Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 26 November 2025, 13:30 - 16:30

Agenda

13:30 - 13:30 0 min

Meeting agenda

- 00. Agenda for Part 1 ICB Board 26.11.25.pdf (5 pages)

13:30 - 13:30 0 min

1. Welcome and introductions - apologies for absence

13:30 - 13:30 0 min

2. Questions

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

13:30 - 13:30 0 min

3. Minutes from previous meeting and matters arising

- 03. 20250924 DRAFT NW ICB Board Part 1 Minutes.pdf (15 pages)

13:30 - 13:30 0 min

4. Declarations of interest

- 04. ICB Board Register New Nov 2025.pdf (3 pages)

13:30 - 13:30 0 min

5. Chair's Action Log

13:30 - 13:30 0 min

6. Matters arising from the previous Integrated Care Board meetings and review of outstanding actions

- 06. Matters arising from the previous ICB meetings.pdf (2 pages)

13:30 - 13:30 0 min

7. Chair and Chief Executive's Report

- 07. Letter to NHS on racism including antisemitism.pdf (2 pages)

13:30 - 13:30 0 min

8. ICB Transition Paper

- 08. Transition Update Report.pdf (13 pages)
- 08.1 Transition Committee ToR v4.0.pdf (5 pages)

13:30 - 13:30 0 min

Learning from People, Staff, and Communities

13:30 - 13:30 0 min

9. We will hear about how the local health system is helping and supporting patients to access and use the NHS App and wider digital services.

13:30 - 13:30 0 min

Strategy and Partnerships

13:30 - 13:30
0 min

10. Joint Quality and Health Impact Assessments

- 10. ICB QIA and EHIA Report for Board Nov 2025.pdf (2 pages)
- 10.1 ICB QIA and EHIA Report for Board Nov 2025.pdf (10 pages)

13:30 - 13:30
0 min

11. Report from the Quality and Safety Committee

- 11. Quality and Safety Committee Report.pdf (8 pages)

13:30 - 13:30
0 min

12. Winter Plan Update

- 12. Winter update for UEC Board November 2025.pdf (9 pages)

13:30 - 13:30
0 min

13. Report from Patients and Communities Committee

- 13. Patients and Communities Committee Report -.pdf (6 pages)

13:30 - 13:30
0 min

14. Norfolk & Waveney Green Plan

- 14. N&W Green Plan - Nov 25.pdf (3 pages)
- 14.1 NW_Green_Plan_v0.6.pdf (27 pages)

13:30 - 13:30
0 min

15. Primary Care Research Report

- 15. PC research ICB Board Report Nov 25.pdf (8 pages)
- 15.1 Appendix 1_RCF Project Impact Report.pdf (16 pages)
- 15.2 Appendix 2_Primary Care RCF 2425 Report.pdf (9 pages)

13:30 - 13:30
0 min

16. Report from Primary Care Commissioning Committee

- 16. Primary Care Commissioning Committee Report.pdf (7 pages)

13:30 - 13:30
0 min

17. Norfolk & Waveney VCSE Partnering

- 17. VCSE Partnering Paper.pdf (4 pages)
- 17.1 Appendix 1 N&W Sector Activity.pdf (17 pages)

13:30 - 13:30
0 min

Ten-minute Comfort Break

13:30 - 13:30
0 min

Commissioning, Delivery and Performance

13:30 - 13:30
0 min

18. Financial Report for Month 6 2025/26

- 18. ICB Finance Report - Month 06 Board.pdf (27 pages)

13:30 - 13:30
0 min

19. Report from the Finance Committee

- 19. Finance Committee Report.pdf (4 pages)

13:30 - 13:30
0 min

20. Medium Term Planning update – 2026/27

- 20. Medium Term Planning Update.pdf (6 pages)

13:30 - 13:30 0 min

21. Integrated Performance Report (IPR)

- 21. Integrated Performance Report ICB Board.pdf (10 pages)
- 21.1 ICB Board Performance Report.pdf (18 pages)

13:30 - 13:30 0 min

System Oversight

13:30 - 13:30 0 min

22. Report from the Commissioning and Performance Committee

13:30 - 13:30 0 min

23. Board Assurance Framework

- 23. Risk Management Report-Board-Pt1-BAF-November 25.pdf (3 pages)
- 23.1 Appendix 1-Board Assurance Framework-Board Pt1 November 25.pdf (14 pages)

13:30 - 13:30 0 min

24. Report from the Audit and Risk Committee

- 24. Audit and Risk Committee Report to Board.pdf (3 pages)

13:30 - 13:30 0 min

25. Constitution and Governance Handbook

- 25. Constitution and Gov Handbook changes.pdf (2 pages)

13:30 - 13:30 0 min

Other items and Committee Reports

13:30 - 13:30 0 min

26. Questions from the Public

13:30 - 13:30 0 min

27. Any other business

13:30 - 13:30 0 min

Norfolk and Waveney
Integrated Care Board

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

Wednesday, 26 November 2025 1.30pm – 4.30pm

Diss Business Hub (Large Horseshoe Meeting Room), Diss Business Park, Hopper Way, Diss IP22 4GT

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 November 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.

Chair: Will Pope (Interim Chair)

Item	Time	Agenda Item	Lead
Introductory Items			
1.	1.30	**Welcome and introductions - apologies for absence** Purpose: to note.	Chair
2.		**Questions** Notification of any questions from members of the public on agenda items for response at the appropriate time on the agenda. Purpose: to note.	Chair
3.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous public Board meeting on 24 September 2025. Purpose: to confirm.	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. Purpose: to note.	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. Purpose: to note and endorse actions taken.	Chair
6.	1.35	**Matters arising from the previous Integrated Care Board meetings and review of outstanding actions** Purpose: to note and endorse actions taken.	Chair
7.	1.45	**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. Purpose: verbal update. *The letter to NHS organisations on racism, including antisemitism included for information as referenced in this item.*	Chair and Ed Garratt

Item	Time	Agenda Item	Lead
8.	1.55	**ICB Transition Paper** Summary of what we know so far on the transition of ICBs both nationally and locally. Purpose: Information.	Ed Garratt Amanda Lyes
		Learning from People, Staff, and Communities	
9.	2.00	We will hear about how the local health system is helping and supporting patients to access and use the NHS App and wider digital services. The presentation will also share the lived experiences of those already using the App, the benefits to patients and the positive impacts to those delivering health services.	Karen Watts
		Strategy and Partnerships	
10.	2.15	**Joint Quality and Health Impact Assessments** Purpose: to receive and respond	Karen Watts
11.	2.25	**Report from the Quality and Safety Committee** Purpose: for information.	Cathy Armor
12.	2.30	**Winter Plan Update** Purpose: for information.	Mark Burgis
13.	2.40	**Report from Patients and Communities Committee** Purpose: for information.	Cathy Armor
14.	2.45	**Norfolk & Waveney Green Plan** Purpose: for approval.	Amanda Lyes
15.	2.55	**Primary Care Research Report** Purpose: for information.	Dr Frankie Swords
16.	3.05	**Report from Primary Care Commissioning Committee** Purpose: for information.	Ian Wake Hein Van Den Wildenberg
17.	3.10	**Norfolk & Waveney VCSE Partnering** Purpose: for endorsement.	Mark Burgis
		Comfort Break	
		Commissioning, Delivery and Performance	
18.	3.20	**Financial Report for Month 6 2025/26** To receive a summary of the financial position as at month 6. Purpose: to note.	Howard Martin
19.	3.30	**Report from the Finance Committee** Purpose: for information.	Hein Van Den Wildenberg

Item	Time	Agenda Item	Lead
20.	3.40	**Medium Term Planning update – 2026/27** Purpose: to endorse.	Richard Watson
21.	3.50	**Integrated Performance Report (IPR)** To provide assurance to the ICB Board and highlight significant elements of the system performance reporting. Purpose: for information.	Richard Watson
22.	4.00	**Report from the Commissioning and Performance Committee V**erbal update as meeting held after submission of Board papers.	Hein Van Den Wildenberg
		System Oversight	
23.	4.05	**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system. Purpose: to note.	Amanda Lyes
24.	4.10	**Report from the Audit and Risk Committee** Purpose: for information.	David Holt
25.	4.15	**Constitution and Governance Handbook** Purpose: for approval.	Amanda Lyes
		Other items and Committee Reports	
26.		**Report from the Commissioning and Performance Committee** No report submitted as the next scheduled meeting date is after the Board meeting.	Hein Van Den Wildenberg
27.	4.20	**Questions from the Public** Where questions in advance relate to items on the agenda.	Chair
28.	4.25	**Any other business**	Chair
Date, time, and venue of next meeting: 1.30pm – 4.30pm, 28 January 2026 Venue TBC			
Any queries or items for the next agenda please contact: nwicb.corporateaffairs@nhs.net			

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.

NHS
Norfolk and Waveney
Integrated Care Board

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.

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Wednesday 24 September 2025

PART 1 – Meeting in public

Council Chamber, Town Hall, King's Lynn

Board members present:

- Will Pope (WP), Interim Chair, NHS Norfolk & Waveney ICB
- Ed Garratt (EG), Interim CEO, NHS Norfolk & Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB
- Howard Martin (HM), Interim Executive Director of Finance, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Executive Director of Nursing, NHS Norfolk and Waveney ICB
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Dr Faisil 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
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armour (CA), Non-Executive Member, NHS Norfolk and Waveney ICB

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director Strategy and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Executive Director of Data & Digital, NHS Norfolk and Waveney ICB
- Jacqui Hunter (JH), Interim Executive Director of People, NHS Norfolk and Waveney ICB
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk

Attending to support the meeting:

- Belle Ward (BW), Executive Assistant to CEO and Chair, NHS Norfolk and Waveney ICB (Minutes)
- Heidi Davey (HD), Senior Corporate Governance Manager, NHS Norfolk and Waveney ICB
- Rebecca Crossley (RCr), Senior CYP and LD&A Programme Manager, NHS Norfolk and Waveney ICB
- Andrew O'Connell (AO), Senior LeDeR Reviewer, NHS Norfolk and Waveney ICB
- Ross Collett (RC), Director of Urgent and Emergency Care, NHS Norfolk and Waveney ICB

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting.	

	Apologies were received from the following Board members: • Stuart Keeble (SK), Local Authority Partner Member • Ian Wake (IW), Local Authority Partner Member It was confirmed that the Board was quorate.	
2.	**Questions**	
	There had been no questions sent in advance of the Board meeting in public and there were no members of the public present.	
3.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 16 July 2025 were approved as an accurate record of the meeting pending the agreed removal of the comment regarding the combined deficit position for both Norfolk and Suffolk, under agenda item 11.	
4.	**Declarations of interest**	
	The Chair noted that the declarations of interest register was kept up-to-date and was available on the ICB's website.	
5.	**Chair's action log**	
	The Chair noted that all Chair's actions were completed.	
6.	**Matters arising from the previous Integrated Care Board meetings and review of outstanding actions**	
	The Chair reviewed all due actions with the Board. <u>Financial Report for Month 2 2025/26</u> Financial recovery plan to be presented at a future Board meeting. *HM confirmed this would be received at the November Board meeting.*	
7.	**Chair and Chief Executive's Report**	
	EG shared the following updates: • EG had met with various co-located teams both internally and externally. Learning had been taken and would be applied when considering future working culture. • The National Oversight Framework ratings had been published – this provides accountability for Trusts in England. NCH&C were reported at the top of the league table whereas it had been more challenging for the Acutes and Ambulance Trust. It was noted NSFT were moving forward in the right direction. The ratings would be refreshed quarterly, and progress would be tracked regularly. • Acknowledged the QEHKL were part of the National Maternity Review – one of fourteen Trusts who are part of the programme to receive additional scrutiny and support. • Great Yarmouth and Waveney had been confirmed as a Wave 2 site as part of the National Neighbourhood Help Programme, but the ICB would be proceeding as though Wave 1.	

	• The QEHKL had celebrated their first year of the Frailty and Same Day Care Unit. Questions and comments from the Board: • Regarding the National Oversight Framework, DH asked what the ICB was accountable for. EG noted the ratings were helpful for providers to see in terms of performance but in addition, this provides transparency to the public as well as to commissioners and providers. **Action:** Paper to be received at a future Board meeting or Board development session to better understand the National Oversight Framework. **Agreed:** The verbal update was received and noted by the Board.	Howard Martin
8.	**ICB Transition**	
	EG provided a summary of the transition of ICBs both nationally and locally. Pertinent points noted: • The new Norfolk and Suffolk ICB will launch on 1 April 2026. • NHS England requested the new Executive Team take effect from 1 October 2025. • Following a recruitment process, the successful candidates appointed to the Executive Team have been announced to staff and would shortly be announced to stakeholders. • EG extended his sincere thanks and gratitude to every director for their outstanding leadership and contribution to the Norfolk and Waveney system. • Confirmed the Agenda for Change staff consultation was in a holding position, pending confirmation of redundancy funding. A resolution was hoped to be confirmed in the coming weeks. • As part of the new arrangements, an Office of Commissioning would be based in each region. Norfolk and Suffolk ICB has been asked to host on behalf of the East of England. Responsibility will cover the entire specialised commissioning budget. The process for recruiting an interim Managing Director is underway and they will take on responsibility prior to the formal legal launch in April 2027. Questions and comments from the Board: • HvdW asked if the Office of Commissioning remit would include the Ambulance Trust to which it was confirmed that it would. **Agreed:** The ICB Board noted the verbal update.	

	Learning from People, Staff and Communities	
9.	**Our lived experience item today will focus on capturing the voice of those with learning disabilities.**	
	PD'O introduced the lived experience item alongside RCr, confirming the focus would be on capturing the voice of those with learning disabilities. This provided the Board with an opportunity to consider an element which had been the focus of the Board for a few years, since the Cawston Park incident which very sadly resulted in the death of three individuals. A video was played to the Board which was coproduced with Healthwatch Norfolk and Opening Doors. The video emphasised the importance of a clear and simple way to report safeguarding concerns, noting individuals with a learning disability were at greater risk of safeguarding concerns such as abuse. Key points from the video included: • Greater education and better understanding were required. • Phone systems should be simplified. • Information must be clear and accessible. • A collective Task and Finish group with system partners including Norfolk County Council had been convened to address and they would work together on the issues highlighted. • Noted how simple changes could enable the voice of those with a learning disability. • Early intervention is critical and was strongly reliant on Navigator Services for both Mental Health and Learning Disability. • Inequity was noted concerning those without or awaiting support from the Autism service. • RCr proudly confirmed that the implications of this had been presented to NHSE and explained the positive impact that two years of funding to address this inequality would have, including improved outcomes and savings. It was noted that this had now gained national interest. • The Wellness on Wheels Bus (WoW Bus) had proven successful in reaching those with Learning Disability & Autism (LD&A) as a health facility. The bus is used by schools and the wider community to promote access and provide much needed resource. Questions and comments from the Board: • AS made a plea that the ICB and Acutes should consider making a funding contribution to the Safeguarding Board. The Chair formally noted this point. • EG referenced the seven thousand health checks delivered, noting he was pleased to see a high percentage with action plans and queried what the process between action plan and outcomes was.	

	• RCr confirmed that quality was continuously being reviewed and shared with practices as to what good looks like. Additionally, the increase in health checks delivered was as a direct result of the WoW Bus. • FSe noted there was learning that could be taken and applied not only to LD&A, in terms of supporting vulnerable people to speak up, and advised NSFT had rolled out vulnerable training to assist reasonable adjustments, and this would be rolled out to Primary Care in the future. **Agreed:** The ICB Board formally recognised the importance of this work and hopes to see the positive trajectory continue.	
	Strategy and Partnerships	
10.	**Learning from the Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) Annual Report**	
	PD'O introduced the 2024/25 Learning from the Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) annual report. AO highlighted the following key points: • 107 notifications for 2024/25 were received, of which 98 were known to be in scope for review. Notifications had increased year on year with an increase of 32% on last year. • As of the end of March 2025, 82% of 556 reviews received since 2017 were completed by the 2024/25-year end. • Of the 63 reviews completed in 2024/25, 40 were initial reviews. • Sadly, people with LD&A continue to have a shorter average life expectancy than the wider population. However, the data shows evidence that each year people with LD&A are reaching an older age (65 years and older). • Most people with a learning disability and/or autism are known to have other complex physical health complications. • Sadly, most deaths fall within the treatable category and 44% of total reviews were coded as avoidable. • Focus must be on signs of 'soft deterioration', for example a chest infection which should be treated with antibiotics in the community rather than deteriorating to an extended hospital stay for pneumonia treatment. • The leading causes of death are pneumonia, aspiration pneumonia, and cancer. • Greater focus is needed on women's health and support for menopause. • The importance of making access to preventative treatments more equitable was discussed and included immunisation. • The benefits of annual health checks was noted, providing an opportunity for professionals to identify unmet or unrecognised health conditions, leading to early interventions and better outcomes.	

	Questions and comments from the Board: • FS advised a bi-monthly LeDeR forum was held and updates on reviews are received at each meeting, so action could be taken quicker. • Noted lessons also apply to the wider population regarding vaccination, cancer screening etc. and several initiatives had been driven by this learning. • EG noted the fantastic work and suggested setting an ambition to have progressed this agenda in one year. • AS requested a simplified guide which Healthwatch could share when undertaking engagement visits. • FSe welcomed closer working with NSFT, explaining NSFT had undertaken a lot of work in the past couple of years on mortality data and governance. The next phase is learning systems. Greater connection is needed between LeDeR and mental health given there is much overlap and a plea was made to work much more closely together. • FW commented access to and improving oral health was needed, given many autistic people have sensory issues – a solution to access was vital. **Action:** EG, FS, FSe and PD'O to consider what further ambition can be set on the LeDeR agenda, setting a stretch target for one years' time. **Agreed:** The Board endorsed the content of the report and approved the LeDeR Annual Report. The Board noted their appreciation to AO and the wider team for their dedication and passion.	**PD'O**
11.	**Norfolk Safeguarding Children Partnership Annual Report 24/25 and Suffolk Safeguarding Partnership Annual Report 24/25**	
	PD'O presented the item, noting the reports were for information only and highlighted the following points, focusing on the Norfolk report: • The Norfolk Multi-Agency Safeguarding arrangements were comprehensive, with strong partnerships. • Norfolk had successfully incorporated education as a fourth statutory partner. This was extremely positive as the education environment is somewhere children were likely to talk regarding safeguarding challenges. • The partnership maintained steadfast commitment to key priorities identified including tackling neglect, supporting vulnerable adolescents, and strengthening family and community networking, with a particular focus on fathers. • The Voluntary Sector remains an integral part of the safeguarding framework. • The partnership's robust use of evidence, data and insight had become a key asset, enabling strategic prioritisation.	

	It was noted there are strong relationships with Suffolk and as the new ICB cluster arrangements come to fruition, this would provide an opportunity to take learning from both Safeguarding Partnerships and embed best practice, keeping the safety of children and young people at the forefront. Questions and comments from the Board: • CA asked whether the ten children in Norfolk on a child protection plan, suggested the situation was getting better or worse. PD'O confirmed the ability for society to recognise safeguarding issues had improved and that preventative actions to maintain family units were being supported, rather than removals. • PD'O noted the increasing metric was reflective of a more open culture and higher level of professional curiosity. • FS noted there were special risk factors and the cost-of-living crisis had seen an increase in safeguarding concerns. • FW reiterated the important role of education and schools, given they see children every day and can identify changes. • PD'O advised in Norfolk there is a Children's Collaborative which includes the Local Authority, Health, and Children's Services and would be moving to a model to wrap around neighbourhood teams (education and schools) to help identify early warning signs. • DH queried whether there were any culture or community distinction themes identified in Norfolk. PD'O confirmed both Norfolk and Suffolk have a targeted approach to preventive work and hold demographic details, which identified hotspots to support a targeted approach where there is greatest concern. Additionally, the workforce is adequately skilled with the ability to refer when there are concerns – this is a protective factor. **Agreed:** The Board received and noted the content of the annual reports.	
12.	**Report from the Quality and Safety Committee**	
	CA presented the item, highlighting key points from the report. • The Committee focused on surge capacity to support Acute Trusts and learned about the use of escalation spaces and the resulting impact on both patients and staff. • Learning from adverse events and complaints report - the Committee received a quarterly report and noted that over the course of Quarter 1, there had been fourteen reported patient safety incident investigations across Acute, Community and Mental Health Providers. Particular concern was highlighted around eight 'never events' that have occurred over the last twelve months. As a system, we have a zero-tolerance approach to never events and the ICB Patient Safety Team is facilitating a deep dive with partners. • Confirmed there was nothing the Committee wished to escalate to the Board.	

	Agreed: The Board received and noted the report.	
13.	**Report from Patients and Communities Committee**	
	CA presented the item, highlighting key points from the report. • Significant risk around hospice sustainability because of inadequate and short-term funding models. • The Norfolk and Waveney system is currently ranked highest nationally for digital weight management which is a significant achievement. • Progress noted on the VCSE action plan, including its relaunch, introduction of a newsletter, gap analysis and the implementation of initiatives to address identified needs. • Confirmed there were no items for formal escalation or approval by the Board. **Agreed:** The Board received and noted the report.	
14.	**Winter Plan**	
	MB introduced the item, explaining this work commenced back in April to review system learning and lessons learned would be incorporated into this year's plans. Despite best endeavours, MB highlighted there is risk going into the winter period given the pressures already seen at the end of the summer in emergency care. MB extended his thanks to system colleagues who despite the pressures had stepped up and contributed to a strong plan. RC provided the Board with the following pertinent points: • System partners had engaged well at a whole system day event on 4 September to test plans against nationally written scenarios. • 64 representatives attended from the system in addition to support from SNEE ICB and regional colleagues. • All three urgent care alliances had taken learning back, two of which had already tested, with the third due next week. • Nationally the following key priorities had been set to keep our population and residents safe: Ambulance response time for Category 2, support reducing handover delays, 4-hour ED performance, reducing waiting lists with particular focus on mental health, discharge delays and making sure children are seen within 4-hours. • Key themes from the system event included staffing challenges and workforce mobility – highlighting the need for flexibility and localised solutions.	

- The ICB had traditionally run the System Coordination Centre reactive to pressures – this year there will be a push for more proactive support using data.
- Noted the need to strengthen primary care resilience and engagement.
- The system has done well in terms of maintaining ambulance conveyance into hospital, this has remained flat for some time on a slight downward trend.
- Within the Single Point of Access, the ICB is providing support and focus to lower the number of Category 2 ambulance calls this winter and will work with the ambulance trust to obtain permission to work with them to redirect appropriate demand.

Questions and comments from the Board:

- The Chair sought confirmation that the Winter Plan would be a live document.
- EG referred to a speech given by Sir Jim Mackey at a national event at which he stated no child should wait for more than four hours in an emergency department and asked how we compared. RC confirmed 90% of children were seen within 4-hours.
- HvdW raised whether staff vaccination was something being addressed along with learning from past years. MB noted the target had increased by 5% this year. ECH&C retain high levels of vaccination whilst other areas continue to encourage staff. It was acknowledged that staff uptake was a challenge which needs to be addressed and improved this year.
- PD'O noted there is vaccination fatigue with staff and that learning should be taken from ECH&C and a multifactorial communications plan must be put in place.
- FS noted the importance of being able to facilitate vaccination with easy access and sought assurance that vaccinations were being offered to social and domiciliary care staff given we rely on each other to maintain flow.
- FC commented he had spent a day in the control centre with ambulance crew and would absolutely support better triage. He questioned why the ambulance trust wouldn't be supportive/why permission would need to be sought to change the way of working.
- RC explained that the ambulance trust executive was seeking assurance that there would be thorough consideration and review of the clinical aspects to ensure safety – if this can be provided then they are supportive of the Unscheduled Care Coordination Hub undertaking triage.
- Triage arrangements would include two call queues, one into 999 and once categorised, it would drop back into the dispatch and the 111 queue. There is also a physical MDT in Norwich which would be empowered to take category 3, 4 and 5 calls.
- HM queried how electives and resilience had formed part of the plan. RC confirmed this is part of manging the flow, to protect electives.
- PD'O commended the planning however noted that we were lacking in asking our communities to do anything differently.

	• MB confirmed there was a communications plan and a leaflet about what would be different this winter and will be available to all providers as well. Social medial would also be used to support effective communications. **Action:** FW to investigate and confirm what arrangements are being put in place for social and domiciliary care in terms of flu vaccination. **Agreed:** The Board noted and approved the plan as presented, acknowledging that minor updates would be needed throughout the autumn to respond to operational circumstances. The Board also approved the NHSE Board Assurance Statement for submission.	**FW**
	Commissioning, Delivery and Performance	
15.	**Financial Report for Month 5 2025/26**	
	HM introduced the item, highlighting key points from the report. • The Norfolk and Waveney system deficit at Month 5 was reported as a £51 million deficit. • NHS England has confirmed deficit support funding would be removed from 2026/27. • Month 4 system position year-to-date is a £13.8 million deficit, which is £5.1 million adverse against plan. • Greatest concern was noted to be the QEH, with grip being lost on costs in the context of a challenging plan. The NNUH position had appeared to be improving over the last two months but reports an adverse variance due to CIP scheme slippage. The JPUH was in a better position and mitigation plans were being put in place to address a short fall in elective income. • There would be no national funding to support Trusts because of Industrial Action. • Month 4 represents a £1.3 million deterioration, and the trend continues for Month 5. • The underlying full year forecast deficit had deteriorated to £95 million. This is a significant and worrying position and HM is in live discussions with Trust CFOs in addition to NHS England support. • The ICB had reported a breakeven year-to-date position, but this had been mainly because of non-recurrent savings. • HM noted concern regarding the overall financial health of the ICB, given the £21 million underlying deficit. • A programme of work commenced in July to bridge the £32 million gap in Cost Improvement Plans, this identified that there remains £11 million risk to delivery. Should this not be mitigated, there would be serious implications on system partners and the system plan. The outcome of this work will require Executive approval at the end of September.	

	• Noted that there have been some positives in respect of the cost improvement plan in areas such as Medicines Management Optimisation and Continuing HealthCare. • Not reported in the forecast was £14 million of risk because of the organisational change programme – confirmation is awaiting following discussion between NHS England and Treasury. • Overall, the system position is challenging and identifies a worrying trend. • ICBs are implementing a new ledger system ISFE2 from 1 October 2025 – this will be resource intense, but longer term would be a more efficient system. • Awaiting formal receipt of three-year revenue allocations and four-year capital allocations alongside the planning framework. HM summarised the following key actions being taken forward: • Concluding clear delivery mechanisms of the CIP Programme. This was being overseen by a newly initiated financial recovery group. • Review of all expenditure lines to seek opportunities to stop or defer, before the end of September. • In depth review of both N&W ICB and SNEE ICB including an analysis of where funding is being deployed, to ensure a like for like comparison to help give us good stead for the newly formed ICB. • Ongoing scrutiny by the Finance Committee. Questions and comments from the Board: • EG asked what would happen due to the removal of the £5 million deficit support funding next financial year – would the ICB be expected to plug the gap? HM confirmed this would be addressed in the awaited operational guidance. • HM commented the plan must be met this year and remedial reviews would commence in October. **Agreed:** The report was noted by the Board.	
16.	**Report from the Finance Committee**	
	HvdW confirmed there had been no Finance Committee meeting since the last Board meeting due to the summer holidays, but the Chair and Vice-Chair of the committee met on 26 August 2025 with the interim Executive Director of Finance and Associate Director of Financial Planning. The next Committee will take place on 30 September 2025. HM noted the importance of submitting an assurance statement regarding meeting the financial challenge to NHS England in October. Failure to do so would result in no deficit funding and would pose significant cash flow difficulties. **Agreed:**	

	The report was noted by the Board.	
17.	**Integrated Performance Report (IPR) and Quality and Safety Performance Report ICB Board**	
	AP provided highlights from the IPR report: • Category Two ambulance performance and 111 had strengthened in UEC although overall, maintained a concerned level of assurance over urgent care. • Mental Health was in a strong position resulting in an improved assurance position of 'average'. • The data informs that elective and cancer waits are of the greatest concern. • Diagnostics had declined and subsequently, weekly meetings with NHE England have been convened. • Work is being undertaken around capacity and demand planning. The System Group has been tasked to come up with a medium-term plan and would need to be considered in next year's commissioning intentions. • There will be changes to performance in light of NOF changes and conversations were underway with region about regulators bringing in additional powers. PD'O provided highlights from the Quality and Safety Performance Report: • Metrics underpin the Quality Strategy. • PD'O noted the QEH had been included within the National Investigation into Maternity Services. • JPUH subject to CQC Section 29a – the draft report from CQC is awaited however early intel suggests the visit was positive. **Agreed:** The ICB Board received and noted both reports.	
18.	**Report from the Commissioning and Performance Committee**	
	HvdW presented the item, highlighting key points from the report. • It was noted there had been corrections made since the report had been written, in respect of the tiering status for the JPUH, confirming the JPUH was in receipt of no tiering for Cancer in both Quarter 1 and Quarter 2. BAF03 (CYP MH) had also been corrected – the mitigated risk for this was changed from 16 to 12. • The narrative report now states assurance levels for each programme of work, and it was proposed to change the assurance level afforded to elective and diagnostics from 'average' to 'concerning'. • There had been a significant number of risks added to the Committee's management in July, focused on Information Governance.	

	• Lynch Syndrome testing had been approved however there was no identified resourcing, and Norfolk and Waveney remain a national outlier. • A review of industrial action by resident doctors identified a wide variation in the provider landscape. • A number of escalation reports were received from 'feeder' groups. • HvdW noted the medium-term financial plan updates had been received from Provider trusts and would require future approval from both the ICB Board and Provider Boards. **Action:** Board to have dedicated time to focus on medium-term financial planning. **Agreed:** The report was noted by the Board.	**HM**
	System Oversight	
19.	**Board Assurance Framework**	
	HD presented the Board Assurance Framework, taking the paper as read. Questions and comments from the Board: • DH noted Primary Care resilience as standing out and questioned the Board's risk appetite. • DH suggested triangulation of clinical strategy, and historical primary care issues should be addressed at a future Board as part of a lessons learned exercise. • AP suggested the structure of the BAF would likely require convergence to align strategic ambitions as we come together in clusters. **Action:** Primary Care lessons learned to be one of the areas of focus at the October Board development session followed by a formal paper to the November Board meeting. **Agreed:** The ICB Board noted the contents of the report.	**MB**
20.	**Governance Handbook**	
	HD presented to the Board proposed changes to the Remuneration, People and Culture Committee Terms of Reference and changes to support transition arrangements. **Agreed:** The ICB Board approved the changes to the Governance Handbook as detailed in the report.	
21.	**Annual Reporting and Accounts 24/25**	
	HM confirmed the Annual Report and Accounts for the ICB were prepared for 2024/25 and audited externally. They had also been scrutinised at the	

	Audit and Risk Committee prior to approval at an Extraordinary Board meeting held on 18 June. It was noted that there were no post approval amendments to action. The external auditors audited the financial statements and confirmed they gave a true and fair view of the respective financial positions. Questions and comments from the Board: • DH reiterated the positive auditor response and noted it was a first to not require any adjustments. **Agreed:** The Board noted the Annual Report and Accounts for NHS Norfolk and Waveney ICB for the period 1 April 2024 to 31 March 2025 and commended the finance team for the delivery of a positive outcome.	
	Remaining Committees Reports and Questions from the public	
22.	**Report from Primary Care Commissioning Committee**	
	HvdW confirmed the Primary Care Commissioning Committee had not met, therefore there was no update given.	
23.	**Report from the Audit and Risk Committee**	
	DH reported there had been an Extraordinary Committee held to receive the full version of the ARRS report. The Committee had also met to sign off the Annual Report and Annual Accounts. **Agreed:** The ICB Board noted the verbal update.	
24.	**Questions from the Public**	
	There were no members of the public present.	
25.	**Medium Term Planning briefing note**	
	AP confirmed the paper was for information. The Board noted the briefing on the new Planning Framework for the NHS and the immediate ICB aims and priorities. Questions and comments from the Board: • FS raised that the Clinical Strategy would need to be built into the outcome framework. **Agreed:** The ICB Board noted the briefing on the new Planning Framework for the NHS and the immediate ICB aims and priorities.	

26.	**Any other business**	
	There were no items raised under any other business. The meeting closed at 15:57.	
Date, time, and venue of next meeting:		
Any queries or items for the next agenda please contact: nwicb.corporateaffairs@nhs.net		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

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

Declared interests of the Board

*** please note below that subject to the merger and restructure of the ICB, the following executives are conflicted for declarations in this area.**

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	Norwich University Of The Arts			X		Chair of Council	01/12/2024	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Workers Educational Association			X		Trustee	Dec-23	Present	
		Evolution Academy Trust			X		Trustee	01/01/2022	Present	
		Cambridge University Press Pensions Schemes			X		Trustee	01/01/2018	Present	
		East Anglian Ambulance				Indirect	Daughter in Law is employed by East Anglian Ambulance	01/01/2019	Present	
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
Howard Martin	Director of Finance - Suffolk and Norfolk ICB and Interim Director of Finance, Norfolk and Waveney ICB	Nothing to Declare				N/A	N/A			N/A
Dr Faisil 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
* Ed Garratt	Interim Chief Executive	University of Suffolk			X	Direct	Visiting Professor	Apr-21	present	To be declared as appropriate
		Deputy Lieutenant for Suffolk			X	Direct		Sep-23	present	To be declared as appropriate
		NHS Suffolk & North East Essex ICB		X		Direct	Chief Executive	May-25	Present	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
Lisa Nobes	Execuitve Director of Nursing	TBC								
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
		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	Norfolk and Norwich University Hospital		X			I hold an honorary contract and work as a consultant endocrinologist / physician approximately one day per week at NNUH	01/07/2022	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		St Martin's Norwich and private mental health counselling				Indirect	My husband works as a counsellor and undertakes sessions for St Martin's and in private practice	01/01/2023	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Long Stratton 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
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	

Richard Watson	Executive Director of Strategy, Digital and Commissioning	Hadleigh Group Practice	X			Indirect	Husband is employee of Hadleigh Group Practice	Oct-19	Present	To be declared when necessary
		Integrated Care, University of Suffolk			X	Direct	Senior Research Fellow for Integrated Care, University of Suffolk	Jan-23	Ongoing	To be declared when necessary
		Hadleigh Community Primary School			X	Direct	Parent Governor Hadleigh Community Primary School	Sep-24	Ongoing	To be declared when necessary
		Strategic Commissioning NHS England			X	Direct	National Programme Director, Strategic Commissioning NHS England	Jan-25	Ongoing	To be declared when necessary
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 QEHKL 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

Norfolk and Waveney
Integrated Care Board

NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD
ACTION LOG

Actions arising

Agenda Item	Action	Lead	Update	Target Date
Report from the Quality and Safety Committee	SK asked on the joint quality and joint quality and health impact assessments and would like to hear on the impact of this at a future meeting. Briefing on quality impact assessments to a future meeting.	Tricia D'Orsi	A briefing on quality and impact assessments will be presented at the November meeting and a note has been made on the forward plan. This item is on the agenda for the November meeting.	26 November 2025
Intensive and Assertive Outreach Review Presentation	All actions on the action plan are on track to be completed within the timeframe. A detailed action plan will be shared with the July meeting.	Karen Barker	NSFT will not have reviewed this at their Board meeting to allow it to be presented to our July meeting. Therefore, this has been placed on the forward planner for the September meeting. Completed. This item has been moved to the November meeting. This item has been placed on the agenda for the January meeting to align with the SNEE agenda also.	28 January 2026
Integrated Performance Report (IPR)	MD to include workforce data in the Integrated Performance Report.	Richard Watson	MD to include data. Target date of November 2025. The IPR will contain workforce data moving forward from the January 2026 meeting.	28 January 2026
Learning from the Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) Annual Report	EG, FS, FSe and PD'O to consider what further ambition can be set on the LeDeR agenda, setting a stretch target for one years' time.	EG, FS, FSe and LN	Placed on forward plan for new Norfolk and Suffolk Board.	September 2026
Winter Plan	FW to investigate and confirm what arrangements are being put in place for social and domiciliary care in terms of flu vaccination.	FW	Verbal update to meeting	26 November 2025
Report from the Commissioning and Performance Committee	Board to have dedicated time to focus on medium-term financial planning.	HM	On forward plan for December OD session.	16 December 2025
Board Assurance Framework	Primary Care lessons learned to be one of the areas of focus at the October Board development session followed by a formal paper to the November Board meeting.	MB	Primary Care Strategy update included on the part 2 agenda for November meeting.	26 November 2025

Chair and Chief Executive's Report	Paper to be received at a future Board meeting or Board development session to better understand the National Oversight Framework.	HM	Future meeting date to be confirmed.	26 November 2025

NHS England

To: ICB, NHS Trust and Foundation Trust:
- Chairs
- Chief Executives
- Chief People Officers

cc. NHS England regional directors
Commissioning support units

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 October 2025

Dear colleagues,

Request for action on racism including antisemitism

We write to ask for your assistance in implementing important initiatives that support our shared commitment to fostering an inclusive, respectful, and professional environment – for colleagues, patients and visitors – across the NHS and assuring our communities of our commitment to tackling hatred in all its forms.

We want to reiterate our zero tolerance stance to all forms of hatred, antisemitism, Islamophobia, racism and to any form of discriminatory behaviour. We reiterate our commitment to creating workplaces and services where everyone feels safe, valued and supported, regardless of their background, faith or identity.

In line with this, NHS England is formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism.

Th UK Government adopted the definition in 2016 and the Secretary of State has today reaffirmed the Department of Health and Social Care's commitment to it. The Secretary of State has asked that other DHSC Executive Agencies and Arms-Length Bodies adopt this.

The definition includes illustrative examples of how antisemitism may manifest in contemporary settings, including but not limited to denial of the Holocaust, accusations of Jewish conspiracy, and the targeting of Israel as a proxy for Jewish people. Criticism of Israel similar to that levelled against any other country, however, cannot be regarded as anti-Semitic.

We strongly encourage all NHS organisations to adopt this definition and to note the associated commitments to free speech in order to reinforce our collective stance against antisemitism – whether experienced by our colleagues, our patients, our communities or partners.

We need to demonstrate equal rigour in tackling all other forms of hatred and racism. During the race riots of 2024, local NHS organisations acted as beacons of hope in their local communities – supporting staff in taking an active stance against racism, in particular at that time against Islamophobia.

The current climate in some of our communities means we need to redouble our efforts to create workplaces where our staff and patients alike feel safe and welcome.

The government is also reviewing the recommendations of the independent working group on Islamophobia.

Uniform and workwear guidance update

Ensuring everybody feels safe to present for care and treatment when they need it and in working environments for our colleagues is a patient safety matter.

Working with stakeholder groups, we will update our existing uniform and workwear guidance, drawing on the policies developed in Manchester, UCLH and other good practice. The guidance will continue to uphold the principles that underpinned its creation including freedom of religious expression, ensuring patients feel safe and respected at all times, and that staff political views do not impact on patients' care or comfort.

Antiracism including antisemitism training

We are also updating the existing NHS Core Skills Framework module on Equality, Diversity and Human Rights, extending the section on discrimination and content on antisemitism and Islamophobia, and including new questions on this in the assessment. We are working to ensure all NHS organisations are aligned to the Framework to ensure that all 1.5m NHS staff are required to complete this training as part of their mandatory training.

Working with Lord Mann, we will update the content developed with EDI, racism, antisemitism and Islamophobia subject matter experts and aligned to the core skills training framework.

The existing training is completed by staff every three years, but we are asking for your help and support to ensure that all staff in your organisation refresh their EDI training as soon as this content is available rather than waiting for the prompt in the current three-year cycle.

Separately, work is underway to draft a new Statutory and Mandatory Training competency framework which will replace the Core Skills Training Framework (CSTF) – setting out all nationally recommended subjects to be mandated and is due to go live by April 2026.

We appreciate your leadership in implementing these changes and we ask you to support all staff in feeling safe and valued at work and also to support our communities accessing NHS services. We also recognise the importance of supporting NHS organisations in implementing these important initiatives and look forward to working with you to do this.

Yours sincerely,

Sir James Mackey
Chief Executive
NHS England

Jo Lenaghan
Chief Workforce Officer
NHS England

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**2025 ICB Cost Reduction and Transition Programme Update**
Presented by:	**Amanda Lyes, Executive Director of People, Governance and Corporate Services**
Prepared by:	**Lizzie Mapplebeck**
Submitted to:	**ICB Board Meeting**
Date:	**26 November 2025**

Purpose of paper:

To provide information regarding the ICBs readiness in response to the 2025 ICB cost reduction and transition programme.

Executive Summary:

Introduction
On 13 March 2025, the government made two key announcements in relation to a national NHS financial reset.

1. NHS England will be abolished, and its functions fully integrated with the Department of Health and Social Care (DHSC) within two years.

2. Integrated Care Boards (ICBs) are expected to make 50% cuts by December 2025, performing the role of strategic commissioner.

On 07 April 2025, ICBs received running cost information and fair share arrangement information.

SNEE is required to reduce running costs from £34 per head of population (equates to £37.4m) to £19 per head of the population (adjusted from £18.76 to reflect the 3.6% NHS pay settlement), this equates to savings of £16.5m (45%).

Norfolk and Waveney is required to reduce running costs from £44 per head of population (equates to £51.7m) to £19 per head of the population (adjusted from £18.76 to reflect the 3.6% NHS pay settlement), this equates to savings of £29.3m (57%).

Together SNEE ICB and Norfolk and Waveney ICB are required to make savings of £45.8m (52%).

The ICB is committed to delivering this cost reduction to support the Government's ambition to deliver more funding for frontline services. The ICB will need to significantly change its organisational structure and the way we work to achieve these savings. This will include merging and transferring organisational boundaries and reducing pay and non-pay.

A ministerial statement was published on 09 September 2025 which announced the formation of three new ICBs for the East of England on 01 April 2026:

- Norfolk and Suffolk ICB (Norfolk and Waveney and Suffolk)
- Central East ICB (Bedfordshire, Luton, Milton Keynes, Cambridgeshire, Peterborough and Hertfordshire)
- Essex ICB (North East Essex, West Essex and Mid and South Essex)

Following the announcement of the three new ICBs, the current six East of England ICBs have entered into a period of transition and staff consultation to deliver the national requirements.

Local Landscape and Preparedness
On 31 March 2026, all six East of England ICBs (Suffolk and North East Essex, Mid and South Essex, Norfolk and Waveney, Cambridge and Peterborough, Hertfordshire and West Essex and Bedfordshire, Luton and Milton Keynes) will be abolished and on 01 April 2026 three new ICBs (Norfolk and Suffolk, Central East and Essex) will be established.

To achieve this transition ICBs are required to undertake a series of readiness activities, these will continue to be developed and built upon. All the lessons learned from the 2023/24 running cost reduction programme have been taken on board and new NHS England guidance is being followed.

Transition to Norfolk and Suffolk

Work is underway to enable the abolishment of SNEE ICB and N&W ICB and establishment Norfolk and Suffolk ICB. The ICBs are recording risks, both operational and strategic, including the impact on operational delivery and our ability to deliver Future Shift and the Joint Forward Plan.

Governance: Transition and Merger Committee and Delivery Workstreams

The joint SNEE ICB and N&W ICB Transition and Merger Committee is now well established and is continuing to support the Chief Executive and ICB Boards in ensuring the maintenance of appropriate governance processes and effective decision making during the period of transition.

The Transition and Merger Committee is part of the governance process reporting to both ICB Boards in considering how to efficiently progress at pace whilst both recognising the impact that such change may have on constituent organisations and their governance. The Transition and Merger Committee also consider and monitor how the organisational changes deliver best value for the regions as well as how performance more generally is measured.

The Transition and Merger Committee provides strategic focus and overview in support of assurance of the overall programme delivery, seeking assurance on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

The Transition and Merger Committee membership comprises of the single Executive Director team covering both ICBs. There are also representatives of other key enabler functions in attendance to assist the committee as follows:

- Chair, (Designate) Executive Director of People, Governance and Corporate Services N&W ICB & SNEE ICB , and Transition SRO

- Deputy Chair, (Designate) Director of Finance N&W ICB & SNEE ICB
- ICB Chair N&W ICB & SNEE ICB
- (Designate) Deputy Chief Executive N&W ICB & SNEE ICB
- Non-Executive Member SNEE ICB Board
- Non-Executive Member N&W ICB Board
- Representative from N&W ICB Internal Auditor
- Representative from SNEE ICB Internal Auditor
- Programme Director from N&W ICB
- Programme Director from SNEE ICB

To support the Transition and Merger Committee and delivery of the transition programme a robust programme framework and structure has been developed. The programme framework includes 13 workstreams, each workstream has an identified lead from each ICB. The workstreams are:

1. Programme
2. HR and Workforce
3. Registers
4. Finance and Liabilities
5. IT and Digital
6. Estates
7. Medical, Nursing and Quality
8. Governance
9. Communication and Engagement
10. Data and Information
11. Information Governance
12. Contracts
13. Business Continuity and EPRR

The 13 workstreams are supported and guided by the programme team who bring the workstream leads together on a fortnightly basis as a Working Group for assurance and programme management purposes.

As of November 2025, the Working Groups have come together to meet as a joint N&W and SNEE Working Group. The programme team provides the Transition and Merger Committee with assurances on delivery and management of risk on behalf of the Working Group.

Joint Committees and Groups

The Board has previously seen a proposal for Norfolk and Suffolk interim governance arrangements which set out an approach of working in common where possible and continuing with existing separate arrangements where necessary. This approach has worked well with several in common meetings taking place including the first in common board meeting on 14 November to consider the launch of the staff consultation.

