PERFORMANCE REPORT

Performance Overview

The purpose of this overview is to provide sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives, and how it has performed during the year.

There is further detail in the Performance Analysis, Accountability Report, and Accounts sections.

Chief Executive Officer and Chair's statement

Welcome to our Annual Report and Accounts for 2024/25. This report outlines our key achievements, challenges, and areas of focus over the past year, as we continue working towards our mission of helping people to lead longer, healthier and happier lives.

This has been a year of significant change, both within our organisation and across the wider health and care system. We completed our organisational review, restructuring the Integrated Care Board (ICB) in response to the Government's requirement to reduce running costs by 30%. This was a challenging period for all involved, and we would like to thank staff for their continued dedication and hard work throughout.

We know that following an announcement from the Government and NHS England in March 2025, that there will be substantial changes to how the NHS is organised in 2025/26, and that this will have a significant impact on staff. Our priority will be supporting them through this over the next year, while also working to improve the services and care people receive in Norfolk and Waveney.

At the same time, the Government is continuing its efforts to reform the healthcare system and develop its 10-Year Health Plan. The plan will be structured around three key shifts: moving from a system that primarily treats sickness to one that focuses on prevention, shifting care from hospitals into communities and primary care, and driving digital transformation in service delivery. Many of our programmes already align with these priorities, but there is more we can and want to do.

A major milestone this year was the confirmation that both the Queen Elizabeth Hospital (QEH) and the James Paget University Hospital (JPUH) remain in Wave 2 of the New Hospital Programme (NHP), following a government review of the wider scheme. These hospitals are among twelve projects cleared to proceed without further review to replace buildings with Reinforced Autoclaved Aerated Concrete (RAAC). This development is a significant step towards improving healthcare infrastructure across the region and prioritising patient and staff safety.

We have made progress in shifting care closer to home. All three acute hospitals have opened Community Diagnostic Centres (CDCs), improving access to tests and scans. In its first year, our Unscheduled Care Coordination Hub (UCCH) prevented over 11,000 unnecessary ambulance dispatches, with people to be treated by community services instead. Nine in ten patients remained at home a week after contact, while those needing admission accessed specialist care directly, reducing Emergency Department waits.

In community and mental health care, we have seen important developments, including the opening of new inpatient wards at the Rivers Centre in Hellesdon, and the launch of the

Willow Therapy Unit at Norwich Community Hospital, which supports earlier discharge from acute hospitals, reducing pressure on the acute hospitals and helping patients transition back home more smoothly.

Primary care has continued to innovate over the last year in order to make it easier for people to get the care they need. This is having an impact; our GP practices are offering more appointments than ever, our Urgent Treatment Service is now offering c2,500 dental appointments every month, and through the Pharmacy First service, over 3,000 consultations are now taking place each month.

Our digital transformation efforts have continued to make a real difference to both patients and healthcare professionals. The Norfolk and Waveney Shared Care Record is now used by over 2,000 staff daily, providing access to critical patient information for 12,000 people. This system has streamlined care, ensuring healthcare professionals can make faster and better-informed decisions while reducing the need for patients to repeat their medical history.

Additionally, all three acute hospitals are progressing with the introduction of an Electronic Patient Record (EPR) system, which will replace paper-based records and improve the speed and quality of care. With the software now installed, configuration work is underway, including mapping clinical pathways and staff training, with the system set to go live in 2026.

We have made all these improvements despite a very challenging financial position. The ICB has delivered its financial plan for the year, which is a real achievement, and the system has made nearly £150m of efficiencies. The financial position remains very difficult though, not just for the ICB, but for the NHS as a whole and public services more widely, which is why we have put a huge amount of effort this year into preparing for 2025/26. Alongside this, we know that there is more to do to improve performance and to ensure that people are consistently getting the level of care we want them to. We will work to simultaneously address both our financial challenge and improve performance over the course of 2025/26.

We want to take this opportunity to acknowledge and thank Rt Hon Dame Patricia Hewitt DBE for her dedication and leadership as Chair of the ICB. After eight years of service, Dame Patricia retired from her role in March 2025, leaving behind a strong legacy of commitment to improving the health and care system in Norfolk and Waveney. We would also like to thank Tracey Bleakley for everything she has done to improve the health, wellbeing and care of the population after leaving her role as ICB Chief Executive in April 2025 to pursue new opportunities within the NHS.

Finally, we extend our sincere gratitude to all our staff, health and care partners, and voluntary sector colleagues for their dedication and collaboration throughout the year. Partnership working will be key to overcoming the challenges ahead, and we remain committed to working together to deliver high-quality care, improve health outcomes, and build a sustainable healthcare system for our communities.

Will Pope

Interim Chair, NHS Norfolk and Waveney

Ed Garratt OBE

Interim Chief Executive Officer OBE, NHS Norfolk and Waveney

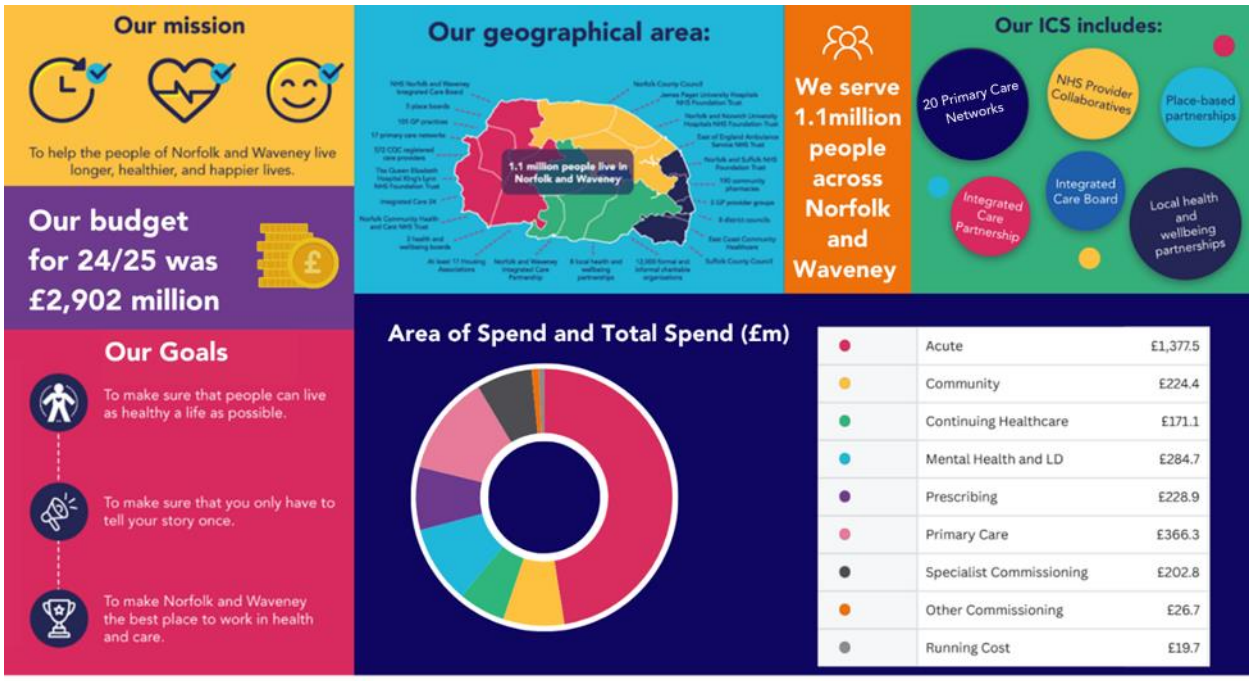
Purpose and activities of the organisation

NHS Norfolk and Waveney is responsible for planning and buying safe, high quality health services. NHS Norfolk and Waveney agreed and administers contracts with hospitals, community services, the mental health trust, GP practices, dentistry, pharmacy, optometry,

the ambulance trust, and other organisations who provide care and treatment services, and monitored the performance of the delivery of these services.

As a result of the Health and Care Act 2022, NHS Norfolk and Waveney is responsible for the budget for the whole of the NHS across Norfolk and Waveney.

2024-25 At a glance



Structure of NHS Norfolk and Waveney

NHS Norfolk and Waveney plans and buys healthcare services for local people and communities. We are accountable for the performance and finances of the NHS across Norfolk and Waveney – a total budget of over £2 billion a year. We work with local people, health and care professionals, and partner organisations to improve the health, wellbeing and care of our population.

The organisation is part of the Norfolk and Waveney Integrated Care System (ICS), which aims to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

There are four pillars of our ICS which broadly bring organisations together:

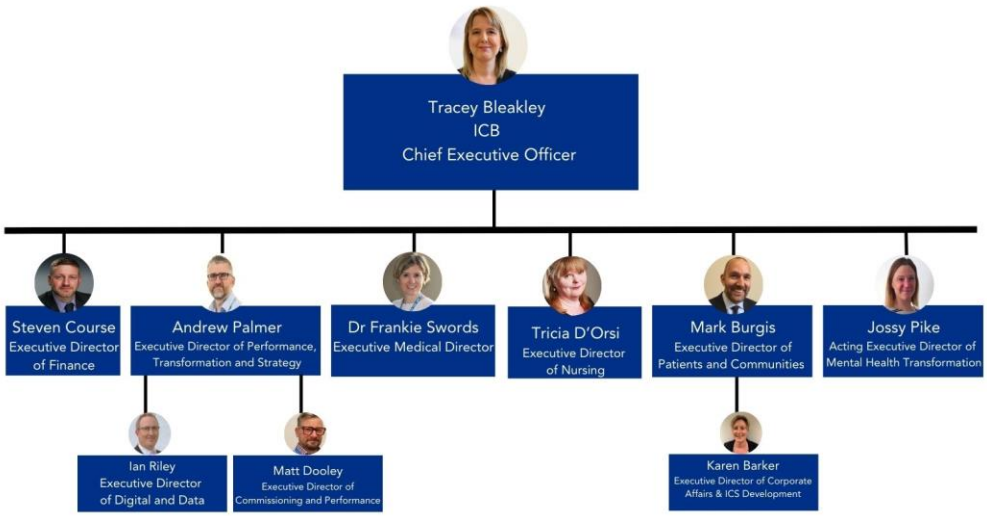
- NHS
- Local Authority
- Voluntary, Community and Social Enterprise (VCSE)
- Our staff, people and communities

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners including social care providers, voluntary and community

groups, social enterprises, charities and local communities. Integrated care involves partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area.

Operationally, NHS Norfolk and Waveney is led by the Chief Executive Officer and a team of Executive Directors who, along with other senior colleagues, meet regularly as an Executive Management Team.

A diagram of the Executive Management Team for 2024/25 is below. The organisation is also supported by a number of other colleagues, officers and Non-Executive Members (NEMs) who support decision making across our organisation. These roles can be found in the Accountability Report.



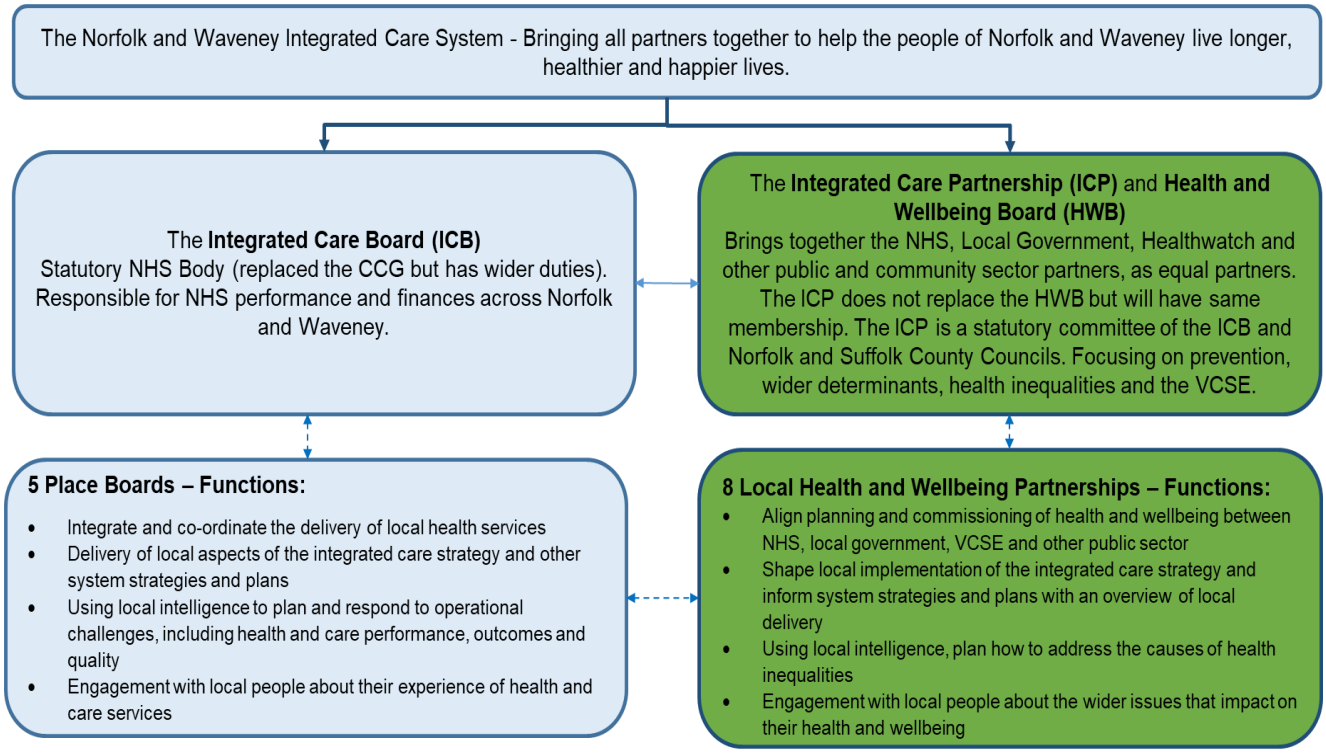
As of 1 July 2022, ICSs are made up of two core elements: Integrated Care Boards and Integrated Care Partnerships. Locally these two elements perform the following core functions:

- The **Integrated Care Board** (ICB) is responsible for the strategic development, funding, and health commissioning activities for the partnership.
- The **Integrated Care Partnership** (ICP) is responsible for integrating the care system with the wider public and charitable sector and has statutory responsibility for developing the strategy to address health inequalities. An overview of the ICP and links to our Integrated Care Strategy can be found later in this report.

NHS Norfolk and Waveney, along with its wider system partners have a clear vision and set of common goals for improving the health, wellbeing and care of people living locally, and has developed the right relationships between the different parts of the health and care system to enable the ambitions of the ICS to be realised.

More information can be found at Norfolk and Waveney Integrated Care System (ICS).

The diagram below provides an overview of the Norfolk and Waveney ICS and describes how each component links and works together.



The goals of the Norfolk and Waveney ICS

The ICS has three overarching goals:

1. **To make sure that people can live as healthy a life as possible** - Preventing avoidable illness and tackling the root causes of poor health to reduce health inequalities across our area.
2. **To make sure that you only have to tell your story once** - Services must work better together so that key information doesn't have to be repeated to every health and care professional.
3. **To make Norfolk and Waveney the best place to work in health and care –** Supporting staff development and wellbeing will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Our mission is the help the people of Norfolk and Waveney to lead longer, healthier and happier lives.

To help drive this vision, the Norfolk and Waveney Integrated Care Partnership has agreed its Integrated Care Strategy. The strategy is an important high-level framework for the system and has four themes: driving integration, prioritising prevention, addressing inequalities and enabling resilient communities.

It sets out the challenges and opportunities which can best be overseen by the Integrated Care System and looks beyond traditional organisational boundaries at complex, long-term issues which need collaborative approaches to succeed. It is designed to influence other strategies and plans in our health and care system, including the Integrated Care Board five-year Joint Forward Plan, as well as the work of our Place Boards and Health and Wellbeing Partnerships.

Also embedded within our decision making and a fundamentally important part of our ICS is working with our VCSE sector. Norfolk and Waveney has an established VCSE Assembly,

which is Chaired by Tim Gardiner. We also have Emma Ratzer on the Board of NHS Norfolk and Waveney to represent the VCSE sector.

Linked to the goals and ambitions of the Norfolk and Waveney Integrated Care System are eight ambitions, which can be found in the Performance Analysis section of this report.

In summary, our system goals, themes and ambitions are interlinked as follows:

Key risks and issues

Over the past year we have been proactive in identifying and managing risks and issues that might adversely affect our plans or business.

Key risks to performance were formally logged on the NHS Norfolk and Waveney Board Assurance Framework (BAF) document, which was reviewed by the NHS Norfolk and Waveney management teams and committees and was reported to the Board of NHS Norfolk and Waveney at each of its meetings. The latest BAF can be found on page 538 of the March 2025 NHS Norfolk and Waveney Board papers.

For each risk identified there are mitigating actions identified and provided to the Board of NHS Norfolk and Waveney with assurance that they are being managed.

During 2024-25, several key issues and risks recorded on the Board Assurance Framework (BAF). These included:

- **Urgent and Emergency Care Capacity**: Risk that the health and social care system lacks sufficient resilience and capacity to meet urgent and emergency care needs, leading to longer response times, delayed hospital discharges, and poorer patient outcomes. This may cause ambulance delays, increased hospital occupancy, and congestion in emergency departments.
- **Mental Health Demand**: Rising demand for mental health services may exceed system capacity, delaying timely care and escalating patient needs. This could worsen health inequalities, increase pressure on other services, and damage the system's reputation.
- **Health Inequalities and Population Health Management**: Risk that the ICB may not meet its statutory requirements to reduce health inequalities or fully implement Population Health Management techniques, leading to preventable poor health outcomes for specific population groups.
- **Elective Treatment Backlogs**: Increased waiting times for elective treatment, diagnostics, and cancer care following the pandemic may not be reduced quickly enough to meet NHS commitments, leading to poor patient experience and increased clinical harm due to delayed treatment.
- **Financial Sustainability**: If the ICB fails to achieve a break-even financial position in 2024/25, it may be unable to sustain current service levels or invest in new initiatives, leading to potential service reductions and negative patient impact.

- **Ageing Population and Complex Care Needs**: Rising numbers of older people with multiple health conditions pose risks to service capacity, increased financial pressures, and potential declines in care quality if demand exceeds available resources.
- **Primary Care Resilience**: Risks to general practice, NHS dentistry, community pharmacy, and optometry due to workforce shortages, contract limitations, and financial pressures. These could lead to reduced access, delays in care, increased clinical harm, and an inability to transition to a proactive, community-based healthcare model.

Performance Analysis

Performance of NHS services

Information about the overall performance of services is contained in the table and information below. The table shows an overall RAG (Red / Amber / Green) performance against constitutional targets, based on an average summary of monthly performance during 2024/25. Green indicates that all targets were achieved, Amber that some targets were achieved, and Red that no targets were achieved.

A detailed summary of performance of these indicators is provided under each ambition area of this report.

Constitutional Area	24/25 Performance RAG	Unknown Metrics * *See Detailed tab*
Cancer Waiting Times	0 / 3	
Diagnostics Waiting Times	0 / 1	
Referral to Treatment Waiting Times	0 / 3	
A&E Waits	0 / 2	
Ambulance Response Times	0 / 6	
Ambulance Handovers	0 / 3	1
Mixed Sex Accommodation	0 / 1	
Cancelled Operations	0 / 1	1
Mental Health	4 / 6	
Patient Safety	1 / 3	3
Community	1 / 1	

NHS Norfolk and Waveney, along with ICS partners, is working to deliver eight core Ambitions which are set-out in our Joint Forward Plan.

Services within NHS Norfolk and Waveney are grouped under these ambitions. The performance analysis for NHS Norfolk and Waveney aims to showcase how services performed in alignment with the priorities.

Ambition one – Population Health Management, Reducing Inequalities and Supporting Prevention

Population Health Management

Since April 2024, the Population Health Management (PHM) programme has made significant progress in delivering the priorities set out in the NHS Norfolk and Waveney PHM strategy. This strategy focuses on using joined-up data and intelligence to identify and understand the health and care needs of the local population, allowing for targeted interventions that improve health outcomes and reduce inequalities. By prioritising prevention and collaboration, the programme empowers professionals to help people live healthier, more independent lives.

A major achievement has been the development of the infrastructure needed to support PHM, including specialist software, analytical tools, and data dashboards to help colleagues across the ICS review population health data and track progress against key priorities. Alongside this, training and resources have been developed to support teams in delivering their own PHM projects.

The PHM programme has played a key role in the Protect NoW initiative, a collaboration between NHS organisations, local authorities, the voluntary sector, and independent partners aimed at improving physical and mental health through proactive support. Several targeted PHM projects have been successfully delivered, including improving access to talking therapies for older adults and those at risk of falls, and the Dementia North Norfolk initiative, which connects people affected by dementia with services such as housing support, benefits advice, social activities, and carers' support. Other initiatives have focused on increasing resilience and self-care for people with mental health conditions, supporting households with cold-related health risks through energy efficiency grants, and providing social prescribing support for pregnant individuals in areas of high deprivation. The programme has also worked to increase referrals to the NHS Digital Weight Management Programme and the National Diabetes Prevention Programme, particularly in communities experiencing the greatest health inequalities.

Looking ahead to 2025, new projects will be introduced, including a cardiovascular disease prevention programme focused on optimising treatment for high blood pressure and cholesterol, an initiative to identify and treat familial hypercholesterolemia (FH) to prevent serious cardiac events, and work to increase participation in the NHS Bowel Cancer Screening Programme by identifying and supporting those at high risk.

A key challenge remains in ensuring that teams across the ICS have the skills and resources to access and interpret population health data effectively, enabling them to develop their own local projects. While there is growing recognition of the benefits of a PHM approach, ongoing investment in training and support will be required.

Health Inequalities

NHS Norfolk and Waveney is committed to reducing health inequalities and supporting equality and inclusion. It recognises and has implemented all legislation relevant to its role and functions including the Equality Act 2010, meeting statutory Human Rights legislation; the Equality Delivery System EDS); the Workplace Race Equality Standard (WRES); the Modern Day Slavery Act; and the Equality Impact Assessments (EIAs) and Equality Analysis.

NHS Norfolk and Waveney, as a public sector organisation, is legally bound by the Equality Act 2010 to prevent discrimination and promote inclusivity in healthcare planning and service delivery. Under the Public Sector Equality Duty (PSED), the ICB must actively consider how

its decisions impact people with protected characteristics, ensuring equitable access to healthcare and reducing health inequalities. The ICB is taking proactive steps to eliminate disparities, improve access, and foster inclusive healthcare services across our diverse communities in Norfolk and Waveney. To meet the PSED, the ICB has a specific duty to publish by March 30 annually:

- Gender Pay Gap information
- Information its staff and service users/population, analysed by protected characteristics
- One or more specific and measurable Equality Objectives, refreshed at agreed intervals.

The EDS (Equality Delivery System) is a framework used by NHS organisations to improve equality performance, ensure fair access to services, and meet legal obligations under the Equality Act 2010. The ICB's 2023-24 Equality Delivery System (EDS2) Summary Report evaluates the progress made in addressing health inequalities through its services, workforce and leadership. The report highlights key initiatives such as improving maternity care access, enhancing diabetes management, expanding audiology services, and fostering inclusive leadership and workforce wellbeing. Based on the assessment, the self-assessment shows an overall "Developing" rating, indicating ongoing efforts to embed equality and health equity improvements across the organisation and the Integrated Care System.

The ICB has implemented a policy and process to undertake equality health impact assessments (EHIA) to support all decisions in respect of service development, commissioning, organisational policy, system policy and clinical pathways. The EHIA's includes protected characteristics and our core20plus communities considering access, outcomes and experience of healthcare taking a health equity approach. There is organisational policy to support this, templates to use and training tool available. A panel of ICB staff subject matter experts consider both the EHIA's and the Quality Impact Assessments together in a supportive environment.

In November 2023 NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) was published. You can read the statement here.

Good progress has been made towards publication of key information on health inequalities and we are developing a Norfolk and Waveney Population Health Management Dashboard that aligns with the statement data requirements and our Health Inequalities Strategic Framework for Action. There is an additional dashboard which aligns to the leadership groups for the Health Inequalities Strategic Framework for Action (Living and Working conditions). This has been undertaken with support from our colleagues in Business Intelligence and Population Health Management, using our extensive data hub which provides an excellent range of resources. We have worked closely with NHSE and other ICBs in our region when developing our response to the statement. This is to ensure that we are aligned with the data NHSE will request to enable the ICBs to look at regional patterns and trends, together with data that is bespoke to Norfolk and Waveney and important for our local decision making, especially at Place level. Oversight of the statement will be through the Population Health and Health Inequalities Board and through the programme of work in collaboration with all our NHS providers in Norfolk and Waveney that will come together in our Health Care Inequalities actions as we implement our Health Inequalities Strategic Framework for Action.

Health Inequalities Strategic Framework for Action

In 2023/24 NHS Norfolk and Waveney led the development of an ICS Health Inequalities Strategic Framework for Action. An extensive engagement programme was developed and implemented which ensured over 100 organisations across the system were part of our 'Health Inequalities Conversation' and had the opportunity to input and help shape the Framework.

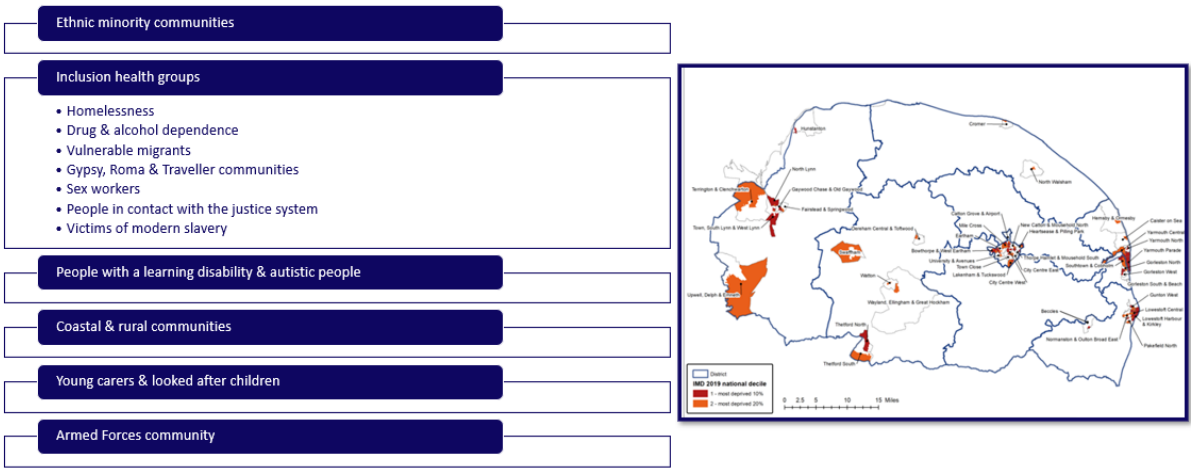
Through attendance at Place Boards, Health and Wellbeing Partnerships and numerous VCSE forums, as well as via a number of system workshops and engagement events, the Framework was co-developed with local government, VCSE and NHS partners. The Community Voices programme, which works with trusted communicators in our VCSE sector, also asked some of our most vulnerable and underserved communities what matters to them, and we engaged with people with lived experience.

The vision for the Health Inequalities Strategic Framework is that the system will come together to tackle unfair and avoidable differences in health outcomes between residents. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

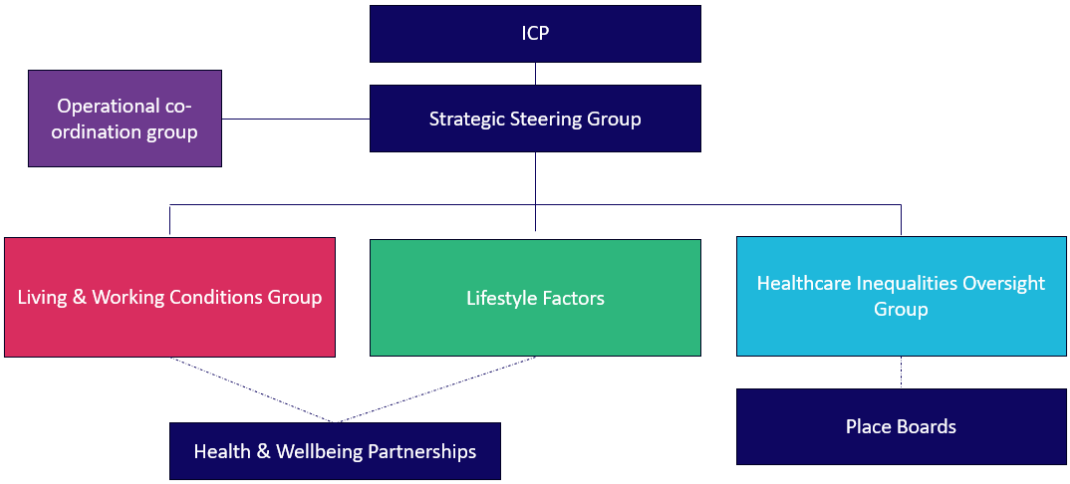
It will adhere to the following guiding principles:

- Everyone needs something, some people need more.
- Enabling communities to have a voice is key and requires creativity and persistence.
- We will work as close to people and communities as possible.
- We want to achieve the right person, the right action, at the right time.
- We strive for accessible services for those in greatest need.
- We know we can make a difference, and this is a long-term commitment.
- Leading for change requires shared responsibility and enduring focus.
- Understanding who is accessing our services, who isn't and why in order to act.
- Recognising the building blocks for good health and wellbeing are not just in health services.
- Building fairer services means supporting change in our organisations.

In order to develop the Framework we defined a clear scope, recognising the wider determinants of health, and defined the Core20plus population groups for Norfolk and Waveney:



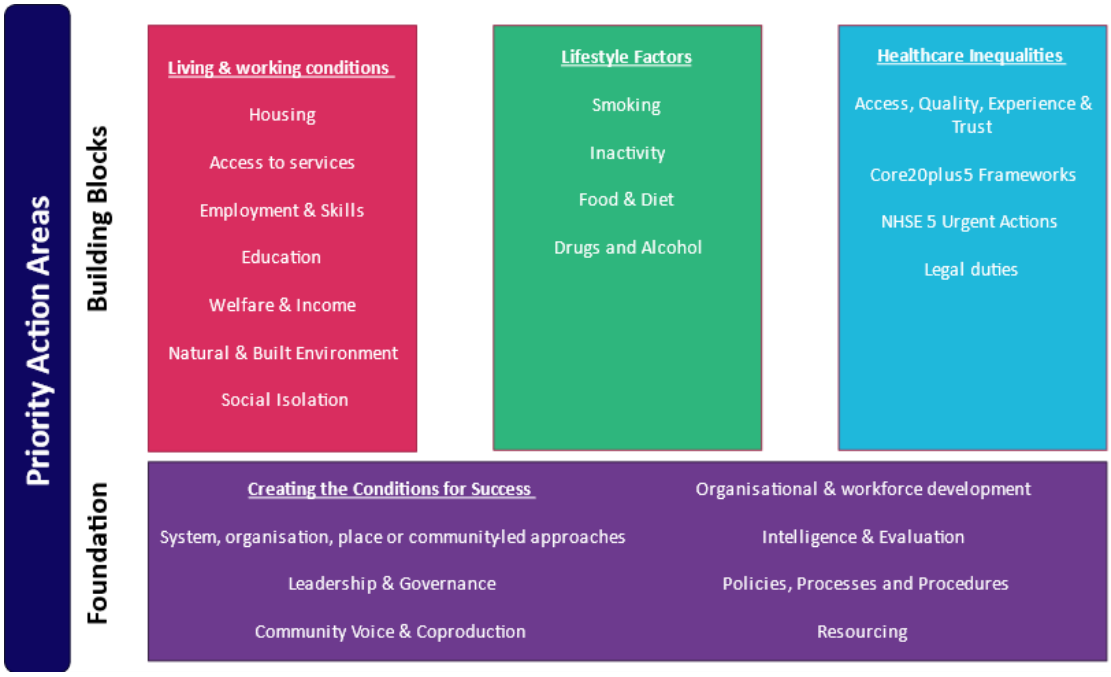
A leadership structure, reporting to our Integrated Care Partnership, has been established to take forward our collective action:



Each building block has its own governance arrangements, with the ICB leading the action around Healthcare Inequalities via the Health Inequalities Oversight Group (HIOG), reporting to the PHI Board.

A Health Inequalities Strategic Steering Group, made up of the Chairs and Vice-Chairs of the Leadership Groups has been established to support, enable and embed our collective action. This Steering Group is supported by an operational Coordination Group, who are practically driving the implementation of the first 10 actions in the first year and responsible for the development of future year plans.

Leadership groups for each of the three pillars or 'areas of focus' of our Framework have been established. Living and Working Conditions is being led by our local government and VCSE colleagues, Health Improvement (primary prevention) by Public Health and Healthcare Inequalities by the ICB. A whole-system, multi-agency approach is implicit within all of these groups.



The Framework identified 10 actions for the first 10 months to be overseen by the Coordination Group; these actions maintain a focus on creating the foundations for success and tackling structural inequalities in our system. They include a clear call to action to come together and take collaborative, as well as organisational level action. It also includes actions that can support and empower communities to take action themselves:

Communications & Pledges	Governance	VCSE Integration
We will continue our 'Health Inequalities Conversation' and roll out a programme which includes commitments and accountability.	We will identify named Senior Responsible Officers/Leaders, Organisational Leads, Clinical leads and Health inequalities champions.	We will further develop the VCSE Assembly, integrate the VCSE sector into all parts of our planning & decision making and support volunteering.
Action Plans	**Self Assessment**	**Organisational Development**
We will produce action plans for each of our building blocks, using existing assets and with our place and system structures working closely together.	We will assess where we are, what good looks like, what we need to do next. We will include actions for anchor institutions.	Including a suite of tools and training, a learning centre to share good practice and case studies, and a health inequalities champions network.
Resources	**Intelligence**	**Monitoring**
Mapping the flow of health inequalities resources & spend across organisations to further develop the business case for investment.	Implement our Population Health Management Strategy, so that we get better at collecting and using data and insights	A Health Inequalities Outcomes Framework developed with clear metrics and targets identified to keep us on track

Participation
Develop a common approach to engaging our communities that experience health inequalities to enable access to services and ensure voices are heard with equity. We will ensure coproduction with experts by experience.

An initial focus was placed upon developing a set of Health Inequalities Commitments to aid in communicating our initial priorities to the system and calling ICS partners to action. These Commitments set out a clear 'ask' of partners, as well as an 'offer' of support and infrastructure. The Commitments were launched at the ICS Conference in October 2024 and organisations were invited to sign up, with 15 organisations signed up to date:

Delivering against the 'Equip' Commitment as set out above, a Self-Assessment was developed and launched to the system to provide a baseline understanding of our organisational and structural inequalities, what is going well, identify 'need' and opportunities. The assessment has been completed by 11 organisations, with strong representation from the VCSE sector. The data collected in the Self-Assessment is being analysed from both a qualitative and quantitative perspective and will be fed back to the system to inform the development of Improvement Plans. The ICB is currently in the process of finalises their Improvement Plan and will be seeking sign off in the early new financial year. As we reach the end of the first year of the framework, planning is underway to identify priorities for year 2; said priorities includes areas such as communications, ICS resources, advocacy networks and community level participation and engagement.

Alongside the delivery of the 10 key actions, the three leadership groups - Living and Working Conditions (LWCG), Healthcare Inequalities Oversight Group (HIOG) and Health Improvement Transformation Group (HITG) - have been progressing their agendas at a system level.

The LWCG group is newly established and in the process of developing its programme of work. The overarching focus of the group is currently: quality safe housing, meaningful employment and social connection. An early priority is the Get Britain Working initiative and how integrate our health and work agendas on a local level. The group is in the process of exploring best practice across the system and national evidence basis for interventions.

The Health Improvement Transformation Group has a focus on physical activity, smoking, healthy eating and behaviour change. Through collaborative working it has overseen the development of a whole-system approach to physical activity - Active NoW – which has seen over 8000 people referred into physical activity in support of their health and wellbeing, with a third of these coming from our Core20plus communities. A Behaviour Change programme

has been developed and is being rolled out across our systems workforce to support the principles of Making Every Contact Count.

The Healthcare Inequalities Oversight Group continues to meet and has overseen the development of the Framework, as well as continuing to oversee existing work programmes that seek to deliver on key local and national strategic objectives, such as Core20plus5, the NHSE five urgent actions, and ensuring compliance with the NHSE Statement on Information on Health Inequalities.

Some examples of health inequalities work are included below:

NHS Anchors

We have established an NHS Anchors Leadership Group, with nominated leads from each of our Trusts and Foundation Trusts, as well as representatives from the ICB. This group Boards to undertake an NHS Providers Health Inequalities Maturity Assessment which gives a clear indication of baseline activity and where there are areas for improvement. The group has also been using the UCL 'How Strong is Your Anchor' toolkit to further our understanding of strengths and opportunities.

Each organisation has been developing their own organisational improvement plans for health inequalities, and the group is working together to develop an ICS improvement plan, recognising where there are opportunities to collaborate.

The ICB has, through a period of engagement across the whole workforce, developed its own Health Inequalities Organisational Improvement Plan (insert link to document here) which includes clear objectives and actions for the next 2 years.

Core20plus5

We have established a cross-organisation Core20plus5 Programme Group, which has brought together strategic leads from across the frameworks areas of focus to share learning and good practice, as well as seek opportunities to work collaboratively and further develop our advocacy approach.

With the support of Business Intelligence colleagues we have collectively developed our NHSE Statement on Information on Inequalities (hyperlink to be included) which sets where we are seeing unwarranted variation, what action we have taken in the last year, and what actions we plan to take in the next 12 months.

Community Voices

The Community Voices programme works with trusted communicators in the VCSE sector and local government organisations to engage communities that experience health inequalities. Initiated during the pandemic, this programme seeks to improve access to services with a focus on the five clinical priorities of the Core20plus5 health improvement frameworks. Through training of trusted communicators, we improve health literacy in communities, and we record and analyse the insights gathered around barriers and enablers to influence and support future service design and strategic decision making via a central Insight bank.

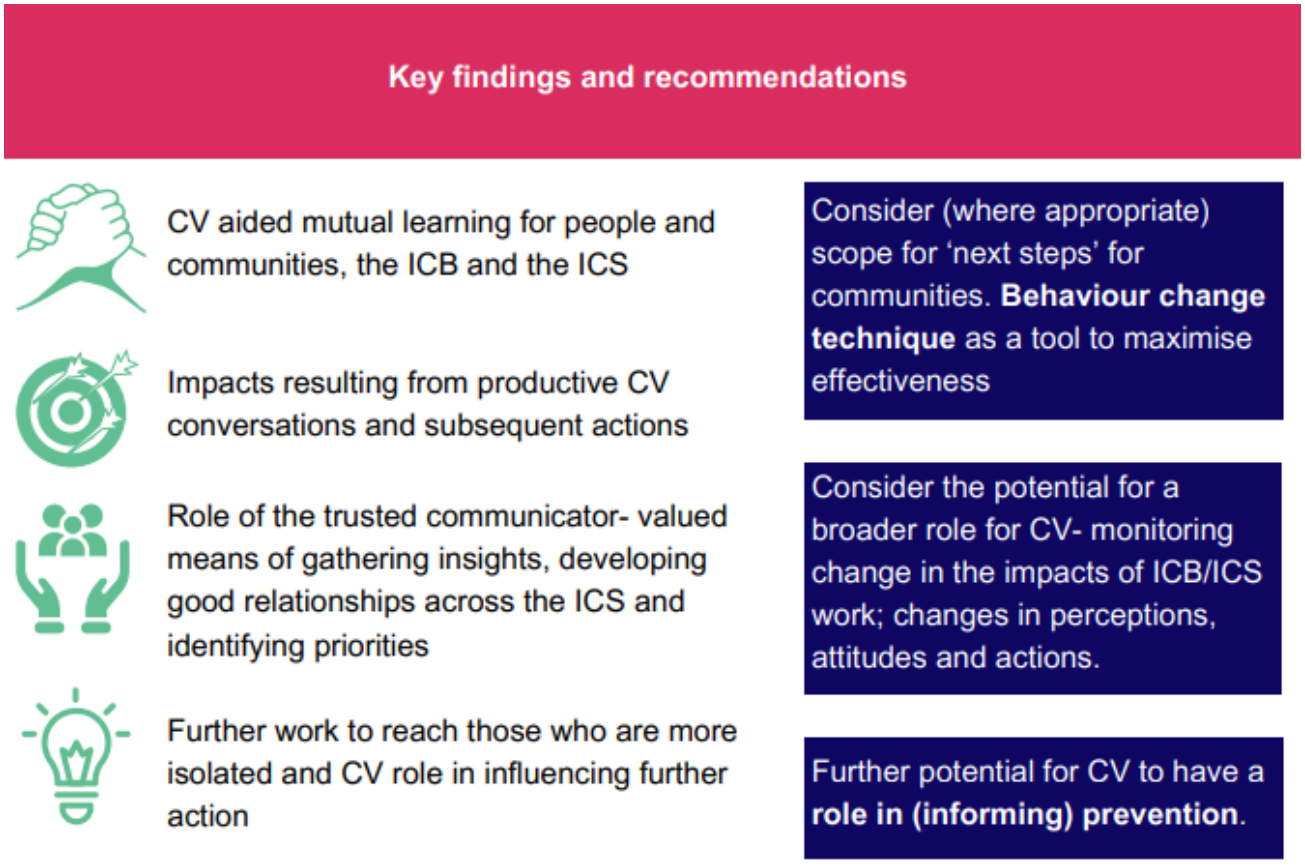
Community Voices has delivered 10 projects, including access to Covid vaccination, bowel cancer screening, smoking cessation, refugee and asylum seeker health, asthma in children and young people, healthy hearts (CVD) and on focusing on diversity in research participation aligned with the Research Engagement Network (REN) programme.

