

Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 21 May 2025, 13:30 - 16:30

Agenda

13:30 - 13:30 **Meeting agenda**

0 min

 00. Agenda for Part 1 ICB Board 21.05.25.pdf (5 pages)

13:30 - 13:30 **1. Welcome and introductions - apologies for absence**

0 min

13:30 - 13:30 **2. Questions**

0 min

 02. protocol-for-submitting-questions-to-the-icb-board.pdf (1 pages)

13:30 - 13:30 **3. Minutes from previous meeting and matters arising**

0 min

 03. DRAFT NW ICB Board Part 1 Minutes 26032025.pdf (13 pages)

13:30 - 13:30 **4. Declarations of interest**

0 min

 04. ICB Board Master Register May 2025.pdf (5 pages)

13:30 - 13:30 **5. Chair's Action Log**

0 min

13:30 - 13:30 **6. Action log – things we have said we will do**

0 min

13:30 - 13:30 **7. Chair and Chief Executive's Report**

0 min

13:30 - 13:30 **8. ICB Transition**

0 min

 08. Transition report v1.pdf (5 pages)

13:30 - 13:30 **Learning from People, Staff, and Communities**

0 min

13:30 - 13:30 **9. Lived Experience Presentation - Prevention and screening**

0 min

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13:30 - 13:30 **Strategy and Partnerships**
0 min

13:30 - 13:30 **10. Report from the Quality and Safety Committee**
0 min

 10. Quality and Safety Committee Report to Board.pdf (7 pages)


13:30 - 13:30 **11. Intensive and Assertive Outreach Review Presentation**
0 min

 11. Intensive and Assertive Programme.pdf (3 pages)

 11.1 Intensive and Assertive Programme.pdf (9 pages)

13:30 - 13:30 **Comfort Break 10 Minutes**
0 min


13:30 - 13:30 **12. Financial Report for Month 12 2024/25**
0 min

 12. ICB Finance Report - Month 12 202425 - Board.pdf (10 pages)

13:30 - 13:30 **13. Report from the Finance Committee**
0 min

 13. Finance Committee Report to Board.pdf (4 pages)

13:30 - 13:30 **14. Integrated Performance Report (IPR)**
0 min

 14. Performance Report 2025.05.21.pdf (18 pages)

 14.1 Integrated Performance Report.pdf (4 pages)


13:30 - 13:30 **15. Report from the Commissioning and Performance Committee**
0 min

 15. Commissioning & Performance Committee Report to Board.pdf (8 pages)

13:30 - 13:30 **16. Primary Care Recovery Plan Report**
0 min

 16. Primary Care Recovery Plan Report.pdf (17 pages)

13:30 - 13:30 **17. Report from Primary Care Commissioning Committee**
0 min

 17. PCCC paper for Board V1.pdf (9 pages)

13:30 - 13:30 **System Oversight**
0 min

13:30 - 13:30 **18. Board Assurance Framework**
0 min

 18. RM Report-Board-Pt1-BAF-May 25.pdf (3 pages)

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13:30 - 13:30 **19. Report from the Audit and Risk Committee Verbal**
0 min

13:30 - 13:30 **20. Report from Patients and Communities Committee**
0 min

13:30 - 13:30 **21. Report from the Remuneration, People and Culture Committee - verbal**
0 min

13:30 - 13:30 **22. Amendment to the ICB Constitution**
0 min

 22. Amendment to the Constitution.pdf (2 pages)

13:30 - 13:30 **23. Questions from the Public.**
0 min

13:30 - 13:30 **24. Any other business**
0 min

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Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Wednesday, 21 May 2025 1.30pm – 4.30pm

**Council Chamber, Great Yarmouth Borough Council, Hall Plain, Great Yarmouth,
NR30 2QF**

Our mission: To help the people of Norfolk and Waveney live longer, healthier, and happier lives.

Our goals:

- 1. To make sure that people can live as healthy a life as possible.**
- 2. To make sure that you only have to tell your story once.**
- 3. To make Norfolk and Waveney the best place to work in health and care.**

Our values:



Questions

Questions relating to agenda items can be submitted via the following means:

1. Please submit questions no later than 12 noon on the 21 March 2025, via e-mail to: nwicb.contactus@nhs.net.
2. Questions will be collated and asked at the relevant item on the agenda at the discretion of the Chair.
3. Questions can also be asked during the meeting by members of the public relating to an agenda item by those present or watching live at the discretion of the Chair.

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Chair: Will Pope (interim Chair)

Item	Time	Agenda Item	Lead
Introductory Items			
1.	1.30	Welcome and introductions - apologies for absence	Chair
2.		Questions Notification of any questions from members of the public on agenda items for response at the appropriate time on the agenda.	Chair
3.		Minutes from previous meeting and matters arising To approve the part 1 public minutes of the previous public Board meeting on 26 March 2025.	Chair
4.		Declarations of interest To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
5.		Chair's Action Log To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Actions to report at this meeting.	Chair
6.		Action log – things we have said we will do To make sure the ICB completes all the actions it agrees are needed. There are no Actions to report at this meeting.	Chair
7.	1.35	Chair and Chief Executive's Report - Verbal To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Ed Garratt
8.	1.45	ICB Transition Summary of what we know so far on the transition of ICBs both nationally and locally.	Ed Garratt Karen Barker

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Item	Time	Agenda Item	Lead
Learning from People, Staff, and Communities			
9.	2.00	Prevention and screening This month's lived experience item draws on the experiences of staff and service users on the impacts of prevention and screening in Norfolk and Waveney. This item will be a presentation.	Tricia D'Orsi
Strategy and Partnerships			
10.	2.20	Report from the Quality and Safety Committee	Cathy Armor
11.	2.25	Intensive and Assertive Outreach Review Presentation	Josy Pike Martin Keegan
2.40 Comfort Break 10 Minutes			
Commissioning, Delivery and Performance			
12.	2.50	Financial Report for Month 12 2024/25 To receive a summary of the financial position as at month 12 2024/25.	Steven Course
13.	3.00	Report from the Finance Committee	Hein Van Den Wildenberg
14.	3.10	Integrated Performance Report (IPR) To provide assurance to the ICB Board and highlight significant elements of the system performance reporting.	Matt Dooley
15.	3.20	Report from the Commissioning and Performance Committee	Hein Van Den Wildenberg
16.	3.30	Primary Care Recovery Plan Report To update on progress of the system capacity and access recovery plan in response to the Delivery Plan for Recovering Access to Primary Care.	Mark Burgis
17.	3.40	Report from Primary Care Commissioning Committee	Ian Wake/Hein Van Den Wildenberg
System Oversight			
18.	3.50	Board Assurance Framework A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker

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Item	Time	Agenda Item	Lead
19.	4.00	Report from the Audit and Risk Committee Verbal As the meeting date of 8 May will not allow time for preparation of a full written report, the report will be received at the 17 July 2025 public Board meeting.	David Holt
Remaining Committees Reports and Questions from the public			
20.		Report from Patients and Communities Committee There is no update from the Committee as there has not been a meeting since the previous Board	Cathy Armor
21.	4.10	Report from the Remuneration, People and Culture Committee - verbal	Cathy Armor
22.	4.15	Amendment to the ICB Constitution	Karen Barker
23.	4.20	Questions from the Public. Where questions in advance relate to items on the agenda.	Chair
23.	4.30	Any other business	Chair
Date, time, and venue of next meeting: 16 July 2025 venue tbc			
Any queries or items for the next agenda please contact: nwicb.corporateaffairs@nhs.net			

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Some explanations of terms used in this Agenda.

Please see further terms defined on our website www.improvinglivesnw.org.uk

Integrated Care System (ICS) - Partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care.

Clinical Commissioning Group (CCG) – NHS bodies that were replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities, and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill and/or accessing care.

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Protocol for submitting questions to the ICB Board

The Board of NHS Norfolk and Waveney holds its meeting in public, which members of the public are welcome to attend and observe.

Questions for the Board relating to agenda items must be submitted in advance by 12 noon, three working days before the meeting.

Questions must only relate to matters within the powers and functions of the Board.

Questions shall not be responded to if the Board Chair deems that the question:

- relates to quasi-judicial matters e.g. (current or potential legal proceedings or consultations)
- relates to confidential or exempt matter
- is not about a matter for which the Board has responsibility
- is defamatory, frivolous, factually incorrect or offensive
- is substantially the same as a question put to a meeting of the Board in the previous six months, however the individual will be directed to the associated response that the Board has published on the ICB website
- is directly about party political matters
- is formed to make a statement rather than to receive information.

Questions relating to agenda items will be addressed alongside the agenda item to which they relate at the Board meeting. These will be read out at the meeting alongside the name of the questioner, where this has been provided. Where multiple questions have been submitted by different individuals or organisations regarding the same subject, key themes will be presented to the meeting with the names of all questioners read out.

A response will also be provided in writing (within 20 working days following the date of the meeting), and a copy of the response will be sent to all members of the Board and published on the ICB website.

Where questions are received that do not relate to agenda items then these will not be read out at the Board meeting but a response will be provided in writing (within 20 working days following the date of the meeting), and a copy of the response will be sent to all members of the Board and published on the ICB website.

If you would like to raise a question with regards to an agenda item this needs to be submitted in writing to the nwicb.contactus@nhs.net no later than three working days/the Friday prior to the meeting.

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NHS Norfolk and Waveney Integrated Care Board
DRAFT Minutes of the meeting on Wednesday, 26 March 2025

PART 1 – Meeting in public

Board members present:

- Hein Van Den Wildenberg (HvdW), Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB (Chair)
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SC), Executive Director of Finance, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney ICB
- Patricia D’Orsi (PD’O), Executive Director of Nursing, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- Stuart Keeble (SK), Local Authority Partner Member
- Ian Wake (IW), Local Authority Partner Member
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Dr Faisal Sethi (FSe), Partner Member – NHS Trusts (Community & Mental Health)
- Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member
- Cllr Fran Whymark (FW), Integrated Care Partnership Member

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director of Performance, Transformation and Strategy, and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney ICB
- Ian Riley, Executive Director of Digital, NHS Norfolk and Waveney ICB
- Stuart Lines (SL), Director of Public Health, Norfolk County Council
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk
- Andy Yacoub (AY), Chief Executive, Healthwatch Suffolk

Attending to support the meeting:

- Belle Ward (BW), Executive Assistant, NHS Norfolk and Waveney ICB (Minutes)

1.	Welcome and introductions - apologies for absence	
	<p>The Chair welcomed everyone to the meeting.</p> <p>Apologies were received from the following Board members:</p> <ul style="list-style-type: none"> • Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services • Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB 	

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	<p>The Chair welcomed Councillor Fran Whymark to the Board.</p> <p>The Chair acknowledged the significant announcement about the reduction in ICB running costs. He noted this was most unsettling news for staff given a restructuring process had only recently concluded. On behalf of the Board, the Chair thanked staff for their hard work and impact they have on the residents of Norfolk and Waveney. The Board is committed to supporting all staff during this period of profound change and to being open and transparent throughout.</p> <p>The Chair noted the resignation of The Right Honourable Dame Patricia Hewitt who had been instrumental in her role as Chair of the Board, bringing significant influence in many changes and improvements in Norfolk and Waveney, which will continue to be built upon. He noted she worked tirelessly on building close working relationships with a wide range of stakeholders.</p> <p>Congratulations was made to Mark Friend, current Chair of James Paget University Hospital who has been appointed as Chair of the newly formed Norfolk and Waveney Hospitals Group.</p>	
2.	Questions	
	No questions were received in advance from members of the public.	
3.	Minutes from previous meeting and matters arising	
	<p>Agreed: The draft minutes from the meeting held on 29 January 2025 were approved as an accurate record of the meeting.</p>	
4.	Declarations of interest	
	The Chair noted that declarations of interest were kept up-to-date and were available on the ICS's website.	
5.	Chair's action log	
	The Chair noted there were no Chair's actions to report.	
6.	Action log	
	<p>The Chair reviewed all open actions with the Board.</p> <p>Action 39 – MB confirmed the ICB dental team had undertaken a lot of work but that it was difficult to quantify. There is good data for urgent demand and highlights a gap of approximately 800 appointments. MB reported there were plans in place to meet this and suggested an update is given at the next Primary Care Commissioning Committee. Action closed.</p> <p>Action 40 – TB confirmed a productive meeting took place with Sara Tough and has involved PD'O and Matthew Win, Chief Executive of Norfolk Community Health and Care Trust. She noted she was pleased with the momentum and will bring back an update at a future Board meeting. Action closed.</p>	

	<p>Item 41 – Action remains open.</p> <p>Item 42 – EDI report including WRES data was included on the meeting agenda. Action closed.</p>	
7.	Chair and Chief Executive’s Report	
	<p>TB introduced the item by highlighting key points from the report.</p> <p>TB noted her personal thank you to the Right Honourable Dame Patricia Hewitt for all of her invaluable support.</p> <p>Regarding the announcement about significant changes to NHS funding and NHS England, TB noted details are awaited for how this will be implemented and the timescale. Staff are being engaged with, with a series of engagement events planned for the first two weeks in April. Further information will be shared with the Board in due course.</p> <p>TB reported planning for 2025/26 is running at pace, and it is clear that it will be a challenging year. A balanced budget for 2023/24 has been submitted.</p> <p>TB reported positive news including the new Community Diagnostic Centre and Willow Therapy Unit. Norfolk and Suffolk NHS Foundation Trust have come out of special measures, this has been a hard journey and TB acknowledged all of the efforts of staff, service users, their families and wider partners.</p> <p>TB noted the three Acute hospital trusts have now published the full case for establishing a group model.</p> <p>The report was noted.</p>	
Learning from People, Staff, and Communities		
8.	The Voice of Youth	
	<p>PD’O introduced the item by thanking Healthwatch Norfolk for preparing this month’s lived experience, drawing on the experiences and voices of our youth growing up in Norfolk and Waveney.</p> <p>PD’O noted that focus was usually heavily on our aging geography and sometimes we miss the benefits of enabling our youth and preventing deterioration throughout one’s lifespan.</p> <p>Questions and comments from Board members:</p> <ul style="list-style-type: none"> • FS reflected on the benefits to young people and the improvement in confidence. • FS commented that we have a duty to those young people by borrowing their ideas and energy and suggested that we should be actively supporting them with interview skills or training. 	

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	<ul style="list-style-type: none"> • PD'O noted there is an academy at the James Paget University Hospital and would take this forward as an action. Additionally, PD'O endorsed the idea of having a young person on interview panels, and that we should embrace this in the ICB going forward. • FW agreed that having a young person on interview panels was very important and this was now normal, good practice in social care. <p>PD'O to explore opportunities to support younger people into health and social care, such as training and interview skills. The Chair thanked PD'O and Healthwatch Norfolk for bringing this topic to the Boards attention, noting the lived experience items were always a highlight.</p> <p>Agreed: The ICB Board noted the report.</p>	
<p>9.</p>	<p>Report from Patients and Communities Committee</p>	
	<p>CA introduced the item, highlighting key points from the report.</p> <p>CA noted that the risks aligned to this Committee had not changed but they felt there should be an additional control around health inequalities and the impact of the systems financial system.</p> <p>Regarding waiting times, the number of patients waiting over 78 weeks or more had reduced considerably over the past year. Those waiting more than 65 weeks had been reducing but the rate of dissent had slowed because of industrial action.</p> <p>CA reported Norwich Place gave a presentation. 39% of the Norwich population lives in deprived areas, meaning that 55,500 residents are at the greatest risk of the poorest outcomes. There is also a 10.4-year gap in life expectancy across the city. Reducing and tackling health inequalities will be one of the top priorities for Norwich Place to tackle.</p> <p>CA spoke about VCSE risks, some of which are related to several VCSE contacts ending at the end of March.</p> <p>There were no items requiring approval.</p> <p>Agreed: The ICB Board noted the report.</p>	
<p>Strategy and Partnerships</p>		
<p>10.</p>	<p>Report from the Quality and Safety Committee</p>	
<p>Davey, J 19/05/2025 17:38:22</p>	<p>CA introduced the item, highlighting key points from the report. The Committee focused much of their attention on the Children and Young People Neurodevelopmental Service.</p> <p>Questions and comments from Board members:</p>	

	<ul style="list-style-type: none"> • DH reflected on the financial situation and subsequent pressures and whether the Quality and Safety Committee will change the weighting on the agenda for greater oversight given there will be really difficult decisions to be made and how can we share the burden across the Board. • PD'O explained that from the inception as an ICB in 2022, we took the approach to have a quality strategy across the whole system, involving all partners. There is a collective across all organisations with an agreed suite of metrics, which are our best indicators for quality. On a monthly basis, these metrics are revisited. • PD'O confirmed that continual changes are monitored both positive and negative and provides opportunity to escalate concerns. This sits alongside the agreed algorithm agreed by the Board. Therefore, all areas are under watchful eye to ensure no deterioration. <p>Agreed: The ICB Board noted the report and formally approved the ICB Integrated Performance Management Framework.</p>	
<p>11.</p>	<p>ICB Board Health Inequalities Maturity Assessment</p>	
	<p>MB introduced the item, highlighting key points from four reports which the ICB has a legal duty to report on. These included:</p> <ul style="list-style-type: none"> • Equality Delivery System – EDS2 • Gender Pay Gap report • Workforce Race Equality Standard Report (WRES) • Workforce Disability Equality Standard Report (WDES) <p>MB sought support from the Board on the following recommendations:</p> <ul style="list-style-type: none"> • Note and agree the prepared reports for publication. • Agree and endorse the ICB Organisational Health Inequalities Improvement Plan, noting actions for Board members and leadership. • Agree oversight for future reporting to be provided by Patient & Communities Committee. • Consider non-exec Director oversight/nominated sponsorship for the implementation of the programme, particularly given national policy shifts and proposed organisational change. <p>MB noted the ICB Organisational Health Inequalities Improvement Plan 2025-2027 shows progress made and identifies areas for improvement. A number of workshops have been held across the ICB and over seventy senior members attended.</p> <p>Questions and comments from the Board:</p> <ul style="list-style-type: none"> • CA requested the gender pay gap report is received at the Remco Committee to review the actions. • ER noted the work gone into the improvement plan was brilliant and highlights how embedded the VCSE is in the ICS. 	

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	<ul style="list-style-type: none"> ER acknowledged that whilst the impact of cost savings is going to be complex, made a plea that there is an appropriate plan for the VCSE team should back-office support diminish. AP noted it was positive to see timeframes on the WRES and WDES set at a more ambitious target. Focus needs to be remain on training for staff, this is essential from both a professional and personal point of view. SK recognised the huge amount of work gone into this. He noted the Health in Action plan looks suitable and broad. Despite the challenging period we're entering, that thought needs to be given to actual measures and outcomes, linking to the quality system indicators. MB confirmed many measures and outcomes tend to be longer term, but this can be refined and detail brought back to Board. MB acknowledged ER comments about dedicated resource. Tackling health inequalities is everyone's business but resource has helped push the agenda. DH noted priority must be given to bringing up the standard for everyone. Plea made for granularity so we're not just taking an average. FS reassured that there is a huge amount of data, with metrics and some fantastic health inequalities dashboards. This work is being led by the Population Health Board, and they are refining the key metrics; data is not the issue, but how we use and refine it is. <p>Agreed: The ICB Board noted the report and agreed to the four recommendations as set out in the report.</p>	
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Commissioning, Delivery and Performance

12.	Financial Report for Month 10	
	<p>SC introduced the item by highlighting key points from the report.</p> <p>SC reported the Month-10 year-to-date position of the ICB as an on-plan position of £0.322million surplus, but includes offsetting variances and other forecast assumptions, the major items being:</p> <ul style="list-style-type: none"> - The recovery plan identified by finance during the Investigation and Intervention process, whereby the assumed unidentified efficiency delivery (£8.1million) is removed from the forecast and replaced by non-recurrent measures. The non-recurrent measures identified were the increased delivery of the Elective Recovery Fund and the headroom within the Delegated Acute Specialised Commissioning budget. SC noted whilst this will reduce the financial risk in-year, it will not improve the underlying deficit or the financial plan for 2025/26. - £0.7million of slippage on identified efficiency delivery within the Prescribing and Better Care Fund portfolios. - £4.0million of non-recurrent mitigations arising from prior year benefits, slowing of project expenditure and withholding of allocations. 	

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	<p>The 2024/25 financial plan included £51.3million of unmitigated risks related to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding and corporate pay costs for the re-organisation.</p> <p>SC reported total net risks, including new risks in addition to planning risks total £2.7million. This is a reduction of £2.3million from last month.</p> <p>The underlying deficit is £122.4million, a deterioration against the planned deficit of £101.8m.</p> <p>SC reported from an ICS perspective, the position for Month-10 year-to-date is a £49.7million deficit, which is £44.6m adverse against plan.</p> <p>SC noted the majority of the deficit is from the acute provider sector.</p> <p>The ICS efficiency plan Month-10 year-to-date against plan is an adverse variance to plan of £27.0million. Full year efficiency programme is forecast at £148.7million, £30.2million adverse to plan.</p> <p>SC reported from a capital perspective we have hit the plan but for month-10 there is a minor overspend of £400,000.</p> <p>Questions and comments from the Board:</p> <ul style="list-style-type: none"> • The Chair referred to month-end forecast deficit position, which sits largely with the acutes and asked if there were driving factors for this in all three acute providers or if there was a nuance driving this. • SC confirmed that the main driving factor of the deficit was not achieving efficiencies. Factors including lost income from industrial action, pay award pressures and operational pressures over winter are impacting some, but not all. There was also some stretch built in from the start which hasn't been achieved. • AP asked if there was a reason behind the £30million gap which is basically the same as the recurrent savings gap. Was this because schemes thought to be recurrent are not or was it a timing and delivery issue? • SC confirmed there were some high-risk areas in the efficiency plans which haven't come to fruition and for some it's pace, where they have started but had not delivered the anticipated full year value. <p>Agreed: The ICB Board noted the report.</p>	
13.	Phase One report NHS England	
	<p>SC introduced the item by highlighting key points from the report.</p> <p>SC explained a 'Investigation and Intervention' programme was developed earlier in the financial year by NHS England and the national team which</p>	

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the Norfolk and Waveney system were put into due to being behind on our financial plan.

This was not formally special measures, but was designed to help the system get back on plan and deliver our finances. The programme consists of two phases and this report is for phase one, which covers:

- System grip and control
- Workforce
- Project management office and governance
- 2024/2025 plan and Cost Improvement Programmes (CIPs)
- Financial opportunities that come from this.

SC explained Deloitte's had been instructed to deliver this work using a procurement framework.

SC highlighted pertinent points from the report:

- Backloaded CIPs, put into the second half of the financial year, had introduced a level of risk.
- Level of non-recurrent reliance is significant.
- Tactical measures rather than real structural changes to the way we might deliver services in a more efficient and productive way.
- Level of unidentified efficiency – introduced risk and is why we are behind on our programme.
- Grip and control – recognition of the positive work the system has around vacancy control.
- Positive reduction in temporarily nursing spend at the Queen Elizabeth Hospital.

SC summarised that overall, this exercise had helped allow us to review and better align grip and control measures across the system, to drive greater consistency.

Questions and comments from the Board:

- DH asked how confident we can be that phase two will identify real actions, that will fill the huge risk gap and will undoubtedly be within the plans that we submit for the coming financial year.
- TB commented that the point of getting external help in, to review our processes was to identify how effective they were, what we have missed structurally and what we need to do differently. She added that to a certain degree, it was reassuring that we do have grip and control in certain areas.
- TB noted that when focusing on productivity, some of the areas had already been identified. So, we must be careful not to double count with some of the productivity packs received centrally from NHS England.
- TB added that whilst much of this is data driven, we essentially need to close the underlying deficit by clinical and pathway transformation,

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	<p>working with our residents to live within our financial means, noting this is our responsibility.</p> <ul style="list-style-type: none"> • SC spoke about a useful session with Deloitte across the East of England based on their experience of the Investigation and Intervention work. A key theme is that it will be transformation that delivers along with relentless hard work. • The Chair thanked SC for the helpful report. <p>Agreed: The ICB Board noted the report.</p>	
<p>14.</p>	<p>Report from the Finance Committee</p>	
	<p>The Chair introduced the item, highlighting that since September the Committee has been flagging the limited assurance, they could provide on meeting the financial plan at system level, but that in the recent reports they were able to provide reasonable assurance of meeting the financial plan for the ICB.</p> <p>Agreed: The ICB Board noted the report.</p>	
<p>15.</p>	<p>Integrated Performance Report (IPR)</p>	
	<p>AP introduced the item on behalf of MD, highlighting key points from the report, asking the Board to note:</p> <ul style="list-style-type: none"> • Performance against the diagnostic standard observed a common cause decline (worsening position). • While the number of people waiting 65 or more weeks for elective care has not yet met the national standard, there is a continued trend of special cause improvement. • Cancer has observed improvements with the 28-day Faster Diagnosis Standards (FDS) showing special cause improvement. • Inappropriate Out of Area Placements (adult mental health) achieved target of zero. • Dementia Diagnosis remains in special cause improvement though a further dip against plan was observed in January. • The numbers of people with Learning Disability or Autism in inpatient admission remains high against plan. • Urgent and Emergency Care performance remains below standards, noting data flow issues with 4-hour A&E reporting and a common cause improvement in Cat. 2 Ambulance response times. • Financial position against plan remains a significant risk. • Reporting against the implementation of Women's health hub and Patient Safety Incident Response Framework (PSIRF) have been removed as both have been implemented. <p>Questions and comments from Board members:</p> <ul style="list-style-type: none"> • The Chair extended his thanks for bringing some recent statistics on UEC, observing an encouraging trend. 	