However, as the transition programme has evolved it has become clear that some areas would benefit from the establishment of joint working ahead of the anticipated formal merger. Both Chairs of the respective Finance Committees and the Executive Finance and Contracts Director have agreed to seek to establish a Joint Finance Committee from January 2026. A

joint committee will enable a streamlined approach to planning for the coming financial year across a expanded ICB footprint as well as promote learning across the whole of the SNEE and NW areas. The Joint Committee would work in parallel to the Essex Joint Committee which will operate a finance sub-committee which into which North East Essex financial data would be reported.

Regional Working

To enable the safe transfer of people and assets to Essex ICB, SNEE ICB representatives form part of the Essex Working Group and Joint Essex Transition Committee. At an operational level, collaborative work has enabled the commencement of a joint due diligence checklist to support the completion of key activities required to gain full assurance to enable the safe transfer.

Weekly meetings are in place with programme colleagues from all six East of England ICBs to discuss the transition and merger process. An NHS England representative is also present to provide insight on expected national guidance, plans and timeframes which enables the programme teams to work pro-actively together.

Due Diligence and Assurance

In October 2025, NHS England provided a national due diligence checklist.

The due diligence checklist has been developed from checklists supporting previous change programmes (CCG mergers and ICB establishment) and has been co-produced by NHS England, ICBs and other stakeholders as a tool for use by ICBs to provide evidence of appropriate due diligence to support the transfer of people (staff) and assets in ICB mergers and for significant ICB boundary changes.

The ICB has built the completion of the due diligence checklist into the programme to ensure all leads undertake a thorough due diligence exercise to prepare for the transfer of staff and assets in advance of the transition.

Completion of the full checklist is not itself mandated by NHS England, however, all ICBs in the East of England have agreed to complete all tabs.

The Chief Executive will be requested to provide written assurance to the Chief Executive of NHS England of due diligence to enable the signing of the legal instruments to enact the proposed changes. The checklist will be used to support the due diligence exercise. This will support the legal transfer of staff and property, close down of current ICBs, establishment of new ICBs and boundary changes to be enacted on 1 April 2026.

NHS England regional teams will undertake assurance reviews to ensure progress. Thers are referred to as 'check points'. Each Check point will require evidence to be submitted to show achievement at a point in time and identify whether ICBs require any additional support. The indicative timing of those check points is as follows

- Check Point 1: 1 October 2025 - ICB merger / boundary change programme plan is in place including a high-level due diligence plan. (Complete, SNEE and N&W received a high level of assurance).
- Check Point 2: 307 January 2026- ICBs on target to complete the due diligence programme and compile a staff list and for those impacted by boundary changes they are also on target to compile a comprehensive property list(s).

- Check Point 3: 18 February 2026 - ICBs on target to complete the due diligence programme and compile a staff list and for those impacted by boundary changes they are also on target to compile a comprehensive property list(s).
- Check Point 4: 18 March 2026 - Confirmation from ICB CE, with a copy to NHSE's RD, that due diligence processes have been completed and for those impacted by boundary changes, that the comprehensive staff and property list(s) have been completed, schedules duly signed off by the sending and receiving organisations (CE of new / receiving ICB) and submitted to the regional team.
- Check Point 5 (action for the national team): 20 March 2026 - Order and Staff and Property Scheme signed by NHSE CE.

Transfer of Staff and Assets to Essex

The functions carried out by SNEE ICB will be divided based on geographical delegation, the North East Essex functions will transfer to the new Essex ICB (with all remaining functions transferring to Norfolk and Suffolk ICB). Alongside the functions, North East Essex facing staff and assets will also transfer. To enable a safe transfer of people and assets a series of activities have commenced, all of which will conclude on 01 April 2026. For the purposes of transition assets include people (staff), contracts, estates, finance, information assets, information flows, systems and policies.

Transfer of Assets

To enable a safe transfer of assets a series of registers are being developed. The purpose of the asset registers is to ensure that key details about assets are easily accessible and standardised to support the transfer from N&W ICB and SNEE ICB to Essex ICB and Norfolk and Suffolk ICB.

The following registers are being developed.

- Contract Register: Provides information about all provider contracts that are currently held that will be transferred to Essex ICB and Norfolk and Suffolk ICB. This includes details of the contract (including any performance notices), a copy of the contract and agreement (if required) about the lead and associate contract management arrangements
- People Register: Details a list of staff employed by SNEE ICB that will be transferred to Essex ICB and Norfolk and Suffolk ICB and all accompanying staff records, including any reasonable adjustments and pay information. This makes up the Employee Liability Information (ELI) which will be sent to Mid and South Essex ICB 28 days prior to transfer.
- Asset Register: Details all land, building and equipment that will transfer to Essex ICB and Norfolk and Suffolk ICB.
- Information Asset and Information Flow Register: This details a description of the information record (both paper and electronic), the volume of records, storage information, retention periods, level of confidentiality (if it contains personally sensitive information) and access to the information for all information that will transfer to Essex ICB and Norfolk and Suffolk ICB.
- Finance Register: Provides details regarding allocations, payments and financial flows that that will be transferred to Essex ICB and Norfolk and Suffolk ICB.
- System Register: Provides information about the systems in place to manage data flows, information (including performance), finance, people, access to records and provider management that will be transferred to Essex ICB and Norfolk and Suffolk ICB.

- Policy Register: Details all clinical and threshold policies that are currently in place, and any staff related policy (HR) that will be transferred to Essex ICB and Norfolk and Suffolk ICB.

The registers act as a central repository, preventing the reliance on fragmented spreadsheets which ensures everyone uses the same, consistent data which is easy to cross-reference. The registers will provide an instant, organised inventory of what is being transferred, streamlining the physical and administrative handover process.

The asset registers will be foundational to the due diligence process as they will significantly reduce risk and time spent during the intensive due diligence phase. The registers ensure the ICBs have documented and verified the assets existence which in turn will enable Essex ICB and Norfolk and Suffolk ICB to be assured of their transfer and receipt to enable ongoing management.

SNEE ICB have completed an exercise to identify and map all key decisions that relate to Essex that are required to take place between October 2025 and April 2026. This includes decisions pertaining to

- Contracts
- Procurement
- Business Cases
- Annual Reports and Forward Plans

The mapping includes which committee of the Board will be making the decision and when and if the decision relates to Suffolk and North East Essex (as a whole) or just North East Essex. The mapping has been shared with Mid and South Essex (MSE) to ensure the correct Essex committee is sited and assured. In total 119 decisions were mapped and shared.

The regional programme and joint workstream specific meetings enable discussion on the transfer of assets and joint governance arrangements to provide assurance and approvals.

Transfer of Staff
Identified staff will transfer to Essex ICB, all remaining staff will transfer to Norfolk and Suffolk ICB. The staff transfer will be conducted in accordance with the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). To ensure consistency and reduce the risk of grievance or Employment Tribunal claims, a clear threshold for identifying Essex-facing roles has been set.

Staff have been identified based on their alignment to functions and services transferring to Essex ICB. The threshold for inclusion is 60% or more of time spent on Essex-facing activities, such as meetings with others working in Essex, programmes targeting health of Essex residents, work relating to institutions in Essex. This threshold is consistent with Hertfordshire and West Essex ICB. For SNEE ICB this includes North East Essex alliance, transformation, clinical leadership and teams, and medicine optimisation roles directly supporting Essex programmes.

SNEE ICB commenced informal engagement with staff on 03 November 2025, this will conclude at the end of November. Currently the indicative total of the number of roles/staff proposed to transfer from SNEE ICB using the 60% threshold is 71 roles, this may change following conclusion of informal engagement. It is a legal requirement for sending organisations to provide Employee liability information (ELI) to the receiving organisations at least 28 days prior to the transfer date, SNEE have already shared anonymised data with MSE to support early due diligence. Following informal engagement, formal consultation will commence in January 2026 with the TUPE transfer being completed on 01 April 2026.

Pay Programme: Leadership and Workforce

Work has commenced and is progressing positively regarding the pay savings for ICB functions across Norfolk and Suffolk ICB.

ICBs have a legal duty to make sure that policies, services and functions do what they are intended to do in a way that does not discriminate and promotes equality and inclusion. An Equalities and Health Inequalities Impact Assessment (EHIIA) has been co-produced by the five Staff Networks and the Staff Reference Group.

The EHIIA identified negative impacts which are summarised as 'There will likely be jobs losses (redundancies) for a significant number of ICB employees.' However, this negative impact has been justified as valid as the potential reduction in headcount will ensure the ICB is adhering to national direction. A series of mitigating actions have been developed to ensure the negative impacts do not disproportionally impact those with protected characteristics.

It is anticipated that many of the mitigations identified for one group may well also benefit other groups, and the programme team will continue to identify where we can extend best practice to support all our staff.

Executive Leadership

On 01 September 2025, following approval from the Secretary of State for Health and Social Care, NHS England in the East of England confirmed the appointment of Professor Will Pope as the chair who will lead the Norfolk and Suffolk ICB.

On 29 September 2025, Dr Ed Garratt was announced as the Chief Executive for Norfolk and Suffolk ICB.

Following a period of consultation, the recruitment and appointment process has concluded for the Executive Directors for Norfolk and Suffolk ICB. The new designate executive director team for the Norfolk and Suffolk ICB is now operational. The appointments, announced in September, are in preparation for the new organisation that will start on 1 April 2026.

- Executive Medical Director – Dr Frankie Swords
- Executive Director of Nursing – Lisa Nobes
- Executive Director of Primary Care and Neighbourhood Health (Norfolk) – Mark Burgis
- Executive Director of Primary Care and Neighbourhood Health (Suffolk) – Maddie Baker-Woods
- Executive Director of People, Governance and Corporate Services – Amanda Lyes
- Executive Director of Strategy, Digital and Commissioning – Richard Watson
- Executive Director of Finance and Contracts – Howard Martin

Non-Executive Members

The Chair commenced recruitment for Non-Executive Members (NEMs) to sit on the Norfolk & Suffolk ICB Board on 4 November 2025. All the incumbent NEMs (four in SNEE and three in NW) were invited to express an interest in taking up a NSICB role. The portfolios of the new NSICB NEMs have not yet been set and all four NEM roles have the same role description. The appointment process is expected to be concluded by late December/ early January. A similar appointment process for partner members on the NSICB Board will have to be undertaken in the new year.

Staff Consultation

On 11 November 2025, the SNEE ICB and N&W ICB RemCom approved the approach to consultation and the launch including the consultation documentation and provided assurance to Board that the ICB is complying with all relevant employment legislation and ICB Change Management Policies. RemCom also provided assurances to Board that the new structure will support the ICB's strategic objectives and allow the ICB to fulfil its statutory and other duties.

On 11 November 2025, the ICB Board approved the overall financial envelope for both the new structure and the potential redundancy bill and provided assurances that the new structure will support the ICB's strategic objectives and allow the ICB to fulfil its statutory and other duties.

SNEE ICB and N&W ICB entered a period of consultation with Agenda for Change (AfC) staff on 19 November 2025. The consultation period will last for 55 calendar days, concluding on 12 January 2026.

Alongside the commencement of consultation, the ICBs are providing a voluntary redundancy (VR) scheme to run concurrently with the consultation. The VR scheme will provide the ICBs with the opportunity to rebalance the roles and skills alongside compulsory redundancy to achieve the pay cost reduction whilst maintaining good motivation and morale.

NHS England issued a model voluntary redundancy scheme for use by ICBs on 11 November 2025. The ICBs are utilising the model scheme in its entirety.

Non-Pay Programme

A separate exercise has taken place to review non-pay.

£5.1m of non-pay savings have been identified across SNEE ICB and N&W ICB; the most significant areas have been in IT, Digital and Data.

There is at least a further £1.4m of non-pay budget areas that are being reviewed in line with the
current planning period, including arrangements for outsourcing CHC support services and a Medicines Optimisation contract in Norfolk and Waveney.

As with the pay programme, non-pay savings will require focused delivery during the remaining part of this year to minimise financial risk in 2026/27.

Staff Support

The ICB has invested in various staff health and wellbeing support offers and continues to promote kindness, openness and transparency.

Virtual Staff Briefings

The ICB committed to communicating honestly, transparently, regularly and quickly to all staff regarding the ICB changes. As such, a virtual staff briefing was held on 13 March, less than 24 hours post the government announcement (shared publicly via the HSJ). Subsequently 20 further virtual staff briefings have been held.

All virtual staff briefings are recorded and made available to watch back on the intranet.

Weekly News Bulletin

At the end of each week a weekly roundup bulletin regarding the ICB changes is circulated via email to all staff. This is sent even if there are no updates or new information to share. The weekly bulletin covers:

- National News
- Local News
- A summary of the most recent staff briefing
- Links to the intranet page that hosts the recording of the staff briefings and list of FAQs
- Details of the next ICB Staff Reference Group
- Support for Staff, detailing all offers that are available for staff, from formal courses to informal sessions and links to HR and assistance programmes.

The first weekly bulletin was issued on 28th March.

Support for Staff

General Staff Health and Wellbeing: The staff intranet hosts a Staff Health and Wellbeing page which provides details of support services available to staff. This includes contact information for HR (and the ability to be able to book 1:1 time with HR), information about Staff Networks and Groups, details for occupational health and wellbeing teams, information on our Mental Health First Aiders, information and access details for the ICB Employee Assistance Programme, information and contact details for the Freedom to Speak Up Guardian service, information and contact details for the Professional Nurse Advocates, information and contact details for the Unions and professional bodies, information and details of how to access the SNEE Coaching Network and resources and advice and signposting that helps staff with finances and financial wellbeing.

Change Management HR Bitesize Training: Staff are able to access training to understand how the management of change process works, the relevant sections in the Agenda for Change Terms and Conditions and Employment Law, and the potential practical implications for staff.

Understanding the Voluntary Redundancy Scheme HR Bitesize Training: Staff are able to access training to understand how a Voluntary Redundancy Scheme works, how to apply, the process to expect and the terms of the scheme. Currently we have not been given detail of the scheme.

Resilience and Emotional Health and Wellbeing webinars: A number of Resilience and Emotional Health and Wellbeing webinars have been provided by STEP (Samaritans Training and Engagement Programme), as below.

Emotional health and wellbeing: This webinar covers: What is emotional health? Recognising when you might not be OK. Tips to support your own, and others emotional health.

Staying resilient: This webinar covers the following topics: The connection between emotional health and resilience, the potential impact of stress on our resilience and wellbeing, recognise and respond to warning signs of stress, how negative 'self-talk' can impact self-esteem and resilience and practical strategies to strengthen our personal resilience.

SNEE ICB Coaching Network: The SNEE ICB Coaching Network is in place to support staff if they would like some coaching. Staff are able to book a coach by completing a form on the Intranet.

Inhouse Workshops: A series of workshops specifically designed for smaller group work are being offered to staff, these are informal and interactive with time built in for discussion and a safe space for reflection. Workshops include Applications, CVs & Interviews (Presenting Self), Your Career (Control, Reflection & Influence), Your Wellbeing, Understanding & Managing Self, Maximising Talent & Development, Engagement, Experience & Wellbeing, Equality, Diversity & Inclusion, Change & Team Dynamics, Data & Technology, Understanding Benefits, CV and Interview Skills, Self-employment seminar, Retrain and Reskill and Your Money, Your Future

Mental Health First Aiders (MHFAs): SNEE ICB has a cohort of trained Mental Health First Aiders who are there to support colleagues, lend a listening and caring ear and signpost to further support if needed. All the ICBs Mental Health First Aiders have recently been provided refresher training. Staff are able to book a 1:1 wellbeing session with a MHFA by completing an MS form found on the intranet.

Mindfulness: Mindfulness sessions have been scheduled and offered to all staff. These take place during the working day for 30 minutes and focus on breathing and being present.

Support Through Change: The ICB has developed a dedicated Support Through Change programme which is a collection of free training and education, networking and health and wellbeing events, open to all colleagues. This includes careers days, job fairs and support through change webinars. A support through change day was held in September which hosted representatives from the Department of Work and Pensions, Sizewell C, Menta business support group, Wesleyan Financial Services, NSFT, The National Careers Service, the ICB's HR team, MIP Union, RCN, Apprenticeships Suffolk and the Eastern Education Group. This enabled staff to discuss opportunities available outside of the ICB.

HR and Policy

Change Management Policy: An updated ICB Change Management Policy has been published. The changes have reduced the size of the policy, meaning a smaller, clearer policy for staff to use. The policy is toolkit based, providing explanation for each stage of a restructure and examples of letters. A comparison has been completed regarding Norfolk and Waveney's Policy and Suffolk and North East Essex's Policy, some minor difference were noted but nothing material, therefore they are suitable to utilise during aa period of joint organisational change. Region has requested sight of all Change Management Policies for regional approval in December 2025.

Pension Webinars: Additional pension seminars have been scheduled and made available to all staff.

Existing Job Vacancies from our NHS partners: Every week staff are informed of job vacancies within our system.

Job Matching: 16 members of SNEE ICB have now completed the national Job Matching training course. This was a two-day course that enabled attendees to be certified to sit on job matching panels. This is a lesson learned from the 2023 running cost reduction, during this programme the ICB did not have enough trained staff to sit on these panels which led to a delay in the plan.

Mental Health Policy: A new Managing Mental Health Policy has been developed to support line managers and staff.

Recruitment Freeze: All vacancies have been frozen, and no active recruitment is taking place, unless failing to fill the role would expose patients to material harm or the ICB to unacceptable risk i.e. failure to discharge a statutory duty.

Job Descriptions: Job descriptions for all SNEE staff are being compiled by HR, this is to ensure any gaps are identified in advance of any consultation.

Trade Unions: Trade Unions (TU) are being actively engaged on all activities. Prior to any Virtual Staff Briefing, the Director of Workforce and People provides a summary brief to the TU representatives, who are also invited to attend the briefings.

Staff Networks and Groups

The ICBs have re-focused the Staff Reference Group to support staff to receive peer support, ask any questions and share concerns in a safe space regarding the cost reduction and transition programme. The Trade Unions have been invited to attend these sessions. The Staff Reference Group meets monthly, via Teams for one hour. Currently there are 63 members with every band (excluding Executive Director) and every directorate represented. Any member of staff is able to join the Staff Reference Group.

A monthly Network Leads meeting has commenced, all Network Leads, HR and the programme director attend to ensure everybody's needs are fully considered throughout the process. The group reviews any formal documentation that may be needed from an accessibility point of view and makes any adaptations or revisions to meet people's needs, this includes the co-production the EQIA.

National direction and information

We have representatives attending all national and regional meetings regarding the 2025 cost reduction and transition programme. All information is fed into the programme team to ensure it is reflected in planning documentation and the risk and issue log.

Next Steps
The consultation period and VR scheme will close on 12 January 2026. All six East of England ICBs have the same launch and close dates, ensuring consistency and equity across the region.

The ICBs will hold a genuine and meaningful consultation with its employees, we will talk and listen to affected employees and Trade Union representatives. The consultation will adhere to the ICBs Change Management Policy.

During consultation, we will discuss:

- The changes that are needed, what we plan to do, and why.
- Ways to avoid or make fewer redundancies.
- The skills and experience needed for the future.
- The criteria for selecting employees for redundancy.
- Any concerns employees may have.
- How we can support and arrange time off for affected employees, for example to update their CVs and get training.

During the consultation period, staff will have the opportunity to provide feedback on the proposed structures via a feedback form.

On 12 January, following the closure of consultation and VR, work will immediately commence to process all VR expressions of interest. This includes the process of hearing all expressions of interest at a VR panel, concluding their outcomes and the completion of a VR appeals process.

The review of consultation feedback and amendments of structures will commence upon consultation close; however, the finalisation of structures and staff outcome letters will not be concluded until completion of the VR process to ensure the accuracy of the staff outcome letters (e.g. slot-in, ringfenced etc.).

The process of applying and interviewing for roles will take place over a period of 10 weeks, enabling a redundancy business case to be submitted to region.

Work will continue on the actions required to deliver transition (including due diligence and assurance activities).

Recommendation to the Board:

The Board is asked to note the ICB progress regarding the 2025 ICB cost reduction and transition programme**.**

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining its reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	
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)	Board for approval

NHS Norfolk and Waveney ICB
NHS Suffolk and North East Essex ICB

Transition and Merger Committee

Terms of Reference

1. Introduction

1.1. The government plans that a new NHS Norfolk and Suffolk ICB will be in place by 1 April 2026. This will be formed by clustering the existing NHS Norfolk and Waveney ICB (NW ICB) and NHS Suffolk and North East Essex ICB (SNEE ICB) (the ICBs) prior to the establishment of Norfolk and Suffolk ICB.
Therefore, the commissioners of health care in the ICBs recognise the opportunities to work more effectively together whilst valuing their local relationships and local system working.

1.2. The ICBs have agreed to work closer together by forming a single management team. As part of this work the ICBs wish to look at ways of working more efficiently and effectively together and have agreed a common Chair and Chief Executive to start this process.
The ICBs have a Single Leadership Team (SLT) of Executive Directors across both ICBs which will provide focus and oversight.

1.3. The Chair, the Chief Executive and the ICBs' respective Boards are seeking accelerated review and support of their plans through establishing a Transition and Merger Committee (TMC).

1.4. The TMC is authorised by both ICB Boards and the Chief Executive to act within its terms of reference. All members and employees of the two constituent ICBs are directed to cooperate with any request made by the TMC.

1.5. The work of the TMC is expected to be concluded by, or soon after, 31 March 2026. Any further requirement to continue beyond this date will be considered by the TMC based on business need.

2. Objectives

2.1. The TMC is established to support the Chief Executive and both ICB Boards in ensuring the maintenance of appropriate governance processes and effective decision making during a period of rapid change.
The TMC is part of the governance process reporting to both ICB Boards in considering how to efficiently progress at pace whilst both recognising the impact that such change may have on constituent organisations and their governance.

2.2. The TMC is established to support the delivery of the programme of work of the SLT in looking at where efficiencies to working practices can be made and to implement these swiftly.

2.3. The TMC will review both plans put forward by the “Programme Team” and the implementation of the programme plan.

2.4. The TMC will also consider and monitor how the organisational changes deliver best value for the regions as well as how performance more generally is measured.

2.5. The TMC will provide strategic focus and overview in support of assurance of the overall programme delivery by SLT, to the individual ICB Boards. It will also seek reports and assurance from other officers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

2.6. The TMC will ensure the effective communication of plans and their implementation is always maintained.

3. Membership

3.1. Reflecting its objectives as set out above, TMC membership is comprised of the single Executive team covering both ICBs. There are also representatives of other key enabler functions in attendance to assist the committee as follows:

- Chair – Amanda Lyes, (Designate) Executive Director of People, Governance and Corporate Services, and Transition SRO
- Deputy Chair Howard Martin (Designate) Executive Director of Finance and Contracts - NHS Norfolk and Suffolk ICB
- (Designate) Deputy Chief Executive NWICB & SNEE ICB
- (Designate) Director of Finance NW ICB & SNEE ICB
- 1 Non-Executive Member SNEE ICB Board
- 1 Non-Executive Member NW ICB Board
- Rep NW ICB Internal Auditor
- Rep SNEE ICB Internal Auditor

3.2. The Chair of NHS Norfolk and Waveney ICB and Suffolk & North East Essex Integrated Care Board has a standing invitation to contribute by attending meetings of the Committee to contribute.

3.3. There shall be one officer from each ICB in attendance who will provide project support to the Committee and wider programme.

3.4. Senior Managers from either ICB or any other clinical or senior officer may be requested to attend the TMC meetings as directed by members of the TMC.

3.5. There shall be an administrator to the TMC attending to take notes, record actions from the meeting and to provide appropriate support for the Chair and/or Deputy Chair and members.

4. Remit and Responsibilities of the TMC

4.1. The roles and responsibilities of the TMC are as follows:

4.1.1. To provide strategic assurance to the two constituent ICB Boards on the programme delivery by SLT regarding the closure of the existing ICBs and establishment of the new ICB.

4.1.2. To oversee the delivery of the agreed transition and merger plan by receiving reports and assurance from the programme work streams.

4.1.3. To oversee the management of key interdependences within the programme.

4.1.4. To monitor performance against the objectives and targets set out in the programme plan, making recommendations or the agreement of remedial actions where performance is adverse.

4.1.5. To manage governance, risks and issues identified by the workstreams and make recommendations regarding the mitigating actions within the programme plan, escalating to the Chief Executive or Boards as required.

4.1.6. To make recommendations to the Chief Executive and/or the Boards as per established governance regarding change management decisions.

4.1.7. To work confidentially recognising the sensitivity of the information which the TMC will be asked to consider.

4.2. Key aspects to be considered by the TMC include:

- Oversight of the development of the new ICB structure
- Oversight of staff consultation processes
- Review of the ICBs' Schemes of Delegation
- Development of a Collaboration Agreement to cover elements of how the ICBs will work together including but not limited to schemes of delegation, information sharing and decision making
- Ensuring that the single management team structure is affordable within the ICBs' reduced combined running cost allocation by December 2025
- Ensure efficient and consistent working across the two ICBs
- Consider future arrangements for sharing functions with other ICBs
- Provide input to the Model Region work Programme and any ongoing national programme of work related to Model ICBs

- Overview the safe transfer of the North East Essex business and resources elements of SNEE ICB to the new NHS Essex ICB.

5. Meetings of the TMC

5.1. The TMC will meet at least fortnightly. The Chair may call a meeting of the TMC at any time outside of the fortnightly meetings.

5.2. **Chair of the TMC**

5.2.1. See 3.1 for details of the Chair. If the Chair is absent from the meeting, the Deputy Chair shall preside.

5.2.2. If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair shall preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, another member shall be chosen by the members present, or by the majority of them, and shall preside at that meeting.

5.3. **Quorum**

At least three of the members shall be a quorum. At least one of these must be a Non-Executive Member and two Executive Members.

5.3.1. If the quorum is lost due to member/s being disqualified from taking part in a vote or discussion due to a declared interest, then the ICBs' Managing Conflict of Interest Policy will be followed.

5.4. **Decision making**

5.4.1. The TMC will only make decisions based on the authority it has in relation to its functions set out in these terms of reference.

5.4.2. Meetings of the TMC may use teleconferencing/virtual or other electronic methods to support the contribution of its members. Urgent decisions may be approved by calling an extraordinary meeting either in person or using virtual/electronic means.

5.5. **Meeting notes**

5.5.1. The notes will record the names of the individuals in attendance. The name of the administrator will also be included.

5.5.2. The notes will identify decisions, actions, risks and issues, and will be circulated within 2 working days of each meeting.

6. Relationship with the Board of each ICB, Chief Executive and SLT

6.1. The TMC will support the SLT and the Chief Executive. The TMC will report to the respective Boards of the ICBs to the extent that is required and proportionate.

7. Policy and best practice

7.1. The TMC will apply best practice in the decision-making process, for example by following Conflicts of Interest guidance published by NHS England and will ensure that it delivers the best value financially.

7.2. The TMC is authorised by the Chief Executive and the Board of the ICBs to instruct professional advisors and request the attendance of individuals and authorities from outside the ICBs with relevant experience and expertise if it considers this necessary or expedient to exercise its functions. The TMC also has full authority to commission any reports or surveys it deems necessary to help fulfil its obligations.

7.3. The TMC is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

8. Conduct of the TMC

8.1. The TMC shall conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice, including the Nolan Principles, managing conflicts of interest and standards of business conduct policies.

8.2. The TMC will assess its performance, membership and terms of reference regularly as required, with any amendments to be approved by each Board of the constituent ICBs.

Date agreed by SNEE Board:

Date agreed by NW Board:

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	ICB Quality Impact Assessment and Health Inequalities Impact Assessment Annual Report to Board November 2025
Presented by:	Karen Watts, Director of Nursing and Quality
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board - Board Meeting
Date:	26 November 2025

Purpose of paper:

To provide the Board with an update on the work of the ICB Quality Impact Assessment and Health Inequalities Impact Assessment Panel over the last year.

Executive Summary:

ICB Project and Programme Leads have responsibility for producing robust and thorough impact assessments as part of the ICB Sustainable Commissioning approach. These assessments seek to identify, explore and mitigate the risk of any unintended impacts, early within planning and influence decision-making to ensure that quality and equity are central.

The paper provides an update on activity and themes over the last year and sets out the development plan for the year ahead; including consideration of how we shape the process with Suffolk colleagues as we move towards the organisational merge.

Links to national frameworks are provided below under 'reference documents'.

Recommendation to Board:

The Board is asked to receive and respond to the content of the report, noting activity, themes and plans for future development.

Key Risks	
Clinical and Quality:	The assessment of impact and risk in relation quality, equality and health inequalities is a key mechanism for supporting safe and sustainable commissioning.
Finance and Performance:	Quality and health equity, in terms of service accessibility and service user outcomes, both have a significant impact on the financial and operational performance of the ICB.
Impact Assessment (environmental and equalities):	N/A

Reputation:	Maintaining and improving quality and understanding and addressing health inequalities are both central to the reputation of the ICB and its commissioning approach.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	NHS England » Quality Impact Assessment and NHS England » Equality and Health Inequalities Impact Assessment
NHS Constitution:	QIA and EHIA supports compliance with NHS Constitution and the Public Sector Duties of the Equality Act.
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

NHS
Norfolk and Waveney

ICB QIA and EHIA Assurance Report

November 2025

Karen Watts, Director of Nursing and Quality
Evelyn Kelly, Senior Quality Governance & Delivery Manager

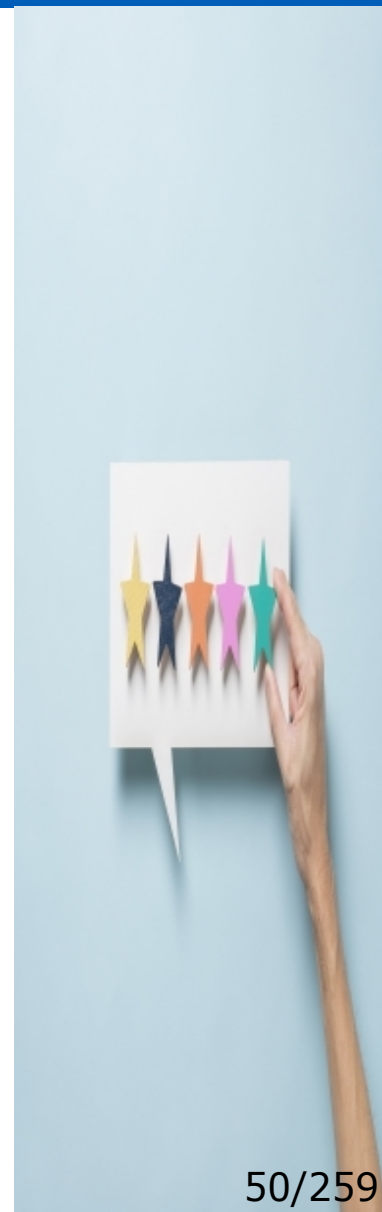
1. Introduction: QIA and EHIA

ICB Project and Programme Leads have responsibility for producing robust and thorough impact assessments as part of the ICB Sustainable Commissioning approach. These assessments seek to identify, explore and mitigate the risk of any unintended impacts, early within planning and influence decision-making to ensure that quality and equity are central.

- **Quality Impact Assessment** looks at the potential for a commissioning change to impact on the quality of care delivered, looking at factors such as comprehensive service provision, clinical quality, safeguarding, sustainability and workforce.

- **Equality and Health Inequalities Impact Assessment** looks at the potential for a commissioning change to impact unfairly across populations, including people with protected characteristics (e.g. age, sex, race), and other communities including inclusion health groups (e.g. homeless, sex workers, migrant communities), residents in Core20 areas of higher social deprivation, carers of all ages and our armed forces community.

The robustness and thoroughness of a completed impact assessment sits with the commissioning team, as they have the in-depth knowledge of the proposed change, the healthcare landscape and the population needs that they are responding to. Advice, guidance and feedback is provided by our Panel.



1. Introduction: QIA and EHIA

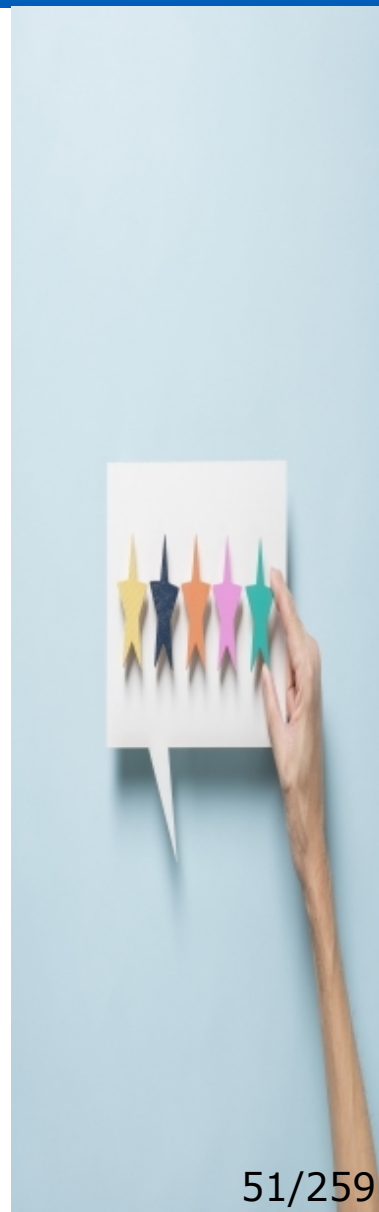
QIA and EHIA are not a new process. However, in October 2024 the ICB identified an opportunity to centralise the processes which were taking place across individual commissioning teams up to that point. This provided the opportunity to:

- Bring QIA and EHIA together so that the processes are more aligned and to enable a collective discussion around quality, accessibility and equity of health outcomes, drawing from a multi-disciplinary panel.

- Refresh templates and guidance and update policies to reflect best practice e.g. national frameworks.

- Formalise approval and feedback via panel. This provides more robust centralised governance around the completion the impact assessments and a better oversight of potential risks and mitigations, as well providing live feedback that helps improve the confidence and skills of colleagues completing them.

- A more central and coordinated approach has also helped ensure there is consistency across teams and enabled continuous reflection and process improvement to ensure that the ICB process continues to embed and develop, especially as new national guidance emerges.



2. QIA and EHIA Panel

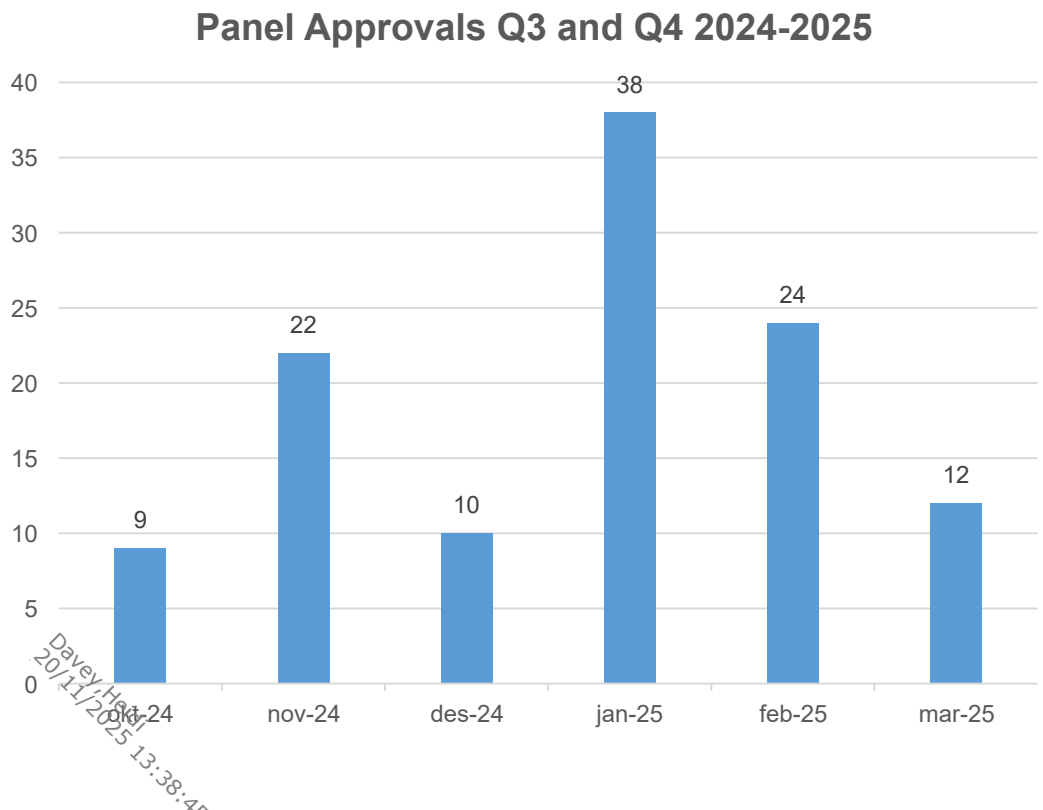
The ICB QIA and EHIA Panel is a multidisciplinary panel made up of ICB subject experts across the clinical quality, CYP and health inequalities teams. It is co-Chaired by the ICB Director of Nursing & Quality and the ICB Clinical Advisor for Health Inequalities and Health Inclusion.

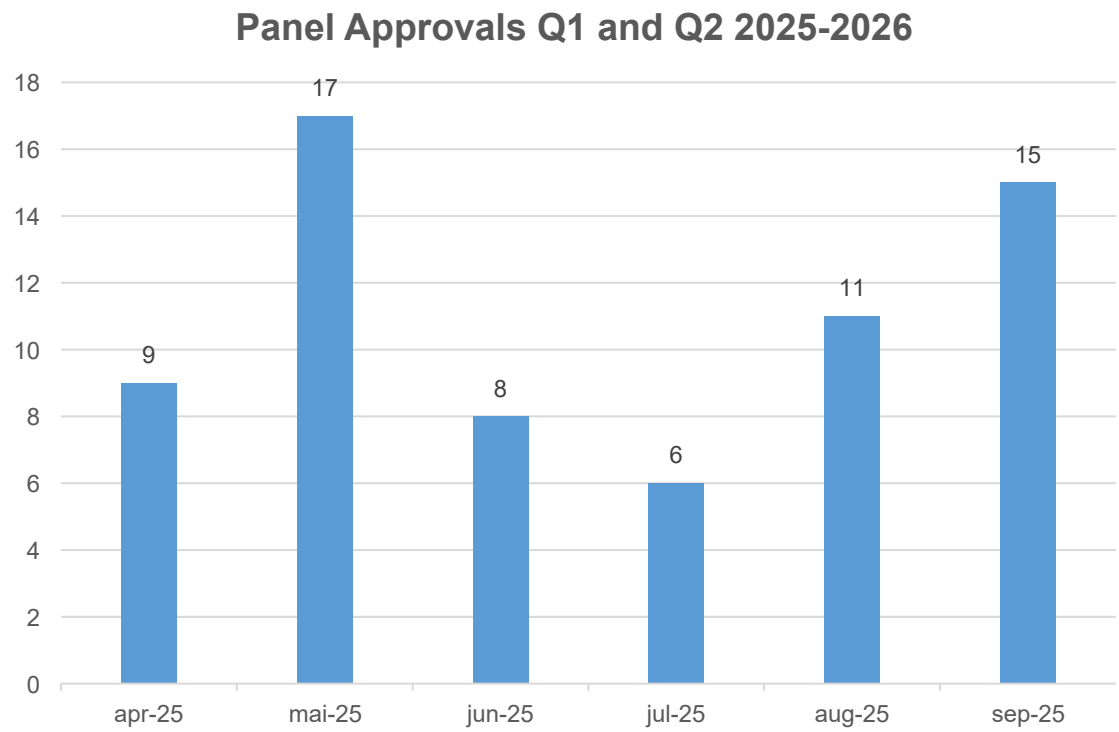
Panel has responsibility for:

- Reviewing and agreeing that the submitted impact assessments have been undertaken robustly as per ICB policy and that there are action plans in place to mitigate any potential negative impact.
- Providing feedback to project and programme leads that helps to ensure fair, consistent assessment of impact.
- Making clear recommendations to project and programme leads, to ensure that potential impacts are followed up and mitigated robustly.
- Ensuring that supportive training materials are available for staff undertaking QIA and EHIA.
- Listening to the feedback from project and programme leads to help develop processes that are user-friendly and inclusive.

3. QIA and EHIA Panel Activity

The first ICB QIA and EHIA Panel was held on 10/10/2024. Approval data to end of September 2025:

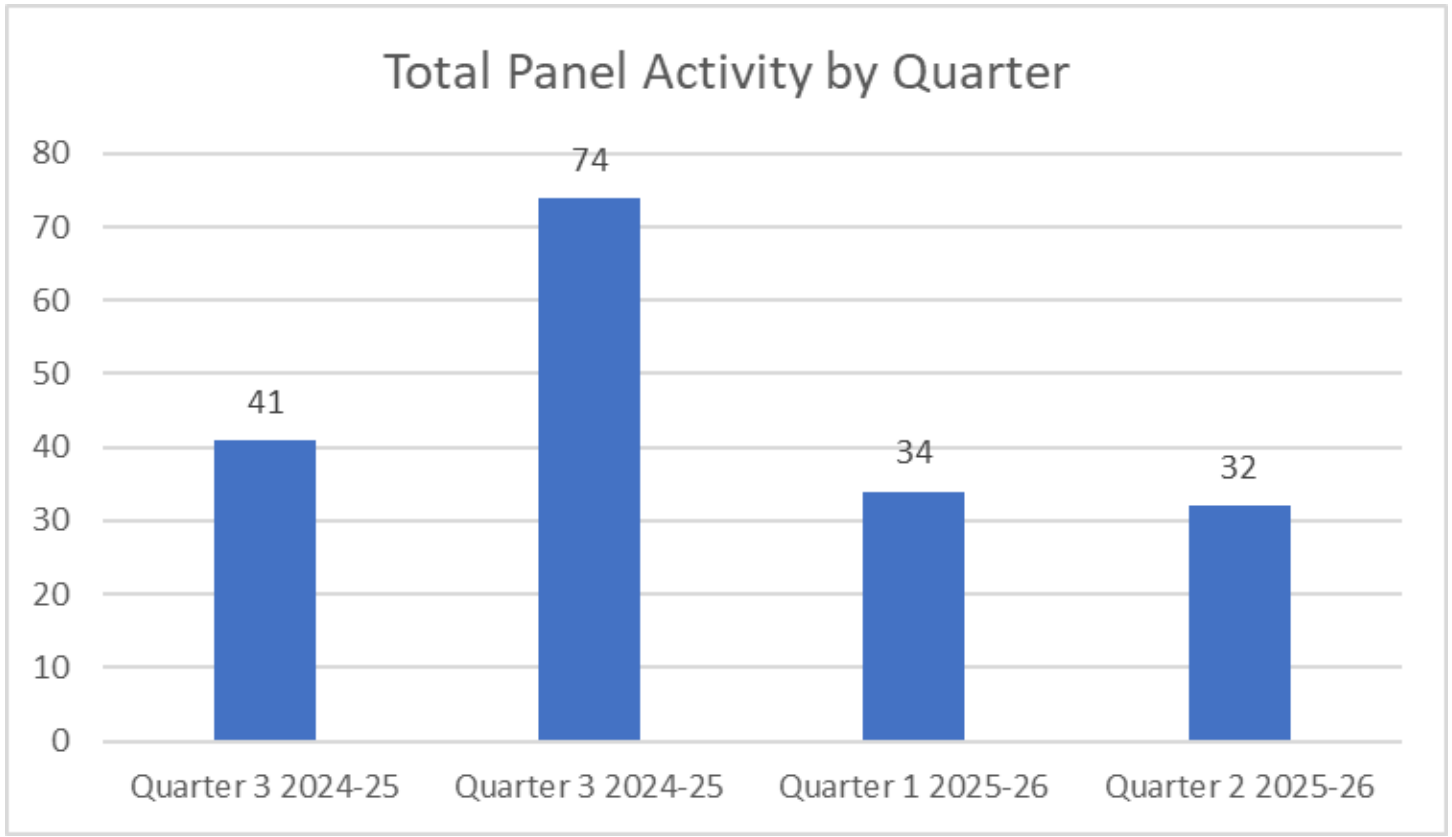




Since 10/10/24 we have set up and run a total of **46** panel sessions and approved **181** combined QIA and EHIA. Panel members have provided advice and guidance via panel and offline. Individualised feedback has been given on every assessment.