- Gained insights from over 1,500 residents that experience significant health inequalities and recorded these on the central insight bank.
- Worked in partnership with 50+ VCSE and local government organisations.
- Provided training to over 120 trusted communicators, such as Making Every Contact Count (MECC) and behaviour change, COM-B and smoking, asthma risk and management, CVD and cancer signs, symptoms and screening.
- Read a Community Voices case study

Community insights and data recoded in the Insight bank is being used to inform service reviews, to target services in certain areas of Norfolk and Waveney where access has been poor, and to support multiple funding bids. For example, Community Voices insights have informed and supported:

- the procurement of the NHS talking Therapies in Norfolk
- the development of the Health Inequalities Framework for the Norfolk and Waveney Integrated Care System

Evaluation of the programme was carried out by the ICB research and innovation team which highlighted below key findings and recommendations for the development and sustainability of Community Voices to help reducing health inequalities faced by the underserved communities in Norfolk and Waveney



Wellness on Wheels (WoW)

Access to vaccination was identified as a barrier to increasing uptake in areas of deprivation and for inclusion health groups. Therefore, the WoW bus operates across Norfolk and Waveney supporting underserved communities and Core20plus populations to access

vaccinations, health interventions and screening. This is supported via NHSE access and inequalities funding by the ICB's vaccination team.

The bus provides services such as Stop Smoking support, sexual health self-testing kits, seasonal vaccinations, NHS Health checks and much more.

The WoW programme works in partnership with the voluntary sector and district councils in all places/localities to meet the needs of the local population, taking a Population Health Management (PHM) approach and making every contact count.

Partnering was essential to increase engagement and trust with communities that have a historical mistrust of the NHS and other governmental organisations. This bus provides an opportunity to reach into those communities that do not access health and care in more traditional ways or who are underserved by fixed delivery models such as Gypsy, Roma and Travellers, those experiencing homelessness and Asylum seekers.

Inclusion Health

Inclusion Health is a priority for Norfolk and Waveney ICB as these communities are a key part of the Core20plus NHS England approach to reduce Health Inequalities. Inclusion Health Groups are the one of the Plus groups for Norfolk and Waveney, over the last year we have been working to implement the NHS England Inclusion Health Framework working alongside system colleagues but especially those in Public Health. The Inclusion Health Network continues to develop to support the wider ICS implementation of this framework.

There continues to be asylum seekers in dispersal and contingency in Norfolk and Waveney supported by an Asylum Seeker Healthcare team commissioned by the ICB which works with General Practice that support all Inclusion Health groups through the LES.

Currently the ICB is conducting a public consultation out for the Norwich Vulnerable Adult Service and the Walk in Centre to inform the APMS procurement which will include service provision aligned to the NHSE Inclusion Health Framework to support underserved communities across Norfolk and Waveney.

We are working with Magdalene Group to host a women's health champion who will connect and reach into communities, such as Inclusion Health groups e.g., sex workers, asylum seekers and those women experiencing homelessness.

We are supporting Public Health with the development of the Gypsy, Roma and Traveller Network across Norfolk to support the outcomes and address gaps in service offers such as the LES, WoW bus.

The Health Inequalities team links with the Norfolk Drug and Alcohol Partnership in respect of embedding health inequalities within the programmes of work relating to vulnerable communities with substance misuse.

Place-based approaches to reducing health inequalities

Great Yarmouth and Waveney Place has developed a data-driven, preventative scheme to support vulnerable Core20 communities in Waveney who are at risk of living in a cold, damp, energy inefficient home. Starting in September 2024 and delivered in collaboration with our Place partners, the projects aim is to help eligible individuals to access home energy efficiency grants to reduce the likelihood of poor health exacerbations or hospital admissions. There is robust evidence that chronic health conditions can deteriorate significantly from living in cold and damp homes. A population health management approach has been adopted, by combining EPC data to identify poor housing quality, with data showing residents with serious health conditions. By sharing linked data directly with East

Suffolk Council, the Warm Homes team in the Council has been able to proactively contact vulnerable individuals, using targeted and needs led approach.

Local government receive significant national funding to support those living in the least energy efficient homes, with a focus on low income and vulnerable households. This includes a criteria for households with occupants whose health conditions may be adversely affected by living in a cold home. By working together 1500 residents have been identified within Waveney as being both clinically vulnerable, within our Core20 communities and living in an energy inefficient home; so most in need of targeted support.

Great Yarmouth and Waveney Place has delivered similar targeted schemes in previous winters supported by NW Protect NoW, but this the first occasion where suitable information governance agreements have enabled information data to be shared directly with the local Council so they can proactively contact residents most in need. This targeted approach has proven extremely effective. A traditional Council mailout for a free home improvement scheme normally achieves a 1-2% response rate. By working together to identify both clinically and socially vulnerable residents, has seen a 24% response rate. So far 315 vulnerable households have been contacted with 73 homes actively receiving support including surveys for home upgrade grants, benefit checks, financial assistance and wider social support. Place partners will continue to work together to support as many households as possible through the multimillion-pound funds. The project will report any marked improvement in the EPC rating of the home following the upgrade and we are hoping to be able to demonstrate any improvement on health outcomes as a result.

In **West Norfolk** a place has been secured on the Marmot Place Programme. A 'Marmot Place' is a place which has a significant commitment to tackle health inequalities through action on the social determinants of health. The Institute of Health Equity[1], established by Professor Sir Michael Marmot, has supported over 40 Local Authorities to become 'Marmot Places', through a process of analysis, reporting and implementing recommendations, that typically runs over a two-year period. Being part of the programme enables access to expert advice and guidance, mentoring and facilitation in developing partnerships that are better equipped to face the complex challenges associated with tackling health inequalities, supporting a culture shift that means that health inequalities is part of everybody's business and learning from an ever-growing network of Marmot Places that provide peer support.

Supporting prevention

Vaccinations

Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease.

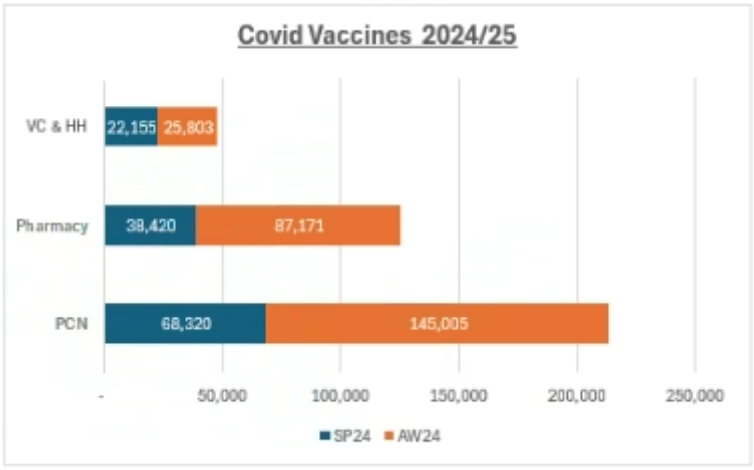
The NHS Norfolk and Waveney Vaccination Team has continued to lead the rollout of the Covid vaccination programme during 2024/25, working closely with partner organisations across the wider system. The NHSE Vaccination Strategy advocates that the NHS and its partners will reduce morbidity and mortality from vaccine-preventable diseases by increasing vaccination uptake and coverage, particularly in underserved populations. This is achieved by vaccination services that:

…are high quality, convenient to access and tailored to the needs of local people	…are supplemented by targeted outreach to increase uptake in underserved populations.	…are delivered in a joined-up way by integrated teams, working across the NHS and other organisations, to improve patient experience and deliver value for money.

The ICB has continued to deliver flexible and holistic vaccination services, reaching deep into communities to ensure everyone has access to life-saving vaccines. Through a collaborative approach involving GP practices, community pharmacies, vaccination centres, and hospital hubs, health professionals have worked to bring vaccines closer to people's homes. This has been particularly important for those who may not engage with traditional healthcare settings. Alongside this, in-person support has been offered to improve vaccine confidence, ensuring that those most at risk have the opportunity to protect themselves.

Since the start of the COVID-19 vaccination programme, more than 3.7 million vaccines have been administered across Norfolk and Waveney, with over 380,000 delivered in 2024/25 alone. The region has continued to lead the way, achieving some of the highest vaccine uptake figures in the country—ranking first in the East of England and third nationally. This success has been recognised both regionally and nationally and is the result of strong partnerships across the system, including 94 GP practices, 68 community pharmacies, 18 Primary Care Networks, one large-scale vaccination centre, four hospital hubs, and the innovative Wellness on Wheels (WOW) bus.

A key focus over the autumn and winter was increasing vaccine uptake among frontline staff. By improving accessibility and flexibility in vaccine provision, Norfolk and Waveney achieved uptake rates above the national average, with 33% for COVID-19 and 51% for flu. The programme also ensured full coverage of all eligible care homes, vaccinating 87% of residents in older adult care homes and 82% in non-older adult care homes.



Managing the growing number of community pharmacies offering COVID-19 vaccinations, which increased from 33 to 68, required a careful and responsive approach to vaccine distribution. To ensure clinics remained open and local demand was met, 37,500 doses were transferred between sites, keeping vaccine wastage at one of the lowest levels nationally and the lowest in the East of England.

Looking ahead, NHS England is exploring how to integrate the COVID-19 vaccination programme into the wider immunisation framework, building on decades of successful vaccination delivery. Norfolk and Waveney's Vaccination Team is actively engaged in discussions on the future delegation of vaccinations alongside screening services, with plans being developed for potential changes from April 2026.

The Wellness on Wheels bus (WOW)

To further improve access for underserved communities, the ICB introduced the Wellness on Wheels (WOW) bus in partnership with Voluntary Norfolk. This initiative was designed to remove barriers to vaccination by taking services directly into communities, particularly in areas of deprivation and among groups with historically lower engagement with healthcare.

The WOW bus has attended supermarkets, markets, and community events, providing a trusted and convenient way for people to receive vaccinations and health advice.

Since April 2024, the bus has had various vaccinations available daily during campaigns. The bus provides a MECC (make every contact count) approach and the other services that have also been on board are as follows:

- Seasonal vaccinations, including MMR, Covid, Flu, RSV, Pertussis, teenage and childhood vaccines
- Immunisation records review and missed vaccines guidance
- NHS Health Checks
- Smoke free services
- Dental services
- Eye clinics
- Early help and family support (family hubs)
- Learning Disabilities Health Check promotion
- Breast Cancer awareness / screening
- iCaSH Norfolk (Sexual Health services)
- Healthy Hearts

Highlights from April 2024 to January 2025

- Over 1096 Covid vaccines and 281 “other vaccinations” delivered.
  Over 168 Health checks carried out;
- Patient vaccination records reviewed and then brought up to date with the missing vaccinations administered without delay.

WoW bus visiting the Swanton Road Travellers site in Norwich

Kirsty from Reed Wellbeing set her scales and height measure outside the bus – this led to several of the children to come over and be weighed and measured, giving us chance to engage with them. Overall, both ourselves and Kate felt that this was a positive experience, and we have started at least to become more visible to this community and hopefully that will begin to break down some barriers.

HCT saw an 18-year-old on the WOW bus at the Pathway lunch, Great Yarmouth. He was outstanding his teenage boosters. He told us he thought this was a great service as he would not visit the GP surgery for these vaccines and us being available somewhere he was at already made it easier for him to decide to have these done today.

Ambition two – Primary Care Resilience and Transformation

Primary Care (Community Pharmacy, Dentistry, General Practice, Optometry)

Throughout 2024/25, significant progress has been made in improving access to and the experience of primary care services across Norfolk and Waveney. General Practice has continued to implement the Modern General Practice Access model, a key element of NHS England's delivery plan for recovering access to primary care. This has included substantial investment in upgrading digital phone lines to make booking GP appointments easier, with 30 GP surgeries moving to cloud-based telephony systems, 20 surgeries receiving feature upgrades, and 35 surgeries migrating to the GP Voice platform as part of a national pilot scheme. Additionally, six GP surgeries have participated in the General Practice Improvement Programme, bringing the total to 31 surgeries and one Primary Care Network, with plans for further expansion in the coming year.

The Primary Care Digital Team has supported six GP surgeries in streamlining their systems and processes, introducing technology to facilitate total triage models that improve efficiency and ensure a more consistent patient experience. Community pharmacies have played an integral role in delivering clinical services under the national Pharmacy First initiative, with over 3,000 consultations taking place each month. In addition to the seven common conditions covered by Pharmacy First, community pharmacies are also providing oral contraception and blood pressure checks, with activity levels reaching 200 and 3,200 per month, respectively. More than 1,000 urgent medicine supplies are dispensed monthly, ensuring patients have timely access to essential medication.

In dentistry, the publication of the Long Term Dental Plan for 2024-2029 reflects the priorities identified by local communities, including increasing access to urgent care, improving dental services for children and young people, and tackling health inequalities. New services commissioned during the year include an Urgent Treatment Service, a Shared Care Dental Pathway in its final stage of mobilisation, child-focused dental practices aimed at improving access for vulnerable young people, and an Access Improvement Scheme targeting NHS dental provision in areas of greatest need.

Recruiting, training, and retaining primary care staff remains a priority. The 'Golden Hello' incentives have supported 46 dental professionals in securing substantive roles. In general practice, 93% of surgeries are now approved learning organisations, increasing medical placements by 25%, and 95% of practices have accessed Continuous Professional Development opportunities. The NHS General Practice Staff Survey showed improvements across most elements of the NHS People Promise, although staff engagement levels remained unchanged. Equality, Diversity, and Inclusion have remained key priorities, with dedicated programmes in place for 2025/26. There are now 93 trained health and wellbeing champions across primary care and eight TriM (Trauma Risk Management) champions supporting staff wellbeing.

A major advancement has been the introduction of artificial intelligence software to monitor vacancy levels across the primary care system, allowing for more effective workforce planning. This initiative has enabled reporting on workforce risks, with 79% of GP practices engaging in workforce and retention programmes.

Despite ongoing workload and workforce pressures, primary care has achieved notable successes. The total number of GP appointments recorded locally rose by more than 250,000 compared to the previous year. Robotic process automation has been deployed across 15 GP practices to streamline repeat prescription processing, handling 126,000 prescriptions, with plans to expand the automation across the system. A toolkit developed for the Pharmacy First service relaunch has strengthened relationships between primary care providers, improving confidence and collaboration.

In dentistry, the urgent dental treatment service has delivered over 2,000 appointments per month, increasing to 2,500 in early 2025. Between April 2024 and January 2025, nearly 22,000 urgent dental appointments were provided, and 81,000 new patients were seen by NHS dentists, marking an increase of 4,200 compared to the previous year. The Newly Qualified GP Incentive scheme was recognised nationally, receiving a ‘Highly Commended’ award at the HSJ 2024 Workforce Initiative of the Year awards. In 2024/25, the scheme supported 40 newly qualified GPs into substantive roles and expanded to include 11 newly qualified nurses and nursing associates and five newly qualified optometrists.

Advancements in business intelligence platforms have revolutionised the ability to monitor workforce data, allowing for detailed segmentation by role, demographics, and location to better inform workforce planning.

Engagement with patients, communities, and stakeholders has remained a core focus. A new Community Pharmacy ICB Friends and Family Test is set to launch in 2025/26, providing real-time patient feedback to inform service improvements. The Community Voices project continues to ensure that insights from underrepresented communities help shape local NHS services. Feedback from the national GP patient survey and Healthwatch has been regularly reviewed to identify trends and address patient concerns.

Looking ahead, there are challenges to navigate. A review of seven short-term General Practice contracts due to expire in 2025 and 2026 is underway, with a work programme in place to bring greater stability to these services over the next two years. Public consultations on proposed service changes, including those affecting Holt Medical Practice (Blakeney Branch Surgery) and Toftwood Medical Centre in Dereham, have been conducted, with the outcomes shaping future service provision. A consultation on a fairer funding proposal for general practice services, the Norwich Walk-in Centre, the GP Out of Hours Service and the Vulnerable Adults Service was also started, before a decision was taken not to pursue the potential changes.

The work undertaken in primary care resilience and transformation aligns closely with key NHS corporate priorities, including urgent and emergency care, mental health transformation, planned and elective recovery, and financial recovery. The progress made this year sets a strong foundation for continuing to improve access, workforce sustainability, and patient experience in the years ahead.

Ambition three – Improving services for babies, children and young people, and developing our Local Maternity and Neonatal System

The Children and Young People Team is making significant strides in improving engagement and representation within the Norfolk and Suffolk systems. Their work is embedded in local action plans and deep dive activities, ensuring wider NHS participation.

In Special Educational Needs and Disabilities (SEND), the SEND Training Group, co-led by the Designated Clinical Officer (DCO) team, has developed and updated e-learning resources on SEND awareness, essentials, and tribunals. While these resources are available, efforts continue to improve communication and uptake. The DCO team, alongside NHS Suffolk and North East Essex ICB (SNEE), has also provided training for the Education, Health, and Care Plan (EHCP) workforce, strengthening their understanding of NHS services. Data and evidence are being gathered in collaboration with the Business Intelligence team to measure impact and outcomes.

Collaboration with Norfolk and Suffolk County Councils remains a priority in implementing the SEND strategy, local action plans, and a quality assurance framework. Regular engagement with EHCP teams has increased awareness of NHS provision, improving both knowledge and outcomes. However, staffing challenges persist, with the DCO team currently operating at reduced capacity due to maternity leave.

Neurodiversity remains a key focus, with a System Collaborative bringing together education, health, and care stakeholders to tackle system-wide challenges. Efforts include digital interventions, a universal needs mapping tool, a multidisciplinary team (MDT) community pathway, and universal training. A co-produced neurodiversity digital library is now live on Just One Norfolk, providing clinically validated resources for parents, carers, and professionals. Additionally, work has been undertaken with a broad stakeholder group to improve guidance for families seeking NHS, Right to Choose, or independent assessments. Updated communications now clarify pathways for neurodevelopmental support and access to services, with primary care, education, and VCSE sector colleagues receiving guidance to ensure consistent messaging and support.

Across Learning Disabilities and Autism (LDA), progress continues in Transforming Care. The Dynamic Support Register continues to show positive outcomes, with inpatient numbers remaining at or below NHS England's targets. Care, Education, and Treatment Review requests have remained stable, with timely quality assurance submissions ensuring compliance. Efforts to reduce over-medication have also seen success, with updated guidance for the STOMP and STAMP programmes and the appointment of a consultant nurse to lead prescribing guidance. A Section 117 (S117) register has been established to track children and young people subject to aftercare arrangements, with further plans in place for transition support.

The team has also been working closely with parents and carers to review processes following a Global Developmental Delay diagnosis, supported by a new diagnostic tool pilot. The recently launched "Reasonable Adjustments: Our Statutory Duty" training received 100% positive feedback, leading to its expansion across the VCSE sector, primary care, and social care. Annual Health Checks for children and young people have increased, with further initiatives planned into 2025/26, helping reduce crisis-driven hospital admissions. Additionally, the Early Intervention Forum is now operational, ensuring timely responses for children, young people, and their families.

In Continuing Care, the team has processed 60 new referrals since April 2024, with 35 progressing to full assessment. The current caseload includes 83 children – 64 in Norfolk and 19 in Waveney—marking a slight decrease from the previous year. Seventeen children

have been discharged due to improved health, and four families have opted out of Continuing Care services. However, the increasing complexity of cases – driven by advances in neonatal medicine and the extended life expectancy of children with complex needs – has required closer collaboration with safeguarding experts. The team is also working to better identify psychological and emotional needs, ensuring accurate scoring on the Decision Support Tool. Risk assessments are regularly conducted to prioritise cases, balancing health and social care needs. Training gaps for carers receiving personal health budgets (PHBs) are being addressed, while joint funding agreements with education and social care are being strengthened through bi-weekly and monthly panel meetings.

Since April 2024, the team has achieved several key milestones. The DCO and Senior SEND Advisor in Norfolk successfully developed and delivered multi-agency training on writing good SEND advice, receiving positive feedback. The SEND Training Working Group continues to evolve, ensuring ongoing improvements. Early identification and notification of pre-school-age children with SEND has been prioritised within the Norfolk SEND and Alternative Provision strategy. Meanwhile, the neurodiversity assessment provider framework is now live, ensuring providers meet NHS Norfolk and Waveney ICB's quality benchmarks. The expansion of the neurodiversity digital library, following the success of Speech and Language Therapy (SLT) and Occupational Therapy (OT) resources, has further increased access to clinically validated information. The psychological support for epilepsy pilot has also been extended until March 2026 across all three acute trusts.

Work is underway to support the rollout of Hybrid Closed Loop systems for diabetes care, ensuring equitable access for children and young people. Improvements in inhaler techniques for children with asthma are being introduced, aligning with national best practices. The ICS Children and Young People Asthma Clinical Network has been re-established, with active engagement in the Getting It Right First Time (GIRFT) initiative to enhance clinical services and patient outcomes. A light-touch review of weight management services has provided valuable insights into available support. The children and young people's commissioning team remains engaged in national programmes such as the Core20PLUS5 ambassador programme, which is focused on addressing healthcare inequalities.

National recognition continues for the Palliative and End of Life Care (PEoLC) and OT programmes, which support children and young people across Norfolk and Waveney. Phase 2 of the PEoLC Education Programme is now being delivered by clinical educators, with plans to present at the Together for Short Lives Conference in May 2025. Ongoing collaboration with SNEE and NHS Cambridgeshire and Peterborough ICBs aims to develop a joint agreement with East Anglia's Children's Hospice (EACH).

Despite these achievements, challenges remain. The Suffolk SEND area inspection in 2023 highlighted systemic issues requiring urgent action. The shift toward a needs-led approach rather than a diagnosis-driven model remains a priority, alongside efforts to improve data consistency and manage competing service demands. Financial constraints for 2025/26 pose risks to transformation plans, particularly for neurodivergent children and young people. Workforce shortages, particularly in psychiatric services, continue to impact access to ADHD medication and neurodevelopmental assessments. Additionally, the rising number of young people with complex safeguarding concerns or challenging behaviours has increased pressures on Continuing Care services, necessitating new solutions for long-term placements.

Moving forward, the children and young people team remains committed to integration across health, education, and social care, tackling health inequalities, and ensuring young people lead healthy lives. Their work continues to align with corporate priorities, ensuring that families only need to tell their story once. Progress has been made in enhancing the quality of health advice in EHCPs, launching the Neurodevelopmental Quality Assured

Provider Framework, and expanding support through sensory training and family drop-in sessions. However, challenges remain in ensuring young people's voices are consistently reflected in statutory health advice, improving data reporting, and fully integrating Continuing Care assessments with EHCPs.

Maternity

The Local Maternity and Neonatal System has continued to improve maternity care in line with the Three-Year Delivery Plan for Maternity and Neonatal Services. This plan, published in March 2023, brings together recommendations from safety reports, the experiences of maternity staff, and the voices of women and pregnant people. It sets out how the NHS will make maternity and neonatal care safer, more personalised, and more compassionate. The plan's four key priorities are: listening to women and families, strengthening the workforce, fostering a culture of safety and learning, and improving standards and structures. In November 2024, the system reported good progress towards delivering these priorities.

Listening to women and families remains a priority. The establishment of Maternity and Neonatal Voice Partnerships ensures service users' voices are heard and valued. In Norfolk and Waveney, our approach follows national guidance and is supported by strong governance. To further strengthen their role, Healthwatch Norfolk has been commissioned to review the partnerships, with findings expected to inform planning for 2025/26. Another key development has been the full integration of the Perinatal Pelvic Health Service in April 2024, following a successful two-year pilot. This service provides essential support for women and birthing people experiencing pelvic floor dysfunction.

Strengthening the workforce remains central to improving maternity services. Targeted recruitment efforts, including the hiring of student midwives, have helped reduce midwifery vacancies. Ongoing professional development through the national Core Competency Training Framework and Neonatal Life Support Training continues to enhance staff skills and confidence.

A culture of safety, learning, and support is being actively developed. Local Learning Events provide opportunities for knowledge-sharing across the system, addressing key issues in maternity and neonatal care. When clinical incidents occur, the system-wide approach ensures staff receive additional training through Safer Practice Notices and shared learning events. New Collaborative Perinatal Safety Incident Meetings have been introduced to bring together trust-level expertise and further drive safety improvements. Data and digital dashboards are also being developed with the Integrated Care Board's Business Intelligence team to support national digital transformation priorities. These tools aim to improve the quality of maternity care by ensuring both patients and staff have access to the right digital resources and training.

Efforts to improve maternity standards and structures continue. Personalised Care and Support Plans (PCSPs) have been introduced, allowing individuals to receive care tailored to their needs. Breastfeeding support has been strengthened, with increased investment in mentoring services to help achieve UNICEF Baby Friendly Initiative accreditation by 2027. Work is also underway to expand antenatal education. A new system-wide programme, including digital resources and in-person group sessions, is being developed in partnership with the Real Birth Company, with staff training already underway.

Service user engagement remains integral to all improvements. Our Maternity and Neonatal Voice Partnerships ensure that the experiences of women, families and carers directly influence maternity and neonatal care. Each hospital trust in Norfolk and Waveney has its own partnership representing service users from their communities. These partnerships have worked alongside colleagues from the Local Maternity and Neonatal System, as well as individual NHS trusts on a range of projects, including staff training, personalised care

plans, antenatal education, infant feeding support, improving communication and consent, and bereavement care. Notably, their contributions have supported the development of the QEH Butterfly Garden, a dedicated space for bereaved families.

Despite significant progress, challenges remain. Care Quality Commission inspections have revealed varied outcomes across local providers. While Norfolk and Norwich University Hospital (NNUH) and QEH received positive ratings, areas for improvement were identified at JPUH. A Maternity Improvement Plan has been implemented, with most actions now completed.

Health inequalities also continue to affect maternity outcomes, particularly in areas of deprivation. Tobacco dependency remains a key risk factor, with 10.7% of the birthing population in Norfolk and Waveney recorded as smokers at the time of delivery in November 2024, compared to the national target of 6%. However, the introduction of Maternity-Led Tobacco Dependency Pathways has already helped to reduce smoking rates at delivery. Targeted interventions, including the recruitment of a Pre-Term Birth Midwife and Project Manager, are also in place to improve neonatal outcomes.

The ongoing digital transformation of maternity services presents both opportunities and challenges. Digital innovations have the potential to improve access to care, but digital exclusion remains a concern, particularly for vulnerable communities. The Maternity Digital Hub Project is working to address these barriers and ensure equitable access to services.

All of this work aligns with key NHS priorities, including the Joint Forward Plan, Quality Strategy, and Digital Strategy. The Local Maternity and Neonatal System remains on track to meet the requirements of the Three-Year Delivery Plan. Workforce targets are being achieved, with midwifery vacancy rates reduced to below 9% in November 2024. All three local trusts have successfully met the requirements of the Clinical Negligence Scheme for Trusts' Maternity Incentive Scheme, demonstrating compliance with ten maternity safety actions.

Looking ahead, the focus remains on addressing health inequalities, strengthening workforce resilience, improving digital access, and continuing to enhance safety and personalisation in maternity care.

Looked After Children (LAC), Care Leavers and Child Death Review (CDR)

In Looked After Children (LAC) services, the appointment of a Deputy Designated Nurse for LAC in early 2025 has strengthened capacity for strategic planning. The team has also worked closely with Norfolk County Council on a new Enduring Consent form, ensuring timely and appropriate consent is obtained for children in care.

The Designated Nurse for LAC has attended workshops with care-experienced young people to understand their views on health assessments, feeding this into service improvements. The Child Death Review team has used family feedback to improve health promotion efforts.

In LAC services, the consistent number of children in care, often presenting with complex trauma, has placed pressure on suitable placements and mental health support. Unaccompanied Asylum-Seeking Children have also required additional physical and mental health support, with ongoing challenges in meeting their needs within existing resources. There has been a backlog in tuberculosis and blood-borne virus screening for these children, requiring urgent resolution. Additionally, the discontinuation of the Care Leavers Nursing Team in late 2023 due to funding constraints has left a gap in health provision for care leavers, despite their prioritisation within the NHS Long-Term Plan.

The Child Death Review process continues to focus on identifying risk factors and improving prevention strategies. The team remains committed to reducing preventable deaths and ensuring bereaved families' experiences shape service improvements.

Ambition four – Transforming Mental Health services

A significant amount of work has been undertaken during 2024/25 to improve mental health services. This table provides a summary of our performance against a set of key indicators for mental health services:

Mental Health

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend *(Mar 25 vs AVG 24/25)*	Mar-24
EBS3	Inpatients followed up within 72 hours of discharge	%	80%	76.9%	83.4%	↓	95.0%
EH4	MH - EIP 2 week treatment	%	60%	85.7%	88.6%	→	84.6%
EH1	MH - Talking Therapies 6 week waits (entered treatment in month	%	75%	98.9%	98.7%	↑	99.4%
EH2	MH - Talking Therapies 18week waits (entered treatment in mont	%	95%	99.8%	100.0%	→	100.0%
EH10	MH - CYP ED Routine 4 weeks	%	95%	81.8%	76.9%	↑	76.9%
EH11	MH - CYP ED Urgent 1 week	%	95%	100.0%	91.7%	↑	100.0%

The table shows that we have delivered against the indicators related to early intervention in psychosis, talking therapies and inpatients being followed-up after discharge, but there is more to do to improve eating disorder services.

This table shows how much we have spent on mental health services over the past three years:

Financial Years	2022-23	2023-24	2024-25
Mental Health Spend	£182.0m*	£199.4m*	£208.1m**
ICB Programme Allocation	£2,209.9m	£2,455.4m	£2,678.0m
ICB Programme Allocation (net of Pharmacy, Ophthalmology and Dentistry introduced in 2023-24)***		£2,355.3m	£2,576.4m
Mental Health Spend as a proportion of ICB Programme Allocation	8.20%	8.50%	7.55%

*Figure from audited Mental Health Investment Standard Compliance Statement of the respective financial year
**Figure to be audited
*** First year of delegation in 2023-24, therefore removed to provide normalised comparator (estimated reduction included for 2024-25)

Adult Mental Health

Over the past year, the ICB has worked with partners to strengthen and transform adult mental health services by embedding new pathways, improving access, and shaping services based on community needs. Following the implementation of the Norfolk and Waveney urgent and emergency care transformation programme, efforts focused on integrating these new services into the Mental Health Crisis pathway. A central crisis pathway workshop in June 2024 brought together clinical and voluntary sector partners to review existing services and explore ways to streamline support. Monthly touchpoints were introduced to encourage collaboration and shared learning, with more workshops planned for the future.

Mental Health Practitioners and Enhanced Recovery Workers have been fully integrated within Primary Care Networks, ensuring individuals receive timely support closer to home.

This collaboration has enhanced access to mental health services, offering early intervention and continuity of care. In late 2024, a competitive tendering process was held to recommission the Individual Placement and Support (IPS) service, which helps people with severe mental illness find and sustain employment. The service will continue until 2030, ensuring vital, person-centred employment support for individuals with conditions like psychosis and schizophrenia.

In April 2024, a new Dual Diagnosis service was launched in Waveney, offering dedicated support to individuals with both mental health needs and substance misuse issues. This enhanced service aims to improve care engagement, reduce relapse risk, and ensure seamless support to prevent crisis escalation. Co-production has been a key priority in mental health services, with a draft Mental Health Co-production Strategy presented in early 2024 and the final strategy launched in November. This strategy ensures that lived experience is embedded in decision-making across the Integrated Care System, with further steps planned to establish a Co-production Community of Practice and promote mental health equity.

The Right Care Right Person (RCRP) programme went live in May 2024, ensuring health-related calls are directed to the most appropriate agency rather than defaulting to the police. Within seven months, police deployments for health-related incidents fell from 55% to 47%, and officers spent less time on mental health-related handovers. Norfolk has since been recognised as a best-practice example, with other police forces seeking advice on its approach. A review of Intensive and Assertive Outreach services was also conducted in 2024, leading to the development of an action plan to ensure these services remain effective for those needing intensive support.

As part of a restructure, the Adult Mental Health Strategic Commissioning Team was reorganised in 2024/25 into three key functions: business and performance management, system-wide collaboration, and place-based commissioning. This ensures services are tailored to local needs while supporting broader system-wide transformation. A three-year review of acute mental health inpatient services is also underway to ensure high-quality, timely, and accessible care, with a focus on autism support and specialist training.

A pilot Avoidant/Restrictive Food Intake Disorder (ARFID) service has been running in Norfolk and Waveney, supporting individuals with complex eating difficulties. Plans are underway to expand the service beyond the pilot phase by increasing workforce capacity and integrating it into standard commissioning arrangements.

A newly commissioned NHS Talking Therapies launched in September 2024, offering improved access to psychological support through a neighbourhood-based approach. As the new service develops, it will operate from an increasing number of sites across Norfolk and Waveney. Mobile access will also be provided, taking services out into local communities, making treatment and support as accessible and convenient as possible.

To address rising demand for ADHD assessments, a dedicated initiative supported 550 individuals, and a new ADHD Framework has been established to ensure sustainable access to high-quality assessment and treatment services.

Norfolk and Waveney's perinatal and maternal mental health services received recognition from NHS England in September 2024, with a site visit highlighting the success of the Maternal Mental Health Service (Lotus), which supports those experiencing mental health difficulties related to trauma or loss. In the summer of 2024, NHS England colleagues visited to review the improvements made to crisis services, including the introduction of Mental Health Response Vehicles, the 111 Mental Health Option, and new crisis support services such as Short Stay Recovery Houses and Evening Sanctuaries.

Engagement with patients and communities has remained central to service development, with key successes including the launch of the Mental Health Co-production Strategy, which outlines how individuals with lived experience will influence decision-making, and the development of I and We Statements with Experts by Experience to outline quality commitments for commissioners, providers, and system leaders.

Children and Young People Mental Health

During the 2024/25 period, significant progress was made in transforming mental health services for children and young people in Norfolk and Waveney. A key milestone was the continued development of the Children and Young People's System Collaborative, established in April 2023. Led by five key system partners, this initiative has focused on improving integrated working practices and enhancing support for neurodiverse young people, as well as those needing emotional wellbeing and mental health services. A case for change was approved for neurodiversity, while mental health services saw an expansion of community-based and school-led support, reinforcing a commitment to 'place-based provision' in school zones.

The national NHS planning guidance for 2025/26 has reinforced the priority given to children and young people's mental health, with a strong emphasis on increasing access to services, improving productivity, tackling health inequalities, and expanding Mental Health Support Teams (MHSTs). This has provided a framework for further progress in transforming services locally.

Since April 2024, several key initiatives have taken shape. The prevention and wellbeing agenda has been advanced through enhanced integration within the Family Hub and Start for Life programme. A fourth year of funding for perinatal mental health and parent-infant relationship services was secured, enabling NHS Talking Therapies and the Parent Infant Relationship Service to increase their capacity. All staff within the core family hub workforce—around 300 individuals—have now been trained to identify and support perinatal mental health and parent-infant relationship challenges. Additionally, funding was provided to 19 voluntary sector organisations to support fathers in the first 1,001 days of their child's life.

Mental Health Support Teams have expanded, with a target to achieve 100% coverage by 2029/30. Norfolk and Waveney currently have 10 operational teams, with an 11th in training, and access performance has significantly improved. Each team now supports at least 400 young people on average, surpassing the national target of 350. The paired outcome scores for young people engaging with these services have increased to 65%, well above the national target of 50%. The Working on Worries (WoW) pilot, designed to train pastoral staff in parent-led cognitive behaviour therapy, has been rolled out, with 212 staff trained and 380 families expected to benefit in 2024/25. A Community Youth Work offer has also been established across four Primary Care Networks, improving engagement with young people not in education and helping them return to school.

Progress has also been made in community mental health transformation. The Access to Mental Health Advice and Support Service, which launched in April 2024, now processes around 650 requests per month, with urgent cases triaged within two days. The introduction of this service has resulted in a 30% reduction in referrals to Norfolk and Suffolk Foundation Trust (NSFT), with more young people receiving support from community and voluntary organisations. The Professional Therapeutic Pathway has been particularly impactful, providing tailored support to over 500 young people, including those on waiting lists and those at risk of exploitation. Furthermore, 16 charities received funding to support disadvantaged groups, with all reporting excellent outcomes.

Efforts to enhance urgent and emergency care have also yielded results. The Mental Health Navigator Team is now fully mobilised, supporting 40 young people at risk of admission or in crisis, which has contributed to a reduction in specialist inpatient admissions from 12 to 7. Mental health practitioners based on acute paediatric wards continue to facilitate early discharge, ensuring children and their families receive appropriate care with the right clinical expertise. In addition, a crisis pathway review is underway to address concerns around service quality and access, with a focus on returning crisis teams to extended hours in line with national guidance.

Support for young people with eating disorders has expanded. The Avoidant Restrictive Food Intake Disorder (ARFID) pathway is now embedded within the broader eating disorder service, addressing an area of previously unmet need. Additionally, the Lighthouse Intensive Eating Disorder Day Service has become a model for best practice and is now being replicated across the East of England. Eating Matters continues to provide early intervention counselling for young people with mild to moderate disordered eating, helping to reduce escalation into specialist services.

Over the past year, engagement with young people and families has strengthened. The Youth Governance Group has led on the development of a Children and Young People's Mental Health Charter Implementation Toolkit, ensuring that commissioned providers are held to the charter's commitments. The participation model has been re-procured to improve representation, particularly among under-11s, families, and those with physical health needs. Young people have played an active role in service design, including renaming the Integrated Front Door service to the Advice, Support and Access Service following a dedicated workshop. Parent carers have been fully integrated into governance structures, with representation on the Children and Young People's Mental Health Executive Management Board and regular engagement through monthly forums.

Despite these achievements, challenges remain. Financial pressures continue to impact service delivery, requiring ongoing transformation and innovation to ensure sustainability. While significant strides have been made in reducing waiting times and improving access, further work is needed to address pressures on voluntary sector providers, who have seen increased demand as more young people are supported outside of NSFT. Workforce recruitment and retention also remain a challenge, affecting providers' capacity to meet demand. Although the number of children waiting for treatment has significantly decreased over the past year, further efforts are required to maintain and build upon this progress.

The programme aligns with key corporate priorities, including supporting children and young people to lead the healthiest lives possible, reducing the need for them to tell their story multiple times, and making Norfolk and Waveney the best place to work for those delivering mental health care. The commitment to expanding Mental Health Support Teams and embedding early intervention models in schools is central to these aims, ensuring young people receive support as early as possible. The Advice, Support and Access Service has further streamlined pathways, improving access and outcomes for children and young people by offering a system-wide approach to triage and assessment.