Davey Heidi
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	<ul style="list-style-type: none"> The Chair gave his compliments for the performance narrative, noting it an excellent document and thanked the team. <p>Agreed: The ICB Board noted the report.</p>	
16.	Performance Management Framework approval	
	<p>AP introduced the item, explaining the performance management framework was a combined strategy and a plan. The framework describes how the organisation will set goals and targets, monitor progress and will respond to substandard performance of metrics.</p> <p>AP noted good progress and improved oversight across performance and quality metrics, compared to what we have had before.</p> <p>AP extended his thanks to Diane Smith and the ICB Digital Team for the huge amount of work they've put into this.</p> <p>AP noted this had been reviewed at length through the Commissioning and Performance Committee, the Primary Care Committee and the Quality and Safety Committee.</p> <p>Questions and comments from the Board:</p> <ul style="list-style-type: none"> The Chair noted this was an excellent piece of work. The Chair commented that this will be reviewed in the future to check how it is working in practise but was very happy to see it, and happy to ratify the document. <p>Agreed: The ICB Board confirmed support and ratified the framework for formal implementation by Norfolk and Waveney ICB from March 2025.</p>	
17.	The Joint Forward Plan Refresh 2025/26 – 2029/30	
	<p>AP introduced this item, highlighting key points.</p> <p>AP extended his thanks to Liz Joyce and the team, as well as all the provider partners for the huge amount of work they've done, but also to the ICB directorate teams and Place teams for really informing the metrics and making detailed improvements.</p> <p>AP explained that it was a statutory requirement to have a Joint Forward Plan and is effectively our delivery plan – what we are going to do in response to the needs of our population.</p> <p>AP explained there are two parts to the report for approval today. Part one, sets out our priorities and what has been updated through our partners and programme boards. Part two reflects our legal duties and the actions the ICB and system needs to take in order to comply.</p>	

	<p>Agreed: The ICB Board approved the refresh of the Joint Forward Plan, subject to some minor edits.</p>	
18.	<p>Report from the Commissioning and Performance Committee</p> <p>The Chair introduced the item by highlighting key points from the report, noting the contents referred to the meeting held on 20 February.</p> <p>The Chair advised the Committee had met more recently and concerns were raised around the paediatric audiology service at the Queen Elizabeth Hospital. The ICB is working closely with the trust to ensure patients receive the right care with support from the Norfolk and Norwich University Hospital, as well as regional colleagues.</p> <p>Noted there is a very big efficiency stroke saving ask, with associated service delivery risks.</p> <p>The Chair advised they had approved the patient choice policy after extensive external engagement, this policy outlines the legislative rights of patients in Norfolk and Waveney.</p> <p>Agreed: The ICB Board noted the report.</p>	
19.	<p>Primary Care Commissioning Committee</p> <p>The Chair introduced the item, highlighting key points from the report including a deep dive review of the resilience of Community Pharmacy risk, financial viability and workforce concerns.</p> <p>The Chair also referred to a strategic digital report, explaining cloud-based telephony is now available in 86 GP practices and nearly 60 percent of eligible patients have the NHS app.</p> <p>They also noted the primary care workforce recruitment and retention programme report, which provided good detail on a wide range of initiatives – the Chair commented they were duly impressed with the breadth and success of the work programme.</p> <p>Agreed: The ICB Board noted the report.</p>	
System oversight		
20.	<p>Governance Handbook updates</p> <p>KB introduced the item, explaining that the proposed amendments mainly related to changes in guidance from the national team.</p> <p>Agreed: The ICB Board noted and approved the amendments to the ICB Governance Handbook as detailed in the report.</p>	
21.	<p>Board Assurance Framework</p>	

	<p>KB introduced the item, noting the Board Assurance Framework sets out strategic risks and they had been reviewed in line with the process.</p> <p>Questions and comments from Board members:</p> <ul style="list-style-type: none"> • DH noted the Audit and Risk Committee will be acting as a coordinator, maintaining a forward plan for Committee deep-dives and will provide the Board with assurance going forward. • The Chair suggested there should be recognition of the significant running cost reductions in the next version. • AP noted that risk profiles will be monitored more closely than ever and that mapping across the Committees was important. Recommendation made to adjust the format of this report to make it easier to follow. • PD'O welcomed the work KB and her team lead on. Suggestion made to summarise areas which require additional attention at the end of each Board meeting, the Board needs to be live to increasing risk. <p>Agreed: The ICB Board noted the report.</p>	
<p>22.</p>	<p>Report from the Audit and Risk Committee</p>	
	<p>DH highlighted the key message taken away from the Audit and Risk Committee, which was that there are a web of systems and system interdependencies.</p> <p>The importance of common standards and risk appetite around cyber security was discussed.</p> <p>Agreed: The ICB Board noted the report.</p>	
<p>Remaining Committees Reports and Questions from the public</p>		
<p>23.</p>	<p>Report from the Remuneration, People and Culture Committee</p>	
	<p>CA reported that the committee had not met, so there was nothing to report to the Board.</p>	
<p>24.</p>	<p>Questions from the Public</p>	
	<p>There were no questions from the public.</p>	
<p>25.</p>	<p>Any other business</p>	
	<p>No other business was raised.</p>	
<p>Date, time, and venue of next meeting:</p> <p>13:30 – 16:30, Wednesday 21 May 2025 Council Chamber, Great Yarmouth Borough Council</p>		
<p>Any queries or items for the next agenda please contact: nwicb.corporateaffairs@nhs.net</p>		

Minutes agreed as accurate record of meeting:

Signed:
Chair

Date:

DRAFT

Davey, Heidi
19/05/2025 17:38:22

**NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests**

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Educational Association			X		Trustee, Workers Educational Association	Dec-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Council, Norwich University of the Arts			X		Chair of Council, Norwich University of the Arts	2024		
		Evolution Academy Trust			X		Trustee, Evolution Academy Trust	2022		
		Cambridge University Press Pension Schemes		X			Trustee, Cambridge University Press Pension Schemes	2018		
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust			
Jon Barber	Partner Member	Broadland St Benedicts			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group. No direct interest although conflicts of interest noted if necessary		Present	Although risks are minimal this will always be declared as with Trust Board declaration of interests
		James Paget University Hospitals NHS FT	X	X	X	Direct	Director of Acute Trust – commissioning decisions could impact my employer.		Present	Decisions impacting the allocation of resources etc to providers would require me to declare an interest not vote on the decision
		Great Yarmouth & Waveney		X		Direct	Place Chair – Gt Yarmouth & Waveney Place Board. No direct interest although conflicts of interest noted if necessary.		Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Acle Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	interest.
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Ltd			X	Indirect	Wife is an employee of a physiotherapy business	Sep-15	Present	Ensure not involved in any decision making that may involve the company
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			X	indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	To date	Will withdraw from any discussions and decision that might directly involve the department or discipline that relates to the declared conflict.
		Norfolk Deaf Association	X			direct	I am the Chief Executive Officer of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB	2010	To date	Not involved in any discussions and decisions that might benefit Hear for Norfolk
		Derrett Consultancy Ltd	X			indirect	I am the Director of Derrett Consultancy Ltd	2018	To date	Low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		Norfolk & Waveney MIND	X			indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	To date	Not involved in any discussions and decisions that might benefit N&W Mind
		Lakers Games Ltd	X			indirect	I am the Director of Lakers Games Ltd	Nov-24	To date	Very low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		St Stephens Gate Medical Practice				X		Patient at a Norfolk and Waveney GP Practice	Ongoing	
Dr Faisal Sethi	Partner Member - Mental Health and Community	Norfolk and Suffolk NHS Foundation Trust		X		Direct	Chief Medical Officer and Deputy Chief Executive Officer, Norfolk and Suffolk NHS FT	Sept 2024	Present	
		Faculty of Health and Social Sciences, Bournemouth University, Poole			X	Direct	Visiting Professor, Faculty of Health and Social Sciences, Bournemouth University, Poole	Sep-21	Present	
		Arts & Mental Health Charity, Hospital Rooms, London			X	Direct	Trustee & Board Member, Arts & Mental Health Charity, Hospital Rooms, London	Feb-19	Present	
		Lensfield Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal college of Nursing			X	Indirect	Professional Body - RCN Union			

**NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Ed Garratt	Intrim Chief Executive	University of Suffolk			X	Direct	Visiting Professor	Apr-21	Present	To be declared as appropriate
		Deputy Lieutenant for Suffolk			X	Direct	Deputy Lieutenant for Suffolk	Sep-23	Present	To be declared as appropriate
		NHS Suffolk & North East Essex ICB		X		Direct	Chief Executive	May-25		To be declared as appropriate
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Ministry of Defence	X			Direct	NED Audit & Risk Assurance Committee	2022	Present	
		Newberry Clinic				Indirect	Wife a Consultant Community Paediatrician	2023	Jul-24	
		Sole Bay Health Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Stuart Keeble	Director of Public Health and Communities for Suffolk and member elect of Norfolk and Waveney ICB	Director of Public Health Suffolk County Council		X			Commissions and funds services		Present	Remove himself from relevant conversations at N&W
Andrew Palmer	Deputy Chief Executive Officer, Norfolk and Waveney ICB	Beccles Medical Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		James Paget University Hospital		X			My wife works at the JPUH, in a non-decision making role		Present	Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the decision will be taken in the best interests of the system with the necessary due-diligence taking place prior to final decision being made.
William Pope	Interim Chair	Chair of NHS Suffolk & North East Essex Integrated Care Board		X	X	Direct	Chair of the Integrated Care Board	2022	Present	Both Boards have appropriate governance management processes and systems

**NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests**

Declared interests of the Board

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Co-Chair of the Suffolk & North East Essex Integrated Care Partnership			X	Direct	Co-Chair of the Integrated Care Partnership	2022	Present	Both Boards have appropriate governance management processes and systems
Emma Ratzer	Partner Member - VCSE	Norfolk & Waveney Integrated Care Board	X			Direct	My employing organisation holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Long Stratton medical partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Norwich University Hospital			X	Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Multiple patient charities			X	Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		British Medical Association			X	Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Better Help, and VCSE provider: St Martin's Housing Trust	X				Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE provider: St Martin's Housing Trust	2022	Present

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**NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests**

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Ian Wake	Executive Director of Adult Social Services	Norfolk County Council		X		Direct	Executive Director of Adult Social Services, Norfolk County Council	14/10/2025	Present	
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHL and borough council)	2021	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Broadland Housing Association	X			Direct	Non-Executive Director and Board member for Broadland Housing Association	2024	Present	Will excuse myself from any decisions relating to Broadland Housing Association
Fran Whymark	Partner Member Integrated Care Partnership	Norfolk County Councillor and Cabinet Member for Public Health and Wellbeing.			X	Direct	Chair of; Norfolk Health and Wellbeing Board and Integrated Care Partnership	05/03/2025	Present	
		Broadland District Councillor			X	Indirect	Leader of Conservative Group	13/05/2023	Present	
		Rackheath Community Councillor			X	Indirect	Community Councillor	May-15	Present	
		Fairhaven Woodland and Water Garden			X	Indirect	Member	20/03/2021	Present	
		National Trust			X	Indirect	Member	28/07/2018	Present	
		Ramblers Association			X	Indirect	Member	31/05/2022	Present	
		Hoveton & Wroxham Men's Shed			X	Indirect	Treasurer	Nov-20	Present	
		Educational Foundation of Alderman John Norman			X	Indirect	Trustee	Jun-07	Present	
		Leeds Educational Charity Bawdeswell and Foxley			X	Indirect	Chairman and Trustee	Jun-15	Present	
Thorpewood Medical Group,			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared		

Davey Heidi
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Agenda item: 08

Subject:	ICB transition
Presented by:	Karen Barker, Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
Prepared by:	Chris Williams, Head of Communications and Engagement, NHS Norfolk and Waveney ICB
Submitted to:	Integrated Care Board - Board Meeting
Date:	21 May 2025

Purpose of paper:

To update members of the Board on the national changes to the role, functions and budgets of Integrated Care Boards, and the work being done locally in response.

Executive Summary:

In March, significant changes were announced to how the NHS in England is organised, including the role, functions and budgets of integrated care boards (ICBs). Subsequently, documents produced by NHS England have provided further details about the changes, and discussions between the six ICBs in the East of England have helped to shape the local response.

ICBs are now required to create plans that are affordable within the reduced running cost envelope – for sign off by the end of May – with implementation during Quarter 3 (between October to December). This work is underway and will be managed by a Transition Committee.

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Report

A. Background

In March, significant changes were announced to how the NHS in England is organised, including the role, functions and budgets of integrated care boards (ICBs). Sir James Mackey, Chief Executive of NHS England, has been clear that ICBs will have a critical role to play in the future as strategic commissioners and that this role will be central to realising the ambitions that will be set out in the 10 Year Health Plan.

NHS England has asked all Integrated Care Boards (ICBs) to reduce their running costs by approximately 50%, so that they operate on a budget of £18.76 for each member of the population they serve. This is a significant ask, and as a result, ICBs across the East of England have been asked to look at how we are structured and how we can continue to deliver our core responsibilities with fewer resources.

Initial analysis has looked at each ICB individually, considering factors such as population size, number - and boundaries of - local authority partners, where GP practices and hospitals are located, and costs for different options. This work has also included local considerations, such as ways of working between local authorities, the desire to avoid significant variations in the population size covered by an ICB, and locations of specialised services. We also expect that some teams or services may work across ICB boundaries in future, as part of shared regional arrangements.

Regional Design principles

To enable effective change that successfully addresses national challenges, we need to ensure all ICBs can operate effectively within any new configuration. The regional design principles for a sustainable and effective system are that:

1. Each local authority only works with one ICB
2. Each ICB includes more than one acute Trust
3. Each ICB can work effectively on neighbourhood transformation
4. Each ICB covers at least one million lives
5. ICBs can be financially sustainable individually and collectively across the region
6. Each ICB can operate with reduced running costs.

B. Early thinking

In line with the design principles, all potential models are being considered. At this stage, there is consensus around a number of potential models for further exploration and consideration, including:

Potential Model A

- Norfolk, Suffolk, Cambridgeshire & Peterborough (C&P)
- Greater Essex
- Hertfordshire, Bedfordshire, Luton & Milton Keynes (BLMK)

Potential Model B

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- Norfolk & Suffolk
- BLMK & C&P
- Greater Essex & Hertfordshire

Potential Model C

- Norfolk & Suffolk
- BLMK, C&P & Hertfordshire
- Greater Essex.

These are conceptual models that have needed further development, and no decisions on preferred models have yet been made.

C. Clustering and merging of ICBs

To support and inform the discussions that are taking place between ICBs across the country, NHS England has produced some frequently asked questions about clustering and merging of ICBs. With ICBs expected to realise running costs savings in quarter three of 2025/26, the document is clear that ICBs should be planning to cluster as soon as possible.

Clustering of ICBs

Clustering ICBs means:

- Making joint senior appointments, including chairs and chief executives and possibly non-executives – i.e. the individual is appointed by and has authority from each of the relevant ICBs (executives jointly appointed will have an employment contract with each of the ICBs).
- Forming combined teams, where relevant, whereby employees of different ICBs work together under shared management.
- Establishing joint committees between the ICBs and delegating authority to them, so as to minimise duplication in governance. We may also look to form committees in common when clustering.

The ICBs remain separate legal entities, having to ensure they each individually fulfil their statutory functions and manage their financial position.

Merging of ICBs

It is expected that rather than retaining one of the legacy ICBs, it will be preferable to take the following approach:

- NHS England abolishes the ICBs and establishes the new successor ICB (this would need to happen with effect from 1 April of the relevant year)
- Staff assets and liabilities transfer to the new ICB (via transfer scheme made by NHS England)
- A new ICB board is appointed
- The ICB and its partner local authorities form a new ICP
- The legacy ICBs are closed down.

Six months is needed before 'go live' to implement technical transition (for example of digital and data and finance), so a final decision to proceed must be taken by 30th

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September 2025 or 2026 depending on whether a merger would be on 1 April 2026 or 2027.

D. The 'Model ICB Blueprint'

On 2 May, NHS England shared its 'Model ICB Blueprint'. The document sets out the initial thinking on the core activities that an ICB should be responsible for, and the functional changes that could happen over time.

The blueprint will support ICBs to create locally driven indicative plans by the end of May 2025, ensuring these are affordable within the reduced running cost envelope and implemented by the end of Q3 2025/26. Reducing costs of ICBs by 50% is a considerable challenge, but one we must meet to unlock the full potential of ICBs and position them effectively for the future, particularly recognising the critical role they will play in the delivery of the forthcoming 10 Year Health Plan.

Delivering these core priorities will require a leaner and simpler way of working, where every part of the NHS is clear on their purpose, what they are accountable for, and to whom. The Model ICB Blueprint identifies a number of functional changes that ICBs will have to manage and indicates the responsibilities they may look to grow, adapt or potentially transfer. It will be for regional and system teams to work together to determine their future form.

The document explains that as ICBs focus on system leadership for population health, they will need to develop capabilities that support better understanding of population needs and pathway design, and that enable efficient resource allocation aligned to long-term population health outcomes.

The Model ICB Blueprint has functional implications for different parts of the system and the next steps will need to be developed through close working with partners nationally and within local systems over the coming months.

The Blueprint shows that at the end of the transition, ICBs will continue to have a critical role to play as strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high-quality care for our patients.

E. Next steps

- Each ICB must now set out how it intends to achieve the £18.76 operating cost target in a planning template.
- These plans need to be submitted to NHS England by 30 May 2025.
- As set out in the blueprint we are establishing our Transition Committee. This is not a formal Committee of the Board but will oversee the process for the staff organisational change as well as the development of the joint working of the ICBs.

Throughout this, we will continue to keep the Board and staff informed, as well as partner organisations, and to support our workforce through what is a challenging and unsettling time for them.

Davey, Helen
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Recommendation to the Board:

To note the update.

Key Risks	
Clinical and Quality:	The proposed changes to ICBs will not result in any changes to services or the quality of care people receive.
Finance and Performance:	The work underway will ensure that ICBs can operate within the reduced running costs.
Impact Assessment (environmental and equalities):	As an employer, we will follow our change processes and policies to mitigate the impact on staff. The Model ICB Blueprint is clear that addressing health inequalities will be a priority for ICBs in the future.
Reputation:	N/A
Legal:	As an employer, we will follow our change processes and policies. We will need to ensure that we continue to deliver our legal duties and functions until such time that the duties and functions of ICBs are changed.
Information Governance:	N/A
Resource Required:	Resource is required to manage this period of change. This will mean asking some staff to adjust their workload and priorities to ensure we complete the work required by the national deadlines.
Reference document(s):	The Model ICB Blueprint.
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	This report has not been presented to any other committee.
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Davy Heidi
19/05/2025 17:38:22

Agenda item: 10

Subject:	Quality and Safety Committee Report
Presented by:	Cathy Armor, Quality and Safety Committee Deputy Chair
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board - Board Meeting
Date:	21 May 2025

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 26 March 2025 to 21 May 2025.

Committee:	Quality and Safety
Committee Chair:	Aliona Derrett (Deputy Chair Cathy Armor)
Meetings since the previous update:	03 April 2025, 14:00 – 17:00 (chaired by Deputy Chair) 01 May 2025, 14:00 – 17:00 (chaired by Deputy Chair)
Overall Objectives of the Committee:	
<p>To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of implementation of the ICS Quality Strategy and NHS National Patient Safety Strategy.</p> <p>To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.</p> <p>To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.</p> <p>To review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.</p> <p>To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality</p>	

improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.

<p>Main purpose of meeting:</p>	<p>03 April 2025</p> <ul style="list-style-type: none"> • Community Nursing Unallocated Visits Risk Deep Dive • ICB QIA & EHIA Panel Assurance Report • Right Care NoW (Discharge) Update • Infection Prevention & Control Update • NSFT Waiting Times Report • NSFT Mortality Action Plan Update <p>01 May 2025</p> <ul style="list-style-type: none"> • New ICB Guidance on Infectious Disease Outbreaks • CYP Neurodevelopmental Service Provision Update • Patient Safety and Complaints Report • Safeguarding Health Assurance Network (SHAN) <p>Committee Approvals for this period:</p> <ul style="list-style-type: none"> • ICB Local Resolution for NHS CHC Policy • ICB Adult Safeguarding Policy • ICS Community Wound Infection Pathway
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<p>BAF and any Board Operational risks relevant / aligned to this Committee:</p>	<p>Risk 011: Continuing Healthcare Risk remains at 16, reflecting the challenges in sourcing appropriate care due to care market capacity, particularly in relation to specialised care for people with complex needs. This creates risk in relation to quality and experience of care, as well as increased financial cost of sourcing care.</p> <p>Risk 012: EEAST Response Time and Patient Harms Risk remains at 20, reflecting the pressures in our urgent and emergency care system, with delays in handover of patients into hospital impacting on ambulance response times to calls in the community. This is a dynamic risk reflects ambulance response time trends.</p> <p>Risk 034: Surge Capacity to Support Acute Trusts Risk remains at 16, reflecting the seasonal pressures currently being experienced within the system and reflects the increased use of surge beds, which creates risk in relation to quality and experience of care. This is also a potential area of moral injury to staff.</p> <p>Risk 035: Community Nursing Unallocated Visits Risk remains at 16, reflecting the current challenges in demand and capacity, which creates risk in relation to the quality and experience of care as well as moral injury to staff and resilience across the wider community services. A deep dive is planned to return to Committee in the next</p>
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quarter, to understand the risk across the two local community healthcare providers and give additional assurance on mitigating actions.

Risk 038: CYP Mental Health Case Managers

Risk remains at 16, reflecting the challenges in meeting demand for case management allocation, which in turn creates risk in relation to quality and experience of care and the potential for poorer long-term outcomes. **A deep dive into all CYP Mental Health risks is planned to come to Committee in the next quarter.**

Risk 039: CYP Mental Health Waiting Lists

Risk remains at 16, reflecting the challenges in demand and capacity, which creates risk in relation to delayed treatment which impacts on the long-term outcomes for children and young people as they move into adulthood. This is also a potential area of moral injury to staff and resilience across the wider mental health pathways.

Risk 040: CYP Speech and Language Therapy

Risk remains at 16, reflecting the fact that NCC, as lead commissioner, are not currently assured of service delivery against some of the provider's key performance measures. This creates risk in relation to accessibility, quality and experience of care and outcomes for children and families.

Risk 042: Children's Mental Health Team Skill Mix

Risk remains at 16, reflecting the Trust's challenge in accessing available trained staff to deliver its services for babies, children, young people, and families, which creates risk in relation to delayed treatment and long-term outcomes for children and young people.

Risk 044: Care Provider Capacity System-Wide Impact

Risk remains at 15, reflecting local social care market capacity, and the risk of providers terminating care provision or closing due to failure to comply with statutory regulations. The national NI increase is also understood as a risk to small business resilience; ICB and local authority market engagement will continue to support and monitor impact. The risk has the potential to impact on hospital discharge activity as well as LD&A hospital admissions.

Risk 047: Tuberculosis Service Provision

Risk reduced to 12 at the May 2025 meeting, reflecting the recent triple-lock approval of additional funds to extend existing capacity, while the longer-term model for local TB services is explored and developed. An element of risk remains around increasing demand and complexity of cases

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and inequity in the service offer across the system, which may impact on patient safety, quality of care and public health protection.

Risk 048: 12hr DTA Mental Health Breaches

Risk remains at 16, reflecting the impact of 'decision to admit' breaches where a specialist mental health bed cannot be found in a timely way. This causes extended waits for service users in busy A&E departments, that raises the risk of poor experience of care and exacerbation of symptoms in a clinically unsuitable environment.

Risk 058: Public Trust and Reputational Damage

Risk remains at 15, reflecting the impact of poor patient experience and patient harms in respect of delayed ambulance conveyance. This is a dynamic risk reflects ambulance response time trends and operational pressures in the system.

Risk 059: Deconditioning and Infection

Risk reduced to 9 at the April 2025 meeting, reflecting the improved position following reduction in seasonal illness rates. The impact of prolonged hospital length of stay for patients who are medically fit to be discharged will continue to have oversight at a team level; **Committee agreed to de-escalate the risk to the Nursing and Quality Team Risk Register.**

Risk 060: Specialist Palliative and End of Life Care

Risk remains at 12, reflecting the variation in accessibility and quality of specialist palliative and end of life care (PEOLC) across the Norfolk and Waveney footprint, resulting in variation in patient experience and outcomes and associated health inequalities.

Risk 061: CYP MH Responsible Clinicians

Risk remains at 16. NSFT is currently reviewing its crisis pathways, which will include consideration of an all-age psychiatric liaison that will cover these roles. In the interim, the Trust is using community resources to mitigate the gaps.

Risk 080: Instrumental Assessment for CYP Dysphagia

New risk opened at the May 2025 meeting, to reflect the lack of a local service to fully assess 'safety of swallow' for children across Norfolk and Waveney. NNUH has the equipment but does not currently have the staff to perform the service. Delayed access to swallowing assessment via video fluoroscopy raises a risk that there will be babies, children and young people will have untreated, poor

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	<p>functioning swallowing. This has the potential to impact on lung health, speech and language development, nutrition and aversion to eating and drinking which could have long term consequences. Committee agreed escalation of this new risk to Committee oversight at a score of 16.</p>
<p>Key items for Board to take note of:</p>	<p>ICB QIA & EHIA Panel Assurance Report Board received the first formal assurance report on the ICB's joint Quality Impact Assessment (QIA) and Equality and Health Inequalities Impact Assessment (EHIA) panel, highlighting the first quarter's activity which reviewed and approved 115 combined impact assessments over 21 sessions. Committee discussed feedback themes identified by the panel, such as cumulative impact of change, VCSE value, and the need for better demographic data use as part of sustainable commissioning. Opportunities for further support for staff completing these assessments are currently being scoped, including workshops with people with lived experiences that reflect the importance of health inclusion and addressing inequalities within commissioning.</p> <p>Right Care NoW (Discharge) Update Committee discussed the work of the provider collaborative forum and actions being taken to address communication issues, medication challenges, and the need for better decision-making and shared ownership in the discharge process, highlighting the importance of involving the voluntary sector in supporting patients. Opportunities were identified for the ICB Head of Discharge to link in with the Better Care Fund programme to understand their discharge metric, and with the NNUH Outreach Therapy Team, to integrate clinical governance meeting outcomes with discharge planning work to support cohesive learning and improvements. The Chair of the Norfolk and Waveney VCSE Health and Social Care Assembly identified an action to look at impact and outcome metrics to ensure that voluntary sector support post-discharge is measured to quantify its value and effectiveness.</p> <p>NSFT Mortality Action Plan Update Committee received feedback on the Trust's recent audit on their processes for learning from deaths which is reported into their Board for transparency. It was noted that the Trust has achieved external accreditation through the Royal College of Psychiatrists for their safety incident response processes, providing further evidence of robust processes. An external review by a consultancy company is pending to provide second- and third-line assurance on the robustness of the processes and to identify any gaps for further learning. The Trust is building on its strengthened</p>

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processes to ensure that learning is translated into improvement actions.

Committee agreed that enhanced reporting could be stood down and that trends and themes would now be picked up through the overarching ICS Learning from Deaths Forum reports.

CYP Neurodevelopmental Service Provision Update

Committee received an update on system-wide efforts to address the high demand and long waiting lists for paediatric neurodevelopmental services, emphasising the importance of early identification of needs and intervention to support children and families. Committee noted the benefit of the new provider framework to support the quality and oversight of independent providers accessible through 'right to choose'. This includes mechanisms to address quality issues with providers and support primary care to navigate different referral pathways. Validation of waiting lists continues to help ensure accurate data and oversight of demand and capacity. Additional work is being undertaken to review and update information and guidance for families and professionals, in collaboration with Parent Carer Forums. Committee also noted the impact of national initiatives, such as Partnership for Inclusion of Neurodiversity in Schools (PINS) as well as local projects to improve early help and support.

Patient Safety and Complaints Report

The ICB Patient Safety Specialist presented the quarterly report, providing an update on the implementation of the national Patient Safety Incident Response Framework (PSIRF) across the system. Committee heard that provider partners are currently updating their PSIRF plans with new local priorities, to make patient safety improvements within their organisations. Committee noted that the Norfolk and Waveney system is taking forward an innovative approach to launch a shared 'system' PSIRF priority as a response to multi-agency learning around ambulance handover and response times. Committee also heard that there is joined up work taking place via the ICS Patient Safety Specialist Network, hosted by the ICB. This includes a thematic review of inpatient falls, particularly looking at falls from commode equipment, delivery of meaningful engagement training to support patient and family involvement in learning from adverse events, and development of a 'safety standard operating procedure' to support patient care in side-rooms, which supports the national New Hospital Build expectation that wards will have increased single room provision.

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	<p>ICS Community Wound Infection Pathway Committee received an update on the development of a standardised ICS Community Wound Infection Pathway which was originally discussed in March 2025. Committee feedback had been taken onboard, and the pathway documentation had been taken through some additional consultation, including the LMC, ICS General Practice Nurse Forum and Prescribers Group. Committee were briefed on the plans to roll out the pathway, including a training programme to ensure full engagement and support the aim to reduce inappropriate antibiotic prescribing. Committee members suggested that the pathway leads link in with Health Innovation East to explore evaluation of impact once it has embedded into practice. An action was also taken to build in a biannual review of the formulary and prescribing best practice with the ICB Medicines Management Team. Committee approved the pathway and noted it as good collaborative work across the system.</p> <p><u>Committee Approvals</u></p> <p>ICB Local Resolution for NHS CHC Policy Responsibility for informing individuals of their eligibility for NHS Continuing Healthcare (CHC) and their right to request a review lies with the ICB with which the individual is a patient. This policy outlines a local resolution procedure, aligned to national best practice, to address requests from individuals or their representatives to review an eligibility decision.</p> <p>ICB Adult Safeguarding Policy This policy outlines key definitions, roles, responsibilities and processes associated with adult safeguarding, as it relates to ICB staff and ICB duties to ensure that safeguarding continues to be a key priority. The review captured changes to the ICB's Freedom to Speak Up arrangements and moved the policy towards alignment with the new 'all age' safeguarding approach within the ICB.</p> <p>ICS Community Wound Infection Pathway As described above under 'key items'.</p>
Items requiring formal approval of Board:	None this month.
Confirmation that the meeting was quorate:	The April and May 2025 meetings were quorate, as defined in the Governance Handbook.

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Agenda item: 11

Subject:	N&W ICS Mental Health Intensive and Assertive Outreach Services Review and Action Plan
Presented by:	Martin Keegan – Adult Mental Health Senior Collaborative Lead
Prepared by:	Martin Keegan (N&W ICB & NSFT); Claire Holmes (NSFT); Jackie Jackie Bland (SNEE ICB)
Submitted to:	Integrated Care Board - Board Meeting
Date:	21 May 2025

Purpose of paper:

NHSE require all ICB Public Boards to receive an update on the Intensive and Assertive Outreach Reviews, and ICB Action Plan before June 2025.

Executive Summary:

NHS England included a requirement in the [2024/25 NHS Priorities and Operational Planning Guidance](#) that all Integrated Care Boards review community services to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up, but where engagement is a challenge.

Integrated Care Boards were asked to report any gaps and barriers to delivering good care that they identified (e.g. resourcing and workforce implications of delivering this care).

This work was presented to Norfolk and Waveney ICB public board in November 2024 and covered:

- Background & Context
- Characteristics of the cohort of service users
- Services in scope of review
- Gaps identified through the review process
- Barriers and challenges identified through the review
- Integrated Care Board Action Plan

ICB's have been asked to present updated action plans back to Public Boards by June 2025.