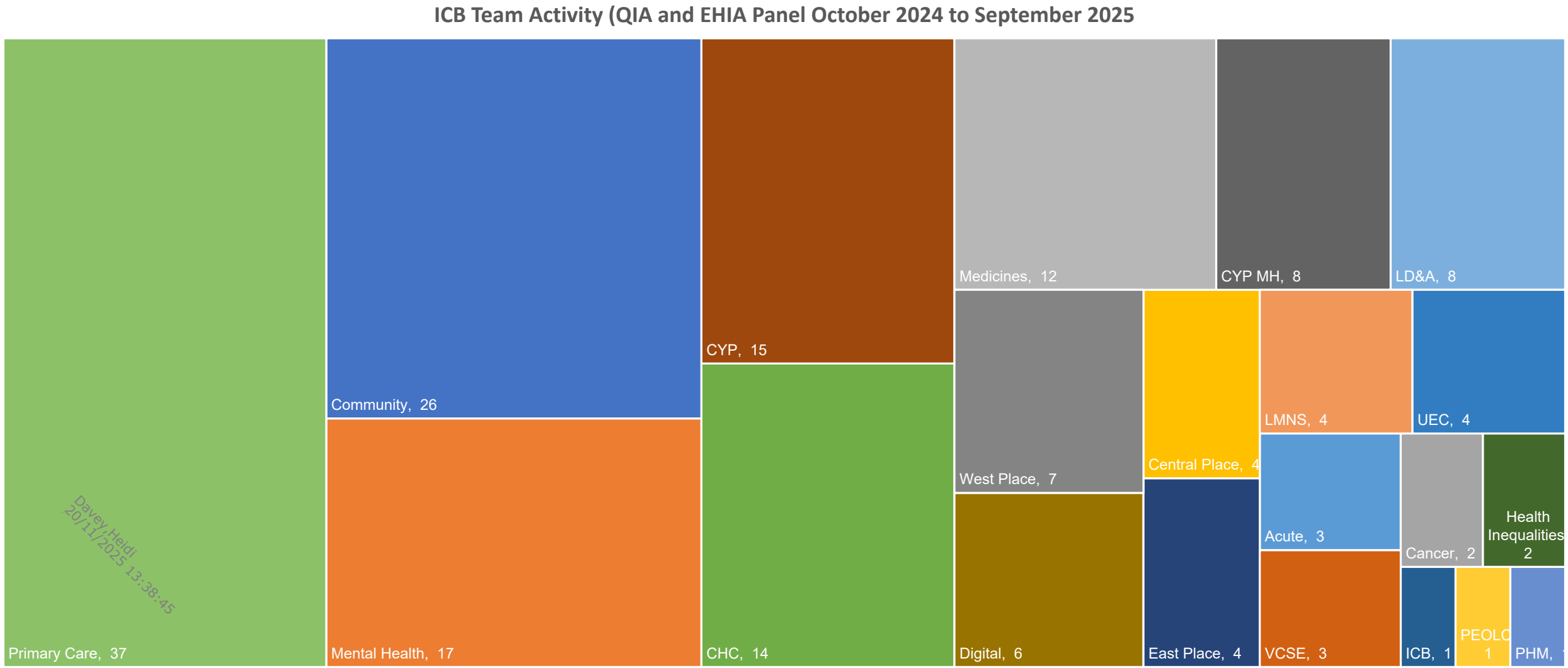
3. QIA and EHIA Panel Activity

Total approval data, by quarter:



The Panel continues to work flexibly and deliver proactive weekly panel meetings as well as reactive additional dates to support time-critical projects or enable ‘themed’ panels focussed on a particular area of activity or set of inter-related projects or schemes.

4. Impact Assessment Activity Across Teams

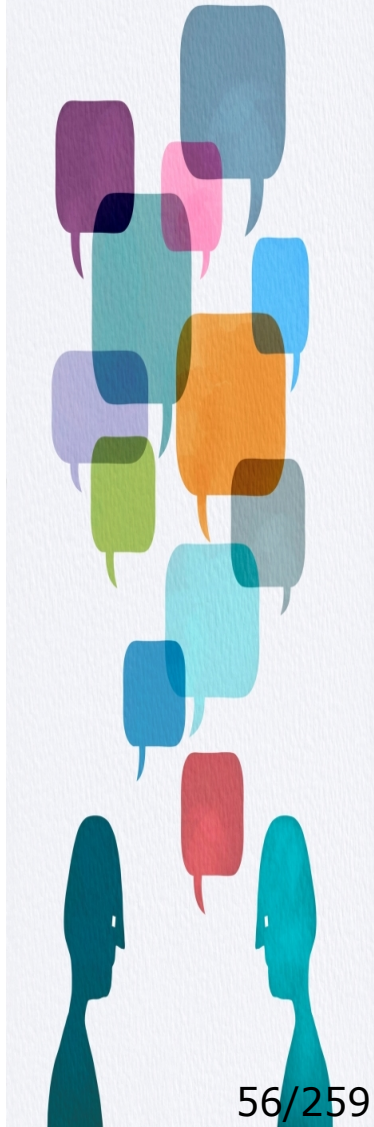


Continuing Healthcare (CHC), Children and Young People (CYP), Children and Young People's Mental Health (CYP MH), Learning Disabilities and Autism (LD&A), Local Maternity and Neonatal System (LMNS), Palliative and End of Life Care (PEOLC), Population Health Management (PHM), Urgent and Emergency Care (UEC) Voluntary, Community and Social Enterprise (VCSE).

5. Panel Outcome Themes (1/2)

Themes from panel feedback and recommendations have included:

- Consideration of cumulative impact of contract changes across the VCSE landscape. Consideration of sector stability and social value.
- Importance of embedding quality KPI, activity and accessibility information for grant-funded provision.
- Flagging opportunities for additional consultation with staff and service users.
- Recommended review of demographic data to ensure that sufficient community insights are being used to understand potential impact of changes (good practice noted too).
- Encouraging collaborative and joined up impact assessments across commissioning teams to identify duplications and gaps and share good practice. AN example of this is where a panel discussion brought together CYP and Adult Continuing Care Teams to take forward a joint project around tracheostomy care spanning all ages.
- Identification of commissioning activity supporting left-shift goals. Plan to align panel reporting to the three national drivers (left-shift, digital and prevention) next quarter.



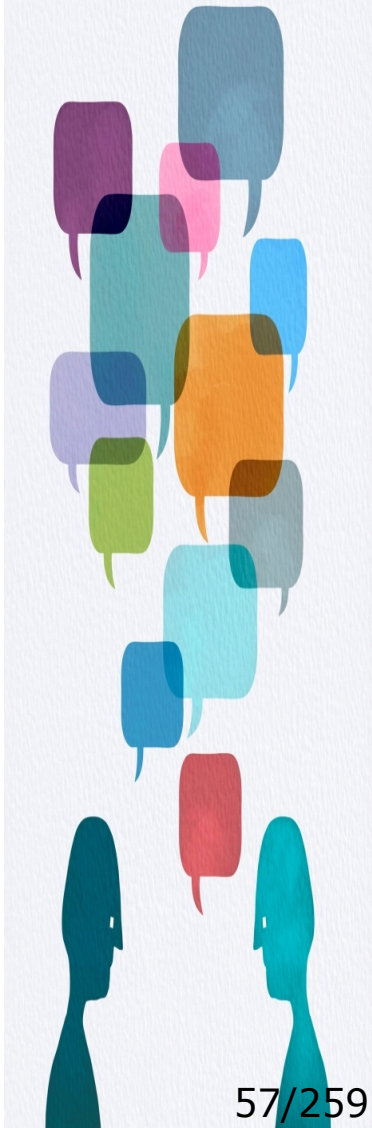
5. Panel Outcome Themes (2/2)

- Consideration of the needs of people who do not access primary care through universal routes; i.e. people on the national Special Allocation Scheme. This is a relatively small cohort but important to consider, especially when broadening access to health improvement via community-based services.

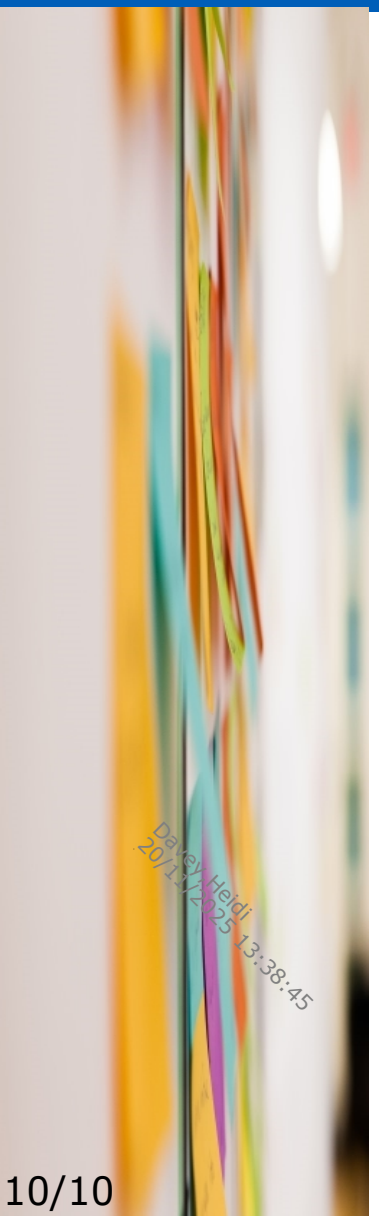
- Panel continue to promote and support continuous live assessment of impact as projects and schemes develop, and evaluation of impact after change; this continues to be part of the tool most likely to be missed. Panel have directed this more formally on several potentially high-impact schemes; setting quarterly milestones for review and return to panel for enhanced oversight and support.

- Panel are seeing improving confidence and good practice developing around completion of impact assessments. Good feedback to Panel on helpfulness of discussion and engagement. All feedback from commissioning and project management colleagues has been constructive and valuable.

- Feedback from ICB staff and panel members taken on the tool's format and functionality; revisions made to make the tool more streamlined and user-friendly. PMO Team support to help teams to embed the process has been pivotal.



6. Development and Next Steps



- National QIA Framework and Tool published June 2025. ICB reviewed and against internal process and identified actions to make sure we are aligned as we move forwards. Potential for this work to inform a single shared ICB approach as we work towards merging.
- Discussion with commissioning and PMO leads identified a ‘risk level’ approach to summarising panel outcome and this has been added to the new tool. This will be built into reporting next quarter.

- The Health Inequalities Team led a survey of the process which identified opportunities for additional learning to support completion of the form and to continue to embed awareness of health inequalities within wider commissioning activities. The **Voices in Focus** programme has been developed as part of the ICB Health Inequality Improvement Plan. First session on carers held on 28/10/25 with positive feedback; next session will focus on the Armed Forces.

- The Nursing and Quality Team are now screening and providing support for all submitted QIAs prior to panel, so that practical guidance and support is offered earlier in the process.

- Potential to consider expanding process during 2026-2027 to include panel review of impact assessments made on ICB policies, including clinical threshold policies.

- Policies updated to reflect Executive lead for compliance, following TIAA feedback.

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

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:	**26 November 2025**

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 24 September 2025 to 26 November 2025.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett (Deputy Chair Cathy Armor)
Meetings since the previous update:	02 October 2025,14:00 – 17:00 (chaired by Deputy Chair) 06 November 2025,14:00 – 17:00 (chaired by Deputy Chair)

Overall Objectives of the Committee:

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.

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.

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.

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.

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

improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.	
Main purpose of meeting:	**02 October 2025** • System Discharge Update • Risk deep dive on ED 12hr Mental Health Breaches • Risk deep dive on UEC Public Trust and Reputation • UEC Quality and Ambulance Response Times Report • LeDeR Annual Report 2024/25 • Quality Strategy Refresh Approach 2026 • All-Age Safeguarding Assurance Report • Infection Prevention & Control Report **06 November 2025** • Risk deep dive: Assessment of CYP Dysphagia • Learning from Adverse Events and Complaints • Assurance Report from ICB QIA & EHIA Panel • NHS Continuing Healthcare Assurance Report • Medicines Optimisation and Safety Committee Report • JPUH and ICB Joint Quality Review • System Quality Account Overview • ICS Substance Use and Mental Health Strategy
BAF and any Board Operational risks relevant / aligned to this Committee:	**Risk 011: Continuing Healthcare** Risk remained 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 care experience, as well as increased financial costs. **Risk 012: EEAST Response Time and Patient Harms** Risk reduced to 12 in October and returned to 15 in November, reflecting the current pressures within the system in relation to handover and response times. This risk is dynamic and fluctuates in response to operational pressures. Committee were briefed on initiatives supporting recovery, including 'Handover 45' and the addition of extra roles by EEAST to support clinical decision making. **Risk 033: Industrial Action Clinical Impact** Risk reduced to 9, reflecting the decrease in risk after completion of the strike action in July 2025. Between the time of writing Committee papers and meeting, new dates were announced for November and the ICB Executive Medical Director provided a verbal update, noting that the focus of business continuity will be to minimise impact on elective care. The risk score will be reviewed in month.

	Risk 034: Surge Capacity to Support Acute Trusts Risk remained at 12. Committee noted that the risk continues to be dynamic linked to overall system flow, including 'front door' and discharge activity. **Risk 035: Community Nursing Unallocated Visits** Risk remained 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. **Risk 038: CYP Mental Health Case Manager Allocation** Risk remained 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. **Risk 039: CYP Mental Health Waiting Lists** Risk remained 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. **Risk 040: CYP Speech and Language Therapy** Risk remained 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 remained 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 reduced to 12, reflecting the 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 impact has not been as wide-reaching as anticipated and planned for, with the current market remaining static. ICB and local authority market engagement will continue to support and monitor impact. **Risk 047: Tuberculosis Service Provision** Risk increased to 20, reflecting the fragile position of current specialist community provision and the need for a more resilient and sustainable model for the future. A Committee

	update on the potential impact on patient safety and quality of care is reported in this paper under 'key items of note for Board'. **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, which raises the risk of poor experience of care and exacerbation of symptoms in a clinically unsuitable environment. Committee undertook a deep-dive discussion on this risk which provided an update on a downward trend since May 2025, with ongoing monitoring required to determine if this represents a sustained improvement. **Risk 058: Public Trust and Reputational Damage** Risk remained 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. Committee undertook a deep-dive discussion on this risk which provided an update on ongoing efforts to mitigate the risk, including delivery of flow initiatives, learning from significant cases, sharing best practice and winter planning. **Risk 061: CYP Mental Health Responsible and Approved Clinicians** Risk remained 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** Risk remained at 16, reflecting 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 functioning swallowing which could have long term consequences. A Committee deep dive on this risk is reported in this paper under 'key items of note for Board'. **Risk 083: Quality Impact of ICB Organisational Change** Risk remained at 12, reflecting the risk that the restructure will have a destabilising impact on teams and system relationships, which could impact on the ICB's ability to

	deliver statutory activities and quality improvement priorities that deliver access to safe, high quality, equitable care, at the planned pace and scale. This risk links to the overarching risk around organisational change held by the ICB Transition Committee. **Risk 085: Provision of Paediatric Audiology (QEHKL)** Risk increased to 16, reflecting the risk that babies, children, and young people living in West Norfolk may not receive accurate and timely diagnosis of hearing loss, due to service provision issues. Missed opportunities to provide early and effective support to enable children to develop their language and communication skills can lead to long-term harm and poorer outcomes. NNUH are supporting patients in West Norfolk whilst QEHKL focuses on recruitment and backlog reduction. **New Risks** **Risk 104: Long Waits in Emergency Departments** New risk drafted to reflect the risk around long waits in ED, which have an onward impact on patient experience and outcomes as well as wider implications for hospital flow and ambulance handover times. Committee noted the initiatives taking place to mitigate the risk including the System Control Centre function and reintroduction of intelligent conveyancing and efforts to improve ambulance handover and admission avoidance. Committee agreed escalation of this new risk to Committee oversight at a score of 12.
Key items for Board to take note of:	**<u>October 2025</u>** **LeDeR Annual Report 2024/25** People with a learning disability and autistic people often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. LeDeR focuses on learning from the lives and deaths of people with a learning disability and autistic people. Committee approved the LeDeR annual report capturing data, insights and improvements made over the last year. The report showed that each year we are reviewing more deaths at an age of 65 years and older and while the data sample is much too small to comment on the overall mortality rate, Committee reflected that it is positive to see evidence of people with learning disabilities and/or Autistic people living into their older age. We can also see that the grading of people's quality of care continues to improve, although there are opportunities to do more to reduce these very real health inequalities.

	Committee discussed efforts to engage individuals and their families and carers in annual health checks, with targeted support from the ICB LD&A Health Improvement Team alongside work by provider partners to reduce inequalities in uptake across areas and improve access, experience and quality of these checks. Committee noted that pneumonia and aspiration pneumonia remained the most common causes of death and discussed plans for additional education and early detection initiatives to support best practice in managing respiratory health, as well preventative measure such as vaccination. The Committee VCSE representative took away an action to link in with the LeDeR Team around opportunities for the sector to support and promote initiatives around healthy lifestyles. **Infection Prevention & Control (IP&C) Report** Committee received an update from the last ICS IP&C and Antimicrobial Stewardship Partnership Meeting held in July. Key issues highlighted for escalation were an increase in invasive and non-invasive Group A Streptococcal (GAS/iGAS) infections in the community, and TB management. Committee were briefed on two clusters of GAS, spread over different areas of the county (South Norfolk and East Norfolk), in 2025. Epidemiology has taken place to identify the strains and help identify links and associated factors. The ICB IP&C Team have been involved in post-infection reviews and sharing learning and good practice, working closely with UKHSA and other partners to reduce the risk of further incidences. Committee discussed the fragility of local community TB services, which are generally small or single-clinician specialist teams, and the need for a sustainable long-term model of case management and treatment. This sits in the wider context of national drivers for improved practice around TB management, including the national Getting It Right First Time (GIRFT) review published in March 2025 and new guidance on management of TB in prisons published in October 2025. Committee were updated on the outputs of a recent community workshop in Lowestoft that took place to explore how services wrap around people living with TB; especially those with multiple factors of deprivation or social isolation. **<u>November 2025</u>** **Risk deep dive: Assessment of CYP Dysphagia (080)** Committee were briefed on the lack of instrumental assessment for dysphagia in children and young people, in Norfolk and Waveney, which is affecting around five

	children every month. This has resulted in repeat hospitalisations and families have experienced delayed diagnosis and the need to travel to tertiary centres. Committee noted that the equipment required to deliver the service is accessible at NNUH but that this is not currently staffed. Committee acknowledged the commissioning activities being undertaken to mitigate the risk in the short term whilst highlighting the importance of reinstating a local service to address the emerging health inequality. Committee's NNUH representative took an action away to link in with commissioners and understand the current barriers to upskilling and staffing the local service, reporting back to Committee as part of the management of this risk. Committee's VCSE representative offered to explore the potential for linking with voluntary sector organisations who can potentially provide wellbeing and financial support for families impacted. **Assurance Report from ICB QIA & EHIA Panel** An update was provided on the last two quarters covering 25 panel sessions that approved 66 combined Quality Impact Assessment (QIA) and Equality and Health Inequalities Assessments (EHIA). Committee noted that forms and paperwork had been updated to improve user experience, and the team continue to assess local processes against the new national QIA framework to develop best practice. An ICB staff survey indicated ongoing training needs, and the Health Inequalities Team has launched a 'Voices in Focus' programme to embed an understanding of lived experience and health inequalities into the commissioning approach. A report on the full year's activity has been submitted to Board this month. **NHS Continuing Healthcare Assurance Report** Committee were updated on the NHS England CHC Assessment submission which demonstrates the ICB's effectiveness as a provider organisation. It was acknowledged that staffing vacancies and service pressures have impacted performance, particularly in meeting timelines for families. It was noted that the ICB is working on increased capacity and different management models to support Fast Track hospital discharges, which enable people at the end of their life to be supported to spend their last days in a place of their choice. **Medicines Optimisation and Safety Committee Report** Committee received the annual report. It was noted that there has been a shift in the monitoring metrics of antimicrobial prescription, which allows for more accurate system-wide comparisons. The system achieved over 70%

	compliance with the new metric, ranking highly both nationally and regionally and illustrating the impact of the ICB's work with local partners. Committee discussed the impact of the ICS working group on teratogenic drugs, which has evolved into a broader Medicines Safety and Quality Group, enabling regular collaboration on safety issues and fostering joined up working across the system. Committee acknowledged considerable progress made in reducing the prescription of opioids, anxiolytics, and hypnotics, noting that the system is no longer a national outlier. The average daily quantities prescribed have decreased, attributed to sustained efforts and partnership with primary care. This is a significant shift in reducing the use of potentially dependency-forming medications. A prescribing quality scheme is in place to maintain and further reduce prescribing rates. **ICS Substance Use and Mental Health Strategy** The strategy was shared with Committee for information. Members supported the joint approach and commended the scope and breadth of the work undertaken by the ICB Mental Health Commissioning Team and partners. It was felt that the strategy would have a positive impact on patient experience and access to the right care and treatment at the right time, where historically, some people have felt that their needs have fallen 'between' services. The dual strategy approach looks to make care pathways easier to navigate and more cohesive. **<u>Committee Approvals</u>** **LeDeR Annual Report 2024/25** Approved, as reported above. **Quality Strategy Refresh Approach 2026** Committee responded positively to the light touch refresh of the current quality strategy, reflecting current national drivers for quality improvement. It was agreed that this work would help inform the development of a new Norfolk and Suffolk strategy which will support the organisational merger and align to the new national Quality Strategy and its associated frameworks and guidance, due to be published in the new year.
Items requiring formal approval of Board:	Nothing additional escalated for Board approval at these meetings.
Confirmation that the meeting was quorate:	The October and November 2025 meetings were quorate, as defined in the Governance Handbook.

Improving lives together
Norfolk and Waveney Integrated Care System

NHS
Norfolk and Waveney

Winter update for ICB Board November 2025

Background and update pack

- Winter plan presented to ICB board in September 2025
- ICB Exercise Aegis conducted 4 September 2025
- Work ongoing to implement learning from Exercise Aegis
- Number of workstreams being worked on to fully support Winter 2025/2026
- Providers continue to provide regular updates as plans change in the lead up to the festive period
- Additional support put in for Pharmacy opening over the four-day bank holiday period

The System Control Centre (SCC) Leads have been working with system partners to implement the recommendations from the lessons learnt from winter 2024/2025

- Ensuring empowered decision makers are available
- Appropriate decision makers have formed part of the command structures during winter planning
- ICB has undertaken bed modelling and forecasting to support decision making regarding requirements for winter
- Forecasting undertaken for flu and covid based on activity in the Southern Hemisphere

- All actions are being captured in times of pressure by the SCC team
- Providers have been asked to ensure their plans have the appropriate level of staffing against known periods of pressure
- IPAC leads invited to attend resilience form for winter planning and over winter strategic meetings to maintain links, updates and consistency
- Care home relationship strategies identified regarding management of IPAC patients
- Incident management framework in place via LRF to ensure impact and effectiveness is measured

- **Doctor Industrial Action (IA) November 2025 update;**
  - **Action from Friday 14th November until Tuesday 18th November 2025**
  - No patient safety mitigation (PSA) forms submitted from any provider across Norfolk and Waveney
  - No significant gaps in rota cover, and where there have been gaps mitigation has been put in place
  - Reduction in media enquires this time compared to previous IA
  - Early data suggests that there appears to be reduced numbers of Doctors taking action
  - Really positive full system engagement in twice daily calls, and reporting everyday including the weekend

Winter Planning Update

Following on from the Norfolk and Waveney Aegis event which took place on 4 September 2025, work streams have been set up to address the issues/recommendations and identified gaps. These have been broken down into several work areas, with updates on each below

Discharge –
Discharge and community surge gaps including night services and transport bottlenecks
Incorporating UEC elements to link health and social care in a planned and managed way
Developing system wide inter-professional standards regarding timeframes and expectations regarding UEC activities, for example MHAA in ED, discharges at weekends

Mental Health – NSFT being asked to look at developing a mental health surge protocol including 7-day senior cover and crisis house utilisation, S136 suite capacity and lack of 7-day cover

Action Cards - meetings have been set up with each provider to go through their action cards with the System Control Centre team and remain under review to ensure actions are taken alongside the pressures

Admission Avoidance - Funding request for additional GP capacity to increase UCCH capacity and hours has been submitted, decision expected 19/11/2025
Call Before You Convey (CB4C) is pushed daily with phone number to all crews on shift AM and PM
CB4C is part of EEASTs winter comms campaign with EEAST will mandate CB4C for all care home patients (date to be agreed)

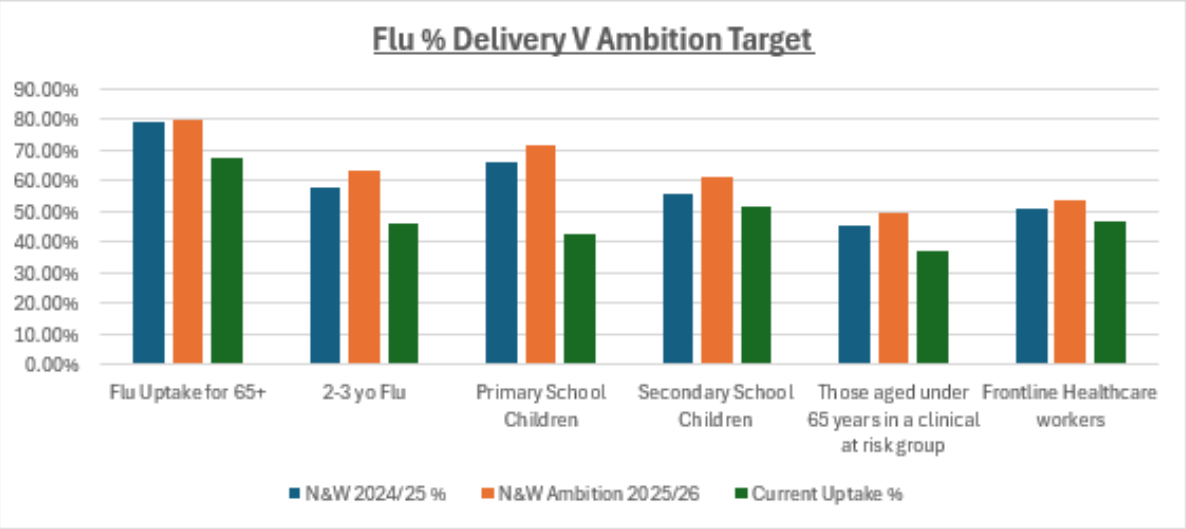
Data Quality – meetings to be arranged with providers to review SHREWD data – quality frequency and feed.
SCC segment of SHREWD developed to provide system overview

Infection Prevention and Control - consideration being given to Establishing PPE (FFP3) resilience with system-level fit-testing register and compliance monitoring, creating a system-wide FFP3 register

Workforce – request providers have conversations with staff regarding adverse weather in advance, so that staff have plans in place for traveling into work and childcare.

Primary Care –Improved communication with primary care.
Primary care have increased Pharmacy provision over key dates

Flu Target Ambitions for N&W 25/26 National Plan



Programme	Cohort	N&W 2024/25 %	N&W Ambition 2025/26	Estimated Vaccination to achieve ambition	YTD Actual 2025/26	Current Uptake %
Flu	Flu Uptake for 65+	79.34%	79.79%	219,795	185,626	67.4%
Flu	2-3 yo Flu	58.04%	63.34%	11,178	8,143	46.1%
Flu	Primary School Children	66.07%	71.57%	51,888	30,795	42.5%
Flu	Secondary School Children	55.55%	61.01%	37,717	31,829	51.5%
Flu	Those aged under 65 years in a clinical at risk group	45.60%	49.91%	67,752	50,098	36.9%
Flu	Frontline Healthcare workers	51.00%	53.76%	10,190	8,902	47.0%

Davey Heidi 20/11/2025 13:38:35

N&W currently 1st Nationally with Overall uptake %

Focus on staff

N&N at No1 in EOE & Nationally

Focus on Children

N&W have 407 Primary schools 260 visited to date – 415 Secondary Schools 261 visits. = 63.4% of schools visited.

Focus on Clinical at risk

Uptake % is currently ahead of this time last year

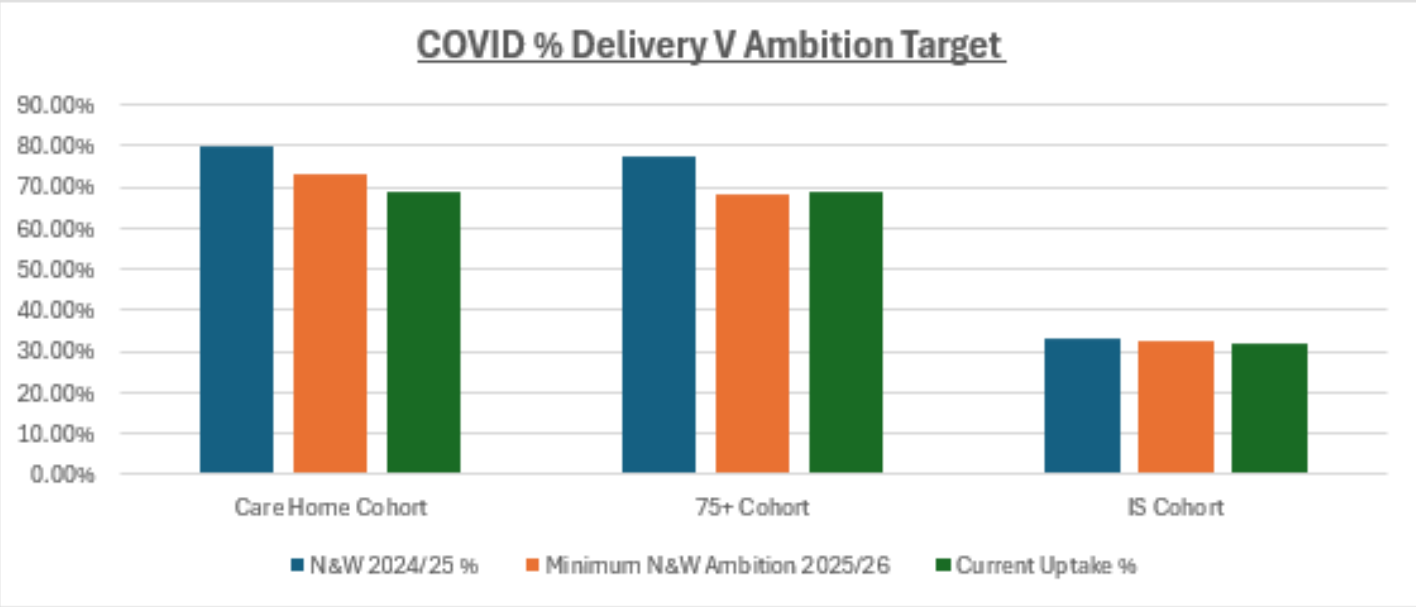
Flu Frontline HCW Uptake as at 09/11/25

Trust Local Data

Trust	All Staff			Front Line		
	Cohort	Doses Given	% Uptake	Cohort	Doses Given	% Uptake
JPUH	5,043	1,930	38.3%	3,559	1,475	41.4%
NNUH	9,791	6,132	62.6%	8,576	5,633	65.7%
NSFT	5,396	2,151	39.9%	3,962	1,494	37.7%
NCH&C	2,896	993	34.3%	2,348	770	32.8%
QEH	4,733	1,708	36.1%	3,283	1,249	38.0%
ECCH	530	341	64.3%	530	341	64.3%
EEAST			TBC	952	556	58.4%

Table on above shows all trust local data including All staff. Please note NCHC and EEAST figures to be confirmed.

ICB actual –v- ambition for Covid AW25/26 as at 09/11/25



National request to maintain target continuing strong baseline uptake in N&W

Programme	Cohort	N&W 2024/25 %	Minimum N&W Ambition 2025/26	Estimated Vaccination to achieve ambition	YTD Actual 2025/26	Current Uptake %
Covid	Care Home Cohort	80.00%	73.34%	6,026	5,738	68.7%
Covid	75+ Cohort	77.20%	68.19%	97,201	87,905	69.1%
Covid	IS Cohort	33.07%	32.49%	9,733	9,716	31.9%

Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Patients and Communities Committee Report**
Presented by:	**Cathy Armor, Deputy Chair – Patients and Communities Committee**
Prepared by:	**Rachael Parker, Executive Assistant**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 November 2025**

Purpose of paper:

To provide the Board with an update on the work of the Patients and Communities Committee for the period 25 September to 3 November 2025.

Committee:	Patients and Communities Committee
Committee Chair:	Cathy Armor
Meetings since the previous update on 25 September 2025	This paper provides an update from the meeting held on 3 November 2025.
Overall objectives of the committee:	The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.
Main purpose of meeting:	Main purpose of meeting reported on and updated in this area: • General Update including Executive Team Appointments, Strategic Priorities, and Neighbourhood Development Initiatives • Spotlight on: Waiting Times including Patient Stories • Access to Primary Care Services

	• Comms and Engagement Update • Community Voices Update *Standing Items:* • Healthwatch Suffolk Update • Healthwatch Norfolk Update • VCSE Assembly Update • Ageing Well Programme Board Update including Dementia Workstream Update • Population Health and Inequalities Board Update
BAF and any Board Operational risks relevant / aligned to this Committee:	**Risk 8** – Health Inequalities and Population Health Management and the ICB meeting its statutory duty. **Risk 31** – around the increasing number and complexity of the ageing population in Norfolk and Waveney. **Risk 84** – Hospice Sustainability and the significant risk to hospice sustainability due to inadequate and short-term funding models. One new risk has been added to the committee risk register since September's meeting: **Risk 106 - Shrewd Contract:** The Shrewd contract, vital for the System Coordination Centre's data feed, was due to end in March 2026. This platform supports monitoring of live UEC metrics like ambulance arrivals, handover times, ED data, and OPEL status. Its termination would threaten system-wide data coordination and response capabilities. The issue was raised to joint EMT, and the contract has been extended to April 2027 to maintain service continuity.
Key items for Board to take note of:	The committee agreed the following should be included in this report to provide assurance to the Board. **Ageing Well Programme and Dementia Workstream Update:** The committee received updates on dementia initiatives: • **Prevention and Care Home Initiatives:** Targeted campaigns reduced unnecessary emergency visits from care homes. Frailty scoring and toolkits are now widely used to better identify and manage frailty. • **Dementia Diagnosis and Support:** Diagnosis rates continue to rise due to recent interventions. The dementia charter is in place, with expanded community assessments and improved support for patients and families. • **Digital Innovation:** North Norfolk launched a pilot of the New Health Dementia app, helping with patient identification and prioritization. Social prescribers have helped onboard participants, with early positive feedback.

	• **Information and Training:** A Dementia Information Pack was developed and more training on dementia and delirium provided. Integration of frailty and dementia data enhances coordinated care planning for complex cases. **Access to Primary Care Services:** An update covered dentistry, pharmacy, and general practice, focusing on workforce initiatives, digital inclusion, and targeted interventions for underserved communities. • **Dentistry Access:** Short- and long-term plans are being implemented with increased investment, including contracts for rural and deprived areas. Child-focused practices and shared care pathways support patients with complex needs, though urgent dental care remains a challenge. • **Pharmacy Services and Workforce:** The Pharmacy First programme broadens access to care for common conditions. Incentives for dental professionals support workforce stability and commissioning plans. • **General Practice and Digital Transformation:** Appointments and online service use have increased, aligning with new digital requirements. However, patient satisfaction varies, highlighting ongoing digital inclusion needs. • **Workforce Trends:** There is a move towards salaried GPs and fewer GP partners. Alternative care models and additional roles reimbursement schemes, supported by local medical and dental schools, are influencing the sector. • **Community and Voluntary Sector Collaboration:** Involving the voluntary sector and community communicators is vital for addressing health inequalities, digital inclusion, and access barriers. The committee further recommended that the following item be brought to the Board's attention: **VCSE Sector Resilience and Strategic Monitoring:** Concerns were raised regarding the closure of voluntary organisations and the necessity for strategic monitoring of sector resilience. It was agreed that this issue would be addressed through the assembly's risk register and action plan. Below is a summary of the other agenda items from November's meeting. **General Update:** • Norfolk and Suffolk executive team appointments have been finalised, with key leaders in place.

	• Strategic priorities include boosting healthy life expectancy, reducing health inequalities, and improving care access—matching the committee's ongoing objectives. • The five-year population health and strategic commissioning plan aims to tackle inequalities and improve regional outcomes. • Neighbourhood development is advancing, with a pilot in Great Yarmouth and Waveney focused on local progress before the national programme's second phase. **Spotlight on Waiting Times including Patients Stories:** The committee reviewed illustrative case studies demonstrating the impact of extended NHS waiting times, assessed elective care performance, and discussed measures to address delays, communication issues, and health inequalities. • **Patient Case Studies:** Recent Healthwatch case studies highlighted patients experiencing significant delays in areas such as rheumatology, ENT, neurology, mental health, and gynaecology. These cases underscored the risks of harm, repeated cancellations, and gaps in communication with patients. The committee recognised the need to reprioritise patients who have suffered harm and to strengthen communication channels. Follow-up actions are being undertaken for specific cases, with recognition of barriers to digital tool usage, such as the NHS app. • **Elective Care Performance and Oversight:** The current elective care position was summarised, noting an increase in long waits due to capacity and workforce constraints. Oversight mechanisms in place include remedial action plans, mutual aid arrangements, and productivity improvement initiatives. • **Health Inequalities Analysis:** Ongoing analysis of waiting lists continues to identify and address disparities affecting deprived and underserved populations. Plans are in place to apply population health management approaches and risk stratification to better target interventions. • **Digital Access and NHS App Usage:** The committee discussed low uptake and usability challenges associated with the NHS app, particularly among older and younger adults. There was agreement to review communication strategies and enhance support for digital inclusion. **Communications and Engagement Activities:** An overview was provided on recent communications and engagement work, highlighting collaborative campaigns with

	Suffolk and Norfolk partners, active monitoring of campaign effectiveness, and the introduction of new leadership communications. **Community Voices and Voluntary Sector Engagement:** The Community Voices programme now works with over 60 grassroots organisations across projects like asthma, HIV, primary care access, and women's health. Collaboration with Queen Elizabeth Hospital led to recommendations for better communication, tailored support, and recruitment adjustments for underrepresented communities. Voluntary sector input has shaped women's health commissioning, such as co-designed compassionate care training and integrating lived experiences into services. The VCSE assembly remains strategic in advocacy and sector integration, with recent activities highlighting the need for stronger partnerships and concerns about voluntary sector resilience. **VCSE Assembly Update:** The assembly's strategic priorities include advocacy, achieving positive outcomes, and supporting the voluntary sector's integral role within the health and care system. Recent engagement activities were highlighted, alongside the ongoing need for enhanced partnerships in commissioning and addressing concerns regarding the resilience of the sector. **Healthwatch Updates and Patient Feedback** Healthwatch Suffolk and Healthwatch Norfolk provided updates on recent Healthwatch activities, focusing on patient engagement, feedback regarding access and communication, and ongoing project work. Both emphasised the importance of clear communication and enhanced support for carers. **Healthwatch Suffolk:** Reported on recent engagement with various community groups, highlighting feedback related to prescription ordering processes and the challenges patients and carers face, particularly concerning dementia support and digital access. **Healthwatch Norfolk**: outlined ongoing and recent Healthwatch Norfolk projects, including work on digital tools, mental health carers, adult social care, and assessments of smoking cessation initiatives and health checks. She provided a series of recommendations for improving communication and support, particularly for those navigating health and care services. **Patient Communication and Complaints** A case study was shared demonstrating the positive outcomes achieved through direct and clear communication between clinicians and patients. It was suggested that increasing the use of correspondence addressed directly to

	patients could further enhance patient understanding and satisfaction. **Population Health and Inequalities Board (PHIB):** The committee received a highlight report from the PHIB, key highlights include: • Norfolk and Waveney ICB leads the country in NHS Digital Weight Management Programme referrals, achieving 86% of its eligible target. • The Maternity Community Project shows promising initial results and may become standard practice. • Data collection for the Inequalities, Prevention, and Outreach Strategic Review is progressing as planned. • The PHM Annual Report 2024-25 is endorsed and will be published; further review set for January 2026. • VCSE Assembly events support statutory-voluntary sector cooperation. • The upcoming ICS Conference will showcase voluntary sector contributions. • Year two priorities for the Health Inequality Strategic Framework include a new workforce development resource hub. • No major new risks; some scores updated for current issues. Ongoing concerns involve resources, data quality, finances, and sector engagement.
Items requiring formal approval of Board:	There are no items requiring approval from Board.
Confirmation that the meeting was quorate:	The meeting on 3 November was not quorate; according to the Terms of Reference, it could proceed with attendees' agreement, but no decisions could be made.

Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**Norfolk & Waveney Green Plan**
Presented by:	**Amanda Lyes & Andrew Urquhart/Russell Pearson**
Prepared by:	**Russell Pearson, Andrew Urquhart, Craig Boyles & Christian Mayes**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 November 2025**

Purpose of paper:

Executive summary

NHS England » Green plan guidance was issued in February 2025. All ICBs and Trusts are required to follow the minimum guidance. All Trusts and systems are required to have a green plan published with Board approval by end of November 2025.

N&W (& SNEE) Green Plans are more ambitious than the national guidance requirements, including twelve themed/priority areas versus the required nine. The additional themes are air pollution/air quality, green spaces/nature/biodiversity and waste/recycling).

The core strategic approach in the Green Plan is to deliver sustainable value; reducing environmental and financial cost whilst maintaining (or improving) the quality of care we provide and creating a positive social impact. To achieve this, the approach is via the sustainable care principles lens (prevention, patient self-care/empowerment, lean & lower carbon) to deliver what is termed a 'three up and three down' outcome.

"Three down" being; reducing carbon emissions, air pollution and waste whilst at the same time supporting "Three up" which is increasing/improving nature (including green spaces and water), climate resilience and social value (to tackle inequalities) in support of the NHS 10-year plan. This approach will be underpinned by strategic commissioning, our partnerships and integration with local authority & other partners.

In light of ICB clustering, the N&W & SNEE sustainability leads have worked together and drafted the respective plans in a style that will facilitate them being merging into a single plan to a timetable (TBC) during 2026/27.

To summarise; The N&W Green Plan showcases the progress made by the organisation on the Green & Sustainability agenda, it is fully compliant with latest

guidance and is “owned” & and committed to delivery by our current N&W theme leads/subject matter experts.

Also we can demonstrate that our statutory obligations are discharged through our general duties as per section 14Z44 of the Health & Care Act 2022 and the Procurement (Social Value Acts) and complies with CQC ‘well led sustainability’.

And finally, both the N&W & SNEE Green Plans are drafted in a way that facilitates them to be merged into a single combined organisational Green & Sustainability Plan during 2026/27 (timetable TBC).

Recommendation to Board:

To seek Board approval for the Norfolk & Waveney Green Plan.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	Financial possible; Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. Approach is complaint but further guidance is yet to be released for 25/26. Performance; no risk if programme is accepted and resourced (internally via Subject Matter Experts).
Impact Assessment (environmental and equalities):	Sustainable Impact Assessment forms part of the delivery mechanism. Green Plans underpin and support environmental and inequalities work (the latter through social value model).
Reputation:	Non-compliance poses reputational risk.
Legal:	Our approach fulfils general duties as per section 14Z44 (Duties as to climate change, environment, climate resilience) and sustainable resource use of the Health & Care Act 2022
Information Governance:	None
Resource Required:	As per current resource: Sustainability Programme Lead and theme leads/our subject matter experts
Reference document(s):	NHS Net Zero Strategy Statutory Requirement. ICB Green Plans NHS Board approved NZ Supplier Road map

NHS Constitution:	Supports the overall aims of the NHS re: service & environmental factors that impact on population health
Conflicts of Interest:	None

Improving lives **together**
Norfolk and Waveney Integrated Care System

Our ICB Net Zero Green Plan

NHS Norfolk and Waveney

2025-2028

Version: draft 0.6
Version date: 5th November 2025
Produced by: ICB Estates Team
Approved by:

Foreword

Being sustainable saves lives, saves money, and improves the health and wellbeing of our communities. By reducing our carbon emissions, the UK could save over 100,000 lives per year through more active lifestyles, less vehicle pollution, and healthier carbon-friendly diets. These preventative health actions help us tackle an array of health issues including obesity, diabetes, cardiovascular disease, respiratory disease, cancer, and mental health and wellbeing.

The goal of our Green Plan is to deliver sustainable value and reduce environmental and financial costs whilst maintaining (or improving) the quality of care we provide and creating a positive social impact. Ours is an integrated approach that links environmental, social, and economic thinking to support the new NHS 10-year plan with its three key shifts for a heathier society - 'sickness to prevention', 'hospital to community' and 'analogue to digital'.

This will be achieved by focusing on activities that reduce carbon emissions, air pollution, and waste, increasing our support for nature and our resilience to climate change, and by delivering more social value to our communities through our efforts to help reduce inequality. We have an ambitious programme across 11 priority areas with a focus on action that puts people and their health first and foremost.

We are proud of the progress we have made over the last three years by beginning to embed sustainability in everything we do, however, we know there is still much more that we can achieve and do. Everybody has a role to play in this journey. We hope you enjoy reading our Green Plan and feel inspired to support us. Together we can create a healthier planet and healthier people.

Will Pope

Ed Garratt

Amanda Lyes

titles and images to be added once approved and signed-off

Contents

Green Plan Development and Governance

This document is a refresh of our original ICS Green Plan which we published in 2022. We are now launching our next three-year Green Plan for 2025-2028. The structure of the document remains largely unchanged and still seeks to address how we intend to achieve the NHS's net zero ambitions in the context of the eleven key focus areas covered.

The Green Plan has been developed through a collaborative approach with stakeholders across the system; gaining the input of subject matter experts through a number of engagement sessions to help shape the direction of our Green Plan, objectives and delivery action plans, as well as ensuring alignment to national and local context, strategies and priorities.

The **ICS Net Zero Oversight Group** is the key operational group within the ICB, whose main role is to bring key system partners together to share best practice and discuss strategic priorities and objectives regarding Green Plan development and delivery. The Net Zero Oversight Group is **chaired by our Lead for Sustainability at the ICB**, and membership includes ICB, NHS Trust, Primary Care and NHS England sustainability colleagues.

The Oversight Group links operationally into the **Net Zero Exec Leads Group**, which is chaired by the **ICBs SRO for Net Zero and Sustainability** and membership consists of Net Zero and Sustainability SROs from NHS Trusts. The role of the leads group is to monitor and examine planning and delivery against the commitments made in Delivering a Net Zero NHS and our local Green Plans.

Merger between Norfolk and Waveney and Suffolk and North East Essex

At the time of publication, the ICB is undergoing an organisational restructure, including the planned clustering and subsequent merger with a neighbouring ICB to establish the Norfolk and Suffolk ICB. This development represents a strategic commitment to delivering integrated, sustainable healthcare across a broader footprint. While this Green Plan reflects the priorities of Norfolk and Waveney, it is anticipated that, in due course, the two existing plans will be consolidated into one comprehensive strategy.

As part of a clustering approach between the two organisations prior to the merger, this process has already commenced with a shared strategic objective across both organisations green plans, ensuring alignment with shared objectives and the NHS Net Zero and sustainability ambitions

Our Joint Strategic Approach

Both SNEE & N&W ICB Green Plans have started to cluster prior to our merger. We are more ambitious than the national Green Plan guidance; we have 11 themed or priority areas versus the required 9 (adding air quality, green spaces/biodiversity and waste/recycling). We share a common overall strategic approach in both green plans, namely;

A goal to deliver sustainable value; reducing environmental and financial cost whilst maintaining (or improving) quality of care we provide and creating a positive social impact.