Several targets have been successfully met, including the implementation of 11 Mental Health Support Teams, an increase in access to support from 12,658 young people in 2023/24 to 15,075 in 2024/25, and improved paired outcome scores across all commissioned voluntary sector providers. However, some challenges remain, such as meeting the national target for urgent and routine referrals for eating disorders within 7 and 28 days, respectively, and ensuring 24/7 crisis support is available. While progress has been made, particularly in reducing waiting times, further service improvements are planned, including increased investment in crisis services and additional support for voluntary sector providers to manage rising demand.

Looking ahead, the focus remains on continuing to drive forward transformation efforts, ensuring children and young people in Norfolk and Waveney receive high-quality, timely, and effective mental health support.

Ambition five – Transforming care in Later Life

The Ageing Well programme is dedicated to helping older people in Norfolk and Waveney live healthier, more independent lives. Through a combination of proactive care, community engagement, and integrated health and social care services, the programme has improved access to healthcare, reduced avoidable hospital admissions, and enhanced overall wellbeing.

A key focus has been to ensure that older individuals receive the right care, in the right place, at the right time, supporting them to remain in their own homes and communities whenever possible.

Anticipatory Care and Crisis Support

A major achievement of the programme has been the development and expansion of anticipatory care planning, which ensures that older adults—particularly those at risk of deteriorating health—receive personalised and timely support. By working in close collaboration with primary care networks, social care teams, and voluntary sector organisations, the programme has helped identify those most in need and implement early interventions to prevent health crises. This proactive approach has empowered individuals to take control of their own health and wellbeing, reducing unnecessary hospital visits and enabling more people to receive care in their preferred setting.

The urgent community response service has also been strengthened, providing rapid assessment and intervention for individuals experiencing a crisis at home. By offering timely support, this service has prevented unnecessary hospital admissions and ensured that people receive the care they need in familiar, comfortable surroundings. The programme continues to work in partnership with local providers to ensure that urgent care pathways are efficient, accessible, and responsive to the needs of older people.

Supporting Frailty and Dementia Care

Recognising the increasing need for frailty and dementia support, the programme has made significant strides in improving the assessment, diagnosis, and management of these conditions. The Frailty Attuned Acute Care workstream has successfully collaborated with health partners to implement a unified Clinical Frailty Scale, which is now being piloted at NNUH and QEH. This standardised tool is helping healthcare professionals assess frailty more effectively and guide appropriate care planning, both in hospitals and primary care settings.

To improve dementia care, the Dementia Attuned Care workstream held a System Round Table event in September 2024, bringing together clinicians, social care providers, and individuals with lived experience. Discussions highlighted key challenges in dementia care and reinforced the need for an integrated Dementia and Frailty pathway, as well as a system-wide digital solution to improve early identification and coordination of support for those living with dementia. These insights are shaping future service improvements, ensuring that dementia patients and their carers receive timely, personalised, and well-coordinated care.

Social Isolation and Improving Community Support

Social isolation is a growing concern for older people, impacting both mental and physical health. To address this, the Prevention workstream, in partnership with Norfolk County Council Public Health, conducted a Social Isolation and Needs Assessment to better understand the challenges faced by vulnerable groups. Drawing on data from national and regional surveys, as well as direct engagement with health and non-health partners, the findings have helped update local strategies and ensure that social isolation is a key consideration in service planning.

Community-based initiatives, such as befriending schemes, social prescribing, and local activity programmes, have been expanded to encourage social connection and engagement. These efforts have played a vital role in supporting older people's mental wellbeing, helping them remain active and connected to their communities.

Care in Residential and Nursing Homes

The Care Homes and Housing with Care workstream has been working closely with social care providers to improve nutrition, hydration, infection prevention, and oral health among care home residents. In November 2024, the team hosted its first face-to-face Nutrition and Hydration Champions workshop since 2019, bringing together a wide range of residential and nursing home providers to share best practices and enhance learning. Feedback from attendees highlighted the value of in-person engagement, leading to increased demand for further workshops and training sessions.

Beyond formal training, engagement events have been held to support care homes in advocating for their residents, adopting age-friendly practices, and reducing avoidable hospital admissions. By equipping care home staff with the right knowledge and tools, the programme is helping to ensure that residents receive high-quality, person-centred care that promotes their health and wellbeing.

Future Priorities for Ageing Well

The Ageing Well programme will continue to build on its successes by further integrating health and social care services, ensuring seamless and person-centred care pathways. Strengthening partnerships with voluntary organisations, local government, and community groups will remain a priority to enhance support networks for older people. The programme will also expand proactive care models, including anticipatory care planning and urgent community response services, to improve early intervention and prevent avoidable hospital admissions. Enhancing digital solutions will play a key role in improving data sharing and enabling the early identification of vulnerable individuals. Additionally, the programme will drive innovation in frailty, dementia, and care home support, ensuring better outcomes for older people. By keeping older individuals at the heart of its approach, the Ageing Well programme remains committed to helping people maintain independence, access high-quality care, and live fulfilling lives within their communities.

Ambition six – Improving Urgent and Emergency Care

A significant amount of work has been undertaken during 2024/25 to improve urgent and emergency care (UEC). This table provides a summary of our performance against a set of key indicators:

Emergency

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend *(Mar 25 vs AVG 24/25)*	Mar-24
EB5	A&E attendance seen <4 hrs	%	78%	72.8%	74.1%	→	77.0%
EBS5	Proportion of Service Users attending A&E who wait more than 12 hours from arrival to discharge, admission or transfer	%	2%	6.7%	5.6%	↓	5.3%
	Ambulance - Cat 1 7min mean	Min	7	09	10	↑	10
	Ambulance - Cat 1 15min 90th centile	Min	15	17	18	↑	18
	Ambulance - Cat 2 30min mean	Min	30	33	41	↑	41
	Ambulance - Cat 2 40min 90th centile	Min	40	70	90	↑	91
	Ambulance - Cat 3 120min 90th centile	Min	120	206	289	↑	269
	Ambulance - Cat 4 180min 90th centile	Min	180	240	382	↑	225
EBS7a	Ambulance - Arrival to handover <15mins	%	65%	30.3%	35.2%	↓	37.5%
EBS7b	Ambulance - Arrival to handover <30mins	%	95%	54.2%	60.9%	↓	63.1%
EBS7c	Ambulance - Arrival to handover <60mins	%	100%	71.7%	77.0%	↓	78.9%
EBS8	Ambulance - Handover to Clear >30mins	#	0			→	

Over the course of 2024/25, Norfolk and Waveney made significant progress in improving UEC performance, resulting in the system being moved from NHS England's highest level of intervention - Tier 1 - to a lighter-touch support programme in Tier 2. This achievement was driven by sustained improvements against two key national standards: ensuring that 78% of A&E patients were admitted, transferred, or discharged within four hours, and reducing Category 2 ambulance response times to an average of 30 minutes.

These improvements were made possible through strong collaboration across the system. One of the most impactful changes was the expansion of the Community Virtual Ward, which provided an alternative to A&E attendance and emergency admissions. This allowed more patients to receive hospital-level care in their own homes, reducing the strain on hospitals while improving patient outcomes. The introduction of the Unscheduled Care Coordination Hub (UCCH) also played a crucial role in improving urgent care. Bringing together urgent care doctors, paramedics, community and mental health nurses, and social services, the hub enabled a multi-disciplinary team to assess and coordinate care for complex patients accessing 999 and 111 services. By ensuring patients received the right support at home where possible, the UCCH reduced unnecessary ambulance dispatches and hospital admissions, ensuring emergency resources were available for those in greatest need.

Hospitals across Norfolk and Waveney also made significant improvements in ambulance handover processes, reducing waiting times and ensuring ambulances could return to the community more quickly. In addition, a focus on reducing hospital length of stay allowed more patients to be discharged safely and efficiently, freeing up capacity for those in need of urgent care.

Despite these improvements, challenges remain in ensuring consistent performance across the region. Norfolk and Waveney's rurality and road infrastructure continue to impact ambulance response times, and the growing number of patients attending A&E for minor conditions has placed increasing pressure on emergency departments. Seasonal fluctuations, including flu outbreaks in winter and population surges due to summer tourism, have further complicated demand management. As a result, performance fluctuated throughout the year. Four-hour A&E targets varied, with an average performance of 74.1%, while Category 2 ambulance response times remained higher than in other areas of the East of England but still fell short of the 30-minute target.

Key Achievements in 2024/25

One of the most notable successes this year was the continued effectiveness of the Urgent Community Response (UCR) service. On average, UCR teams exceeded the national two-hour response target in 70% of cases, ensuring patients received rapid care at home and avoiding unnecessary hospital admissions.

The UCCH has also had a significant impact since its launch. In its first 12 months, the hub reviewed more than 17,800 emergency calls, with 11,270 patients receiving care from community providers rather than being conveyed to hospital. This approach has not only improved patient outcomes but has also been recognised nationally, earning shortlistings for both the Urgent Care UK and Health Service Journal awards.

The expansion of Virtual Wards has been another critical development, particularly in supporting care home residents – one of the most vulnerable groups at risk of unnecessary hospital admissions. The model has now been refined to integrate both step-up and step-down beds, allowing greater flexibility in meeting patient needs. A system-wide review is currently underway to maximise the potential of Virtual Wards, helping to further reduce hospital admissions and enable earlier discharges.

Further improvements have been seen in emergency care services, including the procurement and implementation of a new Non-Emergency Patient Transport Service (NEPTS), which transitioned to a new provider, Health Transport Group (HTG), in October 2024. Work has also continued across the region's acute hospitals to improve patient flow and reduce delayed discharges. One example is the frailty Same Day Emergency Care (SDEC) unit piloted at QEH, which has successfully prevented unnecessary admissions and secured permanent funding for its continuation.

Priorities for 2025/26

Building on the progress made in 2024/25, Norfolk and Waveney remains committed to improving urgent and emergency care, ensuring patients receive the right care in the right place at the right time. Key areas of focus include further reducing ambulance response times, improving hospital flow, and enhancing rehabilitation and recovery services.

In emergency response, the system will work towards maintaining average Category 2 ambulance response times at 30 minutes and ensuring all ambulance handovers are completed within 15 minutes, with no handover exceeding 45 minutes. Further investment in hear and treat services will reduce unnecessary ambulance dispatches, while increasing capacity in Same Day Emergency Care (SDEC) units will help prevent unnecessary hospital admissions. The Virtual Ward programme will also be expanded, providing additional capacity for both step-up and step-down care.

In hospitals, the focus will be on improving A&E performance, with a goal of ensuring at least 78% of patients are admitted, discharged, or transferred within four hours by March 2026. Efforts will also be made to reduce length of stay across all inpatient settings, ensuring patients can be discharged in a timely manner and freeing up capacity for those in need of urgent care.

In the recovery and rehabilitation phase, the priority will be to maximise patient flow through intermediate care and domiciliary care pathways, enabling more patients to be discharged safely from hospital. Reducing hospital readmissions will also be a key focus, ensuring that patients receive the support they need to manage their recovery at home.

These priorities align with the national objectives outlined in NHS England's Urgent and Emergency Care Recovery Plan and 2025/26 Planning Guidance. By continuing to improve urgent and emergency care services, Norfolk and Waveney aims to provide a more responsive, efficient, and patient-centred system, ensuring better health outcomes for the entire region.

Patient Story

Jim's experience of care

Jim is 75 years old. He has a history of Chronic Obstructive Pulmonary Disease (COPD) with a recent exacerbation. In the past Jim has had a stroke, has mild dementia, unstable angina and problems with his oesophagus. Jim lives at home on his own and is supported by his family.

Jim called 999 for an ambulance when he experienced chest pain. His 999 call was coded as Category 2, the second most serious type of call. Jim received an ambulance on blue lights and sirens at his home address. On arrival the Paramedics found Jim in considerable discomfort and very worried with pain in his chest area but he had a clear ECG. The Paramedics called the Unscheduled Care Coordination Hub to discuss Jim's presentation with an urgent care doctor.

The consultation between the UCCH Doctor, Jim and the Paramedic centred on the cause of Jim's pain and the most appropriate treatment for him. All agreed Jim needed immediate further tests – bloods, the ECG repeated over time, and an X-Ray. Jim's clinical presentation was stable and he could wait in a clinic, not ED, which would be a better way to manage Jim's dementia and reduce his stress.

A number of options were ruled out, such as referral to his own GP and attendance in an Outpatient clinic. A&E was not the best place for Jim to receive care because of his dementia. Virtual Ward wouldn't fully meet Jim's needs as the cause of the chest pain required further investigation.

A plan was agreed with Jim and his family, alongside the Paramedics attending Jim and the UCCH Doctor. The UCCH Doctor arranged an appointment for Jim in a Same Day Emergency Clinic (SDEC) at hospital to review and understand the cause of his chest pain. A referral was also made to Virtual Ward who would support Jim at home following discharge from the same day clinic.

Ambition seven – Elective Recovery and Improvement

A significant amount of work has been undertaken during 2024/25 to improve elective care. This table provides a summary of our performance against a set of key indicators:

Waiting Times

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend (Mar 25 vs AVG 24/25)	Mar-24
EB4	Diagnostics completed <6 weeks	%	95%	73.9%	71.5%	↑	71.4%
EB3	RTT - Incomplete Pathways	%	92%	55.0%	53.9%	↑	51.4%
EBS4	RTT - Incomplete pathways > 78 weeks	#	0	22	206	↑	531
EBS4	RTT - Incomplete pathways > 65 weeks	#	0	297	1,654	↑	3,385

Cancelled Operations

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend (Mar 25 vs AVG 24/25)	Mar-24
EBS2	Number of patients not treated within 28 days of last minute elective cancellation	#	0	93	88.3	↓	85
EBS6	No urgent operation should be cancelled for a second time	#	0			→	

Efforts to reduce long waiting times for planned treatments have continued, with the number of people waiting 78 weeks or longer reduced to less than one-tenth of the previous figure. This remains a national priority, and further work will focus on ensuring that patients receive timely care. The successful expansion of patient-initiated follow-up pathways has given patients more control over their ongoing care, while the rollout of the Patient Engagement Portal has improved access to appointments and reduced administrative burdens. Continued engagement with patients and communities will remain at the heart of service improvements, ensuring that care is responsive to the needs of the local population.

Community Diagnostic Centres have opened at QEH and two locations in the Great Yarmouth area, as well as at the NNUH. These facilities are helping to diagnose patients more quickly, reducing delays in treatment.

Across the three acute hospitals in Norfolk and Waveney, we are working hard on the introduction of an Electronic Patient Record (EPR) system. This new system will replace paper-based records, allowing healthcare staff to access patient information quickly and securely, improving the speed and quality of care. The software has been installed, and work is underway to configure it for use, including mapping clinical pathways and preparing staff training. While the programme is in its early stages, significant progress will be made over the next year as we move towards the system going live in 2026. This will improve coordination between services and ensure that healthcare professionals have access to the information they need.

In infrastructure developments, two hospitals in Norfolk and Waveney - QEH and JPUH - have been approved to move forward under the New Hospital Programme, marking a major step in strengthening healthcare facilities. Additionally, the new Orthopaedic Centre at JPUH opened in January 2025, increasing capacity for surgical procedures.

Collaboration across the system has been a key focus, ensuring that hospitals inside and outside Norfolk and Waveney, as well as independent providers, are working together to meet patient needs. A new internal Multidisciplinary Team (MDT) has been established within the ICB to address operational challenges, improve data accuracy, and resolve quality concerns, ensuring that patients receive high-quality care. The Elective Recovery Team, including Patient Coordinators, has played an essential role in expanding capacity through independent sector providers, helping patients access treatment and providing travel support where needed.

Several targeted service improvements have been introduced. A new Norfolk and Waveney-wide Musculoskeletal (MSK) Single Point of Access was launched in April 2024, enabling patients to receive assessments and treatment regardless of where they live. A dedicated

patient website now provides self-management support and allows people to self-refer without needing a GP appointment.

The Women's Health Hub programme has also seen significant developments. A virtual hub now delivers the eight core services from the Women's Health Strategy, supported by the KnowledgeNow platform. Training for 50 new contraceptive fitters is underway, pharmacists have been trained to improve contraceptive services, and pessary fitting and removal training will begin in April 2025. A breast pain assessment pilot received 98% positive feedback, and community engagement is ongoing to ensure that services reach underserved populations. An independent sector provider contract has been secured until November 2026 to improve access to gynaecology services.

The Clinical Policy Development Group has established a robust review and approval process for Individual Funding Requests. It also leads the development and updating of policies, oversees the Clinical Threshold Policy, and conducts horizon scanning to anticipate future needs. All policies are publicly accessible on the Knowledge NoW website.

For older people, the Frailty Attuned Acute Care programme has introduced a system-wide approach to integrating care and reducing falls and fractures. A Virtual Frailty Ward launched at QEH in April 2024 has already supported over 800 patients, significantly reducing infection risks and functional decline. The North Norfolk Frailty Project has provided post-ED support for patients over 50 who have suffered falls, benefiting 800 individuals and leading to 248 referrals for additional care. The Dementia Charter was introduced in May 2024, with six out of seven statutory organisations signing up to improve dementia care. Other initiatives include the Warm and Well campaign to support residents through winter and the Nutrition and Hydration Workshop, the first in-person session since 2019, which saw strong attendance and demand for further sessions.

Palliative and end-of-life care services have also been strengthened. A new training package has been developed to improve healthcare professionals' communication skills for end-of-life discussions. A "Yellow Folder" is being introduced to standardise key information for end-of-life patients, ensuring that their care preferences are clearly documented. A digital dashboard has been created to identify health inequalities and explore the use of AI to enhance service delivery.

Despite progress, challenges remain. Managing demand within the financial constraints of a break-even budget while improving service delivery will require innovative approaches. Workforce shortages continue to impact waiting times, and ensuring timely access to diagnostic services remains a priority. Work will continue to optimise resources, improve efficiency, and develop new insights into health inequalities to support those most in need.

The improvements in elective recovery are closely linked to all other healthcare priorities, including urgent and emergency care, primary care, mental health, and financial recovery. A system-wide approach is essential to managing demand effectively and ensuring that elective services continue sustainable improvements.

Cancer

A significant amount of work has been undertaken during 2024/25 to improve cancer care. This table provides a summary of our performance against a set of key indicators:

Cancer

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend *(Mar 25 vs AVG 24/25)*	Mar-24
EB27	Cancer - 28 days Faster Diagnosis Standard	%	77%	79.6%	67.5%	↑	73.9%
EB8	Cancer - 31 days	%	96%	88.2%	88.9%	→	86.0%
EB12	Cancer - 62 days	%	70%	61.7%	59.1%	↑	61.3%

Over the past year there have been several developments in cancer services across Norfolk and Waveney. Despite continued challenges with cancer waiting times across the three trusts, efforts have been focused on reducing diagnostic and treatment backlogs. Cancer transformation funding has been used to support these trusts in clearing these backlogs and working towards recovery of the Cancer Waiting Time (CWT) targets. To support this, a new system group was set up to promote more collaborative working and the sharing of best practices for streamlining cancer diagnostic pathways. Additionally, teledermatology has been introduced in one of the acute trusts, and a decision support tool for Primary Care is being trialed to reduce variation in urgent suspected cancer referrals. The uptake of the FIT test for colorectal cancer in Primary Care has remained high at 80%, meeting the national target. A "FIT test negative" pathway has also been implemented to help clear the colorectal cancer pathway backlogs in local trusts.

Lung Cancer Screening, previously known as Targeted Lung Health Checks (TLHC), is now operational in Great Yarmouth/Gorleston and Lowestoft, with plans for expansion across Norfolk and Waveney starting in Summer 2025. Ten thousand patients have been invited to participate, with 27 lung cancer diagnoses made so far. Over 60% of these cases were diagnosed at stage 1 or 2, where treatment is often more successful. The programme has also included efforts to engage with the smoking community to improve uptake, in partnership with the ICNB Community Voices programme.

A pilot project has also been launched in partnership with local Community Pharmacies and the Local Pharmacy Committee, allowing pharmacists to refer patients for assessment via the local Rapid Cancer Diagnostic Service. Nine pharmacies have completed 26 consultations, resulting in 13 urgent suspected cancer referrals and one cancer detection. This initiative is particularly important for people who may not otherwise visit their GP.

The ICB has worked with people with lived experience of learning disabilities and autism (LD&A), in partnership with the Opening Doors advocacy charity, to gather insights into the cancer care experience. These insights have helped inform a charter for care providers to improve service delivery. Furthermore, the ICB has collaborated with the Community Voices initiative and Women's Health to address barriers to accessing bowel screening, starting a population health management project to maximise uptake.

Work continues to improve access to personalised care for people affected by cancer in Norfolk and Waveney, with trials underway to improve psychological support access in local trusts, in partnership with Macmillan. Insights from the National Cancer Patients Survey are being used to reduce variations in the patient experience of cancer care reviews.
The ICB is working closely with trusts to advance the cancer workforce strategy, focusing on recruitment, retention, and development, which includes the introduction of new Care Navigator roles. This work ties into planning for a new model for cancer services.

Key achievements since 1 April 2024 include progress on the "hub and spoke" model for cancer oncology services, the implementation of the FIT test negative pathway, positive feedback on the primary care upskilling pathway for breast pain, and widespread implementation of the C the Signs system, with 96% of practices signed up. The lung cancer screening programme has made significant strides, with 10,000 patients invited and 27 lung cancer diagnoses made, many at earlier and more treatable stages. The Community

Pharmacy pilot has been hailed as a national exemplar, and collaboration with Opening Doors has led to improvements in the cancer pathway for people with LD&A.

The ICB and local trusts have used a variety of engagement methods, including insights from the National Cancer Patients Survey, to shape services. Additionally, the partnership with Community Voices has provided valuable feedback on barriers to accessing lung cancer screening.

Cancer care remains a challenge, with waiting time targets proving difficult to meet despite focused efforts to reduce variation and clear diagnostic and treatment backlogs. Cancer transformation funding has been used to support local trusts in tackling these challenges, and work is ongoing to improve access to timely cancer care.

There also continues to be variation in operational surges in urgent suspected cancer referrals, workforce constraints, and variable uptake of teledermatology. Additionally, there is still a reliance on fixed-term funding to support cancer transformation.

In the coming year, the ICB will continue to focus on improving operational performance, particularly in Primary Care and elective recovery, while working to address health inequalities and the variation in patient care. The targets for cancers diagnosed at stages 1 and 2 aim to reach 75% by 2028, with Norfolk and Waveney currently at 56.3%, though this figure is subject to data completeness. The continued work on teledermatology and the implementation of strategic service development plans for dermatology and oncology will be key priorities moving forward.

Musculoskeletal (MSK) Health Services

A key milestone this year has been the implementation of a full MSK Single Point of Access (SPoA), ensuring that all routine MSK patients have equal access to triage, assessment, and treatment, regardless of their location.

One of the major achievements has been the launch of the self-service app, AirMid, which allows patients to book their own treatment appointments, enhancing accessibility and convenience. Additionally, the introduction of the NoW website provides clear signposting to services, along with self-management exercises and advice. The referral pathway has also been improved, leading to a reduction in unnecessary secondary care referrals. This has been supported by the planned full implementation of the MSK N&W Musculoskeletal Assessment and Triage Service (MATS).

Collaboration has been a crucial part of these improvements, with East Coast Community Healthcare (ECCH) and Norfolk Community Health and Care (NCHC) working together to ensure that patients can access treatment anywhere in Norfolk and Waveney. Enhanced data monitoring has also been introduced, allowing for better tracking of patient journeys. In addition, new service specifications have been developed for both MATS and SPoA, ensuring a more structured and consistent approach to service delivery.

Patient and stakeholder engagement has played a vital role in shaping these developments. The NoW team has worked closely with Healthwatch, while the ICB has engaged with key stakeholders to ensure a collaborative approach to transforming the MSK pathway. Their insights and feedback have been instrumental in refining the service to better meet patient needs.

Looking ahead, the expansion of MATS services remains a priority. Plans are in place for MATS in West Norfolk and North Norfolk, with the North Norfolk service expected to be operational by April 2025 and West Norfolk following later in the year.

Diabetes

A key development during 2024/25 has been the successful implementation of the Type 2 Diabetes Path to Remission (T2DR) Programme, which provides a low-calorie, total diet replacement treatment for individuals with type 2 diabetes and obesity. This programme encourages participants to adopt healthy lifestyle changes to achieve weight loss and potentially put their diabetes into remission.

Further progress has been made with the Diabetes Injectable Therapies Training initiative, where more healthcare professionals in GP practices have received training to manage complex diabetes care. This training has included interactive sessions to improve their understanding and management of injectable therapies for diabetes. Additionally, the introduction of Hybrid Closed Loop (HCL) systems has improved the quality of life for individuals with Type 1 Diabetes by combining a continuous glucose monitor with an insulin pump to regulate blood sugar levels effectively.

Enhanced Primary Care pilots have also begun, offering an additional level of care for people with more complex diabetes needs. These pilots are being run in various local PCNs, including West Norwich, Swaffham and Downham, and Great Yarmouth and Northern Villages, with the aim to improve outcomes for individuals with diabetes.

Key achievements have been made across several areas. The NHS Diabetes Prevention Programme (NDPP) has seen significant success, with Norfolk and Waveney improving from a low-performing area to one of the best in the country. Between April 2024 and January 2025, 9,715 referrals were received, and 4,670 people started the programme, exceeding the target by 173%. Additionally, the Structured Education programme has led to increased participation in digital education for individuals with Type 2 Diabetes, with 2,900 new accounts registered.

The Type 2 Diabetes Path to Remission (T2DR) Programme has also been successful, with 450 referrals received, 360 deemed eligible, and 205 individuals starting the programme. Participants have shown an average weight loss of 14.3kg, or a 12% reduction in body weight. There has also been progress in the completion of care processes for individuals living with diabetes, with the percentage of patients who had all care processes completed increasing from 36.3% in March 2021 to 61.9% by March 2024.

The Transition and Young Adult (TYA) Pilot Project, launched in March 2023, has improved outcomes for young adults with diabetes, particularly from deprived communities, by reducing missed appointments and improving diabetes control. The insights from this pilot will be used to inform broader application across the ICS.

The service has also actively engaged with patients and communities to shape and evaluate diabetes services. 940 individuals participated in the National Diabetes Experience survey, providing valuable insights into the experiences of those with Type 1 and Type 2 diabetes. This feedback highlighted areas for improvement, particularly in the availability of diabetes courses and the experience of annual reviews for individuals with Type 1 diabetes and addressing the financial impact of living with diabetes for those with Type 2 diabetes.

Despite these successes, several challenges remain. Diabetes continues to be a significant financial burden, with an estimated cost of £190 million annually in Norfolk and Waveney. There are also ongoing challenges in providing the right services with the necessary expertise to support healthy living and prevent complications.

Looking ahead, the service will continue to focus on Planned and Elective Recovery, particularly in relation to diabetes care. Several targets have been met, including significant improvements in diabetes prevention, structured education, and the Type 2 Diabetes Path to Remission programme. However, challenges remain in completing care processes for individuals with Type 1 diabetes, achieving treatment targets for both Type 1 and Type 2 diabetes, and increasing engagement in reviews for early-onset type 2 diabetes (T2DaY).

Overall, while there has been considerable progress in the delivery of diabetes care, the service continues to face challenges in ensuring all patients receive timely and effective care, particularly those with complex needs or early-onset type 2 diabetes.

Ambition eight – Improving Productivity and Efficiency

Strategic Transformation

Lord Darzi's report on the state of the National Health Service in England (*Independent investigation of the NHS in England*, September 2024) showed that NHS services are stretched to breaking point and that radical change is needed as incremental improvement will not resolve the challenges. In response, the government is developing a 10-year plan for health and care, based on three 'big shifts' they want to see in health and care, moving from:

Hospital to Community Services: The biggest improvements to health and care will come from prioritising services outside of hospital. That means greater investment in the primary and community services that support people before they need hospital treatment.

Treating sickness to preventing it: political focus on public health strategies that keep people healthy and prevent illness in the first place.

Analogue to digital: Using digital technology to improve patient experience and outcomes and help deliver the ambition of moving care closer to home.

More locally, across the East of England, the NHS delivers health care to over 6.4 million people, covering a large and diverse urban and rural geography. Despite this diversity, NHS services face similar challenges of limited capacity to support an ageing population that is rapidly growing, high rates of multi-morbidity, rising demand, significant health inequalities, preventable long-term conditions, a need to better manage and co-ordinate care for improved patient outcomes and a workforce that needs to adapt to meet the future care needs of the people it serves. Collectively, these challenges are creating unsustainable healthcare costs.

There is increasing demand on healthcare services from a growing population, with increasing (national annual rate of 6.1%) prevalence of multimorbidity who need support to live well, for longer. Therefore, a different model of care is needed that provides an alternative, safe and sustainable option.
This transformative approach shifts from traditional acute care to a community-based model that enhances accessibility, patient satisfaction, and operational efficiency. Our priority is to empower people by placing access to care directly in their hands, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease.

This regional approach, owned by all ICBs, sets out a new care model covering four areas of delivery and implementation:

1. **Digital Enablement**: Utilises electronic health records (EHRs) and telemedicine to enhance patient care, streamline data sharing, and reduce costs. Digital tools will improve efficiency, accessibility, personalised care, and patient outcomes, while also allowing patients to manage appointments and access health records online.

2. **Health Optimisation**: Focuses on prevention, early detection, and management of chronic conditions. It targets high-risk populations with personalised interventions to improve health outcomes and reduce healthcare utilisation.

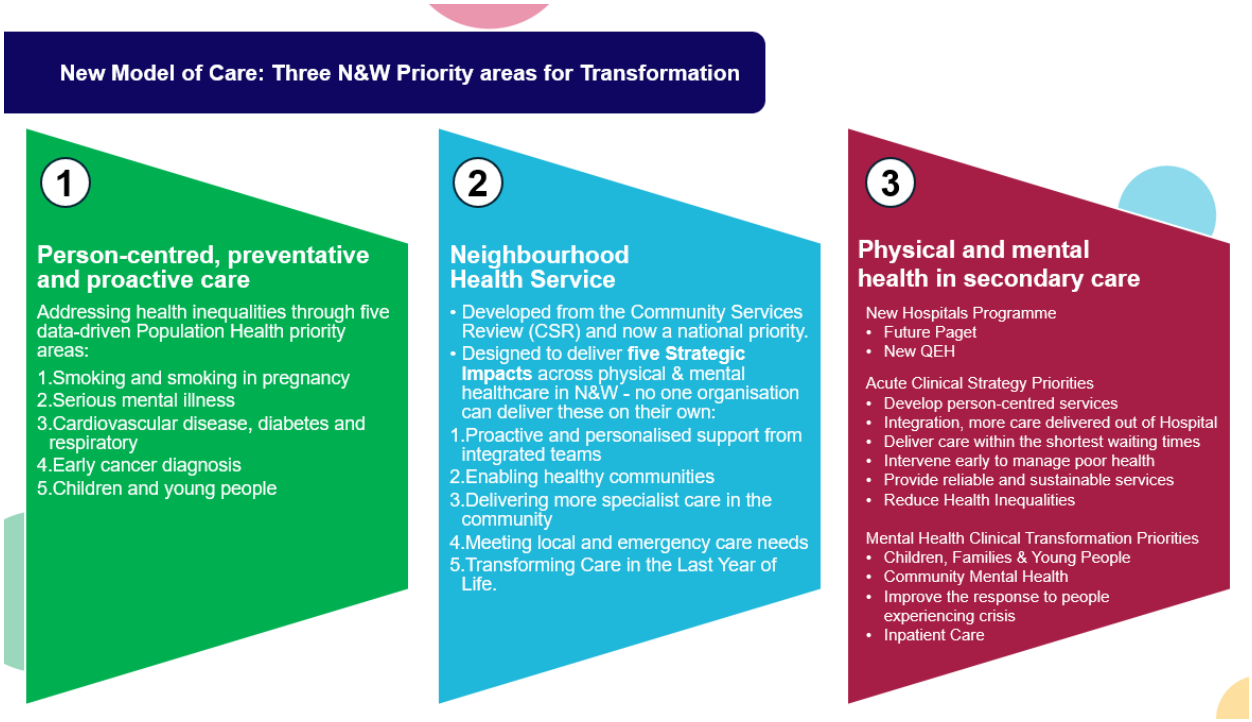
3. **Acute Illness Management**: Integrates multi-disciplinary teams (MDTs), case managers, and a virtual hospital infrastructure to streamline patient care, reduce delays, and ensure seamless transitions. This model emphasises community-based acute care and reduces unnecessary hospital admissions.

4. **Advanced Illness Care**: Enhances quality of life for individuals in their last two years by providing personalised support, managing end-of-life care, and reducing hospital admissions through better community care.

We are working to develop our new local model of care to tackle the local, regional and national challenges. We have started to draft the framework that sets out our system approach to efficiency, productivity and transformation over the next five years. Alongside our other strategies and plans, this work will:

- Set out the overall vision for how the system will function and the key services that will be delivered
- List the priorities for transformation (including Prevention and Anticipatory Care, the Neighbourhood Health Service, Acute Collaboration, End of Life Care, Ageing Well and Long-Term Conditions Management)
- Describe our ambition for these areas:
    - We will use expertise (nationally and worldwide) to help us create the very best models for our community
    - We will embed a culture of innovation and continuous quality improvement to evolve services, but we will also future proof and protect services from regular, disruptive systemic change
    - We will start from a 2030 blank page (building up from demand, capacity and need), and then work back to fit in our current assets, existing plans and strategies and plan to fill the gaps
    - We will balance making the necessary short-term changes and efficiencies, with the new models in mind and the aim to achieve a high performing but lower cost system
- Describe the structures that will deliver the new models and what fundamentally will be delivered at each level of:
    - System
    - Place
    - Neighbourhood Health Service via our Integrated Neighbourhood Teams

The emerging transformation priorities are detailed below:



The framework will provide clarity and direction on the agreed roadmap and model for implementation to deliver this scale of change. The immediate focus of the new model of care work is to support with the Queen Elizabeth Hospital (QEH) and James Paget University Hospital (JPUH) outline business case development, through the outline design of the service changes needed to deliver the activity and capacity mitigations described in the outline business cases. At the time of writing, the outline business cases are due for submission by the QEH by July 2025 and JPUH by October 2025.

Joint Forward Plan (JFP) 2024/25

The strategic transformation described in the emerging new model of care will be an important strand within successor plans. We will develop these around the new 10-Year Plan for Health when published later this year, and the 2025/26 JFP will effectively be a forerunner to this. In 2024/25 our Board Assurance Framework (BAF) was re-organised to align risks to the eight Ambitions in the JFP.

In the meantime, there is still a statutory requirement to refresh our JFP each year and we did this in 2024/25, which was the second iteration of our rolling five-year plan. Our 2024/25 plan can be found here and the format was a Part 1 and Part 2 as before: https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/

There was a clear expectation to continue the priorities set out in the previous year's JFP so our eight Ambitions remained unchanged. We updated Objective 3d which is about improving services for babies, children and young people. The updated Objective reflected a priority to improve the offer for children's neurodiversity and reflected local priorities.

The JFP is one of delivery mechanisms for the Health and Wellbeing Strategies for Norfolk and Suffolk and aims to describe the key work that can only be achieved by working in partnership together. It is not a work plan for all that we do, or a response to the NHS Long Term Plan. The Norfolk Health and Well Being Board received a report on 12 June 2024 in

relation to the 2024/25 – 2028/29 JFP which was a combined report describing the good progress made against the Norfolk and Waveney Integrated Care Strategy.

Part 2 of the Joint Forward Plan sets out the ICB's response to our legal duties and Financial Duties are set out on page 9.

Within this section we explain how capital and revenue sources are assigned and managed. The transformation described within the JFP is aligned to our medium-term financial plan and capital plan and the 21 objectives within the eight Ambitions each have a bespoke section describing 'How are we going to afford to do this?'.

The Commissioning and Performance Committee has been monitoring implementation of the 2024/25 JFP bi-annually and took on this responsibility from the Transformation Board when that was forum was retired. The first six-month report was received in October 2024, and a year-end report is due in April 2025. A summary of the first six months of achievements was published on the JFP web-page here.

The eight Ambitions and the 21 underpinning Objectives are tracked according to what has been completed, is in progress and delayed. The format of the bi-annual report follows the structure of the eight Ambitions.

In the October 2024 report we shared several outcomes that improve experience for patients. For example, fewer patients have fallen due to the intervention of the Unscheduled Community Care Hub, a flowchart for anti-depressant prescriptions has been introduced in primary care to ensure we are not over-prescribing, and patients are regularly reviewed and offered alternatives e.g. access to NHS Talking Therapies.

There was some excellent engagement, for example with Community Voices in the Targeted Lung Checks prevention programme which is supporting uptake, with schools in the Partnership for Inclusion of Neurodiversity (PINS) pilot and Healthwatch Norfolk have supported feedback sessions on the use of the NHS App.
There is strong leadership within the system for example the adoption and dissemination of both the Health Inequalities (HI) Framework for Action and the Population Health Management (PHM) Strategy. Support from the Integrated Care Partnership has been excellent.

Some of the challenges were and still are around capacity, for example within primary care to deliver prevention workstreams, specifically the hypertension objective (1d). Similarly, the capacity of care home and primary care staff to be fully engaged in the Transforming Care in Later Life Ambition may impact on the ability to record frailty scores.

The elective recovery Ambition 7 and Ambition 8 Improving Productivity and Performance remain challenging to deliver, which reflects the local and national position.

Looking forward to 2025/26, the JFP will undergo a third light touch refresh and be published on our ICS website before 1 April 2025. Year 1 of the rolling JFP is always aligned to the Operational Planning guidelines of that same year, and there is a renewed focus on productivity improvements and elective recovery.

Clinical Strategy Alignment

Linked to the JFP is a parallel workstream of system strategy alignment.

The Commissioning and Performance Committee has been coordinating the delivery of the ICS Clinical Strategy and aligning it to the JFP.

The clinical strategy outlined six key objectives, which was that my NHS in Norfolk and Waveney would:

- Tackle health inequalities
- See me as a whole person
- Be one service
- Reduce long waiting times
- Act early to improve health
- To be reliable.

The six areas of focus for Year 2 were:

Objective	Year two proposed focus
1 See me as a Whole Person	People with MH needs
2 Be one high quality resilient service	Primary care, including dentistry, and clinical care for CYP
3 Reduce Long Waiting Times	Elective care including cancer care and care closer to home
4 Act Early to Improve Health	PHM, prevention and care for older people
5 Be reliable	Emergency care
6 Tackle Health Inequalities	Health Inequalities

We published an April – September 2024 half year progress report for Year 2 in December 2024, which is on the ICS website and be found here: https://improvinglivesnw.org.uk/clinical-strategy-year-2-progress-april-september-2024/

We will continue to publish progress updates at six-monthly intervals, with the next one due in April 2025, working to the same reporting timescale as the JFP.

Transition of the commissioning of specialised services from NHSE to the ICB

On 1 April 2024 the six ICB's in the east of England received legal delegation of 59 'specialised services'. The rationale for delegating the commissioning is to enable population based, end-to-end commissioning of services with decisions made closer to communities, and care provision is better joined up for the benefit of the local population. Specialised services are typically (but not exclusively) those that fewer numbers of the population need to access as they are for more complex care. Some of them are provided locally but some are in specialist hospitals such as Great Ormond Street, Papworth or Moorfields for example. The ICB took on responsibility for commissioning pharmaceutical, ophthalmic and dentistry services in 2023. These additional 59 specialised services follow the roadmap of delegation, with another 11 services being delegated on 1 April 2025 including learning disability and autism and mental health.

The Commissioning and Performance Committee has overseen what needs to be in place for the safe transition of the services day one for each of the tranches of delegation. Post transition this work has moved into the commissioning and performance team at the ICB but NHSE resource is available for all the functions as it is now, through the hosted team.

BLMK ICB is the lead/host ICB for the NHSE Commissioning Team who TUPE to them in July 2025, but all six ICB's are working closely together to develop principles of collaboration which are reflected in a signed Collaboration Agreement. This sets out how we will plan

services together and make collective decisions, for example about budgets and prioritisation of transformation work.

