the developing infrastructure and opportunities to increase participation in research, particularly in underserved communities and through commercial research.

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Remuneration COMMITTEE

Date: 8 September 2026

Chair: Janet Wood

Item Status	Update
Assure	**Organisational Change Programme Update** The Committee received an update on final steps of the HR aspect of the ICB reorganisation. The Committee requested that officers produce a report for a future Board meeting providing a full overview of the impact on ICB staff of the reorganisation including the representation of different groups has changed and the sickness absence rate.
Assure	**Employment Rights Act 2025 (Employment Rights Bill) – Implications for Norfolk and Suffolk ICB** The Committee received an overview of the new Employment Rights Bill and the impacts this would have on the ICB's staffing arrangements and those of the providers the ICB commissions. The Committee suggested that it would be useful for the Board to receive a similar update at a future development session.
Assure	**Workforce Metrics Report** The Committee received a dashboard developed by the HR Team which set out metrics relating to the ICB's staff including vacancy rate and sickness absence. The Committee referred the dashboard to the Finance, Performance, and Workforce Committee to be incorporated into the performance metrics reported at that meeting.
Assure	**Staffing and Employment Matters** The Committee considered a number of items relating to the employment of individuals. The Committee was satisfied that the ICB was acting inline with its policies, contractual terms and conditions, and wider NHS England policies.

Guidance

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Finance, Performance & Workforce Committee

Date: 23rd July 2026 and 20th August 2026

Chair: Janet Woods, Non-Executive Member

Item Status	
Alerts	**23/7/26** **Finance** National position on short term price increases linked to supply chain issues. **Performance** Several indicators including RTT, Cancer, Primary Care are being reported as 'consistently failing' in the performance reports. **20/8/26** **Prescribing costs** National price concessions are giving rise to overspends which are currently estimated at £7m for the year. **Finance** National position on short term price increases linked to supply chain issues. **Performance** Removal of medical undergraduate placements from QEHKL – the committee were updated on this issue – noting that NHSE is working closely with the Trust to resolve this. Overall acute sector provider pressures materialising across both finances and performance. Several indicators including RTT, Cancer, Primary Care are being reported as 'consistently failing' in the performance reports.
Advise	**23/7/26** **System pressures** The committee was advised that system partners are financially overspending, over workforce establishment and underperforming on many performance metrics, The committee asked for this to be triangulated for future meetings identifying what providers are doing, what the ICB is doing and how the ICB can help further, within our newly defined system remit. **Performance metrics** The committee noted that many of the metric had been static (or improving slowly) for some length of time. It was agreed to deep dive further into these metrics at future meetings, focusing on what providers are doing, what the ICB is doing and how the ICB can help further. Colleagues also shared plans for the format of future committee reporting which should add to assurance levels**.** Future performance reports to committee should

	focus on highlighting the key areas of risk and narrative that sets out what corrective actions are being taken. **20/8/26** **System pressures** System partners continue to overspend against approved plans, be over workforce establishment and underperforming on many performance metrics. The committee continues to be informed on actions the ICB are taking and the support to providers as require d under our current system remit and contractual arrangements. **Performance metrics** The committee noted that many of the metric had been static (or improving slowly) for some length of time. It was agreed to deep dive further into these metrics at future meetings, focusing on what providers are doing, what the ICB is doing and how the ICB can help further. Future performance reports should give assurance that the problems are understood, actions identified and in train, and the impact of these actions.
Assure	**23/7/26** **Planned Care** The committee had a deep dive into the PA consulting report and what the ICB is doing as a strategic commissioner to deliver – this included system infrastructure in relating to outpatients, gynaecology and ENT. The committee were assured that this work would include system partners, clinicians and input from VCSFE and co-production. The plan is to have recommendations for approval in the autumn. **Finance** The committee were assured that finances are currently being managed. This is not without risk and these are to be further reviewed over the next few weeks. The committee reviewed capital plans, spend and the status of the left shift and other investments. The TAG/IMOC terms of reference were approved – there will be reporting to both Quality and FPW committees. **20/8/26** **Planned Care** The committee had a deep dive into the Mental Health this month. Plans to deliver the agreed strategy were shared and there was a deeper dived into performance metrics. The Committee noted good progress but there are still some areas for improvement. The Committee noted the good relationship the ICB has with NSFT but noted that there is room for improvement in local authority relationships. **Finance** The committee were assured that finances are currently being managed. This is not without risk and these are to be further reviewed over the next few weeks. The committee reviewed capital plans, spend and the status of the left shift and other investments. The underlying financial position was also reviewed – early indications that the underlying position has improved but is still showing an underlying deficit. The progress the ICB has made in concluding its restructure and some left shift investment slippage has meant that £20m is to be released to support improved

	waiting list reductions – plans on how this is to be deployed are being developed.