This will be **approached through the sustainable care principles lens** (prevention, patient self-care/empowerment, lean & lower carbon).

To deliver a '3 up and 3 down' outcome which is; reducing carbon emissions, air pollution and waste whilst increasing/improving nature (includes green spaces and water), climate resilience and social value (to tackle inequalities).

That **supports the NHS 10-year plan** which is the government's health mission to build a health service fit for the future.

This approach will be **underpinned by adhering to the role of ICBs in Green Plan guidance namely; strategic commissioning**, supporting partner Trusts, supporting primary care, sharing best practice, aligning with strategies including our Joint Forward Plans and Infrastructure strategies and, continued partnerships and integration with local authority and other partners.

Our approach ensures that

- both ICBs align our strategies prior to our merger
- we can demonstrate our statutory obligations are discharged through our general duties as per section 14Z44 of the Health & Care Act 2022. And the Procurement (Social Value Acts).
- we meet the NHS Triple Aim.
- we comply with the Care Quality Commission 'well led sustainability'.
- we provide the value for money for the communities we serve.

Our green plans will merge to an agreed timetable and process in 2026/27.

Norfolk & Waveney Green Plan

Welcome to our Green Plan, supporting the NHS in leading the charge to become the world's first net zero health service. Climate change is a formidable challenge, but it is one we are determined to tackle head-on.

In 2020, the **NHS became the world's first health system to commit to reaching net zero emissions. The Health and Care Act 2022 reinforced this commitment, placing new duties on Integrated Care Boards (ICBs)**, and NHS Trusts to consider statutory emissions and environmental targets in their decisions. ICBs and Trusts are expected to meet these duties through the delivery of board-approved green plans.

The NHS has set ambitious targets to guide our journey:

1. **NHS Carbon Footprint: We are aiming for net zero by 2040 for emissions we control directly, with an interim target of an 80% reduction by 2028 to 2032.**
2. **NHS Carbon Footprint Plus: For emissions we can influence, our goal is net zero by 2045, with an interim target of an 80% reduction by 2036 to 2039.**

Our Green Plan will cover the **ICB's role** in:

- Shaping sustainable models of care by prioritising prevention, improving population health outcomes, and embedding Net Zero principles into strategic commissioning, long-term planning and resource allocation.
- Ensuring that Green Plan priorities are aligned with and reflected in the ICB's Joint Forward Plan, Estates Infrastructure Strategy, Capital Plans, and other system-wide plans.
- Delivering a set of priority actions at system, place and neighbourhood levels, as set out in our areas of focus section.
- Providing system leadership on emissions reduction and engaging with the wider system partners.
- Supporting partner NHS Trusts to deliver their Green Plan objectives and overseeing progress, including through contract monitoring and annual reporting.
- Supporting Primary Care in developing and delivering net zero initiatives and contribute to emission reduction.
- Sharing best practice across partner organisations, supporting collaboration and facilitating engagement with relevant research and innovation activities.

Norfolk & Waveney Integrated Care System

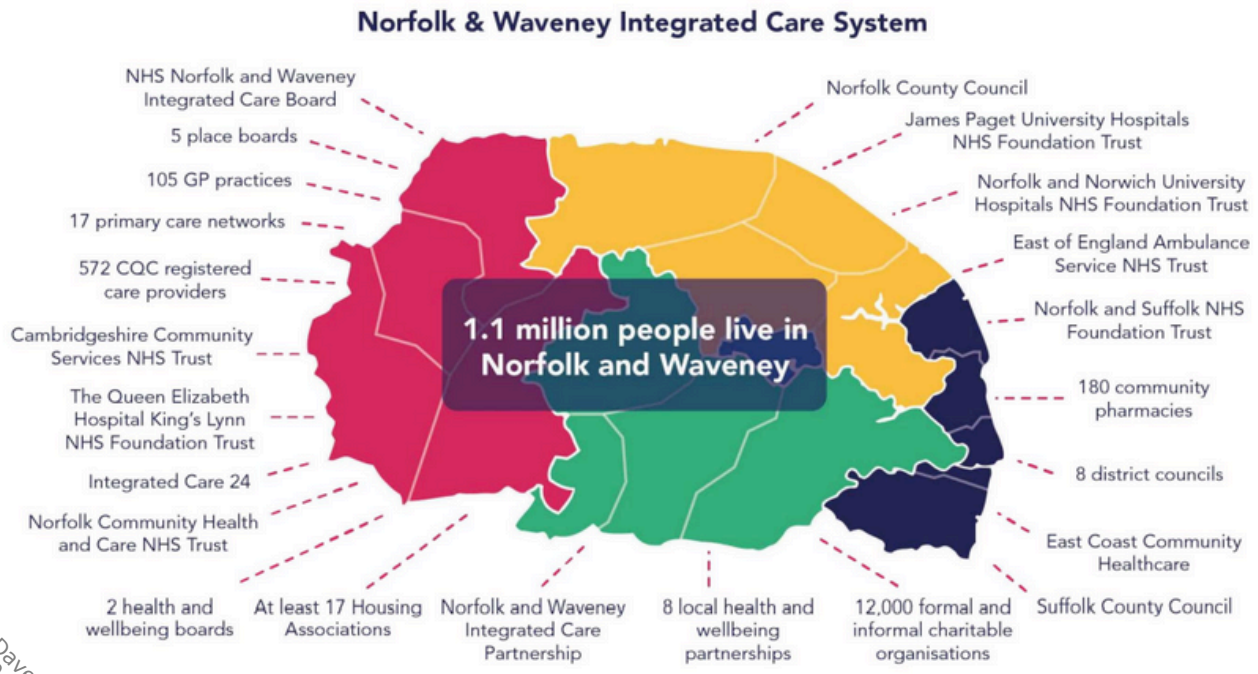
Integrated Care Systems (ICSs) bring together Primary Care, NHS organisations, councils and wider partners in a defined geographical area to deliver more joined-up approaches to improving health and care outcomes. ICSs remove barriers between organisations, and have the potential to drive improvements in population health and tackle inequalities by reaching beyond the NHS to address social and economic determinants of health.

ICS partners share a common vision to improve health and care, backed by robust operational and financial plans, collective leadership and accountability.

The Norfolk and Waveney ICS, as with all ICSs in England, is working to:

- **Improve outcomes in population health and healthcare**
- **Tackle inequalities in outcomes, experience and access**
- **Enhance productivity and value for money**
- **Support broader social and economic development**

The organisations that sit under the Norfolk and Waveney Integrated Care System umbrella, as well the geographical coverage of our 5 places highlighted by colour, are shown in the stakeholder map below.



ICS Performance Reporting

The Greener NHS Dashboard has been created by NHS England to allow monitoring of progress against targets and key performance indicators. The dashboard can be viewed at a national, regional, system, and provider level.

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

The Norfolk & Waveney ICB utilise the dashboard to track and report consumption, emissions, and general progress towards the targets set out. The ICB reports an annual summary of progress on delivery of our Green Plan to our ICB Board, the report provides an update on progress made, delivery of actions and milestones set out in our Green Plan, and our key achievements.

An area requiring improvement is the inclusion of quantitative data and metrics reporting in future reports - there is currently no national or local method for calculating a complete system level carbon footprint.

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

As part of the ICBs role in supporting Primary Care in developing and delivering net zero initiatives and contributing to emission reduction, work is required to develop an equivalent reporting methodology for Primary Care providers and infrastructure. This should feature in future annual reporting.

System Leadership & Priorities

The role of the ICB is to provide system-wide leadership on emissions reduction and embed sustainability into all operational and strategic activities across the ICS. The ICB will work together with Primary Care, NHS Trusts and wider system partners including local authorities and VCSE organisations to facilitate and support work towards meeting net zero obligations.

While individual trusts and organisations remain responsible for delivering their own plans, the ICB provides overarching leadership to ensure alignment with system-wide priorities, that best practice is shared and adopted and that we continue to make progress collaboratively towards our green plan objectives.

The key areas that our ICB should be responsible for and lead on, are:

- Linking environmental sustainability and strategic commissioning; embedding it in the way services are planned, procured, and delivered.
- Embedding sustainability into everything we do through improved engagement, and ensuring sustainability is a key feature across system policies, strategies, and priorities.
- Supporting the delivery of high-quality, equitable care through environmentally sustainable models, recognising the interdependence between population health and planetary health.
- Addressing wider sustainability goals including climate resilience, biodiversity, social value, and community wellbeing. Embedding these in commissioning decisions, estate planning, and service transformation to ensure a holistic and future-proofed approach.
- Adopting an approach to ensure coherence across system levels; linking national policy, regional frameworks, and ICS strategy with place-based delivery, organisational action, and service-level implementation .
- Working with local authorities on appropriate areas of common interest, such as local plans, heat networks, sustainable travel plans, and nature recovery strategies.
- Generating engagement with Primary Care and Trusts in regard to research and innovation activities, including promoting events, training & producing business cases which take advantage of economies of scale.
- Promoting system-wide investment towards sustainability and net zero, in a prioritised way, to help deliver our Green Plans, meet sustainability goals, and reduce carbon emissions.

Our Journey So Far

Following publication of our first ever system Green Plan in 2022, the Integrated Care Board (ICB) has made significant strides in embedding sustainability and advancing net zero ambitions across each of the focus areas.

From building carbon literacy among staff to transforming commissioning practices, sustainability is becoming a core principle in how we plan, deliver, and evaluate care. These efforts reflect a growing organisational commitment to environmental responsibility, health equity, and long-term system resilience.

This section highlights programmes, interventions, and innovations that have been successfully delivered to date.

Workforce, Networks & Leadership

- Initiated ICB awareness and training offers through the Centre for Sustainable Healthcare, including carbon literacy, net-zero leadership training for boards, and sustainability in quality improvement.

- Expanded our awareness and training offers to all primary care colleagues across the ICB as part of the continuous professional development programme, and launched the Greener Dentistry toolkit within primary care settings.

- Established an NHS Anchors Group, made up of health inequalities leads across system NHS Trusts and providers, focussing on the 5 areas of what it means to be an NHS Anchor, including a focus on sustainability and climate.

- Continued to engage and collaborate with regional and system partners through our ICS Net Zero Exec Leads Group and our ICS Net Zero Delivery Group, as well as engaging through wider national, regional, and system level meetings to ensure learning, ideas, and best practice was captured, shared and promoted.

- Published the Primary Care Workforce Strategy 2024 – 2027, that has a Sustainability Pillar aligned to the areas of carbon emissions, taking responsibility to support the operational delivery to reduce emissions, improve efficiencies, and support the sustainable delivery of health services.

- Recruited a Primary Care Sustainability Clinical Fellow, for 12 months, to work at place level and systematically explore physical, social, psychological and environmental factors which impact on outcomes in the context of climate change and its impacts on and interactions with human health, with a view to improving them.

Our Journey So Far

Clinical Transformation

- Delivered primary care training schemes enabling increased care in the community, at local primary care clinics, preventing travel to secondary care sites.

- Greater use of digital delivery and education programmes to provide knowledge, skills and evidence-based health benefits to reduce the need for higher intensity face-to-face services.

- Utilised allocated non-recurrent funding to improve services and develop a health hub approach and deliver care closer to the patient's home.

- Local screening programmes to encourage uptake and earlier diagnosis to support effective preventative measures, reducing demand on GP and secondary care services.

- Proactive health prevention programmes, providing advice and support at an earlier stage to reduce multiple health conditions and reliance on emergency healthcare.

- Implementing personalised, co-ordinated and patient-centred care to ensure patients and families receive the appropriate support, improving healthcare experience and reducing the number of inappropriate interventions.

- Introduced an MSK Single Point of Access, reducing patient travel and supporting lower carbon emissions by enabling care closer to home or work.

- Establishment of an urgent care dental service to provide appointment availability across Norfolk and Waveney and enable patients in pain to be treated closer to home without the need for them to attend ED.

Medicines

- Rolled out green inhalers and medicines waste support for general practice. High level of sign-up by general practice to the Prescribing Quality Incentive Scheme, which encourages and supports the switch to green inhalers.

- A repeat prescribing resource has been made available through ICB supported by Prescribing Leads. Demand is high and feedback is positive from practices.

- Structured Medication Reviews continue to be part of the PCN Contract for 2025/26, another tool to reduce medicines waste as well as improve quality and safety.

- Strong progress made in embedding Pharmacy First services, supporting patients care closer to home for seven common conditions, and avoiding the need to wait for a GP practice appointment.

Our Journey So Far

Supply Chain & Procurement

- Established an ICS Procurement collaborative forum with our system NHS Trusts and lead for Sustainable Procurement to encourage sustainable procurement practices.
- Member of the National Procurement Hub and the Target Operating Model for Procurement programme.
- Embedded the 5 Rs of sustainable procurement in policy and plans e.g. through the use of re-manufactured goods (refuse, reduce, reuse, repurpose, and recycle).
- Linked with and increased close working with NHS Supply Chain, and continued adherence to the commitments in the NHS supply chain roadmap, including the 10% social value weighting.
- Were key players in driving forward a regional programme focussed on glove reduction across the system, via our Infection Prevention and Control team.

Digital Transformation

- Rolled out SDWAN and Wi-Fi across 151 primary care sites: enabling remote diagnostics and reducing travel; decommissioning legacy hardware and reducing energy use and e-waste; achieved zero network downtime and improved service reliability.
- Delivered digital communications enhancements: enabling 553,000+ users on the NHS App to reduce paper use and travel; and optimised SMS messaging.
- Automated repeat prescriptions and registrations in Primary Care, saving £1m and 45 FTE hours; improved efficiency and a further 660+ hours saved via implementation of Power Automate.
- Migrated General Practice sites to cloud infrastructure, eliminating physical servers and hardware, improving data access and uptime and reducing energy consumption and emissions.
- Rolled out 'Connect NoW' (collaboration via Intranet), helping to reduce internal emails by 30%, improve document sharing, and reduce printing.
- Unified General Practice IT domains, reducing inter-site travel, improving remote working and care continuity. 12,000 miles/year and over 3 tonnes CO_2 saved.

Our Journey So Far

Estates

- Published a 10-year Estates Infrastructure Strategy, with 'Improving Environmental Sustainability' incorporated as one of the four key objectives, and a supporting call to action within the '*how do we get there*' section.

- Developed a Capital Investment 'Prioritisation Matrix', aligned to the Estates Infrastructure Strategy, that considers Sustainability and Net Zero alongside other estate infrastructure capital programmes, and aids prioritisation.

- Initiated intel gathering on 400+ primary care properties, including display energy and energy performance certificates, to help understand consumption and help propose interventions.

- Delivered the new King's Lynn Health Hub, a new carbon-neutral building constructed to net-zero standards and achieving BREEAM outstanding rating. A second is under construction.

- Delivered estates infrastructure schemes that support care closer to home, in the community, helping to improve patient care whilst reducing travel and associated emissions.

Adaptation & Resilience

- The ICS Local Health Resilience Partnership (LHRP) has worked closely with Local Resilience Forum (LRF) partners to ensure that severe weather risks are reflected in Community Risk Registers. This collaboration has enabled the development of multi-agency response plans tailored to local climate threats and severe weather events to safeguard public health and community resilience

- Coordination with the National Security Risk Assessment process has ensured that Reasonable Worst-Case Scenarios (RWCS) for severe weather are aligned with national standards, ensuring a comprehensive approach to mitigating potential climate change threats

- Multi-agency response documents have been developed and tested to address a range of severe weather scenarios. These plans have been activated during recent weather events, enabling coordinated responses that effectively mitigate risks and protect communities

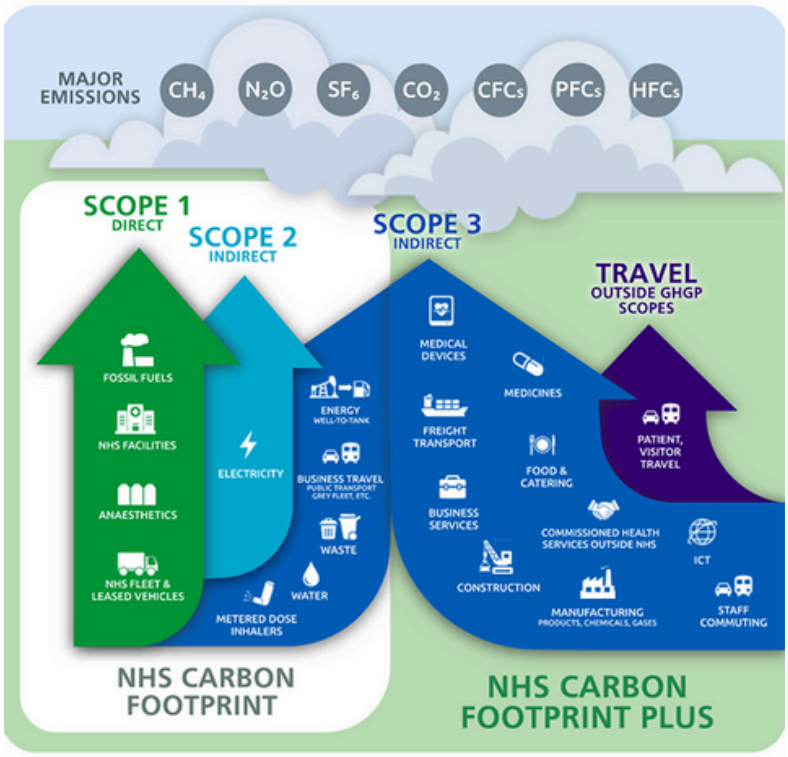
Future Focus

Building on the progress we have made, this new Green Plan sets out a clear and ambitious plan for where we want to be across each of the nine sustainability focus areas.

This plan is aligned with the NHS's national net zero targets and reflects our local priorities for improving health outcomes, reducing inequalities, and enhancing system resilience. Our Green Plan also aligns with the NHS 10-Year Health Plan by embedding environmental sustainability and the focus on shifting care from hospital to community, focusing on prevention, and leveraging digital innovation. These changes not only improve health outcomes and reduce inequalities but also support the NHS Net Zero ambition by cutting emissions, reducing waste, and building climate resilience across integrated care systems.

To help us deliver this plan, we have identified a series of actions and enablers that will guide our delivery over the next three years. These actions are tailored to the opportunities and challenges within each focus area and are designed to be specific, measurable, achievable, relevant and time-bound.

Progress will be tracked through a robust set of Key Performance Indicators (KPIs), aligned with national and local reporting frameworks. These KPIs will enable us to monitor outcomes, evaluate impact, and ensure accountability at every level of the system. Regular reviews and transparent reporting will help us adapt our approach as needed and maintain momentum toward our net zero goals.



Workforce, Networks & Leadership

Introduction

A sustainable NHS depends on an informed and empowered workforce. Staff at all levels play a vital role in reducing the environmental impact of healthcare delivery.

We aim to build a climate-conscious workforce where sustainability is embedded in every role and supported by leadership at all levels. To achieve this, we will deliver carbon literacy training, embed sustainability in job descriptions, and empower staff through leadership and engagement initiatives.

Where we want to be

- A climate-literate workforce with sustainability embedded in all roles.
- Equipping staff with the ability to meet obligations under the Health and Care Act 2022, and make sustainable decisions.
- Green leadership at all levels, and across all focus areas.
- Staff considering the environmental impacts of everything we do and empowered to contribute to sustainability goals.
- Collaborative networks across the ICS, delivering change together.

How do we get there

- Deliver carbon literacy and subject specific training for staff.
- Provide social value guidance and training to support commissioning and procurement evaluation.
- Appoint a board-level sustainability SRO and sustainability lead.
- Embed sustainability in job descriptions, appraisals, and CPD.
- Establish a 'Green Team' with members from each focus area, and across the ICS.
- Utilise the Health Anchor Measurement Toolkit to strengthen our role as Anchor organisations across each domain.
- Run campaigns on greener practices to highlight ways everyone can contribute.

Key Performance Indicators (KPIs)

- Number of staff trained in carbon literacy and/or subject specific training.
- Named board-level SRO and sustainability lead for Green Plan delivery.
- Net Zero Exec Leads and Net Zero Oversight Groups membership.
- Number of activities implemented via the Health Anchor toolkit model.
- Number of pledges made during greener practice campaigns.

Monitoring and Evaluation Methods

- Annual staff surveys on sustainability awareness.
- Internal audits of training, leadership roles, meeting attendance, and pledges.
- Terms of Reference and membership for net zero groups.
- Health Anchor measurement toolkit baselining.

Air Quality

Introduction

Air Quality is a critical determinant of health, with poor air quality contributing to respiratory and cardiovascular disease, exacerbating health inequalities, and increasing demand for NHS services.

As an ICB, we have a responsibility to work collaboratively with local authorities, providers, and communities to reduce exposure to harmful pollutants and promote cleaner environments as part of our Net Zero and population health ambitions

Where we want to be

- Air Quality embedded in health planning and prevention strategies.
- Increased community engagement and local initiatives to raise awareness and reduce pollution.
- Indoor air quality standards for healthcare settings and primary care premises.
- Influence local planning and transport policies to improve outdoor air quality.

How do we get there

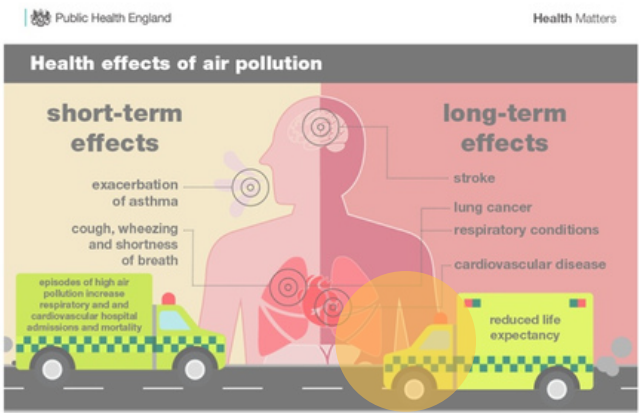
- Embed air quality considerations into strategic commissioning decisions, especially for respiratory care.
- Partnership working with local authorities and public health teams to align clean air zones and transport strategies.
- Introduce air quality monitoring in high-risk healthcare settings such as hospitals and GP practices.
- Deliver staff and patient education campaigns on reducing exposure and emissions.

Key Performance Indicators (KPIs)

- Number of sites with real-time air quality monitoring installed.
- Average Air Quality Index (AQI) around NHS premises (target AQI <50).
- Number of staff completing air quality and sustainability training.

Monitoring and Evaluation Methods

- DEFRA UK Air Quality Network.
- Local Authority Air Quality Reports.



Digital Transformation

Introduction

Digital transformation is a key enabler of sustainable healthcare. Digital tools can significantly lower our carbon footprint, by improving operational efficiency and reducing the need for travel.

Our goal is to harness digital innovation to reduce emissions, improve care access, and modernise our infrastructure. We will achieve this by expanding digital-first services, investing in efficient technologies, and embedding sustainability into digital strategy.

Where we want to be

- Digital-first care that reduces emissions and improves access.
- IT infrastructure that is energy-efficient and low-carbon.
- Maximise the benefits of digital transformation to reduce emissions.

How do we get there

- Expand virtual pathways and remote monitoring where clinically appropriate.
- Procure energy-efficient hardware.
- Digital inclusion and device recycling, with circular economy principles.
- Sustainable AI and data infrastructure.
- Digital records and automated lifecycle management.
- System-wide intranet and collaboration tools.

Key Performance Indicators (KPIs)

- % of outpatient appointments delivered virtually.
- % of digital equipment meeting sustainability criteria.
- Number of devices refurbished and redistributed.
- Adoption of energy-efficient AI models.
- Adoption of AI-assisted classification and retention tools for lifecycle management.
- % reduction in office paper use.
- % reduction of emails.

Monitoring and Evaluation Methods

- Internal ICB BI dashboards.
- Model Health System.
- Internal audit of digital infrastructure, devices, platforms, and models.
- IT asset lifecycle tracking.
- Emissions modelling from digital services.

Clinical Transformation

Introduction

Clinical care is at the heart of the NHS, and transforming clinical pathways to be more sustainable is essential for achieving net zero. Clinical activities contribute significantly to healthcare emissions.

Sustainable models of care and the beneficial impacts are widespread. By embedding sustainability and net zero principles into clinical decision-making and pathway redesign, we can improve patient outcomes while reducing environmental impact.

Where we want to be

- Clinical pathways that are evidence-based, patient-centred, and low-carbon.
- Sustainability integrated into clinical governance and quality improvement.
- Widespread use of low-carbon alternatives in high-impact areas (e.g. anaesthesia, respiratory care).
- Sustainable community based models of care that reduce unnecessary interventions and hospital admissions.

How do we get there

- Identify and prioritise high-emission clinical areas for intervention.
- Develop and implement low-carbon clinical policy and guidelines.
- Embed Net Zero principles into strategic commissioning, long-term planning and resource allocation.
- Implement sustainable models of care, prioritising prevention and improving population health outcomes.
- Incorporate sustainability impact assessments alongside quality impact and equality & health inequality impact assessments.
- Enhance the adoption of social prescribing, green social prescribing, and physical initiatives in every local area.

Key Performance Indicators (KPIs)

- Number of low-carbon clinical pathways implemented.
- Low carbon clinical policy and guidelines implemented.
- Number of sustainability impact assessments completed.
- Number of adopted social and green social prescribing initiatives.

Monitoring and Evaluation Methods

- Internal ICB BI dashboards.
- Model Health System.
- Clinical audit reports and quality improvement outcomes.
- Sustainability impact assessments.

Medicines

Introduction

Medicines account for a significant proportion of NHS carbon emissions, particularly through manufacturing, transport, and disposal. Optimising medicines use and reducing waste can lead to both environmental and financial benefits. A sustainable medicines strategy supports better patient care and system efficiency.

Where we want to be

- A medicines pathway that minimises environmental harm and waste.
- Prescribing practices that prioritise clinical effectiveness and sustainability.
- Improved patient outcomes through optimised medicines use.
- Primary care and pharmacy teams actively engaged in sustainability initiatives.

How do we get there

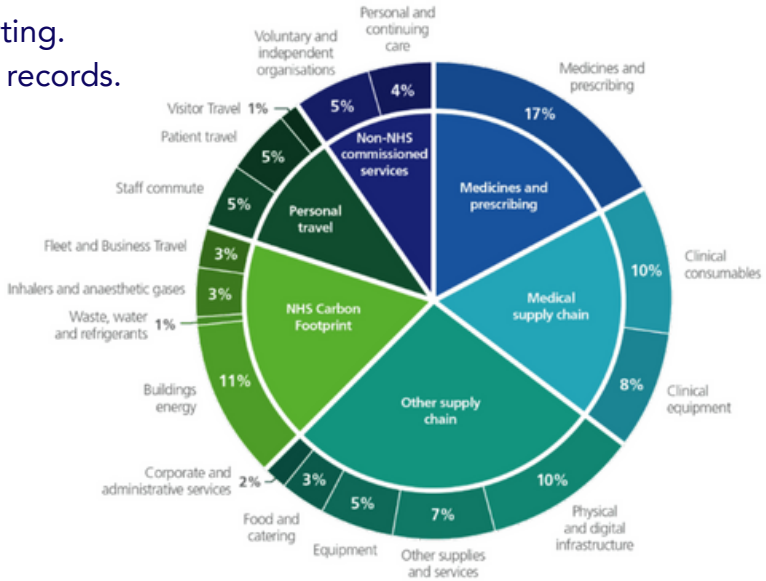
- Promote the use of dry powder inhalers and other low-carbon alternatives.
- Implement new toolkit to reduce overprescribing and unnecessary polypharmacy.
- Launch a new reducing medicine waste campaign and improve medicines waste segregation and recycling.
- Engage primary care and pharmacy teams in green initiatives and training.
- Collaborate with suppliers to reduce emissions in the medicines supply chain.

Key Performance Indicators (KPIs)

- Average inhaler emissions per 1,000 patients.
- % of prescribed inhalers that are MDIs vs DPIs.
- Volume of medicines waste recycled or safely disposed.
- % of insulin pen patients moved to reusable pens with cartridges.
- Number of primary care led sustainability projects.

Monitoring and Evaluation Methods

- Prescribing data analysis.
- Pharmacy waste audits.
- Greener NHS dashboard reporting.
- Staff engagement and training records.



Estates

Introduction

The NHS estate is a major source of carbon emissions. Transforming our buildings to be energy-efficient and climate-resilient is essential for achieving net zero and ensuring continuity of care in the face of climate change.

To facilitate progress the ICB will continue to work with local and national colleagues to understand, appraise, and map the options and technologies available and identify those best suited for decarbonising our buildings based on types, size and demand profiles.

Where we want to be

- Net zero, energy-efficient, and climate-resilient healthcare buildings.
- Estate infrastructure that enables care closer to home, from hospital to community.
- Clear alignment between Estates Infrastructure Strategy and Green Plan.
- Capital projects aligned with sustainability and adaptation goals.

How do we get there

- Promote retrofitting with insulation, LED lighting, and smart controls; and installation of renewable energy systems such as solar panels and heat pumps across our primary care estate.
- Develop primary and community estate infrastructure that enables sustainable models of care and clinical transformation.
- Support system partners to access funding offers to help deliver upgrades.
- Integrate sustainability into capital planning, business case, design standards and construction.
- Fully utilise core estate and dispose of inefficient, not fit for purpose buildings, removing the associated emissions.
- Ensure estate decarbonisation planning aligns to local priorities, heat networks, and funding opportunities.

Key Performance Indicators (KPIs)

- % reduction in estate related emissions (tonnes CO2e per year)
- Number of retrofitting and renewable energy projects delivered.
- Value of capital prioritised and invested to deliver energy-efficiency projects.
- All estate infrastructure schemes to incorporate net-zero principles.

Monitoring and Evaluation Methods

- Annual carbon footprint reporting.
- Programme plans and reporting.
- Capital investment and business cases.
- EPCs and DECs (energy certificates).
- BREEAM assessments and ratings.

Waste

Introduction

Waste management is a critical component of the NHS sustainability agenda, given its significant environmental impact, cost implications, and contribution to carbon emissions. The NHS Clinical Waste Strategy sets a clear direction to reduce waste generation, improve segregation, and adopt circular economy principles.

As an ICB, we have a responsibility to influence commissioning, estates planning, and provider practices to ensure compliance and progress toward Net Zero targets.

Where we want to be

- Full adherence to HTM 07-01 and the NHS Clinical Waste Strategy
- Achieve the targeted 50% reduction in carbon emissions from waste by 2026
- Meet the 20:20:60 segregation Clinical Waste Strategy standard (20% incineration, 20% infectious, 60% offensive)
- Increase reuse, remanufacture, and recycling of medical devices and consumables.

How do we get there

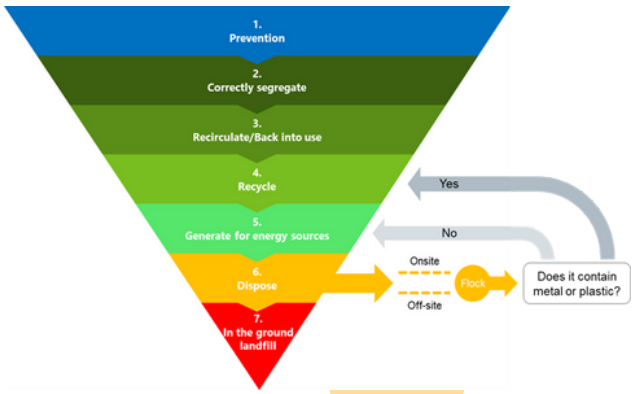
- Embed waste management requirements in commissioning contracts for providers.
- Explore implementation of technologies to treat infectious waste on-site to reduce reliance on high-temperature incineration and reduce carbon emissions.
- Develop waste reduction initiatives with system partners, local authorities and waste contractors.
- Collaborate with suppliers under the NHS Net Zero Supplier Roadmap to reduce single-use plastics.

Key Performance Indicators (KPIs)

- % reduction in waste related emissions (tonnes CO2e per year).
- % compliance with 20:20:60 segregation standard.
- Volume of waste sent to high-temperature incineration (tonnes per year).
- % of reusable/remanufactured medical devices in procurement.

Monitoring and Evaluation Methods

- Annual carbon footprint reporting.
- HTM 07-01
- NHS Clinical Waste Strategy
- Waste contractor reports
- Greener NHS dashboard reporting.



Travel & Transport

Introduction

We provide services across a large rural area; therefore, travel and transport contribute significantly to NHS carbon emissions, particularly through staff commuting, patient travel, and fleet operations.

Promoting active travel, reducing travel demand, and transitioning to zero-emission vehicles are key to reducing our environmental impact and improving public health.

Where we want to be

- A shift to active, public, and zero-emission transport options.
- Reduced emissions from NHS fleet, staff travel, and patient journeys.
- Reduced travel demand through digital services and local care delivery.
- Improved air quality and reduced congestion around healthcare sites.

How do we get there

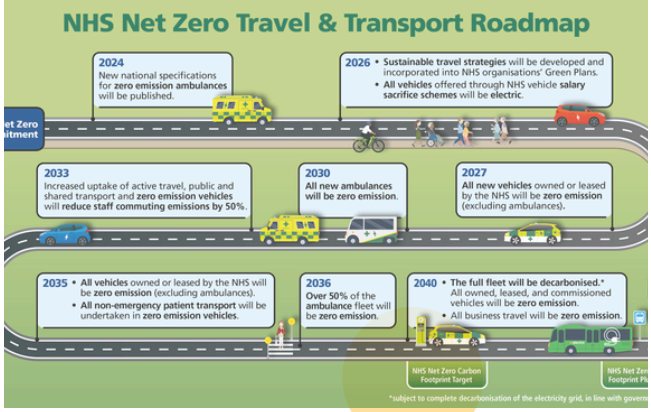
- Develop and implement a Sustainable Travel Plan by 2026.
- Expand EV charging infrastructure across our estate.
- Implement active travel and low-emission fleet policies across the NHS.
- Promote active travel through cycle-to-work schemes and secure bike storage.
- Work with local authorities and local transport authorities to maximise funding and infrastructure across the system.

Key Performance Indicators (KPIs)

- Sustainable Travel Plan in place.
- % reduction in NHS-related transport emissions (tonnes CO2e per year)
- Number of EV charging points installed.
- % of NHS fleet being zero or ultra-low emission vehicles.
- Salary sacrifice and cycle-to-work schemes available.
- Number of collaborative interventions delivered with local authorities and local transport authorities.

Monitoring and Evaluation Methods

- Annual carbon footprint reporting.
- EV infrastructure usage data.
- Greener NHS dashboard.
- Staff travel behaviour audits.



Supply Chain & Procurement

Introduction

Although, this forms part of our Carbon Footprint Plus, and emissions we can influence rather than directly control, the NHS supply chain accounts for over 60% of its carbon footprint.

Sustainable procurement practices are essential to reducing emissions, promoting circular economy principles, and ensuring suppliers align with net zero goals. Responsible sourcing also supports social value and ethical standards. We will embed into our procurement strategies the 'Building Net Zero into NHS procurement' roadmap to support our journey.

Where we want to be

- A net zero-aligned supply chain with transparent emissions reporting.
- Procurement decisions that prioritise sustainability and circularity.
- Suppliers actively reducing their environmental impact.
- Reduced reliance on single-use items and packaging.

How do we get there

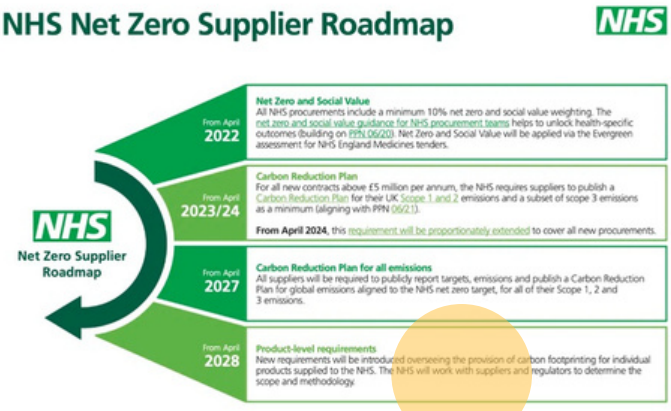
- Implement the NHS Net Zero Supplier Roadmap.
- Require suppliers to publish Carbon Reduction Plans.
- Influence our suppliers and encourage sustainable procurement practices.
- Prioritise reusable, recyclable, and low-carbon products.
- Collaborate with NHS Supply Chain to embed green criteria.

Key Performance Indicators (KPIs)

- % of suppliers with published Carbon Reduction Plans.
- % of suppliers engaged with the Evergreen Sustainable Supplier Assessment.
- % of procurement spend aligned with sustainability criteria.
- % reduction in single-use plastics and packaging.

Monitoring and Evaluation Methods

- Procurement audit reports.
- Supplier engagement dashboards.
- NHS Supply Chain sustainability metrics.
- Contract performance reviews.



Adaptation & Resilience

Introduction

Severe weather events are recognised in the National Security Risk Assessments published by the Cabinet Office and reflected in the Community Risk Registers of Local Resilience Forums in Norfolk and Suffolk. These risks include storms, high temperatures/heatwaves, low temperatures/snow, and coastal, fluvial, and surface water flooding. The changing climate could affect the likelihood of these risks occurring, thereby impacting local populations and health and care settings.

Strategies, policies and plans will continue evolving to mitigate the risks and effects of climate change and severe weather conditions on services and functions. This will include implementing sustainable practices, enhancing infrastructure resilience, and promoting adaptive measures to ensure continued service delivery during adverse weather events.

Where we want to be

- A climate-resilient health system prepared for extreme weather and long-term climate risks.
- Adaptation integrated into all levels of planning and operations.
- Staff trained and equipped to respond to climate-related emergencies.
- Infrastructure designed to withstand future climate impacts.

How do we get there

- Conduct climate risk assessments and implement robust adaptation strategies.
- Develop, update and test adaptation and emergency response plans.
- Integrate adaptation into business continuity and capital planning.
- Train staff on climate resilience and emergency preparedness.
- Collaborate with local authorities on regional adaptation strategies.

Key Performance Indicators (KPIs)

- Number of completed climate risk assessments and adaptation strategies.
- Number of updated and tested adaptation and emergency response plans.
- Number of staff trained in climate resilience.
- Inclusion of adaptation in capital project planning.
- Business continuity statements to consider climate change adaptation planning.

Monitoring and Evaluation Methods

- Emergency preparedness audits and annual assurance process.
- Climate risk assessment reports.
- Training records and staff feedback.
- Resilience metrics in NHS planning frameworks.

Green Space & Biodiversity

Green spaces and biodiversity are essential components of a sustainable healthcare system. They contribute to physical and mental wellbeing, reduce health inequalities, enhance climate resilience, and support nature recovery. The NHS has a unique opportunity to lead by example, transforming its estate into a network of biodiverse, accessible, and health-promoting environments.

Where we want to be

- High-quality, biodiverse green spaces that support staff, patient, and community wellbeing.
- NHS estates contribute to Local Nature Recovery Strategies (LNRS)
- Green infrastructure is integrated into new developments and refurbishments.
- Green spaces to support nature-based interventions and pathways.

How do we get there

- Conduct biodiversity and green space audits across our estate.
- Collaborate with local authorities, Natural England, Wildlife Trusts, and community groups to co-design green spaces.
- Incorporate green infrastructure into estate planning, business case and design.
- Ensure all new developments align with BNG and LNRS requirements.

Key Performance Indicators (KPIs)

- Number of NHS sites with biodiversity action plans in place.
- % increase in green space coverage across the estate.
- Number of patients referred to green social prescribing programmes.
- Number of developments incorporating green space and biodiversity measures.

Monitoring and Evaluation Methods

- Annual biodiversity audits and green space assessments.
- GIS mapping of green infrastructure and access metrics.
- Patient and staff surveys on wellbeing impacts of green spaces.
- Monitoring of social prescribing outcomes (e.g. reduced GP visits, improved mental health).
- Reporting through the ICB's sustainability dashboard and annual Green Plan review

Key Strategy & Policy Documents

Below is a list of key strategic and policy documents for the NHS that set out Net Zero carbon and broader sustainability priorities:

- The Health and Care Act (2022)
- NHS Constitution: Principle 6 – The NHS is committed to providing best value for taxpayers' money
- NHS Long Terms Plan (2019)
- 10-Year Infrastructure Strategy
- Delivering a 'Net Zero' National Health Service (2020)
- Estates & Facilities Net Zero Carbon Delivery Plan (2021)
- NHS Net Zero Supplier Roadmap (2024)
- NHS England » Net Zero travel and transport strategy
- 2025/26 NHS Standard Contract
- 2025/26 NHS Planning Guidance
- NHS England » NHS clinical waste strategy
- NHS England » National medicines optimisation opportunities 2024/25
- DEFRA Health & Care Adaptation Reports
- NHS England » 4th Health and climate adaptation report
- NHSX Digital What Good Looks Like
- Design for Life Roadmap - GOV.UK

Broader Government commitments:

- Climate Change Act 2008
- Public Services (Social Value) Act 2012
- The Paris Agreement 2015
- United Nations Sustainable Development Goals 2015
- The Ten Point Plan for a Green Industrial Revolution
- Digital Services UK Strategy
- UK Government ICT Sustainability Strategy and STAR
- TCFD-aligned disclosure guidance for public sector annual reports - GOV.UK

Acknowledgements

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Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Research in primary care**
Presented by:	**Dr Clara Yates**
Prepared by:	**Dr Clara Yates and the NWICB Research and Innovation Team**
Submitted to:	**ICB Board**
Date:	**26 November 2025**

Purpose of paper:

The purpose of the paper is to share the progress, successes and future plans for both commercial and non-commercial research in primary care across Norfolk and Waveney

Executive Summary:

The Research and Innovation (R&I) team at NHS Norfolk and Waveney ICB have diverse and complimentary expertise across the R&I pathway. From supporting development of early stage research ideas all the way through to implementation of innovations. All of our work is aligned with the four principals defined in our ICS Research and Innovation strategy:

1. Focused on our communities
2. Driven by a confident and capable workforce
3. Collaborative and coordinated
4. Embedded in everything we do

We believe that R&I are the tools which enable the health and care system to improve. R&I increase the quality and efficiency of services for the benefit of everyone in Norfolk and Waveney.

This report highlights current research support and activity provided to primary care. We have funded the development of community research hubs linked with general practice to increase participant recruitment, in particular in areas experiencing health inequalities. We have worked with the team at Grove Surgery in Breckland to support the successful application for a Primary Care Commercial Research Delivery Centre (PC-CRDC), one of only 14 in the country. This significant achievement will focus on expanding the range of innovative commercial research available to our population including, access to new medicine and vaccines.

The ability for primary care to engage in research activity is predicated on a trained, connected and interested workforce. Since April 2025 we have invested £180,000 in primary care research capacity and capability building, at a practice and PCN level enabling an increase in commercial and non-commercial research, with one practice restarting research after a three year gap.

Subject to the ICB restructure consultation, the team aim to continue to provide expert advice and guidance, continue to increase research capability and ensure diverse communities have the opportunity to engage with and participate in health and care research.

Three further report are available: 1. R&I Annual report 2024-25, which explains the work of the wider R&I team; 2. Research Capability Funding Impact report 2022-2025; 3. Primary Care Research Capability Funding Impact report 2024-25.

Report

Background:

The benefits of research taking place in a primary care setting are well documented, evidence shows that research active practices have better patient outcomes, staff have enhanced job satisfaction and work in an environment with a culture of learning and continuous improvement.

Norfolk and Waveney General Practices have historically been, and continue to be, strong performers in delivery of National Institute for Health and Care Research (NIHR) portfolio research, being both nationally and regionally competitive and bringing repeat business back to the region from research teams who want to work with our practices again.

Over the three years ending March 2025, 18,646 participants were recruited to research in General Practice in Norfolk and Waveney, representing more than one third of the total recruits (56,564) across all 6 ICB regions in the East of England and exceeding that of any other ICB region in the East of England. In line with the Government ambition to be a global leader in clinical trials and medical research we have started to see a shift in the number of practices looking to develop and grow their commercial research portfolio. Whilst numbers remain small compared to non-commercial/ academic research activity, over the last three years commercial research has grown from just five participants taking part in one study in one practice in 2022-23 to 140 participants across seven studies in three sites in 2024-25. In addition, one of our practices is taking on their first ever commercial trial this year.

This report will detail how the support for primary care, aligned to the ICS R&I strategy principles, has enhanced and accelerated research for the benefit of our population and staff.

Principle 1, focused on our communities:

NHSE Research Engagement Network**:** Since 2023 NWICB has successfully bid for funding from NHSE England for the Research Engagement Network (REN) Program. The overall aim of the program is to work with the VCSE sector to increase the diversity of people taking part in research. This in turn means that the results are more relevant and impactful. We have been working with Community Action Norfolk (CAN) and the NIHR Regional Research Delivery Network (RRDN) and primary care to support community groups to become involved in health and care research. The most recent round of REN funding asked ICBs to focus on increasing recruitment of participants to research studies.

Our approach to this is to work with our existing network of community organisations to turn these connections into identifiable research hubs based in Lowestoft, Great Yarmouth, King's Lynn, Thetford and Norwich (table 1).