The ICB is engaged in the development of a strategy and work plan for the transformation of specialised services. The priority areas of cardiac and cardiovascular disease, cancer, renal, neurology, neonatal and paediatrics, mental health and trauma have been identified. This strategic piece of work has been aligned to all six JFP's across the east of England. The ICB has also been very engaged in an EoE Specialised Commissioning Inequalities review, which has informed the strategy development.

Digital Transformation

Significant progress has been made in developing and expanding digital services across Norfolk and Waveney, improving access to healthcare and enhancing the efficiency of services for both staff and the public.

The Shared Care Record has continued to bring major benefits to health and social care teams by ensuring that critical patient information is readily available. This has allowed healthcare professionals to make faster, more informed decisions while reducing the need for patients to repeat their medical history. Over 2,000 staff now use the system daily to access the records of 12,000 people, streamlining care and improving patient experience.

Infrastructure improvements have also been a key focus, with resilient Wi-Fi connections installed in all GP practices, linking them to an integrated care system-wide network. This means that visiting healthcare professionals, including paramedics, midwives, and mental health workers, can now connect seamlessly to the internet when working in GP premises. Networking improvements have also resulted in faster internet speeds across practices, further enhancing operational efficiency.
Cloud telephony systems have been installed in over 80 GP practices, ensuring full coverage across Norfolk and Waveney. These systems offer better reliability, increased phone line capacity, and the option for patient callback, reducing waiting times and improving access to primary care services. Additionally, automation of administrative tasks in GP practices has helped free up staff time, allowing them to focus on delivering care.

The promotion of digital health tools has been another area of success. The NHS App has been actively promoted through direct engagement with GP practices and attendance at public events, increasing uptake across the region to 57% of people. Further support has been provided to GP practices to improve digital access for patients, including the rollout of a new national online registration system that allows people to register with a GP practice more easily when moving house or registering a newborn.

The focus on digital innovation has contributed directly to key corporate priorities, including improving primary care access, supporting urgent and emergency care, and contributing to financial recovery by increasing efficiency across the system. The successful expansion of the Shared Care Record and digital infrastructure has strengthened the foundations for further innovation in patient care.

Engagement with patients and local communities has played a crucial role in shaping these digital developments. Working closely with Healthwatch, valuable insights were gathered on the rollout of the Shared Care Record in general practice and the use of the NHS App. As a result, additional training has been provided to practice staff, and promotional materials have been updated to appeal to a broader audience, ensuring that more people benefit from digital health tools.

Despite these achievements, challenges remain. Public discussions around artificial intelligence in the NHS highlight the need for clear governance and defined use cases to ensure safe and effective implementation. Increasing uptake of the NHS App remains a priority, as greater adoption would improve patient access to healthcare information. Additionally, raising awareness of the Shared Care Record among health and social care staff will help ensure that more professionals use the system, reducing the need for patients to repeatedly share their medical history.

Targeted initiatives have successfully met external objectives, including the full implementation of cloud-based telephony and the national 'Register with a GP' service. Looking ahead, continued efforts will focus on expanding digital adoption across the health and care system, improving patient access, and enhancing efficiency in primary and urgent care services.

Research and Innovation

The Research and Innovation Team has continued to drive forward research, evidence-based practice, quality improvement, evaluation, and innovation. The team supports research design and delivery across primary and community care, as well as in schools, prisons, and care homes. To strengthen the organisation's commitment to continuous learning and improvement, quality improvement has been formally integrated into the Research and Innovation Team, enhancing coordination of system-wide improvement initiatives and expanding training opportunities for primary care and other non-hospital settings.

The team has focused on embedding the four core principles of the ICS Research and Innovation Strategy: a community-centric approach, building a confident and capable workforce, fostering collaboration, and integrating research and innovation seamlessly into operational processes. A significant priority has been increasing engagement with underserved communities through the NHS England-funded Research Engagement Network (REN) programme. By working closely with the Voluntary, Community, and Social Enterprise (VCSE) sector, the team has facilitated workshops that connect researchers with local communities. These workshops have helped develop clear guidelines on inclusive research practices to ensure that equality, diversity, and accessibility are embedded in study design. To further strengthen this work, a Research and Innovation Lead will be appointed to the ICS VCSE Assembly, ensuring that community-driven research remains a priority.

In collaboration with the Regional Research Delivery Network in the East of England, efforts are being made to identify and address barriers to cross-organisational research delivery. By bringing partners together, the team is developing shared principles and working methods to increase research participation opportunities across Norfolk and Waveney. The ICB has also been selected for a second consecutive year on the prestigious InSites programme, remaining the only ICB represented. Continued funding allows further expansion of innovation activities while benefiting from shared learning with 17 other InSites. Contributions have included supporting the development of national innovation resources related to evaluation and the triaging of innovations.

The innovation culture, competency, and capability development programme has progressed significantly, supporting leaders, innovation champions, and network members across the ICS. This work has played a crucial role in identifying and implementing innovations in key areas such as cancer care and urgent and emergency care. Alongside this, the team has continued to provide evidence and evaluation support to colleagues across the ICB and wider system, ensuring that service design and decision-making are informed by high-quality evidence. A number of evaluations have been undertaken, including an in-depth assessment of the virtual ward programme to understand its impact and effectiveness.

During 2024/25, the team has supported the development of 34 grant applications, with 18 submitted under the ICB, requesting over £11.3 million in funding. Twelve NIHR research grants have been secured, totalling nearly £18 million, including six new grants worth £4 million this year. These grants address a range of healthcare challenges, such as improving long-term care for people who have undergone bariatric surgery and increasing flu vaccination uptake among care home staff. Additionally, the ICB received £701,000 in Research Capability Funding to enhance research application development, early career fellowships, primary care research capacity, and workforce training. Across primary care, 57 research projects have been successfully rolled out.

As part of efforts to accelerate innovation, the ICB has been selected as a Health Foundation Accelerating Innovation Systems site, which enables further collaboration with other ICBs in enhancing innovation activities. The team has worked with ICS colleagues to identify key healthcare challenges and match potential innovations to address these needs. This has included supporting the implementation and evaluation of a cardiovascular disease prevention programme, Lowestoft Healthy Hearts, and securing funding for a pilot project to trial mobile x-rays in the community. Work has also continued in refining the innovation pathway and toolkit, alongside hosting innovation showcases and demonstrations to encourage the adoption of new approaches.

In addition to these activities, 10 service evaluations have been completed, and an evidence briefing has been delivered. The team has provided advice and support on 45 projects, helping teams integrate evidence into service design and evaluation. A structured programme of nine "lunch and learn" sessions has been delivered, covering topics such as using evidence, planning evaluations, and data collection methods.

The research and innovation approach adopted by the ICB has gained national recognition, with multiple ICBs across the country seeking to learn from the work being carried out in Norfolk and Waveney. From an engagement perspective, the REN programme has been instrumental in strengthening connections with the voluntary sector, improving research accessibility and inclusivity. The virtual ward evaluation has provided valuable insights from patients and carers about their experiences, shaping future service improvements. Recognising the need for deeper community involvement in innovation, the ICB has also commissioned the Integrated Care Academy to help develop a model for patient and public engagement in innovation. This work began in late 2024, with community workshops planned for March 2025 to inform the approach.

While significant progress has been made, challenges remain. Embedding a culture that fully values research and innovation as a driver for improvement continues to be a key priority. Expanding participation in research, particularly among underserved groups, is essential to ensuring more inclusive and meaningful outcomes. Across all areas, the team’s work supports the ICS’s key priorities, including primary care, urgent and emergency care, mental health transformation, planned and elective recovery, and financial recovery.

Services which support delivery of all priorities

Designated All-Age Safeguarding Team

During the 2024/25 period, the All-Age Safeguarding Team at the ICB has made significant progress in strengthening safeguarding across all age groups. A key development was the recruitment of a new Head of Safeguarding, providing strategic leadership and driving the transition to an all-age safeguarding approach. This philosophy reinforces that safeguarding is everyone’s responsibility and should be embedded in everyday practice.

The team has worked closely with colleagues across the ICB and partner agencies to respond to emerging safeguarding issues, address health inequalities, and improve collaboration. The safeguarding of babies, children, young people, adults, and elderly populations remains a statutory responsibility, and NWICB has continued to work with health commissioners, providers, social care, police, education, voluntary sectors, and families to uphold these duties. Ensuring the Human Rights Act is at the centre of safeguarding activity has been a priority, in line with all relevant legislation.

Throughout the year, the team has enhanced communication and coordination to ensure safeguarding is better understood and integrated across the system. This has included evaluating safeguarding service provision, providing oversight on safeguarding in service contracts, supporting the implementation of statutory review recommendations, and strengthening governance through serious incident reporting, quality visits, and engagement with national and regional safeguarding bodies. The team has also played an active role in strategic safeguarding forums, including partnerships focused on domestic abuse, community safety, and youth offending.

The all-age safeguarding approach has helped embed the "Think Family" model, ensuring individuals receive holistic support throughout their safeguarding journey. By leveraging the expertise within the team, NWICB has strengthened its ability to respond to safeguarding risks while promoting person-centred care.

In the year ahead, the team has set out four key priorities. The first is to continue collaborative work with Integrated Care and Safeguarding Partnerships to embed learning from safeguarding cases across the health system. The second focuses on improving the use of data to identify safeguarding risks, address health inequalities, and support strategic decision-making. The third priority is to enhance safeguarding during transitional periods, ensuring young people moving into adulthood receive appropriate support to protect them from harm and neglect. The final priority is to strengthen safeguarding governance, both internally within the ICB and externally with NHSE and partner agencies.

The past year has seen several key achievements. In CYP safeguarding, the team has continued to advocate for health's role in safeguarding decisions, leading a multi-agency audit for the Norfolk Safeguarding Children Partnership and ensuring cases from the health system are reviewed for local learning. A new transitional safeguarding post has been created to support young people navigating the transition into adult services, ensuring a personalised approach to safeguarding.

The safeguarding team has engaged extensively with patients, families, and communities to shape services. Safeguarding supervision has also been strengthened, ensuring robust safeguarding practices across provider organisations. Additionally, the team has actively engaged in PREVENT work, supporting Channel Panels in Norfolk and Suffolk.

Despite these successes, several challenges remain for the year ahead. In adult safeguarding, the team is working to launch an ICB training programme, increase capacity, and manage a growing number of Domestic Abuse-Related Death Reviews and Safeguarding Adult Reviews. The introduction of the ICB’s Sexual Safety Charter also requires continued oversight.

For safeguarding children, priorities include improving engagement with families and communities, addressing neglect as a leading cause of child protection plans, and strengthening understanding of child sexual abuse within the region. Transitional safeguarding presents challenges in supporting young people with complex needs and ensuring CYP with special educational needs and disabilities receive appropriate safeguarding support.

Estates

The Estates Team is responsible for the development and delivery of Estates Infrastructure Strategies, enabling the ICBs commissioning function and system clinical strategies through supporting decisions where changes, developments and/or improvements to healthcare buildings is required or helpful. Through developing and adapting the estate, the team helps to ensure services can most effectively meet the needs of providers and the population.

The Estates Team has worked with partners across the ICS to refresh the Estate Strategy to incorporate the latest NHS England guidance for System Infrastructure Strategies. Our system strategy is also reinforced by individual NHS Trust, general practice, and PCN estate strategies.

Our buildings and estate infrastructure play a vital role in achieving the system's mission and ambitions, and our ten-year strategy sets out how we will enable this and deliver our vision of providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care. We are making significant investments in our hospitals, GP practices, community and mental health services. Coupled with our investment in new technology, this will help us to improve the quality and safety of people's care, the services we provide and the working lives of the thousands of people who work in health and care. Our refreshed Estates Infrastructure Strategy is framed around four key goals: to improve access; to improve quality and condition; to improve environmental sustainability; and to improve efficiency.

The Team has also developed the first standalone general practice estates strategy for the ICS, responding to the continuing challenges faced by primary care estate in terms of increasing workforce and population growth. These challenges will intensify with the expected increase in housing growth and the transformation of healthcare services in response to national drivers and local infrastructure and commissioning changes. National policies and funding for investment in primary care estate remains of central importance in helping the local system respond to these challenges and provide quality healthcare services for our local population.

The Team has focussed on the implementation of the Wave 4b Primary Care Hubs, a nationally funded scheme investing £25.2 million in primary care estates. The programme has seen two schemes complete: a new build King's Lynn Health Hub and refurbishment at Thetford Healthy Living Centre. Two schemes will complete in 2025: a new build at Rackheath and a refurbishment at Sprowston Primary Care Centre. The Team remain grateful to the Steering and Engagement groups for these projects, with representatives from the communities guiding the ongoing developments of the schemes. These groups will also be important in supporting the post project evaluation of the schemes after completion.

A number of proposed premises schemes are at various stages of the business case approval, with some being scoped and others underway. These schemes will improve and expand general practice and healthcare capacity.

Building on the achievements from 2023/24, the Estates Team secured a further £777,903 in Community Infrastructure Levy funding to support premises extension and improvements at Cutler's Hill Surgery. A further £545,042 has also been secured, through Section 106 agreements via North Norfolk District Council, to support infrastructure expansion and improvements in Cromer, and £80,730 via South Norfolk District Council to support expansion in Diss. Discussions with Local Authorities continue on scoping new healthcare premises around Norwich and in South Norfolk.

Learning Disabilities and Autism

Over the past year, the ICB has continued to make significant progress in supporting people with learning disabilities and autism, improving access to care, and enhancing service quality.

The implementation of Oliver McGowan Mandatory Training has been a key focus, ensuring that health and social care staff across Norfolk and Waveney receive training appropriate to their roles. This follows the Health and Care Act 2022 requirement for all CQC-registered providers to provide autism and learning disability training. With funding from NHS England, NWICB secured a training provider and began delivering sessions in January. Ringfenced training opportunities have been allocated to health and social care organisations, and any unfilled spaces are made available across the region. A dedicated steering group promotes the training through newsletters, bulletins, social media, and events, and the NWICB website now provides clear information on how staff can access the training. The training has been localised to include key regional data from the LeDeR report and additional information on annual health checks.

The system-wide effort to stop the overmedication of people with a learning disability and autistic people (STOMP) has also gained momentum. A dedicated working group has been established, and baseline clinical data has been analysed to support individuals looking to reduce unnecessary antipsychotic prescriptions. A new project is in development, aiming to safely deprescribe antipsychotic medication for people with learning disabilities who do not have a diagnosed mental illness, with the goal of reducing medication use in this cohort by 20% within a year.

The LeDeR (Learning from the Lives and Deaths of People with a Learning Disability and Autistic People) programme has seen a significant increase in notifications, projected to be 30-40% higher than last year. This has put pressure on the team's ability to meet the national target of completing reviews within six months, which has been flagged as a key risk. Despite this challenge, the team is on track to complete more reviews than in previous years while maintaining high-quality assurance and governance standards. New learning has been generated, particularly regarding the impact of late autism diagnosis, chronic pain management, and post-diagnostic support. The team has also contributed to policy initiatives, including the relaunch of the ReSPECT process and the development of accessible information on end-of-life care.

The system continues to improve inpatient care and community support. This year, 18 adults with learning disabilities have been discharged from inpatient units, including individuals who had been in hospital for over three years. Governance around the Dynamic Support Register (DSR) and Care (Education) and Treatment Review (C(E)TR) processes has been strengthened to ensure consistency and better support individuals at risk of hospital admission. A new Intensive Support Service, launched in May 2024 in partnership with Hertfordshire Partnership Foundation Trust (HPFT) and Norfolk Community Health and Care (NCHC), has played a critical role in reducing both admissions and readmissions.

Annual health checks for people with learning disabilities have continued to improve in both quality and uptake. The register now includes approximately 7,500 patients, with 700 aged 14-17. Despite workforce pressures, GP practices have remained committed to delivering these checks, and there has been a notable reduction in the number of patients failing to attend appointments. The ICB remains on track to meet or exceed the national minimum requirement of 75% for health check uptake. Targeted initiatives have helped increase engagement, such as local projects with Mencap and the Norfolk Community LD Team, recruitment of specialist practitioners, and collaboration with Suffolk and North East Essex

ICB to improve pre-health check questionnaires. A new data dashboard now allows practices to identify patients who have missed checks, supporting better follow-up.

Key achievements this year include securing the delivery of 1,076 Oliver McGowan training sessions over the next two years, training over 21,000 health and care staff. A team of 36 facilitators and experts with lived experience has been recruited to co-deliver the training. In the LeDeR programme, additional insights have been gathered into mental health risks for autistic people, particularly around suicide prevention and crisis care. The programme has also contributed to initiatives such as the ICB's end-of-life yellow folder project and work to address risks related to emollient use in care settings. Collaborative efforts have focused on ensuring appropriate oversight for antipsychotic prescribing and improving dementia diagnosis and management for people with learning disabilities. Training has been enhanced for care staff to help them identify early signs of deterioration and improve respiratory health awareness.

Community engagement remains a priority. The Learning Disability Health Improvement Team has continued to support people with learning disabilities in accessing healthcare, particularly through annual health checks. Outreach activities, home visits, and events have helped raise awareness of preventative healthcare, with a particular focus on increasing participation among ethnic minority communities. The team also provides training to GP practices and care providers to promote reasonable adjustments and ensure people with learning disabilities can access vaccinations and screening services.

System-wide collaboration has strengthened through participation in the Learning Disability and Autism Partnership Boards, co-chaired by individuals with lived experience. The ICB works closely with voluntary sector partners, including ASD Helping Hands and Opening Doors, to ensure services remain responsive to community needs. Engagement with Suffolk's equivalent boards ensures that Waveney residents are equally supported.

Looking ahead, several challenges remain. The introduction of a reasonable adjustment flag across digital health records is a priority, ensuring that individual needs are recognised across the system. There is also a need to improve inpatient care and reduce admissions and readmissions for autistic people, supported by the new Autism Intensive Support Service pilot with Norfolk and Suffolk Foundation Trust. Reducing the waiting time for adult autism assessments remains a challenge, with continued efforts required to meet the 18-week target and provide interim support for those on the waiting list.

Further work is needed to meet NHS England's trajectory for inpatient numbers, with the system currently above target. A new LD&A Inpatient Plan is being developed to transform services, focusing on earlier discharge planning, eliminating out-of-area placements, and improving overall patient experience. Strengthening the use of the Dynamic Support Register and C(E)TR processes will be crucial in reducing the number of people in inpatient settings.

Despite these challenges, the past year has seen significant progress in improving care for people with learning disabilities and autism across Norfolk and Waveney. Continued collaboration across health and social care will remain essential in ensuring high-quality, accessible, and person-centred services for the future.

Medicines Optimisation

The Medicines Optimisation team has made significant progress in improving the quality, safety, and efficiency of prescribing across Norfolk and Waveney. This has included the

development and implementation of ambitious efficiency plans and targeted schemes to enhance prescribing quality while reducing costs. A key achievement has been the reduction of the carbon footprint of key medicines, achieved through the work of pharmacy teams across the integrated care system and primary care.

The team's work focuses on five key areas: improving quality and safety by minimising medication errors and ensuring best practices; enhancing interface and formulary governance to ensure effective commissioning and use of medicines; using population health data to guide decision-making and address health inequalities; strengthening clinical experience and delivery by working with primary care and community professionals to promote evidence-based prescribing; and providing repeat prescribing support to GP practices to improve efficiency and reduce waste.

A major achievement this year has been the successful implementation of patient safety initiatives, including leading the response to the valproate safety alert issued by the Medicines and Healthcare products Regulatory Agency (MHRA). The updated guidance, published in November 2023, required new regulatory measures for prescribing valproate due to its risks during pregnancy. The team acted swiftly, bringing together a working group with representation from secondary care, primary care, community providers, and sexual health clinics to develop an action plan that met the new requirements. This collaborative approach led to the creation of a prescribing guideline, ensuring compliance across the system. When a similar alert was issued in June 2024 regarding topiramate, the established expertise and working group structure allowed for a rapid response. The success of this initiative has strengthened relationships across providers, and the group will transition into a regular medicines safety group to continue sharing knowledge and learning.

The team has also worked closely with GP practices to implement the repeat prescribing toolkit, improving the efficiency of prescription ordering, reducing medicine waste, and enhancing the patient experience.

Looking ahead, polypharmacy and overprescribing remain challenges, with a focus on reducing unnecessary medication use and preventing hospital admissions caused by adverse drug reactions. A new working group will be established to implement recommendations on deprescribing and structured medication reviews, ensuring patients receive only the medicines they need.

Place Based Working

Over the past year, the focus on place-based working across South Norfolk, Norwich, and North Norfolk has strengthened partnerships and delivered real benefits for local communities. By bringing together health, social care, and voluntary sector organisations, each Place has been able to respond to its population's specific needs and improve access to care and support. This collaborative approach has been vital in shaping services that are both effective and equitable, ensuring that people receive the right care in the right setting.

North Norfolk

In North Norfolk, significant progress has been made in supporting vulnerable residents, particularly older people with complex needs. The Frailty Programme has taken a proactive approach to identifying patients aged 50 and above who have fall-related injuries but are not admitted to hospital. Using the Rockwood Scale, these individuals have been referred for interventions ranging from rehabilitation to social support. Between June and December 2024, 799 patients were identified through this pathway, with nearly 250 receiving additional

support following outreach from the district council. Multidisciplinary meetings across GP practices have also been improved, with shared templates developed to enhance care planning and coordination. The programme is undergoing a full evaluation, with a 12-month review planned to assess its long-term impact.

Improving end-of-life care has also been a key priority. GP practices in North Norfolk have adopted the Daffodil Standards, a framework developed by the Royal College of General Practitioners and Marie Curie, to enhance palliative and end-of-life care. This initiative supports both practice development and the experience of patients and their families, ensuring that individuals receive compassionate and high-quality care in their final stages of life.

Strengthening the voluntary sector has been another focus, with a comprehensive survey and workshops undertaken to map the local voluntary, community, and social enterprise (VCSE) landscape. The insights gained are now shaping an action plan to better support and strengthen this sector. Additionally, a new VCSE engagement group has been established to serve as a reference group for the North Norfolk Place Board and wider system partners, helping to improve collaboration and service delivery.

Norwich

Norwich has continued to lead the way in developing integrated, person-centred services that address both health and social needs. The INTERACT programme, hosted at City Hall, has brought together multiple agencies, including Age UK Norwich, Norfolk Citizens Advice, Norwich City Council, and Norfolk County Council, to provide holistic support for individuals whose housing situation negatively impacts their health. Since its inception, INTERACT has received over 900 referrals, with evidence showing improvements in housing satisfaction, physical and mental health, and reduced reliance on statutory services.

Building on this work, Safe Habitable Homes was introduced to support individuals at high risk due to self-neglect or hoarding. Delivered in partnership with St Martins, Norwich City Council, and Norfolk County Council, the service provides trauma-informed, tenure-neutral support. Over the past two years, 149 referrals have been made, with 30 people successfully meeting their goals. For those still being supported, risk levels have significantly decreased, demonstrating the positive impact of this intervention.

The CHESS programme, run by Age UK Norwich, has provided wrap-around support for frail and older individuals with complex needs, aiming to maintain independence and prevent health deterioration. The service has been highly effective, with 87% of participants avoiding emergency GP appointments, 92% avoiding hospital admission, and 80% experiencing fewer falls. Additionally, there was a 31% increase in self-reported health and wellbeing scores, highlighting the programme’s success in improving overall quality of life.

To foster greater collaboration among professionals, Tea @ 3 – Connecting for Healthier Communities was launched in March 2023. This networking initiative, hosted in community settings, has helped rebuild relationships impacted by the pandemic and remote working. Through service overviews, updates on key initiatives, and informal networking, these bi-monthly sessions have strengthened cross-sector working, improved workforce morale, and enhanced the local offer for Norwich residents.

South Norfolk

South Norfolk has focused on strengthening integration between health and local government services to improve community wellbeing. Jointly funded roles have been created using Community Transformation Funding, embedding ICB staff within district councils. These roles vary across councils but include operational and strategic leadership in areas such as social prescribing, integrated care models, and health and wellbeing partnerships. By having dedicated resources in place, South Norfolk has been able to develop and deliver initiatives that align with both health and local authority priorities.

One of the key projects introduced this year is the Community Health and Wellbeing Worker (CHWW) initiative in Watton. Developed in partnership with Breckland Council, NHS Norfolk and Waveney ICB, and Watton Medical Practice, this programme aims to proactively engage residents with unmet health and wellbeing needs. CHWWs, based within the community and GP practices, have visited over 240 households, providing health guidance and linking individuals to local support services. Adapted from a successful model in Brazil, this approach has already demonstrated improvements in self-management of long-term conditions and reduced reliance on urgent and emergency care services.

In response to increasing mental health referrals, a Community Mental Health Caseload Review was carried out in collaboration with primary care, NSFT, and social prescribing teams. A triage system was introduced to ensure patients with lower-acuity needs were redirected to community-based support instead of specialist mental health services. This initiative successfully redirected over 40 cases, improving access to appropriate support while reducing pressure on secondary mental health teams.

Great Yarmouth and Waveney

Recognising the importance of localised support, Great Yarmouth and Waveney continues to develop place-based initiatives tailored to specific community needs. Their Health Connect programme was introduced in response to evidence showing that many residents struggle to access appropriate community support, particularly following a hospital discharge.

This collaborative initiative, led by the NHS, voluntary, community, and social enterprise sectors, as well as local government, provides practical and emotional support to residents recovering at home. Now in its second year, Health Connect has:

- Contacted over 9,000 residents following hospital discharge or community healthcare intervention.
- Provided one-on-one follow-up support to over 2,000 residents, ensuring they can safely remain at home and avoid unnecessary readmissions.
- Helped individuals access a wider range of health, social, and community services, ensuring a holistic approach to recovery and ongoing wellbeing.

Feedback from residents has been overwhelmingly positive, reinforcing the importance of linking clinical care with broader social and community-based support to improve long-term health outcomes.

System-Wide Challenges and Priorities for the Year Ahead

Despite the significant progress made across all three Places, challenges remain. The role of Place needs to be further defined, with a clear strategy and shared outcomes to ensure alignment with NHS England's neighbourhood health guidelines for 2025/26. Greater investment in Place-based working is required, with a system-wide framework for allocating resources equitably based on need, reducing health inequalities, and achieving the greatest impact.

Urgent and emergency care pressures continue to be a major issue. Ambulance response times remain longer than acceptable, and emergency departments face delays due to high hospital occupancy rates. Solutions must focus on expanding community-based services to prevent avoidable hospital admissions while ensuring timely discharge for those who are medically fit to leave.

Environmental Matters

NHS Norfolk & Waveney has a vital role to play in relation to environmental matters and sustainable development. Whilst utilising public funds for the delivery of health and care services NHS Norfolk and Waveney also has the opportunity, and obligation, to spend public funds in ways that generate positive effects on the natural environment we all reside in.

Sustainability in this context means spending public money efficiently on our services but also minimising the impact on the natural world with our use of resources. By making the most of social, environmental, and economic assets we can improve population health. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

Climate change presents a profound and growing threat to people's health. Taking action to reduce harmful carbon emissions will save lives and improve health now, and for future generations. As one of the top ten largest employers in the world, contributing almost 5% of UK carbon emissions, the NHS has a real opportunity, responsibility, and interest in tackling this threat head on.

In October 2020 the NHS set the ambition to be the first 'net zero' health service in the world, in recognition of the global 'climate emergency which is also a health emergency'. It committed to two challenging targets:

- To reach net-zero by 2040, for the carbon emissions we control directly (the NHS Carbon Footprint), and
- To reach net-zero by 2045 for the broader emissions we can influence.

NHS Norfolk and Waveney acknowledged this responsibility to our patients, local communities, and the environment by working hard to minimise our carbon footprint.

Working together, the ICS Green Plan Delivery Group worked developed and published an ICS Green Plan for 2022-2025. The first three-year phase of the ICS Green Plan was developed with National Greener NHS guidance, with a focus on coordinating and enabling health and care providers and commissioners to assess their Net Zero maturity and outlining plans to reduce carbon emissions over directly commissioned health and care services.

Building on the progress made in the first two years, during 2024/25 our NHS partners have developed and implemented their green plans with support from the ICB. By Summer 2025/26 the ICB will publish a refreshed green plan with the content including more specific initiatives and work plans where our own service areas will support the contribution to net zero.

Task force on climate-related financial disclosures (TCFD)

The DHSC GAM has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.
TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Risk management, and Metrics and targets. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the ARA and in other external publications.

Green Plan Governance
NHS Norfolk and Waveney ICB has considered the wider impact of climate-related risks within our broader responsibilities of delivering healthcare for the population of Norfolk and Waveney.

The ICB exercised its functions to ensure compliance with the statutory duties. The ICB's green plan was developed and published in 2022 and included the 12 themed areas as per the original guidance. Progression on delivery of the plan is via the system wide NHS partners sustainability forum and the Executive Leads sustainability meeting chaired by our SRO for Sustainability.

Working with our partner organisations remains a key element of the ICB sustainability agenda but the refresh of our green plan for July 2025 will focus on more specific & deliverable actions. The rationale being to enable more effective oversight and review of Green Plan delivery within the ICB.

Managing risk and improving our climate resilience
In publishing an ICS green plan, Norfolk and Waveney ICB's aspiration is to be at the forefront of managing climate change risks and bolstering resilience. By assessing local climate risks and rolling out strategies to cut emissions and adapt to the ever-evolving climate, the ICB intends to actively pave the way for a sustainable future. This endeavour

includes a shift to renewable energy sources, efficient resource usage, and the promotion of eco-friendly practices within healthcare services.

Key strategies to consider climate change risks and enhance resilience include:

Green Plans: The creation and regular updating of Green Plans to steer adaptation efforts. These plans will endeavour to reduce emissions and fortify resilience throughout the system.
Climate Change Risk Assessment: Risk Assessments should be used to identify local climate risks unique to sites and services. This will enable a prioritisation of risks and the allocation of resources to the most effective adaptation measures.

Reducing Emissions:

- Embracing Renewable Energy to make making buildings more carbon-efficient
- Resource Usage including gas, electricity, and water in lowering carbon emissions.
- Promoting Sustainable Practices such as equipment reuse.

Adapting to Climate Change Impacts:

- Investing in resilient infrastructure and technology will help healthcare sites and services withstand climate-related events.
- A diverse supply chain will mitigate risks to the availability of essential supplies, even in the face of climate disruptions.
- Protecting and restoring natural systems like green spaces aids in climate mitigation and adaptation.

Collaboration and System Leadership: Systems should lead emission reduction efforts and engage with broader system partners, such as local authorities, to support system-wide mitigations and resilience.

Encouraging Sustainable Practices: To encompass the promotion of sustainable travel options, supporting home working, and engaging local communities in climate change mitigation and resilience efforts.

Monitoring and Evaluation: The monitoring and evaluation of Green Plan progress will ensure effective implementation and continuous improvement in climate change mitigation and resilience.

Metrics and targets - Green Plan summary

The Greener NHS Dashboard has been created by NHS England to allow monitoring of progress against targets and key performance indicators. The dashboard can be viewed at a national, regional, system, and provider level and is within NHS England's app portal
Greener NHS Dashboard (NHS Organisations): Views - Tableau Server

The dashboard presents data on a range of measures related to carbon equivalent emissions associated with NHS activity, as well as policy and contractual levers which support a Net Zero NHS. It covers focus areas set out in our Green Plan, including Assurance & Governance, Estates & Facilities, Medicines, Supply Chain, Adaptation, Travel & Transport and Food & Nutrition.

The Norfolk & Waveney ICB utilise the dashboard to track and report consumption, emissions, and general progress towards the targets set out.

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

Improve Quality

This table provides a summary of our performance against a set of key indicators related to the quality of care and patient safety:

Mixed Sex Accommodation Breaches

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend *(Mar 25 vs AVG 24/25)*	Mar-24
EBS1	Mixed-sex accommodation breach	#	0	7	19	↑	19

Patient Safety

Metric ID	Short Description	Values	Target	Mar-25	AVG 24/25	Trend *(Mar 25 vs AVG 24/25)*	Mar-24
EAS4	MRSA	#	0	0	0.7	↑	1
EAS5	CDiff	#	27	24	31	↑	28
	Minimise rates of gram-negative bloodstream infections (NHS Trusts / FTs only)	#	91	90	90	↑	111
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	%	95%			→	
	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	%	90%			→	
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	%	90%			→	

Nursing and quality services in Norfolk and Waveney have seen significant development over the past year, with a strong focus on improving patient care, ensuring safety, and driving system-wide collaboration.

From April 2024, the commissioning of specialised services has been transitioning from NHS England to local Integrated Care Boards (ICBs) in the East of England. Specialised services support people with rare and complex conditions, requiring expert teams and a wider population base. A central team, hosted by Bedford, Luton, and Milton Keynes ICB, oversees these services across regional boundaries, ensuring quality assurance and accessibility for patients in Norfolk and Waveney. This transition presents opportunities for better management of patient pathways and closer collaboration between quality oversight and commissioning. In April 2025, additional specialised mental health and learning disability services will also be delegated to the ICB.

Supporting urgent and emergency care remains a priority. The ICB Nursing & Quality Team facilitates the System UEC Serious Incident Group, which brings together partners to review incidents, share learning, and implement improvements. The team has continued to support resilience within discharge pathways, focusing on improving system intelligence and digital solutions to streamline workflow and enhance patient assessments. Working closely with local authorities, the ICB supports the social care provider market to ensure patients can access safe, appropriate care that supports their recovery. During periods of increased pressure, the team has maintained a strong focus on quality, safety, and infection prevention and control.

Elective care has also been a key area of focus, with ongoing work to improve pathways and patient experience. Senior Quality Nurses participate in harm review forums, providing external oversight to ensure patient safety is prioritised throughout the waiting list management process.

Infection prevention and control (IP&C) remains a core aspect of the ICB's work, with rates of key bloodstream infections (Klebsiella, Pseudomonas, and MRSA) below the regional average. The ICB coordinates system-wide efforts to reduce healthcare-associated infections, working with partners across health and social care. A key focus has been supporting IP&C Link Practitioner Groups in general practice and social care, as well as exploring the development of a local training course to strengthen workforce expertise. This year, the IP&C team has also led successful peer review visits across various provider settings, including GP practices, optometry, dental clinics, ambulance bases, and hospices, ensuring high infection control standards are upheld.

The implementation of the NHS Patient Safety Strategy continues to be a key focus. The ICB is working with system partners to ensure a collaborative approach to patient safety, strengthening governance and learning from incidents. The Patient Safety Network and the Patient Safety Investigators Forum play a crucial role in driving improvements and sharing best practices. A key development this year has been the launch of a system-wide Patient Safety Learning Forum, as well as the introduction of a Learning from Deaths Forum, which collates and shares public health mortality data and insights. The ICB has also developed a new risk management policy to ensure that system-wide risks are identified and managed effectively.

Ensuring resilience and quality in primary care remains a priority. The ICB continues to support practices facing challenges, providing senior clinical input to strengthen governance and workforce wellbeing. Work has also progressed in embedding a robust approach to quality oversight across primary care, including pharmacy, optometry, and dentistry. The introduction of a Dental Provision Heatmap has supported targeted interventions to improve service quality and access.

Mental health transformation has continued, with the ICB working closely with Norfolk and Suffolk NHS Foundation Trust to implement recommendations from the Care Quality Commission (CQC) and drive quality improvements. Collaboration with NHS Suffolk and North East Essex ICB has supported a more joined-up approach to service transformation, with a focus on in-patient, community, and crisis care. Efforts have also been made to engage private providers to ensure high-quality care and strengthen integration within the local mental health system.

The ICB has maintained its commitment to a system-wide approach to quality improvement, guided by the ICS System Quality Strategy. This strategy, which runs until 2025, sets out the ambition to deliver safe, high-quality, and equitable care based on patient and workforce needs. Work is already underway to develop the next strategy for 2026 onwards, aligning with national priorities around patient safety and quality. A key achievement this year has been the development of a Deteriorating Quality Framework, which provides a clear approach to identifying and addressing emerging quality concerns across the system.

Key achievements over the past year include improvements in urgent and emergency care, such as efforts to enhance ambulance handovers and increase access to Same Day Emergency Care (SDEC) services. The UCCH has played a vital role in ensuring that less urgent ambulance calls are managed more effectively, enabling patients to receive care in the most appropriate setting. The ICB has also championed staff wellbeing, raising awareness of the impact of moral injury on healthcare professionals working in high-pressure environments.

Infection prevention and antimicrobial stewardship efforts have delivered tangible improvements, including a new process to follow up on patients discharged from hospital before a positive MRSA result is known, ensuring timely treatment. Collaborative work with general practice has helped reduce the overuse of broad-spectrum antibiotics, with one local practice receiving national recognition for its efforts. The ICB has also led a successful hydration pilot in care homes, improving both resident and staff wellbeing. The system's Catheter Quality Group, established in response to surveillance data, has driven quality improvements and was a finalist in the HSJ Early-Stage Patient Safety Innovation of the Year category.

Patient engagement has remained central to service improvement. Patient Safety Partners continue to provide valuable insight, and local organisations have actively participated in a new NHS England regional support forum. Quality improvement pilots have incorporated direct feedback from service users and staff to shape pathway development. The ICB has also supported a national survey on patient experiences of long waits outside hospitals, ensuring findings are shared with the Ambulance Service and regional partners to inform improvements.

Despite these achievements, challenges remain. The ICB continues to address national oversight requirements while ensuring meaningful and sustainable system-wide improvements. Pressures on urgent and emergency care services persist, requiring ongoing mitigation to reduce patient harm. Efforts to recover elective care pathways remain critical, alongside the continued development of an integrated and resilient primary care model. Workforce recruitment, retention, and training remain significant challenges across health and social care. The ICB is also working to improve access to national Learning From Patient Safety Event (LFPSE) data and develop system-wide patient safety policies. Additionally, the UCCH is looking to expand its work with care homes to prevent unnecessary hospital admissions and support residents to remain safely at home.

NHS Continuing Healthcare

Continuing Healthcare (CHC) during the financial year 2024/25 has assessed, processed and supporting the following care packages (data - March 2025):

CHC Area	Total Patients	New Patients	Reviews – Total	KPI % *
Learning Disability Adults	255	23	89	80%
Physical Disability Adults	131	51	122	
Mental Health Adults	285	108	51	
Fast Track	215	2078	1186	2.2 days
Funded Nursing Care	819	509	155	89%

*KPI% is a National Measurement – Target is 80% of all reviews to be completed on time
Fast Track – 48hrs turnaround from referral to placement agreed
All other CHC Reviews – 28 Days turnaround from referral to placement agreed

Key activities within the year have been focussed on simplifying and speeding up the assessment of Fast Track patients to support discharge in acute and community inpatients that is timely and cost effective for the individuals and their families.

The other main area of focus this financial year has been the reviews of complex care patients to support appropriate cost-effective care for all. The ICB has utilised the skills and expertise of Liaison in this area to ensure consistency of service (as with previous years).

The new structure of the CHC Operational Team has been embedded during the financial year (with some ongoing vacancies) and the connections with Norfolk County Council (NCC) have also continued with the integrated post provided by NCC remaining in the CHC Team Structure.

During 2024/25 to support the CHC Operational Team and to maintain a focus on cost effectiveness (CHC had a 7.2% efficiency target in 2024/25) which ensures each NHS £1 can reach more CHC eligible patients a new multi-disciplinary monthly Team meeting was introduced which brought CHC Operations, Finance and Procurement together to focus on Quality, Safety and Finances.

CHC remains a highly complex area for the ICB which requires the right skills and processes in order to deliver appropriate care at the right cost.

Engaging our staff, people and communities

NHS National Staff Survey

NHS Norfolk and Waveney is committed to improving staff experiences across the NHS and takes part in the annual NHS National Staff Survey. The survey's strength is in providing a national picture alongside local detail. It helps us understand how staff are feeling, how they experience their working lives, and allows us to improve local working conditions to ultimately improve patient care. While the survey is a snapshot in time, the information is gathered at the same time each year allowing us to identify trends and track improvement.