Guidance

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Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 18
Date: 23 September 2026

Title: Amendment to the Scheme of Reservations and Delegations

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

Author: Tom McColgan, Corporate Governance Manager

Purpose: Approve

Recommendation: That the Board approves an amendment to the Scheme of Reservations and Delegations to delegate financial approval limit of £500,000 to the Strategic Commissioning Delivery Group.

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1. Background

1.1. The Scheme of Reservation and Delegation (SoRD) is published as part of the ICB's Governance Handbook. The SoRD sets out financial approval level for Committees, Groups, and Individuals.

2. Key Issues and risks

2.1. The Strategic Commissioning Delivery Group (SCDG) is accountable to the Strategic Commissioning Committee. The SCDG provides robust check and challenge to proposition mandates and business cases prior to them coming forward for approval.

2.2. It is proposed that the SCDG be delegated an approval limit of £500,000 to allow it to approve business cases with a total expenditure of £500,000. Currently SCDG has no authority to approve expenditure. This means that all business cases but go to Strategic Commissioning Committee. A limited delegation to SCDG would allow for Committee adequate time to fully consider more substantial expenditure items while ensuring that there was no delay in approval for smaller business cases.

Norfolk and Suffolk
Integrated Care Board

NHS Norfolk and Suffolk Integrated Care Board Meeting

Agenda Item number: 19
Date: 23 September 2026

Title: Risk Management and Board Assurance Framework

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

Author: Tom McColgan, Corporate Governance Manager and Agnes Earl, Corporate Governance and Risk Management Officer

Purpose: Information

Recommendation:

The Board is asked to note and support the strategic direction of risk management and the progress being made in strengthening the organisation's risk management framework, specifically:

- Progress in embedding the organisation's risk management framework through the continued development of the Corporate Risk Register and Risk and Resilience Group.
- The agreed approach to the development of the Board Assurance Framework by aligning strategic risks to organisational objectives, with further work being undertaken to finalise the objectives against which risks will be aligned.

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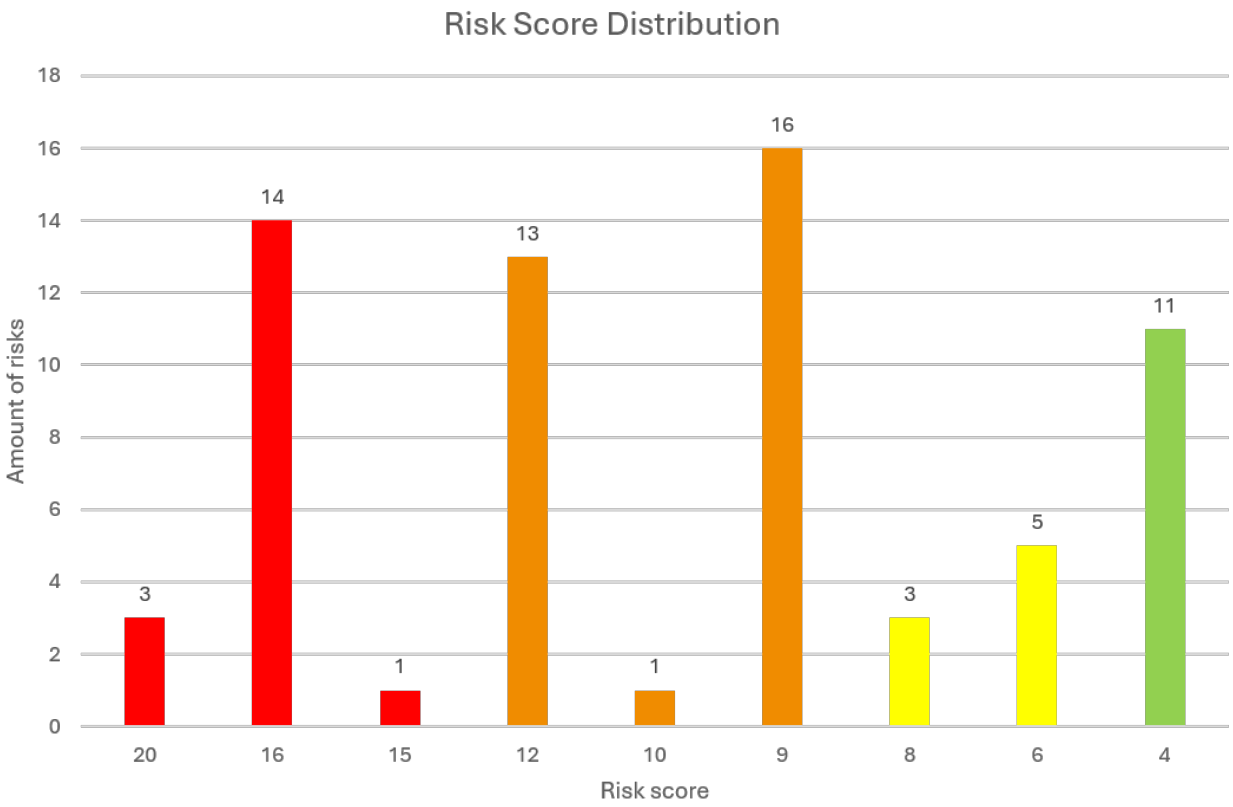
1. Background