Research hub location	**Community groups**
Great Yarmouth	**Shrublands Youth and Adult Centre** providing educational, recreational, and social activities for people of all ages to improve wellbeing and community cohesion. **Feathers Futures** offering a safe, inclusive space and support services for women to build confidence, resilience, and friendships through social groups, mentoring, and practical help. **Procommunity CIC** working with residents, services, and businesses to strengthen communities in Great Yarmouth
Lowestoft	**Kirkley Peoples Forum** A resident-led initiative in Lowestoft supporting local action and community events to reduce health inequalities **Disability Advice North East Suffolk (DANES)** providing free, confidential advice and support to people with disabilities or long-term health conditions and their carers **Women Like Me** supporting women's mental health and wellbeing through gardening, walking groups, and peer support
Thetford	**The Polish School based in the Charles Burrell Centre** A school in Thetford teaching Polish language, culture, and history to children and adults
Norwich	**Vision Norfolk** charity for people with sight loss, providing practical and emotional support, equipment, and activities to help people live independently. **Opening Doors** A user-led organisation run by and for people with learning disabilities in Norfolk, offering advocacy, training, and support to empower individuals to lead independent lives.
Kings Lynn	**Purfleet Trust** supporting people experiencing homelessness with housing, health, and wellbeing services to help them rebuild their lives. **West Norfolk Deaf Association** support, advocacy, and social opportunities for deaf and hard-of-hearing people in West Norfolk, promoting inclusion and access to services.

Table 1. Community Groups involved in research hubs across Norfolk and Waveney

An important approach to hub development is that they be led by the community groups in each area; focusing on what they need to help them get up and running and support the recruitment into research studies.

Together the hubs will work to offer more opportunities for people to learn about and join research studies in their area. There are a number of different models emerging that reflect the community groups in each area. In most areas, a small number of core groups are coming together to form the hubs and work with the ICB, RRDN and local GP practices (see Principle 2) to identify appropriate studies and support required. Once identified, these core group members are then disseminating and highlighting relevant research studies within their local networks.

The hubs are being supported by the REN partners and we talk to each hub about what training they need to help them run the hubs well, and make sure everyone feels welcome to join in.

From an outcome perspective we track how many people take part in research or sign up for Be Part of Research. This will help us find out if this idea could work in other areas of the country and will form part of our report to our funder, NHSE.

Principle 2, coordinated and collaborative

Breckland Alliance Primary Care Commercial Research Delivery Centre (CRDC):
The R&I team provided expert advice and guidance to the team at Breckland Alliance during the initiation, development and submission of a £1 million application to the National Institute for Health and Care Research (NIHR) for a Primary Care (PC) CRDC. Aligned with the government's health and growth missions, PC-CRDCs will support the shift of research and care from hospitals into community settings. Following an extremely competitive process, the Breckland Alliance (BA) team were successful and are now part of a network of just 14 PC CRDCs across England. The CRDC will implement a coordinated and strategic program to expand the volume, range, and inclusivity of high-quality commercial research within primary care. The CRDC will enable our population to access cutting edge medicine and vaccines closer to home.

The centre will prioritise underserved populations, including rural, coastal, and socio-economically disadvantaged communities. Methods to enable flexible research delivery (eConsent, evening and weekend appointments, and home or housebound visits) will be employed to improve accessibility. The centre will also work with local pharmacies and community health services to deliver research in non-traditional settings and promote opportunistic recruitment. A Patient and Public Involvement lead (PPI) and steering group will ensure research activity reflects local needs and

community priorities. Co-design with patients, carers, and stakeholders will guide public facing materials and study delivery. We will invest in tools to overcome language and communication barriers to enhance participation in these underserved groups. The team at Breckland Alliance are already working with the REN Thetford Community Research Hub (table1), building relationships with VCSE organisations which will support recruitment of diverse populations into commercial research.

The CRDC will act as a catalyst, coordinating efforts across a broad regional footprint that includes urban, rural, and coastal communities in Norfolk and Suffolk. The ICB are a named partner organisation of the CRDC and will continue to work with Dr Gordon Irvine (CRDC Director) and Charlie Martin (CRDC Operations Manager) to ensure the success of the centre.

Principle 3, driven by a confident and capable workforce

Research Capability Funding (RCF): Each year NWICB receives RCF from DHSC as a result of holding NIHR research grants, in collaboration with our academic partners. During 2024-25 we used £100k of RCF to support 13 awards across Norfolk and Waveney, strengthening the system's capacity for high-quality, community-based research aligned with the shift of care, and therefore research, closer to home.

The RCF program helped embed research into everyday primary care, expanded commercial trial delivery, and developed a confident pipeline of future research leaders across Norfolk and Waveney. The key impacts were:

- Strengthened Research Capacity Across Primary Care: General Practices (GP) and Primary Care Networks (PCNs) embedded research roles, upskilled staff, and built sustainable infrastructure, transforming research from an ad hoc activity into a core component of routine care.
- Revitalised Commercial Research Engagement: Several sites re-entered commercial research after prolonged absences, initiated their first industry-led trials, and collectively submitted over 30 expressions of interest to deliver research, generating income and enhancing research visibility.
- Improved Patient Access and Community Reach**:** Practices increased research participation across rural and underserved populations through local events, targeted communications, and enrolment in national research initiatives.
- Development of Future Research Leaders: RCF investment enabled the time to train as Associate Principle Investigator (PIs), research-trained GPs, and Advanced Nurse Practitioners (ANPs), creating a confident pipeline of future leaders in both commercial and non-commercial research delivery.
- Cultural Shift Toward Research as Core Business: The program catalysed a shift in perception across primary care, establishing research as an integrated, valued function aligned with patient care, workforce development,

and ICS priorities with one practice sharing; *The whole GP surgery team have become enthusiastic about research… we have developed a wonderful, positive team spirit striving to enhance Research awareness and participation within our patient population*." – Ludham

Building on this approach we have awarded a further £80k for 2025-26, this time funding projects at a PCN level. This focus on scale has enabled experience practices to support research naïve practices within the same PCN and we are ensuring links to the REN program to increase recruitment of participants from a wide range of communities.

Principle 4, embedded in everything we do

Collectively the activity presented in this report, from the REN, to the CRDC to the use of RCF supports and enables a thriving primary care research culture. This is underpinned by the expert research governance advice the team provides. Unlike Trusts, individual primary care organisations do not have their own dedicated Research and Development (R&D) support. The team at the ICB provide this for PC and wider community settings, in conjunction with the research team at Cambridgeshire and Peterborough ICB, funded by the RRDN. This model is nationally recognised as an exemplar approach, and we have participated in DHSC round table discussions on the future national model for primary care R&D.

We have a research interested and keen Primary Care workforce, who have a strong track record for delivery of research resulting in Sponsors coming back to the region with their new studies. The R&I team, together with the RDN regional team, offer a collaborative and holistic approach to supporting Practices and championing research in Primary Care; together this gives us a strong foundation for delivery of research and we are well placed to respond to the national drivers, and ambitions to bring more research into community and primary care settings.

Norfolk and Waveney ICB also host 16 current NIHR research grants focused predominantly in out of hospital settings worth just under £19m – these include:

- Prof Debi Bhattacharya - iMAB-Qi – A 5-year £3m program of work to develop a package of support for healthcare practitioners to use the IMAB-Qi (Identification of Medication Adherence Barriers Questionnaire intervention) in General Practice and to test whether the IMAB-Qi is safe and effective in helping patients to take their medication as prescribed. Project duration: 2024–2029.
- Prof Chris Fox/Prof Jane Cross - SPLENDID – A £3m program of work to develop, implement and evaluate an effective model of social prescribing for people living with dementia. Project duration 2023-2028.

- Dr Sion Scott – A £200k Research for Patient Benefit award to co-design a toolkit for ICSs to support primary healthcare professionals to deprescribe unnecessary antidepressants. Project duration 2026-2027.

The future:

Subject to the ICB restructure consultation, the team aim to continue to provide expert advice and guidance, continue to increase research capability and ensure diverse communities have the opportunity to engage with and participate in health and care research. We anticipate that as research is designed and funded aligned to the three government shifts that there will be increased activity in primary care and wider care settings. We are ideally placed, within the ICB, to ensure research activity continues alongside changes in the health and care system, including a shift to neighbourhood models of care. We also have an opportunity to increase activity in pharmacy, optometry and dentistry, although activity in these settings is limited by the pipeline of research.

Recommendation to the Board:

The report is provided for information.

Key Risks	
Clinical and Quality:	R&D risks are mitigated through adherence to the DHSC Research Policy Framework for Health and Social Care and review / approval of research projects by Health Research Authority (HRA). Collaborative working between RRDN team, general practice and researchers reduces clinical risk. Patient access to potentially new treatments and therapies.
Finance and Performance:	Close performance monitoring ensures the flow of research monies to practices and the Research Office, ensures delivery against contracts and SLAs, and increases opportunities for patients and the public.
Impact Assessment (environmental and equalities):	Any adverse impact on equality and diversity is minimised by HRA and ethical review.
Reputation:	Achievement of targets and patient recruitment is essential for good research delivery and achievement of funding from RRDN East of England. Achievement of research grants hosted by the ICB enhances ICB reputation and generates additional income in the form of RCF. R&D assessment and review ensures appropriate approvals, facilitating timely set up of studies to minimise the risks to the patient, the study, the host organisation and the reputation of primary & community care research in Norfolk & Suffolk.
Legal:	Robust performance monitoring mitigates legal risks associated with research activity. Sponsors

	and permission givers (GP practices) take legal responsibility for research. HRA takes responsibility for the review it conducts, and indemnity arrangements for research is assessed as part of this review
Information Governance:	All research work is compliant with information governance rules associated with data handling and research. Robust processes are in place at all stages of research from review by HRA and Ethics to management and roll out of studies locally and dissemination and assessment of impacts. Evaluations are planned and carried out in consultation with ICB IG team.
Resource Required:	R&I Team is fund through a variety of sources including RRDN East of England, NHSE, DHSC held research grants and RCF and through SLA arrangements with Suffolk, Norfolk Community Health and Care and East Coast Healthcare CIC. Research monies are managed in line with NIHR and DHSC rules and financial governance frameworks
Reference document(s):	1. ICS Research and Innovation Strategy, May 2023 2. ICB Duty to facilitate or otherwise promote research, evidence use and innovation, Health and Care Act 2022 3. UK Research Strategy -Best Research for Best Health, May 2021 4. NHS Long Term Plan, January 2019 5. UK Policy Framework for Health and Social Care Research, 2017.
NHS Constitution:	NHS Commitment to the promotion, conduct and use of research.
Conflicts of Interest:	Any conflicts have been managed in line with Norfolk and Waveney ICB policy
Reference to relevant risk on the Board Assurance Framework	Currently there are no risks on the BAF. Research has risk register in line with corporate governance requirements and research governance standards

Governance

Process/Committee approval with date(s) (as appropriate)	

Norfolk and Waveney
Integrated Care Board

Research Capability Funding

Project awards impact summary

October 2025

1. Summary

To support researchers to develop high-quality National Institute for Health and Care Research (NIHR) funding applications, we offer Research Capability Funding (RCF) in the form of short-term project awards. Since 2022, NHS Norfolk and Waveney ICB (NWICB) has allocated £431,178.12 through 40 awards to support early-stage research development activity led by clinical and non-clinical academic researchers across the region

RCF-supported research projects have demonstrated a consistent pattern of impact, with funding used to strengthen trial readiness, expand research capacity, and build collaborative networks. Projects have engaged stakeholders at local, regional, and national levels, including service users, voluntary sector partners, ICB leads, and national policy teams, ensuring that research design is closely aligned with NHS priorities and commissioning needs. Patient and public involvement has been integral to shaping interventions, identifying barriers, and co-producing solutions, particularly for underrepresented populations.

The RCF programme has laid important foundations for a more research-active health system across Norfolk and Waveney. RCF has generally resulted in:

- Embedding patient and public involvement
- Progression to larger-scale studies and national funding
- Shaping future service design and commissioning
- Developing workforce skills and leadership
- Positioning Norfolk & Waveney as a research-active system

By enabling researchers to generate early insights, build collaborative momentum, and amplify patient voices, RCF has reinforced the pipeline of research aligned with local, regional and national priorities. These investments are yielding benefits that extend beyond individual projects, strengthening patient care, workforce development and system-wide research.

2. Background

The Research and Innovation Team at NHS Norfolk and Waveney Integrated Care Board (NWICB) works with many organisations including local hospitals, universities, councils, the voluntary sector and our communities, as part of the wider Integrated Care System (ICS), to improve health and social care in Norfolk and Waveney through high quality research activities. We are committed to driving and supporting the development of nationally relevant out-of-hospital research that addresses the health and care needs of people in our communities. To support researchers to develop high-quality National Institute for Health and Care Research (NIHR) funding applications, we offer Research Capability Funding (RCF) in the form of short-term project awards.

Since 2022, NWICB has allocated £431,178.12 to support early-stage research development activity led by clinical and non-clinical academic researchers across the region (see table 1). These awards aim to strengthen the local research ecosystem by enabling researchers to progress promising ideas toward future NIHR applications, build collaborative partnerships, and collate evidence that supports integrated care priorities.

Table 1: RCF funding awarded

Year	Total awarded	Number of Projects
2022-23	£134,096.00	13
2023-24	£161,937.72	15
2024-25	£135,144.40	12
Total	**£431,178.12**	**40**

The project awards spanned clinical and service innovation ideas, from improving post-bariatric surgery care and supporting couples living with Motor Neurone Disease (MND), to tackling health inequalities in annual health checks for people with learning disabilities and using big data to support people living with multiple long-term conditions. All recipients focused on early-phase development, including stakeholder engagement, evidence synthesis, patient and public involvement and engagement (PPIE) activity, and application scoping.

This summary report presents key outcomes and impacts from these projects awards over the last three years, highlighting how modest investments have laid strong foundations for future externally funded research, while already producing tangible ripple effects across services, communities, and policy engagement. The financial return on investment of these project awards is outlined in the box below.

Return on investment for RCF for 2022-25

Total RCF project awards: **£431,178**
NIHR application success from RCF projects: **£8,355,027**

Return on investment: **£19 for every £1 invested**

3. Impacts and case studies

The purpose of this review is to describe the impact and outcomes associated with our RCF spend over the previous three years. A list of project awards can be found in appendix 1.

We have reviewed all outputs produced as a condition of RCF funding by academic teams. We have grouped the impact and outputs together in themes. What follows is a summary of these themes. Alongside these broad themes, a set of exemplar case studies has been selected to illustrate the range, depth and trajectory of impact achieved. These exemplars were selected as they demonstrate system relevance, clear potential for patient and service benefit, and the trajectory from small-scale investment to major programmes and NIHR-level funding applications.

Together, the case studies reflect the full spectrum of the research and innovation pathway, from early risk prediction for gastrointestinal cancer (*Alexandre et al.*), through to integrating pharmacogenomics into community pharmacy (*Wright et al.*), enhancing structured medication reviews through behavioural approaches (*Bhattacharya et al.*), and the safe discontinuation of antidepressants in primary care (*Scott et al.).* Each of these case examples generated a competitive funding application to a relevant NIHR funding stream.

Case study 1: PROMISE CARE-I: Improving long-term care after bariatric surgery

What the researchers did

- Convened two stakeholder meetings with commissioners, clinicians, national obesity team, public health experts, and patients.
- Conducted literature reviews on integrated health hub models and post-bariatric surgery care.
- Built collaborations with academic leaders in obesity research and health economics.

Findings

- Strong support for a regional hub model, with interest from ICBs to act as pilot sites.
- Stakeholders emphasised health economics as primary outcome, to demonstrate cost savings and self-funding potential.
- Patients valued inclusion of remote options and quality of life outcomes.

Impact / Next Steps

- Building national collaborations to strengthen evidence base and ensure scalability.

3.1 Stakeholder engagement

All projects have shown a strong commitment to involving patients, carers, professionals, and community organisations early and throughout the research process. For example, *Blake et al.* engaged 20 stakeholders to guide trial design for a stroke project, *Notley et al.* worked with a diverse PPIE panel to improve trial processes, and *Parretti et al.* consulted national, regional, and local stakeholders to co-develop service

models. Projects often worked with ICBs, national clinical networks, voluntary sector organisations, and service user groups to broaden relevance and reach. The InflAIM project engaged a wide spectrum of stakeholders, patients, carers, clinicians, system partners, and national policy groups, to map the lived experience of people with multiple long-term conditions (MLTCs). Overall, this collaborative approach has ensured projects are grounded in real-world needs and have the buy-in required to enable a pathway to impact over the longer term.

PPIE input was central in determining intervention formats, timelines, and outcome measures (e.g., remote vs in-person hubs, primary outcomes for randomised controlled trials (RCT)). PPIE groups proposed practical solutions to known problems (e.g., improving saliva sample returns in the Quit Sense trial) and identifying tangible barriers and solutions. Efforts were made to reach groups underrepresented in research, such as smokers from minority backgrounds, people with learning disabilities, and post-bariatric patients in remote areas, ensuring inclusivity.

A consistent strength has been a focus on underrepresented populations, aligning with system and NIHR priorities to reduce inequalities. This ensures RCF reaches communities with the greatest unmet needs. Recommendations often centred on making interventions easier to access, whether through digital tools, remote hub models, or inclusive community-based delivery thereby promoting service accessibility. Several projects sought to bridge structural gaps by designing interventions that integrated care across primary, secondary, and community services.

Case study 2: Improving the experience and uptake of annual health checks (AHCs) for people with learning disability

What the researchers did

- Used RCF to develop a collaborative programme with people with learning disability (with/without autism), families, and carers.
- Conducted literature reviews on barriers/enablers to AHCs and on best practice in research co-production.
- Established partnerships with advocacy groups, VCSEs, and health and social care providers.

Findings

- Identified persistent barriers to AHC uptake, including lack of accessible information and inconsistent support.
- Ripple effects already seen: one participant booked an AHC directly after a co-production focus group.
- Created momentum across advocacy and provider networks for improving engagement.

Impact / Next Steps

- Expanding partnerships regionally to ensure diverse lived experience informs future work.
- Early impact shows feasibility of collaborative approaches to improve equity in preventive care.

A small number of funded projects have also worked closely alongside our Research Engagement Network (REN) funded through NHS England, to join up efforts to engage communities in both research development and research delivery.

Case study 3: Improving medicines adherence through IMAB-Qi

What the researchers did

- Co-designed strategies for testing an adherence intervention in the main grant application with patient (n=16) and pharmacist (n=9) workshops.
- Produced indicative content to guide Structured Medication Review delivery.

Findings

- Patients emphasised emotional and equity barriers; pharmacists wanted practical tools and resources.
- Both groups endorsed embedding strategies into SMRs with prompts and guidance to reduce mental load.

Impact / Next Steps

- Refinement of IMAB-Qi intervention combining IMAB-Q and tailored support strategies to enable further testing in the main grant application.
- Contributed to the development of a structured, evidence-based tool for pharmacists to improve adherence and patient safety.

3.2 Preparing NIHR applications

Alongside stakeholder engagement, RCF has also been important in strengthening research capacity and capability. RCF has been used to support research teams, improve readiness for future large-scale studies, and undertake essential early-phase preparatory work (e.g. refining research questions, designing protocols, mapping feasibility), and preparing NIHR funding applications.

Several projects (SNAP, Acceptance and Commitment Therapy (ACT), bariatric hub model) identified the need for feasibility trials before a full RCT to address unanswered delivery and implementation questions. Collaborators, including those in primary care and community partners, were exposed to research processes, improving future funding application writing and trial participation capacity. Projects such as “SNAP”, “InflAIM” and learning disability annual health checks built multi-partner teams and refined research methods, strengthening their readiness for future NIHR applications. Others, like “MND couples” and bariatric surgery follow-up, developed advisory groups and pilot frameworks that directly informed their NIHR applications.

RCF projects are not only collating evidence for their subsequent applications but also identifying how to put it into practice. This is particularly important to address in the *Pathways to Impact* section of NIHR funding applications. This includes developing cost-effectiveness arguments, improving trial engagement strategies,

and co-designing resources with particular communities. These outputs ensure that future NIHR applications are not only scientifically strong but also practically grounded in real-world delivery.

3.3 Supporting commissioning and integration

Projects have explored how new interventions can be embedded into existing care pathways, such as *MacGregor et al*. highlighting how fragmented pathways for MLTCs create inefficiencies and duplication. Some projects also tested models in community and voluntary settings e.g. *Blake et al.* aligned their design with NHS stroke services, *Parretti et al.* explored regional hub-and-spoke models for weight management services, and *Nightingale et al.* engaged with learning disabilities communities and ICB partners to improve uptake of existing health checks for people with learning disabilities.

MacGregor et al's project explored how information from across the health landscape might help to plan services more efficiently and fairly and better support people with multiple long-term conditions - a particular focus for health systems and the NIHR. This team invested heavily in patient and stakeholder engagement to obtain their views. Patients, in particular, expressed strong preferences for clearer communication, better joined-up IT systems, and a single point of contact. Patients also wanted care that addressed the whole person, not just each condition in isolation.

Case study 4: Supporting safe antidepressant discontinuation in primary care

What the researchers did

- Established a Research Advisory Group of people with lived experience and HCPs.
- Conducted workshops to scope research priorities and design appropriate methods.
- Undertook a scoping review of barriers, enablers, and existing interventions.

Findings

- Barriers: short consultations, limited follow-up, lack of proactive reviews.
- Enablers: additional professional support, referral pathways, and patient-centred tapering guidance.
- Interventions: education/training, prompted reviews, and Mindfulness-based Cognitive Therapy.

Impact / Next Steps

- Directly addresses NHS priorities around deprescribing and medicines safety.

Projects often conducted targeted evidence reviews to support trial design and justify future funding applications. However, a requirement of the award is the production of an evidence review that can be made publicly available and shared with commissioning colleagues within the ICB. This is one of the collateral benefits of hosting research within a commissioning organisation.

Case study 5: Clinical effectiveness of Acceptance and Commitment Therapy (ACT) after stroke

What the researchers did

- Engaged 20 stakeholders (stroke survivors, carers, health professionals) to shape research priorities and trial design.
- Conducted literature review to identify gaps and align evidence with stakeholder priorities.
- Created a thematic map highlighting nine key areas, including therapy flexibility, carer needs, optimal timing of psychological support, and implementation considerations (e.g. cost-effectiveness, integration).

Findings

- Strong stakeholder support for ACT, particularly for addressing adjustment challenges after stroke.
- Emphasis on the need for tailored, flexible therapy, earlier and ongoing emotional support, and better integration into NHS stroke pathways.
- Barriers identified: limited specialist workforce, requirement for robust cost-effectiveness data, and integration challenges.

Impact / Next Steps

- Building the case for NIHR funding with cost-effectiveness evaluation and integration into service models at the forefront.

The evidence generated by academics can be disseminated quickly to colleagues who may be working on service design and development. This supports the ICB statutory duties around research. The evidence reviews can be accessed freely through our Norfolk and Waveney Evidence Repository.

3.4 Mental health & behavioural interventions

A number of RCF-supported projects over the past three years have focused on improving mental health outcomes and enhancing behavioural support for a variety of health-related issues in primary and community care. These projects have addressed challenges ranging from post-stroke adjustment and antidepressant prescribing to smoking cessation and medication adherence. They share a strong emphasis on PPIE, ensuring that research priorities reflect lived experience and that new interventions are both feasible and acceptable in practice. Examples include informing the development of an intervention to support stroke survivors, optimising the Quit Sense smartphone app to prevent relapse during quit attempts, and work to enable primary care staff to safely support patients in discontinuing long-term antidepressants. Alongside these, innovative approaches such as integrating pharmacogenomic testing into community pharmacy are being explored to personalise antidepressant prescribing and reduce trial-and-error approaches.

Collectively, these projects demonstrate the role of RCF in seeding early-stage work that combines methodological innovation (digital tools, genetics, behaviour change frameworks) with direct system

relevance. Many have generated findings that will inform NIHR applications and service design, particularly around workforce training, equity of access, and commissioning models for integrated mental health support.

3.5 AI, machine learning and data-driven research

Several RCF-funded projects demonstrate how artificial intelligence (AI), machine learning (ML), and advanced data-driven methods are already shaping healthcare in Norfolk and Waveney. From predictive algorithms for gastrointestinal cancer and inflammatory bowel disease, to intelligent monitoring platforms for polymyalgia rheumatica (PMR), these projects show how modest investment can catalyse research development and innovation and position the region at the forefront of data-enabled healthcare.

Work led by *Alexandre et al.* established the feasibility of developing clinical risk prediction tools for gastrointestinal malignancy using Clinical Practice Research Datalink (CPRD) datasets. Analysing over one million patient records, the team identified key predictors of cancer risk in patients with iron deficiency. Their findings point toward a practical tool to help clinicians target endoscopy referrals more effectively, balancing the benefits of early detection with the risks and costs of invasive investigation.

Case study 6: Prediction of gastrointestinal malignancy in patients with iron deficiency

What the researchers did

- Used the Clinical Practice Research Datalink (CPRD) GOLD to identify >1 million adults with iron deficiency.
- Calculated cancer incidence in patients with and without anaemia.
- Extracted 20 candidate predictors to inform a future risk prediction tool.

Findings

- 354,903 patients with iron deficiency anaemia; 4,163 (1.2%) diagnosed with GI cancer within 5 years.
- 671,044 with iron deficiency without anaemia; 1,593 (0.2%) diagnosed with GI cancer.
- Demonstrated feasibility of building a robust risk prediction model.

Impact / Next Steps

- Proof of concept for a predictive model to support better patient selection for endoscopy.
- Offers potential to optimise NHS resources by reducing unnecessary invasive procedures.

Building on a similar approach, *Chan et al.* examined how faecal calprotectin testing in primary care could be used more effectively to predict inflammatory bowel disease (IBD). Using CPRD Aurum data, the team explored thresholds, repeat testing patterns, and demographic predictors, laying the groundwork for future NIHR funding applications. Importantly,

patient and clinician perspectives were embedded from the outset, ensuring that future predictive tools reflect lived experience and address inequities in access to care.

A significant benefit of RCF lies in enabling researchers to understand data availability and quality before developing a larger NIHR application. *Welch et al.* used their RCF to determine data availability and quality in relation to biochemistry results, lifestyle and socio-demographic factors before designing the EAMIT tool to identify malnutrition earlier using GP records.

Beyond algorithmic prediction and service reconfiguration, RCF has also supported methodological innovations that will underpin AI-enabled healthcare. The PMR relapse and remission project worked with patients and clinicians to define which concepts and outcomes matter most, feeding into the international OMERACT-PMR working group. By creating consensus-based criteria, this work ensures that future AI models and clinical trials are built on robust, meaningful, and comparable outcome measures.

Case study 7: Preparing systems for multiple long-term conditions management

What the researchers did

- Reviewed the existing research and mapped how patients with multiple long-term conditions moved through the system.
- Looked at what information is or isn't shared along the way.
- Workshops were held with people who live with long-term conditions, their carers, and health professionals.

Findings

- Care for people with multiple long-term conditions is often fragmented and frustrating; describing repeating their story to different professionals over and over again.
- Many people had to attend several appointments in different places. This was especially hard for those relying on public transport or care support.
- Clinicians shared these concerns and welcomed the idea of changes that would make the system easier to navigate.

Impact / Next Steps

- Explore how data might help to plan services more efficiently and fairly, without using real patient records.
- Positioned for further evaluation and wider application across other long-term conditions.

4. Summary of impact

The RCF programme has laid important foundations for a more research-active health system across Norfolk and Waveney. By enabling researchers to generate early insights, build collaborative momentum, and amplify patient voices, RCF has reinforced the pipeline of research aligned with local, regional and national priorities. These investments are yielding benefits that extend beyond individual projects, strengthening patient care, workforce development, and system-wide research.

Embedding patient and public involvement

RCF-funded projects have consistently demonstrated how meaningful PPIE strengthens research relevance, equity, and acceptability. Future work will deepen links with voluntary and community organisations (particularly with links to the REN programme), ensuring that underrepresented populations continue to shape research design and service models. This approach not only improves outcomes but also builds trust and engagement between communities and the health system.

Progression to larger-scale studies and national funding

The majority of funded projects positioned themselves to progress to full-scale NIHR applications and other competitive national calls. By de-risking early ideas, RCF has enabled research teams to collate the preliminary evidence, engage patients and communities, and build collaborative networks, all prerequisites for successful funding applications. It also helped them to explore potential pathways to impact at an early stage.

Shaping future service design and commissioning

The evidence produced is directly relevant to current system challenges, such as early cancer diagnosis, pathway redesign, workforce development, and integrated digital care. Predictive models for gastrointestinal cancer and inflammatory bowel disease, for example, can help optimise referral pathways and protect scarce diagnostic capacity. Together these outputs may provide the ICB and partner organisations with actionable insights to inform commissioning and service planning.

Developing workforce skills and leadership

Investment through RCF has enhanced capacity, from pharmacists trained in behaviour-change interventions to GPs and academics leading NIHR-ready projects. Building on this momentum, future projects will continue to develop early-career researchers and clinical leaders, embedding research readiness into routine care. This will help sustain a culture where research is seen as integral to delivering high-quality, equitable care.

Positioning Norfolk & Waveney as a research-active system

RCF has positioned the system as a credible test bed for new research

ideas, attracting interest from national bodies, academic partners, and commercial organisations. Continued investment will consolidate Norfolk and Waveney's role as a leader in research-enabled service transformation at a system level, ensuring local priorities shape national policy debates and that national opportunities translate into tangible local benefit.

We are grateful to everyone who contributed to this impact report.

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Appendix 1: List of all RCF project awards from April 2022 – March 2025

A link to the evidence briefing is provided in the table below by clicking on the title.

2022-2023

Project	Lead Applicant	Lead Institution
RCF Evidence Briefing: Supporting coastal communities to stop smoking	Caitlin Notley	University of East Anglia
RCF Evidence Briefing: Developing an intervention to identify and address patients' medication adherence barriers	Debi Bhattacharya	University of Leicester
RCF Evidence Briefing: Maternal and child outcomes from pregnancies after bariatric surgery: a CPRD feasibility study	Helen Parretti	University of East Anglia
RCF Evidence Briefing: Prediction of gastrointestinal malignancy in patients with iron deficiency	Leo Alexandre	University of East Anglia
RCF Evidence Briefing: Hearing Loss and Dementia Risk	Michael Hornberger	University of East Anglia
RCF Evidence Briefing: Can GP data be used to analyse the association between birth weight developing childhood asthma/the High-BMI Asthma phenotype?	Sadiyah Hand	University of East Anglia
RCF Evidence Briefing: Exploring barriers and enablers to uptake in Diabetes Prevention Programmes (DPPs) for UK ethnic minorities and people living in deprived areas	Thando Katangwe-Chigamba	University of East Anglia
RCF Evidence Briefing: Mental Health and Wellbeing within SMEs	Valerie Gladwell	University of Suffolk
RCF Evidence Briefing: Reflective Practice Groups for Social Workers working with Children and Young People	Bryony Porter	University of East Anglia
RCF Evidence Briefing: Developing the EAMIT (East Anglian Malnutrition Identification Tool) Tool for earlier identification of malnutrition in the community	Ailsa Welch	University of East Anglia
RCF Evidence Briefing: Managing high intensity use of primary care services	Stella Lartey	University of East Anglia

RCF Evidence Briefing: Interventions to support mental health conditions associated with long COVID	Chantal Ski	University of Suffolk
RCF Evidence Briefing: Integrating Pharmacogenomics (PGx) Testing into the Community Pharmacy Delivered New Medicines Service (NMS) for Depression	Erika Sims	University of East Anglia

2023-2024

Project	Lead Applicant	Lead Institution
RCF Evidence Briefing: IMPROVE-PMR - An Intelligent Monitoring Platform with Risk-stratification and clinical Oversight in a Virtual Environment to support integrated diagnosis and management of polymyalgia rheumatica (PMR)	Max Yates	University of East Anglia
RCF Evidence Briefing: Ask what matters to me.	Sarah Hanson	University of East Anglia
RCF Evidence Briefing: Quit Sense – a smoking cessation smartphone app that delivers real time 'context aware' behavioural support	Joanne Emery	University of East Anglia
RCF Evidence Briefing: The Support Needs Approach for Patients (SNAP)	Morag Farquhar	University of East Anglia
RCF Evidence Briefing: How are healthcare professionals supported to collaborate with specialised physical activity programmes to promote increased physical activity in patients and the wider community?	Valerie Gladwell	University of Suffolk
RCF Evidence Briefing: The clinical effectiveness of Acceptance and Commitment Therapy (ACT) after stroke	Josh Blake	University of East Anglia
RCF Evidence Briefing: Primary care healthcare professionals supporting patients to discontinue antidepressants	Siôn Scott	University of Leicester

RCF Evidence Briefing: Evaluation of a short-term autism support service and measuring its impact on autistic adults' wellbeing	Karen Dures / Tracey Walton	University of East Anglia
RCF Evidence Briefing: Improving young carer support: developing a study to adapt the Carer Support Needs Assessment Tool Intervention (CSNAT-I) for use with Young Carers	Morag Farquhar	University of East Anglia
RCF Evidence Briefing: Integrated care approaches for frailty prevention in Suffolk	Valerie Gladwell	University of Suffolk
RCF Evidence Briefing: Improving Care for patients with Smell and Taste Disorders (SATDs): Creating an Equality, Diversity, and Inclusion strategy	Carl Philpott	University of East Anglia
RCF Evidence Briefing: Investigating the experiences of families accessing a Personal Health Budget (PHB) for their children with complex medical needs	Kristy Sanderson / Lisa Franks	University of East Anglia
RCF Evidence Briefing: Exploring the use of Velcro Wraps for the management of venous leg ulcers in care homes	Philip Stather	University of East Anglia
RCF Evidence Briefing: Embedding an integrated system approach to the development and implementation of a Prehabilitation programme for cancer patients	Noreen Cushen-Brewster	University of Suffolk
RCF Evidence Briefing: Smoking cessation intervention for under-serviced groups in primary care	Caitlin Notley	University of East Anglia

2024-2025

Project	Lead Applicant	Lead Institution
RCF Plain English Summary: Nutrition intervention design to support well-being through the menopausal transition which is meaningful to a diversity of women	Anne-Marie Minihane	University of East Anglia
RCF Plain English Summary: Behaviour change interventions to promote bone health among individuals experiencing menopause.	Allie Welsh	University of East Anglia

RCF Plain English Summary: Patient and clinician perspectives on definitions and determinants of relapse and remission in polymyalgia rheumatica	Max Yates	University of East Anglia
RCF Plain English Summary: Stratification of people after stroke to streamline provision of mirror therapy to those most likely to benefit	Elizabeth Chandler	University of East Anglia
RCF Plain English Summary: What's in a Vape? Co-Developing an Educational Resource Package on Illicit Vaping in Schools	Caitlin Notley	University of East Anglia
RCF Plain English Summary: Helping older people in care homes talk about what they would like to happen if their health deteriorates	David Wright / Linda Birt	University of Leicester
RCF Plain English Summary: Improving the long-term care of patients who have had bariatric surgery	Helen Parretti	University of East Anglia
RCF Plain English Summary: Development of a vaping cessation intervention	Felix Naughton / Emma Ward	University of East Anglia
RCF Plain English Summary: Developing a targeted intervention to support the couple relationship following an MND diagnosis	Noreen Cushen-Brewster	University of Suffolk
RCF Plain English Summary: Predicting the risk of Inflammatory Bowel Diseases in patients	Simon Chan	University of East Anglia
RCF Plain English Summary: Improving the experience and take up of Annual Health Checks	Chris Nightingale	University of Suffolk
RCF Plain English Summary: Preparing Systems for Multiple Long-term Conditions Management	Alex MacGregor	University of East Anglia

Norfolk and Waveney
Integrated Care Board

Primary Care Research Capability Funding (RCF)

24-25 Impact Summary

1. Summary

The 2024-25 Primary Care Research Capability funding (RCF) programme supported 13 awards across Norfolk and Waveney, strengthening the region's capacity for high-quality, community-based research.

The RCF programme helped embed research into everyday primary care, expanded commercial trial delivery, and developed a confident pipeline of future research leaders across Norfolk and Waveney. The key impacts were:

- **Strengthened Research Capacity Across Primary Care**
  General Practices (GP) and Primary Care Networks (PCNs) embedded research roles, upskilled staff, and built sustainable infrastructure, transforming research from an ad hoc activity into a core component of routine care.
- **Revitalised Commercial Research Engagement**
  Several sites re-entered commercial research after prolonged absences, initiated their first industry-led trials, and collectively submitted over 30 expressions of interest to deliver research, generating income and enhancing research visibility.
- **Improved Patient Access and Community Reach**
  Practices increased research participation across rural and underserved populations through local events, targeted communications, and enrolment in national research initiatives.
- **Development of Future Research Leaders**
  RCF investment enabled the time to train as Associate Principle Investigator (PIs), research-trained GPs, and Advanced Nurse Practitioners (ANPs), creating a confident pipeline of future leaders in both commercial and non-commercial research delivery.
- **Cultural Shift Toward Research as Core Business**
  The programme catalysed a shift in perception across primary care, establishing research as an integrated, valued function aligned with patient care, workforce development, and ICS priorities.

2. Background

In 2024-25, NHS Norfolk and Waveney ICB allocated a total of £98,335.35 through 13 RCF primary care awards across the ICS (see appendix 1 for map of participating practices). These awards were established to build primary care research capacity and capability and increase engagement across general practices and primary care networks. The funding enabled practices and PCNs to develop research capability within their workforce, enhance access for patients to participate in research opportunities and start to embed research into everyday service delivery.

Supported activities aligned with strategic priorities of both the ICB and National Institute for Health and Care Research (NIHR). Core objectives of the RCF initiative

was to enable practices to become research-ready and support the development of early-career clinical researchers. This included improving engagement with local patient populations and communities, and expanding participation in both non-commercial and commercial research studies. Collectively, the primary care RCF awards have contributed to an increase in research leadership, patient involvement, and cross-sector collaboration within the region.

This summary report presents the most impactful outcomes arising from the 2024-25 primary care RCF programme, featuring reflections from participating practices and PCNs.

3. Research Engagement and Capacity Building

In many PCNs, RCF catalysed a renewed focus on collaborative, multi-practice research delivery. Practices reported a marked increase in the volume and variety of research activities undertaken, as well as a shared commitment to working across PCNs. Notably, many sites participated in commercial research for the first time, opening new funding and learning streams.

Through funded training and support, multiple practices increased the number of staff trained in Good Clinical Practice (GCP), positioning them to respond quickly to future research opportunities. Several teams noted that RCF enabled them to consider studies they would have previously declined due to limited staff or coordination capacity. This expansion of capability has resulted in greater resilience across the local research landscape.

> "*The whole GP surgery team have become enthusiastic about research… we have developed a wonderful, positive team spirit striving to enhance Research awareness and participation within our patient population*." – Ludham

> "*The funding has significantly enhanced our ability to engage in research activity without compromising patient care*." - Fleggburgh

4. Workforce Development and Leadership

RCF was useful in creating protected time for research leads, Associate PIs, and aspiring investigators to step into leadership roles. Practices used the funding to mentor staff, develop Associate PIs, and support administrative and clinical staff in gaining research awareness and technical readiness.

The funding particularly strengthened the pipeline of future PIs, enabling more equitable distribution of responsibility and greater continuity when key staff were on leave or transitioning between roles.

> "*It has allowed reception staff to confidently answer patient queries regarding the studies and research team, and has created a better relationship and*

awareness between the research team and surgery staff resulting in quicker query resolution and better patient care." – Breckland

"*Looking to the future, as an accredited Associate PI, I am now better qualified to support the current Principal Investigator at our practice. We hope that this will improve resilience and ensure continuity of research work delivery*…" – Beccles

5. Patient Access, Recruitment and Engagement

One of the most meaningful impacts of the RCF award was its ability to bring research closer to local patient communities. Practices reported hosting community events, enhancing in-practice visibility of research, and involving the wider team in research promotion.

Teams used RCF support to run research health events, create new study promotion materials, and embed feedback systems for patients interested in participating. Many sites signed up to national initiatives for the first time (e.g. Join Dementia Research, RCGP virology swabbing), contributing data to population health research and increasing community confidence in the NHS as a research-active organisation.

"We ran 3 ' Research, health and wellbeing' events in village halls in our most remotely located populations and also in a central town location. We had a footfall of around 200 persons in our remote locations and over 500 in the town location. We had huge charity, volunteer and PPG support. This demonstrated the high level of enthusiasm and interest in research within our surgeries and was incredibly rewarding." - Ludham

"During the last six months the practice has signed up to two research projects Dare to think with support from a research nurse and Indigo Trial with a third project pending (Virology)." – NN1

"*The funding has led to more patients across the PCN being given the opportunity to take part in clinical research*." - NN4

"Carried out first new research activity since become research ready - Join Dementia Research, sending out text to patient to join in with research." – Bridge Street

"We were able to work collaboratively with RRDN and the ICB Research Team to begin deprescribing work on Benzodiazepines and Z Drugs, we have begun a commercial research study for the first time, we have promoted 3 research studies, we are actively participating in 6 non commercial research studies. We have also joined RCGP virology swabbing and have thus far completed 94 swabs." – Ludham

6. Infrastructure, Tools, and Sustainability

Several practices used the RCF award to strengthen their internal processes and readiness for future research. This included creating collaborative CVs to support grant applications, dedicating time for study site qualification visits, and increasing visibility with sponsors and study teams. Practices reported improved internal communication, greater leadership buy-in, and the ability to more confidently plan for commercial and non-commercial studies.

In some areas, the funding acted as an enabler to revisit previously declined opportunities, or to deepen collaboration with neighbouring sites and PCNs—helping establish a more joined-up, sustainable research infrastructure.

> "*It is also allowing some of the practices to expand their research portfolio's. Eg in Bridge Road, I have been able to now accept a study that I thought we would need to refuse, but also the newly trained nurse is to work with my existing nurse so we are better placed to put in EOI for commercial studies*…" – Lowestoft

> "*The groundwork has been laid to take on more research studies, particularly those aligned with local population health needs and areas of deprivation*." – Castle

> *"Integrating research into our practice is a valuable endeavor that requires dedication, collaboration, and continuous learning. By building a strong research team and leveraging available resources, we can contribute significantly to medical research and improve patient care*." - Wensum Valley

> "*We are now better positioned to take on more studies, including those that focus on rural health and health inequalities—areas particularly relevant to our patient demographic*." - Fleggburgh

7. Commercial Research Engagement and Impact

The RCF funding has played an important role in strengthening commercial research readiness across primary care in Norfolk and Waveney. Through dedicated research time, team development, and increased collaboration with infrastructure partners, PCNs have built capacity to engage with commercial partners. This included training additional staff, and preparing the documentation required for sponsor engagement, such as expressions of interest (EOIs), and collective CVs - collated summaries of staff training, experience, and research roles - which help demonstrate a site's readiness to commercial sponsors.

> "*Norwich North PCN used RCF funding to establish a structured commercial research development plan, appoint dedicated research leadership roles, and coordinate efforts across multiple practices. This enabled the PCN to develop*

a collective CV, submit over 30 EOIs for commercial studies. They also gained acceptance onto the NIHR Commercial Principal Investigator (PI) Scheme and applied for the NIHR Commercial Research Infrastructure grant – positioning the PCN for future commercial research delivery." – *Norwich North PCN*

As a result, a number of practices either re-entered commercial research delivery after prolonged absences or initiated commercial research activity for the first time. Examples include Ludham and Stalham Green launching their first commercial trial alongside six non-commercial studies; Lowestoft practices expanding their research portfolios and planning EOIs for upcoming commercial trials; and Hoveton and Wroxham commencing setup for their first commercial study in five years in partnership with AstraZeneca.

"*We have begun a commercial research study for the first time… We are keen to continue to develop our commercial Research portfolio*." – *Ludham and Stalham Green*

This growing infrastructure and confidence have positioned PCNs to lead in competitive national schemes. Breckland PCN, for example, applied to the Primary Care Clinical Research Delivery Commercial (PC-CRDC) scheme, reflecting a mature and proactive approach to commercial trial delivery and strategic alignment with the NIHR's objectives for high-quality, community-based research.

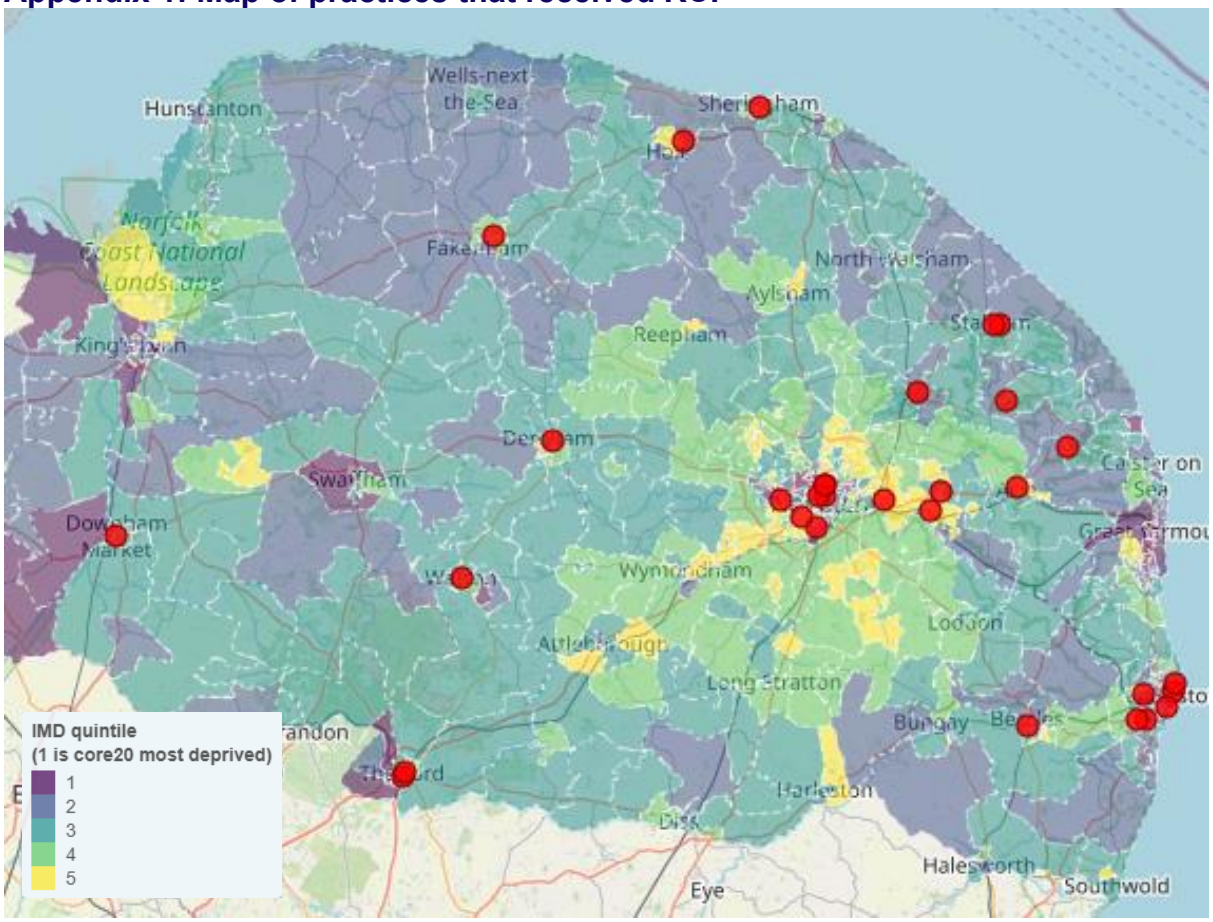
"*Allow our Lead research GP to attend GP forums in person and attend virtual meetings to discuss research with the RDN, including applications for the PA commercial scheme, the PC-CRDC call…*" – *Breckland PCN*

8. Next steps

We will use the feedback presented in this report to shape the design of our next Primary Care focused RCF awards during 2025/26. The map in Appendix 2 will also inform where we might target future RCF awards to maximise opportunities across all of Norfolk and Waveney. We will also disseminate this report to practices to highlight how RCF funding can be used to build research capacity and capability in primary care

We are grateful to everyone who contributed to this impact report.