The latest survey ran from October to December 2024. The response rate for NHS Norfolk and Waveney was 68.2% (439 responses) which was higher than the previous year, but slightly below the average of 72% for our comparator group which includes other ICBs. Overall the survey results declined nationally this year. However, they told a more positive story for Norfolk and Waveney ICB with our results being above the comparator average for all the People Promise domains, with improvement against the 2023 results in several areas (see detailed results below).

In response to this year's survey results, we will be focusing on improving management support, through the introduction of a 'People Management Fundamentals' programme, as well as continuing to prioritise staff health and wellbeing.

Detailed Staff Survey Results

The survey results are summarised against the seven elements of the NHS People Promise, which we as an ICB are committed to delivering for our staff. Staff engagement and morale are considered to be the two main headline measures.

Our staff engagement score of 6.66 was above the comparator average, as well as improving slightly on our score of 6.61 in 2023. Staff engagement includes questions on their sense of involvement in decision-making, their motivation and advocacy – notably whether they would recommend the ICB as a place to work.

Our staff morale score of 6.04 showed greater improvement against 2023, when we scored 5.83, as well as being significantly above the comparator average. The assessment of morale includes questions on whether staff are thinking of leaving, as well as on the pressures they experience at work and the stressors that cause them.

People Promise Domain	ICB Score	Comparator Average Score
1. We are compassionate and inclusive	**7.34**	7.23
2. We are recognised and rewarded	**6.62**	6.46
3. We each have a voice that counts	**6.76**	6.58
4. We are safe and healthy	**6.37**	6.28
5. We are always learning	**5.18**	5.05
6. We work flexibly	**7.30**	7.22
7. We are a team	**7.05**	7.01
Staff Engagement	**6.66**	6.48
Staff Morale	**6.04**	5.69

In addition to being above comparator benchmarks for all seven People Promise domains and the headline staff engagement and staff morale scores, highlights for the ICB in 2024 include:

- areas showing the greatest improvements include opportunities to show initiative, welcoming suggestions, and involvement in decision-making.
- areas showing a decline over the last 12 months include support from immediate managers and a sense of working together to achieve objectives. These results were in line with a national deterioration in these areas.

The decline in collaboration and line management support were not entirely a surprise, given the organisational restructure of the ICB over the last year. Addressing them will be the focus of our "re-set" plans, notably the "People Management Fundamentals" programme we are delivering from February 2025. This programme is based on NHS England's national framework The expectations of line managers in relation to people management which was tailored in-house to our local context.

The full results of our National Staff Survey in 2024 can be found here National results across the NHS in England | NHS Staff Survey.

Feedback into Action

Staff experience is incredibly valuable to NHS Norfolk and Waveney ICB and across Norfolk and Waveney as a system. We are committed to listen to what our staff are saying and feeling, so that we can continue to make improvements where necessary. Our aspiration as an ICB is to consistently co-create solutions with our staff to address the issues they raise in direct feedback or through staff surveys.

We will continue to seek feedback from our staff through participation in the quarterly 'People Pulse' surveys, as well as in the annual national survey. We collaborate closely with our Staff Involvement Group to look continually for ways to improve staff experience and to respond positively to their feedback.

We are committed to being "a great place to work" as we want to recruit and retain the best people to ensure we provide outstanding care for our communities. We have recently

conducted a cultural assessment which, along with our staff survey results, will shape our plans to foster a culture that actively promotes the collaboration and inclusion of all our people, in the delivery of our Joint Forward Plan.

Enhancing Staff Health and Wellbeing

In line with our latest NHS National Staff Survey results, improving staff health and wellbeing will continue to be a priority. The last 12 months have seen a significant focus on staff health and wellbeing, particularly in supporting them during the uncertainty caused by the ICB restructure. Three new health and wellbeing champions have been recruited, with bi-monthly updates on any key issues and initiatives from the staff health and wellbeing steering group to the lead non-executive director. 88.8% of staff have accessed our health and wellbeing platform over the last 12 months – one of the highest sign-up levels amongst all the organisations supported by our provider, Vivup, across the UK. Twelve employees accessed our counselling services during the year.

We are currently researching improvements to our menopause offer, with the intention of becoming an accredited menopause-friendly workplace. Our strengthened EDI support for staff has been reflected in significant improvements in the latest primary care staff survey results. Salary sacrifice purchases by staff have generated £2,866 of NI/pension contribution pay-roll savings which will be reinvested in further improving the health and wellbeing service offered to staff in general practice.

Equality Diversity Inclusion (EDI)

We're continuously work to enhance resources for our staff and communities across Norfolk and Waveney to support EDI. Some of this work includes:

- The ongoing promotion of the EDI Resource Hub, promoting best practices and fostering an inclusive workplace culture.
- Implementing local portals for anonymous reporting of micro-aggressions.
- Continuing to develop and promote de-biasing recruitment and retention tools.
- Supporting the 'Stop the Abuse' anti-bullying and harassment campaign.
- The establishment of Freedom to Speak Up Guardians to encourage a culture of open communication.

Our continued focus for 2024/25 was on the EDI Improvement Plan, prioritising actions to address discrimination and bias. We've been aligning with NHS values and the People Promise, implementing measurable objectives for leaders and Board members.

Leadership support programmes and mentoring/coaching opportunities are in place, alongside efforts for consistency across all provider organisations within the ICS. This includes:

- Just and Restorative Culture training
- Schwartz Rounds for empathy and compassionate care
- Support for staff network groups and psychological safety spaces.

As an organisation, we are committed to supporting initiatives like 'Let's Talk Menopause' and the Antiracism Strategy. Our aim continues to be to create environments where our workforce feels valued, respected, and motivated.

The ICB's EDI group continues to meets monthly to support and empower all staff to achieve their potential through creating positive change. The overall goal is to increase the level of knowledge, skills and understanding of issues surrounding equality, diversity and inclusion within the ICB.

We promote EDI awareness through various channels and provide Employee Assistance Programmes. Our focus areas include de-biasing policies, empowering staff voices, and enhancing education on EDI.

Our approach to Working with People and Communities in Norfolk and Waveney

Listening to the lived experience of the people and communities in Norfolk and Waveney is vital in helping people live longer, healthier and happier lives. It also helps us make sure that the care and support offered in Norfolk and Waveney is designed around our population. All the partners in our ICS are talking and listening to people and communities every day. Our vision is that people will tell their story of lived experience once and that it's heard by everyone in the ICS. We want to develop ongoing relationships with communities to learn what matters to them, and work together to address waiting times, improve access to services and support people to live the healthiest life possible.

We want to build on the existing engagement and insight that happens across all our system partners and find ways of working together to share and learn from this insight. Working together will also mean we can pool our resources and work more efficiently across the ICS. We have developed a Working with People and Communities Strategy, which is currently being refreshed.

People and Communities Hub

The ICS website hosts a dedicated people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS.

The hub also gives a measurable focal point to engagement activity undertaken by the ICB as part of its legal duties. Specific projects and opportunities for working with people and communities are being advertised, and 'You said, We did/We can't' reports detailing the results of the feedback and any improvements that resulted are being uploaded.

Key Engagement Activities

Consultation on changes to services in Norfolk and Waveney

In March 2025, the ICB launched a public consultation on proposed changes to services. The options included potential changes to the bases the GP Out of Hours Service operates from, investment in GP practices, the future of the Norwich Walk-in Centre and whether the Vulnerable Adults Service based in Norwich should move to an outreach model that supports people across Norfolk and Waveney.

The consultation ran from 3 March and was due to end on 25 May 2025. The ICB engaged with the public via a survey and had planned drop-in sessions across Norfolk and Waveney. Healthwatch Norfolk also gathered feedback through its community engagement events.

On 19 May, the ICB made the decision to end the consultation, to keep the Norwich Walk-in Centre open, and not go ahead with the changes being proposed to the GP Out of Hours Service and Vulnerable Adults Service.

The decision was made to align with the ICB's strategic aim to increase neighbourhood-level services and improve access to primary care, and what was expected to be in the government's 10 Year Plan for health.

Consultation on closure of Toftwood Medical Centre

In December 2024, the ICB approved the closure of Toftwood Medical Centre in Dereham from 1 April 2025. This decision followed years of discussions, negotiations with the property owner, and a formal public consultation process to explore alternative options and gather public feedback on the future of primary care provision in Dereham.

The consultation ran from 10 October to 21 November 2024, during which the ICB engaged with patients, stakeholders and the wider community. This engagement included an online survey, a public meeting and drop-in sessions in the local area. A full consultation report detailing the feedback and key themes raised by the public was carefully reviewed before the final decision was made.

As part of the transition, patients registered at Toftwood Medical Centre were automatically transferred to either Orchard Surgery or Theatre Royal Surgery. Patients had the option to re-register with another practice if they chose, provided they live within the practice's catchment area.

Looking ahead, the ICB has joined the Dereham Town Planning Group to contribute to discussions on the long-term future of healthcare provision in the area. This approach will help ensure that the growing population of Dereham continues to have access to high-quality NHS services.

Public engagement on NHS 10-year plan

As part of the Government's Change NHS initiative, the ICB undertook a range of targeted engagement activities to ensure local voices contribute to shaping the future of health and care services in England. This engagement focused on gathering insights to inform the development of a new 10-year plan designed to improve accessibility, efficiency, and sustainability in the NHS.

The ICB facilitated an inclusive engagement process, drawing on a combination of targeted workshops and existing community feedback from previous consultations and listening events. Engagement activities involved a diverse range of stakeholders, including patients, young people, community groups, vulnerable populations, and NHS staff.
Participants were invited to share their views on three key priorities:

1. **Moving care from hospitals to communities** – ensuring more care is provided closer to home.
2. **Making better use of technology** – integrating digital advancements to improve patient experiences and outcomes.
3. **Focusing on preventing sickness, not just treating** it – prioritising prevention to reduce the demand on healthcare services.

Key feedback themes for the future of the NHS include improving accessibility, efficiency, and inclusivity while maintaining its core values of free, high-quality, and patient-centred care.

- Digital innovation, such as enhanced appointment systems and AI-driven support, is seen to streamline services, though concerns about digital exclusion and maintaining human interaction remain.

- Shifting care from hospitals to communities could improve access and reduce pressure on hospitals, but funding and coordination challenges must be addressed.
- A prevention-first approach, focusing on education, early intervention, and community-based support, is essential to improving long-term health outcomes and reducing costs.

The insights gathered through this engagement will directly inform both national and local healthcare planning. Nationally, findings will contribute to shaping the government's 10-year plan, ensuring it reflects the needs of local communities. Locally, the feedback will be used to guide the development of health and care services in Norfolk and Waveney, influencing future funding allocations and supporting the ongoing Joint Forward Plan refresh. Effective implementation of these changes requires sustainable investment, workforce development, and seamless integration across services.

The full report can be read here.

Ongoing Engagement and Working with our People and Communities

General Practice engagement

Most of our GP practices have patient groups, often referred to as Patient Participation Groups (PPGs). They offer members of the public the opportunity to become more involved in how the practice runs. This could be about the physical building, waiting times, services offered or wider healthcare issues.

A webpage is in place which features case studies, including examples that promote different models of patient engagement. There is also other information and links to resources including a toolkit produced by Healthwatch Norfolk following the period of engagement, which aims to give practices and PPGs a step by step guide.

Norfolk and Waveney Community Voices Programme

The ICB is working with district councils and the local VCSE sector to continue to develop and deliver Community Voices, an engagement programme to help us listen to our communities and better understand experiences and opinions of accessing healthcare. It started during the COVID-19 pandemic to help us understand vaccine uptake but has since looked at a range of services such as bowel cancer screening and stop smoking.

Community Voices works with trusted communicators to speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney. We expect to hear about the challenges faced by local people in accessing services, and about the issues that prevent wellbeing across a range of factors, including those outside the direct health sphere such as housing, employment and finances.

Norfolk and Waveney Insight Bank

All the qualitative data we collect as part of the Community Voices programme is being stored in an 'insight bank'. This is currently a survey collection tool, but the vision is that it will be developed into a much wider bank of insight for use across the ICS housed within a robust data platform. The qualitative data is already being shared with ICB staff through a

Power BI platform, however it is envisaged that it will eventually provide anonymised information useful for all ICS partners giving insight on a street, neighbourhood, place and system level which will be useful for health and care planning and other services too.

Norfolk and Waveney Patients and Communities Committee

The Patients and Communities Committee provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of our patients and communities across Norfolk and Waveney. That is based on engagement and feedback from local people and groups.

The Committee also specifically focusses on how NHS Norfolk and Waveney and the wider Integrated Care System is actively addressing and reducing health inequalities experienced by individuals and communities. The Committee also receives insight, makes sure it is gathered appropriately, and monitors progress to ensure that change is happening. It also refers to the 'so what' question – what this means for our people and communities.

Patient Experience and Engagement Leads Group

The Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place regularly for several years. They give an opportunity for people working in NHS provider trusts to meet and share practice across the system, to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to, and involve patient experience feedback in quality and wider commissioning.

Equality Impact Assessments (EHIAs)

We will continue to support the production of EHIAs for projects and transformation within the engagement function of NHS Norfolk and Waveney Integrated Care Board. These have been recognised as key to reference that due thought has been given to protected characteristics and communities of interest, and to highlight areas where the voice of people and communities is missing. They are a key part of the Health Inequalities Strategic Framework and are reviewed and monitored by the Health Inequalities Oversight Group (HIOG).

Co-production

Communications and engagement work, at a local level, is key to developing ongoing relationships with people and communities, and our engagement networks are vital to support the Joint Forward Plan.

One area of participation that we want to develop further with partners is around the promotion of true co-production. This refers to a process of shared power to effect change.

Examples of co-production in Norfolk and Waveney:

- Development of a co-production hub as part of our People and Communities hub to share examples from the system, to promote co-production principles and to signpost to support materials.
- Development of a Norfolk and Waveney Mental Health Co-production strategy and interactive toolkit for lived experience to effectively influence ICS mental health transformation, services and support.
- The Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities. This is in partnership with Norfolk County Council Adult Social Care.

- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement, research and health inequalities.

Joint Health and Wellbeing Strategies

NHS Norfolk and Waveney ICB is an active member of both the Norfolk and Suffolk Health and Wellbeing Boards. The ICB has worked to support the four priorities in Norfolk's Joint Health and Wellbeing Strategy, as well as the cross-cutting themes in Suffolk's strategy. This section of our Annual Report summarises how the ICB has contributed to the priorities of our two local health and wellbeing strategies. Drafts of this section were shared with both Norfolk and Suffolk Health and Wellbeing Boards in June 2025 for their comments.

Norfolk priority: Driving integration
Suffolk cross-cutting theme: Greater collaboration and system working

The ICB has continued to work with partners to develop and strengthen our Integrated Care System over the past year. Our Joint Forward Plan sets out how the local NHS and care services will implement our Integrated Care Strategy / the Norfolk Joint Health and Wellbeing Strategy.

As a system, we have delivered and made progress with a wide range of projects and changes that have and will improve the health, wellbeing and care of local people. The ICB has played an important role as a convenor, bringing together partners from across the system and providing skills and expertise, data and insight to enable us transform how we care for local people. Examples include:

Working as a system to treat people in the community and preventing them from being taken to hospital in an ambulance when they don't need to be: Our Unscheduled Care Coordination Hub brings together colleagues from different organisations who work together to help people who call 999 that could be better cared for by community services instead of being taken to a hospital by ambulance. The service has had an impressive first year, preventing more than 11,000 unnecessary ambulance dispatches.

Sharing data better to make it easier for frontline health and care professionals to understand people's conditions and to treat them: For example, the Norfolk and Waveney Shared Care Record is now used by over 2,000 staff daily, providing access to critical patient information for 12,000 people. This system has streamlined care, ensuring healthcare professionals can make faster and better-informed decisions while reducing the need for patients to repeat their medical history.

Making it easier for children and young people to get support for their mental health and wellbeing: For example, in April 2024 we launched the Access to Mental Health Advice and Support Service, which provides an integrated front door for children and young people to access support. The service now processes around 650 requests per month, with urgent cases triaged within two days. The introduction of this service has resulted in a 30% reduction in referrals to the Norfolk and Suffolk Foundation Trust (NSFT), with more young people receiving support from community and voluntary organisations.

While our Integrated Care System is not fundamentally about structures and governance, to achieve our mission and to deliver more projects and changes like these, it is vital that we have the right foundations and ways of working in place. The ICB concluded an organisational review in 2024/25 and implemented a new structure and operating model that supports greater collaboration and system working.

As a system, we are strengthening integration at all levels. The ICB has:

- continued to support the development of our Primary Care Networks (PCNs) and integrating our workforce.
- worked with partners to continue to develop our five Place Boards, which bring together colleagues from across health and care to integrate services at a more local level.
- been an active partner in the eight local health and wellbeing partnerships, working with district councils, VCSE organisations and others to address the wider determinants of health.
- continued to contribute to the development of our Integrated Care Partnership and both Norfolk and Suffolk's Health and Wellbeing Boards.
- supported greater collaboration between providers, including the development of the Norfolk and Waveney University Hospitals Group and the coming together of Cambridgeshire Community Services NHS Trust and Norfolk Community Health and Care NHS Trust.

Norfolk priority: Prioritising prevention
Suffolk cross-cutting theme: Prevention: stabilising need and demand

This year we have made significant progress in delivering the priorities set out in our Population Health Management strategy. The strategy focuses on using joined-up data and intelligence to identify and understand the health and care needs of the local population, allowing for targeted interventions that improve health outcomes and reduce inequalities. By prioritising prevention and collaboration, the programme empowers professionals to help people live healthier, more independent lives.

A major achievement has been the development of the infrastructure needed to support this work, including specialist software, analytical tools, and data dashboards to help colleagues across the Integrated Care System to review population health data and track progress against key priorities.

We have continued to develop Protect NoW, which is a collaboration between NHS organisations, local authorities, the voluntary sector and independent partners aimed at improving physical and mental health through proactive support. Several targeted projects have been successfully delivered, including improving access to talking therapies for older adults and those at risk of falls, and the Dementia North Norfolk initiative, which connects people affected by dementia with services such as housing support, benefits advice, social activities, and carers' support.

Norfolk priority: Addressing inequalities
Suffolk cross-cutting theme: Reducing inequalities

As a system, we are committed to working together to tackle unfair and avoidable differences in health outcomes between residents. We do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

The ICB works with partners to reduce health inequalities by:

- using population health management techniques.
- improving access to services.
- collaborating through our place boards and local health and wellbeing partnerships
- having a Patients and Communities Committee, whose remit includes examining how the ICB is reducing health inequalities.

A key step we have taken this year has been to finalise and start to implement our Norfolk and Waveney Health Inequalities Strategic Framework for Action, which sets out the actions we are going to take as a system to tackle health inequalities.

Norfolk priority: Enabling resilient communities
Suffolk cross-cutting theme: Connected, resilient and thriving communities

The ICB is committed to supporting people to live independent healthy lives in their community for as long as possible, through promotion of self-care, early intervention and digital technology where appropriate. As set out above, we are using population health management techniques to provide more anticipatory care and early intervention. We are also using technology to empower people to manage their health and wellbeing better, for example by giving people greater visibility and control over their treatment and care journeys.

Vital to creating more resilient communities is working with the voluntary, community, faith and social enterprise sector. The ICB values the work of the sector and wants to work with the sector as a trusted partner, including through the VCSE Assembly which the ICB has established with both the sector and other partners.

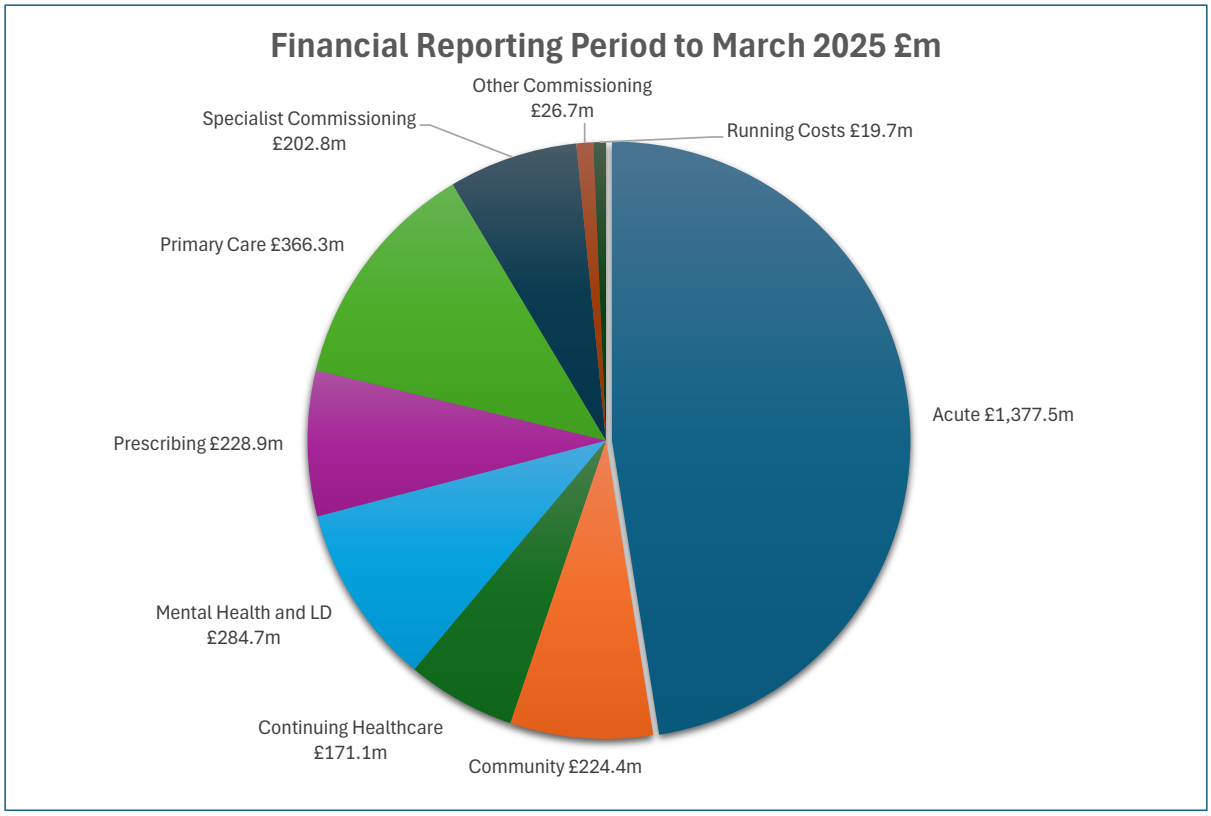
Financial review

The introduction of NHS Norfolk and Waveney on 1 July 2022 brought about the cessation of Clinical Commissioning Groups (CCGs) and inception of Integrated Care Boards (ICBs). Therefore, the financial year 2024/25 represents the second full 12-month reporting period for ICBs. The following information reflects the twelve-month accounting period for the ICB to 31 March 2025.

• The total allocation for the accounting period was £2,902.0m.
• This was split between Commissioning Health Services (£2,882.0m) and Running Costs (£19.7m).

The following table and chart provide a breakdown by category of how the allocation was spent:

Area of spend	Total spend (£m)
Acute	1,377.5
Community	224.4
Continuing Healthcare	171.1
Mental Health and LD	284.7
Prescribing	228.9
Primary Care	366.3
Specialist Commissioning	202.8
Other Commissioning	26.7
Running Costs	19.7
Total	**2,902.0**



For 2024/25 Financial year, NHS Norfolk and Waveney delivered its statutory duty to breakeven, with the final reported position being a £0.6m underspend.

Within this underspend, NHS Norfolk and Waveney also remained within the allocated running cost budget and therefore delivered on all financial duties as reported in note 19 'Financial Performance Targets' of the Annual Accounts.

A key contributor to the achievement of the overall financial position was successful delivery of £44.3m of efficiencies. The main areas of delivery were:

- Prescribing (£13.4m)
- Continuing Health Care (£11.9m)
- Corporate (£7.1m) – this included non-recurrent benefits of phased recruitment, redeployment of displaced staff and savings on corporate estate.
- Non-recurrent savings (£11.9m) – these included slippage on investments, contractual management and spend reviews.

The above efficiency delivery has enabled NHS Norfolk and Waveney to deliver its statutory financial duty, whilst simultaneously providing additional resources to support the ICS during a period of sustained operational pressure. Further financial information is included in the Annual Accounts section.

[redacted]
Ed Garratt OBE
Interim Accountable Officer
18 June 2025

ACCOUNTABILITY REPORT

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

NHS Norfolk and Waveney became a statutory body on 1 July 2022 in accordance with the Health and Care Act 2022 and following the dissolution of the NHS Norfolk and Waveney Clinical Commissioning Group on 30 June 2022.

Members' report

NHS Norfolk and Waveney's Constitution came into effect on 1 July 2022. The Chair of NHS Norfolk and Waveney is the Right Honourable Patricia Hewitt and the Chief Executive Officer is Tracey Bleakley.

Member profiles and practice

NHS Norfolk and Waveney has 105 member GP practices grouped into 20 Primary Care Networks (PCNs). More information on PCNs can be found in the Performance Report.

Composition of Board – the members of the Board are:




Rt Hon Patricia Hewitt Chair	Tracey Bleakley Accountable Officer	Steven Course Executive Director of Finance	Dr Frankie Swords Executive Medical Director
			
Patricia D'Orsi Executive Director of Nursing	Hein van den Wildenberg Non-executive Member	Cathy Armor Non-executive Member	David Holt Non-executive Member
			
Aliona Derrett Non-executive Member	Cllr Fran Whymark Member - Integrated Care Partnership	Ian wake Partner Member Local Authority	Stuart Keeble Partner Member Local Authority
			
Emma Ratzer Member from VCSE Assembly Board	Jon Barber Partner Member NHS Foundation Trust	Dr Hilary Byrne Partner Member	Dr Faisil Sethi Partner Member NHS Trust

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Committees, including Audit and Risk Committee

Please see the Annual Governance Statement page 83 for details of the Audit and Risk Committee and all other Board Committees.

Register of Interests

The Register of Board Interests can be found via the following link: https://improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/conflicts-of-interest/. More information on how NHS Norfolk and Waveney manages interests can be found in the Annual Audit of Conflicts of Interest Management section on page 104.

Personal data related incidents

During the period 1 April 2024 to 31 March 2025 and up to the submission of the Annual Report and Accounts there were two data security breaches reported to the Information Commissioner's Office (ICO). The ICO confirmed they would not be taking any action, provided general feedback to the ICB and confirmed that the cases were closed.

Modern Slavery Act

NHS Norfolk and Waveney ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Ed Garratt OBE
Interim Accountable Officer
18 June 2025

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

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

Ed Garratt OBE
Interim Accountable Officer
18 June 2025

Governance Statement

Introduction and context

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

NHS Norfolk and Waveney's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 April 2024 and 31 March 2025, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

I am responsible for ensuring that NHS Norfolk and Waveney is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within NHS Norfolk and Waveney as set out in this governance statement.

Governance arrangements and effectiveness

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

NHS Norfolk and Waveney Governance Framework

NHS Norfolk and Waveney's Constitution and Governance Handbook

NHS Norfolk and Waveney's Constitution is based on the Integrated Care Board Model Constitution produced by NHS England in May 2022.

The Constitution sets out NHS Norfolk and Waveney Board membership, the appointment process for Board as well as the organisation's governance arrangements and includes the standing financial instructions. It also sets out how NHS Norfolk and Waveney discharges its statutory functions via its governing structure.

This is supported by NHS Norfolk and Waveney's Governance Handbook which includes the terms of reference for each of NHS Norfolk and Waveney's committees as well as the scheme of reservation and delegation, conflicts of interest policy and standards of business conduct policy.

Board

The Board is comprised of 16 members; the chair, chief executive officer, 4 non-executive members, 5 partner members from local NHS trusts, foundation trusts, primary medical services and Norfolk County Council and Suffolk County Council, an executive director of finance, an executive medical director and executive director of nursing, a member from the VCSE Assembly Board and a member from the Integrated Care Partnership Board.

The quorum for the Board is 10 members and needs to include either the chief executive officer or the executive director of finance and either the executive medical director or the executive nursing director and at least one independent member which can include the chair and at least one partner member.

There have been four changes to the membership of the Board during the reporting period as follows:

- Debbie Barlett, Interim Executive Director of Adult Social Services of Norfolk County Council, retired in October 2024 and Ian Wake, Executive Director of Adult Social Services of Norfolk County Council was appointed to the role in October 2024
- Caroline Donovan, Chief Executive of Norfolk and Suffolk NHS Foundation Trust stood down as a Partner Member in November 2024 and Dr Faisil Sethi, Deputy Chief Executive Officer & Chief Medical Officer of Norfolk and Suffolk NHS Foundation Trust was appointed to the role in November 2024
- Cllr Bill Borrett, Chair of the Integrated Care Partnership and Health and Wellbeing Board stood down in January 2025 and Cllr Fran Whymark Chair of the Integrated Care Partnership and Health and Wellbeing Board was appointed to the role in March 2025
- Rt Hon Patricia Hewitt, Chair of the ICB resigned on 10 March 2025. Hein van den Wildenberg, non-executive Member became the acting Chair.

Meetings

NHS Norfolk and Waveney held 6 Board meetings in public between 1 April 2024 and 31 March 2025.

Details of how members of the public are able to attend public meetings in person or join virtually, access meeting papers and minutes from previous meetings can be found on NHS Norfolk and Waveney website: https://improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/our-icb-meetings-and-events/. Members of the public are also able to raise questions with the Board by submitting questions to email nwicb.contactus@nhs.net.

Each meeting had been well attended and quorate. Members of the Executive Management Team also routinely attended meetings. Membership and 'voting' attendance is recorded in the table below:

Name	Member	Attendance
Patricia Hewitt *Until 10/03/2025*	Chair (resigned 10 March 2025)	3 out of 5 meetings 60%
Tracey Bleakley	Chief Executive Officer	6 out of 6 meetings 100%
Steven Course	Executive Director of Finance	6 out of 6 meetings 100%
Dr Frankie Swords	Executive Medical Director	6 out of 6 meetings 100%
Patricia D'Orsi	Executive Director of Nursing	5 out of 6 meetings 83%
Hein Van Den Wildenberg	Non-Executive Member	6 out of 6 meetings 100%
Cathy Armor	Non-Executive Member	6 out of 6 meetings 100%
David Holt	Non-Executive Member	5 out of 6 meetings 83%
Aliona Derrett	Non-Executive Member	4 out of 6 meetings 67%
Dr Hilary Byrne	Partner Member Primary Medical Services	0 out of 6 meetings 0%
Bill Borrett *Until 24/01/2025*	Member from Integrated Care Partnership	6 out of 6 meetings 100%
Fran Whymark *From 17/03/24*	Member from Integrated Care Partnership	6 out of 6 meetings 100%
Debbie Bartlett *Until 27/10/2024*	Partner Member Local Authorities, Norfolk County Council	0 out of 3 meetings 0%
Ian Wake *From 28/10/2024*	Partner Member Local Authorities, Norfolk County Council	2 out of 3 meetings 67%
Stuart Keeble	Partner Member Local Authorities, Suffolk County Council	5 out of 6 meetings 83%
Emma Ratzer	Member from the VCSE Assembly Board	4 out of 6 meetings 67%
Jonathan Barber	Partner Member NHS Trusts and Foundation Trusts	5 out of 6 meetings 83%
Caroline Donovan *Until 28/11/2024*	Partner Member – NHS Trusts (Mental Health and Community Services)	2 out of 4 meetings 50%
Dr Faisil Sethi *From 28/11/2024*	Partner Member – NHS Trusts (Mental Health and Community Services)	1 out of 2 meetings 50%

Additional private meetings were held throughout the year for Board development and to discuss matters where the wider public interest or commercial confidentiality clearly required it.

The Board approved the Constitution and Governance Handbook at its inaugural meeting on 1 July 2022. The Governance Handbook has been updated regularly since then with updates approved by the Board in September, November 2024 and March 2025.

The Board has a number of functions conferred on it by the Health and Social Care Act 2012 (the "Act"). The main function is to ensure that NHS Norfolk and Waveney has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with good governance. The Board also leads on setting the vision and strategy of the organisation. The Board has established a Remuneration, People, Culture Committee to determine the remuneration, fees and other allowances payable to employees or other persons providing services to NHS Norfolk and Waveney.

NHS Norfolk and Waveney's Constitution sets out the responsibilities delegated to the Board. These include providing assurance of strategic risks, ensuring registers of interest are reviewed regularly, and that financial reports including details about allocation and financial variances against plan are reviewed. These matters are standing agenda items at each Board meeting.

The following topics are frequently discussed by the Board at its meetings:

- system pressures
- elective recovery
- clinical threshold policy recommendations
- financial reporting
- risk reporting
- reports from committees.

The Board completed a self-evaluation of its own performance and effectiveness in April 2025. This was discussed at a Board meeting on 30 April 2025 and the findings from the self-evaluation were that the Board was effective. However, areas were identified where actions could be taken to support the continued improvement and development of the Board. In addition, the Board continues to undertake a programme of development and regularly meets to focus on this work.

Board Joint Committee – Integrated Care Partnership

The Integrated Care Partnership (ICP) Committee is a joint statutory committee of NHS Norfolk and Waveney ICB, Norfolk County Council and Suffolk County Council. Councillor Bill Borrett was the Chair of this joint committee until January 2025 when Cllr Fran Whymark was appointed. The Rt Hon. Patricia Hewitt, Chair of the ICB, is one of the Vice-Chairs.

The role of the Committee is to promote the close collaboration of the health and care system across Norfolk and Waveney.

The Committee provides a forum for stakeholders to come together as equal partners to discuss and resolve crosscutting issues. The Committee has a central role in the planning and improvement of health and care in Norfolk and Waveney. Details of the ICP and its meetings can be found at the following link: https://improvinglivesnw.org.uk/about-us/our-integrated-care-partnership/.

Since 1 April 2024 and up to 31 March 2025 the Committee has met 4 times with an Integrated Care System conference held for the system in October 2024 and a Members Development session in February 2025. Meeting attendance was good, and all meetings were quorate.

The work of the committee during the reporting period 1 April 2024 to 31 March 2025 included:

- Integrated Care Strategy progress
- Norfolk All Age Autism Strategy
- Norfolk Adults and Children's Safeguarding
- Better Care Fund Plans and quarterly reports
- All Age Carers Strategy
- West Norfolk - becoming a Marmot Place
- Norfolk Drug and Alcohol Partnership progress
- Preparing for Seasonal Pressures: ICS Framework for 2024/25
- Driving Integration Through Digital, Data and Technology
- Norfolk and Waveney Health Inequalities Strategic Framework for Action
- LeDeR Annual Report and Learning Disabilities Plan
- Driving Integration through system wide training opportunities
- Norfolk Health Protection Assurance Board work and progress
- Norfolk and Waveney Health and Wellbeing Partnership event and progress
- Place Boards and progress.

Board Committees

The Board appointed eight committees, and these are detailed below.

Primary Care Commissioning Committee

The role of this Committee is to carry out the functions relating to the commissioning of primary care matters under the terms of Delegation Agreements with NHS England. This includes the functions relating to the commissioning of primary medical services (except those that relate to individual GP performer list concerns which have been reserved to NHS England) and also from 1 April 2023 responsibility for pharmaceutical, general ophthalmic and dental (primary, community and secondary care) services.

The Committee reviewed its terms of reference during the reporting period in line with its terms of reference and these were approved by the Board.

Membership of the Committee comprises:

- a local authority partner member from NHS Norfolk and Waveney Board (Chair)
- Non-Executive Member (Vice Chair)

- Executive Director of Nursing or their nominated deputy
- Executive Director of Finance or their nominated deputy

Since 1 April 2024 and up to 31 March 2025 the Committee met 5 times.

Membership of the Primary Care Commissioning Committee together with the attendance record is provided in the table below

Name	Member	Attendance
Debbie Bartlett *Until 27/10/2024*	Chair, Local Authority (Norfolk) Partner Member from the Board	3 out of 3 meetings 100%
Ian Wake *From 28/10/2024*	Chair, Local Authority (Norfolk) Partner Member from the Board	0 out of 2 meetings 0%
Hein Van Den Wildenberg	Deputy Chair, Non-Executive Member	5 out of 5 meetings 100%
Steven Course (or nominated deputy)	Executive Director of Finance	5 out of 5 meetings 100%
Patricia D'Orsi (or nominated deputy)	Executive Director of Nursing	5 out of 5 meetings 100%

Highlights of the work of the committee during April 2024 to March 2025 include:

- understanding of responsibilities for contractual, commissioning and quality matters for all primary care services: medical including PCN contracting matters, dental, optometry and community pharmacy
- strategic leadership, challenge and support to the primary care system drive improvement in primary care
- performance review and monitoring of activity and finance across all primary care including transformation, workforce, digital and estates budgets to manage risk and provide assurance
- oversight and development of governance structures for managing responsibilities for all four primary care contractor groups through the establishment of two new delivery groups for dental and general practice, to ensure robust decision making, assurance and escalation processes are in place
- review, monitoring and assurance of Primary Care Risk including work to improve the interface between primary and secondary care, and measures taken to improve resilience of all primary care services
- overseeing achievement against national primary care priorities such as the uptake and quality of learning disability health checks and severe mental illness health checks
- considered individual general practice resilience issues and approving action plans
- made decisions in relation to complex or reputational contractual and resilience matters thereby ensuring continuity of patient care for the local population
- approval of programmes and strategic plans, such as primary care workforce development and transformation, access and improvement and primary care ambitions in the Joint Forward Plan including the ICB's Long Term Dental Plan and Primary Care Access and Recovery Plan

- drive improvement in quality of primary care services including the oversight of CQC inspections, understanding the challenges emerging and the actions being taken by practices and ICB support needed
- receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs, monitoring progress to meet national benchmarks
- receive regular reports on primary care estates plans and progress in digital developments to support general practice and PCN plans
- approve plans for the commissioning of Local Enhanced Services
- receive reports from the Pharmaceutical Services Regulations Committee to provide assurance and oversight of decision making
- receive reports on optometry contractual and commissioning matters and make decisions as required
- represent primary care matters in the wider system and at Board level.

Audit and Risk Committee

The Audit and Risk Committee provides the Board with an independent and objective view of NHS Norfolk and Waveney's assurance processes. This is achieved by reviewing financial systems, the risk management structure and ensuring compliance with the laws, regulations and directions that govern NHS Norfolk and Waveney.

The Audit and Risk Committee is comprised of:

- Non-Executive member with a lead for Audit and Risk, who is also the Chair
- a minimum of 2 but up to 3 Non-Executive members other than the Chair, 2 of whom must be on the Board of the ICB
- the Chair of the Audit and Risk Committee is David Holt who is the Non-Executive member with a lead for Audit and Risk and also NHS Norfolk and Waveney's Conflicts of Interest Guardian.

The Committee reviewed its terms of reference and membership during the reporting period and undertook a self-assessment which provided the Committee with the assurance of a 'good' outcome.

During the reporting period the Audit and Risk Committee met 5 times. Each meeting was well attended and quorate.

Membership of the Audit and Risk Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
David Holt	Chair, Non-Executive Member	5 out of 5 meetings 100%
Cathy Amor	Non-Executive Member	4 out of 5 meetings 80%
Emma Ratzer	Partner Member	4 out of 5 meetings 80%

The Committee was supported by regular attendance of NHS Norfolk and Waveney's Executive Director of Finance, Executive Director of Corporate Affairs and ICS Development, Executive Medical Director, Executive Director of Nursing, Director of Financial Management

and Director of Commissioning Finance. The ICB Chief Executive Officer also attends a meeting annually during which the Committee oversees the year end sign off of the annual report and accounts.

The primary role of the Audit and Risk Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across NHS Norfolk and Waveney's activities supporting the achievement of NHS Norfolk and Waveney's objectives.

The Audit and Risk Committee reviewed the adequacy and effectiveness of:

- internal control systems
- risk and control related disclosure statements prior to endorsement by NHS Norfolk and Waveney
- principal risks and policies for ensuring compliance with regard to regulatory, legal, code of conduct requirements and self-certification
- policies and procedures for work related to fraud and corruption and information governance.