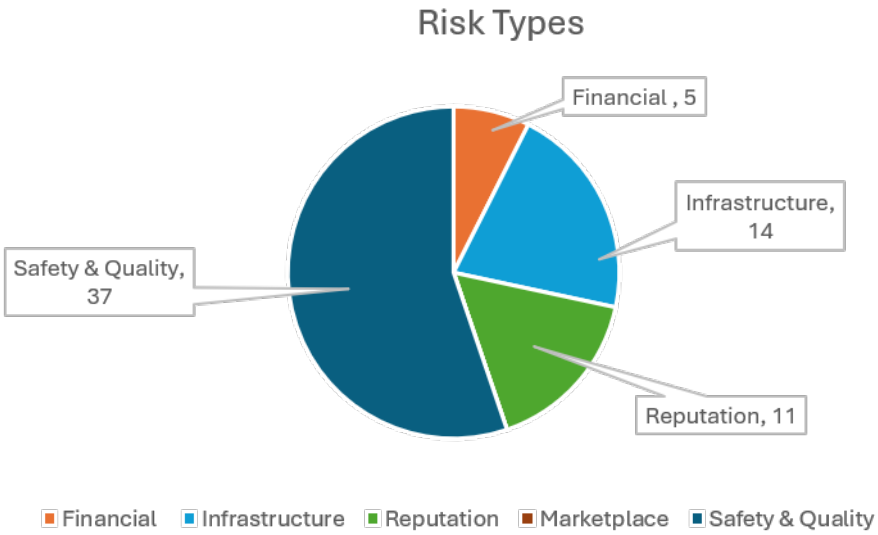
1.1. Since 1 April 2026 Norfolk and Suffolk have implemented a new approach to risk management, introducing a centralised Corporate Risk Register (CRR) to hold all organisational risks.

1.2. Officers continue to look ahead and identify new and emerging risks for inclusion on the Corporate Risk Register (CRR). Risks are being added as they are identified, ensuring that the register remains current and reflects the evolving risk landscape across the organisation. Existing risks are also reviewed periodically to ensure they remain relevant and are scored appropriately within the context of the organisation.

1.3. A total of 67 risks are live on the CRR. Of these, 31 score 12 and above, the scoring is broken down into the following scores:



1.4. The distribution of the 67 open risks by risk type is shown in the pie chart below.



2. Key Issues and risks

Risk and Resilience Group

2.1. The Risk and The Risk and Resilience Group (RRG), established in May 2026, continues to support the development of the organisation's risk management framework. Meeting monthly and with membership from all directorates, the group provides a forum for the review and discussion of organisational risks, helping to

identify interdependencies and areas requiring further oversight. Through its monthly spotlight sessions, RRG has also promoted greater organisational understanding of risks and encouraged cross-directorate collaboration.

2.2. Since May the group has approved 36 new risks for inclusion on the Corporate Risk Register, including 10 risks with a mitigated score of 12 or above, ensuring that significant strategic and operational risks are identified, reviewed and escalated through the appropriate governance arrangements. In addition, a monthly organisational risk profile report is presented to the group, providing oversight of risk trends, scoring and mitigation effectiveness to support informed decision-making and assurance.

3. Operational Risks

3.1. Listed below are the organisation's new risks and the operational risks scoring 12 and above.

3.2. These risks continue to be considered at Committee level as the Risk Register continues to develop. This process is to ensure that risks are appropriately aligned to the relevant Committees and accurately reflect the organisation's risk profile.

3.3. These risks provide an important foundation for identifying and informing future strategic risks, highlighting areas of significant exposure requiring organisational oversight. Once developed, these operational risks will be linked to the Board Assurance Framework (BAF) risks.