Appendix 1: Map of practices that received RCF



Appendix 2: spotlight examples

Spotlight - Orchard Surgery

- **Strengthening the research team**
  The practice used RCF to protect time for their Nurse Practitioner to act as Sub-Investigator and supported Practice Nurses through essential research training
  Impact: addressed workforce limitations and established a cohesive, multi-disciplinary research team.

- **Focus on long-term condition management**
  This enabled them to participate in asthma trials, directly supporting priorities around managing chronic disease.
  Impact: "*Teamwork has been exceptional, with strong coordination among staff members, particularly in studies aimed at improving long-term conditions such as asthma. This collaborative approach has significantly strengthened our research capacity*."

- **Planning for sustainable research delivery**
  Looking ahead, the practice plans to recruit a part-time research nurse to support integrated research across primary care and community services.
  Vision: "By embedding research within everyday practice, we hope to promote a sustainable model of evidence-based care that benefits patients, providers, and the wider health system."

Reflections - Wensum Valley - Building Research Foundations

- **Impact on practice development**
  As a full-time GP partner, the Research Lead at Wensum Valley has actively worked to integrate research into routine clinical care, seeing it as vital for improving patient outcomes and contributing to the broader medical community.
  Impact: "Realised the importance of building a dedicated research team to effectively manage and execute research projects."

- **Next steps for capacity building**
  Early efforts focused on laying strong foundations: achieving GCP certification, completing the NIHR Principal Investigator Essentials course, and participating in the RELIEF asthma study. The team has also prioritised recruiting a dedicated research nurse to further develop internal capability.

- **Vision for long-term impact**
  Despite challenges in securing approvals, the practice remains committed to growing its research infrastructure and partnerships.
  Impact: "Integrating research into our practice is a valuable endeavor that requires dedication, collaboration, and continuous learning. By building a strong research team and leveraging available resources, we can contribute significantly to medical research and improve patient care."

- Looking ahead, the practice plans to recruit a part-time research nurse to support integrated research across primary care and community services.
  Vision: "By embedding research within everyday practice, we hope to promote a sustainable model of evidence-based care that benefits patients, providers, and the wider health system."

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

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:	**26 November 2025**

Purpose of paper:

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

Committee:	Primary Care Commissioning Committee
Committee Chair:	Ian Wake, Local Authority Member
Meetings since 24 September 2025	1 October 2025 – main topics covered included in this paper 19 November 2025 – *verbal update to Board meeting*
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.
BAF and any significant risks relevant	**BAF02 – Primary Care Resilience and Transformation Current mitigated score – 5x4=20.**

/ aligned to this Committee:	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, 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** • 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. **As agreed by Committee in July, all primary care risks are being reviewed through deep dive meetings with any revisions due to be presented to the Committee by**

	January. Officers were also asked to consider the gap between the tolerated and current mitigated risk scores.
Key items for assurance/noting:	Members received reports on the following areas: • **Continuous Professional Development (CPD) Funding for Primary Care – 2025/26** had been approved offline on 26 August by voting members and was therefore noted. £210,677 had been approved non-recurrently for 20 targeted, approved PCN CPD plans, ensuring workforce development was responsive to local identified needs and compliant with requirements. £10,534 was approved to support the system CPD top-slicing programme. • **The Director of Primary Care report** was noted. This provided an update on the wider work of the directorate as well as an update on the new national planning framework. Concern was expressed by members about the compressed timeline. • **A strategic digital report** was noted. Appreciation was expressed for the digital team's work, including seeing the GP practice infrastructure upgrade completed, procurement of a new IT provider which would see reliance on on-site servers removed, exploration of ambient voice technology and implementing automation of repeat prescription processes. • **New GP Contract requirements** were noted, along with the progress on implementation. The report focused on the key elements of online consultations, You and Your GP Patient Charter compliance and implementation of GP Connect. The commissioning team would continue to take a supportive approach to implementation. • **Delivery group reports** for the Dental Services, Dental Delivery and General Practice and Community Pharmacy Delivery Groups were noted. Committee received a progress update on year 2 of the Long-Term Dental Plan and key decisions were made, including agreement to issue breach notices for underperformance where appropriate. • **The Pharmaceutical Services Regulation Committee and General Ophthalmic Services Quarterly reports** were noted. • **A strategic finance report** for month 8 was noted. A slight overspend of £0.1 million against a £629.1 million

	budget, explained that GP prescribing was broadly on plan with a £14 million efficiency requirement being met. • **A strategic prescribing report** was noted and focused on anti-microbial stewardship. An update on efforts to target prescribing to children aged 0-9 was provided. Antibiotic use in children had improved over the last 12 months with a reduction from 40% to 31.4%, moving closer to the target of 27%.
Items for escalation to Board:	No other items for escalation outside of the risks reported to ICB Board.
Items requiring approval:	• The **Risk Register** was approved which included the latest updates to BAF and BORR. The gap between the current risk score of 20 and the target score of 12 in the Primary Care Resilience risk was discussed, therefore there was support for the proposed shift in emphasis on risk monitoring, but the importance of addressing the existing gap was stressed. • The **GP practice alignment for the ICB transition** was approved, with all existing Norfolk and Waveney GP practices aligned to the new Norfolk and Suffolk ICB.
Confirmation that the meeting was quorate:	There are four voting members and three are required to be quorate. The meeting was quorate with the following attendance: Ian Wake, ICB Board Local Authority Partner Member, Chair Hein van den Wildenberg, ICB Board non-executive member, Deputy Chair Karen Watts, deputising for Lisa Nobes, executive director of nursing, ICB James Grainger, deputising for Howard Martin, executive director of finance, ICB

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
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

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Norfolk & Waveney VCSE Partnering**
Presented by:	**Mark Burgis, Exec Primary Care and Neighbourhood Health Director Norfolk & Waveney**
Prepared by:	**Shelley Ames, Head of Health Inequalities & VCSE Partnering, NWICB** **Philippa Gregory, Senior Programme Manager Health Inequalities & VCSE Partnering, NWICB** **Rachel Jennings, Communities Lead, SNEE**
Submitted to:	**Norfolk & Waveney Integrated Care Board**
Date:	**26 November 2025**

Purpose of paper:

This paper, and the associated appendix, provides the ICB Board with an overview of the work to date to understand the current status of the VCSE sector, key challenges and opportunities and the 'asks' articulated in the Norfolk VCSE open letter. It also sets out the work being undertaken by the ICB in response, and how we intend to move forwards as a Norfolk & Suffolk ICB through key strategic actions to strengthen partnership working and deliver on system priorities.

Executive Summary:

The VCFSE sector is a critical strategic partner in delivering integrated health and care, tackling inequalities, and amplifying community voice. Recent baselining and sector engagement across Norfolk and Waveney have identified clear challenges and opportunities for system improvement. The Norfolk and Waveney VCSE Open Letter and associated reports, articulate sector 'asks' and recommendations, many of which align with national policy and the ICB's strategic commissioning framework.

This has informed a clear set of recommendations as we move forwards and as we become a Norfolk and Suffolk ICB.

Report

Both Norfolk and Waveney ICB and Suffolk and North East Essex ICB have a strong track record of working in partnership with the VCFSE sector, people and communities and wider partners in the health and care sector. There is a commitment that the new Norfolk and Suffolk ICB will continue to build upon and value the relationships with wider partners, recognising the importance of enabling genuine partnership working across the full breadth

of partners, and the need to acknowledge and actively address the risk of an imbalance of powers.

Appendix 1 of this report provides an overview of the baselining activity that has been undertaken across the Norfolk and Waveney system over the past 2 years, along with a summary of 'asks' and 'recommendations' resulting from this work. It seeks to identify the key challenges and opportunities and understand where work is already underway within the ICB and VCSE Assembly and how we might collaborate further, moving forwards.

The Model ICB Blueprint and the Strategic Commissioning Framework outlines the ambition that in the future ICBs will continue to work in partnership, work with a broad range of local stakeholders, use a clear understanding from people with lived experience, take a biological, psychological and social view of population health, be transparent in their decision making processes and continue to use their role as anchor institutions. This means that working in genuine partnership and ensuring a voice for everyone in the VCFSE and people and communities space is a requirement for every directorate in the new ICB.

Creating the conditions for this to be a reality will require a clear overarching strategic approach by the ICB supported by appropriate governance and local networks and a clear organisational policy co-produced with relevant partners, a space to build trust, surface conflict, and build relationships. The co-production of the policy will commence in the new year, ensuring that all partners are involved and that it builds upon the knowledge, experiences and work already undertaken with partners so far.

Recommendation to the Board:

With the role of the sector so clearly articulated in key strategic documents, and the ask from the sector clear through the various reports and open letter summarised in *Appendix 1* of this document, we are recommending 3 key actions:

- *Continued support of the VCSE Assembly models, building on the learning from the last 4 years and ensuring the sector are supported and empowered to work with us on the identified actions.*
- *Development of a progressive ICB organisational policy for partnership working to enable stronger partnering with the VCSE sector and continued investment into community engagement*
- *Embed the commitment to partnership working with the VCSE sector into the Population Health Commissioning Strategy and commissioning intentions*

The Board is asked to endorse the recommendations above.

Key Risks	
Clinical and Quality:	Unfair and avoidable differences in access to care, quality and experience of care within our Core20plus communities and those with protected characteristics. This will impact on outcomes for individuals and contribute to system pressures.
Finance and Performance:	N/A

Impact Assessment (environmental and equalities):	N/A
Reputation:	If the ICB does not seek to maximise its role as a partner to the VCSE sector, there is a risk to the trust and relationships the ICB holds with the VCSE sector, as well as outcomes for communities in receipt of services delivered by the sector.
Legal:	The NHS has legal duties that relate to health inequalities as outlined in the NHSE Statement on Information on Health Inequalities. These include to: - Arrange services to meet reasonable needs - Have regard to reducing inequalities in access and outcomes. - To improvement in quality of services. - To promote integration. - To consider effects of wider decisions on inequalities. - Include consideration for inequalities in annual plans, joint forward plans, performance assessments and annual reports.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	Appendix 1- Norfolk and Waveney State of the Sector Summary Activity and Summary of Asks 2025 https://openletter.earth/open-letter-to-stakeholders-and-statutory-partners-in-norfolk-a-shared-commitment-to-partnership-with-the-vcse-sector-ef7ec24a
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
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)	

Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk & Waveney State of the Sector Activity and Summary of 'Asks' 2025

Setting the Scene

State of the Sector - System Baselining

Over the past two years, the Norfolk and Waveney System has carried out a series of baselining activities to understand the current state of the Norfolk and Waveney VCSE sector. The aims of these pieces of work include:

- setting out the key challenges and demand organisations are facing
- support needs
- opportunities to implement change

This work has been carried out by a range of key system stakeholders both within the VCSE sector and statutory partners. The range of baselining activities include:

→ **Empowering Communities *State of the Sector 2024 & 2025***
→ **North Norfolk and West Norfolk Place Boards *State of the Sector 2025***
→ **Norfolk Community Foundation *State of Norfolk Reports***

This work is set against a backdrop of large scale system change, including Devolution, Local Government Reorganisations, and NHS Reforms. These changes will undoubtedly have a significant impact on the make up and future of the system. However, this does pose an opportunity for us to do differently as a system, especially in light of Neighbourhood Health and Strategic Commissioning ambitions.

The recent VCSE open letter, published on 6th August and signed by over 130 sector leaders, represents a unified call from Norfolk's voluntary, community and social enterprise (VCSE) sector for more equitable, transparent, and collaborative relationships with statutory partners.

This documents seeks to bring together all of the system work to date to summarise the key challenges and opportunities in response to the VCSE Open Letter. It also looks to identify where work is already underway and how we might collaborate further moving forwards.

Work to Date: Baselining

Below is a summary of the work to date across the system to baseline activity *(please note, for full details please see the original reports - references can be found at the end of this document)*:

Empowering Communities Partnership (ECP) *State of the Sector 2024 & 2025*

Starting in Summer 2024, the Empowering Communities Partnership went out to the VCSE sector to survey organisations to establish their key priorities and challenges, as well as gaining feedback on Empowering Communities and their 'offer' of support. There was a total of 100 responses from 92 organisations, representing 2,740 staff and 9,770 volunteers of all sizes and footprints. 6 months later, the exercise was repeated and 20 of the organisations who contributed to the original survey contributed to the 2025 survey.

Norfolk Community Foundation (NCF) *State of Norfolk*

NCF have established a quarterly *State of Norfolk* bulletin which seeks to set out key insights into Norfolk's VCSE sector. These insights are based on data collected through funding applications to NCF's funding pots - both the Winter 2024 and Spring 2025 bulletins have been referenced in this document.

North Norfolk/West Norfolk Place Boards and Community Action Norfolk *State of the Sector Survey*

This piece of work seeks to build on the wider ECP *State of the Sector* survey and focus in on North Norfolk and West Norfolk to gain a much more thorough understanding of who is operating at a Place level, as well as the challenges and experiences of those organisations. A survey was launched, accompanied by a series of workshops across North and West Norfolk and 1:1 discussions with VCSE sector colleagues, delivered by Community Action Norfolk.

These range of sources provide us with a comprehensive picture of the challenges and opportunities within the VCSE sector today.

Key Challenges

The table below is a high level summary of the core challenges identified in the three key pieces of work, and have been categorised for ease (NB: this is a high level summary and details can be found in the original reports - see appendix 3):

Key Challenges - at a Glance	
Increased Demand for Services	**Recruitment/Retention of Volunteers**
ECP Surveys • 47% of 100 respondents identified this as a concern (2024) **NCF State of Norfolk** • The growing trend of in-work individuals reaching out for support. • Community charities are catching those falling through the cracks. **North/West State of the Sector** • A 61% increase in the number of people being supported and 45% increase in the complexity of support provided. For 29% of respondents, this is not manageable. • It also noted a 67% increase in demand for services/activities with 29% saying this is not manageable.	**ECP Surveys** • 34% of 100 respondents identified this as a concern (2024) **NCF State of Norfolk** • 39% were not confident that they will be able to recruit the additional staff or volunteers they need over the next 12 months. However, 41% were somewhat confident and 25% very confident they will have the skills they need within their team either through recruitment or training. • 49% were somewhat confident, yet 16% not very confident, they will be able to retain existing staff and volunteers.
Funding	**Financial Security**
ECP Surveys • 59%, securing funding or commissioning is a main challenge (2024). **NCF State of Norfolk** • Many funders are pausing grant-making due to demand, leaving gaps in opportunities. **North/West State of the Sector** • An increase or maintenance in expenditure for 61%.	**ECP Surveys** • A third of respondents identified economic instability as a key concern (2024). • 71% reported their financial position had worsened over the past 6 months (2025). **NCF State of Norfolk** • Key challenges include rising costs e.g. utilises and wages.
Skills Development	**Internal Capacity**
NCF State of Norfolk • Charities are in need of specialist skills to strengthen their work. **North/West State of the Sector** • Looking ahead at the next 12 months, 41% of respondents were not confident they will be able to explore new technology.	**ECP Surveys** • A third of respondents identified internal capacity this as a concern (2024). • 50% of organisations reported paid roles being at risk (2025 - up from 33% in 2024). **North/West State of the Sector** • 25% were not very confident, and 35% were somewhat confident that they will have the capacity/resources to develop new services/projects over the next 12 months.

'Asks' and Recommendations

The insights collated from across the system set out some clear challenges for the VCSE sector and our communities. In response to this, a series of 'asks' or 'recommendations' have been made. This includes the recent open letter from Empowering Communities to system stakeholders and VCSE Partners. Since the publishing of said reports and receipt of the open letter, work has been undertaken to consolidate information and begin to map existing system activity.

Systems ‘Asks’ and Reccomendations

VCSE Open Letter

The VCSE Open Letter sets out a series of 12 ‘asks’ based on the outputs of the system baselining referenced above:

Value our contributions: Measure and publicly report the unpaid time VCSEs give to partnerships and systems development work and the outcomes these lead to.

VCSEs must have a seat at the table: Provide consistent and transparent VCSE representation in decision-making spaces, with equitable opportunities for involvement.

Invest in our infrastructure: Fund VCSE infrastructure to strengthen collective capacity and support measurement of the sector’s economic and social value in Norfolk.

Track VCSE spending: Report quarterly on all funding and spending with VCSEs to increase transparency, strengthen relationships, and highlight opportunities.

Unlock in-kind support: Share unused space, training, and resources to reduce overheads, foster collaboration, and support sector development.

Fair procurement: Simplify processes, offer smaller contract lots, support consortia bids, and invest in VCSE capacity to ensure equitable access.

Create one central platform: Develop a shared digital space to promote consultation and co-production opportunities across Norfolk, making it easier for communities and organisations to engage meaningfully.

Enable VCSE-led engagement: Resource VCSE organisations to design and lead participation activities, ensuring they are inclusive, accessible, and shaped by those closest to communities.

Clear, prompt payments: Publish grant and contract payment terms at the application stage and report regularly on performance against these. Timely payments are vital to VCSE sustainability, especially as reserves shrink.

Open decision-making: Share decision-making timelines upfront, communicate delays promptly, and provide regular updates. Transparency builds trust and enables continuity of service delivery.

Set clear expectations and provide feedback: Ensure reporting requirements are proportionate and clearly outlined from the outset so VCSEs can plan and resource them effectively. Provide feedback on submitted reports to close the loop, recognise our work, and support continuous improvement.

A Shared Commitment to the Covenant: We ask all partners to adopt and embed the principles of the Civil Society Covenant into our shared work. This is not just a framework, it is a call to act with fairness, equity, and shared responsibility for the communities we serve.

North/West Norfolk State of the Sector

Community Action Norfolk's report similarly sets out some clear 'asks' and recommendations for consideration:

Communication

- Resources tailored to the VCSE sector and communities explaining in 'simple English' the purpose, boundaries and priorities of health structures relevant to West and North Norfolk. Along with mechanisms for tailored updates to the VCSE sector on new approaches, priorities, opportunities etc and how VCSEs can express their interest in engaging with these.
- Publication of case studies by the ICB to increase awareness, understanding and recognition of the support and services offered by VCSE's, and the direct and indirect impacts of these on individuals, communities, and wider determinants.

Community Resilience

- Greater rural proofing of services, projects and initiatives, acknowledging a 'one size fits all' approach rarely suits rural areas with unique characteristics.
- Facilitation of VCSE support for young people to build confidence and resilience around practical life and employability skills, including mentoring and intergenerational activities. For all ages 'stepping stone' provision that develops people's confidence and ability to access services and support.
- Asset Based Community Development (ABCD) approaches that enable communities to develop better social cohesion and ownership of local health inequalities initiatives. To include ABCD training for statutory and VCSE staff on how this differs from the current deficit delivery model and how to adapt targets to align more effectively with community needs.

Cross-Sector Collaboration

- Greater support of existing and valued local networks as mechanisms for networking, awareness raising, and engagement with the VCSE sector.
- Facilitation of targeted, meaningful and local cross-sector conversations building on themes identified in this report, such as transport and youth, focused on solutions and action. With VCSE organisations resourced to lead, plan and facilitate consultation events ensuring engagement is shaped by those closest to communities and designed with inclusion at its heart.
- Co-ordinated approach to developing local relationships between community assets, faith groups and businesses in rural communities that increases local awareness of the VCSE sector and its ability to meet with clients within their local community.
- 'Service User Transport Fund' easily accessible by the VCSE sector in a short timeframe for transport costs associated with enabling service users to access services or support.

VCSE Capacity Building

- Practical in-kind support and resources shared by statutory partners upskilling VCSE sector colleagues around data, digital, communications, and accessibility.
- 'VCSE Funding Officer' roles which address the capacity of the VCSE sector to explore and apply for funding opportunities.
- Funding of CANs 'Trustee Recruitment and Succession Project' which would develop a toolkit of templates and resources that would support the resilience of community assets.

Cross Cutting Themes

In addition to some more place-based suggested activity in North Norfolk and West Norfolk, there are a number of cross cutting themes including:

- *Enabling in-kind support between statutory and VCSE partners*
- *Involvement of the VCSE sector in decision making*
- *Fair and transparent funding opportunities which are open and accessible to consortia bids*
- *Clarity in our communications*
- *Recognising contributions of VCSE sector and impact on our communities*

What work is already happening within the ICB?

In response to the VCSE Open Letter and State of the Sector recommendations, the ICB has been mapping the existing programmes of work. There is an opportunity to build on this existing work and collaborate with the VCSE sector and beyond to meet our shared goals. Below is a summary of the activity:

VCSE Assembly

The ICB has invested into a VCSE Assembly since 2022 and this Assembly has acted as a vehicle to guide strategic discussions about how the sector and the ICB and wider ICS work together. Much learning has arisen from this approach, with a focus on building trust, relationships and the culture that underpins strong collaborative working.

More recently the Assembly, in alignment with the Suffolk approach, has launched a series of engagement mechanisms to enable a wider interaction with the VCSE sector in Norfolk and Waveney. This has included regular communications, workshops and Assembly events that enable a platform for dialogue and discussion with the wider sector.

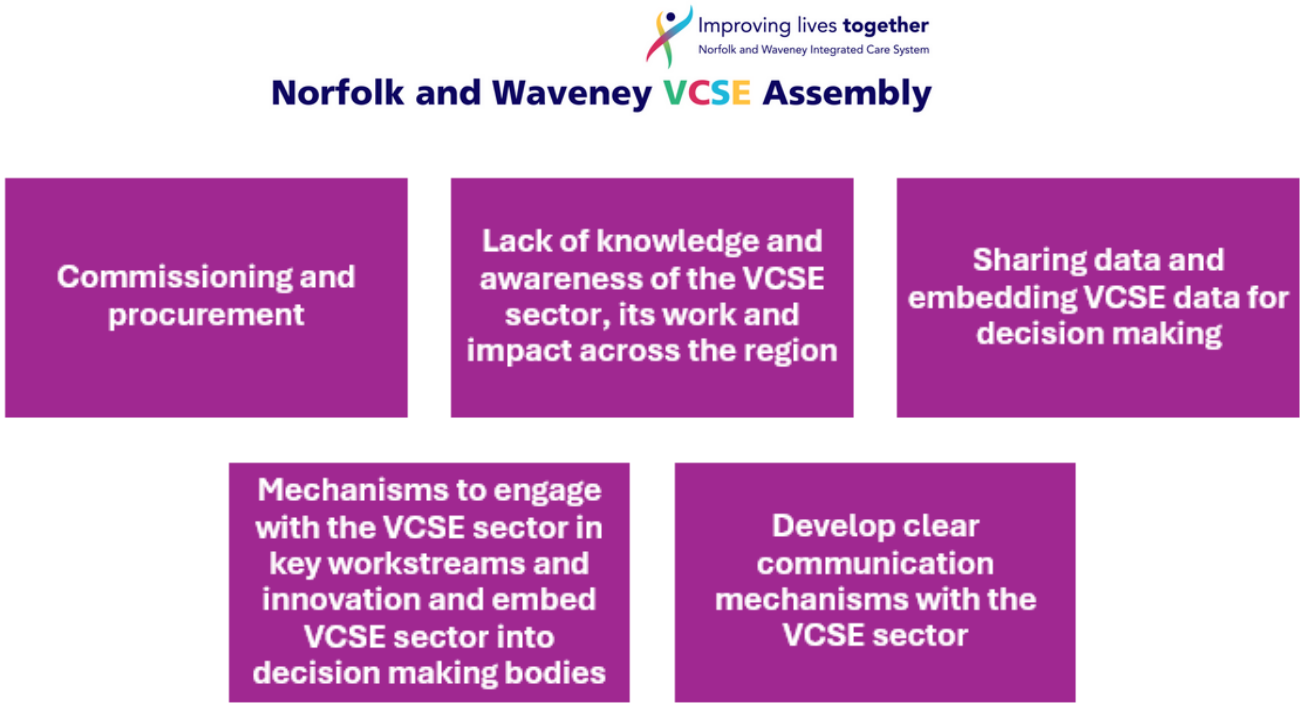
The ICB has appointed a remunerated Chair position, Tim Gardiner, who works alongside the Health Inequalities & VCSE team to drive the action required to grow and develop the Assembly in alignment with national VCSE partnering guidance.

A modest grant, administrated by Voluntary Norfolk, allows for remuneration of colleagues to attend ICB meetings and support the implementation of key actions identified by the group.

The approach is led by a Strategic Steering Group which includes a diverse range of VCSE leaders and is attended by commissioners and strategic leads to enable discussions and an advisory function.

VCSE Assembly Action Plan

The VCSE Assembly has developed a clear Action Plan (appendix 1) which aims to address sets out to tackle some key challenges facing the VCSE sector, many of which has been identified through the baselining to date and the VCSE Open Letter. These key priority areas include:



Each priority area sets out some clear challenges and actions; see *appendix 1* for the full action plan.

Norfolk and Waveney ICB VCSE & Volunteering Strategy Group

The VCSE & Volunteering Strategy Group was established within the Norfolk and Waveney Integrated Care Board to enable ICB teams to come together to share learnings, explore ways of working and ultimately improve how we partner with the VCSE sector.

Some areas of focus include:

- *In alignment with the VCSE Assembly, integrate the VCSE sector as equal partners in health (and care) planning.*
- *Shape commissioning principles .*
- *Improve collaboration and communication across system partners, ensuring shared priorities and fair procurement.*
- *Explore volunteering opportunities as part of health system development and community engagement.*

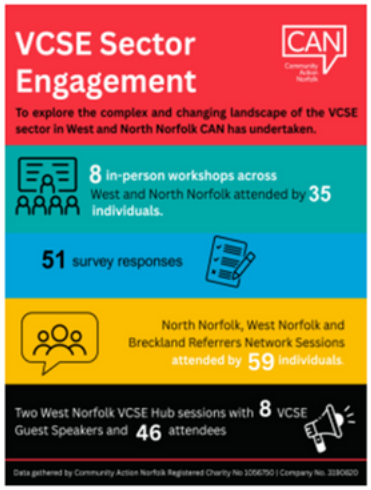
The group has representation from across the ICB, including: *Health Inequalities & VCSE Team, Place Teams, Commissioning Teams, Workforce*. The group is also attended by the Chair of the VCSE Assembly and representatives from Norfolk County Councils internal VCSE group coordinating similar activities, in order to ensure alignment where appropriate. Reciprocal attendance is in place with Norfolk County Council 'Partnering with the Sector' meetings.

Areas of discussion to date include:

North and West Norfolk State of the Sector

As referenced in the document so far, Community Action Norfolk has delivered a piece of work commissioned by the North Norfolk and West Norfolk Place boards to gain a more detailed understanding of the needs of the sector at a Place level.

The outputs of the work are informing the direction of travel for the ICB VCSE & Volunteering Strategy Group, along with Place based activity. See a summary of the report in Appendix 2.



Community Voices Programme

The Community Voices programme is an initiative led by NHS Norfolk and Waveney ICB in partnership with local councils and the Voluntary, Community and Social Enterprise (VCSE) sector. Its purpose is to amplify the voices of underrepresented communities and use those insights to shape health and care services

The programme engages the VCSE sector through trusted communicators, co-design processes, network meetings and capacity-building initiatives, ensuring community insights drive system change and health equity. The programme has worked with a vast number of organisations, many of whom belong to the VCSE sector:

The Community Voices model has provided the opportunity to partner closely with a wide range of VCSE organisations, which has allowed us to collectively maximise skill sets and expertise, as well as their role within communities. The programme has allowed us to strengthen our partnering practices with the sector, supported by shared learning and collaborative design of projects.

Next Steps

The Norfolk and Waveney system is experiencing significant change, underpinned by new national policy and guidance.

The role of the VCSFE sector is clearly articulated in the recently published Strategic Commissioning Framework, which explicitly recognises the VCSE Sector as a key strategic partner in health and care systems.

The Strategic Commissioning Framework emphasises collaboration across NHS, local authorities and VCFSE organisations to improve population health and tackle health inequalities. The Framework is clear that VCSFE organisations are not just service providers, they are seen as co-designers of strategies and pathways, bringing community insight and lived experience into commissioning decisions.

The Neighbourhood Health Guidelines (2025/26) set out a vision for integrated, community-centred care and the VCSFE sector is positioned as a critical partner in making this happen. The guidance emphasises integrated working as the norm and highlights the role of VCSE organisations in this.

Furthermore, VCSFE organisations are recognised for their trusted relationships with communities, enabling personalised care and tackling wider determinants of health such as housing, employment and social support. Neighbourhood guidance clearly calls for co-design of services with communities, where VCSE organisations act as intermediaries to amplify citizen voice and ensure services reflect local need.

With the role of the sector so clearly articulated in key strategic documents, and the ask from the sector clear through the various reports and open letter summarised in this document, we are recommending 3 key actions:

1. *Continued support of the VCSE Assembly model, building on the learning from the last 4 years and ensuring the sector are supported and empowered to work with us on the identified actions.*
2. *Development of a progressive ICB organisational policy for partnership working to enable stronger partnering with the VCSE sector and continued investment into community engagement*
3. *Embed the commitment to partnership working with the VCSE sector into the Population Health Commissioning Strategy and commissioning intentions*

Appendix 1: VCSE Assembly Action Plan

What is the issue?	Why is this important?	What will we aim to do to tackle this?
Commissioning & Procurement	Funding and commissioning has been highlighted as a key issue facing VCSE organisations across the region. Key issues include: • Short term grant funding rather than long term funding creates instability and uncertainty within the sector. This makes long-term planning, investment in capacity, and staff retention extremely difficult for the sector. • Procurement legislation can hold back commissioners the ability to innovate and be more "risk taking" • Tendering processes are frequently complex, lengthy, and resource-intensive. This is sometimes disproportionate to the scale of funding available. This disadvantages smaller, local VCSE organisations who lack capacity to apply for the tender. • Short timeframes for commissioning and bids, which creates a disadvantage for VCSE organisations to participate effectively, and favours larger and sometimes national organisations over more local VCSE organisations • Payment timelines and contract awards can lead to lack or late payment, despite an organisation continuing or starting delivery. For those with ongoing renewable contracts, VCSE have previously been	• Co-produce a commissioning framework with ICB and ICS colleagues to embed social value, social impact within commissioning principles that will help highlight the wider impact of commissioning VCSE organisations within the region. • Develop clear guidance and best practice to highlight the best way of commissioning to support the VCSE sector within the system. • Work with commissioners and procurement colleagues to look at how we manage innovation and procurement legislation. • Create a mechanism for highlighting ongoing best practice and an accountability forum to support commissioners to deliver best practice and resolve issues, barriers and highlight provider concerns
	made aware of outcomes at a late stage, which can make staff retention and quality delivery difficult.	
Lack of knowledge and awareness of the VCSE sector, its work and impact across the region	The VCSE sector is a diverse and vital sector that delivers essential services to support communities. The amount of individual organisations and a wide range of thematic workstreams often makes it challenging for ICS colleagues to fully grasp the breadth of its work and the impact it has within our communities. This can lead to outcomes such as the duplication of work, missed opportunities for effective partnerships, and a lack of understanding of the specific groups of people they aim to support. Without the support and integral involvement of the VCSE sector, the ICS will find it difficult to operate in an integrated way, achieve meaningful co-production, and successfully deliver on strategic objectives like the NHS Long Term Plan.	• Create a report to highlight the importance and work of the VCSE sector within the region. This will include data, case studies, impact reports linking to key priorities and highlighting return on investment. • Guidance on how to work with the sector and key principles for ICS staff, Chairs, Senior Leadership and NEDs • Develop training and awareness sessions that can be delivered to senior leaders and commissioners. • Provide regular engagement sessions for the ICS with the VCSE sector, to facilitate conversation on key themes, workstreams and issues.
Sharing Data and Embedding VCSE Data for decision making	There is a wealth of data from across the system, however often within decision making, the data held by VCSE organisations is not considered, which means that insights and invaluable quantitative and qualitative data is missed. The ability to embed and compare VCSE data alongside data from other ICS partners, will help provide a richer picture of issues and trends, as well as helping to identify potential solutions.	• Provide VCSE colleagues access to data dashboard developed by the ICB to support in VCSE decision making. • Embed VCSE data into key data sets and align this with key workstreams, to provide better picture of the needs of community. • Support guidance on how VCSE data can

	The VCSE sector would gain great insight from being able to access the wealth of data held by ICS colleagues, which could be used to help identify gaps in provision, help with service design, as well as utilise in funding bids for external funders. Currently access to data is limited and requires data sharing agreements or specific systems to access.	support decision making away from clinical based data, and push towards prevention agenda. • Allow VCSE data to be utilised in decision making.
Mechanism to engage with the VCSE sector on key workstreams and innovation and embed VCSE sector into decision making bodies.	The VCSE sector can provide a wealth of knowledge and expertise to help co-produce delivery and innovation to meet the health and care needs of the population of Norfolk and Waveney. Currently there is a lack of a specific mechanism which allows colleagues from across the ICS, and this results in engagement being different across thematic schemes, often based on historic relationships between the ICS and VCSE sector. It is vital that we can integrate the voice of the VCSE sector into workstreams, to help provide greater services for our population. This can also help better integration across the system in regards to utilising community assets and reducing duplication of services.	• Develop a space for VCSE to highlight opportunities and share ideas. • Highlight key VCSE forums and networks for ICS colleagues to be aware of • Commissioners attend key thematic VCSE forums, to understand the work of the sector and use it as a way of engagement. • Embed VCSE reps in key decision making working groups - meaningful representation, rather than sign-off boards and committees. • Map relevant key decision making bodies, to highlight where VCSE expertise could be utilised; this includes New Hospitals workstream, Norfolk Group Acute Model, NHS 10 year Plan delivery, Integrated Neighbourhood Teams and Place based work.
Develop clear communication mechanisms with the VCSE sector	It is vital that the VCSE Assembly is open and transparent, being clear about its work and its aims to support the sector. The engagement of the wider sector with the VCSE assembly should be simple, easy and allow for a two way feedback loop. The VCSE Assembly should also help to be transparent about its action plan and progress, as well as work alongside ICS colleagues.	• Have a newsletter each month to highlight updates • Regular updates of web page to make sure information is correct • Have a webpage showing steering group members, which meetings they attend and forums they are associated with. • Have meeting notes on webpage and included in newsletter • Action plan on webpage • Dedicated page to engagement events, with clear details on how to engage with these events • Have a mechanism annually to gauge the voice of the wider VCSE sector which will support the direction of travel for the VCSE assembly

Appendix 2: North/West Norfolk State of the Sector Summary

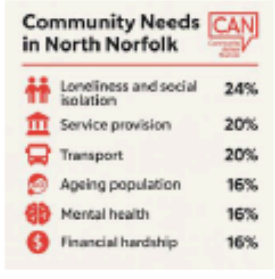
The VCSE Sector Landscape in West and North Norfolk

CAN was commissioned by the Norfolk and Waveney Integrated Care Board (ICB) to explore the experiences and capacity of the Voluntary, Community and Social Enterprise (VCSE) sector in West and North Norfolk.

Our engagement has shown that the VCSE sector operating in West and North Norfolk is facing unprecedented challenges and uncertainity highlighted by the closure of West Norfolk Carers in March 2025 after more than 30 years of delivering services and support. The pressures on the VCSE sector are varied, complex and interconnected, with common factors being significant and sustained increases in demand, client complexity, expenditure, and uncertainity. This is impacting the VCSE sector's capacity and capability to deliver services and support, and is inhibiting its resillience and ability to engage with an ever evolving statutory landscape. Within the VCSE sector there is a lack of clarity regarding decision making structures and access to these, particularly within the Integrated Care System (ICS), adding to the challenges of collaborative working with the sector feeling undervalued as a partner in tackling health inequalities.

Deeply intertwined social, economic, and geographic challenges can be seen when looking at the needs of communities in West and North Norfolk, in an environment where existing support structures are increasingly under strain. Whether loneliness and social isolation, transport, mental health, or young people our engagement with the VCSE sector shows that understanding local nuances and complexities, and how these interplay with broader societal trends such as the transition to digital, is vital.

Against a backdrop of substantial change including Devolution, Local Government Reorganisation, ICB Budget Cuts, Marmot Place Programme in West Norfolk, and other strategic developments, the next few years will be a critical time for ensuring that the VCSE sector is a valued partner in addressing the underlying causes of inequality and wider determinants of health. The VCSE sector has highlighted that to effectively support shared outcomes there needs to be transparent, honest and open communication that enables trusted local relationships to be developed and maintained, in an environment based on inclusiveness, empowerment and fairness.



*78% of survey responses from registered charities and 14% from unregistered community groups.

Our survey responses echoed all of the themes outlined above, as well as these additional themes.

- Rurality impacts VCSE workforce recruitment, retention, expenditure and reach affecting the viability of delivery.
- The VCSE sector's diversity and expertise needs to be valued, recognised and understood with resources shared and collaboration supported.
- The VCSE sector champions prevention with growing concern that young people are increasingly experiencing interconnected complex needs in relation to isolation, loneliness, mental health and wellbeing.

Our survey showed that over the last 12 months there has been;

- A 61% increase in the number of people supported and 45% increase in the complexity of the support provided, with 63% and 49% respectively expecting these trends to continue over the next 12 months. For 29% this is not manageable with current resources and capacity.
- For 67% increased demand for services/activities, with the number of services/activities delivered increasing for 49%. 67% expect increased demand for their services/activities to continue over the next 12 months, with 29% saying this is not manageable with current resources and capacity (24% not sure).
- For 61% expenditure has increased yet income has stayed the same or decreased from donations for 47%, from trading for 20%, from grants for 45% and from contracts or service level agreements with public bodies for 38%. 53% of respondents expect expenditure to continue to increase over the next 12 months, with 25% saying this is not manageable with current resources and capacity (22% not sure).
- For 25% the health and wellbeing of staff and/or volunteers has decreased and for 49% this has stayed the same.
- Referrals received from statutory organisations/services has increased for 35% and from other VCSE organisations/services increased for 27% (31% said stayed the same).
- Referrals or signposting made to other organisations/services has increased for 37%.
- Understanding amongst others of the services or support respondents offer has increased for 37% and stayed the same for 33%.

Looking ahead over the next 12 months;

- 41% were not confident they will be able to explore new technology, such as Artificial Intelligence (AI), within their organisation.
- 45% were somewhat confident, however 22% not very confident, they will be able to secure the required funding for them to continue delivering their services or activities.
- 25% were not very confident, with 35% somewhat confident, they will have the capacity or resources to develop new services/projects.
- 39% were not confident they will be able to recruit the additional staff or volunteers they need. However, 41% were somewhat confident and 25% very confident they will have the skills they need within their team either through recruitment or training.
- 49% were somewhat confident, yet 16% not very confident, they will be able to retain existing staff and volunteers.

The top three VCSE support needs were;

1. Support with funding e.g. making applications or identifying income streams.
2. Facilitation support to develop projects or services with partners.
3. Training for staff and/or volunteers.

Further insights can be found in our full report, avaliable here, and on our PowerBi Dashboard.

Recommendations

Communication

- Resources tailored to the VCSE sector and communities explaining in 'simple English' the purpose, boundaries and priorities of health structures relevant to West and North Norfolk. Along with mechanisms for tailored updates to the VCSE sector on new approaches, priorities, opportunities etc and how VCSEs can express their interest in engaging with these.
- Publication of case studies by the ICB to increase awareness, understanding and recognition of the support and services offered by VCSE's, and the direct and indirect impacts of these on individuals, communities, and wider determinants.

VCSE Capacity Building

- Practical in-kind support and resources shared by statutory partners upskilling VCSE sector colleagues around data, digital, communications, and accessibility.
- 'VCSE Funding Officer' roles which address the capacity of the VCSE sector to explore and apply for funding opportunities.
- Funding of CANs 'Trustee Recruitment and Succession Project' which would develop a toolkit of templates and resources that would support the resillience of community assets.

Cross-Sector Collaboration

- Greater support of existing and valued local networks as mechanisms for networking, awareness raising, and engagement with the VCSE sector.
- Facilitation of targeted, meaningful and local cross-sector conversations building on themes identified in this report, such as transport and youth, focused on solutions and action. With VCSE organisations resourced to lead, plan and facilitate consultation events ensuring engagement is shaped by those closest to communities and designed with inclusion at its heart.
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- Greater rural proofing of services, projects and initiatives, acknowledging a 'one size fits all' approach rarely suits rural areas with unique characteristics.
- Facilitation of VCSE support for young people to build confidence and resilience around practical life and employability skills, including mentoring and intergenerational activities. For all ages 'stepping stone' provison that develops people's confidence and ability to access services and support.
- Asset Based Community Development (ABCD) approaches that enable communities to develop better social cohesion and ownership of local health inequalities initiatives. To include ABCD training for statutory and VCSE staff on how this differs from the current deficit delivery model and how to adapt targets to align more effectively with community needs.

Appendix 3: Report References

Empowering Communities State of the Sector Reports

- **2024:** https://www.ecnorfolk.org.uk/strategic-voice-and-advocacy/state-of-the-sector-reports/
- **2025**: https://www.ecnorfolk.org.uk/strategic-voice-and-advocacy/state-of-the-sector-reports/

Norfolk Community Foundation State of Norfolk

- **Winter 2024**: https://www.norfolkfoundation.com/what-we-ve-been-up-to/state-of-norfolk-winter-2024/
- **Spring 2025:** https://www.norfolkfoundation.com/what-we-ve-been-up-to/state-of-norfolk-spring-2025/

North Norfolk/West Norfolk State of the Sector Reports (Community Action Norfolk)

See Appendix 2 for summary document.

VCSE Open Letter

https://openletter.earth/open-letter-to-stakeholders-and-statutory-partners-in-norfolk-a-shared-commitment-to-partnership-with-the-vcse-sector-ef7ec24a

Improving lives together
Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

November 2025

(Month 6 2025-26)

ICB Board Meeting 26 November 2025

Contents

1. Executive Highlights

- The following report is based on the financial plan submitted to NHSE on 30 April 2025, which included a breakeven position.
- This report represents the **M06** September **2025** year-to-date position of the ICB as part of the 2025/26 Financial Year.
- The ICB has reported a breakeven **year-to-date position**,
- The ICB has reported a breakeven **Forecast out-turn position**, but includes offsetting variances and other forecast assumptions, the major items being:
    - When closing the Month 6 position, there was a requirement to forecast achievement of sustainable commissioning efficiencies of £8.8m (This is an improvement from M05, which was £11m). These efficiencies are work in progress schemes, which are being considered in the efficiency delivery programme for the remainder of 2025/26. The associated risks has been captured in the ICB's risk reporting.
    - £6m of cost pressures as a result of exponential growth in Neurodevelopmental Disorder (NDD) assessments. This is being driven by the patient right to choose process. A spotlight report on this was presented at the last Finance Committee.
    - £1.3m of cost pressures due to increased demand for the Tier 3 Weight management services. Again, this is largely driven by the patient right to choose process.
    - £0.5m costs for the estimated cost of redundancies for the VSM section of the ICB reorganisation process.

- The **2025/26 Financial Plan included £34.7m of Net Unmitigated Risks** relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding and corporate pay costs for the Re-Organisation.
- As at M06, the £34.7m net planning risks were reassessed to £6.5m (£12.2m at M05), which are excluded from the forecast. **Total net risks, including new risks and mitigations in addition to planning risks, total £13.1m**. This is a reduction of £6.1m from M05, which is primarily due to the identification of new mitigations and stable prescribing figures.
- The **underlying full year forecast deficit has improved to £88.5m (M05 was £91.7m)**, the primary reasons are the full year effect of the new Designate Executive Team and reduced dispensing costs.

2.1 Executive Summary

Reporting regime:
The ICB submitted a 2025-26 break-even Financial Plan in April 2025.

The planning net risks were calculated at £34.7m.

The significant areas of risk relates to the delivery of the Financial Efficiencies, CHC demand, GP Prescribing, and Patient Demand for NDD assessments. The gross risk and net risks also include the cost of the reorganisation.