The Committee primarily utilises the work of Internal Audit and External Audit but is not limited to these sources. It also seeks reports and assurances from directors and managers as appropriate. The Committee concentrates on the overarching systems of integrated governance, risk management and internal control.

The Audit and Risk Committee is also responsible for ensuring that arrangements are in place for countering fraud and reviews the work of the counter-fraud specialist.

The Committee has undertaken a series of deep dives that have focused on key strategic risks that could potentially impact the organisation. The deep dives have included a review of the challenges and risks around the continuing healthcare workstreams, cyber security risks, freedom to speak up challenges, financial delivery and the impacts on the workforce following the staff reorganisation. Each of these deep dives has stimulated discussion and review of key areas of strategic risk for NHS Norfolk and Waveney and have helped inform the work of the Committee as well as provide assurance on work being undertaken to address and mitigate risks.

Other key areas of work of the Audit and Risk Committee during the reporting period includes:

- reviewing the Risk Management Framework and Board Assurance Framework providing assurance to the Board
- reviewing the Annual Report and Accounts
- reviewing reports on internal controls and counter fraud

- discussion on delegation of responsibility for specialised commissioning from NHS England to NHS Norfolk and Waveney.

The Audit and Risk Committee Chair has also met with system audit Chairs to review system effectiveness. Meetings have discussed the Joint Forward Plan and financial environment as well as system risk registers and risk appetite including the interdependency of cyber security and risk. Risk registers are shared between partners to ensure a system wide understanding of key issues.

Conflicts of Interest Committee Sub Committee

This committee is a sub-committee of the Audit and Risk Committee. It contributes to the overall delivery of NHS Norfolk and Waveney objectives by providing oversight and assurance to the Audit and Risk Committee on the adequacy and effectiveness of conflict of interest processes within NHS Norfolk and Waveney. The committee is authorised to make decisions on behalf of the Board about issues which could not be decided by the Board due to conflicts of interest and thus acts independently and provides a space to deliberate matters of interest.

Membership of the committee consisted of the following:

- Non-Executive Member (Chair)
- At least one further Non-Executive Member from the Board
- Executive Director of Finance (Deputy Chair)
- Executive Medical Director.

The committee reviewed its terms of reference to ensure that it has the appropriate level of responsibility to discuss and decide upon possible breaches of NHS Norfolk and Waveney's Conflicts of interest Policy. The committee also reviewed the refreshed the Conflicts of Interest Policy.

The Committee met twice during the reporting period of 1 April 2024 to 31 March 2025, but meetings can be convened if required more frequently. The membership of the Conflicts of Interest Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
David Holt	Chair, Non-Executive Member	2 out of 2 meetings 100%
Hein Van Den Wildenberg	Non-Executive Member	2 out of 2 meetings 100%
Dr Frankie Swords	Executive Medical Director	2 out of 2 meetings 100%
Steven Course	Executive Finance Director	2 out of 2 meetings 100%

Key areas of the work for the committee include:

- committee's terms of reference
- review of refreshed Conflicts of Interest Policy
- review of process
- conducting regular 'deep dives' into key themes to monitor the ICB's compliance with conflicts of interest.
- review of potential breaches
- the agreement of an annual workplan
- oversight of staff conflicts training
- oversight of the governance of the management of conflicts processes.

Remuneration, People and Culture Committee

The Remuneration, People and Culture Committee is accountable to the Board. This Committee contributes to the overall delivery of NHS Norfolk and Waveney objectives by providing oversight and assurance to the Board on the strategic people and culture agenda as well as determining pay arrangements.

The members of the Part 1 and Part 2 Remuneration, People and Culture Committee are:

- 3 non-executive members of NHS Norfolk and Waveney who are not the Chair of the Audit and Risk Committee.

In addition, the following are members of the Part 1 section of the meeting only:

- 1 other member appointed from the wider Norfolk and Waveney System with the relevant experience as to people and culture
- Executive Nursing Director or nominated deputy.

The Committee's terms of reference were reviewed during the reporting period, but no changes were made.

Part 1 meetings were supported by the Executive Director of People or nominated deputy. This section of the meeting contributes to the overall delivery of NHS Norfolk and Waveney objectives by providing oversight and assurance to the Board on the strategy people and culture agenda for NHS Norfolk and Waveney and its partner constituents. It scrutinises the delivery of the strategic people priorities in order to provide assurance to the Board that risks to the delivery of the people agenda are being managed appropriately.

The Part 1 Remuneration, People and Culture Committee's work during the reporting period included:

- review of the staff survey
- review of system initiatives including staff retention, a shared staff bank, shared recruitment.

Part 2 meetings were supported by the Executive Director of Corporate Affairs and ICS Development or nominated deputy and the Executive Director of People or nominated deputy.

The Part 2 meeting determines the pay and remuneration for the Chief Executive, Members of the Board and other Very Senior Managers as well as termination of employment and other contractual terms and non-contractual terms. In addition, it determines NHS Norfolk and Waveney pay policy for staff including contractual arrangements and termination arrangements taking into account national guidance as appropriate. NHS Norfolk and Waveney is supported in its work by specialty advisors and the Committee is responsible for determining their pay and overseeing contractual arrangements. This section of the meeting also reviews HR policies and is responsible for providing assurance in relation to ICB statutory duties including the Fit and Proper Person Regulations.

From 1 April 2024 to 31 March 2025 the Part 2 section of the Committee met 6 times in addition to 5 extraordinary meetings in the same period. Membership of the Part 2 section of the Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Cathy Armor (Chair)	Non-Executive member	6 Out of 6 meetings 100%
Hein van den Wildenberg	Non-Executive member	5 Out of 6 meetings 83%
Aliona Derrett	Non-Executive member	4 Out of 6 meetings 67%

The Part 2 Remuneration, People and Culture Committee's work during the reporting period included:

- reviewing and determining executive and Board level pay
- reviewing and approval of HR policies for the Integrated Care Board
- oversight of the ICB's organisational change programme including voluntary redundancy scheme
- review and approval of Fit and Proper Persons Test Policy
- review and approval of national pay increase for Very Senior Managers.

Patients and Communities Committee

This Committee provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of patients and communities. This is based on engagement and feedback from local people and groups and takes account of and reduces the health inequalities experienced by individuals and communities. The committee exists to scrutinise the robustness of, and gain, and provide assurance to NHS Norfolk and Waveney that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee reviewed its terms of reference and membership during the reporting period and amendments were reviewed and approved by the Board at its meeting on 27 January 2025.

Since 1 April 2024 and up to 31 March 2025 the Committee met 5 times. Membership of the Committee changed in October 2024 following a review of the terms of reference. The

attendance record is provided in the table below, members noted with an * are now recorded as attendees of the Committee following the update to the terms of reference noted above:

Name	Member	Attendance
Aliona Derrett	Non-Executive Member of NHS Norfolk and Waveney Board (Chair)	5 out of 5 meetings 100%
Cathy Amor	Non- Executive Member of NHS Norfolk and Waveney Board	5 out of 5 meetings 100%
Emma Ratzer	VCSE Board Member on NHS Norfolk and Waveney Board	5 out of 5 meetings 100%
Mark Burgis	Executive Director Patients and Communities, ICB	5 out of 5 meetings 100%
Tricia D'Orsi	Executive Nursing Director	5 out of 5 meetings 100%
Dr Frankie Swords	Executive Medical Director	5 out of 5 meetings 100%
*Karin Bryant *(from September 2023)*	A representative from Commissioning, ICB	1 out of 3 meetings 33%
*Suzanne Meredith	Senior Public Health Officer Norfolk County Council	3 out of 3 meetings 100%
*Tracy Williams	A representative from the Place Boards and Health Inequalities advisor	3 out of 3 meetings 100%
*Paula Boyce	A representative from the Health and Wellbeing Partnerships	1 out of 3 meetings 33%
*Alex Stewart or deputy	A representative from Healthwatch Norfolk	3 out of 3 meetings 100%
*Andy Yacoub	A representative from Healthwatch Suffolk	3 out of 3 meetings 100%

Quality and Safety Committee

The Quality and Safety Committee is accountable to the Board. The Committee provides the Board with assurance in relation to the quality and safety of its commissioned services and NHS Norfolk and Waveney's internal processes to support safe and effective care which is underpinned by a culture of continuous improvement. The Committee has oversight of the ICS Quality Strategy and its delivery plan.

A key role of the Committee is to monitor the quality and safety of care. The Committee identifies risks and issues and provides assurance to NHS Norfolk and Waveney ICB Board. The Committee receives, and reviews quality and safety focussed reports and agrees any recommended actions to fully understand and work towards mitigation of potential and known clinical risks. It ensures all such risks are documented within the directorate or risk register for the Committee and where relevant, escalated to the Board Assurance Framework. The Committee identifies learning and improvement opportunities and communicates and shares them appropriately. Where appropriate it provides reports to external bodies.

The Non-Executive Member Deputy Chair remained a member of the Committee during the year but an internal error did not enable attendance. This has been corrected for forthcoming meetings. The Committee reviewed its terms of reference during the year to ensure they were fit for purpose.

From 1 April 2024 to 31 March 2025 the Quality and Safety Committee 10 times.

The membership of the Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Aliona Derrett (Chair)	Non-Executive Member	8 out of 10 meetings 80%
Cathy Armor/Hein Van Den Wildenberg (Deputy Chair)	Non-Executive Member	9 out of 10 meetings 90%
Patricia D'Orsi	Executive Director of Nursing	7 out of 10 meetings 70%
Dr Frankie Swords	Executive Medical Director	7 out of 10 meetings 70%
Dr Hilary Byrne	Partner Member Primary Medical Services	0 out of 0 meetings 0%

The Quality and Safety Committee provides constructive feedback on ICB policies and reports that impact on clinical quality and patient safety. Documents for approval that have been reviewed and/or ratified by the Committee during the reporting period include:

- 2023/24 Norfolk and Waveney LeDeR Annual Report
- 2023/2024 Child Death Overview Panel (CDOP) Annual Report
- ICB Continuing Healthcare 121 Policy
- ICB Continuing Healthcare General Policy
- ICB Domestic Abuse and Sexual Violence Policy
- ICB Quality Impact Assessment (QIA) Policy
- ICB Equality and Health Inequalities Impact Assessment (EHIA) Policy
- ICB QIA and EHIA Approval Panel Terms of Reference
- ICB Experimental and Unproven Treatments Policy
- ICB Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- ICB Mental Health Individual Funding Request Policy
- ICB Pandemic Response Plan
- ICB Patient Choice Policy
- ICB Children's Continuing Care Policy
- ICB Local Resolution for NHS Continuing Healthcare Policy
- ICB Research & Evaluation Policy
- ICB Early Identification of System Quality Deterioration Framework
- ICS Advanced Practice and Competency Framework
- ICS Cross System PSIRF Response Coordination Process
- ICS Quality Strategy 2025 Refresh
- ICS System Quality Group Terms of Reference
- NHSE Controlled Drugs Memorandum of Understanding
- Norfolk and Suffolk Section 11 Safeguarding Self-Assessments
- Revised Regional Ambulance Delay Learning Process

Finance Committee

The Finance Committee supports the Board in scrutinising and tracking delivery of key financial priorities, plans and targets from both a system perspective, as well as NHS Norfolk and Waveney as a stand-alone entity, as specified in NHS Norfolk and Waveney's Strategic and Operational Plans. The Committee submits information as appropriate to the Audit and Risk Committee and makes recommendations to the Board on strategic financial matters.

The membership of the Finance Committee comprises of:

- Non-Executive Member with the lead for Finance (Chair)
- Non-Executive Member (vice-Chair)
- Executive Director of Finance
- Executive Director of Performance, Transformation and Strategy
- Acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with
- current experience in an acute NHS provider setting)
- Non-acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer
- with current experience in a non-acute NHS provider setting)
- Non-Executive Director (from NHS provider organisation)
- a clinical person with primary care experience
- a finance lead from Local Authority
- a person with financial expertise from the VCSE or wider community.

The Finance Committee met 11 times from 1 April 2024 to 31 March 2025. Each meeting was well attended and quorate. Membership of the Finance Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Hein van den Wildenberg	Chair, Non-Executive Member	11 out of 11 meetings 100%
Cathy Amor	Non-Executive Member	10 out of 11 meetings 91%
Steven Course	Executive Director of Finance	9 out of 11 meetings 82%
Andrew Palmer	Executive Director of Performance, Transformation and Strategy – Deputy Chief Executive	7 out of 11 meetings 64%
Liz Sanford	Acute Chief Finance Officer	11 out of 11 meetings 100%
Andrew Hopkins	Non acute Chief Finance Officer	10 out of 11 meetings 91%
Dr Imran Ahmed	Person with primary care experience	9 out of 11 meetings 82%
Graham Ward	Non-executive director from NHS provider organisation	11 out of 11 meetings 100%
Andrew Jamieson	Finance lead from local authority	6 out of 11 meetings 55%
Lucy De Las Casas Until 26/11/24	Person with financial expertise from the VCSE or wider community	1 out of 7 meetings 14%
Dan Mobbs From 26/11/2024	Person with financial expertise from the VCSE or wider community	4 out of 4 meetings 100%

Key pieces of work undertaken to secure assurance include:

- review of the membership, terms of reference, and remit of the Committee
- review annual budgets, medium term financial plans and detailed plans for approval by the Board
- monitor NHS Norfolk and Waveney's financial standing in-year and recommend corrective action to the Board should year-end forecasts suggest that the financial plan will not be achieved. For most of the financial year, the system was in a so-called 'triple lock', placing additional controls on expenditures above a certain threshold
- monitor the financial standing and financial risk profile in-year of NHS organisations in the N&W system and keep Board and other stakeholder apprised in case of

financial plan not being achieved
- receive detailed reports at each meeting concerning the financial performance of all six NHS organisations in the N&W system, to incorporate narrative relating to key variances from plan
- receive in-depth insights into area requiring specific attention of the committee
- during this financial year, the committee received updates, including financial implications, on the following topics: Triple Lock, Mental Health Investment Standard, Continuing Health Care, Elective Recovery Fund, Better Care Fund, Primary Care and Medicines Prescribing, ICB efficiency schemes, Medium Term Financial Planning, Health Inequalities, ICS Estates, Dental Optometry & Pharmacy expenditure, and the JPUH and QEH hospital new builds
- scrutinise NHS Norfolk and Waveney's Strategic Financial Risk Register
- monitor implementation of any recommendations arising from the internal audit of finance functions.

The committee's work dovetailed with that of the Audit and Risk Committee in order to provide assurance to the Board that robust management of finance was in place.

Commissioning and Performance Committee

The Commissioning and Performance Committee was established May 2024, to build on the wider remit of the previous Performance Committee to provide NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that ensures a high performing system. The Committee exists to scrutinise the robustness of and gain and provide assurance to NHS Norfolk and Waveney regarding the delivery of, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.

The membership of the Commissioning and Performance Committee comprises of:

- ICB Board Partner Member, Primary Medical Services (Chair)
- Executive Director of Performance, Transformation and Strategy (Deputy Chair)
- Non- Executive Member
- Executive Director of Nursing or nominated deputy
- Executive Director Patient and Communities or nominated deputy
- NHSEI Director or nominated deputy (to discharge NHSEI's statutory responsibilities in relation to provider undertakings or other SOF requirements, from time to time the NHSEI Director may need to chair an extraordinary part 2 of the committee).

Other attendees include provider Chief Executives, County Council representatives and ICB functional leads. The Committee reviewed its terms of reference during the reporting period.

The Commissioning and Performance committee met 9 times from 1 April 2024 to 31 March 2025. Each meeting was well attended and quorate. Membership of the Commissioning and Performance Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
Dr Hilary Byrne	Chair, ICB Board Member, Primary Medical Services	0 out of 0 meetings 0%
Andrew Palmer	Deputy Chair, Executive Director of Performance, Transformation and Strategy	9 out of 9 meetings 100%
Hein Van Den Wildenberg	Non-Executive Member, Deputy Chair	9 out of 9 meetings 100%
Matt Dooley *From 1/11/2024*	Executive Director of Commissioning and Performance	4 out of 4 meetings 100%
Dr Frankie Swords	Executive Medical Director	7 out of 9 meetings 78%
Steven Course	ICB Executive Director of Finance	7 out of 9 meetings 78%
Jo Segasby	One member from the Norfolk and Waveney Acute Trust Collaborative	8 out of 9 meetings 89%
Nick Clinch	One member from local authorities	2 out of 9 meetings 22%
Thandie Matambanadzo	One member from mental health services	5 out of 9 meetings 56%
Ian Hutchinson	One member from community services	7 out of 9 meetings 78%

Key pieces of work undertake to secure assurance include:

- regular review of activity, performance, issues and risks from key areas of:
    - Urgent and Emergency Care
    - Elective Recovery
    - Cancer services
    - Diagnostic services
    - Mental Health services
- oversee the performance and improvement against the NHS Oversight Framework
- introduce and embed working to an Integrated Performance Management Framework, enabling oversight, assurance and accountability for key performance that measures system performance

- oversee the development of the Integrated Performance Reporting system, which will be used by system partners review progress against activity and performance measures and highlight where further action may be needed
- consider areas for an in-depth review, to seek greater assurance of service delivery, access and transformations being undertaken to improve performance.

Freedom to Speak Up (Whistleblowing)

NHS Norfolk and Waveney is keen to ensure that staff can speak up about any concerns that relate to within the workplace or externally, in relation to danger, risk, malpractice or wrongdoing which affects others. This can be something that doesn't feel right such as not following a process, feeling discriminated or where the behaviour of others is affecting the wellbeing of patients or colleagues. Speaking up plays a vital role in protecting patients and ensuring their safety and also improves the lives of workers. People are the eyes and ears of an organisation. Their views, improvement ideas and concerns can act as a valuable early warning system that a policy, process or decision is not playing out as anticipated or could be improved.

NHS Norfolk and Waveney has adopted the 'standard integrated policy' as recommended by Sir Robert Francis following his review into whistleblowing in the NHS aimed at improving the experience of whistleblowing in the NHS; this policy has been further updated with the strengthened arrangements set out by NHS England in 2022. We have adopted this policy which is produced by NHS England as a minimum standard to help to normalise the raising of concerns for the benefit of NHS staff and patients so that staff can speak up about anything that affects patient safety or affects their working life. Recent developments for Freedom to Speak Up in Primary Care, where Sir Andrew Morris has written a letter to all ICB Chairs and Chief Executives, setting out the expectations of Freedom to Speak up arrangements for all staff. This includes the adoption of the national FTSU policy ensuring primary care workers have access to a FTSU Guardian. In response to this NHS Norfolk and Waveney will continue to raise the profile of Freedom to Speak Up in Primary Care for the benefit of all.

NHS Norfolk and Waveney has a Non-Executive Board Member as sponsor for Freedom to Speak Up, an Executive Director as Senior Reporting Officer and Principal Freedom to Speak Up Guardian, a fully trained and registered Freedom to Speak Up Guardian and a Freedom to Speak Up Champion who raises awareness and promotes speaking up. There is also a recruitment campaign to recruit a further Guardian and a network of Champions. NHS Norfolk and Waveney also includes as mandatory training for all staff 'Speak Up' and 'Listen Up' and 'Follow Up' for Senior Managers. The three modules are cumulative and managers and senior staff were required to complete the requisite number of modules.

Executive Management Team Meeting

The Executive Management Team (EMT) is an ICB meeting comprising the Accountable Officer, Executive Director of Finance and the Executive Directors of NHS Norfolk and Waveney (as set out in the Remuneration report) as well as other senior representation. It is the operational forum for exercising the Accountable Officer and Executive Director of Finance's authority under NHS Norfolk and Waveney's Scheme of Reservation and Delegation. It is not, however, a formal committee of the Board.

The EMT meets weekly and monitors the operational discharge of statutory duties, approves corporate contracts and oversees HR and organisational development and establishment control and monitors budgets. The EMT also regularly reviews the Board Assurance Framework. The EMT report relevant items to the Board via the Accountable Officer's report.

In addition, an ICS EMT meets monthly. This meeting is attended by all the system Chief Executives and ICB Executive Directors. The aim of this meeting is to provide a forum to discuss system issues including system pressures, and financial matters.

Joint Senior Leaders Meeting (JSL)

The Joint Senior Leaders (JSL) meeting is a forum for the ICB's senior managers, including EMT members, to meet and discuss a range of ICB issues. The meeting facilitates the sharing and communication of key matters. The JSL meets monthly and has no formal decision-making authority. It is chaired by the Chief Executive and topics discussed during the year include general updates from members, the staff reorganisation, the ICB's budget and financial updates, and commissioning intentions. This meeting will become the Organisation Management Board (OMB) from March 2025 as the ICB reviews the most effective mechanisms for decision making across the organisation.

NHS Arden & Greater East Midlands Commissioning Support Unit (AGEM CSU)

NHS Norfolk and Waveney is supported in its work by a range of outsourced support services by AGEM CSU. These services are transactional HR support, GPIT, DSCRO and Data Services, Procurement and Freedom of Information Request services from AGEM CSU.

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

NHS Norfolk and Waveney's integrated risk management strategy and framework sets out NHS Norfolk and Waveney's approach to risk management.

In accordance with the framework, risks are evaluated in terms of the likelihood and consequence using an organisational risk matrix. Scores for likelihood and consequence are

given out of 5 and multiplied together. The results give one of four categories of risk grading as follows:

Very High Risk - immediate action required by a director
High Risk – urgent senior management attention needed with action plan
Moderate Risk - responsibility for assessment and action planning allocated to a named individual
Low risk – normal risks which can be managed by routine procedures

NHS Norfolk and Waveney developed a Risk Management process to ensure that risks were identified throughout the organisation. This is supported by the Risk Management Framework to ensure that the process is clearly understood.

The Board Assurance Framework (BAF) has been developed as the overarching approach to risk within the ICB. The BAF brings together all the relevant information about risks to the Board's eight ambitions (strategic objectives) as set out in the Norfolk and Waveney 5 year Joint Forward Plan (2024-29).

The Operational Risk Register (ORR) contains all the operational risks for the organisation which score 12 –14. Operational risks are 'live' risks the organisation is currently facing which are by-products of day-to-day business delivery. These risks are assigned an executive director and assigned to, overseen by ICB Board Committees.

Operational risks with a mitigated score of 15+ will be escalated to the Board Operational Risk Register (BORR) from the ORR. The BORR is owned by the Executive Management Team and will be presented to the Board along with the BAF. These risks are still assigned an executive director and assigned to, overseen by ICB Board Committees.

The Audit and Risk Committee reviews the risk management framework. Risk is reviewed regularly by the Executive Management Team with risks assessed, rated and agreed for either escalation or removal from the ORR. The Audit and Risk Committee reviews the risk register to ensure that matters are appropriately reported and that action plans are robust and progress is being made. Through these mechanisms NHS Norfolk and Waveney's risk appetite is assessed and regulated.

The Board meets in public every other month. Members of the public are able to see Board papers including the BAF ahead of the meetings and they are able to ask questions at the meeting or raise queries via the website in advance.

NHS Norfolk and Waveney has various controls to address its risks and identifies both internal and external assurances on these controls. These are set out clearly for each risk in the assurance framework. In addition, consideration is given to any gaps in controls or assurances so that they are considered and factored into decision making.

NHS Norfolk and Waveney's control mechanisms are used to protect financial assets, operational systems and ensure that important laws and regulations are complied with. The table below sets out some of the internal controls used and the benefits they provide:

Management of current risks	ICB Board Assurance Framework; Regular assurance and finance reports to the Board. This year a key aspect of assurance reporting focussed on the vaccination programme. Identification of risks associated with the provision of services to patients. These are mitigated though the work of the quality team and contract management of provider contracts via the contract with the CSU and in house commissioning staff; A robust programme of counter fraud and anti-bribery activity supported by the Counter Fraud Specialist whose annual plan is scrutinised by the Audit and Risk Committee.
Prevention of Risk	Through the processes mentioned above NHS Norfolk and Waveney regularly horizon scans to identify potential areas of risk. In addition, NHS Norfolk and Waveney uses its experience of and learning from adverse events to ensure that lessons are learnt. Preventative measures include: • Policy development; • Identifying and ensuring that staff comply with mandatory training requirements; • Establishing risk-sharing agreements; • Root cause analysis of incidents; • Mandating limits to decision making authority; and • Ensuring secure access to IT systems.
Deterrent to risks arising	Developing risks are managed through a number of systems and include: • Risk review by Committee and Board meetings as well as executive management team meetings; • Finance reports to the Board; • Robust programme of counter fraud and anti-bribery supported by the Counter Fraud Specialist.

Capacity to Handle Risk

NHS Norfolk and Waveney's Integrated Risk Management Strategy and Framework supports a positive staff attitude to risk management, encouraging staff to identify, assess, manage and report risks. Staff are clear about their personal accountability and responsibilities through the Risk Management Framework, appraisal, induction and on-going training. Support and training is given to risk owners by the Corporate Affairs Team.

As set out above the Board Assurance Framework, Board Operational Risk Register from the Operational Risk Register (ORR) and ORR risks are reviewed monthly by the senior management including the Executive Management Team (EMT). At these meetings risks are further discussed and escalated as appropriate to the relevant register. This ensures that changes to risk registers are debated and agreed at the EMT to ensure the risk sits on the most appropriate register.

To provide further assurance the Audit and Risk Committee reviews the overarching Risk Management Framework which incorporates the Integrated Risk Management Strategy and Framework and the Staff Handbook, this having been approved by the Board.

In addition, work is underway to look at system risks collectively with system partners to better inform and direct the work of the system. This work is reviewed by a meeting of system audit committee chairs.

NHS Norfolk and Waveney continues to develop its approach to risk management, drawing on best practice and recommendations from the internal auditors. The internal audit assurance rating for risk management in March 2025 was reasonable assurance.

Risk Assessment

Risk is assessed using a standardised organisational risk matrix, looking at risk based on likelihood and consequence. Guidance in the form of the Risk Management Framework has been produced setting out a formal process for risk identification and evaluation.
The key risks identified as part of this process with an average risk rating of 16 or above include:

System Urgent & Emergency Care (UEC) Pressures

There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment and delays in being discharged from hospital, resulting in potentially poorer outcomes for our patients with associated clinical harms. This manifests itself as worsening ambulance response times and lengths of hospital stay for patients, therefore congesting emergency departments.

Mitigation to this risk is provided by strategic oversight by the Urgent and Emergency Care Programme Board. This meeting oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our urgent and emergency care pathways. In addition, there is a System Control Centre and East of England Ambulance Service System Oversight Cell. These work alongside providers to coordinate operational responsiveness when individual or multiple providers are unable to meet patient demand in a timely and safe way.

Barriers to Full Delivery of Mental Health Transformation Programme (CYP)

There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk.

There is a system approach to increasing knowledge, skills and expertise across agencies and an effective system wide governance framework. As well as these mitigations there is a commitment from system partners to adopting The Thrive Approach which recognises that mental health needs to be considered and addressed in wider health and social care settings.

The Resilience of General Practice

There is a risk to the resilience of general practice due to several factors not limited to workforce pressures and increasing workload including secondary care workload interface

issues. There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues. Practices could see their ability to deliver care to patients impacted through lack of capacity and infrastructure, and neighbouring practices may take on additional workloads; all resulting to delays in general practice services.

Mitigations are in place including the Commencement of LMC General Practice Alert State sitreps and PCN ARRS (additional roles reimbursement scheme). ARRS funding has provided additional capacity but has not grown in this contract year. GPs have now been added to the scheme.

Locality teams and strategic primary care teams are structured around supporting the resilience of general practice. All practices have previously been supported to review business continuity plans. A System interface group with representation from primary, community and secondary care system partners has been established and local interface groups involving the three acutes is expected to be established by April 2025.

Underlying Deficit Position

If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.

This risk is being mitigated with the development of a detailed medium-term financial model that will highlight the key drivers of the deteriorating underlying deficit. In addition, key lines of enquiries have been reviewed and provide assurances as to strong financial governance and best practice adoption.

Resilience of NHS General Dental Services and Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)

Primary Care Services, and secondary care dental services, became the responsibility of the Integrated Care Board from 1st April 2023. The risk is the unknown resilience, stability and quality of secondary care dental services, and critical challenges relating to the recruitment and retention of professionals and waiting lists. Issues also include a lack of resource within the ICB Primary Care team to implement the recommendations from the East of England NHSE and to monitor and manage three secondary care contracts.

Mitigations include active engagement with dental contractors, secondary care, LDC and Local Professional Network (and Managed Clinical Networks) with a regular dental newsletter. Clinical expertise provided by NHSE through the Regional Chief Dental Officers and Managed Clinical Networks extended for 2024/2025 for strategic development, transformation and commissioning purposes. A dental Long-Term Plan and local primary care Workforce Plan was agreed 7 May 2024 which sets out ambitions for primary care, level 2 and secondary care service collaboration. An ICB primary care team has been recruited and is working alongside newly recruited Quality Dental Nurse. The Primary care workforce and training team are working closely with the primary care commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans.

Continuing Health Care

There is a risk that NHS Continuing Healthcare (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. This could place extra demand on staff, staff vacancies and absences may increase. This may lead to poor outcomes for patients and increased financial cost to secure a care package.

There are several controls in place to mitigate this risk. These include but are not limited to recruiting to vacant posts within the CHC team, linking with local authority workforce teams to support care providers in additional training and support required, monitoring of time taken to secure complex care packages and escalation process for the CHC team if unable to source.

RAAC Planks

There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan. This could affect the safety of patients and staff.

The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work.

A regional RAAC response plan has been established and there is a region-wide scoping piece commissioned to look at ongoing service transition and recovery. Trusts have robust plans to manage a possible incident, however, these only cover immediate evacuation and not reprovision.

EEAST Response Time and Patient Harms

Clinical risks to patients awaiting ambulances in community – C1 and C2 response times including inability to undertake rapid release of ambulances. Handover and inter-facility transfers resulting in patient harms, occurring during periods of significant system pressure.

The CQC served a notice under Section 29A of the Health and Social Care Act 2008 on the Trust on 10 February 2025 for failing to meet requirements relating to several staffing and operational matters.

This risk is managed with daily situation reports to ensure that NHS Norfolk and Waveney is sighted on real-time demand and resource. This includes pre-alert drop and go processes in place with safety netting for patients waiting to be seen. In addition, there are proactive public communications to promote the use of NHS service options reinforced by seasonal campaigns.

Delayed decision making re ICB business case for the Lynch Syndrome testing and surveillance pathway

Lynch is an inherited condition that significantly increases the risk of developing several cancers (in particular, colorectal and endometrial cancer). When patients present with one of these cancers, biopsy specimens can be tested to see if the cancer has been caused by lynch, if so they can be offered specific cancer treatments and risk reducing measures.

Relatives of the patient should also be invited to be tested for lynch, and they too can then be offered risk reducing measures. In the absence of a commissioned pathway, there is a risk that not all patient cohorts will be tested for lynch syndrome and that potentially affected family members will not be offered testing.

This risk cannot be mitigated unless the pathway is commissioned as defined nationally. A pre-implementation audit has been completed across the three Trusts and educational webinars are being provided to Primary Care to prepare for full implementation. A system specification, pathway and Standard Operating Procedure have been developed ready for implementation. Additional capacity for bowel screening will be offered to lynch positive patients, this has been confirmed at the NNUH by the NHSE screening from April 2023.

Community Nursing Unallocated Visits

There is an increased demand and complexity of referrals (including for phlebotomy services) for community nursing with a high number of unallocated visits resulting in delayed care and an increased risk of harm and poor outcomes for patients cared for by Community Nursing Teams (CNT). This results in challenges around the timely delivery of patient care, increasing unallocated visits, deferred, or reprioritisation of visits.

Mitigations include ‘Waiting Safely’ principles in place at provider level. Monitoring by the Clinical Reference Group (CRG), to review the impact and outcomes of periods of escalation. Aligning CNT daytime hours across Norfolk; 8am to 8pm (involves a staff consultation) with an aim to release night-time capacity to better respond to 2-hour referrals. Piloting a dedicated Care Home Team with HomeLink. CNT review currently taking place to identify areas where most demand is within community nursing. This is a combined review between NCHC (Norfolk Community Healthcare) and ICB. Unallocated community visits are reported into SCC daily to enable oversight.

Speech and Language Therapy

Norfolk and Waveney Integrated Care Board and Norfolk County Council jointly commission Cambridgeshire Community Services to deliver speech and language therapy services across the system. NCC who are the lead commissioner are not assured of service delivery against key performance measures. There is a risk that pathway waits for children awaiting clinical assessment for speech, language and communication needs are adversely impacted. If this happens children and young people may not have access to timely and safe speech and language therapy.

Mitigations include additional funding agreed to support mobilisation and backlog activity. A robust governance and reporting structure in place across Local Authority and ICB to monitor activity and performance. In December 2023 a new SLT Board was established, which will be held three times a year (one Board meeting per school term). This is for the purpose of greater oversight of delivery, progress and achievement. Wider engagement with SLT from e.g., eEarly Years & prevention, Inclusion etc.

Adult Speech and Language Therapy

Several gaps in service provision are emerging within speech and language therapy across the system. Reasons for this vary but include historical commissioning gaps, amendments to inclusion and exclusion criteria by providers and a lack of specific skill sets.

A paper has been submitted through prioritisation regarding a system wide review of the SaLT service. The NNUH and NCHC will discuss appropriate care setting for some individual patients. Local Commissioning Team are working directly with providers on specific issues.

TB Service Resilience and Capacity

Following an increase in TB related incidents over recent months, it has become apparent that existing specialist nurse resource is insufficient and unable to meet growing demand. While TB services across the system are affected, the NCH&C service is particularly vulnerable with only one member of staff covering Central Norfolk. As a single-handed service there is no specialist nurse contingency for annual leave or sickness. The West Norfolk TB service is currently provided by QEHKL and there isn't a community service. This means that there is an inequitable service across the system and an overall risk around resilience of TB services in the community, across Central and West Norfolk.

Mitigations include Commissioners and IP&C Team developing options available at no / low cost to increase resilience. NCHC recruited a Band 4 Nurse to support the Specialist TB Nurse. Some additional specialist input is being provided to the NCHC IPAC Team via region and NNUH.

ICB application of the sustainable commissioning process and compliance with procurement regulations

There is a risk that the number of contracts expiring in Q3 and Q4 of 2024/25 without an agreed plan in place as at 31/10/2024, leads to a lack of capacity and appropriate timeframes to follow the commissioning processes, namely: sustainable commissioning; Triple Lock; procurement; contracting. If this happens, the Integrated Care Board (ICB) may not be compliant with relevant procurement regulations and may be in a position of having to extend contracts or operate under implied contracts until process(es) can be appropriately followed. This may lead to several potential consequences including equitable access, impact on financial efficiencies and the ICB potentially operating in contradiction to the NHS Constitution for England.

Mitigation for this include Commissioners being alerted at 12, 6 and 3 months prior to contract end. All contracts now have named commissioning leads assigned. Regular meetings in place to review contracts ending with the ICB multi-disciplinary team.

The resilience of Community Pharmacy

The resilience of Community pharmacy is at risk due to several factors including workforce pressures. The risk could ultimately lead to an increase in the number of permanent closures of pharmacies within our ICB which would reduce the accessibility of pharmacy services to

our population. The rurality of Norfolk and Waveney does mean that this risk is significant due to geographical distance between existing providers.

Current mitigations include engagement with the Locality teams and the Local Medical Committee, the establishment of Head of Pharmacy Workforce role within the ICB and integration funding.

Deconditioning and Infection

There is clinical risk to patients who no longer meet a Criteria to Reside (C2R) and who cannot be discharged out of hospital. This results in prolonged admissions in both acute and community provider Trusts thereby increasing the risk of deconditioning and healthcare acquired infections while waiting discharge support.

Mitigations include the ICB IP&C Team providing ad-hoc support as a liaison between hospitals and care homes when discharge is delayed due to IP&C concerns, providing guidance and advice. Continued vigilance in monitoring patients for potential symptoms and ongoing surveillance of ward level infections by the ICB IP&C Team. Providers to ensure staff are compliant with IP&C mandatory training and audits such as hand hygiene, high impact interventions and environmental cleanliness.

Other sources of assurance

Internal Control Framework

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

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

The Board assures itself that the organisation has effective control via regular reporting of the highest red rated risks to the Board and delegating to its Audit and Risk Committee the review of the assurance framework. In addition, the Audit and Risk Committee has the role of reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across NHS Norfolk and Waveney's activities.

NHS Norfolk and Waveney established the Quality and Safety Committee to seek assurance that robust clinical quality is in place. This Committee regularly reports to the Board.

Internal Audit provides regular reports to the Audit and Risk Committee on key areas as set out in its audit plan. This plan was reviewed and agreed by the Audit and Risk Committee in March 2024 for 2024/25.

NHS Norfolk and Waveney's External Auditor is Ernst and Young who were appointed by NHS Norfolk and Waveney's predecessor organisation in January 2021. Other control mechanisms include:

- Financial Plan and Reporting

- the Serious Incident (SI) process for reporting and investigating serious incidents
- adoption and review of various policies
- the Quality and Safety Committee monitors provider serious incidents and risks
- the Finance Committee reviews finance performance and risk
- the Information Governance team including the Senior Information Risk Owner, Data Protection Officer and Caldicott Guardian, review data protection and confidentiality compliance, implementation of privacy by design and default, information and cyber security, management of information risk, which is evidenced by NHS Norfolk and Waveney's annual Data Security Protection Toolkit submission
- the work of the Counter Fraud Specialist.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

NHS Norfolk and Waveney's Internal Auditors completed the conflicts of interest audit in September 2024. It also assessed the adequacy of the process for declaration and approval of business interests', recording, monitoring, reporting and reviewing of business interests.

The finding from this audit was that reasonable assurance could be provided to NHS Norfolk and Waveney's management of conflicts of interest. The audit found three routine findings. They were to ensure that the draft conflict of interest risk was agreed and transferred to InPhase for monitoring and review, to ensure that all staff annual declarations of interest are completed and returned within a set timescale and that the conflicts of Interest register, and declarations are to be included as a standard agenda item on the Contract Monitoring meeting moving forward.
As part of conflicts of interest management, NHS Norfolk and Waveney maintains Registers of Interests for Board and Committee members and all staff.

Declarations of interest are a standing item on all ICB Committee agendas. A Declaration of Interest form is also completed by all candidates as part of the recruitment process, and by all parties involved in any procurement evaluation process. Parties involved in procurement evaluation processes are those people (typically only ICB employees) that are part of the evaluation team. Evaluation team members will typically be requested to contribute to evaluating specific aspects of a proposal or tender based on their area of expertise such as finance, quality etc.

NHS Norfolk and Waveney also ensures that staff and Board members complete mandatory conflicts of interest training. The ICB uses a training module produced by NHS England for this purpose which is a mandatory requirement for all ICB staff and Board members to complete.

NHS Norfolk and Waveney's Conflicts of Interest Guardian is David Holt, the Non-Executive Member for governance and audit and who is also the Audit and Risk Committee Chair and the Conflicts of Interest Committee Chair.

Data Quality

NHS Norfolk and Waveney recognises the need to provide accurate, timely and clear information. Papers for the board are provided one week in advance of the meeting. This gives members time to read and adequately prepare in advance of the meeting so that they can fully contribute to it. Papers are also reviewed by senior management prior to distribution to ensure that they are clear and complete.

The Board also considered the following statement in relation to the quality of data as part of their annual self-evaluation in April 2025 as follows:

- are agendas, minutes, actions and reports circulated in good time for Board Members to give them due consideration?

All Board Members responding to this question answered positively. It is noted that some comments also included that paper packs for meetings could be condensed and summarised further.

Information Governance

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

NHS Norfolk and Waveney ICB places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. NHS Norfolk and Waveney ICB has established an information governance strategy and framework and has information governance policies, processes, and procedures in place, in line with the Data Security & Protection Toolkit (DSPT). The DSPT is an online self-assessment tool that enables organisations to measure their performance against the National Cyber Security Centre's Cyber Assessment Framework (CAF).

The national submission deadline for the DSPT is 30 June 2025. An initial internal audit was completed in March 2025 with the second part of the audit completed in May 2025. The overall audit assessment will be provided in June 2025 and included as part of the ICB's DSPT submission.