Davy Heidi
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A summary slide deck has been prepared for presentation which will outline

- Refresh On Last Public Board Update
- Timeline Since Last Public Board
- Positive Achievements So Far....
- Barriers & Challenges Identified / Experienced
- Updated ICB Action Plan
- Next Steps

Key next steps are:

- Triangulate cohort of service users with adult social care and police.
- Ensure individuals with lived experience are included in policy review
- Specific training programme developed across NSFT to effectively support the cohort
- Ensure cohort have a co-produced and personalised care & treatment plan, making sure that there are internal governance processes within the Trust to oversee this.
- Prepare for arrival of personalised care framework, first draft now out for review / feedback expected in June 2025.
- Begin discussions of how to introduce a multi-agency information sharing forum across health, social care & criminal justice

Recommendation to the Board:

To review and share feedback.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	
Information Governance:	N/A

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Resource Required:	N/A
Reference document(s):	
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	
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Intensive and Assertive Outreach Review and Action Plan

Integrated Care Board Public Board Presentation

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Prepared collaboratively by:
Jackie Bradshaw Hughes (SNEE ICB)
Martin Keegan (N&W ICB)
Claire Holmes (NSFT)

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Updated ICB Action Plan	7
Next Steps	8

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Refresh On Last Public Board Update

At the last public board, we looked at this item of work and covered:

- Background & Context
- Characteristics of the cohort of service users
- Services in scope of review
- Gaps identified through the review process
- Barriers and challenges identified through the review
- Integrated Care Board Action Plan

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Timeline Since Last Public Board

2024 / 25 Milestones	What
December 2024	Notes / Feedback from Norfolk & Waveney (N&W) and Suffolk and North East Essex (SNEE) ICB public boards are incorporated into action plans
January 2025	Cohort identification exercise begins within Norfolk and Suffolk foundation Trust (NSFT) Approach is also shared with Police and Adult Social care.
February 2025	Independent Homicide Review is published NSFT Policy updates continue
March 2025	NSFT and ICB's develop and agree 'Hard to Engage SMI Cohort Clinical Review Form' Phase 1 of cohort identification lists are spot checked and refined, in readiness for sharing with wider system partners
April 2025	Regional team share further guidance the National Intensive and Assertive Community Treatment webinar Board presentation and action plan are adjusted to reflect national guidance.
May 2025	Presentation to N&W ICB Public Board – 21/05/2025 Phase 2 of cohort identification list validation, in readiness for sharing with wider system partners
June 2025	NSFT Public Board

Positive Achievements So Far....

- Cohort Identification (see also Barriers and Challenges on next page). Norfolk & Suffolk Foundation Trust have identified their cohorts of people who meet the criteria for an Intensive and Assertive Outreach service which has been a significant piece of work. Whilst resources have not yet been forthcoming, teams largely know and will already be prioritising work based on risk (this cohort are inherently at higher risk of disengaging with consummate risk to selves and the public).
- Policy review. One of the first and significant requirements within the action plan was to review all operational policies within MH Trusts to ensure that people are not discharged on the basis of 'DNA'. NSFT has updated 8 key policies. Both ICBs are assured that this is now complete.
- Regular collaborative meetings between Norfolk and Waveney ICB, Suffolk & North East Essex ICB and Norfolk and Suffolk Foundation Trust have been established. These meetings have allowed discussion with wider system partners (e.g. Police & Adult Social Care) regarding the hard to engage SMI cohort.

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Barriers & Challenges Identified / Experienced

- Monies to Support the development of an assertive outreach function have not yet been identified by central government. Trusts have modelled the finances required however no commitment has yet been announced (the next spending review is considering a request for monies submitted by NHS England). The absence of additional resource will limit the approach for relevant patients
- Whilst cohort identification has been largely achieved by local teams, trust level data still requires additional validation work. The risk relates more to over-estimating caseload sizes than under-estimating and in NSFT work with the digital team continues to refine search terms and criteria. However local teams will largely be aware of patients who require an assertive and intensive approach to maintain safety.
- Since initial reviews took place in 2024, the scale and scope of this project has expanded and is expected to grow. For example, whilst initial policy review has taken place, this will impact items such as service specifications, standard operational procedures, multi-agency forums and culture changes.

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Updated ICB Action Plan

	Scope	Lead	Deadline	Progress
Implement quality improvement approach to address immediate provider priorities	Develop a plan, in collaboration with wider system partners, to ensure all service users in this group are identified, across all domains and relevant service lines, including 18-25s with mechanisms to do so on an ongoing basis	Chief Operating Officer NSFT	Q3, 24/25	Complete
	Deliver plan to ensure all service users in this group are identified.	Chief Operating Officer NSFT	Q4, 24/25	Complete
	Review key policies.	Chief Operating Officer NSFT	Q4, 24/25	Complete
	Provide assurance against policy implementation in practice.	Chief Operating Officer NSFT	Q4, 24/25 - Q1, 25/26	On Track
	Strengthen risk assessment and safety planning through immediate and medium-term training scheme.	Chief Operating Officer NSFT	Q4 - 25/26	In Progress
Governance	Implement robust assurance arrangements to enable immediate steps are taken to address key gaps identified.	Interim AD Adult Mental Health N&W ICB Deputy Director of Nursing, SNEE ICB	Q3, 24/25	Complete
	Ensure lived experience and carer voice informs quality improvement measures and strategic planning response.	Chief Operating Officer NSFT	Q3, 24/25	In Progress
Strategic Delivery	Plan and execute development of a medium-term implementation framework that responds to wider review recommendations in the context of macro local and NHSE/national policy considerations.	Chief Operating Officer NSFT	Q2, 25/26	In Progress

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Next Steps

- Triangulate cohort of service users with adult social care and police.
- Ensure individuals with lived experience are included in policy review
- Specific training programme developed across NSFT to effectively support the cohort
- Ensure cohort have a co-produced and personalised care & treatment plan, making sure that there are internal governance processes within the Trust to oversee this.
- Prepare for arrival of personalised care framework, first draft now out for review / feedback expected in June 2025.
- Begin discussions of how to introduce a multi-agency information sharing forum across health, social care & criminal justice

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Thank You

Thank You 😊

Any Questions?

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Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

March 2025

(Month 12 2024/25)

ICB Board – Part One: 21st May 2025

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1. Executive Highlights

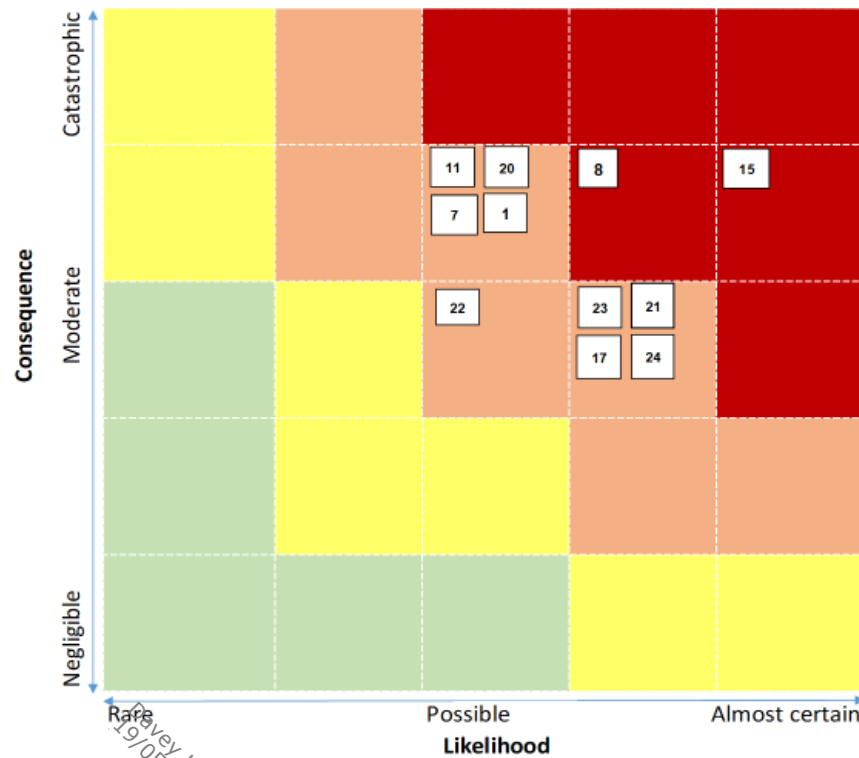
- The following report is based on the financial plan submitted to NHSE on 12 June 2024, which included a planned £387k surplus position.
- This report represents the **M12 March 2025** (draft) year-end position of the ICB as part of the 2024/25 Financial Year.
- The ICB has reported a draft **Surplus of £0.600m**, which is a favourable variance of £0.213m against the **planned year-end position of £0.387m Surplus**,
- The ICB has reported a draft (subject to audit) **of £0.6m Surplus**, this includes offsetting variances, the major items being:
 - No delivery of the unidentified efficiency target (£8.1m)
 - £1.2m of over performance on identified efficiency delivery, this is a net achievement over multiple schemes.
 - £6.7m of Non-Recurrent mitigations arising from prior-year benefits, slowing of project expenditure and withholding of allocations.
- The M12 **underlying deficit is £122.4m**, a deterioration against the planned deficit of £101.8m. This arises from the full year effect of Recurrent CHC packages and the removal of the Non-Recurrent in-year savings being used to deliver the 2024/25 Financial Position. This figure is consistent with M11.

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2. Strategic Financial Risk Register

This risk dashboard categorises the key financial strategic risks by their impact and likelihood to help the strategic focus to be on those that will cause the ICB the greatest issues.

Key: ■ = Worsening Risk □ = Stable risk ■ = Improving risk



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Jan-25	Feb-25	Mar-25	
Achievement of Plan	1	Achieve the 2023/24 financial plan (BAF 11)	12	12	12	12	
	15	Underlying deficit position (BAF 11A)	12	20	20	20	
	17	Inflationary pressures	9	12	12	12	
	20	Impact of new prescribing guidance	8	12	12	12	
	21	Impact of Direct Commissioning transfer	9	12	12	12	
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	9	9	9	
	23	Debt and Working Capital Management (NCC)	6	12	12	12	
Demand and Capacity	7	Continuing Health Care demand growth	9	12	12	12	
	11	ERF: RTT backlog and Acute demand management	9	12	12	12	
	24	Patient Choice (Learning Disabilities & Autism)	9	12	12	12	
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	16	
				Extreme	2	2	2
				High	9	9	9
				Moderate	0	0	0
				Low	0	0	0
				Total Risks	11	11	11

As at M12 (March), 11 Key Financial Risks remain open of which 2 are considered Extreme relating to the ICB Underlying Deficit and delivery against the Efficiency programme.

Against M11 (February), there have been no changes to either the impact and likelihood as well as the risk classifications.

3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st March 2025.

Non-Current assets

The non-current assets balance includes the right of use assets for the lease of the premises at King's Lynn and Norfolk County Council, following implementation of IFRS16 in April 2022. Corresponding entries are also included in both current and non-current Lease Liabilities.

Current assets

Total current assets have decreased since March 2024. The £20.4m balance is made up of aged debtors of £4.4m (including NHS England £2.4m & Norfolk County Council £1.4m), prepayments & accrued income of £4.6m, dental under delivery of £13.1m and a bad debt provision against aged debtors & dental under delivery of £1.7m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee. The cash balance of £0.7m has been brought down to ensure that it is below the 1.25% of March 2025 drawdown value in line with NHSE guidance.

Current liabilities

Total current liabilities has decreased by £6m since March 2024, driven principally by ICB and system invoice accrual timing. The £170m balance is made up of trade creditors of £7m, Prescription Pricing Authority & dental accruals of £33m, payroll costs including GP pensions of £3m, deferred income of £6m, and ICB and system invoice accruals of £121m.

Provisions include legal, staffing, estate costs, CHC Reimbursement, Debts, and funding clawback.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £9.9m. All invoices raised outside of the contractual conditions against which the ICB made a full and final settlement on remain on-hold.

Long Term liabilities

The non-current lease liabilities balance includes the right of use liabilities for the lease of the premises at King's Lynn and Norfolk County Council, following implementation of IFRS16 in April 2022. The non-current payables balance relating to research & development deferred income was reclassified to current liabilities in March 2025.

General Fund

This ICB is directly funded by NHSE with cash allocated on a monthly basis. Any future commitments to balance the general fund shortfall will be supported by the next month's cash request from NHSE. This will however continue to remain negative as the NHSE principle is that cash should only be drawn based upon one month's commitment at a

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/24	Position as at 28/02/25	Position as at 31/03/25
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,005	1,005	1,005
Accumulated Depreciation	(332)	(508)	(524)
Total non-current assets	673	497	481
Current assets			
Trade and Other Receivables	23,673	18,506	20,440
Cash and Cash Equivalents	376	1,344	693
Total current assets	24,049	19,850	21,133
Current liabilities			
Trade and Other Payables	(174,924)	(198,790)	(169,721)
Lease Liabilities	(218)	(194)	(239)
Provisions for liabilities and charges (including non-current)	(12,786)	(5,731)	(11,719)
Total current liabilities	(187,928)	(204,715)	(181,679)
Long Term liabilities			
Non-Current Payables	(820)	(422)	0
Non-Current Lease Liabilities	(472)	(278)	(278)
Total non-current liabilities	(1,292)	(700)	(278)
Net assets employed	(164,498)	(185,068)	(160,343)
FINANCED BY TAXPAYERS EQUITY			
General fund	(164,498)	(185,068)	(160,343)
Total taxpayers equity	(164,498)	(185,068)	(160,343)

4. ICS Financial Summary – Revenue

- The N&W ICS system financial performance is extracted from the IFR/PFR's submitted to NHSE.

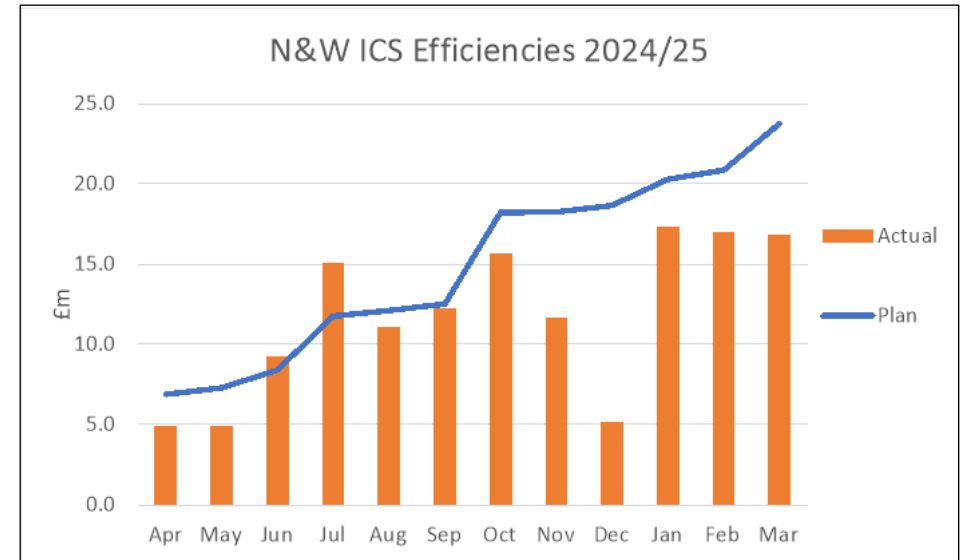
Revenue surplus/(deficit) £m	Month 12 YTD		
Organisation	Plan	Actual	Variance
JPUH	(1.1)	0.0	1.1
NNUH	0.0	0.0	0.0
QEH	(0.8)	(38.5)	(37.7)
NSFT	0.0	0.0	0.0
NCH&C	1.5	1.6	0.1
Provider Subtotal	(0.4)	(36.8)	(36.4)
ICB	0.4	0.6	0.2
N&W System Total	0.0	(36.2)	(36.2)

- The position M12 YTD is a £36.2m deficit, which is £36.2m adverse against plan. This is an improvement of £0.4m from M11 FOT when the position was £36.6m off plan.
- The £36.2m reported position includes the non-recurrent system deficit funding of £21m in M6 and £18m in M11.
- There are no risks and mitigations in M12 reporting.

5. ICS Financial Summary – Efficiency and Transformation

- The N&W efficiency position is from the IFR/PFR's submitted to NHSE.

System Efficiencies £m	Month 12 YTD			Month 12 YTD	
	Plan	Actual	Variance fav/(adv)	Recurrent	Non-recurrent
Organisation					
JPUH	22.4	20.6	(1.8)	8.0	12.6
NNUH	50.1	43.7	(6.4)	22.0	21.7
QEH	29.5	6.8	(22.7)	6.0	0.9
NSFT	17.4	17.4	0.0	6.6	10.8
NCH&C	8.4	8.4	0.0	3.1	5.3
Provider Subtotal	127.8	96.9	(30.9)	45.7	51.2
ICB	51.2	44.3	(6.8)	24.5	19.8
N&W System Total	178.9	141.2	(37.7)	70.2	71.0



N&W ICS efficiency plan for 2024/25 is to deliver £178.9m of efficiencies.

Year-to-date:

- The efficiency position M12 YTD against plan is an adverse variance to plan of £37.7m.
- The variance is mainly due to QEH £22.7m lower than planned, where anticipated efficiency savings have not materialised as expected.
- JPUH, NNUH and the ICB have various CIP schemes that are not meeting plan due to slippage.
- NSFT and NCH&C are on plan.
- Recurrent efficiency delivery is £70.2m against the plan of £112.0m, £41.8m under and NR delivery is £71.0m against the plan of £67.0m, £4.1m over, generating the net under delivery of efficiencies against plan of £37.7m.

6. ICS Financial Summary - Capital Position

- The N&W ICS system Capital Delegated Expenditure Limit (CDEL) position is from the IFR/PFR's submitted to NHSE.

System CDEL £m	Month 12 Year to Date (YTD)										
	System CDEL					IFRS 16			Total System Performance		
	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance
	Inc./(Dec)		(Under)/Over			(Under)/Over			(Under)/Over		
Excluding RAAC											
JPUH	9.1	0.0	9.1	8.9	(0.3)	0.2	0.3	0.1	9.3	9.2	(0.1)
NNUH	15.8	0.0	15.8	16.3	0.6	15.5	5.8	(9.7)	31.3	22.1	(9.2)
QEH	10.7	0.0	10.7	10.5	(0.2)	0.0	0.3	0.3	10.7	10.8	0.0
NSFT	9.7	0.0	9.7	14.2	4.6	3.6	(0.0)	(3.6)	13.2	14.2	1.0
NCH&C	4.6	0.0	4.6	4.6	(0.0)	2.0	0.0	(2.0)	6.7	4.6	(2.1)
Subtotal excluding RAAC	49.9	0.0	49.9	54.5	4.6	21.3	6.4	(15.0)	71.3	60.9	(10.3)
RAAC											
JPUH	7.2	1.7	8.9	8.9	(0.0)				8.9	8.9	(0.0)
QEH	25.0	10.0	35.0	35.0	0.0				35.0	35.0	0.0
Subtotal Including RAAC	82.1	11.7	93.9	98.5	4.6	21.3	6.4	(15.0)	115.2	104.8	(10.3)
Adjustments											
Reduced IFRS 16 Allocation						(10.8)	0.0	10.8	(10.8)	0.0	10.8
N&W System Total	82.1	11.7	93.9	98.5	4.6	10.6	6.4	(4.2)	104.4	104.8	0.4

- For CDEL & IFRS 16, M12 YTD variance to plan is an £0.4m overspend.
- System CDEL is £4.6m overspent, mainly due to the NSFT overspend associated with delayed receipt of c. £4m VAT reclaim on the Rivers Project, now expected to be received 2025/26.
- IFRS16 schemes are £15.0m lower than plan. The underspend is significantly offset by the £10.8m reduced IFRS16 allocation.
- Central programmes are forecasting an underspend primarily due to the NANOC2 delays. With the expectation of funding and completion in 2025/26

Central Programmes £m	Month 12 Year to Date (YTD)										
	CDEL					IFRS 16			Total System Performance		
	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance
	Inc./(Dec)		(Under)/Over			(Under)/Over			(Under)/Over		
Total Central Programmes			128.6	103.1	(25.5)	0.0	0.0	0.0	128.6	103.1	(25.5)
N&W Total Capital Programme			222.5	201.6		10.6	6.4		233.1	207.9	

Specific organisational FOT variances, as previously reported:

- NSFT CDEL overspend due to delayed receipt of c. £4m VAT reclaim on the Rivers Project, expected to be received 2025/26.
- NNUH IFRS 16 underspend due to lower than expected IFRS 16 costs in various procurements e.g. renal contract renewal.
- NSFT IFRS 16 underspend due to deferred procurements and a prior year IFRS 16 overstatement generating a benefit in 2024/25.
- NCHC IFRS 16 underspend due to deferred renewal of the Rackheath lease to 2025/26

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A <u>provider</u> measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi faceted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Agenda item: 13

Subject:	Finance Committee Report
Presented by:	Hein van den Wildenberg, Non-executive Member, Finance Committee Chair
Prepared by:	Emma Kriehn-Morris, Director of Commissioning Finance
Submitted to:	Integrated Care Board – Board Meeting
Date:	21 May 2025

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 29th of April 2025.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 26.03.2025. Subsequent Meetings: 29.04.2025
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the NHS entities in the ICS, and ICB respectively.
BAF and any significant risks relevant / aligned to this Committee:	BAF 8/In-phase 027 – Achieve the 2024/25 (ICB) financial plan. BORR08/In-phase 002 – Underlying deficit position
Key items for assurance/noting:	<i>The information below is based on Month 12 results, i.e. per March 2025. The numbers are considered draft, as they are subject to external audit.</i> Much information regarding Month 12 is already captured in the Finance Report of the Executive Director of Finance, immediately preceding this agenda item. Focusing therefore on the main aspects of Month 12 reporting:

Davy Heidi
 19/05/2025 17:38:22

- At **Month 12 (March 2025)** the NHS entities in the N&W ICS show a deficit of £(36.2)m vs a Planned break-even position, i.e. a shortfall of £(36.2)m largely within QEH hospital. This takes into account deficit funding of some £18m, which allowed to offset deficits in NNUH and James Paget hospital.

This outcome is in line with the previous Chair's report to Board, adjusted for the deficit funding. We have seen a continued trend in shortfalls arising from efficiency savings not secured particularly in the second half of the year, and significant operational pressures arising from reduced activity and associated Elective Recovery Income (ERF) and pay costs often at premium rates.

Efficiency schemes delivered a saving of £141.2m (£69.8 recurrent, £71.4 non-recurrent) against a Plan of £178.9m. This is important context against the 2025/26 plan.

- At **Month 12 (March 2025)** the ICB shows a surplus of £0.6m, £0.2m more than the £0.4m surplus in the plan.
- Initial draft CDEL (**Capital** Delegated Expenditure Limit) expenditure for the year was £104.1m, being £0.3m below the plan of £104.4m. Due to late adjustments at QEH & NNUH the position was updated to the committee. The revised expenditure (subject to audit) is £104.8m, meaning the system is marginally above plan by £0.4m
- The **2025/26 financial plan** is part of the overall 2025/26 plan, which is covered in the Chair's report of the Commissioning and Performance Committee.

The Finance Committee considered the final draft return in its meeting, the day before the final returns were due (April 30th). The 2025/26 shows a balanced financial plan for NHS entities in N&W, with a significant amount of net risk outside the plan (some £35m, fully within the ICB recognising particular risks around the efficiency programme, CHC and prescribing).

The Efficiency ask in the 2025/26 plan is £194.4m (of which ICB is £79.0m), of which £160m (ICB: £ 69.9m) is recurrent.

- The 2025/26 capital plan has:
 - o £59.0m in Business-as-Usual capital spend

Davey Heidi
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- £46.1m in RAAC capital spend
- £68.6m in capital, of which the funding is subject to bidding processes and business case approval. This includes the JPUH Frailty Hub.
- £113.1m in Central Programmes Capital Spend, such as new Hospital programme, Electronic Patient Record

- Other topics covered during the April meeting:

- Review of spend versus the Mental Health Investment Standard (MHIS). The assessment, subject to audit, is that we have met the MHIS and related audit standards for 2024/25.
- Committee was updated that Grant Thornton had concluded that the N&W system had complied with the MHIS and related audit standards for 2023/24. The committee commended the team for a successful audit outcome.

In view of the significant changes expected in the ICB during this financial year, a decision has been made to conduct committee meeting every other month, rather than each month. This is deemed sufficient to maintain assurance, whilst reducing the burden on staff. The chair and vice-chair of the committee will meet the Executive Director of Finance and Director of Commissioning Finance in the intervening months.

Items for escalation to Board:

1. Month 12 results subject to audit
2. The draft financial break-even plan for 2025/26 with an efficiency ask of ca £194m and a net risk outside plan of £35m.

	NHS entities in N&W ICS, including ICB	N&W ICB
Month 12	Actual: Deficit of £(36.2)m vs Plan of £0.0m, i.e. a shortfall of £(36.1)m.	Actual: Surplus of £ 0.6m vs Plan of £ 0.4m
Underlying Deficit <i>(* Basis of 2025/26 Financial Plans)</i>	£(230.7)m *	£(122.4)m Exit Underlying Deficit

Davy Heidi
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	<table border="1"> <tr> <td>Efficiency delivery</td> <td>£178.9m Plan £141.2m Delivered</td> <td>£51.2m Plan £44.3m Delivered</td> </tr> </table>	Efficiency delivery	£178.9m Plan £141.2m Delivered	£51.2m Plan £44.3m Delivered
Efficiency delivery	£178.9m Plan £141.2m Delivered	£51.2m Plan £44.3m Delivered		
Items requiring approval:	None			
Confirmation that the meeting was quorate:	Confirmed that meetings were quorate.			

Key Risks (to extent applicable)	
Finance and Performance:	It is important that there is scrutiny of financial management of the ICB and the collective of NHS entities in the ICS, and this function is performed by the Finance Committee.
Reputation:	Ensuring effective committees and order of business essential for maintaining the financial reputation of the NHS entities in the ICS, including the ICB
Legal:	Finance Committee is a committee of the ICB.

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Commissioning and Performance Committee

[View in Power BI](#) ↗



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19/05/2025 13:22
Last data refresh:
15/04/2025 07:20:55 UTC
Downloaded at:
15/04/2025 12:30:00 UTC



Commissioning and Performance Committee Report

Report Overview

The Commissioning and Performance Committee Report has been created to support the oversight of key metrics by providing actionable information.

The metrics have been agreed by the Commissioning and Performance Committee & any changes must go through this board.

Navigating the Report

Interactive buttons in the header of each tab allow you to navigate to different screens of the report, or clear the filters on the current page.

The data in the report is interactive - if you select a particular area the other charts will update to reflect the selected field, deselecting or clicking on the clear filters button will revert the page to the default view. Select multiple areas by holding down ctrl and clicking on each area.

Data in the report can also be filtered using the available drop down filters on the page, or if the filter pane (to the right) is in use, additional filters can be found there.

If you have any queries please contact the team email address below, and your query will be routed to the appropriate team member.

Information Governance Notes

Under The Data Protection Act 2018 S.171(1) - It is an offence for a person to knowingly or recklessly re-identify information that is de-identified personal data without the consent of the controller responsible for de-identifying the personal data

This report could contain potentially identifiable factors that could be deemed as special category data (sensitive data) and therefore it is not permissible to share outside the relevant departments/organisations. Not following this is a breach of the DPA 2018 S.171 (1) above, and risks the ceasing of this data flow from NHS Digital as it will be seen as a breach of the contract the CCG has with NHS Digital (NHSX). Access to Power BI reports is monitored for auditing purposes and your access may be removed if necessary.