Financial Risks and Mitigations:
Further to the £34.7m Net Risks identified at Planning stage, the ICB also reviews full year Risks and Mitigations monthly undertaking a Probability Assessment of likelihood of occurring. These Net Risks are excluded from the Forecast position due to their uncertainty.

At M06, total Net Risks of £13.1m were assessed; £6.5m relate to the original planning risks, and an additional £6.6m of new net risks. These are shown in detail on 7.2 Financial Risk Report.

Appendix D, Strategic Risks Financial Performance shows these risks in addition to those recognised in the financial position.

Strategic Key Financial risks:
Nine key financial risks remain open of which 6 are considered Extreme with a score of over 15. The risk profile is shown in the following table.
Details are shown by risk in section 6 Strategic Financial Risk Register, and separate Appendix E of this report.

Net Financial Planning Risks and Mitigation	Risk Register Ref	Net Risk/Mitigation £k
Achievement of Plan: Achieve the 2025-26 financial plan (BAF 11/11a)	FINCOM01	4,581
Efficiency: Efficiency, transformation development/delivery	FINCOM08	31,695
Demand and Capacity: ERF: RTT backlog and Acute demand management	FINCOM11	2,500
Achievement of Plan: Impact of new prescribing guidance	FINCOM20	3,000
Achievement of Plan: Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	FINCOM22	-7,095
		34,681

	2025-26 Financial Plan Risks	M6 2025-26			M6 2025-26		
		Gross Risk	Gross Mitigation	Gross Total	Likely Risk	Likely Mitigation	Likely Total
	£k	£k	£k	£k	£k	£k	£k
Financial Plan	34,681	38,470	-22,000	16,470	24,081	-17,600	6,481
New Items	0	27,428	-11,711	15,717	13,540	-6,882	6,658
Reported	34,681	65,898	-33,711	**32,187**	37,621	-24,482	**13,139**
Prior Month		*71,829*	*-37,961*	*33,868*	*45,753*	*-26,463*	*19,290*

	Extreme (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)
Total this month	6	3	0	0
Total last month	6	3	0	0
Overall trend ↑ ↓ ↔	↔	↔	↔	↔

2.2 Executive Summary – Reporting (year to date)

Directorate (£m)	Year To Date Reported Position (Month 6 YTD)			Split	Operational Efficiencies (Month 6 YTD)			Sustainable Efficiencies (Month 6 YTD)			Operational Variance (Month 6 YTD)	
	Plan	Actual	Variance		Plan	Actual	Variance	Plan	Assumed	Variance	£	Notes
Acute	£710.6	£714.6	£4.0		-£5.2	-£5.2	£0.0	-£4.1	-£0.8	£3.3	£0.8	Operational variance due to activity pressures within tier 3 weight management service. **Note** - this position requires delivery of ISP IAPs in line with efficiency programme.
Delegated Specialised (Acute & MH)	£128.3	£128.3	£0.0		£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	On Plan
Community and BCF	£131.7	£133.4	£1.7		£0.0	£0.0	£0.0	-£6.2	-£2.9	£3.3	-£1.6	Underspends on discharge beds, palliative care and neuro packages
Continuing Healthcare	£85.9	£86.0	£0.1		-£5.8	-£5.2	£0.7	£0.0	-£0.5	-£0.5	-£0.1	Patient levels and referrals have remained relatively stable up to M06. Current efficiency plans, whilst challenging, are on target to deliver.
Mental Health	£154.2	£154.8	£0.6		£0.0	£0.0	£0.0	-£1.3	-£0.4	£0.9	-£0.3	Operational variance due to run rate activity pressures within Patient Choice NDD assessments (across adults and children's). Offset by favourable variance across CYP and IPP packages.
Prescribing	£113.4	£114.9	£1.5		-£5.6	-£5.9	-£0.4	£0.0	£0.0	£0.0	£1.9	YTD costs pressures for NDD and weight management drugs prescribed outside of FP10s.
Primary Care	£197.3	£196.3	-£1.0		£0.0	£0.0	£0.0	-£1.3	-£2.0	-£0.7	-£0.3	A minor year to date timing difference due to Pharmacy First allocation.
Other - Combined areas	£13.0	£11.8	-£1.1		-£0.9	-£1.6	-£0.6	£0.0	£0.0	£0.0	-£0.5	Minor net underspend due to OOH/111 dental costs moving to the dental allocation.
Planning	£3.0	-£2.5	-£5.6		-£1.5	-£1.5	£0.0	-£0.2	-£6.9	-£6.8	£1.2	Adverse variance due to slippage in dental clawback (£1.25m)
Running Costs	£8.2	£8.0	-£0.1		-£0.5	-£0.6	-£0.1	£0.0	£0.0	£0.0	£0.0	Small favourable variance due to vacancies and funding received from NHSE
Total	**£1,545.7**	**£1,545.7**	**£0.0**		**-£19.6**	**-£20.0**	**-£0.5**	**-£13.0**	**-£13.5**	**-£0.6**	**£1.0**	**Subtotal**
Efficiencies to be delivered to achieve forecast breakeven	£0.0	£0.0	£0.0		£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Ledger position	**£1,545.7**	**£1,545.7**	**£0.0**		**-£19.6**	**-£20.0**	**-£0.5**	**-£13.0**	**-£13.5**	**-£0.6**	**£1.0**	**Summary of Variances that are not linked to Efficiencies**

This is the breakeven position reported on the ledger and to committees and NHSE. **It's important for readers to understand the following aspects though** ---------->

Split By

This is the reported operational efficiencies delivered at Month 6.

This is the Sustainable efficiencies reported at Month 6. There is £0.6m that has not been delivered. This value has been offset by Non-Recurrent mitigations

Variances that are not linked to efficiencies "Operational Variances". This includes variances such price, activity and unplanned prior year impact.

2.2 Executive Summary – Reporting (Year End Forecast)

Directorate (£m)	Forecast Position (Month 6)			Split	Operational Efficiencies (Month 6)			Sustainable Efficiencies (Month 6)			Forecast Operational Variance (Month 6)	
	Plan	Actual	Variance		Plan	Actual	Variance	Plan	Assumed	Variance	£	Notes
Acute	£1,403.1	£1,412.0	£8.8		-£12.4	-£12.4	£0.0	-£9.4	-£1.7	£7.7	£1.2	Operational variance due to activity pressures within tier 3 weight management service. **Note** - this position requires delivery of ISP IAPs in line with efficiency programme.
Delegated Specialised (Acute & MH)	£250.6	£250.6	£0.0		£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	On Plan
Community and BCF	£260.7	£267.4	£6.7		£0.0	£0.0	£0.0	-£14.3	-£5.8	£8.6	-£1.8	Underspends on discharge beds, palliative care and neuro packages
Continuing Healthcare	£167.7	£163.6	-£4.1		-£15.8	-£16.5	-£0.7	£0.0	-£3.0	-£3.0	-£0.4	Patient levels and referrals have remained relatively stable up to M06. Current efficiency plans, including new stretch commitment, are on target to deliver.
Mental Health	£308.8	£312.2	£3.3		£0.0	£0.0	£0.0	-£3.0	-£1.8	£1.2	£2.1	Operational variance due to run rate activity pressures within Patient Choice NDD assessments (across adults and childrens) of £6m. Partial offset by favourable variance across CYP and IPP packages and service commencement delays
Prescribing	£228.7	£228.7	-£0.1		-£14.0	-£14.0	£0.0	£0.0	-£0.2	-£0.2	£0.2	4 months of data for 2025/26 received and are below plan. Forecast includes a level of growth for weight loss drugs due from July-25.
Primary Care	£400.7	£399.3	-£1.5		£0.0	£0.0	£0.0	-£3.0	-£2.0	£1.0	-£2.4	Reduction in dispensing fees due (£1.6m) and other small variances in Pharmacy and slippage in community dental growth
Other - Combined areas	£24.5	£22.1	-£2.4		-£1.9	-£3.3	-£1.5	£0.0	£0.0	£0.0	-£0.9	Underspend due to OOH/111 dental costs moving to the dental allocation.
Planning	-£8.3	-£10.3	-£2.0		-£4.2	-£4.2	£0.0	-£7.4	-£10.6	-£3.2	£1.2	Adverse variance due to slippage in dental clawback (£2.5m) and planning assumptions (£1.0m) less Prior Year benefit -£2.6m.
Running Costs	£16.6	£16.6	£0.0		-£1.0	-£1.3	-£0.3	£0.0	£0.0	£0.0	£0.3	Operational overspend due to VSM redundancy provision of £0.4m
Total	**£3,053.2**	**£3,062.0**	**£8.8**		**-£49.3**	**-£51.8**	**-£2.5**	**-£37.0**	**-£25.1**	**£11.9**	**-£0.7**	**Subtotal**
Efficiencies to be delivered to achieve forecast breakeven	£0.0	-£8.8	-£8.8		£0.0	£0.0	£0.0	£0.0	-£8.8	-£8.8	£0.0	This includes a value of £8.8m or Efficiencies that are work in Progress.
Ledger position	**£3,053.2**	**£3,053.2**	**£0.0**		**-£49.3**	**-£51.8**	**-£2.5**	**-£37.0**	**-£33.8**	**£3.2**	**-£0.7**	**Summary of Variances that are not linked to Efficiencies**

This is the breakeven position reported on the ledger and to committees and NHSE. **It's important for readers to understand the following aspects though** ---------->

Split By

This is the reported Operational efficiencies forecast to be delivered by Month 12.

This is the reported sustainable efficiencies reported at Month 6 FOT. This includes a value of £8.8m that is for Work In Progress efficiencies

Variances that are not linked to efficiencies "Operational Variances". This includes variances such price, activity and unplanned prior year impact.

3. Pay Reporting

	M06		
	WTE as at M06	Ytd £	Fot £
Gross Pay Cost Budget	702	25,247,775	50,447,657
Efficiency Pay Targets: Vacancy Factor RC		-505,000	-1,010,000
Efficiency Pay Targets: Vacancy Factor Programme		-894,362	-1,790,000
Net Pay Cost Budget		**23,848,413**	**47,647,657**
Actual/Forecast Pay Costs	630	22,315,852	44,942,111
Variance (Favourable)/Adverse	**-72**	**-1,532,561**	**-2,705,547**
	-10%	-6.4%	-5.7%
Analysis of Pay Variances			
Organisational Change Variances			
Cost of Disesablished Roles still in ICB Employment	1	25,537	39,636
Cost of Roles on Pay Protection	5	16,523	35,714
ICB Cluster shared roles	-1	-110,953	-424,479
Benefit of Efficiency: Organisational Change Redeployment Management *	-1	-150,858	-150,858
2025 ICB National reduction VSM redundancies	-5	0	439,500
Net Cost/(Benefit) of Organisational Change Programme	**-1**	**-219,751**	**-60,488**
Operational Variances			
Efficiencies - Vacancy Factor - Programme		-646,048	-1,454,410
Efficiencies - Vacancy Factor - RC		-141,734	-324,372
Ringfenced monies (not taken to VF)		-147,949	-285,113
Cost of Unbudgeted Agency Roles where vacant		78,401	329,339
Clinical Stewards		-181,420	-340,431
Cost of Other Pay Variations (WTE less than budget, Spine points, career breaks, secondments & salary recharges, etc)	-	274,061	-570,072
Net Cost/(Benefit) of Operational Pay Costs		-1,312,811	-2,645,059
Total Net Cost/(Benefit) Pay Variance		**-1,532,561**	**-2,705,547**
		0	0

* Headcount of roles where redundancy payments are no longer due.

ICB Pay Costs: Full Year Forecast.

The ICB has a full year net budget of £47.6m for pay which is after the application of £2.8m of associated efficiency targets. Pay budgets are the gross cost of employment excluding income from external sources such as grants (R&D) for example).

On a WTE basis, the budget consistent with the approved structure, includes 702wte which is for both substantive roles (668wte), and non-substantive roles (29wte) e.g. fixed term roles. In addition to this there are 5wte relating to shared roles with Norfolk County Council.

At month 6 (September) the ICB is forecasting to spend £44.9m on pay which will result in an underspend of £(2.7m). Total of Organisational Change Programme costs of £(0.1)m, and an underspend from our Operational staffing costs of £(2.6)m.

Of the 630wte contracted (in post), 618wte are directly employed by the ICB and 12wte are paid for under either secondments or agency arrangements.

The forecast assumes that vacancy factor savings are achieved based on a rising average of 64wte vacancies throughout the year. At M06 the 72wte variance includes 64wte vacancies and staff appointed to a role at a lower net wte than budget or recharged out. This position needs to be maintained in order to deliver the savings.

ICB Pay Costs: M06 Year-to-date

On a year-to-date basis, the ICB has underspent by £(1.5)m from sum of £(0.2m) of Organisational Change variances and £(1.3m) Operational variances. Variances are driven from vacancies, redundancies and minor changes to plan arising from different persons in roles against budgeted likely costs.

4.1 Efficiency and transformation

2025/26 PLAN

- Efficiency requirement of **£86.3m,** representing 8.0% of the ICB's influenceable spend (i.e. excluding the five N&W block contracts);
- Planned Operational schemes totalling **£44.4m (51%)** were identified in the April plan. Of the identified schemes **£9.1m** related to non-recurrent items;
- The April plan included **£4.9m** of schemes still to be worked up;
- Planned Sustainable Commissiong opportunities of **£37.0m** were included in the April plan;

ACTUAL PERFORMANCE

- Year to date savings for Month 6 is an over achievement at **£33.6m**; FOT is **£85.7m (99%),** this includes **£13.5m** of Sustainable Commissioning/Influenceable Spend Review efficiencies YTD and **£8.7m** in FOT that are still at scoping stage and need to be delivered to breakeven;
- Both YTD and FOT reporting figures contain estimated values as actual data is not yet available, **£24.9m** has been validated and banked;

NON-RECURRENT EFFICIENCIES

- **£44.0m (51%)** of FOT schemes are non-recurrent, these will help to breakeven in 2025/26 but will not help to reduce the underlying deficit;
- Non-recurrent efficiencies included in the plan totalled **£9.1m** so a further **£34.9m** is now non-recurrent, the Sustainable Commissioning efficiencies were assumed to be recurrent however the fully worked up schemes from the FEF Events are predominantly non-recurrent;

IMPACT ON UNDERLYING POSITION

- At month 6 the position assumes that **£41.6m** of efficiencies delivered will be recurrent, if this amount is not achieved then it will have a negative impact on the underlying position;

RISK

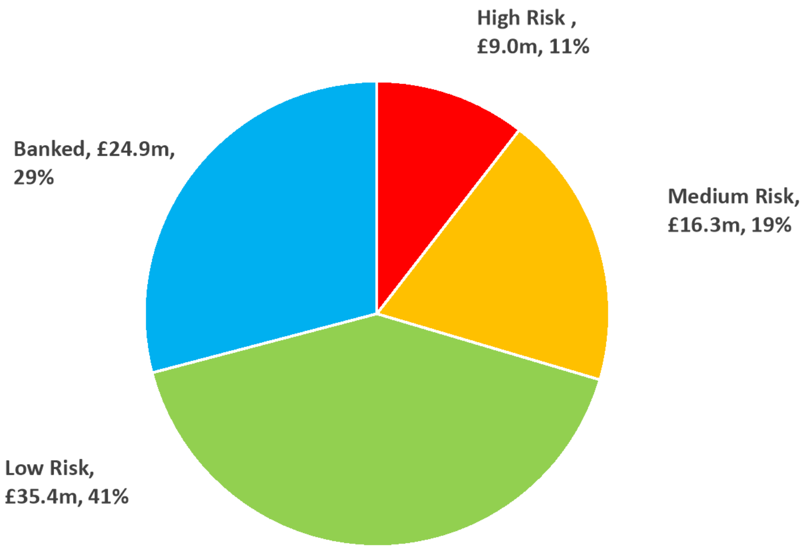
- **£9.0m** of schemes are rated high risk, these are the opportunities still being scoped from the FEF events;

SUSTAINABLE COMMISSIONING

- Of the **£37.0m** Sustainable Commissioning schemes **£8.7m** to be worked up from the opportunities that have been identified, a **£2.3m** improvement from month 5.

Efficiencies by Area £m	YTD - M6			Full Year 25/26		
	Plan	Actual	Variance fav/(adv)	Plan	FOT	Variance fav/(adv)
Prescribing	5.6	5.9	0.4	14.0	14.0	0.0
CHC	5.9	5.2	(0.7)	15.8	16.5	0.7
Corporate	8.1	8.9	0.8	19.5	21.3	1.8
Subtotal - Operational Efficiencies	**19.6**	**20.0**	**0.5**	**49.3**	**51.8**	**2.5**
Sustainable Commissioning	13.0	13.5	0.5	37.0	33.8	(3.2)
Total	**32.6**	**33.5**	**1.0**	**86.3**	**85.7**	**(0.6)**
Recurrent	22.9	12.5	(10.4)	77.2	41.6	(35.6)
Non-Recurrent	9.7	21.1	11.4	9.1	44.0	35.0
Transformational	24.2	12.2	(12.0)	66.8	35.6	(31.2)
Transactional	8.1	21.2	13.1	19.5	50.1	30.6

2025/26 ICB efficiencies programme - £86.3m



High, Medium, Low risk are plans still to be delivered/banked

4.2 Efficiency and transformation

Continuing Healthcare

- Planned savings are **£15.8m** and FOT is **£16.5m**;
- A further **£3.0m** of the **£35.5m** Sustainable Commissioning FOT was identified at the FEF events taking the total CHC total to **£19.4m**;
- 1 scheme from the top 5 performing is expected to contribute **£2.7m** towards this target;
- Banked CHC savings total **£5.2m,** this is **£0.7m** underachieved this is an improvement from month 5;

GP Prescribing

- Both planned savings and FOT are **£14.0m**;
- A further **£0.6m** was identified as part of the **£35.5m** at the FEF event taking the target to **£14.6m,** the team have fully worked up schemes to achieve this target;
- GP Prescribing figures are 2 months in arrears, so YTD actual savings includes estimates;
- YTD GP Prescribing savings total **£5.9m**, this is a **£0.4m** overachievement YTD;

Corporate

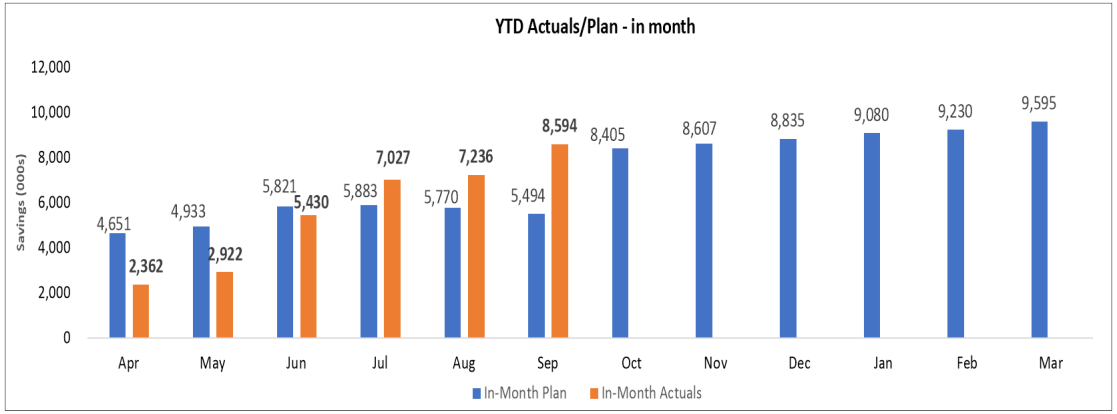
- Planned savings are **£19.5m** and FOT is **£21.3m,** this improvement is from the Vacancies scheme;
- Savings at month 6 are **£8.9m;**
- There are 6 Corporate schemes, 3 have been risk rated as Green and 3 as Amber;
- 3 of the top 5 performing schemes are in Corporate;

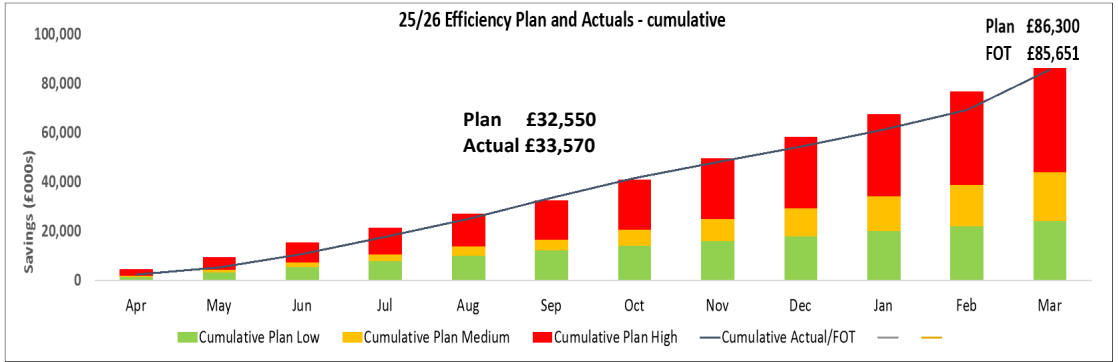
Sustainable Commissioning and Influenceable Spend Review

- Planned savings are **£37.0m** and FOT is **£33.8m**,
- In June and July, FEF events were held and the required **£30.m** of new schemes were identified, **£25.1m** has been validated by Finance at month 6, leaving **£8.7m** assumed to be delivered to be validated;

Top 5 Performing Operational Schemes

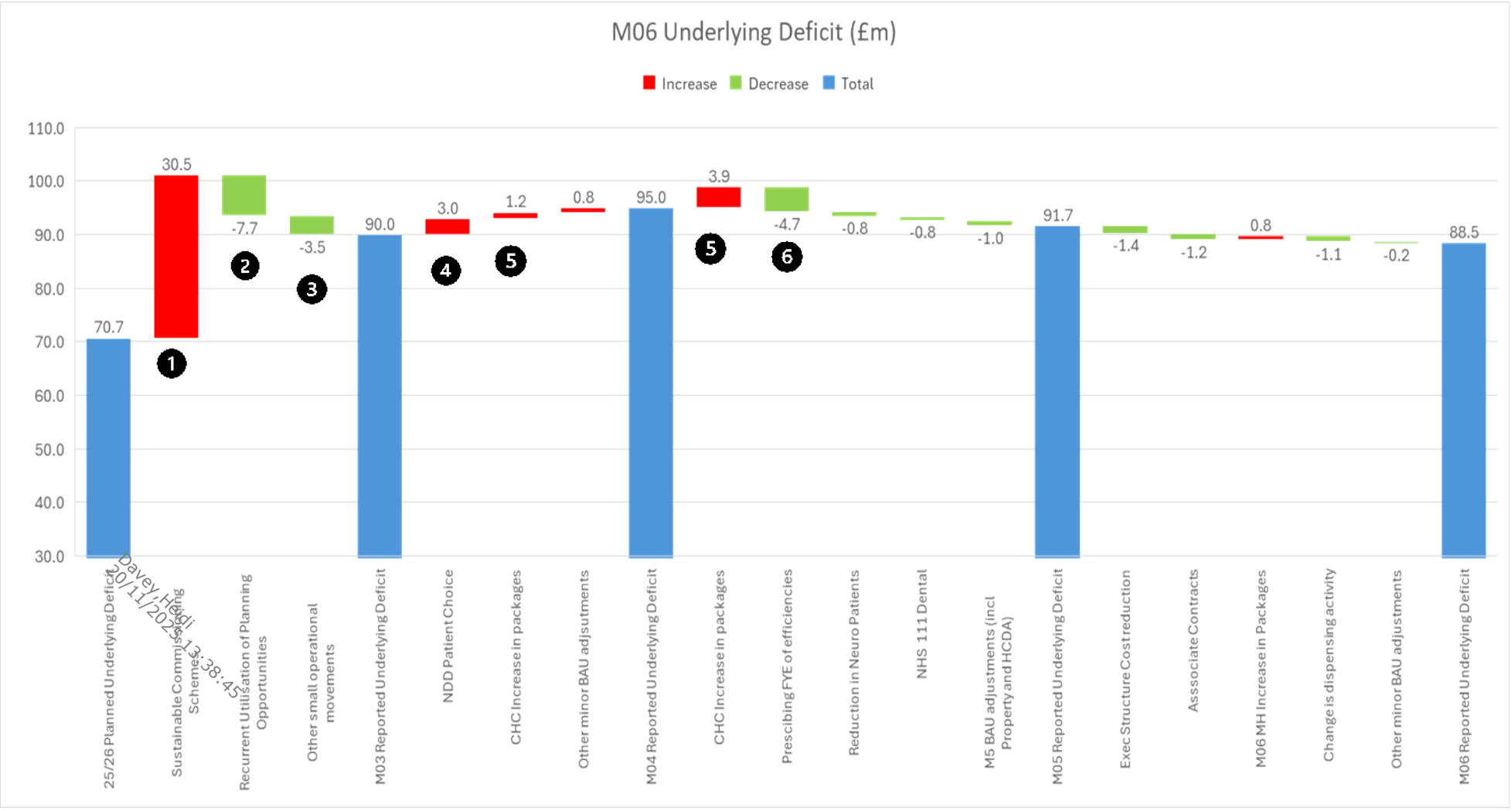
- **£8.8m** of the YTD actual savings come from 5 schemes accounting for 26% of the total YTD savings;
- FOT for the top 5 schemes is **£24.8m** which is 29%





Portfolio	Top 5 performing operational schemes	25/26 Plan (£)	Recurrent (Y/N)	YTD Planned Savings (£)	YTD Actual Savings (£)	Variance (£)	FOT (£)	Variance (£)
		£000's		£000's	£000's	£000's	£000's	£000's
Corporate	ISP Cap and ERF	12,000	Y	4,998	4,998	0	12,000	0
Corporate	Allocation Gateway	3,000	N	900	900	0	3,000	0
Corporate	Vacancies	2,800	N	1,399	2,188	789	4,580	1,780
GP Prescribing	Optimise Rx	2,100	Y	1,050	1,410	360	2,485	385
CHC	1:1 Care commissioning in care homes	2,000	Y	500	546	46	2,700	700
		21,900		8,847	10,042	1,195	24,765	2,865

5.1 Underlying Position (ULP)



1. The 2025/26 Annual plan included the recurrent delivery of £37m of sustainable commissioning efficiencies. As at M06 reporting, the revised forecast, including the FEF event opportunities, is that only £6.5m of these will be delivered recurrently.

2. This includes a number of expected recurrent commitments that, post annual plan, have been identified as opportunities to improve the underlying position

3. This is an aggregate number of multiple operational improvements to the bottom line that have been identified during the M06 reporting process. The largest is within the community directorate for equipment

4. NDD Assessments Pressure from the Right To Choose (RTC) agenda.

5. Increase based on the full year impact of activity packages (especially LD) as at September 2025.

6. This calculation of full year impact of the prescribing efficiencies (including Dapagliflozin).

5.2 ULP Refresh

Traditionally, the ICB has calculated the underlying financial position (ULP) using the recurrent allocation as it is dictated by NHS England. Put simply, the recurrent cost of the ICB's business is compared to the recurrent allocations that the ICB receives at any given month. This is an established process and has been the basis for reporting the ULP to boards and committees since at least the formation of the Norfolk and Waveney CCG.

In August 2025, NHS England issued a new ULP return (as part of the normal monthly reporting process) and the accompanying guidance stated that ICB's should consider all non-recurrent allocations as recurrent. There are a small number of exceptions to this (principally around deficit support funding and associated implications), but this represented a fundamental shift in the calculation process previously employed. The expectation is that this process will be adopted for the forthcoming Medium Term Financial Plan.

This slide and following slide has been included to give the Finance Committee an early sighter of what the implications would be of adopting NHSE's new approach (including an early views on pros and cons of adopting the process).

As part of the month 5 (August) closedown work, the finance team ran a theoretical dual process to understand the impact of the alternative approach to counting non-recurrent allocations as recurrent. This was refreshed for month 6 (September).

The impact has been captured at a granular level but for the purpose of conciseness, has been split into 3 categories:

i) Where costs have previously been included as recurrent commitment, but the allocation has been only awarded on a non-recurrent basis (**Cat 1**).

ii) Where the non-recurrent allocation has been used to support the bottom line but assumed to not be available again in future periods (**Cat 2**).

iii) Where the allocation is recurrent but has been used on non-recurrent basis to support the bottom line and then assumed to be spent in future years (**Cat 3**). *Cat 3 whilst related, is a separate issue that the ICB can unilaterally adopt by committing the associated allocations to the ICB position recurrently.*

5.2 ULP Refresh

Table 1 - Impact of adopting the approach to convert all allocation to recurrent on the ULP

	Existing Approach	Cat 1	Cat 2	Cat 3	Total
Allocation	-2,807.7				
Discharge Fund (BCF)		-8.8			
Primary Care IT (Salaries)		-1.0			
Care Navigators (Salaries)		0.7			
Other minor allocations		-1.0			
ERF (ISP growth)			-17.0		
ERF (ISP Calculation)			-9.9		
ERF (Secondary Dental)			-1.9		
SDF Unallocated			-2.1		
C19 Testing			-1.6		
Allocation Sub-Total	***-2,807.7***	***-10.1***	***-32.5***	***0.0***	***-2,850.3***
Recurrent Spend	2,896.3				
Additional Capacity Funding				-10.2	
Health Inequality Funding				-3.3	
Community Funding				-3.9	
Spend Sub-Total	***2,896.3***	***0.0***	***0.0***	***-17.4***	***2,878.9***
ULP Deficit / (Surplus)	**88.6**	**-10.1**	**-32.5**	**-17.4**	**28.6**

* Cat 3 whilst related, is a separate issue that the ICB can unilaterally adopt by committing the associated allocations to the ICB position recurrently

Table 2 - Pros and Cons

	Existing Approach	New Approach
Pros	- Established way of working - Mitigated risk on NR allocation no materialising - Reconciles to NHSE monthly allocation report	- Aligns with new NHSE guidance - Significantly reduces ULP deficit - Will reduce efficiency requirement if NR allocation is recurrent - Creates certainly on the treatment of Cat 3 budgets
Cons	- Will require additional work at planning to dual run - Likely to be inconsistent with other systems - Will lead to a higher (unnecessary?) efficiency plan	**- If NR allocation is withdrawn, will create late cost pressures** - Delayed NHSE release of allocations, will lead to in-year uncertainty - Resource drain in finance (initially anyway) - Improvement in ULP would effect no benefit in VFM and no cash impact

Summary

Table 1 shows that the ICB could reduce the ULP by as much as £60m if it chooses to adopt the new process (for Cat 1 & Cat 2) and agrees to recurrently utilise the allocations (in Cat 3) in the ULP.

The ICB will now need to consider the pros and cons (table 2) and make a decision on whether to disregard, adopt or partially adopt NHSE's new proposal. For the latter, the ICB could consider a hybrid approach and consider each Non-recurrent allocation independently for ULP treatment. This may help to mitigated the risk of non-recurrent allocations not materialising in 2026/27, for example.

It's important to note that any change in calculation treatment will not impact the 2025/26 financial position, efficiency challenge or cash position.

Next Steps

The Executive Director of Finance has commissioned an external report by PA Consulting:

What have they been asked to do?
1. Evaluate the underlying deficits of SNEE and N&W ICBs, get a true like for like comparison, and advise on the underlying position of the future Norfolk and Suffolk ICB.
2. Provide a high level analysis of how the ICBs allocations have been distributed by sector (acute, community, primary care etc…) over the last 3 to 5 years.
3. Provide a high level analysis of whether differential investments have led to different outcomes and efficiencies in those sectors
4. The work is designed to give us a clear starting point and factual basis from which to work and help us better design our future strategy.

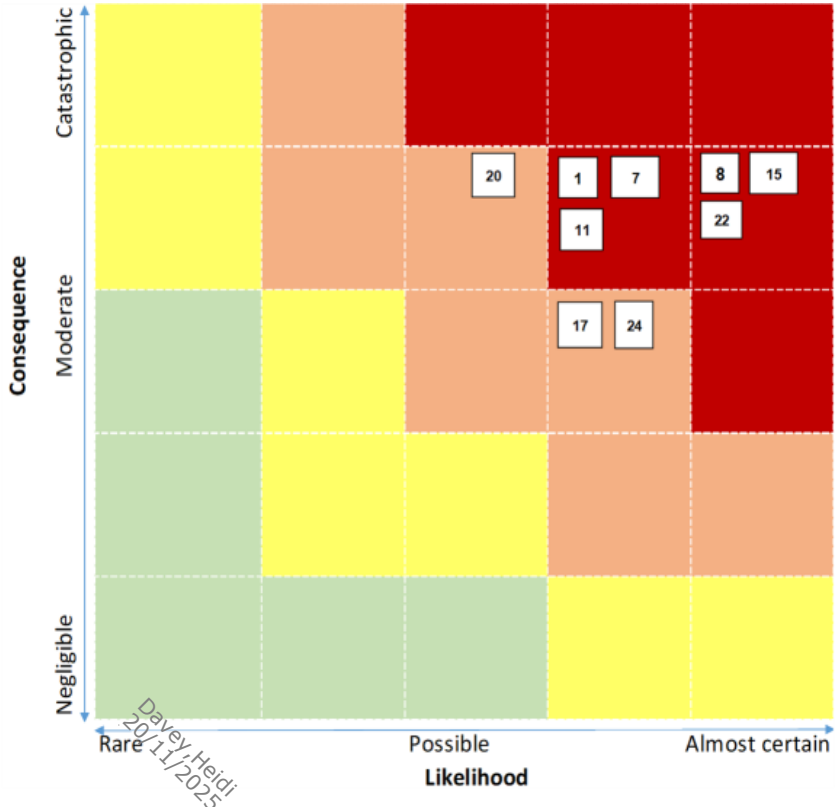
When will the work be completed?
They are expected to conclude in the next 2 weeks, and will be presenting to Executive Committee before the end of October.

Who has input to the work?
This has mainly been a finance exercise, and it has had full input from both ICB finance teams.

6.1 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	Jul-25	Aug-25	Sep-25
Achievement of Plan	1	Achieve the 2025/26 financial plan **(BAF 11)**	12	16	16	16
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	17	Inflationary pressures	9	Closed	12	12
	20	Impact of new prescribing guidance	8	12	12	12
	21	Impact of Direct Commissioning transfer	9	Closed	Closed	Closed
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	20	20	20
	23	Debt and Working Capital Management (NCC)	6	Closed	Closed	Closed
Demand and Capacity	7	Continuing Health Care demand growth	9	16	16	16
	11	ERF: RTT backlog and Acute demand management	9	16	16	16
	24	Patient Choice (Learning Disabilities & Autism)	9	12	12	12
Efficiency	8	Efficiency, transformation development/delivery	8	20	20	20

Extreme	6	6	6
High	2	3	3
Moderate	0	0	0
Low	0	0	0
Total Risks	8	9	9

As at M06 (September), 9 Key Financial Risks remain open of which 6 are considered Extreme relating to the Achievement of the in-year Financial Plan, the ICB Underlying Deficit, the ICB Organisational Change Programme, CHC growth, Independent Activity management and delivery against the Efficiency programme.

Against the M12 closing position of 2024/25, two risks have been closed as they are considered to have concluded specific projects (risks 21 and 23). Remaining risk from 2024/25 in 2025/26 have for three risks increased from High to Extreme. These increases on risks 1, 11 and 22 reflect both the material nature of the financial risk, and also the early stages of the financial year with significant efficiencies and staffing cost risks.

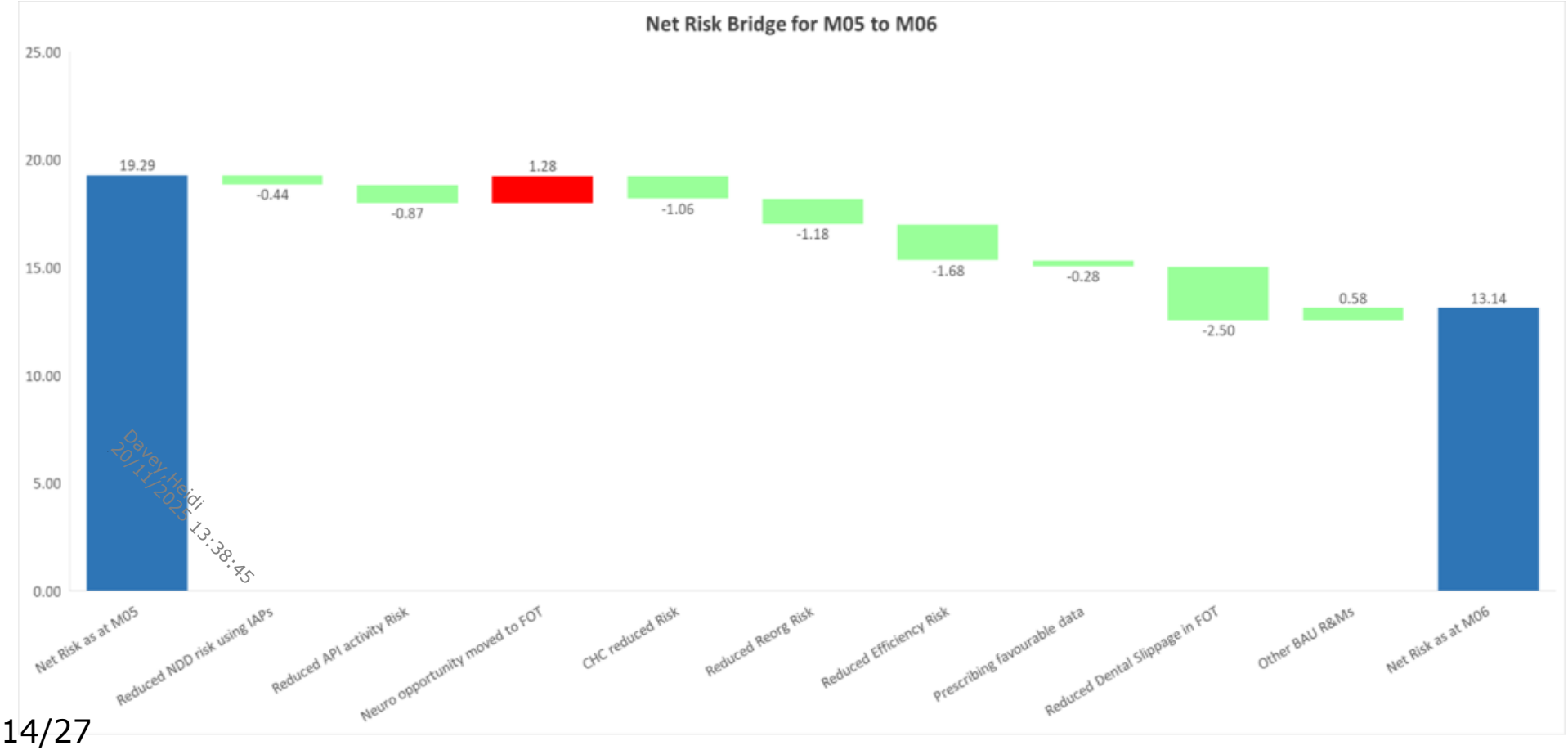
The associated financial risks at a Plan, Reported and Strategic level are detailed in Appendix D in this report. The full risk register is shown in Appendix E (separate to this report).

6.2 Financial Risk Report

Month 06 Net risks in addition to the reported in the forecast position are at £13.1m, an improvement over those identified at Month 05 by £6.1m. The movement is a result of a number of issues in the below waterfall graph, the key ones being

1. The dental Slippage assumed in the forecast has been reduced to £2.5m. This is as a result of new guidance on urgent access by NHSE.
2. A reduction on the efficiency risk aa result of further efficiency identification and delivery.

Bridge for M05 to M06 in Net Risk



Risk & Mitigations at M06

Risks	£m
Sustainable Efficiency Delivery	6.6
NDD Right to Choose activity	3.5
ISP Growth / IAP risk	1.5
Diagnostics / API risk	1.0
Weight Management	0.5
Acute BAU risks	0.3
Wegovy / Ozempic	0.4
Risk to Dental slippage	2.0
Prescribing Efficiency risk	0.5
GP Data line costs	0.3
GP Rent Reviews	0.5
Primary Care BAU risks	0.6
CHC demand and inflation	5.9
CHC Efficiency Risk	1.5
ICB restructuring costs	12.6
Other risks	
Total	**37.6**

Mitigations	£m
ERF and CDC block benefit	-1.2
Advice and Guidance	-0.8
Closing the gap additional savings	-17.6
Additional PC allocation	-1.7
Additional Pharmacy First allocation	-1.7
MH Growth slippage (non-MHIS)	-0.7
Other Mitigations	-0.7
Total	**-24.5**
Net Risk / (Mitigation)	**13.1**

7. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 30th September 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 increased since March 2025. Total Inventories relate to ICES equipment, we have considered the accounting treatment for ICES and have aligned this with our local authority, this is a practice that other ICBs have adopted. The £14.7m balance is made up of aged debtors of £1.8m (including Norfolk County Council £0.9m & Chiesi Ltd £0.6m), prepayments & accrued income of £3.3m, dental under delivery of £10.7m and a bad debt provision against aged debtors & dental under delivery of £1.1m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee. Further details are presented in Appendix C.

Current liabilities
Total current liabilities has increased by £14m since March 2025, driven principally by ICB and system invoice accrual timing. The £188m balance is made up of trade creditors of £6m, Prescription Pricing Authority & dental accruals of £28m, payroll costs including GP pensions of £5m, deferred income of £4m, and ICB and system invoice accruals of £145m. Provisions include legal, staffing, estate costs, CHC Reimbursement, working capital AP, CDC and dental clawback. There has been an in-year part release against these provisions as costs are being incurred.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £3.2m. 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.