NHS Norfolk and Waveney ICB ensures that staff undertake annual information governance training, which is enhanced by additional in-house IG awareness sessions and bespoke training for teams. NHS Norfolk and Waveney ICB has implemented a suite of information governance policies and guidance to ensure staff are aware of their roles and responsibilities in relation to information governance. IG awareness is also promoted through staff briefings as well as via a dedicated IG intranet site where all staff have access to a comprehensive package of resources and learning.

NHS Norfolk and Waveney ICB has processes in place for incident reporting and investigation of serious incidents. NHS Norfolk and Waveney ICB confirms that 2 data security breaches have been reported to the Information Commissioner's Office (ICO) during the period 1 April 2024 to 30 June 2025. The first related to a member of staff's redundancy documents which were sent to an incorrect personal email address. The ICO confirmed they would not be taking any action, however made recommendations and closed the matter. The second related to a member of staff who had been covertly recording conversations with their line manager on a personal device, against ICB policy. The ICO confirmed they would not be investigating, and no further action would be taken. Recommendations were made and the matter was closed.

To demonstrate best practice and ensure that staff learn from the management of incidents, NHS Norfolk and Waveney ICB records low level or near miss incidents within an IG Incident Log, which is reported regularly to NHS Norfolk and Waveney ICB's IG Group. The learning from incidents is used to inform staff awareness bulletins, policy revisions and training.

The IG Team continue to embed a culture of "privacy by design and default" across the organisation which helps the ICB to identify and document its information risk profile and manage its risk appetite. In addition, NHS Norfolk and Waveney ICB has an Information Risk Management Policy in place to ensure that its processing activities are closely monitored, and any information risks are captured within an Information Risk Register. The Risk Register is reviewed regularly by NHS Norfolk and Waveney ICB's IG Group which is chaired by NHS Norfolk and Waveney ICB's Senior Information Risk Owner.

Key Risks Identified:

1. Ransomware / Data Exfiltration
2. Lack of User Awareness
3. Supply Chain Compromise or Disruption

The management of NHS Norfolk and Waveney ICB's IT estate controls these risks through consistent vulnerability monitoring & patching, deployment of anti-virus and endpoint management software, encryption of all portable devices and data in transit and access controls including Multi-Factor Authentication for all ICB staff. Devices are protected by Microsoft Defender Enterprise, monitored both locally and nationally 24x7 by the National Cyber Security Operations Centre. All inbound emails are scanned by centralised systems managed by the NHS.net Connect team, which includes Microsoft Safe Links and Attachments as an additional control layer with safe boundary protection. Annual penetration tests of NHS Norfolk and Waveney ICB's network infrastructure and internet-facing systems are conducted. All staff complete Cyber Security training and are regularly reminded of Cyber risks through a dedicated Cyber Awareness channel in NHS Norfolk and Waveney ICB's MS Teams system.

The security and integrity of corporate data held within the ICB's 365 environment have received assurance via an NHS report. This report details the controls in place for data stored within the 365 environment, confirming compliance with the principles of the NCSC recommendations for data storage in the cloud.

The Information Risk Register and associated policy mirrors NHS Norfolk and Waveney's Risk Management Assurance Framework, which facilitates a process for escalation and de-escalation of risks where necessary.

A key focus for NHS Norfolk and Waveney ICB in 2025-26 is to build on the work started in relation to information assets, expanding on this to encompass more areas of information risk and supporting staff to embrace new technologies safely and securely.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, confirm that an appropriate framework and environment is in place to provide quality assurance of business-critical models.

Third party assurances

NHS Norfolk and Waveney relies on third party providers for a number of services. Assurances are provided in the form of Service Auditor Reports (SARs). The following SARS have been provided to NHS Norfolk and Waveney:

Provider and Services Delivered	Comment
NHS Business Services Authority Prescription Payments Process SAR for the period 1 April 2024 to 31 March 2025	Reasonable
NHS Shared Business Services: Finance and Accounting SAR for the period 1 April 2024 to 31 March 2025	Qualified
Capita – Primary Care Support England Services to NHS England and delegated ICBs	Qualified
AGEM CSU Accounts Payable, Accounts Receivable, Financial Ledger, Financial Reporting Treasury & Cash Management, Payroll	Qualified
NHS England: GP Payments to providers of General Practice services in England SAR	Qualified
National Calculating Quality Reporting Service is an approvals, reporting calculation system for GP practices and supports the CCG's delegated functions	Reasonable
NHS Electronic Staff Record Programme SAR provides NHS organisations with integrated payroll and HR service system	Reasonable
NHS Business Services Authority Dental Payments Process SAR for the period 1 April 2024 to 31 March 2025	Reasonable

The ICB receives payroll services from Whittington NHS Trust which received a reasonable assurance opinion on the internal audit of payroll in March 2024.

Control Issues

The ICB has continued to work with and support system partners to ensure a collaborative and joined up approach across Norfolk and Waveney, to progress transformation and address collective challenges in several key areas. The control issues identified by NHS Norfolk and Waveney and the mitigating actions are:

Quality and Performance – Accident and Emergency

Pressures across the Norfolk and Waveney Urgent and Emergency Care (UEC) pathways continued during 2024. All Acute Hospitals moved between Operational Pressures Escalation Level (OPEL) 3 and 4, regularly utilising Full Capacity Protocols. During this period there has been a commitment across system leaders, especially Acute Hospitals, to

progress with a zero tolerance to ambulance handover delays commencing with a reduction to 45mins. This collaboration across organisations has resulted in a significant reduction in handover times. As a system we continue to work together to deliver UEC improvements plans to deliver the nationally required 78% Emergency Department 4 hour standard and to ensure that our residents are receiving the right care at the right time whenever the need arises, whether that is in hospital or in their own home with support. All of the work being done to ensure our residents receive the right care in the right whenever the need arises links directly to reducing ambulance handover delays and improving the 4hr Emergency Department (ED) performance standard as only those patients who need to be conveyed to hospital are conveyed.

Further mitigations and actions in place included the establishment of an ICB Discharge Board to improve system flow, the approach to escalation in line with new OPEL framework including on site senior support to accelerate discharges and Executive leadership to non-criteria to reside patient review meetings, including complex discharges and closer working with local authority partners.

Quality and Performance – Ambulance Response Times

There has been a significant effort to improve ambulance handover times at our three acute hospitals, to reduce ambulance dispatch and on scene time for crews. All of this work has meant an improvement in C1 and C2 response times to 999 calls in the community, as with more ambulances available the ambulance service is able to respond more quickly. This is contextualised by overall ambulance conveyances rising by just over 3% in the last 12months and overall ED attendances, which includes "walk-ins" rising by over 7% in the last 12 months. Our ICB focus on right care in the right place whenever a need arises has meant we are seeing an increase in appropriate conveyance to hospital and a much greater use of alternative services in the community that allows us to treat patients safely at home. Oversight of ambulance response times and patient harm is discussed by ICB Quality and Safety Committee on a regular basis, highlighting the impact of ambulance waits on patients and staff. The risk is captured on the system risk register and ICB Board Assurance Framework.

Quality and Performance – Mental Health and Dementia

Norfolk and Suffolk Mental Health Trust (NSFT) is our main statutory mental health provider and exited the national Recovery Support Programme (formerly known as ‘special measures’) in February 2025. The Trust continues to transform its services to ensure that it meets required quality, performance and access standards in a timely and responsive way. There are a number of areas requiring mitigation, to support NSFT and to deliver system-level transformation of mental health services include workforce pressures, 12hr ‘decision to admit’ (DTA) breaches, forecasting of increasing dementia prevalence and waits to access mental health support for children and young people.

NSFT mitigations to support these areas include the creation of a workforce plan to address staffing vacancies and a Trust appointed Director of People to oversee organisational development. Continued collaborative work has developed a plan to improve Dementia awareness and management; acknowledging that Dementia is not a mental health condition, the programme of work has now moved to the wider Aging Well programme. The diagnostics

pathway is currently being reviewed to reduce clinical and access variation across the county. NSFT has also successfully implemented a recovery action plan to reduce referral to assessment waits from 52+ weeks to less than 4 weeks and is not focussing on treatment waiting lists.

Quality and Performance – Referral to Treatment (RTT)/52 week wait

There has been a significant impact on RTT/52 week waits. To mitigate this Elective Recovery is overseen by the ICS's Elective Recovery Board (ERB).

In addition to ERB oversight and performance monitoring, the Nursing and Quality Team sit within both provider and system forums to gain further oversight into patient safety and quality concerns. This includes the clinical harm review process of patients on waiting lists, for which the team have recently undertaken a scoping exercise into each Trust's processes around the monitoring and review of patients, including their prioritisation and escalation procedures. The Nursing and Quality Team continue to have oversight of patient safety incidents, associated with waiting times in alignment with the Patient Safety Incident Response Framework.

Quality and Performance – Diagnostics

Significant workforce challenges present a gap in control for key diagnostic areas and occupational groups. For some, including Audiology, ECHO-Cardiography and Neurophysiology, these challenges are not expected to be able to be fully mitigated locally due to known national challenges in workforce. As a result, these challenges are, in some areas, limiting the full use of additional capacity potential as a result of Community Diagnostic Centre’s and similar initiatives. Challenges meeting diagnostic pathway times will have a knock-on impact to treatment pathways, patient experience and potentially, outcomes.

Quality and Performance – Cancer

The impact of ongoing cancer diagnostic and treatment delays contribute to the current inequity of access to timely diagnosis and treatment, and the variation in Cancer Waiting Times. Performance cannot be fully mitigated and may have a detrimental impact on patient outcomes. This situation is also impacted on by oncology workforce constraints in local providers.
Awareness of the benefits of cancer screening, the signs and symptoms of cancer and help seeking behaviours, vary across the system and are linked to health inequalities.

Quality and Performance – Elective activity

Two of the three acute trust buildings in Norfolk and Waveney have RAAC planks within their structures which are outside of their lifespan. This RAAC planking impacts on the capacity of these Trusts, as does the rolling programme of inspections and remedial work (this risk is noted in the ICB Board Operational Risk Register and features in relevant provider risk registers).
Uncertainty about the continuation of the Elective Recovery Funding (ERF) in Q4 24/25 and into 25/26, combined with the deficit at Q4 24/25 and the expected challenging financial

position for 25/26 means that activity planning to meet elective standards is uncertain at present.

Quality and Performance – Maternity

NHS Resolution Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions. Progress against all safety actions has been monitored by the LMNS team, reporting progress to LMNS Board and ICB Quality & Safety Committee. A final report presented to LMNS Board 22 January 2025 confirmed that all Trusts are compliant.

The Norfolk and Waveney Acute Hospitals Collaborative (NWAHC) is committed to implement a single Electronic Patient Record (EPR) across its three acute Trusts by 2026, with maternity and neonatal services prioritised in the initial deployment phase.

EPRs are seen as foundational to:

- improving patient safety
- reducing clinical errors
- enabling better care coordination and decision-making
- supporting integration between healthcare and social care.

The current maternity digital record systems in two of our acute hospitals were during 2024 the focus of a National Patient Safety Alert (NPSA). Whilst this has now been closed the implementation of a single EPR for maternity and neonatal services is a priority.

The JPUH is currently in a Section 29a, support and oversight is being provided via the LMNS, in January 2024 a Quality Review meeting attended by National, Regional and System Leaders identified the progress that has been made whilst recognising areas requiring ongoing support. This will continue to be monitored via the LMNS Board.

Quality and Performance - Infection prevention control (IPC)

Norfolk and Waveney saw higher than expected levels of Flu and other acute respiratory and gastrointestinal infections in year. We have an effective and robust system IP&C System Cell, that brings providers together daily to respond to operational challenges. Providers across the system remain congested, which increases the risk of transmission. The ICB continues to support the interface between hospitals and Care Homes to support safe discharges and support flow. The ICB lead a number of workstreams to coordinate system work around C.difficile, Gram Negative BSI, MRSA, Antimicrobial Stewardship and Sustainability (glove reduction). These come together on a quarterly basis as an ICS IP&C and AMS Partnership. Any change in IP&C policy is undertaken collectively wherever possible based on national guidance and provider risk assessments. An options appraisal is currently being taken forward with ICB EMT to address inequality and resourcing issues around our TB Service provision.

Finance, Governance and Control - Finance and Procurement

Whilst the ICB delivered its 2024/25 financial plan with a £0.6m surplus, the measures utilised for delivery are non-recurrent in nature resulting in a worsening underlying deficit to that planned. The ICB left 24/25 with an underlying deficit of £122.4m.

The ICB ambitions in regards to efficiency delivery are at maximum range levels at 6.1% of influenceable spend (excluding ICS partner block arrangements and national contracts out of scope) resulting in a full year target of £51.2m, of which £44.3m was delivered. Demands on efficiency savings and sustainable commissioning are likely to be more significant in the next financial year and will be further weighted towards recurrent delivery.

The ICB as with other ICBs, faces significant financial challenge in areas of excess service demand and price consequences from inflation and unfunded pay costs, particularly for providers of CHC and LD services outside of the NHS arena. The ICB continue to work to sustain both the financial position and the provision of service in this fragile market, exploring other options of NHS health care provision for a medium-term strategy.

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

The financial year of 2024/25 has seen the continuation of a planned and controlled use of NHS Norfolk and Waveney's financial allocation in line with guidance from NHS England and aligned to its strategy and operational plans. Services have been procured through robust processes in line with relevant guidance and contract management has taken place in-year where appropriate. The Board received reports of financial position and forecasts each month. The Executive Director of Finance was responsible for ensuring that proper procedures were in place to enable regular checking of the adequacy and effectiveness of the control environment, in line with the fiscal responsibilities of NHS Norfolk and Waveney and national guidance. The Finance Committee scrutinised the financial reports and held the Executive Director of Finance to account for financial performance on a monthly basis. This committee conveyed to the Board it's assuredness on the accuracy and transparency of the reported financial position.

The NHS oversight framework encapsulated NHS England's method of oversight of ICBs and trusts. This framework outlines NHS England's approach to NHS oversight and is aligned with the ambitions set out in the NHS Long Term Plan and the NHS operational planning and contracting guidance. This framework assigns a system to one of four support segments (NOF 1 to 4). The segmentation decision indicates the scale and general nature of support needs for the system as a whole. During the financial year 2023/24, NHS Norfolk and Waveney ICS exited NOF4 and progressed to NOF3, as a result of an improvement in the clinical, operational and financial performance; the ICS has remained in NOF3 throughout 2024/25. Further details and the segmentation assessment can be found at the following link: NHS England » NHS oversight framework 2022/23.

External Audit provides an independent opinion on the Annual Accounts, which incorporates the Value for Money opinion. Internal Audit conducts audits and provides opinions on various aspects of business as directed by the work plan, which is set by the Audit and Risk Committee as part of its delegated functions.

NHS Norfolk and Waveney ICB has delivered (a pre-audit) surplus of £600k against a planned surplus of £386k, for the financial year ending on 31 March 2025. Despite a well-documented challenging financial environment, NHS Norfolk and Waveney ICB continues to use the system wide transformation and efficiency processes to identify opportunities to achieve economy, efficiency and effectiveness via the NHS Norfolk and Waveney Programme Management Office (PMO). The PMO team are also embedded within the

system planning and transformation team undertaking wider reviews and benchmarking for best practices.

The central management costs for NHS Norfolk and Waveney ICB were £19.7m, representing circa 0.7% of the total ICB expenditure. This is reduced from 0.9% in 2023/24 due to NHS England mandated efficiency targets for these costs of 20% in 2024/25 and a further 10% in 2025/26.

The challenging financial environment continued to have a profound effect on the 2024/25 planning within NHS Norfolk and Waveney ICB and the wider ICS's plan containing inherent risks. These included significant risks such as not fully delivering the efficiency plan, our reliance on non-recurrent measures to address recurrent expenditure increases, the scale of the elective recovery programme, the high volumes of patients classified as No-Criteria-to Reside impacting on patient flow and requiring additional bed capacity, the requirement to deliver a 20% reduction in central management costs in-year and the significant and deteriorating underlying deficit as a result of non-recurrent mitigations.

All of these risks continue into the next financial year and are being addressed as an organisation and system priority through a Financial Recovery Board to ensure that we do not breach the statutory Break-Even duty nor the Financial Targets, or impact the Value for Money opinion in 2024/25, all whilst ensuring that patient care is not adversely impacted. This emphasises the need for the continuation of efficiency delivery at a system level with a recurrent nature, effective financial governance and reporting and scrutiny processes via NHS Norfolk and Waveney Finance Team and Finance Committee respectively.

Budgets were reviewed by the Finance Committee and recommendations made to the Board as to their approval. Day-to-day financial management and responsibility was delegated to appropriate levels on assigned strategic or operational delegated roles, in accordance with the Detailed Delegated Financial Limits policy. These reviews were in addition to monthly senior finance reviews of variances to maintain a firm grip on NHS Norfolk and Waveney's ICBs financial management, risks and mitigations.

Commissioning of delegated specialised services

Norfolk and Waveney ICB signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 2024/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

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

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

Delegation of functions

NHS Norfolk and Waveney delegates functions internally. In particular:

The **Board** delegated to committees of the Board responsibility for ensuring NHS Norfolk and Waveney exercised its functions effectively, efficiently and economically and adhered to generally accepted principles of good governance:

- the **Audit and Risk Committee** assures the Board that effective systems of integrated governance, risk management and internal control were in place across the whole of NHS Norfolk and Waveney's activities; both internal and external auditors attended these meetings
- the **Finance Committee** monitors delivery of the Financial Plan and provided assurance to the Board on NHS Norfolk and Waveney's financial performance as well as the system financial performance of ICS NHS parties
- the **Quality and Safety Committee** assures the Board concerning the safety and quality of NHS Norfolk and Waveney's commissioned services
- the **Remuneration, People and Culture Committee** scrutinises proposals for the remuneration of employees and other people who provided services to NHS Norfolk and Waveney and made determinations taking into account national and local guidance
- the **Conflicts of Interest Sub Committee** was established to determine matters where the Board was conflicted in commissioning decisions and to ensure the issue would be dealt with in a consistent and transparent way, avoiding conflicts of interest; and
- the **Primary Care Commissioning Committee** was established to carry out the functions relating to the commissioning of primary medical services which included receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs
- the **Commissioning and Performance Committee** was established to provide NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that ensures a high performing system
- the **Patients and Communities Committee** scrutinises the robustness of and provides assurance to NHS Norfolk and Waveney that it is delivering its functions in a way that meets the needs of patients and communities that is based on engagement and feedback form local people and groups.

The Chair of each Committee reported to the Board on the work of their respective Committees, both generally as part of the meeting and as necessary to provide further detail on Committee work.

NHS Norfolk and Waveney contracted with Arden and Greater East Midlands Commissioning Support Unit (AGEM CSU) for the delivery of certain functions. These

functions were subject to both service auditor reporting and internal audit review. NHS Norfolk and Waveney's internal owners of functions are held to account by the Audit and Risk Committee for the resolution of adverse findings.

The Executive Director of Finance was responsible for the overall contract and associated performance discussions with the AGEM CSU, including scrutiny of budgetary performance.

Counter fraud arrangements

NHS Norfolk and Waveney is required under the terms of the Standard NHS Contract and in accordance with the new Government Functional Standard GovS 013: Counter Fraud - to ensure that appropriate counter fraud measures are in place.

NHS Norfolk and Waveney has a robust programme of counter fraud and anti-bribery activity, supported by the appointment of an accredited Local Counter Fraud Specialist (LCFS) whose annual proportionate proactive work plan to address identified risks is monitored by the Executive Director of Finance and the Audit and Risk Committee. The member of the executive board who is responsible for tackling fraud, bribery and corruption is the Executive Director of Finance. The Executive Director of Finance is the first point of contact for any issues to be raised by the Local Counter Fraud Specialist. Online Fraud, Corruption and Bribery Act awareness training is mandatory for all ICB staff.

Counter fraud material including NHSCFA Fraud Prevention Notices is disseminated to staff through the intranet and email. Details of all policies, procedures and key documents reviewed are reported to the Audit and Risk Committee.

The LCFS attends ICB Audit and Risk Committee meetings regularly to provide progress reports and updates, as well as providing an Annual Report of the Counter Fraud Work undertaken. The Counter Fraud Functional Standard Return (CFFSR) for 2023/24 was completed by the LCFS and reported to the Audit and Risk Committee in June 2024. It received an overall rating of Green for its CFFSR submission. The NHS Counter Fraud Authority (NHSCFA) is a health authority charged with identifying, investigating, and preventing fraud and other economic crime within the NHS and the wider health group. As a health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care. Appropriate action is taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for NHS Norfolk and Waveney, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Norfolk and Waveney's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

1. **Reasonable** assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
2. The basis for forming my opinion is as follows:
    i. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

ii. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for NHS England and Improvement purposes e.g. any reliance that is being placed upon Third Party Assurances.

3. There are no matters to bring to your attention which have had an impact on the Head of Internal Audit Opinion.

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

Area of Audit	**Level of Assurance Given**
Board Assurance Framework and Risk Management	Reasonable
Personal Health Budget	Reasonable
Key Finance Systems	Substantial
Procurement	Reasonable
Financial Management	Substantial
Conflict of Interest	Reasonable
Fit and Proper Person Test	Substantial
Primary Care Delegated Commissioning	Reasonable
Collaboration and Partnership	Reasonable
Continuing Healthcare	Limited

The ICB received a 'limited assurance' opinion for the Continuing Healthcare internal audit. The areas of weakness are listed below:

- the ICB has a Norfolk and Waveney ICS policy strategy but requires a separate CHC Strategy to be put in place which clearly sets out the CHC services short-, medium- and long-term priorities

- the CHC Board Operational Risk Register needs to be developed, explored and approved by the CHC management team and the Quality and Safety Committee

- the CHC Risk Register to capture any risks around contractual agreements with CHC providers and report on progress against them. The Contracts Quality Dashboard should be made available to CHC management

- to ensure a robust records management plan for documents, ensuring that any training gaps are addressed so that all check lists and clinical records are managed in a timely manner

- to manage an appropriate and timely process around the Decision Support Tool

- the CHC Risk Register to capture any risks around contractual agreements with CHC providers and report on progress against them and the Contracts Quality Dashboard be made available to CHC management.

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

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Norfolk and Waveney achieving its principles objectives have been reviewed.
I have been advised on the implications of the result of this review by:

- the Board who reviewed the BAF regularly at meetings in public and sought assurances on the effectiveness of controls from senior managers. This was supplemented by regular review at the Executive Management Team meetings

- the Audit and Risk Committee who scrutinised the underpinning processes behind the BAF and sought assurances on the effectiveness of controls from senior managers

- Internal Audit as it provided an independent, objective opinion on systems of internal control as described above

- the Finance Committee that scrutinised annual budgets and medium-term financial plans prior to agreement by the Board and monitored delivery of financial standing in-year, including delivery of the productivity plan, to ensure that NHS Norfolk and Waveney met its financial statutory duties

- the Quality and Safety Committee that scrutinised processes for holding providers to account for the quality and safety of their contracted services and utilised reports from regulatory bodies as appropriate

- reliance where possible was placed on third party assurance (Service Auditor Reports) as described above

- the work of the Health Overview & Scrutiny Committee that provided an independent view of ICB performance; and

- patient and public engagement events and feedback through a variety of mechanisms including complaints and compliments which provided insight into provider services.

Conclusion

With the exception of the internal control issues that I have outlined in the Annual Governance Statement, to which appropriate actions have been or are being taken, my review confirms that a sound system of internal control was in place in NHS Norfolk and Waveney ICB for the period ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

Ed Garratt OBE
Interim Accountable Officer
18 June 2025

Remuneration and Staff Report

Remuneration report

Introduction

This report gives details of NHS Norfolk and Waveney ICBs (NHS Norfolk and Waveney) Remuneration, People and Culture Committee and its policies in relation to the remuneration of its senior managers which the Board defined as Executive Directors and members of the Board.

Details of remuneration payable to the senior managers of NHS Norfolk and Waveney in respect of their services during the period 1 April 2024 to 31 March 2025 (the reporting period) are given in the tables within this report.

This Remuneration and Staff Report is not subject to audit with the exception of those sections specifically marked as such.

Remuneration, People and Culture Committee

The Remuneration, People and Culture Committee is a committee of the Board and has responsibility, under its Terms of Reference for making determinations for the remuneration, terms of service and benefit arrangements for all staff (including the Accountable Officer and Executive Directors). The Committee also has responsibility for agreeing remuneration payable to speciality advisors that support the work of NHS Norfolk and Waveney.

The Remuneration, People and Culture Committee is chaired by Cathy Armor, a Non-Executive Member of the Board. The Committee's other members are Hein van den Wildenberg, and Aliona Derrett who are both Non-Executive Members of the Board. In addition, Tricia D'Orsi or nominated deputy, Executive Director of Nursing and Njokey Yaxley, NCHC Non- Executive Member complete the membership of the Part 1 section of the meeting. Further details of the Committee are available in the Governance Statement on page 86.

Policy on the remuneration of Executive Directors

The salaries for the Chief Executive Officer (CEO) and the Executive Director of Finance (EDOF) of NHS Norfolk and Waveney are determined by the Remuneration, People and Culture Committee and covered by the guidance issued by the NHS England which are informed by and consistent with the principles set out in the Hutton Fair Pay Review. Further, additional consideration of the pay and employment conditions of other employees is taken into account when determining senior managers' remuneration. No bonus payments were made to any Executive Director during the reporting period.

Direction for determining notice periods for the Chief Executive Officer and the Executive Directors were laid out in the NHS Bodies Employment Contracts (Notice Periods) Directions

2008. The contractual notice period for the termination of the Chief Executive Officer and all other Executive Directors of NHS Norfolk and Waveney is six months on either side.

Executive Directors are, subject to eligibility, able to participate in the NHS Pension Scheme which provides salary-related pension benefits on a defined benefit basis.

NHS Norfolk and Waveney did not apply any performance conditions or assessment methods associated with senior staff/Board member reward.

All Executive Directors have rolling service contracts; the table below discloses contract start and end dates for NHS Norfolk and Waveney:

Executive Directors in post 2024-25	Role	Position start date	Position end date
Tracey Bleakley	Chief Executive Officer	01/07/2022	N/a
Steven Course	Executive Director of Finance	01/07/2022	N/a
Patricia D'Orsi	Executive Director of Nursing	01/07/2022	N/a
Dr Frankie Swords	Executive Medical Director	01/07/2022	N/a
Mark Burgis	Executive Director of Primary & Community Care	01/07/2022	N/a
Jocelyn Pike	Acting Executive Director of Mental Health Transformation	01/07/2022	N/a
Karen Barker	Executive Director of Corporate Affairs & ICS Development	01/07/2022	N/a
Andrew Palmer	Executive Director of Performance, Transformation and Strategy – Deputy Chief Executive	01/07/2022 & 16/01/2023	N/a
Ema Ojiako	Executive Director of People	07/11/2022	31/10/2024
Ian Riley	Executive Director of Digital and Data	01/11/2022	N/a
Matthew Dooley	Executive Director of Commissioning and Performance	01/11/2024	N/a

Board Remuneration Policy (excluding executive and partner members remunerated by partner organisations)

Remuneration for the Non-Executive Members consists of a fee that reflects the commitment and time required to fulfil their obligations effectively. They are also eligible to be reimbursed for out-of-pocket expenses incurred on ICB business. Non-Executive Members are not eligible to participate in the NHS Pension Scheme.

The Partner Member for Primary Medical Services is eligible to participate in the GP Solo pension scheme.

Board members (excluding executive members and those partner members remunerated by partner organisations) during the reporting period were as follows:

Board Members	Role	Start date	End date
Patricia Hewitt	Chair	01/07/2022	10/03/2025
Hein van den Wildenberg	Non-Executive Member - Interim Chair	01/07/2022 & 01/01/2025	N/a
Aliona Derrett	Non-Executive Member	24/10/2022	N/a
David Holt	Non-Executive Member	01/07/2022	N/a
Catherine Amor	Non-Executive Member	01/07/2022	N/a
Dr Hilary Byrne	Partner Member - Primary Medical Services	01/07/2022	N/a
Emma Ratzer	Non-Executive Member	01/10/2024	N/a

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	4.8%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5.5%	0%

For 2024 to 2025, the government has given Agenda for Change staff a 5.5% consolidated increase in pay.

Pay ratio information (subject to audit)

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

The banded remuneration of the highest paid director/Member in Norfolk and Waveney ICB in the reporting period 1 April 2024 and 31 March 2025 was £215,000 to £220,000 (1 April 2023 and 31 March 2024 was £205,000 to £210,000).

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

2024-25	25th percentile	Median	75th Percentile
Total remuneration (£)	37,338	48,526	62,215
Salary component of total remuneration (£)	37,338	48,526	62,215
Pay ratio information	5.8:1	4.5:1	3.5:1
2023-24			
Total remuneration (£)	34,581	45,996	58,972
Salary component of total remuneration (£)	34,581	45,996	58,972
Pay ratio information	6.0:1	4.5:1	3.5:1

During the reporting period 2024-25, no employees received remuneration in excess of the highest-paid director/member (2023-24: none). Remuneration ranged from £22,943 to £215,759 (2023-24 £16,608 to £205,485).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. No performance pay or bonuses were paid during the reporting period.

Remuneration increased in line with the 2024-25 Agenda for Change pay award.

Remuneration of Very Senior Managers

Details of remuneration payable to the senior managers of NHS Norfolk and Waveney ICB in respect of their services during the reporting period are given in the table below. 3 Senior managers were paid more than £150,000 per annum.

The salaries for these posts are in accordance with NHS guidance issued in April 2023 and developed and agreed with the Department of Health and Social Care for ICBs with a population size of 1 – 1.5 million. The salaries for these posts have also been approved by NHS England (NHSE).

All very senior manager salaries for ICB roles have been agreed by NHS Norfolk and Waveney's Remuneration, People and Culture Committee having been considered appropriate in line with NHSE guidance.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

Senior manager remuneration (including salary and pension entitlements) (subject to audit) Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Tracey Bleakley - Chief Executive Officer	215-220	0	0	0	52.5-55	270-275
Dr Frankie Swords - Executive Medical Director	205-210	0	0	0	0	200-205
Patricia D'Orsi - Executive Director of Nursing	145-150	0	0	0	95-97.5	245-250
Mark Burgis - Executive Director of Patients and Communities	135-140	0	0	0	25-27.5	160-165
Steven Course - Executive Director of Finance	180-185	0	0	0	27.5-30	205-210
Jocelyn Pike – Acting Executive Director of Mental Health Transformation	135-140	0	0	0	0	125-130

Senior manager remuneration (including salary and pension entitlements) (subject to audit) Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Karen Barker - Executive Director of Corporate Affairs & ICS Development	125-130	0	0	0	27.5-30	155-160
Andrew Palmer – Executive Director of Performance, Transformation & Strategy and Deputy Chief Executive Officer	145-150	0	0	0	20-22.5	165-170
Ema Ojiako - Executive Director of People *to 31/10/2024*	75-80	0	0	0	52.5-55	130-135
Ian Riley - Executive Director of Digital and Data	145-150	0	0	0	22.5-25	170-175
Matthew Dooley - Executive Director of Commissioning and Performance *from 01/11/2024*	55-60	0	0	0	55-57.5	110-115

Senior manager remuneration (including salary and pension entitlements) (subject to audit) Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Hein van den Wildenberg - Non-Executive Member full year and Interim Chair from 01/01/2025	15-20	0	0	0	0	15-20
Aliona Derrett - Non Executive Member	15-20	0	0	0	0	15-20
David Holt - Non Executive Member	15-20	0	0	0	0	15-20
Catherine Armor - Non Executive Member	15-20	0	0	0	0	15-20
Patricia Hewitt - Non-Executive ICS Chair to 10/03/2025	55-60	0	0	0	0	55-60
Dr Hilary Byrne - Partner Member - Primary Medical Services	25-30	0	0	0	0	25-30
Emma Ratzer - Non-Executive Member from 01/10/2024	10-15	0	0	0	0	10-15

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

Name and Title	1 April 2023 to 31 March 2024					
	(a) Salary (bands of £5,000)	**(b) Expense payments (taxable) to nearest £100****	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)**	**(f) TOTAL (a to e) (bands of £5,000)**
	£000	**£**	**£000**	**£000**	**£000**	**£000**
Tracey Bleakley - Chief Executive Officer	205-210	0	0	0	47.5-50	255-260
Dr Frankie Swords - Executive Medical Director	195-200	0	0	0	0	180-185
Patricia D'Orsi - Executive Director of Nursing	140-145	0	0	0	0	55-60
Mark Burgis - Executive Director of Patients and Communities	125-130	0	0	0	7.5-10	135-140
Steven Course - Executive Director of Finance	170-175	0	0	0	0	0
Jocelyn Pike – Acting Executive Director of Mental Health Transformation	120-125	0	0	0	0	20-25
Karen Barker - Executive Director of Corporate Affairs & ICS Development	120-125	0	0	0	25-27.5	145-150

Name and Title	1 April 2023 to 31 March 2024					
	(a) Salary (bands of £5,000)	**(b) Expense payments (taxable) to nearest £100****	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)**	**(f) TOTAL (a to e) (bands of £5,000)**
	£000	**£**	**£000**	**£000**	**£000**	**£000**
Andrew Palmer – Executive Director of Performance, Transformation & Strategy and Deputy Chief Executive Officer	140-145	0	0	0	0	30-35
Ema Ojiako - Executive Director of People	125-130	0	0	0	32.5-35	155-160
Ian Riley - Executive Director of Digital and Data	135-140	0	0	0	0	35-40
Hein van den Wildenberg - Non Executive Member	15-20	0	0	0	0	15-20
Aliona Derrett - Non Executive Member	15-20	0	0	0	0	15-20
David Holt - Non Executive Member	15-20	0	0	0	0	15-20
Catherine Armor - Non Executive Member	15-20	0	0	0	0	15-20
Patricia Hewitt - Non Executive ICS Chair	60-65	0	0	0	0	60-65
Dr Hilary Byrne - Partner Member - Primary Medical Services	25-30	0	0	0	0	25-30

The figures in the table above represent the actual payments made in year rather than full year salaries. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

Pension benefits as at 31 March 2025 (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equiv-alent Transfer Value at 1 April 2023	(f) Real Increase in Cash Equival ent Transfer Value	(g) Cash Equiv-alent Transfer Value at 31 March 2024	(h) Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Tracey Bleakley - Chief Executive Officer	2.5-5	0	10-15	0	125	33	193	0
Francesca Swords - Executive Medical Director	0-2.5	0	75-80	215-220	1,681	3	1,823	0
Patricia D'Orsi - Executive Director of Nursing	5-7.5	5-7.5	50-55	125-130	1,053	110	1,252	0
Mark Burgis - Executive Director of Patients and Communities	0-2.5	0	35-40	0	493	20	563	0
Steven Course - Executive Director of Finance	2.5-5	0	60-65	150-155	1,142	26	1,267	0

Jocelyn Pike – Acting Executive Director of Mental Health Transformation	0-2.5	0	30-35	85-90	679	0	729	0
Karen Barker – Executive Director of Corporate Affairs & ICS Development	0-2.5	0	25-30	0	357	15	412	0
Andrew Palmer – Executive Director of Performance, Transformation & Strategy	0-2.5	0-2.5	45-50	115-120	879	28	983	0
Ema Ojiako - Executive Director of People	0-2.5	0	20-25	0	269	20	337	0
Ian Riley - Executive Director of Digital and Data	0-2.5	0	40-45	105-110	814	23	910	0
Matthew Dooley - Executive Director of Commissioning and Performance	0-2.5	0-2.5	30-35	50-55	517	16	607	0

Due to the reduction in inflationary percentages, from 10.1% in 2023-24 to 6.7% in 2024-25 some figures in the Pension benefits table, (b) Real increase in pension lump sum at pension age, resulted in pension values presenting as negative. Negative values are not disclosed in this table but are substituted with a zero.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called ‘rollback’.

Where a member who is a senior manager is affected by rollback the benefits in respect of their pensionable service during the remedy period are valued as being in the 1995/2008 Scheme. This means you may notice a difference between the benefits and Cash Equivalent Transfer Value (CETV) we quote for this year as compared to the benefits and CETV we quoted for year ending 2024.

In accordance with the Disclosure of Senior Managers' Remuneration (Greenbury) 2020 guidance, no CETV will be shown for pensioners and senior managers over normal pension age (NPA).

The declaration of pension contributions in this report is made in accordance with the guidelines issued under the Greenbury Report.

The details contained in the above tables relate to those members of the Board and Senior Management Team for whom pension details were available. Those not included where:

- Non-Executive Members whose remuneration is not pensionable.
- GPs on the Board who were not members of the normal NHS Pension Scheme but did contribute to the NHS GP Solo Pension Scheme. The GP Solo Pension Scheme benefits are not included in the above table as we are unable to identify which part of that scheme relates to their work as Board Members.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office (subject to audit)

No compensation was paid on early retirement or for loss of office.

Payments to past directors (subject to audit)

There were no payments made by NHS Norfolk and Waveney to past senior managers for services rendered or compensation due either in this or the previous financial year.

Staff Report

NHS Norfolk and Waveney has a highly skilled, motivated and experienced workforce of commissioning managers and support staff. During the reporting period the average workforce was 637.7 WTE (whole time equivalent). In addition to employed staff, NHS Norfolk and Waveney engaged with general practitioners and nurses from across the Norfolk and Waveney area to provide clinical expertise and input into its decision making and actively supporting the organisation in aspiring for better health, better care and better value for the population.

Staff numbers and composition (subject to audit)

As an employer we adopt the National Agenda for Change (AfC) pay framework and the following tables show the breakdown of functional categories and gender as at year end:

The staff headcount is of all staff employed by NHS Norfolk and Waveney as at 31 March 2025.

Staff Composition by Occupational Code (headcount)	Female	Male	Total
Chair & Non-Executive Board Members	4	2	6
Clerical and Administrative	267	62	329
Clinical Members	18	12	30
Managers	113	60	173
Nursing Professionals	86	11	97
Scientific, Therapeutic & Technical Professionals	33	5	38
Senior Managers	16	18	34
Other - Non AfC non-ICB shared posts	6	1	7
Other - Seconded/Agency staff	15	1	16
Total	**558**	**172**	**730**

NHS Occupational codes presented above reflect the nature of the role undertaken, this may show a difference to the roles in the table below. For example, Board Members where occupational codes consider these as Nursing or Clinical.

Staff Composition by band (headcount)	Female	Male	Total
VSM	6	5	11
Chair & Non-Executive Board Members	4	2	6
Other - Non AfC ICB members	18	15	33
Band 9	4	5	9
Band 8d	10	7	17
Band 8c	36	17	53
Band 8b	50	20	70
Band 8a	83	33	116
Band 7	105	32	137
Band 6	100	17	117
Band 5	56	11	67
Band 4	61	4	65
Band 3	18	3	21
Band 2	1	0	1
NCC Shared posts	6	1	7
Total	**558**	**172**	**730**

Whilst these tables detail the breakdown of staffing by banding from a gender perspective, other metrics are monitored including the Workforce Race Equality Standard (WRES) which reflects career progression and personal perceptions of black and minority ethnic staff treatment by colleagues. The progress against workplans are reviewed by both the workforce team and the staff Equality, Diversity and Inclusion Group.

NHS Norfolk and Waveney also recognises that individuals may identify themselves outside of female or male categories however these tables capture NHS Norfolk and Waveney's workforce.

Employee benefits (subject to audit)

For reporting period 1 April 2024 to 31 March 2025	Permanent Employees	Other	2024-25 Total
Employee benefits	**£000's**	**£000's**	**£000's**
Salaries and wages	33,208	2,147	35,355
Social security costs	3,717	75	3,792
Employer Contributions to NHS Pension scheme	7,470	108	7,579
Other pension costs	4	0	4
Apprenticeship Levy	148	0	148
Termination benefits	227	0	227
Gross employee benefits expenditure	44,775	2,330	47,105

PY Comparison	Permanent Employees	Other	2023-24
Employee benefits	**£000's**	**£000's**	**£000's**
Salaries and wages	34,501	2,487	36,988
Social security costs	3,825	154	3,979
Employer Contributions to NHS Pension scheme	6,354	168	6,523
Other pension costs	5	0	5
Apprenticeship Levy	153	0	153
Termination benefits	1,369	0	1,369
Gross employee benefits expenditure	**46,207**	**2,810**	**49,017**

Termination benefits relate to the employer's cost of paid exit packages.