Report Version History

Date	Version	Change Notes
18/03/25	1	Initial Deployment

Data Source: Various

Produced by: N&W ICB Business Intelligence

Email: nwicb.bi@nhs.net



Commissioning and Performance Committee

SPC headlines for core 15 Commissioning and Performance Committee metrics: March 25



Variation indicates consistently **Passing** the target



Variation indicates inconsistently hitting passing and falling short of the target



Variation indicates consistently **Falling** short the target



No Target



Special Cause of Improving nature or lower pressure due to **Higher or Lower Values**



Common Cause - No significant change



Special cause of concerning nature or higher pressure due to **Higher or Lower Values**



	Mental Health - E.A.5 Active Inappropriate Adult Acute Mental Health Out Of Area Placements - ICB	Cancer - 28 Day FDS Performance - ICB Cancer - 62 Day Combined Performance - ICB RTT - 18 Week Performance - ICB RTT - 52 Week Performance - ICB	
Talking Therapies - First Treatment Within 18 Weeks - ICB	Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB UEC - Mean C2 Ambulance Response Times (Mins) - ICB	Diagnostics - DM01 Performance - ICB Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB RTT - 18 Week First Performance - ICB UEC - 111 Calls Answered within 60 secs (%) - ICB UEC - 12 hour A&E DTA breaches - Provider UEC - Total A&E 4hr Performance - Provider	



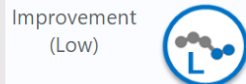
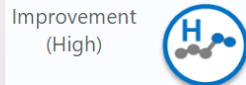
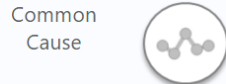
Commissioning and Performance Committee

SPC headlines for core 15 Commissioning and Performance Committee metrics: March 25

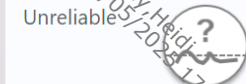
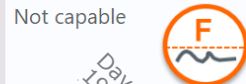


Search:

Variation



Assurance



Davey Heidi
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Metric No.	Metric Name	Latest Date	Result	Target	Target Type	Variation	Assurance	Metric Data Source
1	Cancer - 28 Day FDS Performance - ICB	Jan 25	67.4%	75.8%	Trajectory			National
2	Talking Therapies - First Treatment Within 18 Weeks - ICB	Jan 25	100.0%	95.0%	Target			National
3	UEC - 111 Calls Answered within 60 secs (%) - ICB	Feb 25	83.9%	95.0%	Target			Provider Submission
4	Cancer - 62 Day Combined Performance - ICB	Jan 25	57.7%	66.5%	Trajectory			National
5	Mental Health - E.A.5 Active Inappropriate Adult Acute Mental Health Out Of Area Placements - ICB	Jan 25	0	0	Trajectory			National
6	UEC - Mean C2 Ambulance Response Times (Mins) - ICB	Feb 25	38	30	Target			Provider Submission
7	Diagnostics - DM01 Performance - ICB	Jan 25	71.7%	99.0%	Target			National
8	UEC - Total A&E 4hr Performance - Provider	Feb 25	72.3%	79.7%	Trajectory			National
9	RTT - 18 Week Performance - ICB	Jan 25	54.3%	92.0%	Target			National
10	UEC - 12 hour A&E DTA breaches - Provider	Feb 25	957	0	Target			ECDS
11	Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB	Feb 25	38	0	Target			ECDS
12	Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB	Jan 25	88.2%	80.0%	Target			National
13	RTT - 52 Week Performance - ICB	Jan 25	4.4%	1.0%	Target			National
14	RTT - 18 Week First Performance - ICB	Mar 25	59.9%	72.0%	Target			National

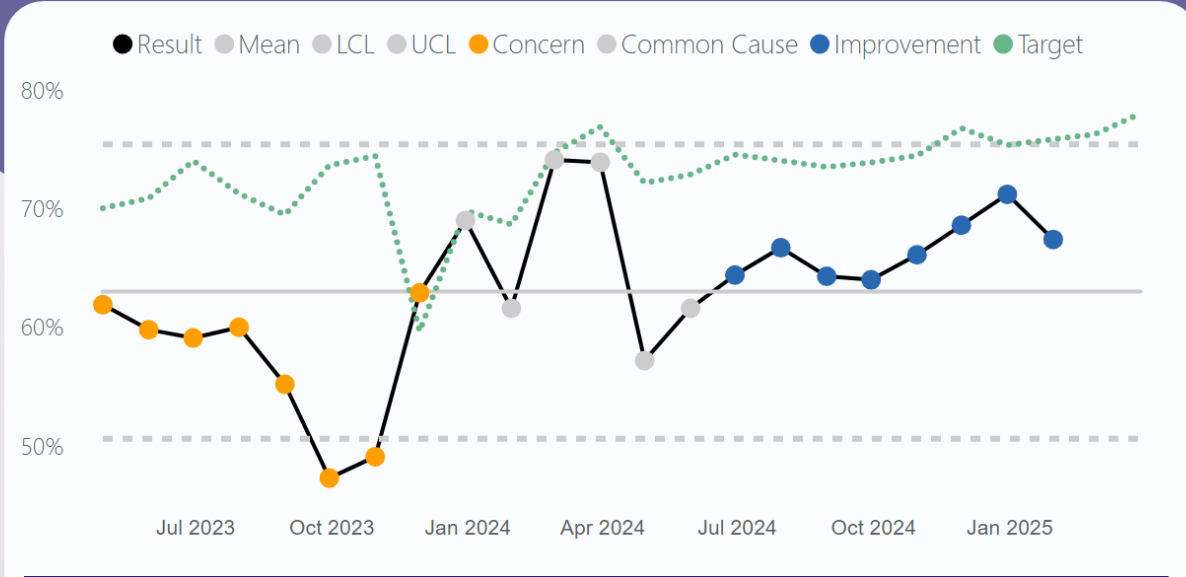


Metric Description

Percentage of N&WICB patients treated within 28 days following an urgent referral for Cancer

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
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Jan 25	National	67.4%	75.8%		
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System Position - Summary and Context

Performance for the 28-day FDS is 67.4% (Jan-25), below the 80.0% target. The SPC shows special cause improvement from mid-2024, indicating a positive trend following a period of concern, but not yet providing assurance of consistently meeting the standard.

Root Causes and Contributing Factors

- High referral volumes creating pressure on diagnostic services.
- Workforce gaps and staffing changes affecting pathway delivery.
- Delays in diagnostics and variable pathway efficiency.
- Reduced capacity due to ended insourcing contracts.
- Some delays linked to patient choice and clinical factors.

Associated Metrics, Insights and Impacts

62-day Cancer Standard.

Diagnostic wait times and capacity issues continue to affect the speed of decision-making, especially Histology and Imaging.

Patient experience may be negatively impacted by delays in receiving a diagnosis, increasing anxiety and uncertainty.

Key Actions and Risks to Actions

1. Implementing *Best Practice Timed Pathways (BPTP)*
2. Cancer Alliance funding to support backlog - risk regards workforce availability
3. Improvement plans for all providers - with risks associated to demand surges and backlogs
4. NHSE-led tiering meetings to keep oversight and support

Cancer Transformation and Oversight Group and the Cancer Alliance own actions. Actions will align to trajectories in 2025/26 planning.



Metric Description

Percentage of N&WICB patients treated within 62 days for Cancer first definitive treatment.

BAF

BAF07

System Position - Summary and Context

Performance for the 62-day cancer standard is 57.7% (Jan 2025) against a 75.0% target. While there has been sustained improvement since mid-2024, recent variability means the SPC does not yet provide assurance of consistently meeting the standard.

Root Causes and Contributing Factors

- Backlog of long-wait patients, particularly in colorectal, urology, gynaecology, and lung pathways, slowing throughput.
- Workforce and capacity challenges, including anaesthetist shortages and theatre constraints, impacting timely treatment.
- Late tertiary referrals, especially in lung and thoracic cases, affecting the ability to complete treatment within the 62-day window.
- Impact of patient choice and clinical complexity, causing delays to planned treatment starts.
- Diagnostic and treatment delays, including imaging and surgical bottlenecks.

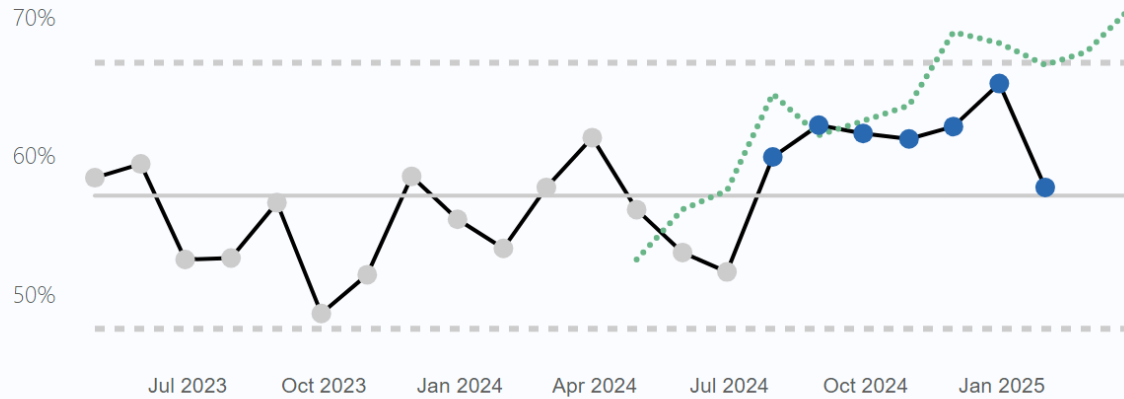
Associated Metrics, Insights and Impacts

- 28-Day FDS performance directly influences 62-day outcomes, as delays earlier in the pathway compress the treatment window.
- Theatre and diagnostic capacity constraints continue to impact delivery timelines.
- Patient outcomes and experience may be negatively affected by treatment delays, particularly for fast-progressing cancers.

Key Actions and Risks to Actions

- Implementing Best Practice Timed Pathways (BPTP)
- Cancer Alliance funding to support backlog - risk regards workforce availability.
- Improvement plans for all providers - with risks associated to demand surges and backlogs.
- NHSE-led tiering meetings to keep oversight and support.

● Result ● Mean ● LCL ● UCL ● Concern ● Common Cause ● Improvement ● Target



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	57.7%	66.5%		

Davey Heidi
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Metric Description

Percentage of N&WICB patients at the end of the month who are waiting under 6 weeks for a DM01 Diagnostic test/procedure

BAF

BAF07

System Position - Summary and Context

Common cause improvement is seen to January 2025. There is not current assurance that the target will be met with consistency.

Root Causes and Contributing Factors

There are key workforce challenges in areas: CT; MRI; non-Obstetric Ultra-sound; Cardiac CT; Endoscopy. Improvements in scheduling, booking processes, and DNA management are beginning to have a positive impact.

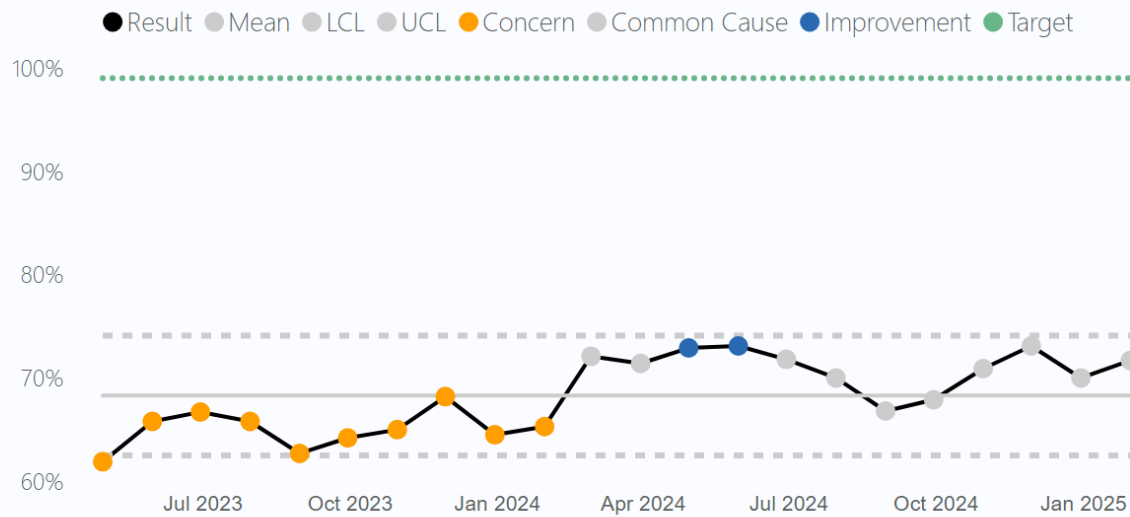
Associated Metrics, Insights and Impacts

Prioritisation is being made in some areas of diagnostics such as Cancer pathways. Waiting times for children and young people are being monitored in key areas such as Audiology.

Key Actions and Risks to Actions

1. Workforce challenges: Recruitment ongoing; Locum cover; upskilling
2. Demand and Capacity: Diagnostics working group standing up from April '25; Insourcing; final CDC opened Feb '25, moving to 7/7 working from May
3. Activity constrained by finance: risks identified; productivity working group

Actions align to Scheduled Care Board and structures underneath. Actions to 31/03/2026



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	71.7%	99.0%		

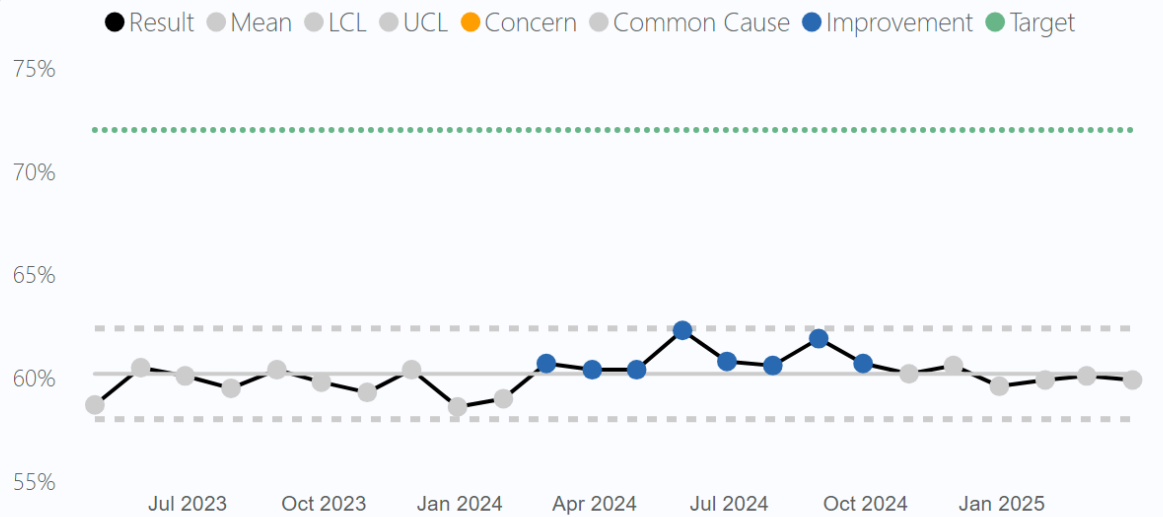
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Percentage of N&WICB patients at the end of the month who are waiting under 18 weeks for a first appointment against the RTT standard.

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
May 25	National	59.9%	72.0%		

System Position - Summary and Context

Performance for RTT 18-week first appointments is 59.9% (Mar 2025), below the 72.0% target. The SPC shows common cause variation with no sustained improvement, offering no assurance that the target will be reliably met.

Root Causes and Contributing Factors

- High referral demand in key specialities.
- Workforce constraints, including shortages in outpatient clinic staffing and diagnostics.
- Diagnostic bottlenecks delaying onward clinical decision-making and treatment pathways.
- WLI requests are being rejected as part of tighter financial controls.
- Vacancy freeze/triple lock process in place for all non-clinical posts.

Associated Metrics, Insights and Impacts

- RTT Incomplete Pathways
- Diagnostics (DM01) performance
- Outpatient productivity
- Specialist Advice utilisation and diversion rates

Key Actions and Risks to Actions

- Demand and Capacity: Diagnostics working group standing up from April '25; Insourcing; final CDC opened Feb '25, moving to 7/7 working from May.
- Activity constrained by finance: risks identified; productivity working group.
- Workforce challenges: Recruitment ongoing; Locum cover; upskilling.
- Demand Management working group in formation, with key connection to A&G and pathway management and national Validation Sprint .



Metric Description

Percentage of N&WICB patients at the end of the month who are waiting under 18 weeks against the RTT standard.

BAF

BAF07

System Position - Summary and Context

Over the past year, the percentage of patients treated within 18 weeks has consistently remained well below the target, showing special cause variation below the mean. Although there has been some marginal upward movement since April-24, the improvement has not been sufficient to suggest a reliable upward trend or to provide assurance that the system is on a path to recovery.

Root Causes and Contributing Factors

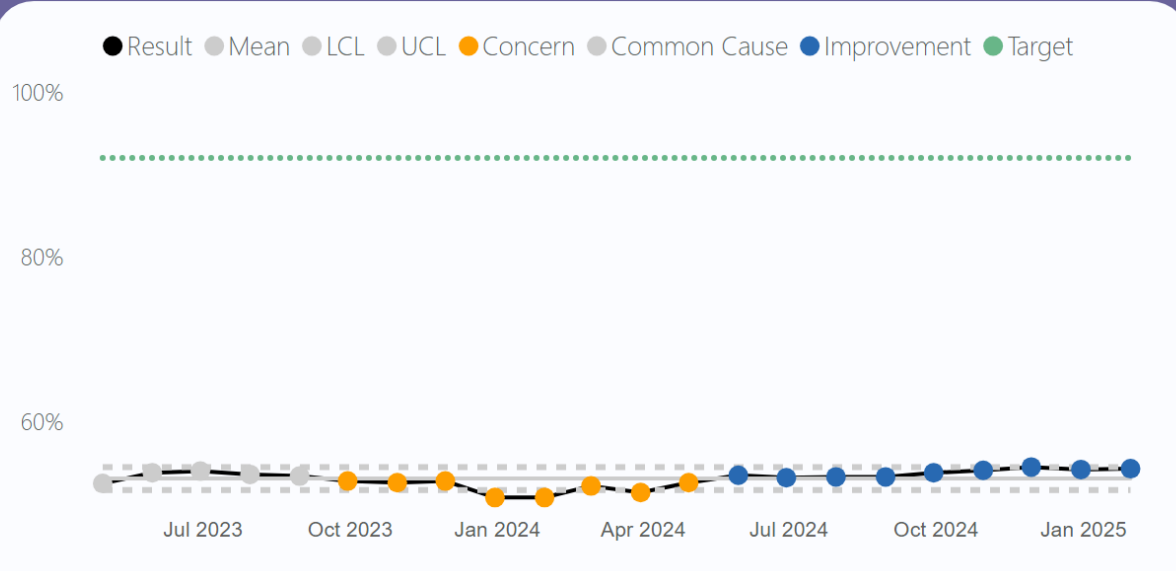
Workforce - recruitment and sickness
Financial challenges and changes to activity available

Associated Metrics, Insights and Impacts

Diagnostics and 52-week Referral to Treatment (RTT) standards.
RTT analysis for key groups is being undertaken routinely.
Harm reviews are in place for those on waiting lists.

Key Actions and Risks to Actions

1. Productivity working group standing up from April 2025, to drive efficiency opportunities
 2. Demand Management working group in formation, with key connection to A&G and pathway management and national Validation Sprint
 3. Activity modelling and tracking across all elective areas
- Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026.



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	54.3%	92.0%		

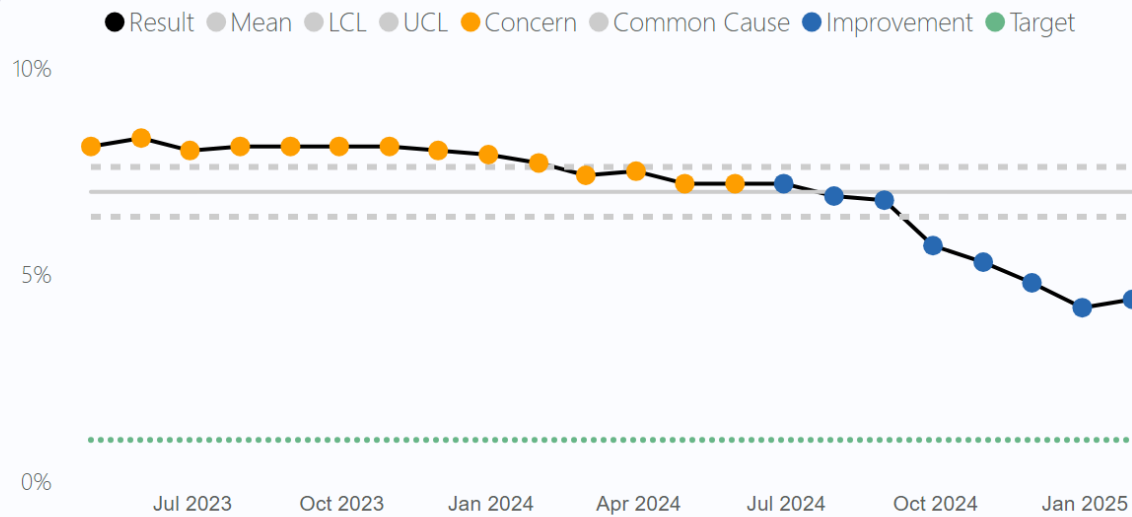
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Percentage of N&WICB patients at the end of the month who are waiting over 52 weeks against the RTT standard

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	4.4%	1.0%		

System Position - Summary and Context

There has been a sustained improvement in breach levels since mid-2024, with performance reaching 4.4% in January 2025 against a 1.0% target. While this indicates a positive shift, the system remains above target, and the SPC does not yet provide assurance of consistently meeting it.

Root Causes and Contributing Factors

Financial restrictions.

Workforce shortages in key clinical areas, impacting the ability to deliver elective care at required levels.

Elective capacity constraints and cancellations, often due to pressures from UEC demand.

Increasing patient complexity, including comorbidities and higher acuity, which extends treatment times and reduces throughput.

Associated Metrics, Insights and Impacts

Diagnostic waiting times (DM01)

RTT Incomplete Pathways

Cancer pathways

Theatre utilisation and cancellation rates

Key Actions and Risks to Actions

Participation in 2025/26 NHSE Validation Sprint.

Acute Operational Leads attending NHSE Planned Care masterclass workshops on 3 and 4 April.

ICS Productivity working group standing up from May '25.

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Commissioning and Performance Committee

UEC - 111 Calls Answered within 60 secs (%) - ICB

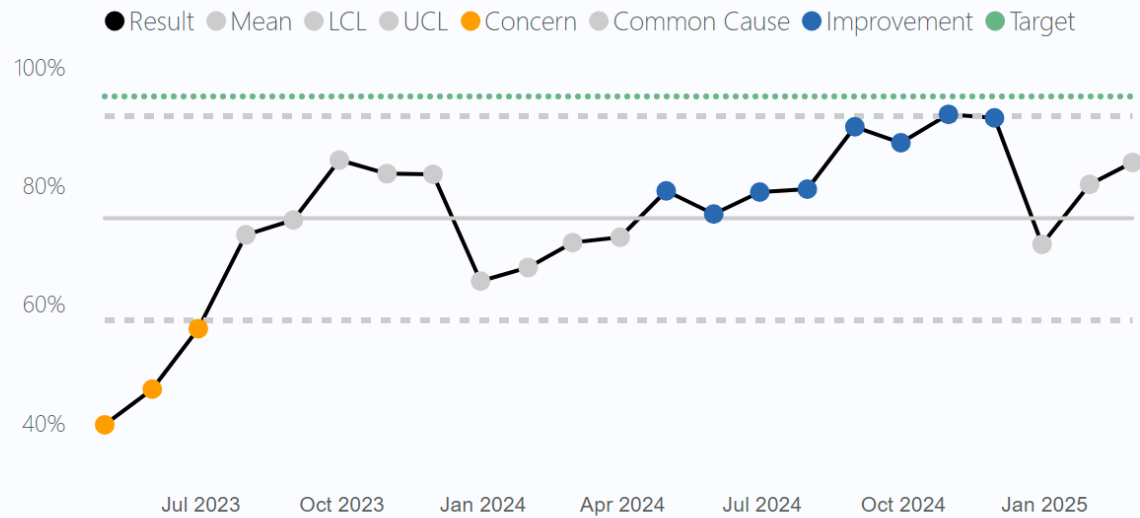


Metric Description

The percentage of 111 calls answered within 60 seconds out of all 111 calls answered.

BAF

BAF06



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Feb 25	Provider Submission	83.9%	95.0%		

System Position - Summary and Context

80.2% of calls were answered within 60 seconds in January which is an increase of 10% on December 24. Abandonment rate remained low for January.

Root Causes and Contributing Factors

January data has seen an improvement however this is still an extremely pressured time for our 111 provider with a bank holiday weekend and coming out of the Christmas / New year period. National contingency's from other providers have an impact on performance for N&W.

Associated Metrics, Insights and Impacts

111 provider remains above the national average for both calls answered within 60 seconds and abandonment rate.

Key Actions and Risks to Actions

Although not achieving 95% target in January there is a recovery trajectory in place with provider which is monitored weekly within ICB and provider to understand challenges.

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Metric Description

Average response times for C2 priority (Mins)

BAF

BAF06

System Position - Summary and Context

C2 response times have also improved from January 42.6mins to 38.6 mins in February.

Root Causes and Contributing Factors

Turnaround delays at each acute have an impact on C2 performance and reduce capacity within the community to respond.

Associated Metrics, Insights and Impacts

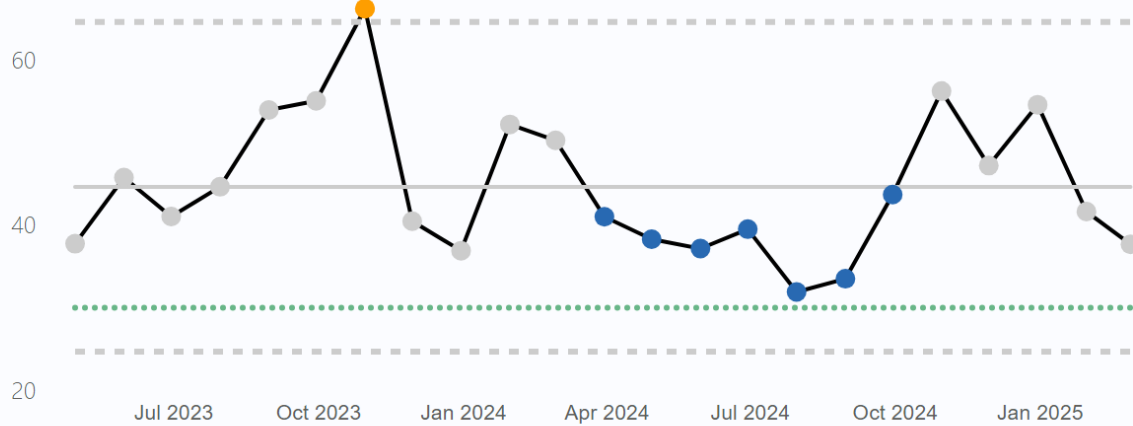
Any incidents and concerns are monitored through EEAST tactical group and any harms investigated.

Key Actions and Risks to Actions

UCCH is working on pre dispatch elements such as call before convey with a target now set of 650 calls from April 25. Hear and treat rates within N&W are highest of the region. The work of UCCH has shown our ambulance dispatch rate is down compared to 23/24 and conveyance rate within N&W is low.

QEH and NNUH have both signed up to handover in 30 minutes and JPUH to handover in 45 minutes.

● Result ● Mean ● LCL ● UCL ● Concern ● Common Cause ● Improvement ● Target



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
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Feb 25	Provider Submission	38	30		
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Metric Description

The percentage of all A&E attendances that leave the department within 4 hours. This includes all department types

BAF

BAF06

System Position - Summary and Context

4 hour all type performance has increased in NNUH from 79.7% to 80.7% and QEH seen a slight dip from 60.6% to 58.8%

JPUH data still a technical issue since Dec (although showing Feb this is incorrect)

Root Causes and Contributing Factors

Capacity within the community is limited to deal with demand resulting in an impact on A&E performance. High bed occupancy, length of stay and discharge processes within the acutes and community further exacerbate.

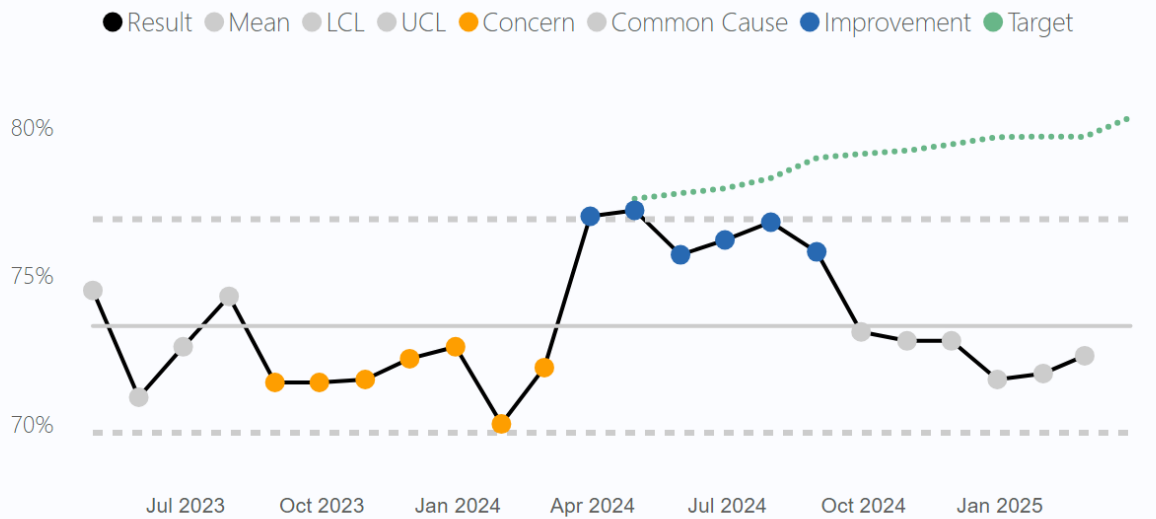
Associated Metrics, Insights and Impacts

All acutes have now submitted their operational plans which show their work towards 78% target.