New Risks (since 15 July 2026) scoring 12 and above

Risk Title	Responsible Executive Director	Mitigated Score
Ongoing provision of respite care in Norfolk	Lisa Nobes	12
General Practice Estate Capacity	Mark Burgis & Maddie Baker-Woods	16
Estates and Neighbourhood Strategic Alignment	Mark Burgis & Maddie Baker-Woods	16
Existing General Practice Infrastructure Overheating	Mark Burgis & Maddie Baker-Woods	16
ICB unable to achieve DSPT Improvement Plan	Amanda Lyes	12
AI usage	Richard Watson	12
Inappropriate Access	Amanda Lyes	12
3 risks related to unfunded NICE medicines	Michael Smith	12 (all)

Risks scoring 12 and above

Risk Title	Responsible Executive Director	Mitigated Score
Lynch Syndrome testing and surveillance pathway	Richard Watson	16
Histopathology delays affecting cancer pathways	Richard Watson	12
Insufficient acute medical staffing in oncology	Richard Watson	12
Failure to Meet Cancer Access Standards	Richard Watson	16
Delays in ED resulting in poor patient experience	Mark Burgis	16

Ambulance response and handover delays	Lisa Nobes	16
Provision of Paediatric Audiology – Queen Elizabeth Hospital	Lisa Nobes	16
Delay in completing BIA process	Amanda Lyes	15
Instrumental Assessment for CYP Dysphagia in NW	Lisa Nobes	16
RAAC in ICS Buildings	Amanda Lyes	12
Failure to meet statutory ICB financial targets	Howard Martin	12
TB Service Resilience and Capacity	Lisa Nobes	12
Neuro-Developmental NHS Pathways	Lisa Nobes	16
Children & Young People (CYP) Mental Health Waiting Lists	Richard Watson	16
Mental Health 12 Hour Breach	Lisa Nobes	16
Elective Recovery	Lisa Nobes	20
Impacts of Climate Change on Health Care Capacity & Resilience	Amanda Lyes	16
RTT (Referral to Treatment) Objective	Richard Watson	20
Diagnostics 6-Week Standard	Richard Watson	20
Staff Burnout	Amanda Lyes	16
Delays across UEC pathways	Lisa Nobes	12

4. Development of the Board Assurance Framework

4.1. A proposal for the Board Assurance Framework was presented to Executive Committee on 20 July. It was agreed that the organisation would adopt an approach that aligns strategic risks to the objectives set out in the Population Health and Commissioning Strategy, in line with the recommendation of the Audit and Risk Assurance Committee.

4.2. Eight key priorities were identified as potential objectives against which BAF risks could be aligned. Following circulation of the proposed framework, the executive team requested that further review of the proposed objectives and alignment be undertaken to ensure they appropriately reflect the organisation's strategic direction. The Corporate Governance and Strategy Team are therefore undertaking additional review ahead of the framework being resubmitted for consideration.

4.3. Executive Committee identified the eight immediate priorities identified in figure 3 ‘Our five-year roadmap’:

Figure 3 Our five-year roadmap

4.4. Each bullet point in the figure above would become an entry on the BAF with all of the risks on the Corporate Risk Register aligned to the relevant BAF entry. The Committees of the Board will review the BAF before every board meeting together with the corporate risks rated 12 and above. BAF entries will be focused on assurance presented following the three lines of defence model set out in the Orange Book:

1. Management Activity – how do ICB officers assure themselves of consistent and correct application of policies and operating procedures.

2. Management Oversight – how does the ICB oversee the management activity i.e. through reporting to committees of the Board, internal audit.

3. Independent sources of assurance – reviews from external regulators such as NHS England or the Care Quality Commission etc.

4.5. The Executive Team has asked that the proposed BAF structure be taken to the Strategic Commissioning Delivery Group on 30 September to help ensure that the identified entries provide the right level of oversight on our strategic objectives. A robust BAF will tell the Board how confident it should be in delivery of the Population Health and Commissioning Strategy and what the risks are that would make delivery less likely. The ICB Executive is also keen to ensure that the entries are defined and not too cross cutting.

4.6. The Executive Committee, SCDG and Audit and Risk Committee will inform a first edition of the BAF reported to the next ICB meeting in December.

5. Patient and Public Engagement

5.1. There has been no patient engagement on this item.

6. Committees and Groups

6.1. The Audit and Risk Committee has oversight of the ICB's risk management framework. The Risk and Resilience Group (the ICB's operational risk management forum) will inform the development and continuous improvement of the ICB's risk management policy and practice.