Sickness absence data

Department of Health & Social Care (DHSC) has taken the decision to not commission the data production exercise for NHS bodies. The link to the latest NHS Digital publication series is as follows:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/january-2025

Staff Turnover

For the reporting period to 31 March 2025 the staff turnover for NWICB stood at 16.95%. For 31 March 2024 this was 17.94%

Staff engagement percentages Staff engagement percentages

NHS Norfolk and Waveney is committed to improving staff experiences across the NHS and takes part in the National Staff Survey (NSS) annually. NHS Norfolk and Waveney participated in the annual NHS National Staff Survey. This opened for responses in October 2024 and closed December 2024.

The response rate for NHS Norfolk and Waveney was 68.2% (439 responses) which was higher than 2024 but slightly lower than our comparator average of 72%. Nationally in 2024 the overall results for the NHS declined this year, however NHS Norfolk and Waveney results told us a slightly different story. Our comparator group includes Integrated Care Boards (ICBs).

Overall, the ICB faired above our comparator average in most domains of the People Promise, and in some areas, we improved on our 2023 results. In response to this year's results we will be focusing on improving management support, through the introduction of a 'People Management Fundamentals' programme and we will continue to prioritise health and wellbeing.

Our staff engagement score was 6.66 which is slightly improved on our 2023 score of 6.61. The motivation factors include questions on involvement in decision-making, motivation and advocacy i.e. would they recommend this organisation as a place to work. Our staff morale score was 6.04 which was an improvement on our 2023 score of 5.83. The morale element includes questions relating to thinking of leaving, work pressure and stressors. All results are summarised against the NHS People Promise, which we as an ICB are committed to delivering for our staff. The seven elements are:

People Promise Domain	ICB Score	Comparator Average Score
We are compassionate and inclusive	7.34	7.23
We are recognised and rewarded	6.62	6.46
We each have a voice that counts	6.76	6.58
We are safe and healthy	6.37	6.28
We are always learning	5.18	5.05
We work flexibly	7.30	7.22
We are a team	7.05	7.01

Staff Engagement	6.66	6.48
Staff Morale	6.04	5.69

Our 2024 ICB results include:

- above our comparator average for all 7 People Promise themes
- above our comparator average for staff engagement and morale
- areas showing most improvement include opportunities to show initiative, make suggestions and involvement in decision making.
- areas showing a decline since our 2023 survey (in line with a national deterioration in these areas) include immediate manager support and working together to achieve objectives. Given our organisational restructure these results are not a surprise, and will be our priority focus in our re-set plans. Our People Management Fundamentals programme is being implemented in February 2025. It has been developed in-house, based on the NHSE Framework NHS England » The expectations of line managers in relation to people management with local context.

Our full results can be found at the following link:

https://www.nhsstaffsurveys.com/results/national-results/

Feedback into Action

NHS Norfolk and Waveney ICB will continue to seek feedback from our staff through participation in quarterly 'People Pulse' surveys and participation in the annual national survey. We work positively with our Staff Involvement Group to continually look for ways to improve staff experience and to respond to their feedback. The survey's strength is in providing a national picture alongside local detail. It captures how people experience their working lives and is aligned to the NHS People Promise. The National Staff Survey is a snapshot in time with the information gathered at the same time each year. It helps us to understand how staff are feeling and to help us to learn from their experience. The results are used to improve local working conditions and ultimately to improve patient care. Staff experience is incredibly important to us at the ICB and across Norfolk and Waveney as a system, and we are committed to continue to listen to what our staff are saying and feeling so that we can make improvements where necessary.

We are focused on being a great place to work as we want to recruit and retain the best people in our bid to continually provide outstanding care for our communities. We have recently conducted a cultural assessment, the results of this, together with our survey results, will shape our plans to foster a culture that actively seeks the collaboration, inclusion, and voice of all our people, aligned to our Joint Forward Plan to meet existing and future opportunities and challenges.

Our aim as an ICB is to consistently co-create solutions with our staff to improve on the issues raised in the feedback from the survey and to move the organisation forwards.

Staff policies

NHS ICB HR policies are based on NHS Business Services Authority policies and as such have been agreed by Trade Unions. HR policies are reviewed and agreed at our People, Culture and Remuneration committee and where relevant HR personnel engage with trade unions to support good working relationships.

HS Norfolk and Waveney follows an Equality, Diversity and Inclusion Policy and is committed to equality of opportunity for all employees. This is about giving fair consideration to applications for employment from groups of people with particular characteristics who may otherwise face discrimination. The nine protected characteristics are age, disability, ethnic origin and race, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

NHS Norfolk and Waveney is committed to improving equality of opportunity to disabled people and gives full and fair consideration to applications for employment made by disabled persons and promotes the provision of training and guidance and the impartial application of all employment policies and procedures. Occupational health advice and support is available to all staff and specialist advice sought for disabled employees.

More information on NHS Norfolk and Waveney's approach to equality and inclusion can be found under 'Other employee matters' below.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) regulations 2017, requires relevant public sector organisations to report on trade union facility time in their organisations. Facility time is paid time off for union representatives to carry out trade union activities.

Table 1 - Relevant union officials

Total number of employees who were relevant union officials during 2024-25:

Number of employees who were relevant union officials during 2023-24	Full-time equivalent employee number
1	1

Table 2 - Percentage of time spent on facility time

Percentage of working time spent on facility time by employees who were relevant union officials employed during 2024-25:

Percentage of time	Number of employees
0%	0
1-50%	1
51-99%	0
100%	0

Table 3 - Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during 2024-25:

Total cost of facility time	£
Provide the total cost of facility time	7,213
Total pay bill	47,104,530
Percentage of the total pay bill spent on facility time	0.02%

Table 4 - Paid trade union activities

Percentage of total paid facility time hours spent by employees who were relevant union officials during 2024-25 on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours	67%

Other employee matters

Equality, Diversity and Inclusion

NHS Norfolk and Waveney has due regard to the three aims of the public sector equality duty under the Equality Act 2010 to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act
- advance the equality of opportunity between people who share a protected characteristic and people who do not share it, and
- foster good relations between people who share a protected characteristic and people who do not share it.

Workforce diversity is viewed positively, we recognise that everyone is different and value the unique contribution of experience, knowledge and skills that staff bring to work. Equality and inclusion are stated objectives.

The promotion of equality, diversity and inclusion is pursued through policies that ensure employees receive fair, equitable and consistent treatment and existing and potential employees are not subject to any form of discrimination, enabling employees to work in an environment where they have an authentic and representative voice and they can give their best. NHS Norfolk and Waveney's Equality, Diversity and Inclusion Policy seeks to meet and exceed our responsibilities as a public-sector employer under the Equality Act 2010.

To support this work, an Equality, Inclusion and Diversity Lead has been appointed by NHS Norfolk and Waveney and we have a well-established Equality, Inclusion and Diversity Staff Group to help ensure that NHS Norfolk and Waveney ICB continues to celebrate diversity and develop equitable opportunities for all employees. More information can be found on our website at the following link: https://improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/equality-and-inclusion/

Health and Safety

NHS Norfolk and Waveney is committed to ensuring the health, safety and welfare of its employees and of course others who may be affected by ICB activities. NHS Norfolk and Waveney takes all reasonably practicable steps to achieve this commitment and to comply with statutory obligations and to promote a positive health and safety culture throughout the organisation. Health and safety training is provided via e-learning for all staff. This mandatory training covers the core requirements for a low-risk office environment and each module contains an assessment that must be passed by staff.

Pension

Employees of NHS Norfolk and Waveney are covered by the provisions of the NHS Pension Scheme.

For information as to how pension liabilities were treated, please refer to accounting policy 3.4. In respect of senior managers in NHS Norfolk and Waveney, pension entitlements are disclosed within this Remuneration Report.

Expenditure on consultancy

Where NHS Norfolk and Waveney does not have the requisite skills or capacity within the organisation to deliver specific aspects of its obligations or to develop further the services that it would wish to provide it relies on external organisations and individuals to provide those skills or capacity.

During the reporting period NHS Norfolk and Waveney spent £572,534 on consultancy services as outlined below. (1 April 2023 to 31 March 2024, £683,436).

Consultancy service	**Cost £'s**
Procurement Consultancy	94
Human Resource, Training & Education Consultancy	75,690
Strategy Consultancy	98,710
IT/IS Consultancy	398,040
Total	572,534

Off-payroll engagements
Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2025 for more than £245* per day

	Number
Number of existing engagements as of 31 March 2025	15
Of which, the number that have existed:	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	8
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB can provide assurance that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary**.**

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245(1) per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	35
Of which:	
No. not subject to off-payroll legislation (2)	34
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	0
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	1
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	2

Exit packages, including special (non-contractual) payments (subject to audit) -

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	18	103,331	0	0	18	103,331	0	0
£10,001 - £25,000	5	61,361	1	24,828	6	86,189	0	0
£25,001 - £50,000	2	58,543	2	62,011	4	120,554	0	0
£50,001 - £100,000	1	93,333	0	0	1	93,333	0	0
TOTALS	26	316,568	3	86,839	29	403,407	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are the full costs of departures agreed in year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period. Where NHS Norfolk and Waveney has agreed early retirements, the additional costs are met by NHS Norfolk and Waveney and not by the NHS Pensions Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table (£Nil).

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	3	86,839
Non-contractual payments requiring HMT approval**	0	0
TOTAL	3	86,839

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Table 1 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, relating to non-contractual payments in lieu of notice. None paid in 2024-25.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Ed Garratt OBE
Interim Accountable Officer
18 June 2025

Norfolk and Waveney Integrated Care Board is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at Page 179.

ANNUAL ACCOUNTS

Financial Statement and Notes

NHS Norfolk & Waveney ICB - Annual Accounts 31 March 2025

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	31 March 2025 £'000	31 March 2024 £'000
Income from sale of goods and services	2	(47,494)	(57,059)
Total operating income		**(47,494)**	**(57,059)**
Staff costs	3	47,105	49,017
Purchase of goods and services	4	2,898,606	2,474,850
Depreciation and impairment charges	4	192	192
Provision expense	4	(1,067)	8,054
Other operating expenditure	4	4,645	2,833
Total operating expenditure		**2,949,481**	**2,534,946**
Net operating expenditure		**2,901,987**	**2,477,887**
Finance expense	6	5	7
Net expenditure for the year		**2,901,992**	**2,477,894**
Comprehensive expenditure for the year		**2,901,992**	**2,477,894**

The notes on pages 147 to 178 form part of this statement.

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £'000	31 March 2024 £'000
Non-current assets:			
Right-of-use assets	7	481	673
Total non-current assets		**481**	**673**
Current assets:			
Trade and other receivables	8	20,440	23,673
Cash and cash equivalents	9	693	376
Total current assets		**21,133**	**24,049**
Total assets		**21,614**	**24,722**
Current liabilities:			
Trade and other payables	10	(169,721)	(174,924)
Lease liabilities	7	(239)	(218)
Provisions	11	(11,554)	(12,413)
Total current liabilities		**(181,514)**	**(187,555)**
Total assets less current liabilities		**(159,900)**	**(162,833)**
Non-current liabilities:			
Trade and other payables	10	-	(820)
Lease liabilities	7	(278)	(472)
Provisions	11	(165)	(373)
Total non-current liabilities		**(443)**	**(1,665)**
Assets less liabilities		**(160,343)**	**(164,498)**
Financed by taxpayers' equity			
General fund		(160,343)	(164,498)
Total taxpayers' equity		**(160,343)**	**(164,498)**

The notes on pages 147 to 178 form part of this statement.

The financial statements on pages 143 to 146 were approved by the Board on 18 June 2025 and signed on its behalf by:

[redacted]

Ed Garratt OBE
Interim Chief Executive Officer
18 June 2025

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	Note	31 March 2025 General fund £'000	31 March 2024 General fund £'000
Changes in taxpayers' equity for 31 March 2025			
Balance at 01 April 2024		(164,498)	(221,000)
Changes in NHS ICB taxpayers' equity for 31 March 2025			
Net expenditure for the financial year	SoCNE	(2,901,992)	(2,477,894)
Net recognised NHS ICB expenditure for the financial year		**(2,901,992)**	**(2,477,894)**
Net funding	SoCF	2,906,147	2,534,396
Balance at 31 March 2025		**(160,343)**	**(164,498)**

The notes on pages 147 to 178 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2025

	Note	31 March 2025 £'000	31 March 2024 £'000
Cash flows from operating activities			
Net expenditure for the financial year		(2,901,992)	(2,477,894)
Depreciation and amortisation	4	192	192
Interest paid	6	5	7
(Increase)/decrease in trade & other receivables	8	3,233	(14,997)
Increase/(decrease) in trade & other payables	10	(6,023)	(50,860)
Increase/(decrease) in provisions	11	(1,067)	8,054
Net cash inflow (outflow) from operating activities		**(2,905,652)**	**(2,535,498)**
Cash flows from financing activities			
Net funding received		2,906,147	2,534,396
Repayment of lease liabilities	7	(178)	(171)
Net cash inflow (outflow) from financing activities		**2,905,969**	**2,534,225**
Net increase (decrease) in cash & cash equivalents	9	**317**	**(1,273)**
Cash & cash equivalents at the beginning of the financial year		**376**	**1,649**
Cash & cash equivalents at the end of the financial year		**693**	**376**

The notes on pages 147 to 178 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICB's) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICB's as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
The financial statements for ICB's are prepared on a Going Concern basis as they will continue to provide the services in the future.
On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on a going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.
The ICB will continue to operate as a Going Concern with no changes to its funding stream, and with an approved allocation for 2025-26 of £3.005 billion, ensuring healthcare service provision throughout Norfolk and Waveney remains unaffected.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Movement of Assets within the Department of Health and Social Care Group

NHS Norfolk & Waveney ICB was approved by NHS England to operate from 1 July 2022 and was created from the transfer of NHS Norfolk & Waveney Clinical Commissioning Group (CCG).
As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities

transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Pooled Budgets**

The ICB has entered into separate pooled budget arrangements with both Norfolk County Council and Suffolk County Council in accordance with section 75 of the NHS Act 2006. Under these arrangements, funds are pooled to jointly commission or deliver health and social care, known as the Better Care Fund. The pools are hosted by Norfolk County Council and Suffolk County Council respectively. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
The ICB has exercised judgement on the accounting for pooled budgets, further details are include in note 15.

1.5 **Revenue**

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Payment terms are standard reflecting cross government principles.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.10 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
All financial assets are recorded at amortised cost.

1.10.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.11 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.
Financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.12 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.12.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Better Care Fund

The ICB has entered into a partnership agreement and a pooled budget with both Norfolk County Council and Suffolk County Council in respect of the Better Care Fund (BCF). From 2022-23 this includes the addendum of the Adult Social Care Discharge Fund. The BCF is a national policy initiative and the funds involved are material in the ICB accounts. Having reviewed the terms of the partnership agreement the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the appropriate financial reporting standards the ICB has determined that there are three elements to the BCF and they are accounted for as follows:

(1) The major part is controlled by both Norfolk County Council and Suffolk County Council which commissions services from various non-NHS providers. Whilst the services are determined in partnership the risks and rewards of the contracts remain wholly with the council. The ICB accounts for this on a lead commissioner basis as healthcare expenditure with the local authority.

(2) The second part is controlled by the ICB which commissions various services from NHS and non-NHS providers. The risks and rewards of these contracts are the responsibility of the ICB which considers itself to be acting as a lead commissioner for those services on behalf of the partnership. The ICB accounts for these costs as healthcare purchased from NHS and non-NHS providers.

(3) The final part of the BCF is an integrated community equipment store. Norfolk County Council acts as the host body for this service which is provided by a third party. Each partner is however wholly responsible for their own share of the expenditure, and this is accounted for as a joint operation. Otherwise, there were no critical judgements apart from those involving estimations (see below) that management has made in the process of applying the ICB’s accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.12.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material

adjustment to the carrying amounts of assets and liabilities within the next financial year.

Prescribing Liabilities
NHS England actions monthly cash charges to the ICB for prescribing contracts. These are issued approximately 6 weeks in arrears. The ICB uses information provided by the NHS Business Authority as part of the estimate for period expenditure. For the year ended 31 March 2025 an accrual of £37,819,452 (2023-24 £35,163,570) was included for February and March anticipated expenditure, this figure is not believed to represent a significant level of uncertainty.

Dental Performance Clawback
NHS Business Services Authority process the monthly cash charges for the ICB's Dental Contracts. Contractual payments are made monthly, with an adjustment for under/over performance occurring 6 months after year end. The ICB uses information provided by the NHS Business Services Authority as part of the estimate for performance adjustments. For the year ended 31 March 2025 a claw back value of £12,500,245 (2023-24 £16,658,047) was included for the delivery adjustment, this figure is not believed to represent a significant level of uncertainty.

1.13 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.
In March 2023 NHS England wrote to all Integrated Care Boards in England directing them to make a real-term running cost reduction of 30% by 2025-26, with at least 20% to be delivered in 2024-25. This direction has precipitated a restructure process within the ICB, resulting in a redundancy provision.

1.14 **Contingent liabilities**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

1.15 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.15.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 4.72% is applied for leases commencing, transitioning or being remeasured in the 2024 calendar year; and 4.81% to new leases commencing in 2025 under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the ‘Depreciation, amortisation and impairments’ policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use

asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.16 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
The ICB has written off £9,018 in the year to 31 March 2025 (2023-24 £615,426). The higher value for 2023-24 was in relation to historic legacy debt that was brought forward into the organisation as part of the absorption transfer on incorporation on 1 July 2022. This write off was fully provided for under the ICB's Bad Debt policy terms.

There were no Special Payments in the year ended 2024-25 (2023-24 £NIL).

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

1.17 **New and revised IFRS Standards in issue but not yet effective**

The Department of Health and Social Care GAM does not require the following IFRS Standard and Interpretation to be applied for the year ended 31 March 2025.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.
● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

The application of IFRS 17, IFRS 18 and IFRS 19 is not anticipated to have a material impact on the accounts.

2. Other operating revenue

	31 March 2025 Total £'000	31 March 2024 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	2
Non-patient care services to other bodies *	5,289	16,402
Prescription fees and charges	12,855	12,124
Dental fees and charges	13,549	12,982
Other contract income	15,801	15,549
Total income from sale of goods and services	**47,494**	**57,059**
Total operating income	**47,494**	**57,059**

* The figure for Non-patient care services to other bodies includes £8.3m for Discharge Transformation Surge Funding in 2023-24, this funding was not received in 2024-25.

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	3,271	-	-	11,608
Non-NHS	2,018	12,855	13,549	4,193
Total	**5,289**	**12,855**	**13,549**	**15,801**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	-	12,855	13,549	-
Over time	5,289	-	-	15,801
Total	**5,289**	**12,855**	**13,549**	**15,801**

In line with the 2024-25 GAM both the prescription and dental fees and corresponding charges have been classified as being at a point in time whereas the remainder of the income derived by the ICB is classified as over time.

3. Employee benefits and staff numbers

3.1 Employee benefits

	Permanent Employees £'000	Other £'000	31 March 2025 Total £'000
Employee benefits			
Salaries and wages	33,208	2,147	35,355
Social security costs	3,717	75	3,792
Employer contributions to NHS Pension scheme	7,471	108	7,579
Other pension costs	4	-	4
Apprenticeship levy	148	-	148
Termination benefits	227	-	227
Net employee benefits excluding capitalised costs	**44,775**	**2,330**	**47,105**

Further analysis of employee benefits is shown in the remuneration and staff report on page 132.

	Permanent Employees £'000	Other £'000	31 March 2024 Total £'000
Employee benefits			
Salaries and wages	34,501	2,487	36,988
Social security costs	3,825	154	3,979
Employer contributions to NHS Pension scheme	6,354	169	6,523
Other pension costs	5	-	5
Apprenticeship levy	153	-	153
Termination benefits	1,369	-	1,369
Net employee benefits excluding capitalised costs	**46,207**	**2,810**	**49,017**

Pay costs excluding termination benefits are consistent with the prior year but reflect a reduced whole time equivalent. This is as a result of the national Agenda for Change 5.5% 2024-25 pay rises.

Further analysis of employee benefits is shown in the remuneration and staff report on pages 118 - 141.

3.2 Average number of people employed

	31 March 2025			31 March 2024		
	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number	Total Number
Total	612	26	638	672	39	711

Of the above:

Further information in respect of staff numbers is included from pages 130 -131 of the annual report.

3.3 Exit packages agreed in the financial year

	31 March 2025 Compulsory redundancies		31 March 2025 Other agreed departures		31 March 2025 Total	
	Number	£	Number	£	Number	£
Less than £10,000	18	103,331	-	-	18	103,331
£10,001 to £25,000	5	61,361	1	24,828	6	86,189
£25,001 to £50,000	2	58,543	2	62,011	4	120,554
£50,001 to £100,000	1	93,333	-	-	1	93,333
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Total	**26**	**316,568**	**3**	**86,839**	**29**	**403,407**

	31 March 2024 Compulsory redundancies		31 March 2024 Other agreed departures		31 March 2024 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	8,112	1	8,112
£10,001 to £25,000	2	32,443	5	95,568	7	128,011
£25,001 to £50,000	1	25,516	6	205,470	7	230,986
£50,001 to £100,000	-	-	7	537,862	7	537,862
£100,001 to £150,000	-	-	2	215,544	2	215,544
£150,001 to £200,000	-	-	1	160,000	1	160,000
Total	**3**	**57,959**	**22**	**1,222,556**	**25**	**1,280,515**

Analysis of other agreed departures

	31 March 2025 Other agreed departures		31 March 2024 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	22	1,187,683
Contractual payments in lieu of notice	-	-	9	34,873
Exit payments following Employment Tribunals or court orders	3	86,839	-	-
Total	**3**	**86,839**	**31**	**1,222,556**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with this departure may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions and conditions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards in full at the year of agreement.

In March 2023 NHS England wrote to all Integrated Care Boards in England directing them to make a real-term running cost reduction of 30% by 2025-26, with at least 20% to be delivered in 2024-25. This direction precipitated a restructure process within the ICB, which resulted in the majority of exit packages noted above in 2023-24 contributing towards the overall running cost reduction.

3.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

The employer contribution rate was 23.7% in 2024-25 (20.6% 2023-24).

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2024, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

For the year ended 31 March 2025 employers' contributions of £7,579,000 (2023-24 £6,523,000) were payable to the NHS Pensions Scheme at the rate of 23.7% of pensionable pay.

4. Operating expenses

		31 March 2025 Total £'000	31 March 2024 Total £'000
Purchase of goods and services			
Services from other ICB's and NHS England		4,042	4,098
Services from foundation trusts	i	1,619,193	1,339,116
Services from other NHS trusts	ii	238,239	201,828
Services from other WGA bodies		-	103
Purchase of healthcare from non-NHS bodies	iii	397,067	313,601
Purchase of social care		15,078	13,945
General dental services and personal dental services		52,077	44,777
Prescribing costs		222,169	214,872
Pharmaceutical services		37,253	34,494
General ophthalmic services		11,092	10,935
GPMS/APMS and PCTMS		246,848	233,460
Supplies and services – clinical		2,587	2,386
Supplies and services – general		21,602	34,563
Consultancy services		573	674
Establishment		9,652	6,074
Transport		12,852	11,465
Premises		3,652	2,704
Audit fees	iv	333	386
Other professional fees		827	1,004
Legal fees		866	600
Education, training and conferences		2,604	3,765
Total purchase of goods and services		**2,898,606**	**2,474,850**
Depreciation and impairment charges			
Depreciation		192	192
Total depreciation and impairment charges		**192**	**192**
Provision expense			
Provisions		(1,067)	8,054
Total provision expense		**(1,067)**	**8,054**
Other operating expenditure			
Chair and Non Executive Members		187	185
Grants to other bodies		-	730
Research and development (excluding staff costs)		2,976	2,866
Expected credit loss on receivables		1,432	(975)
Other expenditure		50	27
Total other operating expenditure		**4,645**	**2,833**
Total operating expenditure		**2,902,376**	**2,485,929**

i - Services from foundation trusts

Significant increases rising from the delegation on 1 April 2024 from NHS England to ICB's for the management of Specialised Commissioning services which equates to £183m and increases in acute service contracts.

ii - Services from other NHS trusts
Significant increases rising from the delegation on 1 April 2024 from NHS England to ICB's for the management of Specialised Commissioning services which equates to £10m and increases in community and ambulance service contracts.

iii - Purchase of healthcare from non-NHS bodies

An element of the uplift in this category is the delegation on 1 April 2024 from NHS England to ICB's for the management of Specialised Commissioning services which equates to £4m and increases in independent sector and continuing health care costs.

iv - Audit fees

This includes the statutory external audit provided by Ernst & Young LLP of £267k (2023-24 £301k) and the Mental Health Investment Standard audit provided by Grant Thornton UK LLP of £66k (2023-24 £85k).

4.1 Limitation on Auditor's liability
The limitation on auditors' liability for external audit work is £2m.

5. Better Payment Practice Code

Measure of compliance	31 March 2025 Number	31 March 2025 £'000	31 March 2024 Number	31 March 2024 £'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	87,223	775,102	84,878	724,775
Total Non-NHS trade invoices paid within target	86,575	765,589	83,957	715,209
Percentage of Non-NHS trade invoices paid within target	**99.26%**	**98.77%**	**98.91%**	**98.68%**
NHS Payables				
Total NHS trade invoices paid in the year	2,060	1,880,863	1,968	1,578,090
Total NHS trade invoices paid within target	2,016	1,877,938	1,881	1,574,186
Percentage of NHS trade invoices paid within target	**97.86%**	**99.84%**	**95.58%**	**99.75%**
Total Payables				
Total trade invoices paid in the year	89,283	2,655,965	86,846	2,302,864
Total trade invoices paid within target	88,591	2,643,527	85,838	2,289,395
Percentage of all trade invoices paid within target	**99.22%**	**99.53%**	**98.84%**	**99.42%**

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%.

In the year ended 31 March 2025 this target delivery was achieved in all categories.

6. Finance costs

	31 March 2025 £'000	31 March 2024 £'000
Interest		
Interest on lease liabilities	5	7
Total interest	**5**	**7**
Total finance costs	**5**	**7**

7. Leases

7.1 Right-of-use assets

	31 March 2025 Buildings excluding dwellings £'000	31 March 2024 Buildings excluding dwellings £'000
Cost or valuation at 01 April 2024	1,005	1,152
Disposals on expiry of lease term	-	(147)
Cost/Valuation at 31 March 2025	**1,005**	**1,005**
Depreciation 01 April 2024	332	147
Charged during the year	192	192
Disposals on expiry of lease term	-	(7)
Depreciation at 31 March 2025	**524**	**332**
Net Book Value at 31 March 2025	**481**	**673**

7.2 Lease liabilities

	31 March 2025 £'000	31 March 2024 £'000
Lease liabilities at 01 April 2024	(690)	(994)
Interest expense relating to lease liabilities	(5)	(7)
Repayment of lease liabilities (including interest)	178	171
Disposals on expiry of lease term	-	140
Lease liabilities at 31 March 2025	**(517)**	**(690)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2025 £'000	31 March 2024 £'000
Within one year	(239)	(218)
Between one and five years	(278)	(472)
Balance at 31 March 2025	**(517)**	**(690)**

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	31 March 2025 £'000	31 March 2024 £'000
Depreciation expense on right-of-use assets	192	192
Interest expense on lease liabilities	5	7
	197	**199**

7.5 Amounts recognised in Statement of Cash Flows

	31 March 2025 £'000	31 March 2024 £'000
Total cash outflow on leases under IFRS 16	178	171

7.6 Nature of lessee's leasing activities

The ICB has disclosed all lease liabilities under IFRS 16 in Note 7.2. This is for properties that the organisation occupies in order to carry out it's provision of Healthcare Commissioning. The ICB has entered into no further leases which would have been capitalised under IFRS 16, however there was one property which the ICB occupied in the year which has been treated as a rental agreement. This property was relinquished during the year. This is owned by NHS Property Services.

8.1 Trade and other receivables

	31 March 2025 Current £'000	31 March 2024 Current £'000
NHS receivables: Revenue	2,712	2,857
NHS prepayments	47	26
NHS accrued income	2,347	816
Non-NHS and Other WGA receivables: Revenue	1,907	2,537
Non-NHS and Other WGA prepayments	1,122	395
Non-NHS and Other WGA accrued income	813	605
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice *	13,152	16,658
Expected credit loss allowance-receivables	(1,724)	(301)
VAT	61	80
Other receivables and accruals	3	-
Total trade & other receivables	**20,440**	**23,673**
Total current and non-current	**20,440**	**23,673**

* As part of the delegation on 1 April 2023 from NHS England to ICB's for the management of Pharmacy, Dentistry and Ophthalmology services, the ICB is reporting an adjustment for under performance in dental of £12,500,245 (2023-24 £16,658,047) this is included in the above Non-NHS receivable balance.

8.2 Receivables past their due date but not impaired

	31 March 2025 DHSC Group Bodies £'000	31 March 2025 Non DHSC Group Bodies £'000	31 March 2024 DHSC Group Bodies £'000	31 March 2024 Non DHSC Group Bodies £'000
By up to three months	412	1,073	1,417	1,339
By three to six months	-	-	32	7
By more than six months	98	11	57	17
Total	**510**	**1,084**	**1,506**	**1,363**

8.3 Loss allowance on asset classes	31 March 2025 Trade and other receivables - Non DHSC Group Bodies £'000	31 March 2024 Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2024	**(301)**	**(1,891)**
Lifetime expected credit losses on trade and other receivables - Stage 2	(1,432)	975
Amounts written off	9	615
Total	**(1,724)**	**(301)**

9. Cash and cash equivalents

	31 March 2025 £'000	31 March 2024 £'000
Balance at 01 April 2024	376	1,649
Net change in year	317	(1,273)
Balance at 31 March 2025	**693**	**376**
Made up of:		
Cash with the Government Banking Service	693	376
Balance at 31 March 2025	**693**	**376**

10. Trade and other payables

	31 March 2025 Current £'000	31 March 2025 Non-current £'000	31 March 2024 Current £'000	31 March 2024 Non-current £'000
NHS payables: Revenue	7,647	-	7,868	-
NHS accruals	15,728	-	4,057	-
NHS deferred income	770	-	492	331
Non-NHS and Other WGA payables: Revenue	18,439	-	21,086	-
Non-NHS and Other WGA accruals	114,980	-	122,682	-
Non-NHS and Other WGA deferred income	5,329	-	10,815	489
Social security costs	459	-	454	-
Tax	498	-	468	-
Other payables and accruals*	5,871	-	7,002	-
Total trade & other payables	**169,721**	**-**	**174,924**	**820**
Total current and non-current	**169,721**		**175,744**	

* Other payables and accruals include £2,205,000 (2023-24 £1,886,000) outstanding pension contributions at 31 March 2025.

11. Provisions

	31 March 2025 Current £'000	31 March 2025 Non-current £'000	31 March 2024 Current £'000	31 March 2024 Non-current £'000
Redundancy	295	-	1,728	-
Legal claims	1,527	-	1,012	-
Other	9,732	165	9,673	373
Total	**11,554**	**165**	**12,413**	**373**
Total current and non-current	**11,719**		**12,786**	

	Redundancy £'000	Legal Claims £'000	Other* £'000	Total £'000
Balance at 01 April 2024	**1,728**	**1,012**	**10,046**	**12,786**
Arising during the year	213	1,312	9,479	**11,004**
Reversed unused	(1,646)	(797)	(9,628)	**(12,071)**
Balance at 31 March 2025	**295**	**1,527**	**9,897**	**11,719**
Expected timing of cash flows:				
Within one year	295	1,527	9,732	**11,554**
Between one and five years	-	-	165	**165**
Balance at 31 March 2025	**295**	**1,527**	**9,897**	**11,719**

* Other Provisions include Estates, Working capital adjustments, CDC Clawback, Dental Clawback, CHC Reimbursements and Standard staffing costs.

All provisions made satisfy the ICB's Accounting Policy in recognition of a present obligation from a past event with a reliable estimate for a probable expenditure.

12. Contingencies

	31 March 2025 £'000	31 March 2024 £'000
Contingent liabilities		
Legal Claim	-	200
Net value of contingent liabilities	**-**	**200**

The contingent liability related to employment and other legal cases where financial risks remained, but the certainty of the value or the outcome was unknown.

13. Financial instruments

13.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.
Because NHS ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.
Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS ICB standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS ICB and internal auditors.

13.1.2 Credit risk

Because the majority of the ICB revenue comes parliamentary funding, NHS ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.3 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

13.1.4 Financial Instruments

As the cash requirements of NHS England are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

13.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2025 £'000
Trade and other receivables with NHSE bodies	2,468
Trade and other receivables with other DHSC group bodies	2,597
Trade and other receivables with external bodies	15,868
Cash and cash equivalents	693
Total at 31 March 2025	**21,626**

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2025 £'000
Trade and other payables with NHSE bodies	250
Trade and other payables with other DHSC group bodies	23,220
Trade and other payables with external bodies	139,196
Finance lease obligations	517
Total at 31 March 2025	**163,183**

14. Operating segments

The ICB consider they only have one Operating Segment, being the provision of Commissioning of Healthcare Services.

15. Joint arrangements - interests in joint operations

ICB's should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

15.1 Interests in joint operations

			Amounts recognised in Entities books ONLY				Amounts recognised in Entities books ONLY			
			As At 31 March 2025		As At 31 March 2025		As At 31 March 2024		As At 31 March 2024	
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets £'000**	**Liabilities £'000**	**Income £'000**	**Expenditure £'000**	**Assets £'000**	**Liabilities £'000**	**Income £'000**	**Expenditure £'000**
Norfolk County Council Better Care Fund	NHS Norfolk and Waveney ICB and Norfolk County Council	Joint Commissioning of Care services, hosted by Norfolk County Council, net accounting adopted	-	-	-	89,873	-	-	-	82,607
Suffolk County Council Better Care Fund	NHS Norfolk and Waveney ICB and Suffolk County Council	Joint Commissioning of Care services, hosted by Suffolk County Council, net accounting adopted	-	-	-	11,453	-	-	-	10,533
Suffolk County Council Mental Health Services	NHS Norfolk and Waveney ICB and Suffolk County Council	Joint provision of mental health services	-	-	-	237	-	-	-	224

Children and Young People's Alliance Agreement	NHS Norfolk and Waveney ICB, Norfolk County Council, Suffolk County Council, Norfolk and Suffolk NHS Foundation Trust, Ormiston Families, Mancroft Advice Project, Cambridgeshire Community Services NHS Trust, James Paget University Hospitals NHS Foundation Trust, East Coast Community Healthcare CIC and Norfolk Community Health and Care NHS Trust	Alliance agreement for Children and Young People	-	-	569	2,735	-	-	1,389	2,726

16. Related party transactions

Details of related party transactions with individuals are as follows:

	31 March 2025		As At 31 March 2025		31 March 2024		As At 31 March 2024	
	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr Hilary Byrne, South Norfolk Health Improvement Partnership (Clinical Director)	3,324	-	-	-	2,459	-	-	-
Dr Hilary Byrne, Attleborough Surgery (GP Partner at Attleborough Surgeries)	3,258	-	-	-	2,956	-	-	-
Aliona Derrett, Hear for Norfolk (Chief Executive)	584	-	-	-	801	-	-	-
Bill Borrett, Breckland District Council (Councillor)	36	-	-	-	107	-	25	-
Fran Whymark, Broadland District Council (Councillor)*	176	-	-	-	202	5	60	-
Emma Ratzer, Access Community Trust (Chief Executive Officer)	543	-	-	-	658	-	8	-

* New Board Member commenced 17 March 2025

The Department of Health and Social Care is regarded as a related party. During the period the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent. The entities with whom the value of transactions exceed £500,000 are listed below:

- Barts Health NHS Trust
- Bedfordshire Hospital NHS Foundation Trust
- Cambridge University Hospital NHS Foundation Trust
- Cambridge and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust

- Community Health Partnerships
- East of England Ambulance Service NHS Trust
- East Suffolk and North Essex NHS Foundation Trust
- Essex Partnership University NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- James Paget University Hospital NHS Foundation Trust
- Mid & South Essex NHS Foundation Trust
- NHS Arden & Greater East Midlands Commissioning Support Unit
- NHS England
- NHS Property Services
- Norfolk & Norwich University Hospital NHS Foundation Trust
- Norfolk & Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- North West Anglia NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- The Queen Elizabeth Hospital NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- University College London Hospital NHS Foundation Trust
- West Suffolk NHS Foundation Trust

In addition, there have been further material transactions in the ordinary course of the ICB's business with a number of other government departments, central and local government bodies as follows:

- Norfolk County Council
- Suffolk County Council

17. Events after the end of the reporting period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025-26 financial year.

18. Financial performance targets

NHS Norfolk & Waveney ICB has a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	NHS Act Section	Duty Achieved?	31 March 2025 Target £'000	31 March 2025 Performance £'000	31 March 2024 Target £'000	31 March 2024 Performance £'000
Expenditure not to exceed income	223H(1)	Yes	2,950,086	2,949,485	2,535,010	2,534,953
Revenue resource use does not exceed the amount specified in Directions	223I(3)	Yes	2,902,592	2,901,992	2,477,951	2,477,894
Revenue administration resource use does not exceed the amount specified in Directions	223J(3)	Yes	20,590	19,676	22,619	22,618

19. Losses and special payments

19.1 Losses

The total number of NHS ICB losses and special payments cases, and their total value, was as follows:

	31 March 2025 Total Number of Cases Number	31 March 2025 Total Value of Cases £'000	31 March 2024 Total Number of Cases Number	31 March 2024 Total Value of Cases £'000
Administrative write-offs	5	9	178	615
Total	**5**	**9**	**178**	**615**

The ICB has written off 5 (2023-24 178) transactions totalling £9,018 (2023-24 £615,426) in the year to 31 March 2025. This write off was fully provided for under the ICB's Bad Debt policy terms.

19.2 Special payments

There were no special payments in the year ended 31 March 2025 and 31 March 2024.

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS NORFOLK & WAVENEY INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Norfolk & Waveney Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 19.2, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Norfolk & Waveney Integrated Care Board as at 31 March 2025 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the Annual Report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

Matters on which we are required to report by exception

We are required to report to you if:

- we issue a report in the public interest under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025; or
- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the '*Statement of Accountable Officer's Responsibilities*' in respect of the Accounts, set out on pages 75-76, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the 'Governance Statement', the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

We understood how the ICB is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the Head of Internal Audit, the Local Counter Fraud Specialist and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.

We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business.

Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management, the Head of Internal Audit, the Local Counter Fraud Specialist and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

We addressed our fraud risks related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions. This included testing the appropriateness of each journal selected and that it was accounted for appropriately.

To address our fraud risk of fraud in expenditure recognition, we tested the appropriateness of expenditure recognition accounting policies and tested that they had been applied correctly during our detailed testing, tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements, reviewed accounting for evidence of management bias, tested a sample of accruals based on our established testing threshold for reasonableness, performed cut-off testing of transactions both before and after year-end to ensure that they were accounted for in the correct year, reviewed the Department of Health (DoH) agreement of balances data and investigated significant differences (outside of DoH tolerances), considered the completeness of liabilities included in the financial statements by performing unrecorded liability testing.

To address our fraud risk in relation to the classification of Admin and Programme costs we reviewed accounting estimates for evidence of management bias, evaluated the business rationale for significant unusual transactions, considered the results of our work on revenue and expenditure recognition as set out above, specifically considering any instances of management bias and tested judgements made by management on the classification of programme and admin expenditure, ensuing the classification is compliant with relevant guidance.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We conducted our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) issued by the Public Audit Forum. We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of NHS Norfolk & Waveney Integrated Care Board.

Use of our report

This report is made solely to the members of the Governing Body of NHS Norfolk & Waveney Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Mark Hodgson

Ernst & Young LLP

Date: 19th June 2025.

Mark Hodgson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Cambridge