Key Actions and Risks to Actions

Further work ongoing within admission avoidance and discharge to reduce attendances to ED and help support flow.

Alliance colleagues currently finalising their plans for 25/26 to support acute in hospital programmes of work.



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Feb 25	National	72.3%	79.7%		

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Metric Description

Percentage of people who attend their first treatment contact in the reporting month with 18 weeks from referral (RTT)

BAF

None

System Position - Summary and Context

Performance remains strong and consistently above target, with the latest reporting period achieving 100% against the 95% national standard. SPC shows the process is in statistical control, with no concerning variation. This provides assurance of sustained delivery.

Root Causes and Contributing Factors

No systemic constraints currently impacting this metric.

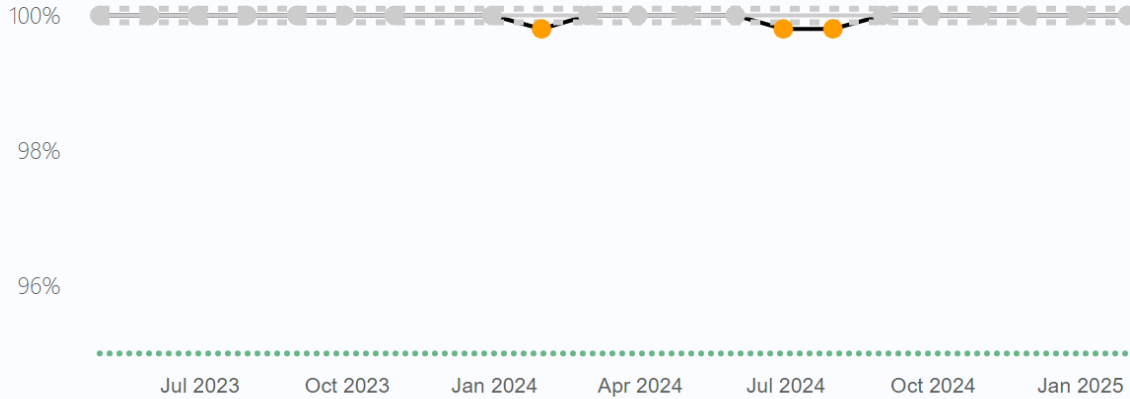
Associated Metrics, Insights and Impacts

- High RTT performance supports improved patient experience and treatment engagement.
- Continued focus on equitable access has reduced disparities, particularly in coastal localities.
- Performance in RTT aligns with recent improvements in recovery rates and reductions in DNAs.
- Early access to treatment supports improved clinical outcomes and reduced escalation into secondary care.

Key Actions and Risks to Actions

1. Maintain triage optimisation to support flow – ongoing (TT Monthly Ops Group)
2. Embed health inequalities analysis into monthly reviews – ongoing (TT Monthly Ops Group)
3. Monitor workforce models supporting access – ongoing (TT Monthly Ops Group)

● Result ● Mean ● LCL ● UCL ● Concern ● Common Cause ● Improvement ● Target



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	100.0%	95.0%		

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Metric Description

A count of A&E patients who attended for a mental health (MH) related compliant waiting for a acute inpatient bed for longer than 12 hours after decision to admit (DTA) has taken place.

BAF

None

System Position - Summary and Context

During the current reporting period, there were 38 12-hour DTA breaches, where the target remains zero. The current variation is not considered acceptable, and improvement actions have been triggered. Benchmarking data (where available) shows that this level of breach is comparable to or slightly better than the national average, where mental health bed pressures and demand challenges are also contributing to breaches.

Root Causes and Contributing Factors

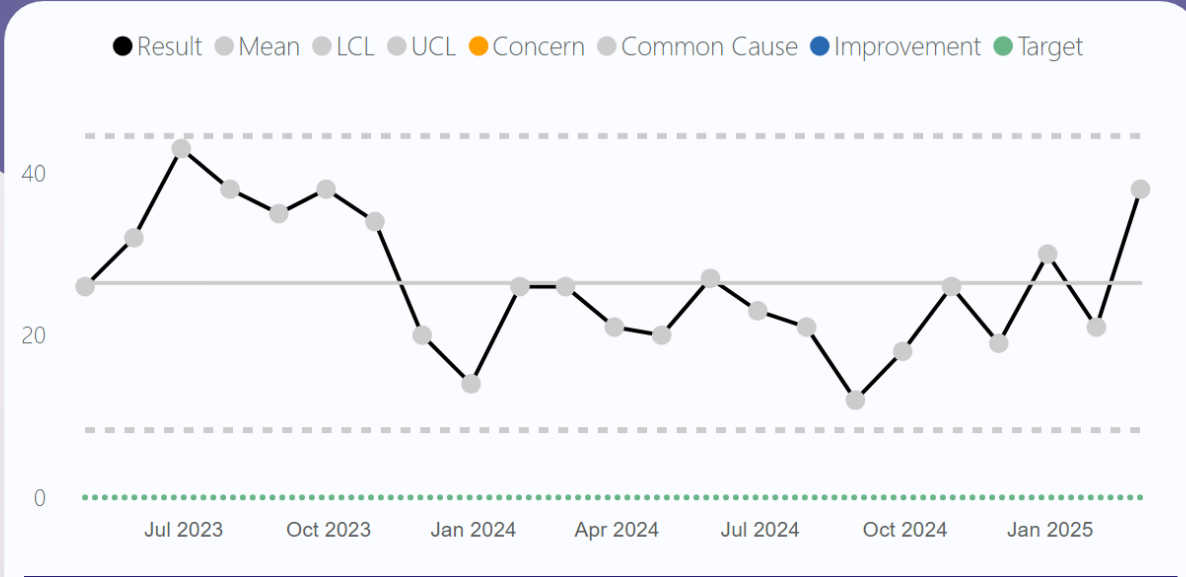
The breaches can be attributed to a combination of increased demand, bed capacity limitations, and workforce pressures within both the local provider and wider system. While the breaches are infrequent, continued pressure on the mental health pathway requires ongoing attention to capacity management, resource allocation, and communication improvements between partners in the system.

Associated Metrics, Insights and Impacts

While the breaches themselves are significant, they represent a symptom of broader system-wide challenges, including resource limitations, workforce pressures, and inequities in access to services. Addressing these issues requires a multifaceted approach, including improving bed availability, workforce resilience, and tackling systemic health inequalities to ensure that all patients, regardless of background, receive timely, appropriate care.

Key Actions and Risks to Actions

- Norfolk and Suffolk Foundation Trust (NSFT) clinical transformation work priority pillar is: Interface with Mental Health Liaison Service (MHLS) & acute hospitals NSFT led
- Some of the key components are seeking clarity re roles and responsibilities between Crisis Resolution Home Treatment Team (CRHTT) & MHLS re crisis pathway (includes Children and Young People (CYP) crisis)
- Review of the MHLS across NSFT including age- appropriate support
- Areas for improvement with acute hospitals & physical healthcare pathway



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Feb 25	ECDS	38	0		

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Metric Description

ED Number of 12 hour breaches, with a breakdown of Destination (Mental Health or Acute)

BAF

BAF06

System Position - Summary and Context

** Technical issue with JPUH data still not updated from December****

Both NNUH and QEH have seen reductions from January to February, with NNUH dropping from 379 to 294 and QEH dropping from 138 to 130

Root Causes and Contributing Factors

High bed occupancy, length of stay and discharge processes within the acutes and community increase 12 hour DTA breaches.

Associated Metrics, Insights and Impacts

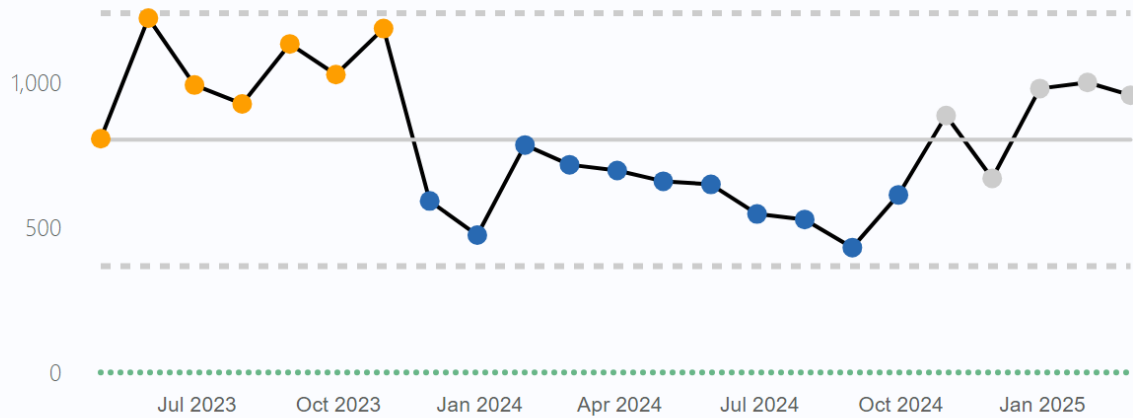
All acutes have submitted their 25/26 operational plans to support reduction.

Key Actions and Risks to Actions

Further work ongoing within admission avoidance and discharge to reduce attendances to ED and help support flow.

Alliance colleagues currently finalising their plans for 25/26 to support acute in hospital programmes of work.

● Result ● Mean ● LCL ● UCL ● Concern ● Common Cause ● Improvement ● Target



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Feb 25	ECDS	957	0		

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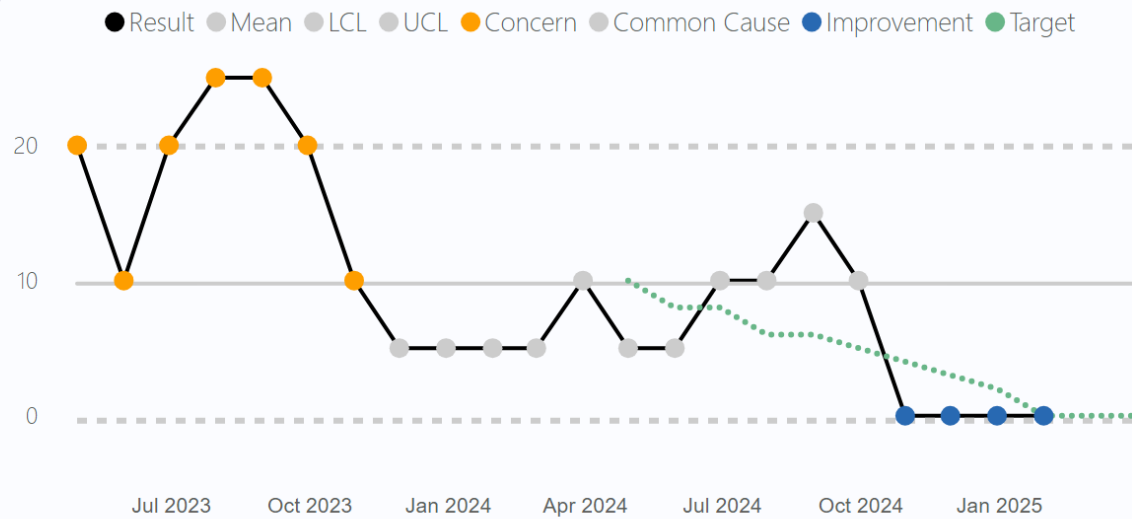


Metric Description

A count of patients that are currently in a out of area acute mental health bed and placed for inappropriate reasons (OAP) as of the last day of the reporting month

BAF

None



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	0	0		

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System Position - Summary and Context

There continues to be significant challenges in maintaining inappropriate out-of-area placements against a target of zero. The target has been maintained for 4 consecutive months with SPC showing 'improvement' in this time, though the challenge of a 'zero' target should be recognised.

Root Causes and Contributing Factors

The root causes of out-of-area placements are complex and multifactorial, involving both local Trust factors and broader systemic issues. Key drivers include limited local bed availability, delayed discharge pathways, regional coordination issues, and workforce shortages. Additionally, increased demand for services and a lack of community-based alternatives are contributing significantly to the challenge. Addressing these root causes will require both strategic changes at the local level and collaboration across regional and national systems to improve capacity, patient flow, and early intervention services.

Associated Metrics, Insights and Impacts

Inappropriate out-of-area placements has significant implications across multiple dimensions of quality care, health inequalities, and system performance. From a quality impact perspective, out-of-area placements disrupt continuity of care, affect patient safety, and reduce satisfaction. They also disproportionately affect vulnerable groups, exacerbating health inequalities, impacted by this issue.

Key Actions and Risks to Actions

The Trust has identified four key actions to address the issue of inappropriate out-of-area placements. These actions include expanding local bed capacity, improving discharge processes, increasing regional bed sharing, and enhancing crisis resolution services. While these actions are critical to reducing out-of-area placements, several risks could affect their successful implementation, including capacity constraints, staffing shortages, and coordination challenges at regional and system levels. Close monitoring and ongoing risk management will be crucial to ensure these actions lead to sustainable improvements.

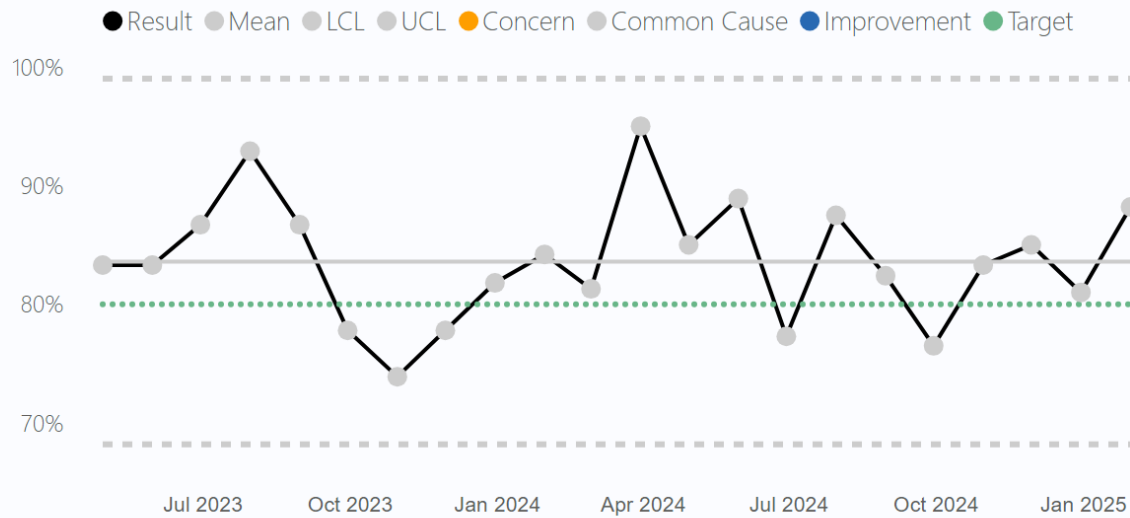


Metric Description

Percentage of adult acute admissions discharged and eligible for a follow up contact seen within 72 hours

BAF

None



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jan 25	National	88.2%	80.0%		

System Position - Summary and Context

This section reflects the positive performance (88.2% vs. target of 80%), acknowledges minor variations that are within acceptable limits, and compares the Trust's position with national/regional benchmarks. It also notes that the SPC chart provides assurance that the Trust is consistently meeting the target, with some acceptable variations during certain periods.

Root Causes and Contributing Factors

The root causes of delays in acute discharges followed up within 72 hours are multifaceted and involve both system-level and provider-level factors. Demand pressures, staffing shortages, discharge planning delays, and communication gaps are key challenges. Additionally, regional variation and external factors, such as patient-level barriers to access, also contribute to delays. Addressing these root causes will require system-wide improvements in capacity, staffing, and coordination between inpatient and community services, alongside better support for patients facing external barriers.

Associated Metrics, Insights and Impacts

The quality impact of timely follow-up care cannot be overstated; it is integral to improving patient outcomes, ensuring patient safety, and enhancing the overall patient experience. However, health inequalities persist, with certain populations facing more significant barriers to accessing follow-up care.

Key Actions and Risks to Actions

The key actions outlined focus on enhancing discharge planning, increasing capacity in community teams, improving communication between inpatient and community services, and targeting high-risk patients for follow-up. These actions are designed to sustain the positive performance of 88.2% for acute discharge follow-up within 72 hours and to ensure continued improvement where necessary. The risks associated with these actions primarily relate to staffing challenges, IT integration issues, and resource constraints, which need to be carefully managed to avoid delays or disruptions in service delivery.

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Subject:	ICB Performance Report
Presented by:	Matt Dooley
Prepared by:	ICB Commissioning and Performance team with contributions from teams working in subject areas.
Submitted to:	ICB Board
Date:	21 st May 2025

Purpose of Paper:

To provide assurance to the ICB Board and highlight significant elements of the reporting taken to Commissioning and Performance Committee.

Executive Summary:

The performance overview reviewed at Commissioning and Performance Committee in April 2025 is provided in the slide deck, taken from the revised Integrated Performance Report (IPR) – now launched as the *Performance and Planning App*. This provides recommended view in Statistical Process Control (SPC) charts and assurance narrative against each metric.

From July 2025 the ICB Board will receive a pack which includes performance from wider areas – Primary Care, People and Culture, and Finance. Additionally, the ICB Board will be provided with an equivalent report from the Quality and Safety Committee to represent the Quality Performance report – please see section 4.

Report

1. Performance overview

Board are asked to note:

- Cancer: 28-day Faster Diagnostic Standard and 62-day treatment standard are in SPC special cause improvement.
- Diagnostics: is in common cause improvement
- Elective Care: 18-week and 52-week Referral to Treatment (RTT) standards are both in special cause improvement. Work remains ongoing to eliminate longer waiting times as per 24/25 ambitions. Reporting has begun against the 18-week standard for first appointment.
- Mental Health: three of the four standards are met, one (Talking Therapies first treatment) with confidence that the standard will be maintained. The fourth standard – 12-hour decisions to admit in A&E – is in common cause improvement.

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- UEC: all areas saw common-cause improvement against target/trajectory. 111 call response times and Category-2 Ambulance response times recorded more significant improvement. A&E 4-hour and 12-hour standards recorded smaller gains in performance.

2. Risk and governance position

		Cancer	Elective	Mental Health	UEC
Is there a recovery trajectory?		Yes	Yes	Yes	Yes
Is there an up-to-date action plan?		Yes	Yes	No	Yes
Is there a contractual escalation in place?		No	No	No	No
Is there a risk logged against performance?	BAF	07 (InPhase 010)		03, 04	06
	BORR	043			
	ORR	057; 051; 050	076; 077; 074; 045		

3. tiaa audit

Through January – May 2025 tiaa auditors have re-assessed the ICB on its *Integrated Performance Management*. Tiaa have indicated that the work that brings together the Integrated Performance Management Framework, the new IPR and the associated documentation and assurance these provide will lead tiaa to improve the rating the ICB receives in this area.

Minor recommendations have been made that will be finalised and instigated in Q1 which support this assessment – these relate to publishing and linking documents with detailed information on the scheduling of reports, SRO role, ownership and sign-off of metrics, as well as removing some duplication. There was also the recommendation that Commissioning and Performance Committee hold the overarching responsibility for agreeing reporting and any subsequent changes.

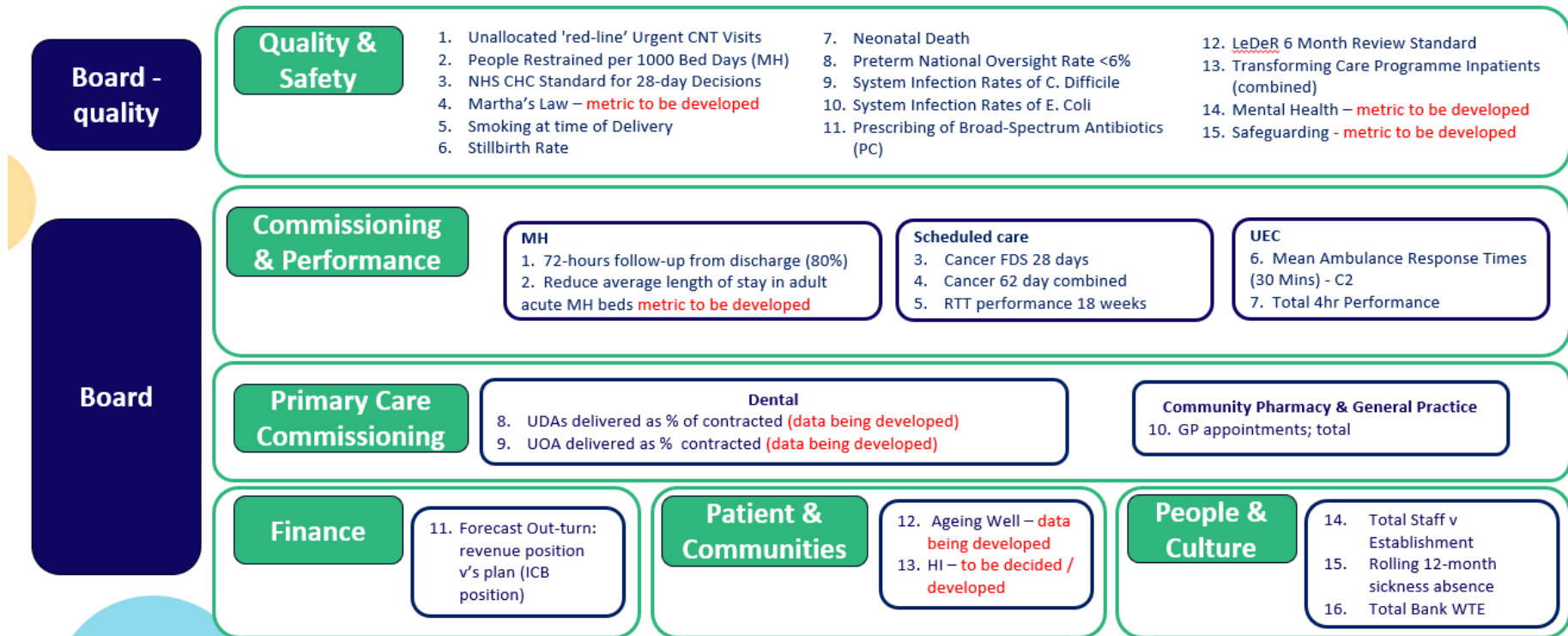
4. Development of reporting to Board

Following engagement with Committees and Programme Boards that feed up to Committees, the following is the set of metrics that is proposed by each group to have sight at the ICB Board meeting. The choice of the metrics takes into account the scheme of delegation and the role of both constitutional and planning metrics.

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ICB Board view

View of metrics to be reported to ICB Board



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Recommendation to the Board:

To consider the current performance areas when considering:

- Plans for delivery on 2025/26 standards and expectations beyond
- Commissioning priorities
- System prioritisation of resources

Governance

Committee Approval	ICB Board, May 2025
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Agenda item: 15

Subject:	Commissioning & Performance Committee (CPC) Report
Presented by:	Hein van den Wildenberg
Prepared by:	Diane Smith, Head of Collaborative Commissioning and Performance
Submitted to:	Integrated Care Board – Board Meeting
Date:	21 May 2025

Purpose of paper:

To provide the Board with an update on the work of the Commissioning and Performance Committee (CPC) for the period since the last Board meeting in Public on 26th March 2025.

Committee:	Commissioning and Performance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update on 26th March 2025	Meeting held in private on 17 th April 2025, 0900 – 1200 via MS Teams
Overall objectives of the committee:	<ul style="list-style-type: none"> • To make financial decisions / recommendations about business cases for commissioning and decommissioning, within the value of its delegated responsibilities as set out in the terms of reference. This forum is where decisions will be made about commissioning, other than for primary care which has its own committee. • To consider and make decisions on clinical policies as recommended by the Clinical Policy Development Group. • To consider and make decisions on recommendations from the medicines optimisation programme board. • To oversee and gain assurance on the operational arrangements that support the commissioning of services. • Oversee the process of any further delegation of commissioning responsibilities from NHS to the ICB. • Provide oversight to the Individual Funding Request panel.

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	<ul style="list-style-type: none"> • Conduct and lead the oversight of NHS system and commissioned provider performance, directing improvement resources and ensuring learning is implemented. This includes coordinating with regulators where formal improvement is required. • Ensure that innovation, best practice, evidence and evaluation and the impact on health inequalities consistently informs our commissioning decisions. • Approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation.
<p>Main purpose of meeting:</p>	<p>The Committee exists to provide assurance and oversight and make decisions (within its delegations) on the commissioning and performance of services to ensure better outcomes for the population of Norfolk and Waveney. It will also consider the management of risk in all its work.</p>
<p>BAF and any significant Board Operational Risks relevant / aligned to this Committee:</p>	<p>The following risks are the responsibility of this Committee, which will be making commissioning decisions and managing performance:</p> <p>Board Assurance Framework (BAF)</p> <ul style="list-style-type: none"> • BAF03 – Barriers to full delivery of the mental health transformation programme (Children and Young People) • BAF04 – Barriers to full delivery of the Mental Health Transformation Programme (Adults) • BAF06 – System Urgent & Emergency Care (UEC) pressures • BAF07 - Elective Recovery <p>These are the risks that are part of the reviewed BAF, signed off by the ICB public Board in July, and aligned to the 8 ambitions in the Joint Forward Plan.</p> <p>The Committee reviewed and discussed the risk ratings for BAF07 to consider the mitigated score and tolerated / target risk rating. Discussion took place on the risk ratings in consideration of other BAF risk ratings and the impact of the 2025/26 planning submission to NHSE. Further discussion will be taken through the Scheduled Care Board and Provider Performance and Planning Oversight Group to further inform the Committee following the resubmitted plan for 2025/26 in late April.</p> <p>Board Operational Risk Register (BORR)</p> <ul style="list-style-type: none"> • (030) Neuro-Developmental Service (NDS) Children and Young People • (045) Risk to CYP health due to long waiting times at NNUH for paediatric podiatry surgery • (046) System wide gaps in Speech and Language Therapy Provision • (049) ICB application of sustainable commissioning and compliance with procurement regulations

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	<p>The following were <u>new risks</u> accepted to committee</p> <ul style="list-style-type: none"> • (077) Diagnostic 6-week standard – March 2025 • (076) Referral to Treatment (RTT) standard – March 2025 • (079) ICB not submitting a Standards Met DSPT – April 2025 • (074) Familial Hypercholesterolaemia – transferred from Quality and Safety Committee March 2025 • (072) Loss of JPUH alcohol care team service due to lack of confirmed funding – NEW added March 2025 • (043) Delayed decision making re ICB business case for the Lynch Syndrome testing and surveillance pathway - transferred from Quality and Safety Committee March 2025 <p>Operational Risk Register (ORR)</p> <ul style="list-style-type: none"> • (037) Tier 3 and 4 weight management. • (057) System failure to meet access standards for cancer diagnosis and treatment <p>The following were <u>new risks</u> accepted to committee, all were transferred from Quality and Safety Committee March 2025</p> <ul style="list-style-type: none"> • (050) Histopathology delays affecting cancer pathways • (051) Insufficient acute medical staffing in oncology across system providers to meet current demand • (052) Hypnotics and anxiolytics prescribing (primary care) <p>Following the acceptance of BORR references 074 and 043 to the committee, these services have secured funding and therefore the risk owners have been requested to review these risks and report to committee in June 2025. Committee were keen to emphasize the commitment to ensuring these services are available to the population in Norfolk and Waveney.</p> <p>The Committee accepted oversight of ICB Information Governance (IG) risks in April 2025. April committee discussed the new risk raised (079) on the challenges the ICB has in meeting standards of the Data Security Protection Toolkit. It was identified that most ICB's are facing similar challenges and that progress is being made in Norfolk and Waveney on evidencing against the requirements.</p> <p>A schedule of 'deep dives' will be established to ensure the issues around risks are examined and discussed at a sufficient level for committee to be assured. The schedule will allow all risks to have a deep dive at least twice per year.</p>
<p>Key items for Board to take note of:</p>	<p>1. (April) The committee reviewed and approved Terms of Reference (ToR) and the ICB Governance Handbook in light of the decision to include oversight of all ICB IG risks as part of the committee.</p>

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2. Performance: The April meeting of the Committee received the first report from the revised Integrated Performance Report (IPR). This report aligns performance assurance with the governance structure reporting to CPC:

➤ **Elective:**

18-week and 52-week Referral to Treatment (RTT) standards are both in special cause improvement. Work remains ongoing to eliminate longer waiting times as per 24/25 ambitions (January data). Reporting has begun against the 18-week standard for first appointment (March data).

Work continues to focus on both elimination of the longest waits, especially that of those waiting 65-weeks, while driving performance on new 52-week and 18-week standards.

➤ **Cancer:** 28-day Faster Diagnostic Standard and 62-day treatment standard are in SPC special cause improvement (January data).

➤ **Diagnostics:** is in common cause improvement (January data).

➤ **Mental health:** three of the four standards are met, one (Talking Therapies first treatment) with confidence that the standard will be maintained (January data). The fourth standard – 12-hour decisions to admit in A&E – is in common cause improvement (February data). Urgent care aspects of mental health services are a key focus for internal and system improvement work, with rapid improvement actions established. Services for older adults is also a key focus within mental health, including but not limited to the services that support diagnosis of dementia.

➤ **Community:** work continues to ensure accurate and informative reporting of community performance position. It was noted that work is underway with community providers to support additional activity in TB screening.

➤ **Urgent & Emergency Care (UEC):** all areas saw common-cause improvement against target/trajjectory. 111 call response times and Category-2 Ambulance response times recorded more significant improvement. A&E 4-hour and 12-hour standards recorded smaller gains in performance (February data).

All teams are thanked for their engagement and support in the process of establishing the new performance assurance processes and reporting against these standards – as can be seen in the inclusion of the new format of reporting pack.

➤ **Primary Care:** the committee noted the report on performance and recovery from the Primary Care

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Commissioning Committee and will not duplicate but consider this position within the overarching system performance view.

➤ **Specialised Commissioning:**

Discussion in April centred on the developments of Mechanical Thrombectomy service and Major Trauma provision in for Norfolk and Waveney.

Delegations in 2025/26 will take forward learning from previous delegations from NHS England. We are reviewing the delegation agreement, which is where NHSE transfers the power to ICBs, and the collaboration agreement, which is the description of how we and the other five ICBs in EoE work together

3. Planning: Planning for 2025/26 was submitted to NHS England as expected. A review and triangulation by NHS England identified the requirement for Norfolk and Waveney to re-submit plans for the year, with a focus on triangulation of data, assurance on the systems ability to deliver the planned position and the dependencies of doing so e.g. workforce. The committee discussed the resubmission, which was subsequently made to NHS England on 30th April 2025.

It was noted that the Better Care Fund submission had been made and the delivery and monitoring of these commitments is connected to the wider system plans.

There was recognition that delivery of the plans is dependent on work in earnest focusing on elective recovery and that three areas of focus are being driven forwards by system working groups:

1. Diagnostics – delivering diagnostic capacity and standards
2. Productivity – the efficient and effective use of resources across and between all system partners
3. Demand management - a focus on demand management will be critical to the system meeting standards set out nationally and/or agreed through the planning process while delivering a financially balanced system position. This will accompany the need to actively and closely monitor the activity delivered against plans across the elective recovery programme.

The Board has discussed the risk profile associated with the planning submission. The accompanying assurance statement reflects these risks in a transparent way.

4. Escalations for ICB Board to be aware of

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	<p>March: Digital Strategy Steering group identified that there has been less than anticipated utilisation of the Shared care Record to date, and the benefits mean this should be driven out across the system.</p> <p>Scheduled Care Board identified services in the system that are significantly challenged and that collaborative efforts across acute hospitals and with support from the ICB and NHS England are supporting mitigations of risk.</p> <p>April: Scheduled Care Board wished for CPC to be aware of the number of organisational changes that are happening in the system and the impact this may have on delivery.</p> <p>5. Committee in public: further discussion in April committee identified that there will be a pause on the plans to hold part of the CPC in public.</p> <p>6. Committee meeting schedule A proposal was made that the CPC meet bi-monthly, with the schedule set to accommodate key holiday periods. Therefore, the next meetings will be June, July, September, November in 2025. It was noted that the importance of this committee means that extra-ordinary meetings may be called between these scheduled meetings, and that the performance report will be circulated in months where no meeting takes place.</p>
Items requiring formal approval of Board:	None
Confirmation that the meeting was quorate:	Yes.

Key Risks – of performance that falls short of expected national or local standards, constitutional requirements and/or plans

Clinical and Quality:

The impact of commissioning decisions on Clinical and Quality are integral part of decision making, and a clear process of assessing this impact is in place. Performance which falls short of expected national or local standards, constitutional requirements and/or plans will frequently have an impact on the clinical care and/or quality of care that can be provided and risks negatively impacting experience and outcomes. Performance review includes the perspective of clinicians, quality leads and people with lived experience.

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Finance and Performance:	Performance and Financial risk are inherently linked. Financial envelope impacts room for performance improvement initiatives. Most discretionary spend decision require sign-off through triple-lock process.
Impact Assessment (environmental and equalities):	Equalities and other relevant impact assessments are completed and reviewed at regular intervals and inform risk management processes.
Reputation:	If performance falls short of expected national or local standards, constitutional requirements and/or plans, this will have a negative impact on reputation of NHS Norfolk and Waveney.
Legal:	Legal risk in general may exist with commissioning decisions, and more broadly new Providers regime.
Information Governance:	None
Resource Required:	Not discussed
Reference document(s):	N/A
NHS Constitution:	Commissioning and Performance Committee seeks to assure we meet NHS Constitutional performance standards.
Conflicts of Interest:	Conflicts of interests is managed carefully, in view of the decision making authority of this committee.

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Agenda item: 16

Subject:	Report on primary care access recovery plan and improving the issues across the primary-secondary care interface
Presented by:	Mark Burgis, Executive Director of Patients and Communities
Prepared by:	Primary Care, Commissioning and Digital ICB Teams
Submitted to:	Integrated Care Board - Board Meeting
Date:	21 May 2025

Purpose of paper:

This paper is an opportunity for the Board to review progress at year end on [the Delivery Plan for Recovering Access to Primary Care](#); and, as part of this, the on-going work to support improvements across the primary-secondary interface. It will also provide an overview of Community Pharmacy.

The paper is for noting.

Executive Summary:

This paper sets out progress made against national requirements set out by NHS England (NHSE) in the Plan for Recovering Access to Primary Care (PCARP)

PCARP includes a range of actions across different areas, including the provision of digital infrastructure; the expansion of clinical services available at community pharmacies; incentives for groups of GP surgeries to work at scale; and workforce recruitment and retention schemes. What binds these actions together is the ways for ICBs to support primary care providers to work more closely together to better understand and respond to the needs of their population, with a focus on addressing health inequalities. This supports a move towards prevention while ensuring appropriate workload for general practice.

These initiatives are also sometimes referred to as “*modern general practice*” (see graphic for this model in body of paper) and are central to the 2022 publication: *Next steps for integrating primary care: Fuller Stocktake Report* [Fuller Stocktake](#).

Overarching aims for PCARP include:

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- Improving patient experience of access and allocation
- Improving staff working environments
- Better aligning capacity with need

Plan for Recovering Access to Primary Care (PCARP)

Key outcomes expected for the second half of 2024/25 included:

- Progress against our interface programme of work and delivery across four key areas
- Increased sign up to and usage of the NHS App together with ongoing support for educational events
- Completion of cloud-based telephony system upgrade programme for GP surgeries
- Support programme for GP surgeries (*General Practice Improvement Programme – GPIP*) to manage workload and better respond to patient needs through the adoption of *Modern General Practice* principles
- Promote a culture of quality improvement across primary care, harnessing the power of technology where appropriate to support this

1. Background

Norfolk & Waveney Integrated Care System’s Vision for Primary Care is for primary care providers to work collaboratively, embedded in their communities, in a way which brings joy and meaning to the workforce and improves outcomes for all our residents.

The **Norfolk & Waveney Integrated Care System 5 Year Joint Forward Plan** includes an aim to bring primary care providers together with their communities and local partners to understand, and respond using their collective assets, to the needs of those they serve with a focus on targeting resource on the highest need - see **Ambition 2 Primary Care Resilience and Transformation** for more detail. [Primary Care, Joint Forward Plan](#)

This paper is presented in the spirit of our commitment to listen to those who receive, deliver or plan primary care.

2. Delivery Plan for Recovering Access to Primary Care - Key Metrics

Increase the use of NHS App and other digital channels to enable more patients access to their prospective medical records and manage repeat prescriptions.

- 559,008 Norfolk and Waveney (N&W) patients have registered for the NHS App (58% of GP patients 13 years +), seeing us broadly in line with national

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benchmarking, which shows 60% of GP patients aged over 13 have registered for the NHS App.

- N&W saw a significant increase in appointments being booked via the app in January 2025 (see Image 1 below), though there is variation across Primary Care Networks (PCNs). The range in appointments being booked via the app by GP surgery is extensive, with 3 surgeries showing 0 appointments to a surgery that has seen 37,605 appointments booked since the NHS App functionality was implemented. It should be noted that some surgeries use other online solutions to enable appointment booking.

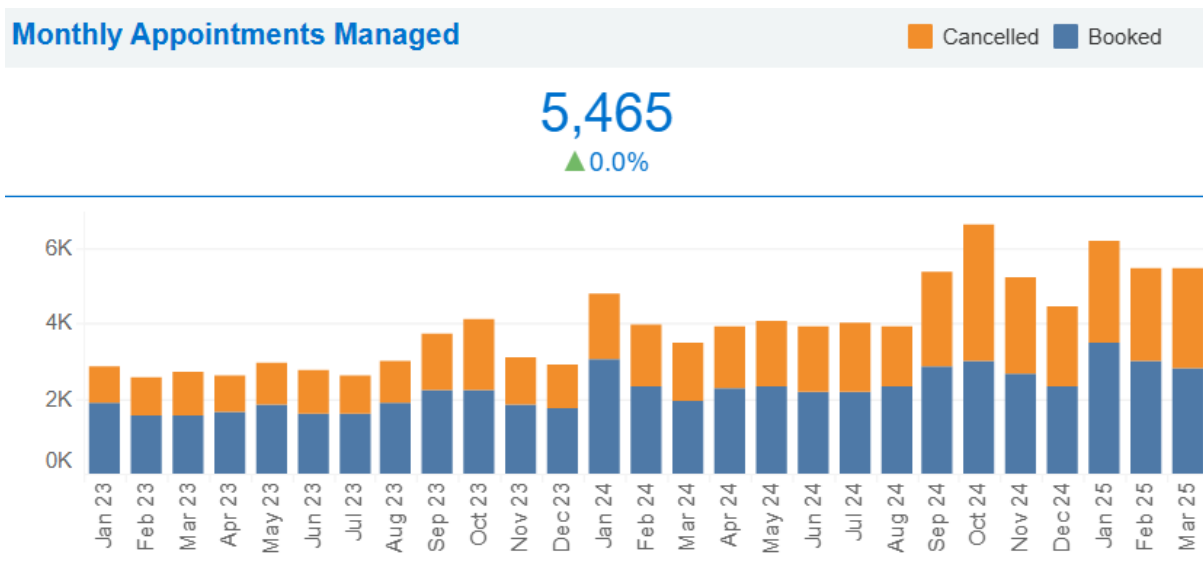


Image 1: Appointments Managed by N&W Registered Patients via the NHS App (Jan 2023 – March 2025)

- N&W ICB have the highest number of NHS App logins per 1000 GP registered population in the East of England (EoE) region (see Image 2 below). Other than October 2024 (which saw the highest total logins for N&W), March 2025 saw an increase in activity with 1,009,983 logins across N&W.

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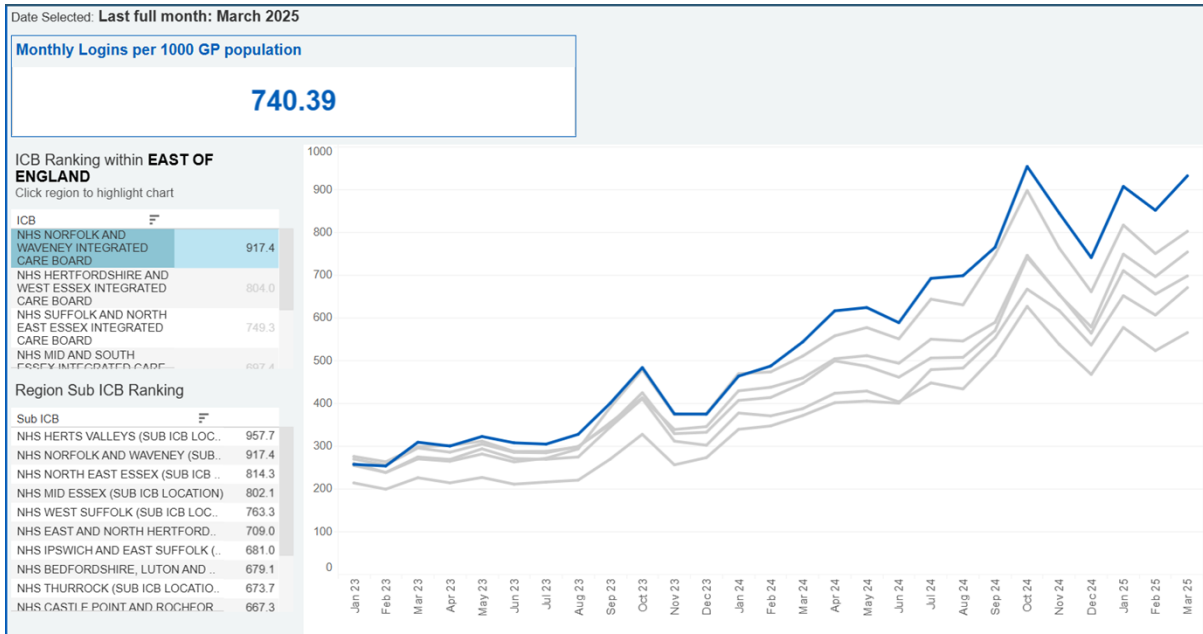


Image 2: Monthly NHS App Logins per 1000 GP registered population by EoE ICB (Jan 2023 – March 2025)

- N&W saw the highest number of repeat prescriptions being ordered via the NHS App in January 2025, with March 2025 showing similar activity (see Image 3 below).

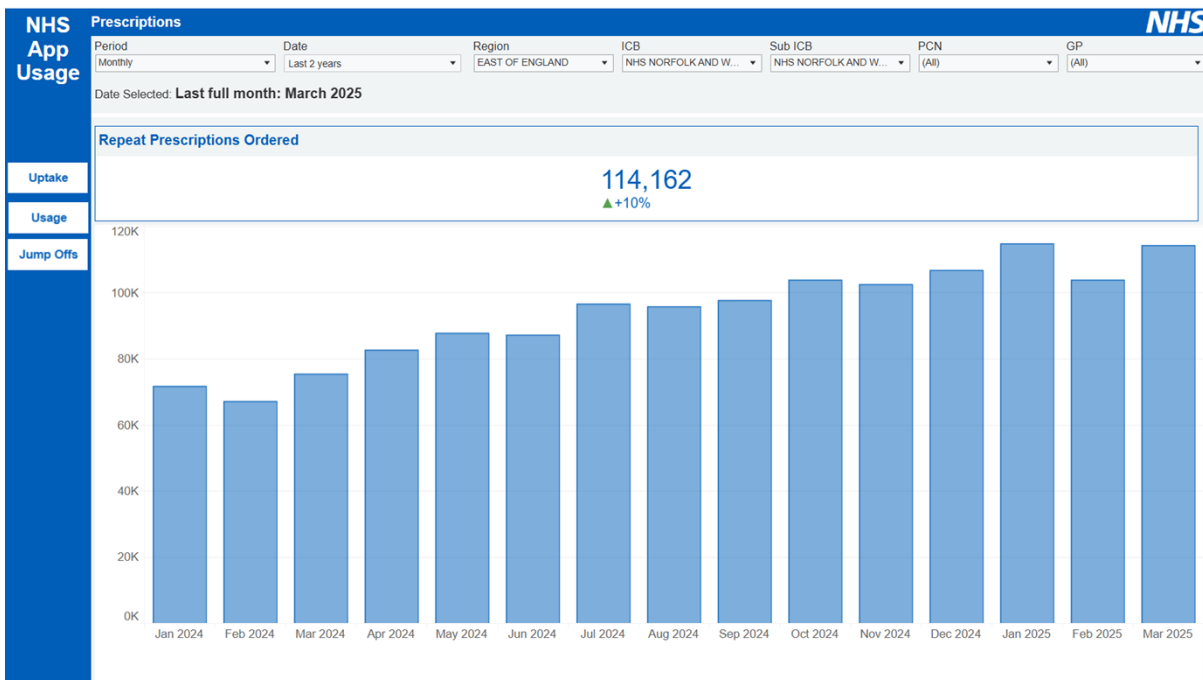


Image 3: Monthly NHS App Repeat Prescriptions Ordered (Jan 2023 – March 2025)

Next steps:

The GP Contract 2025/26 includes the aim that patients have an equitable experience across all access modes (phone, online, walking in). From 1 October 2025, practices will be required to keep their online consultation tool open for the

duration of core hours (8.00am - 6.30pm) for non-urgent appointment requests, medication queries and admin requests. As of 31 March 2025, 19 of 20 PCNs in N&W have claimed for Domain 2 of the PCN Capacity & Access Improvement Plans (CAIP) for 2024/25, declaring their online consultation forms are available for patients to make administrative and clinical requests at least for the duration of core hours. Primary Care Commissioning and Digital teams will be supporting practices to either implement this contractual requirement by October or to manage demand if already being provided.

Another key digital requirement of the new GP Contract for 2025/26 is that by no later than 1 October 2025 practices will also be required to ensure the functionality of GP Connect is enabled which:

- Allows read only access to patient care records (GP Connect Access Record HTML and Structured) by (i) other NHS commissioned providers for the purposes of direct patient care and (ii) providers of private healthcare (only in cases where the private provider obtains explicit permission from the patient to access their NHS GP care record and they are providing direct patient care).
- Allows Community Pharmacy registered professionals to send consultation summaries into the GP practice workflow (GP Connect Update Record), which will reduce the admin burden for general practice teams.

The Primary Care Commissioning and Digital Teams will work together to identify gaps in delivery and support practices to deliver these new contractual requirements.

Make on-line registration available in all practices by October 2024

All surgeries in N&W are using the national online registration system developed by NHS England. 2 N&W surgeries are taking part in an [automation pilot for the online registration](#) system and are due to go live with the pilot on 7 April 2025. This pilot will test direct integration between the *register with a GP surgery* service and GP IT systems, allowing data from patients who meet the pilot criteria to be automatically transferred into GP systems. The feedback from this pilot will guide a possible roll-out of the service.

Continue to expand self-referrals to appropriate services

As part of the 2023/24 operational planning guidance, with a refresh of expectations in 2024/25, ICBs were asked to implement self-referral pathways in 7 named pathways. 5 of these (MSK, Audiology (Elderly hearing) Podiatry, Weight Management and Wheelchair) are measured by the Community Services Data Set (CSDS), the remaining 2 are Community Equipment Services and Falls Service.

The community equipment provider Medequip and British Red Cross have patient-initiated provision in place. This supports hospital discharge, admission avoidance and elements are also incorporated into pathways for patients who have an 'open referral' into them. Factors must be considered regarding clinical and environmental assessment and risk to ensure appropriate equipment issue and use, as well as operational and cost pressures, when considering any self-referral option. Increasing access through self-referral will continue to be considered where appropriate and possible.

Self-referral data for services measured through the CSDS is shared with us by NSHE. The latest data available (for December 2024) shows that N&W continues to perform well when compared to other areas in the East of England Region.

ICB	ICB Rate* per 100,000	Lower 95% CI	Upper 95% CI	Nat rate* per 100,000	Difference to National
EAST OF ENGLAND					
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD	305.7	293.4	318.5	381.6	-75.9
NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD	288.1	276.6	300.0	381.6	-93.5
NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	117.3	111.8	123.0	381.6	-264.3
NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	457.6	445.6	469.9	381.6	76.0
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	650.0	635.6	664.7	381.6	268.4
NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	481.3	468.2	494.7	381.6	99.7

NHSE colleagues are exploring, at a national level, how self-referral can be supported digitally on existing platforms, including the NHS App.

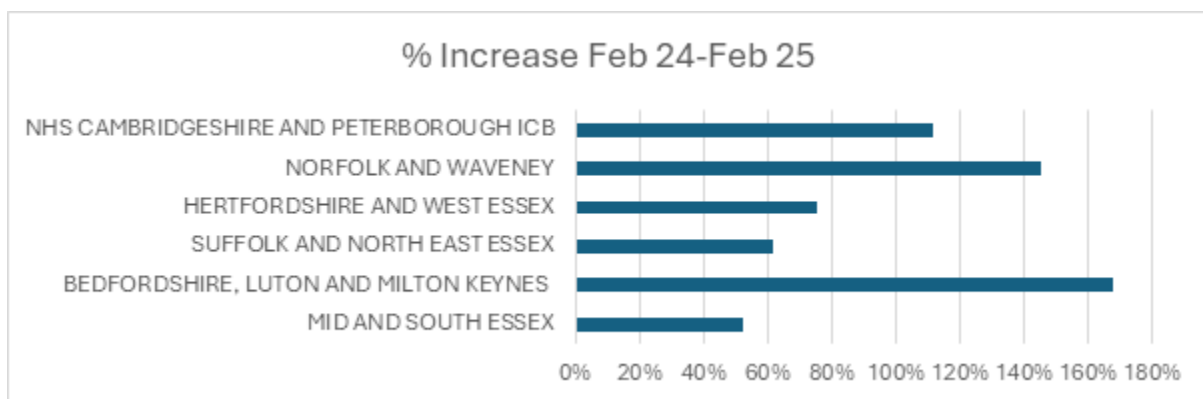
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3. Community Pharmacy Update

The initial target for Pharmacy First clinical pathway appointments was set at 5,240 consultations per month by end March 2025, this was based on a prediction that all contractors would achieve 30 clinical pathways per month by the end of the first year. This target was relevant at the time as minimum threshold targets for an additional payment were initially set at 30 from October 2024.

However, at this time indicative data was not available and therefore adjustments have been made throughout the initial 12 months of performance.

Since the start of the service in February 2024, Norfolk and Waveney ICB have seen a positive 145% increase in the use of the service, which is significant when compared to other ICBs in the region.



The total number of pharmacy contractors in Norfolk and Waveney is 170 and we have 167 community pharmacies signed up. Of those who are not signed up to deliver Pharmacy First:

- 1 is a DAC (Dispensing Appliance Contractor) and has not been signed up from the start.
- 1 is a DSP (Distance Selling Pharmacy)
- 1 has never been registered due to not having a consultation room

The target for Pharmacy First appointments for March 2026 has been provisionally set at 5660. This represents a 33% increase over the year in activity, using February 2025 data as a benchmark. This also takes into consideration the minimum threshold payments due to start in June 2024 following the release of the new Community Pharmacy Contractual Framework (CPCF) on the 31 March 2025. This will see pharmacies achieving 30 clinical consultations in a month receiving the maximum threshold payment of £1000 and those achieving 20-29 receiving a 50% reduced payment of £500.

Data shows 31% of Community Pharmacy contractors met the gateway of 30 in March 2024 with 13% achieving between 20 and 29 clinical consultations, giving an indication that as from June 2024, when the new thresholds come into effect, over 44% of contractors should be receiving some form of additional payment for Pharmacy First activity. The overall impact of the other contractors not meeting the threshold is not known.

Looking forward, and with the investment of a further £215 million nationally in Pharmacy First services, activity will be critical for pharmacies' financial viability going forward.

Other potential barriers that could restrict the ability to absorb the additional increase in activity are:

- Consultation room standards and or the ability to invest in a second consultation space to enable the service to work alongside others, for example during the flu vaccination season
- Clinical skill mix within the pharmacy e.g. lack of pharmacy technicians or accuracy checking technicians (ACT) which prevent the pharmacist having the capacity to leave the core contractual requirements of dispensing and checking to enable clinical services such as Pharmacy First

As an ICB we continue to work with our estates team to explore opportunities for acquiring funds that may enable pharmacies to be 'fit for the future' by having the ability to invest in the development of their pharmacy premises. Our ICB Pharmacy workforce team also continue to work with training providers and contractors to ensure all opportunities for additional training to enable Pharmacy technician qualifications are utilized.

Advancements in Pharmacy dispensing technology, which removes the needs for a final physical check by the pharmacist, are already available and are being used to great effect by some pharmacies to help support the resilience needed to enable the pharmacist to complete all services. This in turn makes them more service focused which will support activity increases and financial viability of the pharmacy.

The target for oral contraception (continuation and initiation) consultations presenting to community pharmacy directly by March 2025 was set at 250 per month. Data for March 2025 recorded 558 consultations resulting in a 100% increase in activity over a 6-month period. To date only 90% of contractors are registered to provide the service but with anticipated bundling of services to receive additional Pharmacy First payments, we expect this to increase to over 98% in line with the Pharmacy First and hypertension services, by the end of March 2026.

The target for Community Pharmacy Blood Pressure check appointments by March 2025 was set at 3,500 per month. Data for March 2025 recorded 3945 clinic checks and 276 ABPM checks (7% conversion) compared to the February 2024 data of 1,718 clinic checks and 77 ABPM checks (4% conversion).

Ambulatory blood pressure monitoring (ABPM) is a method of measuring blood pressure over a 24-hour period, typically while the patient goes about their normal activities ABPM checks.

With a shift of focus within the new contract to ABPM monitoring we do expect there to be an increase in the conversion rate with a national target of 10-12% but there is a risk that this could impact total activity with a drop-in clinic check activity.

Following a review of the 2024/25 data, new targets have been established for the oral contraception service and hypertension case finding service.

The target for oral contraception service consultations by March 2026 is set at 1,000 per month. The target for the hypertension service is set at 3,000 per month, the target reflects the hypertension service is limited by factors, including the availability of ABPM (ambulatory blood pressure monitoring) monitors and the capacity of follow-up treatment and interventions, including primary medical and wellbeing services. Amendments to the hypertension case finding service in the new Community Pharmacy Contractual Framework, has also indicated a change in the service to allow referrals from other healthcare providers such as dentists and optometrists could increase the outreach of the service and hence activity.

To support the continued development of the Pharmacy First service the ICB have provided the following resources to all contractors and stakeholders within Norfolk and Waveney ICB, including locum pharmacists who may travel to work within our ICB footprint

- Face-to-face contraception training workshop to support increase in registrations and increase activity by enhancing skills
- Pharmacy Integration Project – procurement of a provider to support integration of pharmacy services in Norfolk and Waveney
- Pharmacy First Toolkit to support General Practice colleagues in their knowledge of the service and to maximise the opportunity Pharmacy First provides in supporting capacity concerns.
- Pharmacy First poster designed for distribution across schools, colleges and universities

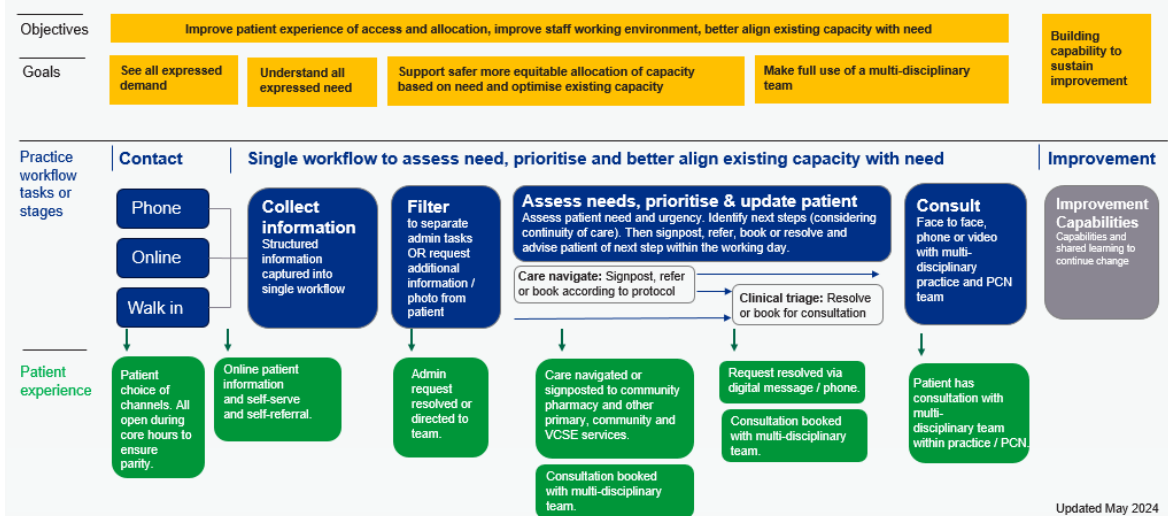
Utilisation of the Minor Illness Referral pathway has remained consistent with the previous CPCS (NHS Community Pharmacist Consultation Service) within Norfolk and Waveney averaging 626 per month, peaking at 743 referrals in March 2024.

The Urgent Medicine Supply service has seen a 25% increase year-on-year with over 12,500 supplies made over 12 months.

4. Adopting Principles from the 'Modern General Practice' Model

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Modern general practice (MGP)



The cloud telephony program saw record investment in installing or upgrading digital phone lines and telephone systems designed to make booking GP appointments easier, including:

- 30 GP surgeries moving from sub-optimal phone systems to cloud based telephony, GP Voice platform to meet the latest NHS England requirements
- 20 GP surgeries receiving feature upgrades to their digital or cloud-based telephony systems to comply with the latest requirements
- 36 GP surgeries migrated to the GP Voice platform, from the original platform they were on as part of an earlier NHS England pilot scheme

All 3 phases listed above were completed on time and meet, or exceed, NHS England's updated requirements for Cloud Telephony, supporting the Modern General Practice model under the National Framework for CBT suppliers.

All Norfolk and Waveney practices have CBT, but do not necessarily meet all the requirements (e.g. call back). Reasons for practices remaining with existing suppliers include recently agreed contracts which were not practical to change; existing suppliers not being on the national framework; and contracts which can facilitate callback but at an additional charge.

5. General Practice Improvement Programme (GPIP)

To date, a total of 31 practices have actively participated in the GPIP initiative, showcasing the commitment and engagement of practices toward enhancing patient care and operational efficiency. Looking ahead to 2025/26, a cohort of 6 practices has been confirmed for a locally commissioned scheme delivered in partnership with the RCGP (Royal College of General Practitioners), with potential for additional practices to join, contingent on securing funding.

Our operational plan includes a target of 50% participation across N&W surgeries by the end of 2025/26, subject to funding, with a focus on embedding the principles of Modern General Practice.

6. Capacity & Access Improvement funding 2024/25

All 20 PCNs submitted CAIP domain claims before the deadline of the 31st March 2025. Of those 20 PCNs, 19 of them have claimed for all three domains, with only one PCN (SNhIP) claiming for domain 1 & 3 only. This means practices will receive their Capacity and Access Improvement Funding payment to PCNs for 2024/25 shortly, which should account for 30% of the Capacity and Access Payment (CAP). The remaining 70% of the Capacity and Access Improvement funding was paid without any conditions via the Capacity and Access Support Payments made monthly over the year.

The three domains which PCN Clinical Directors were asked to declare achievement against each component for all the practices in their PCN were:

MGPA priority domain	All PCN practices to have following components in place and these continue to remain in place
1) Better digital telephony	<p>Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England.</p> <p>Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.</p>
2) Simpler online requests	<p>Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours.</p> <p>Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.</p>
3) Faster care navigation, assessment, and response	<p>Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests.</p> <p>Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.</p>

7. Complete implementation of highly usable and accessible online journeys for patients

There will continue to be an emphasis on online access for patients in 2025/26 as directed by the new GP Contract. Work was undertaken in 2024/25 to lay the foundations for increasing online access, including what has been noted earlier in the report regarding CBT, NHS App usage for appointments, and moving to increased use of online forms, as well as the following:

- Prospective Records Access ([Prospective Records Access](#)) as of early March 2025, all N&W surgeries had enabled their organisational settings to allow prospective access to their patients (Step 1). There are four steps to prospective records access, with a focus on Step 1 and Step 3 (Step 3 - reviewing and enhancing patient access). There are currently 2 surgeries in N&W who have not enabled Step 3 and work is ongoing with the GP surgery teams to address the concerns raised around data protection
- All N&W GPs have opted into the Cloud-based Telephone Data Provision Notice (DPN) and the Online Consultation DPN

8. Build capacity

The Primary Care Workforce Strategy and Operational Delivery Plan was approved by the Primary Care Commissioning Committee on 10 September 2024 supporting the themes of “Train, Retain and Reform”. The plan included 47 programmes, designed for delivery during 2024/25, all with key performance indicators (KPIs) to reflect both national and local targets

- Our Newly Qualified GP Incentive scheme received national recognition, and was awarded Highly Commended “Workforce Initiative of the Year”. Within 24/25 we supported 38 newly qualified ST3 (Speciality Training Year 3) GP Trainees have received substantive primary care employment offers through the 2024/25 scheme, 12 Newly Qualified General Practice Nurses/Nursing Associates
- ‘Golden Hello’ national and local incentive for dental professionals are in place, 46 dental professionals are being supported to secure substantive roles within primary care settings to date
- 93% of practices are now training practices, which has increased medical placements by 25%
- 95% of practices have been supported with continuous professional education programmes supporting our local population needs with long term conditions and health inequalities
- 79% of practices have taken up workforce retention support offers to retain and attract new talent within primary care

- The 2024 NHS General Practice Staff Survey indicates that our system has improved in most of the NHS People Promise elements compared to the 2023 results, with the exception of “Staff Engagement,” which showed no change from the previous year’s position

9. Cutting bureaucracy – background

The N&W System Interface Group, chaired by the ICB Executive Medical Director has continued to meet monthly, bringing together primary, secondary, community and mental health system partners; building on the consensus that when the interface between providers works well the patient experience is more positive. From April 2025 these meetings will move to quarterly and run alongside three local monthly meetings to encourage interface to become part of day-to-day conversations between providers.

A dedicated Interface Manager post has been in place for 8 months, leading on the coordination of engagement across system providers. A system-led workplan incorporating metrics will be developed for 2025/26 to incorporate the Government’s [Red Tape Challenge](#), demonstrate identified improvements, and to ensure that these are measured in a consistent way.

Ongoing reviews will support processes to remain ‘fit for purpose’ and provide assurance that providers have a defined Single Point of Contact for interface, which is universally recognised and understood.

Progress update against the four main National Primary Care Secondary Interface recommendations:

- **Onward referrals**
 - All providers acknowledged the importance of the communication and clarity of the consultant-to-consultant policy within their self-assessment gap analysis
 - A review of data collected through the Interface Reporting system supported an audit and review (ongoing) of compliance with the Consultant-to-Consultant referral policy
- **Complete care (fit notes and discharge letters)**
 - A Task & Finish group has been established to develop Referrals and Discharge Guidance for all providers and support in the development of the Electronic Patient Record project and remains work in progress
 - Fit note guidance and NHSE recommendations have been shared to all provider teams

Call and recall

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- Trusts confirmed there are clear procedures for call and recall, with one Trust noting ongoing work is required to support compliance around communication with General Practice
 - All providers acknowledged communication regarding the policy for managing DNAs (did not attend) and re-referrals and continue to work to embed the recommendations
- **Single point of contact for clinicians**
 - All providers now have a generic contact email to support non-urgent queries, not all providers have departmental contacts emails in place

Cutting bureaucracy sits under our wider Interface workstream, key areas of focus during the second six months of March 2025 include:

- Ensuring non-medical health professionals can appropriately request laboratory tests via the WebICE system (for example for wound swabs, urine cultures, nutrition monitoring bloods) and similarly to receive their own results directly, to reduce clinical risk and prevent duplication of work
 - *This work is an integral piece to the development of radiology access and the Musculoskeletal Assessment and Treatment Service*
 - *The working group for the Norfolk & Norwich and James Paget Hospitals has been paused due to resource challenges. Implementation has been completed by the Queen Elizabeth Hospital*
- Ensuring allied health professionals working in the community, can appropriately request imaging via the WebICE system after completing training in line with Ionising Radiation (Medical Exposure) Regulations (for example first contact physiotherapists being able to request plain X-rays) and similarly to receive their own results directly
 - *A Task & Finish Group agreed the scope of practice for GP Practices, for approval by NNUH and JPUH, but the group has subsequently been paused due to resource challenges. Implementation has been completed by the Queen Elizabeth Hospital*
 - *Progress by community providers (NCHC and ECCH) has also been paused*
- Trusts issuing fit notes for the full duration of absence as opposed to passing these requests back to GPs
 - *A reduction in reporting on this issue was seen during October 2024 – March 2025. Trust are looking to enable electronic fit notes and are currently working through technical issues to support this.*

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- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice
 - *Communication remains one of the highest issues reported in the interface reporting process, along with onward referrals. We continue to receive submissions that reflect concerns regarding communication delays, inadequate information or inappropriate transfer of workload through the interface process. A task & finish group was set up to address improvements in common language, response times and template discharge letters to support effective and consistent communication and this guidance was finalised in February 2025 with a collaborative input from all system leads.*
- Supporting local interface conversations to inform, collaborate and enable solution-based working
 - *Arrangements are in place to promote local discussions to improve interface and support the System Interface Group work programme. By building a foundation of strong relationships we aim to increase opportunities for peers to come together to be transparent about issues they face, which impact patient care, and co-design and agree solutions.*
- Implementing a single point of contact for all stakeholders to raise queries
 - *Ongoing work to ensure there is an effective point of contact for all providers has included a one stop process for practices to follow up with issues via the Interface NoW reporting process. Further work involved in ensuring departmental emails are noted on letters is being implemented with the introduction of Electronic Patient Record at the acutes.*

Recommendation:

Board members are asked to review the report and share feedback on progress reported against the ambitions of the *Delivery Plan for Recovering Access to Primary Care and General Practice and Secondary Care: Working Better Together*.

The Primary Care Commissioning Committee agenda for 14 May 2025 included this Board report for noting, it having been updated to reflect assurance discussions on delivery of PCARP at the General Practice and Community Pharmacy Delivery Group on 8 April 2025.

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Key Risks	
Clinical and Quality:	Quality and capacity in primary care can be impacted due to inefficient working arrangements across the primary- secondary care interface, causing resilience and workforce issues
Finance and Performance:	<p>Care capacity can be negatively impacted due to inefficient working arrangements across the primary-secondary care interface</p> <p>Failure to progress across all the interface requirements of the plan may affect the ICB's and ICS assurance process</p> <p>The ICB may have to consider developing alternative pathways to meet identified gaps in service provision</p>
Impact Assessment (environmental and equalities):	Reduced capacity could constrain the ability to address health inequalities.
Reputation:	<p>Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally</p> <p>Lack of perceived progress against primary secondary interface poses a reputational risk with primary care providers</p>
Legal:	None identified
Information Governance:	System IG Peer Group in place working across ICS.
Resource Required:	Primary Care Workforce Transformation, Primary Care Delegated Commissioning, Community Pharmacy, Medical, Digital and Commissioning teams all support contractors with delivery
Reference document(s):	<p>Delivery plan for recovering access to primary care (england.nhs.uk)</p> <p>Delivery Plan for Recovering Access – Update published 9 May 23 updated 3 September 2024 https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/</p>

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	<p>Delivery Plan for Recovering Access – Update and Actions published April 2024</p> <p>NHS England » Delivery plan for recovering access to primary care: update and actions for 2024/25</p> <p>Cloud Based Telephony https://www.england.nhs.uk/long-read/funding-for-practices-moving-to-digital-telephony/</p> <p>DPN Data Provision notice https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/directions-and-data-provision-notices/data-provision-notices/cloud-based-telephony/20240816-cloudbasedtelephonydataprovisionnoticev1.0.pdf</p> <p>https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/.</p>
NHS Constitution:	<p>NHS Standard Contract https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/</p>
Conflicts of Interest:	Declarations of interest are held on record, there were no direct conflicts of interest noted for this report
Reference to relevant risk on the Board Assurance Framework	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
Governance	Paper taken to General Practice and Community Pharmacy Delivery Group on 8 April 2025 for assurance discussions; updated version taken to Primary Care Commissioning Committee on 14 May for noting
Process/Committee approval with date(s) (as appropriate)	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20

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Agenda item: 17

Subject:	Primary Care Commissioning Committee Report
Presented by:	Hein van den Wildenberg, Non-Executive Member and Deputy Chair of PCCC
Prepared by:	Sadie Parker, Director of Primary Care
Submitted to:	Integrated Care Board – Board Meeting
Date:	21 May 2025

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee (PCCC) from the March 2025 committee meeting.

This paper is based on the agenda for the PCCC meeting on 14 May 2025. As the meeting date coincides with publication date, key points that came out of the discussion will be covered verbally.

Committee:	Primary Care Commissioning Committee
Committee Chair:	Ian Wake, Local Authority Member
Meetings since 26 Mar 2025	14 May 2025
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, and since 1 April 2023 the commissioning of dental, pharmaceutical and optometry services under a Delegation Agreement with NHS England.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.

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BAF and any significant risks relevant / aligned to this Committee:

BAF02 – Primary Care Resilience and Transformation
Current mitigated score – 5x4=20

Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities.

Our high-level outputs include:

- Developing a vision for providing accessible enhanced primary care services
- Improving patient outcomes and experience
- Stabilise dental services and setting a strategic direction for the next five years

Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals.

There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores.

The optometry landscape is less defined at the present time, but workforce and funding challenges are evident across optometry and community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers.

Limitations of national contracts, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population.

This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services.

As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams,

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including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.

BORR08 – secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)

Current mitigated score – 4x4=16

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, and resources within the ICB Primary care team to implement the recommendations from the East of England NHSE report lack of resources to monitor and manage 3 secondary care contracts.

BORR09 – resilience of NHS general dental services in Norfolk and Waveney. Current mitigated score – 5x4=20

The primary care team leads undertook a deep dive meeting into the dental risks, facilitated by the corporate affairs team.

Primary care services became the responsibility of the Integrated Care Board from 1st April 2023; the risk is the resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services. Whilst the ICB is able to mitigate some of the challenges however some of them remain outside ICB control. Until action is taken to resolve some of them, the stability of NHS dental services in Norfolk and Waveney remains fragile and there is an ongoing risk of practice switching to private practice.

Improving access is directly linked to being able to recruit and retain a multi-skilled dental workforce across all dental services (primary, community and secondary care) and therefore the risk score remains the same in all of the risks.

BORR11 – the resilience of general practice

Current mitigated score – 4x4=16

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- The primary risk facing general practice is around resilience, the main drivers are: workforce pressures, financial constraints, increased demand for services from the local population, and the need for greater efficiency savings.
- To help address these challenges, the 2025/26 GP contract has been agreed, with a significant uplift in both core General Practice and Network Contract DES (Directed Enhanced Services) funding amounting to a 7.2% increase, the largest investment in general practice in over a decade. Additional funding is also anticipated following the 2025/26 DDRB (Doctors and Dentists Remuneration Review Body) pay review outcome.
- We note the LMC continues to be concerned about the impact of the NI employers contributions changes on practices and this will be monitored going forwards.
- At this stage the scoring of the risk has not been changed. To manage demand and capacity, key actions include the rollout of GP improvement programmes, support for practices to adopt the Modern General Practice model, and the development of a neighbourhood approach aimed at tackling health inequalities through early intervention.

BORR27 – the resilience of community pharmacy
Current mitigated score – 4x4=16

- The new Pharmacy contract was released end March 2025 alongside an economic analysis of the pharmacy sector (commissioned by NHSE and DHSC) which still confirms a £2bn funding deficit against what is provided versus what is needed to provide pharmaceutical services. So although the new contract is a positive step, it may not fully mitigate the risk.
- Remuneration of advanced services is changing with bundling of services being required to receive payments so this may result in some contractors to be at a disadvantage which may increase the risk of closure due to financial viability concerns which in turn would impact the ability of the remaining pharmacies to provide advanced services such as Pharmacy First due to excessive demand to dispense.
- Until the data is available to advise the ICB of the impact, a score reduction is not appropriate.

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Key items for assurance/noting:

Members received reports on the following areas:

- The report on progress against the **primary care access recovery plan (PCARP)** was discussed and noted. This report is on the ICB Board's agenda for noting.
- **Quarterly Estates Update.**
 - The committee received an update on the Primary Care Utilisation and Modernisation Fund, a fund that was announced by the Government in the October 2024 Spending Review. This concerns capital funding to support the better utilisation of the existing general practice estate, linked to creating capacity for the GP workforce. Seven N&W surgeries will benefit from £1.9m funding subject to due process taking place.
 - An update was received on the Wave 4b Primary Care Hub investments. Most of these have been completed (Thetford, Kings Lynn, Sprowston) with Rackheath expected to be completed during summer 2025.
 - Under Business-as-Usual capital funding surgery improvements and reconfigurations were supported (most schemes utilise third party funding too). Extensions to Blofield and Long Stratton surgeries were completed during 2024/25.
 - The Estates team closely monitors capital funding opportunities through S106 and Community Infrastructure Levy and was working to include community pharmacy and dentistry.
- The Committee received a **Medicines Optimisation Report**. It discussed highlights of the work ongoing in each of the seven pillars. Specific focus area is to arrive at a protocol for prioritising access to Tirzepatide, a weight loss medicine. The strong progress on anti-microbial prescribing was noted.
- **Delivery group reports** for the Dental Services, Dental Delivery and General Practice and Community Pharmacy Delivery Groups were noted.
- **A strategic finance report** was noted. Month 12 (draft numbers for the financial year, subject to external audit) showed a £7.0m overspend. This was mainly due to unidentified efficiencies in prescribing and prior year commitments in LCS spend. Prescribing efficiencies of £13.4m have been delivered during 2024/25, with three

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schemes delivering over £2m each.

- **Pharmaceutical Services Regulation Committee and Optometry Services Contractual Changes and Other Matters reports** were received, noting this work was hosted on the ICB's behalf by NHS Hertfordshire and West Essex.
- Committee received a summary of the key aspects of the **GP Contract changes 25/26**. This is 1 year contract agreement, with an overall increase in investment of £889m across the core practice contract and DES the Network Contract and represents an estimated 4.8% real terms growth. In addition, practices can participate in a new enhanced service for advice and guidance (worth up to £80m). A further uplift may be made following the government's response to the Doctors' and Dentists' Pay Review Body (DDRB) outcomes for 25/26.
- The committee received a paper summarising the recently agreed **Community Pharmacy Contractual Framework (CPCF)**.
Key highlights of the framework include:
 - Increased Funding: Funding for 25/26 of £3.073 billion, a 15% rise compared to 24/25.
 - Expanded Services: Introduction of new services such as a national emergency contraception service and the inclusion of medicines for depression in the New Medicine Service.
 - Pharmacy First Initiative: Continued funding to grow this service, enhancing access to primary care

Community pharmacy has a key role in supporting patients in the communities they serve, and this is essential in delivering the government's ambition to rebuild the NHS and make it fit for the future. The new pharmacy contract is a step change for the sector, recognises the scale of the national funding gap and is a first step towards sustainability for the sector.
- The committee received an overview of the annual electronic self-declaration (**E-Dec**) submission by each GP surgery to the ICB, covering a range of contractual and regulatory compliance matters. 95% completed the submission successfully, with the ICB following up with the remainder. Overall compliance is strong, with some areas for improvement identified to be worked during 2025/26.

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<p>Items for escalation to Board:</p>	<p>The approval of the Long Term Dental Plan is an important milestone, particularly given the underlying risk profile.</p> <p>Note the recently concluded GP Contract 25/26 and Community Pharmacy Contractual Framework 25/26.</p> <p>No other items for escalation outside of the risks reported to ICB Board.</p>
<p>Items requiring approval:</p>	<ul style="list-style-type: none"> • The Risk Register was approved which included the latest updates to BAF and BORR. The impact of national insurance increases across all 4 primary care contractor groups will be monitored in relation to the resilience risks. It was noted all four local representative committees had raised concerns about the impact of increased national insurance contributions on the financial resilience of their contractors. • The Long Term Dental Plan (LTDP) was discussed in two aspects: <ul style="list-style-type: none"> A) Year One of the LTDP led to the following new care pathways being developed and implemented by end March 2025 with an investment (full year effect) of £7.35m: <ul style="list-style-type: none"> ○ Urgent treatment service (more than 25,000 appointments in 24/25), ○ Shared Care Pathway, ○ Child Focused Dental Practices: 6 practices mobilized by March 2025 ○ Access Improvement for new patients (recurrent investment) – more than 98,000 new patients seen in 24/25; ○ Workforce recruitment and retention plan: 46 dental professionals recruited and retained. B) Plans for Year Two of the LTDP . The Year 2 plans represent a significant ambition by the ICB to invest the dental ring-fenced budget across a wide range of projects with the aim of reducing health inequalities and improving access to NHS dental services for the local population. Investment in primary care and community dental services reduces the impact on secondary care and urgent and emergency care services, and importantly supports the shift towards prevention, improving clinical quality outcomes for individuals. <p>The PCCC approved the proposed investment of £ 8.25m that include the following commissioning intentions:</p> <ul style="list-style-type: none"> ○ Oral health prevention and education

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	<ul style="list-style-type: none"> ○ Access improvement (2nd phase) ○ Unscheduled Care Services ○ Level 2 services, including minor oral surgery ○ Targeted UDA (Unit of Dental Activity uplift) in areas of high deprivation, rural and coastal to enable workforce recruitment and retention. ○ ICB plans to meet its share of national target of 700,000 additional appointments (21,520 additional urgent care appointments) <ul style="list-style-type: none"> ● An Integrated Performance Report within the PCCC governance structure was discussed and approved. It clarifies what KPIs will be reported/monitored at Board, PCCC and Programme Board level. ● A Local Dispute Resolution Policy for Primary Care Contracts was approved.
Confirmation that the meeting was quorate:	<p>There are four voting members and three are required to be quorate. The meeting was quorate with the following attendance:</p> <p>Hein van den Wildenberg, ICB Board non-executive member, Deputy Chair</p> <p>Karen Watts, deputising for Patricia D’Orsi, executive director of nursing, ICB</p> <p>Sarah Elliott deputising for Steven Course, executive director of finance, ICB</p>

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are regularly reviewed. Quality responsibilities have been clarified in the revised Terms of Reference.
Finance and Performance:	Finance reports are noted monthly, detailed performance reports are reviewed on prescribing, learning disability and severe mental illness health checks uptake. Access data is reviewed annually through the GP Patient Survey report. The annual contractual e-declaration requirement for practices is reported. A primary care dashboard is being developed and a delivery report is a standing item.
Impact Assessment (environmental and equalities):	All papers considered include consideration of the ICB’s duty to reduce health inequalities.
Reputation:	The committee meeting is held in public and includes attendance from the Local Representative Committees, Healthwatch Norfolk and Suffolk and the Health and Wellbeing Boards in Norfolk and Suffolk

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Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual, ICB general duties.
Information Governance:	Any confidential or sensitive information is heard in private
Resource Required:	Primary care commissioning, quality, finance, primary care estates, primary care workforce, primary care digital, prescribing, locality and BI teams
Reference document(s):	Primary care services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

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Subject:	Risk Management
Presented by:	Karen Barker, Executive Director of Corporate Affairs and ICS Development
Prepared by:	Agnes Earl, Corporate Governance & Risk Management Senior Officer
Submitted to:	Integrated Care Board – Board Meeting Part 1
Date:	21 May 2025

Purpose of paper:

This paper presents the Board with a copy of the updated Board Assurance Framework to assist in the facilitation of discussions around risks associated impacting the ICB's ability to deliver its objectives.

Executive Summary:

Effective risk management is an essential part of the ICB's system of internal controls and supports the provision of a fair and well-illustrated Annual Governance Statement.

The Board Assurance Framework (BAF) sets out the key risks that may impact on achievement of the ICB's strategic objectives by mapping out the key controls that are in place to manage each risk and assurance that has been gained about the effectiveness of these controls.

The risk registers were last presented to the Board in public in March 2025. Since then, many teams have been reviewing and updating their risks.

Please find attached a copy of the following (as at 9 May 2025):

- Appendix 1: Board Assurance Framework (BAF)
- Appendix 2: Risk visual

Attention is directed towards the following notable changes:

Board Assurance Framework (BAF)

Risk	Changes/actions required
Ref 8 (BAF01): Health inequalities and Population Health Management	<ul style="list-style-type: none"> • Target delivery date overdue (31/03/2025) • Risk score reduced from 16 to 12.
Ref 32 (BAF02): Primary Care Resilience and Transformation	
Ref 7 (BAF03): Barriers to full delivery of the Mental health transformation programme (CYP)	<ul style="list-style-type: none"> • Target delivery date overdue (30/11/2024)

Ref 6 (BAF04): Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	
Ref 31 (BAF05): Increasing numbers of older people with complex health needs in Norfolk & Waveney	<ul style="list-style-type: none"> • Mitigated score reduced from 15 to 12
Ref 3 (BAF06): System / Urgent & Emergency Care (UEC) Pressures	
Ref 10 (BAF07): Elective Recovery	<ul style="list-style-type: none"> • Target score reached
Ref 27 (BAF08): Achieve the 2024/25 financial plan	<ul style="list-style-type: none"> • Target delivery date overdue (31/03/2025) • Target score reached

Recommendation to the Board:

The Board are asked to note the contents of this paper.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is appraised of the key risks in the organisation currently.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

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Appendix 2: Risk visual

Board Assurance Framework risks
 Board Operational Risk Register risks

Likelihood

Consequence

		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Negligible		1	2	3	4	5
2 Minor		2	4	6	8	10
3 Moderate		3	6	9	12 08 31	15
4 Major		4	8	12 06 10 27	16 07 03	20 32
5 Catastrophic		5	10	15	20	25

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NWICB - Board Assurance Framework Summary 09 May 2025

Risk Id	Risk Title	Risk Owner	Risk Committee	Date Risk Identified	Target Delivery Date	Target Score	2025 - 2026 Monthly Risk Rating																		
							1	2	3	4	5	6	7	8	9	10	11	12							
Ambition 1: Population Health Management, Reducing Inequalities and Supporting Prevention																									
8	Health inequalities and Population Health Management	Frankie Swords	Patients and Communities Committee	01-Jul-22	31-Mar-25	4	12	12																	
Ambition 2: Primary Care Resilience and Transformation																									
32	Primary Care Resilience and Transformation	Mark Burgis	Primary Care Commissioning Committee	29-Aug-24	31-Mar-27	12	20	20																	
Ambition 3: Improving Services for Babies, Children and Young People and Developing Our Local Maternity and Neonatal System (LMNS)																									
7	Barriers to full delivery of the Mental health transformation programme (CYP)	Tricia D'orsi	Commissioning and Performance Committee	01-Jul-22	30-Nov-24	8	16	16																	
Ambition 4: Transforming Mental Health Services – Adult Mental Health																									
6	Barriers to delivering equitable, safe and consistent care in adult mental health	Jocelyn Pike	Commissioning and Performance Committee	01-Jul-22	31-Mar-26	8	12	12																	
Ambition 5: Transforming Care in Later Life																									
31	Increasing numbers of older people with complex health needs in Norfolk & Waveney	Frankie Swords	Patients and Communities Committee	20-Jun-24	31-Mar-28	12	15	12																	
Ambition 6: Improving Urgent and Emergency Care																									
3	System / Urgent & Emergency Care (UEC) Pressures	Mark Burgis	Commissioning and Performance Committee	01-Jul-22	31-Mar-26	12	16	16																	
Ambition 7: Elective recovery and Improvement																									
10	Elective Recovery	Andrew Palmer	Commissioning and Performance Committee	01-Dec-22	31-Mar-29	12	12	12																	
Ambition 8: Improving Productivity and Efficiency																									
27	Achieve the 2024/25 financial plan	Steven Course	Finance Committee	10-May-23	31-Mar-25	12	12	12																	

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Ref 0000003

Risk Title	System / Urgent & Emergency Care (UEC) Pressures		
Risk Description	<p>There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity in the right care setting 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, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms.</p> <p>This could lead to worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside.' The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed. In turn, this congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls.</p>		
Risk Owner	Responsible Committee	Operational Lead	Risk team
Mark Burgis	Commissioning and Performance Committee	Ross Collett	UEC
Risk programme board	Date Risk Identified	Target Delivery Date	Date risk last reviewed
N/A	01/07/22	31/03/26	16/04/25
Risk type	Quality & patient safety		

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	4	16	3	4	12
Risk appetite:			Risk tolerated:					

Controls

Business Continuity:

- All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds 'business as usual' levels.
- A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed.

National UEC Recovery Strategy:

- Reduce LoS in inpatient settings. This is a core action in the Joint Forward Plan (JFP) to rebalance system flow and meet operational planning target of 78% A&E 4-hour performance. Baseline average LoS is currently 8.1days for non-elective pathway.
- The system continues to fall below the 78% threshold set within the national recovery strategy and current trend suggests this will not be met by the end of March 2025.
- UCCH has now been recurrently funded which will ensure the admissions avoidance work that it has been undertaking will continue and the overall activity trend over time of ambulance dispatch in Norfolk and Waveney will continue to be flat. In addition, the UCCH has launched a specific initiative to support care homes and their residents to prevent unnecessary conveyance and admission to hospital as part of the winter 24/25 plans.
- National UEC Recovery Strategy - Joint Forward Plan
- National UEC Recovery Strategy - Recover Ambulance

Hospital 'Admissions Avoidance:

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- A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that patients who have an 'urgent' care need are seen in a timely way in the right care setting, the core services are:
- 111 / GP led Clinical Advice Service (CAS): This service provides advice to healthcare professionals and the public triaging and referring patients to the most appropriate service and setting that will best meet their needs.
- Unscheduled Care Coordination Hub (SPoA): The UCCH has been established since October 2023 as a single point of access for urgent care. The UCCH reviews the 999 and 111 stack coordinating the most appropriate response based on the patients' needs. The UCCH focusses on some of our most vulnerable and frail elderly patients to ensure only those that need a hospital admission or the service provided by an ED are conveyed. The UCCH also supports ambulance crews en-route and on scene with additional clinical support via the MDT.

Specific controls to improve discharge:

- There is a tactical work programme led by the UEC Programme Board Chair to increase flow by increasing speed of discharge and reducing length of stay ahead of winter.
- Each of the three UEC Alliances have a programme of work focussed on increasing flow and rate of discharge.
- Position continues to improve with a reduction in escalation beds at the Acute hospitals and improvement in C1 and C2 ambulance response times. Ambulance handover into ED is showing signs of improvement, however this needs to embed and sustain before further risk reduction.

Strategic Oversight:

- UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings.
- Associated clinical risks are reviewed monthly by the ICS Clinical Risk Review Panel (CRRP). The panel monitors and through SCC puts in place control measures to mitigate risks and issues, this risk and issues log is shared with the UEC Programme for assurance purposes.

Cohorting:

- A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital.
- Rapid Ambulance Offload: Arrangements in each ED enable a limited number of additional rapid ambulance handovers to release waiting ambulance crews to attend very urgent community calls where there is an extreme risk of adverse clinical outcome from delay.
- Escalation / Surge Beds: Acute and community providers have created additional temporary escalation spaces / surge beds through internal operational changes and using some winter funding. This additional capacity has been maintained in to 24/25.
- All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand.
- Winter 24/25 plans for peak period of demand: The Director of Resilience working through SCC has developed a plan to seek assurance from all providers that there is sufficient resource, grip and control over the peak period.

Actions

Date opened	Action	Owner	Target completion
19/03/25	Agreement being sort from each Place to take 5 additional patients each day to support achieving a C2 response time of 30 mins. The 3 Alliances	Rebecca Richards	16/05/25

	have agreed to the ambition and sign off has been received from NCH&C.											
19/03/25	Discussions being undertaken with system partners to reach agreement for UCCH to take on role of trusted assessor for UCR and virtual ward.										Rebecca Richards	16/05/25
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16										
Change	→	→										

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Ref 0000006

Risk Title	Barriers to delivering equitable, safe and consistent care in adult mental health							
Risk Description	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 the need. 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							
Risk Owner	Responsible Committee		Operational Lead			Risk team		
Jocelyn Pike	Commissioning and Performance Committee		Mark Payne			Mental Health & LD		
Risk programme board	Date Risk Identified		Target Delivery Date			Date risk last reviewed		
N/A	01/07/2022		31/03/2026			04/02/25		
Risk type	Quality & patient safety							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8
Risk appetite:					Risk tolerated:			
Controls								
<ul style="list-style-type: none"> Finance & Planning working group meet monthly to drive robust financial arrangements and deliver planned MHIS investment. System wide governance framework in situ NSFT lead CMHT, CRHT and Inpatient plan transformation programmes. 								
Actions								
Date opened	Action					Owner	Target completion	
20/04/22	<p>Community Transformation: Stocktake of Community Transformation (3-year LTP funded transformation programme) underway to understand current position regarding recruitment, activity and spend against original transformation ambition and plans. Working with NSFT to strengthen and embed the model going into 24/25. Timeline extended to accommodate totality of work. Effective primary care engagement and delayed CMHT diagnostic is a risk to delivery. We continue to support NSFT (who are leading this work) to coproduce a revised model with Primary Care, to ensure the model is sustainable and effective.</p> <p>25/11/24 - Community Transformation Service Development Funding - Mental health Practitioners in Primary Care: NSFT are currently leading on the redesign of the MHPPM model, Additional funding of circa 650K has been redirected to support the shortfall in funding identified following the CT Stocktake in April 2024. NSFT currently engaging with Primary care and the ICB to deliver an agreed plan.</p>					Mark Payne	31/03/25	
29/04/22	<p>Phase 1 of the N&W Long term Plan (LTP) funded MH Transformation Programme Plan completed 31/03/24. Phase 2 with focus on integration of new services and pathway development. Continued co-production with partners and Experts by Experience and Clinical Reference Group is central to sustaining and embedding positive change.</p> <p>Phase 2 of MH Transformation continues to be developed. Recent reviews of community and crisis teams within NSFT are providing the foundations of the next phase of transformation.</p>					Mark Payne	31/03/2025	

29/08/23	Right Care, Right Person (RCRP); ICB Leads working in partnership with Norfolk and Suffolk Constabularies. RCRP launched in Norfolk in early June. Suffolk Police went live October 2023. All workstreams have gone live with daily meetings to review any issues and learning. No significant issues reported to date.	Mark Payne	31/01/25
29/04/22	Focus on MH Workforce and development of new roles central to success of LTP funded transformation funded programme. Several challenges to embedding localised integrated approach (as described in N&W MH workforce strategy published in 2021) including transition from Health Education England to Work, Training & Education at regional level, as well as local focus on ICB restructure. Paper presented to Strategic Oversight board and action agreed to review workforce oversight and set up a MH workforce group. Progress delayed due to restructure, date for completion extended. Met with Workforce Lead lack of organisational capacity and operational readiness currently to progress this action. Plan to review with MH SRO support. No further update at 4/11/24	Mark Payne	31/10/24
25/11/24	Access Pathways - Single point of Access NSFT have stopped operating a N&W Single Point of Referral across N&W locality as per commissioned service. N&W ICB issued a Contract Performance Notice on 24/10/24, re. failure to effectively deliver Single Point of Access and Crisis Resolution Home Treatment Team services. Work is currently ongoing to support NSFT to implement the required service improvement plans.	Mark Payne	31/03/25
25/11/24	Inpatient - NHSE launched the national inpatient programme in April 2024. NSFT have now developed their transformation plan to support the delivery of this programme of work. NSFT, SNEE and N&W ICB will agree this plan and embed into the NHS contract Service Development Improvement Plan (SDIP) with oversight of delivery at Service Performance Review group (SPRG)	Mark Payne	31/03/25
25/11/24	Primary Care - Mental health Practitioners in Primary Care: NSFT are currently leading on the redesign of the MHPPM model, Additional funding of circa 650K has been redirected to support the shortfall in funding identified following the CT Stocktake in April 2024. NSFT currently engaging with Primary care and the ICB to deliver an agreed plan prior to roll out. Concerns raised by primary care concerning: <ul style="list-style-type: none"> • Clarity and responsiveness of NSFT crisis/community pathways • Rejected referrals for CRHT and CMHT • 111 Mental Health Option Clinical Line 	Mark Payne	31/03/25
25/11/24	Crisis and UEC - NSFT have now developed their transformation plan to support the delivery of this programme of work. NSFT, SNEE and N&W ICB will agree this plan and embed into the NHS contract Service Development Improvement Plan (SDIP) with oversight of delivery at Service Performance Review group (SPRG) <ul style="list-style-type: none"> • National MH KPI achievement; developed Oversight Plans with support from NHSEI to work towards recovery of trajectories for the following: Physical Health in Severe Mental Illness (currently meeting trajectory) • Improving Dementia Diagnosis • Reducing Out of Area Placement (OoAP). (Currently meeting trajectory) 	Mark Payne	31/03/25

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Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12										
Change	→	→										

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Ref 0000007

Risk Title	Barriers to full delivery of the Mental health transformation programme (CYP)							
Risk Description	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							
Risk Owner	Responsible Committee		Operational Lead			Risk team		
Tricia D'Orsi	Commissioning and Performance Committee		Rebecca Hulme			CYPM		
Risk programme board	Date Risk Identified		Target Delivery Date			Date risk last reviewed		
N/A	01/07/22		30/11/24			03/01/25		
Risk type	Quality & patient safety							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8
Risk appetite:					Risk tolerated:			
Controls								
<ul style="list-style-type: none"> • Dedicated CYP strategic commissioning team now in place • Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated • All age Eating Disorder Strategy • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment • Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person • Effective System wide governance framework • Commitment from system partners to adopting Thrive approach - mental health needs being considered and addressed in wider health and social care settings • Implementation of system wide transformation programme • Additional partnership working with VCSE • Additional capacity within Professional Therapeutic Pathway in place • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Enhanced support offers for 18-25-year-olds in wellbeing hubs. • Gender Identity Service in place • Integrated Front Door phase one and two in place • Intensive day support unit now open for eating disorders and parent support offer in place. • Professional Therapeutic Pathway in place 								
Actions								
Date opened	Action					BRAG	Target completion	
08/11/23	Castle Green Integrated Intensive Day Support/Short Breaks Unit paper presentation and prioritisation matrix complete. Risks identified regarding financial implications. Presented to deliberation panel – scoring ratified and funding identified. Awaiting next steps. Need to confirm with NHSE due to capital funding allocation.					Rebecca Hulme	31/03/25	

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	<p>Update 19/06/24 funding approved, next steps meeting with NCC to mobilise plan.</p> <p>Update 28.08.24 meeting with NCC taken place. Refinement of model to further develop integrated model and to ensure best use of capacity</p> <p>Update 03.01.25 NHSE have confirmed support for utilisation of capital funding on a range of proposed estates projects. Paper to EMT in January.</p>		
08/11/23	<p>CYP Collaborative continues to develop. System workshop scheduled for 15/12/23 to progress system working and opportunities for stakeholders to align resource.</p> <p>Workshop completed 15/12/2023. Priorities for workstreams proposed and will be established within January 2024</p> <p>Update 19/06/24 workstreams established and scoping vision for priority areas.</p> <p>Update 28.08.24 Case for change in development. For presentation to Executive team in October 2024</p> <p>Update 31.10.2024 case for change agreed. Further work required to develop screening tools and develop business case to be taken through prioritisation process</p> <p>Update 03.01.25 Progress continues on business case for prioritisation review in March</p>	Rebecca Hulme	31/03/25
02/01/24	<p>Castle Green Integrated Intensive Day Support/Short Breaks Unit paper presentation and prioritisation matrix complete. Risks identified regarding financial implications. Presented to deliberation panel – scoring ratified and funding identified. Awaiting next steps. Need to confirm with NHSE due to capital funding allocation</p>	Rebecca Hulme	31/03/25
02/01/24	<p>Additional capacity within Professional Therapeutic Pathway identified using winter funding. Monitor impact through waiting list updates.</p>	Rebecca Hulme	11/01/24
06/11/22	<p>Recruitment remains challenging in core secondary care services. New staff in post but staff leavers nullifying effect. Requirement to address urgent presentations and increased community acuity reducing routine capacity to reduce waiting times.</p> <p>Update 02/01/2024. Recruitment remains problematic. Workforce information requested from NSFT through newly re-established SPQRG</p> <p>Update 28.08.24 Workforce information outstanding. Further discussion has taken place regarding information format.</p> <p>Update 31.10.24 Meeting has taken place with NSFT staff to agree information needed, remains outstanding. Requested again through SPQRG.</p> <p>Update 03.01.25 New place teams confirmed within partnership structures and new leads for transformation. Meetings arranged for January 2025 to re-establish key working relationships.</p>	Rebecca Hulme	31/03/25
25/08/22	<p>Waiting list size within main provider continues to increase. Staff vacancies within central youth team critical. Proposal from provider to declare business continuity. Trust undergoing organisational restructure so delays to replacing key leadership roles. Plan to escalate to NSFT Executive.</p> <p>28.08.24 significant work within main provider to reduce waits. All CYP waiting longer than 52 weeks for assessment have been addressed – plan now to look at those waiting >48 weeks. Corresponding work to reduce referral to treatment waits. Some concerns regarding sustainability raised at SPQRG</p> <p>31.10.24 Delays to treatment still significant despite significant reduction in demand. Request to provider to review productivity. Some referrals still being rejected despite IFD in place and triage at referral.</p>	Rebecca Hulme	31/03/25

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	03.01.25 New place teams confirmed within partnership structures and new leads for transformation. Meetings arranged for January 2025 to re-establish key working relationships.		
02/02/24	Castle Green Integrated Intensive Day Support/Short Breaks Unit paper presentation and prioritisation matrix complete. Risks identified regarding financial implications. Presented to deliberation panel – scoring ratified and funding identified. Awaiting next steps. Need to confirm with NHSE due to capital funding allocation	Rebecca Hulme	31/03/24

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16										
Change	➔	➔										

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Ref 0000008

Risk Title	Health inequalities and Population Health Management							
Risk Description	There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented							
Risk Owner	Responsible Committee		Operational Lead			Risk team		
Frankie Swords	Patients and Communities Committee		Shelley Ames			Primary Care		
Risk programme board	Date Risk Identified		Target Delivery Date			Date risk last reviewed		
N/A	01/07/22		31/03/25			06/12/24		
Risk type	Health inequalities							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4
Risk appetite:					Risk tolerated:			
Controls								
<ul style="list-style-type: none"> Community Voices gathering insights into HI and connecting with local communities to help address. Datahub Population Health dashboards in place to support reporting and population health management approaches. External factors that impact on “Plus groups” (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP. Health and wellbeing partnerships and place boards overseeing local work programmes. Health Inequalities & VCSE Partnering team appointed to lead health inequalities work programme development. The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development. The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP. ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board. New Assembly Chair appointed. Specialty advisors are leading on HI, PHM and the Core20Plus5 clinical areas. ICP supported proposals for a strategic group and co-ordination group to formally oversee delivery of the Health Inequalities Framework for action. Co-ordinating multi-partner health inequalities group now in place. SROs established for Lifestyle factors and Healthcare Inequalities 								
Actions								
Date opened	Action					Owner	Target completion	
31/01/25	Cross-sector organisational sign-up to the Health Inequality Framework commitments. Organisational baseline assessments are underway with a good response from the VCSE. This is informing the ICS Health Inequalities improvement plan. The ICB improvement plan will be presented at the March ICB Board meeting. ICB panel for QIAs and EHIAs established to assess current impact assessments being undertaken by the ICB, with PMO process supporting this.					Shelley Ames	31/03/25	

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	A new Population health and Inequalities strategic dashboard has been developed and released.		
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Visual Risk Score Tracker – 2024/25												
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Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12										
Change	➔	➔										

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Ref 0000010

Risk Title	Elective Recovery							
Risk Description	The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience and may lead to an increased clinical harm for individual patients resulting from prolonged waits for treatment, including waits for diagnostic tests and for cancer care.							
Risk Owner	Responsible Committee			Operational Lead			Risk team	
Matt Dooley	Commissioning and Performance Committee			Diane Smith			Commissioning & Performance	
Risk programme board	Date Risk Identified			Target Delivery Date			Date risk last reviewed	
N/A	01/12/22			31/03/29			29/04/25	
Risk type	Reputational							
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	3	4	12
Risk appetite:						Risk tolerated:		
Controls								
<ul style="list-style-type: none"> Unified process of clinical harm review and prioritisation in line with national guidance. The Provider Productivity and Planning Oversight Group and the Scheduled Care Board have been established to oversee all workstreams to improve performance and reduce harm, driving operational changes from Commissioning and Performance Committee. Workstreams include: Productivity; Diagnostics; Demand Management Independent Sector Providers (ISP) are being utilised to support capacity, with the use of Elective Recovery Funds (ERF). Insourcing and outsourcing opportunities being utilised to create capacity, with focus on challenged specialties." Cancer: Local engagement to raise awareness of signs/ symptoms of cancer and to encourage early presentation to Primary Care/linking with health inclusion groups and areas of deprivation. Non-Specific symptoms (NSS) pathway is in place via the system cancer Rapid Diagnostic Service and the "C the Signs" Primary Care Clinical Decision support tool to improve quality and reduce variation in urgent suspected cancer referrals. Mutual aid process agreed to enable patients to transfer to alternative providers using existing capacity. Within the ICS this is developing into the Group Model. New theatre capacity opened at NNUH in December 23. Additional orthopaedic capacity at NNUH (NaNOC) opened in July 2024 and JPUH is due to open spring 2025. All three N&W Acute Trusts have engaged in the national validation sprint, NHSE funded, and monitoring of effect is in place. 								
Actions								
Date opened	Action						Owner	Target completion
03/02/25	Planning guidance and reforming elective care guidance (2025/26) to be operationalised into Norfolk and Waveney improvement plans, with agreed trajectories and appropriate triangulation. Headline submission outlines some areas not forecast to meet the nationally expected standards. Final submission 27/3/2025 reported not all areas would meet 25/26 planning expectations. Pending NHSE review / feedback and potential re-submission TBC						Diane Smith	31/05/25

22/04/24	<p>65 week position as per KLOE (30/04/2025)</p> <ul style="list-style-type: none"> o JPUH (2025) - March actuals: 117. April forecast: 203. May forecast: TBC o NNUH (2025) - March actuals: 147. April forecast: 187. May forecast: 151 <p>QEH reporting 0</p> <p>ICS forecast date to reach 0 is 31/05/2025.</p>	Diane Smith	16/05/25
01/04/24	<p>52 week position from system KLOE's (30/4/2025)</p> <ul style="list-style-type: none"> - JPUH (2025) - April forecast: 1,929 (TBC). May forecast: 1,826 (TBC) - NNUH (2025) - April forecast: 3,800. May forecast: 3,599 - QEHKL (2025) - April forecast: 603. May forecast: 565 	Diane Smith	31/03/26
28/11/24	<p>Opening and full functionality at the planned Community Diagnostic Centres (CDC's) will decrease the pathway to diagnostics, an interdependent step to treatment and therefore the RTT standards being met</p>	Diane Smith	30/06/25
13/02/25	<p>Provider Productivity and Planning Oversight Group is establishing working groups to address key areas that support elective recovery, such as diagnostics, productivity and demand management. Leads and members to be confirmed, scheduling to be established. Leads and initial meetings set for 2/3</p>	Diane Smith	31/05/25
03/02/25	<p>Highlight the challenge in utilising all capacity in elective care, including new facilities such as NANOC / CDC's / Ortho Elective Hub, due to workforce shortages. This incorporates challenges experienced by providers in securing workforce resource sign-off through triple lock process. To escalate to the appropriate group.</p>	Diane Smith	31/05/25

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12										
Change	➔	➔										

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Ref 0000027

Risk Title	Achieve the 2024/25 financial plan		
Risk Description	If the ICB does not deliver the 2024/25 Financial Plan of a break-even position, THEN the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients.		
Risk Owner	Responsible Committee	Operational Lead	Risk team
Steven Course	Finance Committee	Emma Kriehn-Morris	Finance
Risk programme board	Date Risk Identified	Target Delivery Date	Date risk last reviewed
N/A	10/05/23	31/03/25	28/02/25
Risk type	Financial		

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	3	4	12
Risk appetite:					Risk tolerated:			

Controls

<ul style="list-style-type: none"> Detailed plan for 2024/25 approved by Board and submitted to NHSE/I as part of the break-even system plan. Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis. Monthly Finance Report presented to Finance Committee and Board. Key lines of Inquiries (KLOEs) have been reviewed and provide assurances as to strong financial governance and best practice adoption. The ICB is part of the Triple Lock process with self-imposed reduced limits of £25k. ICS Medium Term Financial Model has been developed on consistent assumptions. Monthly monitoring of risks and mitigations, reported to NHSE/I.

Actions

Date opened	Action	Owner	Target completion
31/07/24	Review of all mitigations and recovery actions to support the financial delivery to plan.	Emma Kriehn-Morris	04/01/24
01/04/24	Review of monthly and year to date performances and assess forecast out-turn evaluated risks and mitigations.	Emma Kriehn-Morris	31/03/25

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12										
Change	➔	➔										

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Ref 0000031

Risk Title	Increasing numbers of older people with complex health needs in Norfolk & Waveney		
Risk Description	<p>The period that older people spend in ill health in Norfolk is getting longer. Older people are already more likely to be living with multiple and complex health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment.</p> <p>The risks are that:</p> <p>a) services will be unable to continue to meet the increasing demand and needs of our ageing population with complex health needs.</p> <p>b) costs associated with care of this population will increase significantly adding to financial pressures</p> <p>c) quality of care for older people may decline if a) and b) are not suitably mitigated</p>		
Risk Owner	Responsible Committee	Operational Lead	Risk team
Frankie Swords	Patients and Communities Committee	Olga Emmerson	Planned Care and Cancer
Risk programme board	Date Risk Identified	Target Delivery Date	Date risk last reviewed
N/A	20/06/24	31/03/28	30/04/25
Risk type	Workforce & people		

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	3	12	4	3	12
Risk appetite:			Risk tolerated:					

Controls

- Increased focus upon early intervention (identify and intervene)
- Increased focus upon upstream prevention and remaining active
- Ageing Well Programme Board with substantive programme manager and specialty advisors in post.
- Workstreams established across all programme areas: Dementia, Frailty Attuned Acute Care, Care Homes & Housing with Care and Prevention

Actions

Date opened	Action	Owner	Target completion
04/11/24	Ageing Well Programme Blueprint developed to establish priorities and align workstreams and agreed at Programme Board	William Lee	31/03/26
04/11/24	Develop appropriate system Dashboard with all core workstream metrics	William Lee	30/06/25

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	15	12										
Change	➔	➡										

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Ref 0000032

Risk Title	Primary Care Resilience and Transformation								
Risk Description	<p>Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities.</p> <p>Our high-level outputs include:</p> <ul style="list-style-type: none"> Developing a vision for providing accessible enhanced primary care services Improving patient outcomes and experience Stabilise dental services and setting a strategic direction for the next five years <p>Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals.</p> <p>There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores.</p> <p>The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers.</p> <p>Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population.</p> <p>This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services.</p> <p>As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.</p>								
Risk Owner	Responsible Committee			Operational Lead			Risk team		
Mark Burgis	Primary Care Commissioning Committee			Sadie Parker			Primary Care		
Risk programme board	Date Risk Identified			Target Delivery Date			Date risk last reviewed		
N/A	29/08/24			31/03/27			30/04/25		
Risk type	Transformational								
Risk Scores									
Unmitigated			Mitigated			Target			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
5	4	20	5	4	20	3	4	12	
Risk appetite:					Risk tolerated:				

Controls

- Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support joined up primary care; including access to sustainable dentistry and general practice services.
- Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care.
- Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC.
- A long-term dental plan has been published, with delivery monitored through PCCC.
- ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams.
- Performance/quality management and reporting in place.
- Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings.
- Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience.
- An overarching strategic vision and principles for primary care are being finalised to support the development long-term plans for general practice and community pharmacy during 2024/25, followed by optometry.
- System Interface Group and matrix working in place to support national requirements for self-assessment.
- Strong relationships in place with local representative committees across all primary care services

Actions

Date opened	Action	Owner	Target completion
28/10/24	<p>Community Pharmacy</p> <ul style="list-style-type: none"> • Oct <p>Materials being developed to support general practice in referring to Pharmacy First. Relaunch of Pharmacy First coming on line in early November. NWICB performance on Pharmacy First is strong when compared to regional colleagues however there is more opportunity to increase referrals</p> <ul style="list-style-type: none"> • Nov/Dec <p>Pharmacy First activity continues to grow, however there remains much potential and referrals from general practice and NHS111 are relatively low. The likelihood of collection action by community pharmacy is increasing, following support to a national ballot by The National Pharmacy Association. Potential impact being modelled.</p> <ul style="list-style-type: none"> • Jan <p>Community Pharmacy Contract negotiations due to commence January 2025, likelihood of collective action is heavily dependent on the result of these negotiations. Norfolk and Waveney General Practice Referral Toolkit launched to support Pharmacy First which still shows steady growth. Workforce Risk incorporated into overall Community Risk PC20.</p>	Sadie Parker	28/02/25
28/10/24	<p>Dental</p> <ul style="list-style-type: none"> • Nov/Dec <p>Continuing to work on priority areas set out in Long Term Plan with a focus on health inequalities. Significant ongoing political interest, which impacts on capacity of the team.</p>	Sadie Parker	28/02/25

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	<p>Clinical advisor has commenced in role and is already making an impact in the work we do and the support to the team.</p> <p>Jan</p> <p>The national DDRB uplift for dental contractors has yet to be confirmed and applied adding to the concerns about the impact on practice incomes in April 2025. There may be an increased risk of contract terminations.</p> <p>Long Term Plan 24/25 individual pathways will be fully mobilised by end March 2025. Planning for implementing 2025/26 plans has commenced to agree project plans, resources and financial impact (where relevant) for approval.</p> <p>20/03/2025 To obtain approval for Phase 2 Long Term Dental Plans 2025/2026 from Operational Management Board in April and Primary Care Commissioning Committee in May 2025</p> <p>16/4/2025 - OMB approval received to enable individual project governance</p>		
28/10/24	<p>Medical</p> <ul style="list-style-type: none"> Nov/Dec <p>Ongoing close monitoring of GP collective action. Referring by letter rather than form is increasing across practices, as reported by providers.</p> <p>Lack of winter resilience funding for general practice is causing concern with practices already reporting increased activity. At the same time, EDs are reporting a significant increase in minors activity. Vision and principles document has been approved, and a PCARP report has been noted by the ICB Board at its me</p> <ul style="list-style-type: none"> Jan <p>Ongoing ICB monitoring of GP collection action with regional oversight. Increases being seen in primary care activity across emergency departments and general practice.</p> <p>7.2% cash growth to GMS has been announced, equivalent to 4.8% real growth. National contract negotiations are ongoing.</p>	Sadie Parker	28/02/25
28/10/24	<p>The focus for the remainder of the current financial year will be on developing a strategic framework for primary care. This will be set against the backdrop of uncertainty and unrest for many primary care providers in terms of national contracts and funding and at a time when national policy drivers are expected to come into play which support and accelerate opportunities for transformation. The document will seek to underpin long-term plans for each pillar and accommodate the forthcoming 10-year plan and operational guidance. The framework will seek to provide contractors and system partners with clarity on local priorities for primary care commissioning and support available for them to be confident and effective system partners. The framework will also reflect the opportunities associated with the significant levels of capital investment planed in N&W together with the collective focus across the ICS on addressing health inequalities.</p>	Sadie Parker	31/03/25

Visual Risk Score Tracker – 2024/25

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20										
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Created by Heidi
19/05/2025 17:38:22

Agenda item: 22

Subject:	Amendment to the ICB Constitution
Presented by:	Karen Barker, Executive Director of Corporate Affairs and ICS Development
Prepared by:	Karen Barker, Executive Director of Corporate Affairs and ICS Development
Submitted to:	Integrate Care Board – Board Meeting
Date:	21 May 2025

Purpose of paper:

To note an amendment to the ICB Board’s Constitution

Executive Summary:

This paper is to formally note in the public domain that the Norfolk and Waveney ICB Board agreed an amendment to its constitution as follows:

The clause at section 3.5.4 (b) that a Chief Executive “will not be eligible if they hold any other employment or executive role” be deleted.

This amendment was submitted to NHS England and approved. The amended current Constitution dated 1 May 2025 is now on our website.

Recommendation to the Board:

To formally note in the public domain the amended Constitution.

Key Risks

Clinical and Quality: N/A

Finance and Performance: N/A

Davy Reid
 19/05/2025 11:38:22

Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	Clause 3.5.4 is in the model constitution nationally
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	
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Davey, Heidi
19/05/2025 17:38:22