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 time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/25	Position as at 31/08/25	Position as at 30/09/25
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,005	1,005	1,005
Accumulated Depreciation	(524)	(604)	(620)
Total non-current assets	481	401	385
Current assets			
Inventories	0	4,805	4,805
Trade and Other Receivables	20,440	14,953	14,664
Cash and Cash Equivalents	693	323	2,258
Total current assets	21,133	20,081	21,727
Current liabilities			
Trade and Other Payables	(169,721)	(183,790)	(187,797)
Lease Liabilities	(239)	(194)	(195)
Provisions for liabilities and charges (including non-current)	(11,719)	(9,764)	(7,912)
Total current liabilities	(181,679)	(193,748)	(195,904)
Long Term liabilities			
Non-Current Lease Liabilities	(278)	(181)	(181)
Total non-current liabilities	(278)	(181)	(181)
Net assets employed	(160,343)	(173,447)	(173,973)
FINANCED BY TAXPAYERS EQUITY			
General fund	(160,343)	(173,447)	(173,973)
Total taxpayers equity	(160,343)	(173,447)	(173,973)

8. ICB Allocations

Funding Element	TOTAL FOR ICS £k	SPLIT BY ICS PARTNER £k								Notes - M06
	QMM (ICB)	JPUH	NNUH	QEH	NSFT	NCHC	ECCH	ICB	Total ICS	
Total Core Funding received	**2,552,372**	**234,144**	**598,549**	**192,772**	**200,858**	**143,146**	**40,747**	1,142,155	**2,552,372**	
Specialist Commissioning	217,209	0	0	0	0	0	0	217,209	**217,209**	
Agreed Service Development Funds (SDF)	56,756	9,926	11,930	2,553	5,248	0	0	27,099	**56,756**	
ERF	127,119	28,242	34,624	10,178	0	100	0	53,975	**127,119**	
COVID-19 Testing Funding	1,619	0	0	0	0	0	0	1,619	**1,619**	
Deficit Support Funding	51,126	19,000	2,800	22,500	6,800	0	0	26	**51,126**	
Depreciation Funding	5,594	1,827	0	3,092	0	675	0	0	**5,594**	
Repayment of 2024/25 system support	0	(500)	0	(500)	(1,400)	0	0	2,400	**0**	
Repayment of £19.7m 2022/23 Deficit Funding	(5,077)	(2,568)	0	(2,509)	0	0	0	0	**(5,077)**	
Redundancy Repayment	(850)	0	0	0	0	0	0	(850)	**(850)**	
QEH Intermediate Care Beds	0	0	0	2,041	0	0	0	(2,041)	**0**	
Dietician Transfer to HPFT	0	0	0	0	0	(170)	0	170	**0**	*Moved in M04*
Pay Award Funding (AfC)	15,828	1,982	4,742	1,509	1,466	993	239	4,897	**15,828**	*Funding allocated in M04 and paid out in M05*
Allocation as per NHSEI May 2025 Schedule	**3,021,696**	**292,053**	**652,645**	**231,637**	**212,972**	**144,744**	**40,985**	**1,446,660**	**3,021,696**	Equals Allocation Schedule from 23/07/2025 (v31)
Adjustments - Allocations in ICS contract values but not yet received										
Missing SDF (non-CDC) not yet received	(165)	0	0	0	0	0	0	(165)	**(165)**	*£654k received in M03, £84k in M06 small balance remains*
Deficit Support not yet received	(12,784)	0	0	0	0	0	0	(12,784)	**(12,784)**	*Q1, Q2 & Q3 has been received in full (£38,342k)*
Revised Subtotal - SLA	**3,008,747**	**292,053**	**652,645**	**231,637**	**212,972**	**144,744**	**40,985**	**1,433,711**	**3,008,747**	
Other Adjustments										
MH Allocation (delegated Spec Comm)	25,522							25,522	**25,522**	
CDC	167	167						0	**167**	
Cancer Alliance Funding 2025/26	5,452	4,252	600	600				0	**5,452**	
Additional PC (CPCF Contract + GP Practice Support)	10,182							10,182	**10,182**	
Additional Allocations for Dental and Community Uplifts	446							446	**446**	
MH Talking Therapies - DWP payment	467				467			0	**467**	
Transformation Funding - Primary Care	1,840							1,840	**1,840**	
Other Transformation Funding - Maternity, Diagnostics, Elective, IT, Prevention & LTC	1,041							1,041	**1,041**	
2024/25 Depreciation Clawback	(1,331)							(1,331)	**(1,331)**	
Other values < £400k	715							715	**715**	
Total Other Adjustments	**44,501**	**4,419**	**600**	**600**	**467**	**0**	**0**	**38,415**	**44,501**	
Allocation as per NHSE August 2025 schedule	**3,053,248**	**296,472**	**653,245**	**232,237**	**213,439**	**144,744**	**40,985**	**1,472,126**	**3,053,248**	

Appendix A – Detailed Financial Position (1 of 3)

Norfolk and Waveney ICB		N&W ICB	N&W ICB Position at Month 6 £000s			N&W ICB	
Service Line	Description	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
Allocation	Allocation - Delegated Co-Commissioning	(369,804)	(189,201)	(189,201)	0	(369,804)	0
	Allocation In Year - Spec Comm	(250,643)	(128,326)	(128,326)	0	(250,643)	0
	Allocation In Year-Programme	(2,416,189)	(1,219,510)	(1,219,510)	0	(2,416,189)	0
	Allocation In Year-Running	(16,612)	(8,643)	(8,643)	0	(16,612)	0
Allocation Total		**(3,053,248)**	**(1,545,679)**	**(1,545,679)**	**0**	**(3,053,248)**	**0**
	Acute Contracts Outside of STP	60,349	30,189	30,189	0	60,348	(0)
	EEAST Ambulance Trust	83,538	41,769	41,769	0	83,538	0
	High Cost Drugs	3,032	1,516	1,572	56	3,087	55
	James Paget Univ Hosp FT	292,131	146,096	145,897	(199)	291,436	(695)
	Local Maternity Services	2,218	1,058	1,031	(27)	2,190	(27)
	Non Contract Activity	11,708	9,691	10,426	735	13,118	1,410
	Non Emergency Patient Transport	13,934	6,967	7,003	36	14,002	69
	Norfolk & Norwich Univ Hosp FT	652,750	326,387	326,387	(0)	652,750	0
	Other NHS Acute Expenditure	18,216	10,743	9,962	(782)	16,864	(1,352)
	Other Non NHS Acute Contracts	43,018	24,541	24,526	(16)	43,003	(15)
	Queen Elizabeth Hospital FT	231,623	115,824	115,825	0	231,623	0
	Sustainable Commissioning QIPP	(9,377)	(4,220)	0	4,220	0	9,377
Acute Total		**1,403,140**	**710,563**	**714,587**	**4,024**	**1,411,961**	**8,821**
Specialised Commissioning	Norfolk & Norwich Univ Hosp FT	115,952	57,976	57,976	0	115,952	0
	Cambs Uni Hosp FT	42,611	21,306	21,306	0	42,611	0
	Other Specialised Contracts	54,682	27,344	27,344	0	54,682	0
	Low Value Agreements	7,287	6,670	6,670	0	7,287	0
	Non NHS	5,751	2,876	2,163	(713)	4,371	(1,380)
	Reserves	1,450	703	0	(703)	0	(1,450)
	ERF Variable	(2,831)	(1,415)	0	1,415	0	2,831
	MH Essex Partnership FT	13,766	6,883	6,883	0	13,766	0
	MH Other Specialised	11,974	5,985	5,985	0	11,974	0
Spec Comm Total		**250,643**	**128,326**	**128,326**	**0**	**250,643**	**0**
Community	Capacity Funding	8,026	4,013	3,713	(300)	7,726	(300)
	Community Services	14,736	7,368	7,032	(336)	14,054	(681)
	Community Transformation	1,576	788	678	(110)	1,400	(176)
	East Coast Community Healthcare	43,101	21,551	21,538	(13)	43,046	(55)
	ICES	9,646	4,823	2,430	(2,393)	4,849	(4,797)
	Intermediate Care	433	217	154	(63)	367	(66)
	Long Term Conditions	8,100	4,050	2,957	(1,093)	6,899	(1,200)
	Norfolk Community Health & Care	144,869	72,452	72,452	0	144,869	0
	Planned Care and Transformation Team	3,863	1,887	1,667	(220)	3,553	(311)
	Sustainable Commissioning QIPP	(14,327)	(6,208)	0	6,208	0	14,327
Community Total		**220,022**	**110,939**	**112,620**	**1,681**	**226,763**	**6,741**

Appendix A – Detailed Financial Position (2 of 3)

Norfolk and Waveney ICB		N&W ICB	N&W ICB Position at Month 6 £000s			N&W ICB	
Service Line	Description	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
Better Care Fund	Collaborative Commissioning (Social)	40,632	20,794	20,794	(0)	40,632	(0)
Better Care Fund Total		**40,632**	**20,794**	**20,794**	**(0)**	**40,632**	**(0)**
Continuing Health	Adult Continuing Care	130,954	67,728	68,857	1,129	127,737	(3,217)
	Children Continuing Care	8,755	4,389	3,640	(749)	8,004	(751)
	Funded Nursing Care	12,766	6,400	6,248	(153)	12,774	8
	Continuing Healthcare Assessment & Support	11,884	5,811	5,742	(69)	11,838	(47)
	Safeguarding	3,367	1,620	1,554	(66)	3,261	(106)
Continuing Health Total		**167,726**	**85,949**	**86,041**	**93**	**163,614**	**(4,112)**
Mental Health - MHIS	Child And Adolescent Mental Health	22,096	11,031	10,383	(647)	21,056	(1,040)
	Learning Difficulties	34,062	16,970	16,347	(623)	34,326	264
	Mental Health Services - Other	42,683	21,028	21,582	554	43,807	1,124
	Norfolk & Suffolk FT Main SLA	212,973	106,486	106,486	0	212,973	(0)
	Sustainable Commissioning QIPP	(2,965)	(1,285)	0	1,285	0	2,965
Mental Health MHIS Total		**308,848**	**154,230**	**154,799**	**569**	**312,161**	**3,313**
Primary Care	Gp Forward View	1,074	125	135	10	1,015	(60)
	Local Enhanced Services	20,349	10,250	10,035	(215)	20,135	(215)
	Other Primary Care	4,674	2,064	1,977	(87)	4,540	(134)
	PMS to GMS Transition	0	0	0	0	0	0
	Primary Care Delegated Co-Commissioning	253,256	124,367	123,393	(975)	251,474	(1,782)
	Primary Care IT	7,469	4,240	4,237	(3)	7,435	(34)
	DOP Delegated pay	362	162	137	(25)	317	(45)
	Ophthalmology Services	11,903	5,909	5,734	(176)	11,668	(235)
	Community Pharmacy	32,464	15,403	14,646	(756)	30,661	(1,803)
	Community Dental	3,607	1,804	1,707	(96)	3,489	(118)
	Primary Dental Services	53,168	26,573	26,596	23	53,166	(2)
	Secondary (Acute) Dental	15,360	7,680	7,680	(0)	15,360	0
	Sustainable Commissioning QIPP	(2,965)	(1,285)	0	1,285	0	2,965
Primary Care Total		**400,723**	**197,292**	**196,277**	**(1,016)**	**399,261**	**(1,462)**
Prescribing	Central Drugs	6,172	2,980	3,134	154	6,326	154
	Gp Prescribing	208,225	104,429	105,328	899	207,145	(1,080)
	Medicines Management - Clinical	3,073	1,466	1,465	(1)	3,049	(23)
	Other Prescribing	7,170	3,217	3,743	526	8,178	1,008
	Oxygen	2,789	1,332	1,257	(75)	2,654	(135)
	Prescribing Incentives	1,319	0	0	0	1,319	0
Prescribing Total		**228,747**	**113,424**	**114,927**	**1,504**	**228,671**	**(76)**

Appendix A – Detailed Financial Position (3 of 3)

Norfolk and Waveney ICB		N&W ICB	N&W ICB Position at Month 6 £000s			N&W ICB	
Service Line	Description	Annual Budget	Budget	Actual	Variance	Forecast	FOT Variance
Other	Covid-19 Costs	645	267	264	(3)	645	0
	Bad Debt W/O	0	0	293	293	293	293
	GP Out Of Hours	10,015	5,007	4,986	(22)	9,971	(43)
	HCDA	820	412	412	0	820	0
	ICS Wide Programmes	17	8	(7)	(15)	2	(15)
	NHS 111	9,844	4,922	4,546	(376)	9,094	(750)
	Pay Vacancy	(250)	646	0	(646)	(1,704)	(1,454)
	Programme Redundancy	0	0	(151)	(151)	(151)	(151)
	Provision Release	0	0	0	0	0	0
	Property	1,403	723	537	(186)	1,210	(193)
	R&D	403	264	248	(16)	354	(49)
	Programme Re-organisation	361	152	137	(15)	347	(15)
	Workforce External OD	356	129	135	5	334	(22)
	Transformational Change Team	866	432	429	(3)	863	(3)
Other Total		**24,480**	**12,962**	**11,829**	**(1,134)**	**22,079**	**(2,401)**
Planning	Depreciation allocation	(1,331)	0	0	0	(3,640)	(2,309)
	Sustainable Commissioning	0	0	0	0	(8,758)	(8,758)
	NHSE allocations outstanding	(12,784)	0	0	0	(10,180)	2,604
	In year saving targets	(25,166)	(7,841)	(10,073)	(2,232)	(17,782)	7,384
	In year expenditure	4,854	2,127	2,219	92	4,855	1
	Prior year, planning benefits and balances	26,102	8,755	5,301	(3,454)	16,398	(9,704)
Planning Total		**(8,324)**	**3,041**	**(2,553)**	**(5,594)**	**(19,107)**	**(10,783)**
Running Costs	Running Costs - CSU	1,005	503	521	18	1,041	36
	Running Costs - Estates & Facilities	319	159	187	27	346	27
	Running Costs - Non Pay	1,420	559	564	4	1,464	44
	Running Costs - Pay	14,231	6,796	6,762	(35)	14,408	177
	Running Costs - Pay Vacancy Factor	(364)	142	0	(142)	(688)	(324)
Running Costs Total		**16,612**	**8,159**	**8,033**	**(127)**	**16,571**	**(41)**
Total Expenditure		**3,053,248**	**1,545,679**	**1,545,679**	**0**	**3,053,248**	**0**
NHSEI Allocation		**(3,053,248)**	**(1,545,679)**	**(1,545,679)**	**0**	**(3,053,248)**	**0**
(Surplus)/Deficit		**0**	**(0)**	**(0)**	**0**	**0**	**0**

Appendix B - Pay Provisions

NHS Norfolk and Waveney ICB

2024-25 Organisational Change Redundancies

		Year-End 2025/26 @ 31.03.2025		M02 2025/26 @ 31.05.2025		M03 2025/26 @ 30.06.2025		M04 2025/26 @ 31.07.2025		M05 2025/26 @ 31.08.2025		M06 2025/26 @ 30.09.2025	
		Count	£	Count	£	Count	£	Count	£	Count	£	Count	£
Voluntary	Opening / B/Fwd Provision	1	144,545	1	144,545	1	144,545	1	144,545	1	144,545	1	144,545
	Provision Utilised Through Exit Payments	0	0	0	0	0	0	0	0	0	0	0	0
	Provision Unwound As ReDeployed/Left ICB	0	0	0	0	0	0	0	0	0	0	0	0
	Provision Movement Other	0	0	0	0	0	0	0	0	0	0	0	0
	C/Fwd Provision	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**
Compulsory	Opening / B/Fwd Provision	1	150,858	1	150,858	1	150,858	0	0	0	0	0	0
	Provision Utilised Through Exit Payments	0	0	0	0	0	0	0	0	0	0	0	0
	Provision Unwound As ReDeployed/Left ICB	0	0	0	0	-1	-150,858	0	0	0	0	0	0
	Provision Movement Other	0	0	0	0	0	0	0	0	0	0	0	0
	C/Fwd Provision	**1**	**150,858**	**1**	**150,858**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total By Month	Opening / B/Fwd Provision	2	295,403	2	295,403	2	295,403	1	144,545	1	144,545	1	144,545
	Provision Utilised Through Exit Payments	0	0	0	0	0	0	0	0	0	0	0	0
	Provision Unwound As ReDeployed/Left ICB	0	0	0	0	-1	-150,858	0	0	0	0	0	0
	Provision Movement Other	0	0	0	0	0	0	0	0	0	0	0	0
	C/Fwd Provision	**2**	**295,403**	**2**	**295,403**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**
Cummulative Position	Opening / B/Fwd Provision	2	295,403	2	295,403	2	295,403	2	295,403	2	295,403	2	295,403
	Provision Utilised Through Exit Payments	0	0	0	0	0	0	0	0	0	0	0	0
	Provision Unwound As ReDeployed/Left ICB	0	0	0	0	-1	-150,858	-1	-150,858	-1	-150,858	-1	-150,858
	Provision Movement Other	0	0	0	0	0	0	0	0	0	0	0	0
	C/Fwd Provision	**2**	**295,403**	**2**	**295,403**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**	**1**	**144,545**

(*) Efficiency Delivery through HR actions

Redundancies

The ICB created a Financial Provision as at 31st March 2024 for the known and accepted Voluntary Redundancies and expected Compulsory Redundancies based on roles in relation to the restructure of 2023 securing over two years the required 30% reductions in running costs. The provision equated to £3.0m equalling 127 persons. At the end of 2024-25 the provision equated to £0.2m. At year-end, this provision was increased to £0.3m.

As at M06 (September) the remaining provision equates to £0.14m for 1 person. One person was redeployed into an ICB permanent role and provision released resulting in a £0.15m benefit.

There may be further benefit beyond that already crystalised in M06.

Provisions exclude any values for the upcoming redundancy risks in relation to the changes to the future strategic natures of ICB and associated staffing levels. Adding that the assessment of this value (shown in Risks and Mitigations) is considered to be c.£13m. As yet the ICB has had no confirmation of any funding in relation to this redundancy risk (Voluntary or Compulsory).

Appendix C - Working Capital and Cash management (1/3)

Net Working Capital *(Current Assets less Current Liabilities)*
The net working capital continues to remain negative as the NHSE principle is that cash should only be drawn based upon one month's commitment at a time. The ICB is striving to improve working capital by focusing on the local authority balances and working with the SBS metrics reports to improve outcomes, focusing on improvements to faster receipt and payments.

Local Authority (Norfolk County Council)
A joint working group has been set-up with Norfolk County Council (NCC) its key principle being to improve the working capital of the organisations going forward. The initial priority of this group is to resolve the invoices raised outside of conditions this year, thereafter, to focus on areas of processing uncertainty and improving contractual and package clarity.

NCC's agreement to the offer made in September 2023 included a condition to not raise any further invoices in 2023/24 for any services relating to prior years as both organisations wanted to conclude legacy transactions to cleanse respective ledgers and aid working capital.

NCC challenged this mutually agreed condition, so both parties agreed to move to the 22nd September 2023 as the cut-off date. This brought 257 invoices into scope at a value of circa £1.2m and the ICB have settled these invoices. Uncertainty over 54 invoices remained at a value of circa £2.2m and the ICB has requested credit notes for these. A credit note for 52 of these has been received equating to £1.7m which was reconciled and allocated in June 2025. Of the remaining 2 invoices for circa £0.5m, 1 item was settled in August for £0.2m and the remaining invoice following a part credit of £0.1m was settled in September 2025. There is also potential risk that NCC may identify further prior year invoices at an undetermined value which they may wish to negotiate despite the new accepted terms.

NHS NORFOLK & WAVENEY ICB WORKING CAPITAL	Oct-24 £000s	Nov-24 £000s	Dec-24 £000s	Jan-25 £000s	Feb-25 £000s	Mar-25 £000s	Apr-25 £000s	May-25 £000s	Jun-25 £000s	Jul-25 £000s	Aug-25 £000s	Sep-25 £000s
NHS Bodies												
Trade Debtors	511	620	1,870	434	1,090	2,712	811	450	1,037	466	561	131
Trade Creditors	(10,591)	(9,583)	(4,489)	(6,292)	(2,991)	(7,339)	(5,400)	(5,169)	(4,638)	(9,995)	(4,127)	(4,538)
	(10,080)	(8,963)	(2,619)	(5,858)	(1,901)	(4,627)	(4,589)	(4,719)	(3,601)	(9,529)	(3,566)	(4,407)
Local Authorities												
Trade Debtors	212	122	135	444	1,348	1,582	680	807	755	756	684	965
Trade Creditors	(12,824)	(9,040)	(7,347)	(10,960)	(11,213)	(11,365)	(7,309)	(6,168)	(7,267)	(7,386)	(5,376)	(7,447)
	(12,612)	(8,918)	(7,212)	(10,516)	(9,865)	(9,783)	(6,629)	(5,361)	(6,512)	(6,630)	(4,692)	(6,482)
Non NHS Bodies												
Trade Debtors	71	77	104	17	147	130	148	121	412	3,554	414	733
Trade Creditors	(15,001)	(16,042)	(15,652)	(16,227)	(14,066)	(15,921)	(17,321)	(16,320)	(15,416)	(14,372)	(14,605)	(8,195)
	(14,930)	(15,965)	(15,548)	(16,210)	(13,919)	(15,791)	(17,173)	(16,199)	(15,004)	(10,818)	(14,191)	(7,462)
Net Working Capital (Funded monthly by NHSEI)	(37,622)	(33,846)	(25,379)	(32,584)	(25,685)	(30,201)	(28,391)	(26,279)	(25,117)	(26,977)	(22,449)	(18,351)

Cash Flow Forecast / Drawdown Rates
The ICB is awarded an annual Cash Drawdown Requirement (CDR) based on Revenue allocations adjusted for non-cash items such as Depreciation. Whilst the CDR can be subject to in-year changes it cannot be breached without prior approval to align to the national levels of cash requirements set by the Department of Health; the **ICBs current forecast 2025/26 CDR is £3.065 billion**.

As at September 2025 the ICB have drawdown more cash than planned on a year-to-date basis, with a forecast to bring this back in line with total CDR for 2025/26, together with meeting it's challenging Efficiency Programme for the year of 8% which equates to circa £86.3m in anticipated savings.

NHS NORFOLK & WAVENEY ICB Cash Expended vs CDR Limit	Actual Apr-25 £000s	Actual May-25 £000s	Actual Jun-25 £000s	Actual Jul-25 £000s	Actual Aug-25 £000s	Actual Sep-25 £000s	Forecast Oct-25 £000s	Forecast Nov-25 £000s	Forecast Dec-25 £000s	Forecast Jan-26 £000s	Forecast Feb-26 £000s	Forecast Mar-26 £000s
CDR to date based on equal monthly allocation	247,707	498,505	752,353	1,011,669	1,265,685	1,526,277	1,780,657	2,035,037	2,289,416	2,543,796	2,798,175	3,065,330
Drawdown/Cash expended on ICB's behalf to date	260,059	518,109	761,294	1,017,872	1,278,224	1,532,049	1,782,395	2,030,760	2,285,129	2,542,358	2,793,490	3,065,330
ICB (over)/under draw position (Cummulative)	(12,352)	(19,603)	(8,941)	(6,202)	(12,539)	(5,772)	(1,738)	4,277	4,287	1,438	4,685	0
ICB (over)/under draw position (Monthly)	(12,352)	(7,251)	10,662	2,738	(6,336)	6,767	4,034	6,015	10	(2,849)	3,247	(4,685)
Percentage of CDR utilised (CFF - Actual/Forecast)	8.7%	17.3%	25.3%	33.5%	42.1%	50.2%	58.4%	66.5%	74.9%	83.3%	91.5%	100.0%
Percentage of months completed (CFF - Plan)	8.3%	16.7%	25.0%	33.3%	41.7%	50.0%	58.3%	66.7%	75.0%	83.3%	91.7%	100.0%

Appendix C - Working Capital - Trade Debtors (2/3)

Debtors

Total debtors at M06 is £15m (M05 £15m). The most significant balance is within accrued income for an adjustment for under delivery in dental and for income that has not been invoiced.

The M06 total trade debtors balance (graph 1) includes 83 invoices; the high value items include £947k with Norfolk County Council (46 invoices), £614k with Chiesi Ltd (6 invoices), and £75k with Eastern AHSN (2 invoices).

The M06 Trade Debt aging (graph 2) shows 34 invoices overdue 90+ days, a decrease of 2 invoices. The overdue debt principally remains with Local Authorities, NHS Bodies and staff debt for which the ICB is continuing to seek full recovery of but does provide for the chance of risk of non-receipt. The debt over 90 days has decreased August to September by £72k.

NHS NORFOLK & WAVENEY ICB Trade and Other Receivables	Oct-24 £000s	Nov-24 £000s	Dec-24 £000s	Jan-25 £000s	Feb-25 £000s	Mar-25 £000s	May-25 £000s	Jun-25 £000s	Jul-25 £000s	Aug-25 £000s	Sep-25 £000s
Trade Debtors	794	824	2,109	895	2,581	4,423	1,378	2,204	4,775	1,659	1,828
Bad Debt Provisions	(383)	(383)	(304)	(324)	(310)	(1,724)	(1,720)	(2,020)	(2,095)	(2,138)	(1,155)
Prepayments	3,488	3,576	3,927	2,818	3,339	1,169	3,484	3,995	4,061	3,210	2,773
Accrued Income	10,487	6,981	7,203	13,007	12,896	16,572	14,149	13,094	13,279	12,222	11,218
Trade and Other Receivables	**14,386**	**10,998**	**12,935**	**16,396**	**18,506**	**20,440**	**17,291**	**17,273**	**20,020**	**14,953**	**14,664**

Bad Debt Provisions

Trade debtors are subject to a review of bad debt for provision or write off, which are presented to the Audit Committee. A bad debt provision is created for trade debtors that are outstanding for more than 90 days. The value of the provision is calculated on an increasing percentage for risk based on the age of the outstanding invoice.

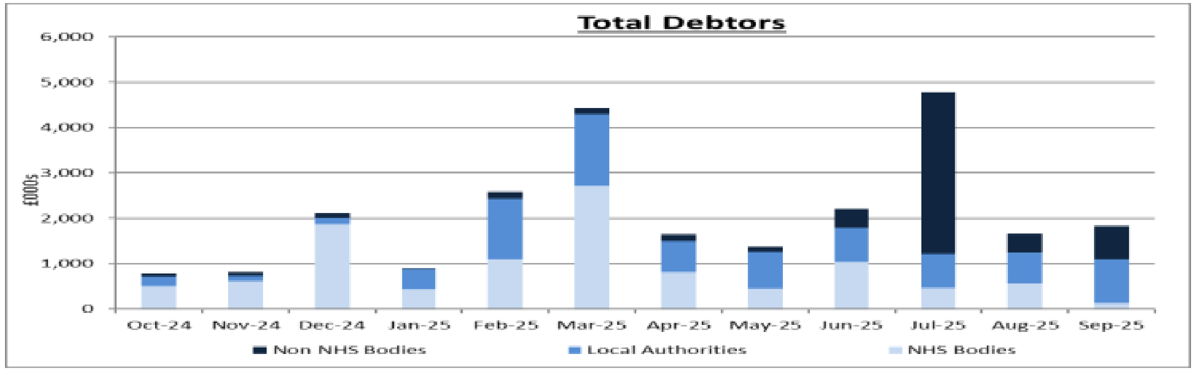
NHS Bodies

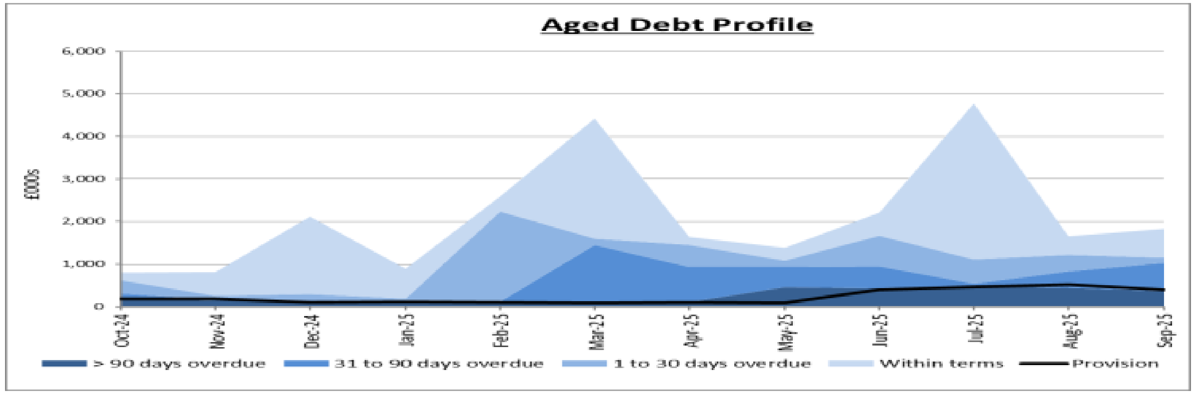
The ICB is providing against NHS invoices outstanding for more than 90 days, these items are being chased for collection by both the ICB and SBS.

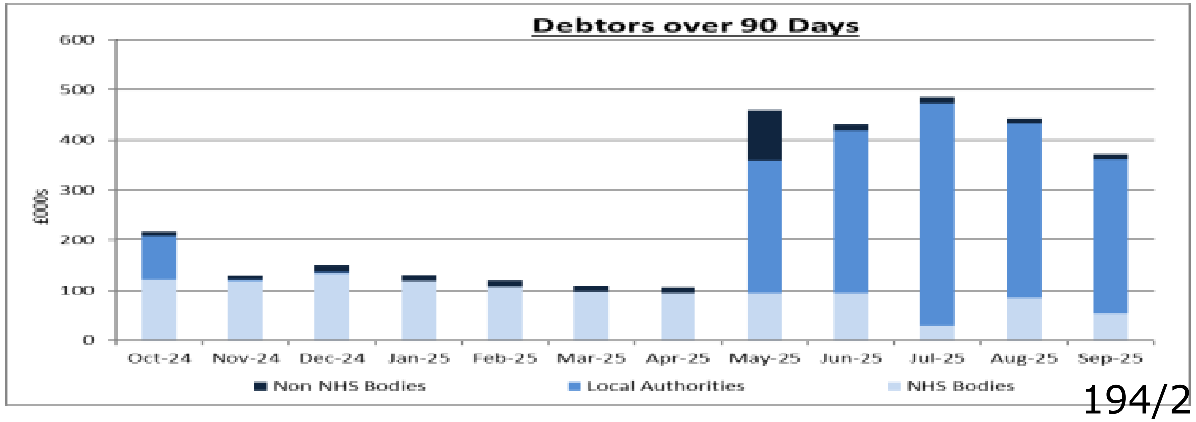
Non-NHS Bodies

The ICB is providing against the collection of the dental under delivery.

NHS NORFOLK & WAVENEY ICB Analysis of Bad Debt Provisions	Oct-24 £000s	Nov-24 £000s	Dec-24 £000s	Jan-25 £000s	Feb-25 £000s	Mar-25 £000s	May-25 £000s	Jun-25 £000s	Jul-25 £000s	Aug-25 £000s	Sep-25 £000s
NHS Bodies	81	81	88	103	91	83	81	81	81	22	49
Local Authorities	88	88	0	0	0	0	0	260	381	446	342
Non NHS Bodies	214	214	216	221	219	1,641	1,639	1,679	1,633	1,670	764
Bad Debt Provisions	**383**	**383**	**304**	**324**	**310**	**1,724**	**1,720**	**2,020**	**2,095**	**2,138**	**1,155**



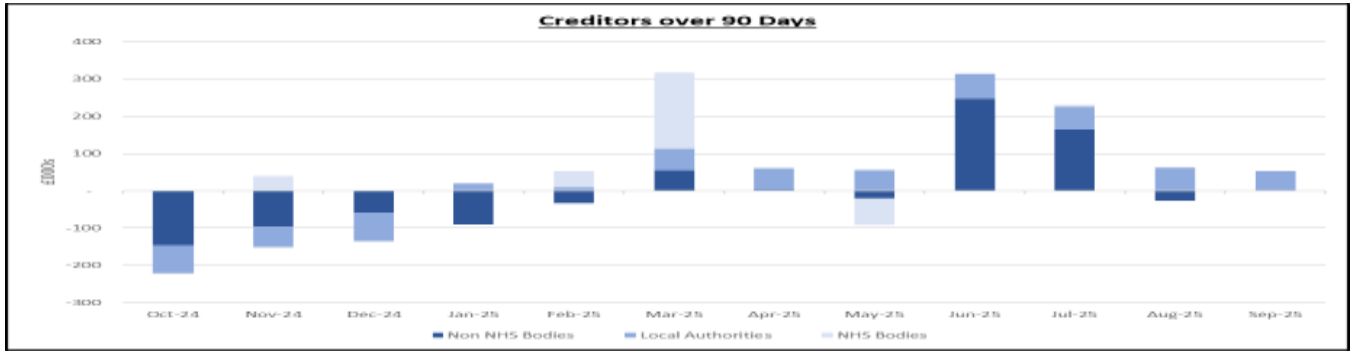




Appendix C - Working Capital - Trade Creditors (3/3)

Trade Creditors
Total Creditors for M06 is £187.8m. The largest element is Accruals whereby financial provision is made for costs which have not been invoiced/invoiced correctly.
Trade Creditors is the processed invoices for which the ICB has yet to pay, as of September 2025, the total of trade creditors is £5.9m.

NHS NORFOLK & WAVENEY ICB Trade and Other Payables	Oct-24 £000s	Nov-24 £000s	Dec-24 £000s	Jan-25 £000s	Feb-25 £000s	Mar-25 £000s	May-25 £000s	Jun-25 £000s	Jul-25 £000s	Aug-25 £000s	Sep-25 £000s
Trade Creditors	(6,848)	(5,470)	(2,557)	(2,688)	(6,782)	(6,500)	(1,664)	(3,598)	(4,596)	(4,120)	(5,867)
Accruals	(142,807)	(151,808)	(150,780)	(152,086)	(187,014)	(153,975)	(162,150)	(165,876)	(182,116)	(172,555)	(173,201)
Deferred Income	(3,216)	(3,119)	(3,368)	(3,264)	(2,060)	(6,099)	(4,040)	(4,400)	(4,076)	(3,713)	(3,573)
Payroll (including GP Pensions)	(3,353)	(3,264)	(2,888)	(2,784)	(2,934)	(3,147)	(3,374)	(3,258)	(3,060)	(3,402)	(5,156)
Trade and Other Payables	**(156,224)**	**(163,661)**	**(159,593)**	**(160,822)**	**(198,790)**	**(169,721)**	**(171,228)**	**(177,132)**	**(193,848)**	**(183,790)**	**(187,797)**



Accruals
Accruals balances will have considered (but not necessarily included) the Non-PO invoices on the accounts ledger that have not been coded at the various month ends. These have been identified in the table below as they represent the working capital cash liability that could occur once these invoices have been approved. The non invoiced accruals will not have an instant cash effect.

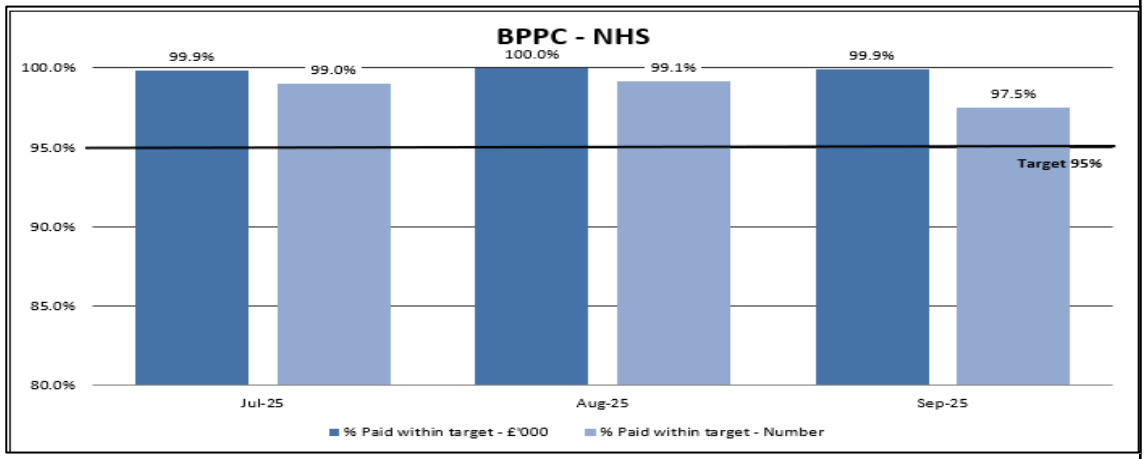
NHS NORFOLK & WAVENEY ICB NON PO INVOICES	Oct-24 £000s	Nov-24 £000s	Dec-24 £000s	Jan-25 £000s	Feb-25 £000s	Mar-25 £000s	May-25 £000s	Jun-25 £000s	Jul-25 £000s	Aug-25 £000s	Sep-25 £000s
NHS Bodies	(7,656)	(6,400)	(4,063)	(6,206)	(2,829)	(5,771)	(5,147)	(4,279)	(7,698)	(3,952)	(4,538)
Local Authorities	(9,481)	(8,823)	(7,418)	(10,872)	(7,379)	(10,571)	(5,149)	(5,666)	(6,735)	(3,428)	(2,498)
Non NHS Bodies	(14,431)	(13,972)	(13,450)	(13,713)	(11,280)	(11,783)	(15,697)	(13,778)	(12,724)	(12,608)	(7,277)
Total Non PO Invoices	**(31,568)**	**(29,195)**	**(24,931)**	**(30,791)**	**(21,488)**	**(28,125)**	**(25,993)**	**(23,723)**	**(27,157)**	**(19,988)**	**(14,313)**
Non Invoiced Accruals	(111,239)	(122,613)	(125,849)	(121,295)	(165,526)	(125,850)	(136,157)	(142,153)	(154,959)	(152,567)	(158,888)
Total Accruals	**(142,807)**	**(151,808)**	**(150,780)**	**(152,086)**	**(187,014)**	**(153,975)**	**(162,150)**	**(165,876)**	**(182,116)**	**(172,555)**	**(173,201)**

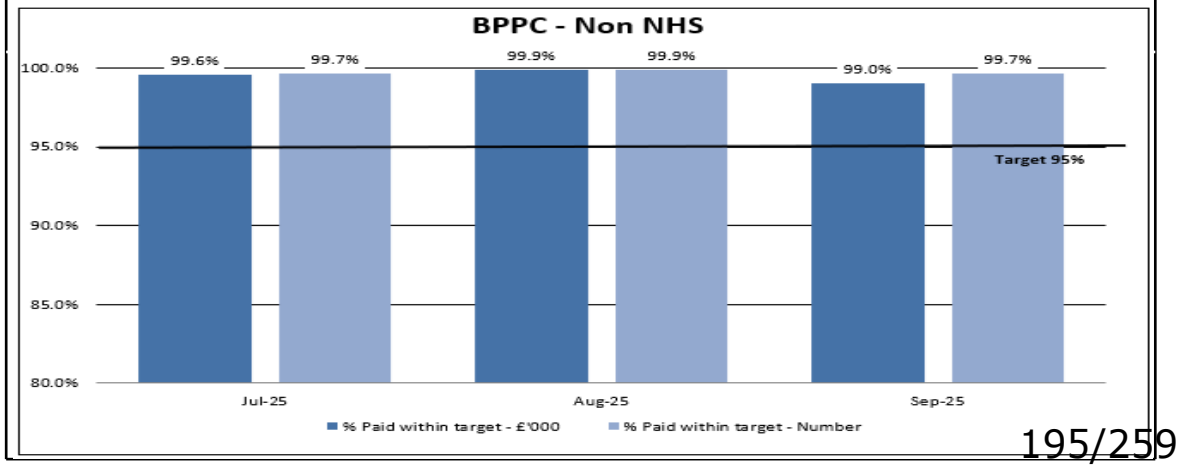
BPPC headlines:

The Public Sector is required to adhere to the 'Better Payments Practice Code' which is a requirement to pay all trade creditors within 30 calendar days of receipt of goods or an invoice.

This is measured in two ways on 1) Value and 2) Number of invoices paid, for both NHS and Non-NHS trade creditors.

The graphs below show the ICB has achieved the target of 95% on all four measures in September 2025.





Appendix D – Strategic Risks Financial Performance

Strategic Risk Financial Performance

BAF Reference	Risk Ref.	Risk Details	Likelihood score This Month	Likelihood score Prior Month	2025-26 Financial Plan £m	YTD Crystalised £m	FOT Crystalised £m	Not in FOT £m
FINCOM01	1	IF the ICB does not deliver the 2025-26 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.	4 X 4	4 X 4	-9.6	-1.9	-3.6	-10.1
FINCOM07	2	IF Continuing Health Care (CHC) expenditure continues to grow, due to market driven price increases, CHC re-introduction and clinical assessment delivery (staff / health and social mix), THEN the organisation may not achieve a break-even position in year.	4 X 4	4 X 4	0.0	0.0	0.0	-1.2
FINCOM08	3	IF the development and delivery of efficiency and transformation does not continue in line with plans, THEN the organisation will struggle to achieve financial delivery in the curent year and financial sustainability in future years.	5 X 4	5 X 4	-31.7	-0.1	-3.1	-8.7
FINCOM11	4	IF the Elective Recovery Plan does not deliver at a ICS level, then Allocations assumed in the plan will be lost, THEN the ICB may not be able to delier the financial plan and cover the cost of its own increased Independent Sector Activity.	4 X 4	4 X 4	-2.5	0.0	0.0	-1.0
FINCOM17	6	IF the availability of goods and services continues to be restricted and the current economic climate maintains or worsens, THEN	4 X 3	4 X 3	0.0	0.0	0.0	-0.1
FINCOM20	7	IF the recent changes in NICE guidance relating to diabetes, heart failure and CKD results in higher prescribing costs, THEN, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.	3 X 4	3 X 4	-3.0	-1.9	-0.2	-0.4
FINCOM22	9	IF the Re-Organisation does not recurrently reduce the Pay Costs in the ICB, THEN, there is a risk that the ICB will not remain within the Running Costs allocations resulting in breaching Financial Targets and Statutory Duties.	5 X 4	5 X 4	7.1	-0.0	-1.2	-12.6
FINCOM24	11	IF the demand for ASC and ADHD assessment services increase whereby access is quicker but the service provided by Non-NHS suppliers more expensive, THEN, there is a risk that the ICB will not remain within the Running Costs allocations resulting in breaching Financial Targets and Statutory Duties.	4 X 3	4 X 3	0.0	0.0	0.0	-3.5
		Total Risks			**-39.7**	**-3.9**	**-8.1**	**-37.6**

Strategic Mitigations Financial Performance

BAF Reference	Mitigation Ref.	Mitigation Details	Likelihood score This Month	Likelihood score Prior Month	2025-26 Financial Plan £m	YTD Crystalised £m	FOT Crystalised £m	Not in FOT £m
N/A	1	Identified Unplanned Benefits (Allocation and Investment Slippage and Prior Year)	1	1	0.0	3.9	8.1	19.5
N/A	2	Assumed as yet UnIdentified Benefits to mitigate identified risks (UnIdentified Efficiencies)	3	3	0.0	0.0	0.0	0.0
N/A	3	Assumed as yet UnApproved Benefits to mitigate identified risks (Dental Unmet Need)	3	3	5.0	0.0	0.0	5.0
		Total Mitigations			**5.0**	**3.9**	**8.1**	**24.5**
		Net Risk / (Mitigation)			❶ **-34.7**	**-0.0**	❷ **-0.0**	❸ **-13.1**

The table opposite identifies the Financial Risks the ICB is experiencing.

The planning submission recognised £34.7m of net risks ❶ including risk to delivery against a significant efficiency programme, ongoing activity and inflationary pressures in CHC and Prescribing, along with the Organisational Changes. Potential mitigations exist around Dental Unmet Need funding, but these are currently out of scope in planning guidance.

Included in the M06 reported position are £3.9m of Risks, fully mitigated by £(3.9)m of Mitigations for the Year-to-date, and £8.1m of Risks fully mitigated by £(8.1)m of Mitigations forecast for the full year ❷.

In addition to the Risks included in the Year-to-date and Forecast position, are additional Risks considered less certain, and assessed for future probability. The net probability assessed Risk totals £13.1m ❸ of which £6.5m relates to the original £34.7m net Planning Risks. New net mitigations equate to £6.6m.

Remaining net risks is presented in detail on 7.2 Financial Risk Report.

Appendix E – Efficiency Plan (Operational & Sustainable)

Project	Executive Lead	Recurrent or Non Recurrent	Status	Risk Rating	Total £000's	YTD Plan	YTD Actual	YTD Variance	Annual Plan	FOT Actual	FOT Variance
GP Prescribing total					14,000	5,553	5,907	(354)	14,000	14,000	0
CHC Total					16,541	5,850	5,181	669	15,800	16,541	(741)
Corporate - Vacancies Programme	Howard Martin	Non-Recurrent	Fully Developed	Low	3,245	895	1,541	(646)	1,790	3,245	(1,455)
Corporate - Vacancies Running Costs	Howard Martin	Non-Recurrent	Fully Developed	Low	1,335	504	647	(143)	1,010	1,331	(321)
Corporate - Closing the Gap	Howard Martin	Non-Recurrent	Plans in Progress	Low	1,200	600	600	0	1,200	1,200	0
Corporate - Allocation Gateway (6- 12%)	Howard Martin	Non-Recurrent	Plans in Progress	Low	3,000	900	900	0	3,000	3,000	0
Corporate - Convergence Provider Application	Howard Martin	Recurrent	Plans in Progress	Medium	500	250	250	0	500	500	0
ISP Cap extra saving	Phil Riedlinger	Recurrent	Plans in Progress	Medium	5,000	1,500	1,500	0	5,000	5,000	0
ISP ERF	Phil Riedlinger	Recurrent	Plans in Progress	Medium	7,000	3,498	3,498	0	7,000	7,000	0
Corporate & Other Total					21,280	8,147	8,936	(789)	19,500	21,276	(1,776)
OPERATIONAL EFFICIENCIES					51,821	19,550	20,024	(474)	49,300	51,817	(2,517)
Sustainable Commissioning as per Planning Template					0	13,000	0	(13,000)	37,000	0	(37,000)
Schemes from FEF Events					0						
Medical	Frankie Swords	Both	Fully Developed	Medium	1,610	0	791	791	0	1,610	1,610
Primary Care	Mark Burgis	Both	Fully Developed	High	2,242	0	2,012	2,012	0	2,242	2,242
Community	Mark Burgis	Both	Fully Developed	Low	754	0	656	656	0	754	754
CHC & LD&A	Lisa Nobes	Both	Fully Developed	Low	3,013	0	500	500	0	3,013	3,013
All age Mental Health	Richard Watson	Both	Fully Developed	Medium	878	0	422	422	0	878	878
Acute	Mark Burgis	Recurrent	Fully Developed	High	0	0	0	0	0	0	0
Provider Growth and IAP Slippage	Howard Martin	Non-Recurrent	Fully Developed	High	0	0	0	0	0	0	0
Finance (CTG)	Colin Bright	Non-Recurrent	Fully Developed	Low	10,549	0	6,905	6,905	0	10,549	10,549
Approved IT products not proceeding	Richard Watson	Non-Recurrent	Fully Developed	Medium	0	0	0	0	0	0	0
ICES Capitalisation	Howard Martin	Non-Recurrent	Fully Developed	Low	4,806	0	2,154	2,154	0	4,806	4,806
Influenceable Spend Review	All	Non-Recurrent	Fully Developed	Low	1,215	0	98	98	0	1,215	1,215
FEF Ideas still being worked up	All	Non-Recurrent	Plans in Progress	High	8,758	0	0	0	0	8,758	8,758
OTHER EFFICIENCIES (Sustainable Commissioning)					33,825	13,000	13,538	538	37,000	33,829	(3,175)
GROSS EFFICIENCY PROGRAMME					85,646	32,550	33,562	(1,012)	86,300	85,646	(654)

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 provider 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 facetted 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.

Norfolk and Waveney
Integrated Care Board

Agenda item:19

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Hein van den Wildenberg**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 November 2025**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 24.09.2025. Subsequent Meetings: 30.09.2025, 28.10.2025
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 2025/26 (ICB) financial plan. BORR08/In-phase 002 – Underlying deficit position
Key items for assurance/noting:	*The information below is based on **Month 6** results, i.e. per September 2025.* Much information regarding Month 6 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 6 reporting:

	- At **Month 6 (September 2025)** the NHS entities in the N&W ICS show a deficit of £(15.2)m vs a Planned deficit of £(7.3)m, i.e. a shortfall of £(7.9)m. The shortfall sits in the acute group of hospitals. Efficiency schemes delivered a saving year to date of £86.4m against a Plan of £83.9m. The Plan for the year is break-even including deficit support funding of ca. £ 51m. At Month 6 there is £16.4m of net risk outside the reported position. This is a considerable improvement compared to the update provided to September Board. The third tranche of deficit support funding was allocated to N&W. - At **Month 6 (September 2025)** the ICB shows a break-even position against a planned break-even position. Efficiency schemes delivered a saving year to date of £33.6m, £ 1.1m more than the plan of £32.5m. The delivery is much more reliant on non-recurring efficiencies than foreseen in the plan. The Plan for the year is break-even. At Month 6 there is £ 13.2m of net risk outside the reported position. - Per month 6, agency spend is £12.1m, £2.5m under plan and nearly half of agency spend same period last year. Per month 6, Bank spend is £51.5m, £3.6m above plan. - Whilst recognising the risk profile inherent in the reported results, there is presently **reasonable assurance** that the NHS entities in the N&W ICS will meet their plan. - Year to Date CDEL (**Capital** Delegated Expenditure Limit) expenditure as of Month 6 (September 2025) was £13.7m, £18.8m below plan. The forecast system CDEL & IFRS 16 capital expenditure is £58.3m, £5.0m below plan. - **Underlying Deficit:** Traditionally, the ICB has calculated the underlying financial position (ULP) using the recurrent allocation as it is dictated by NHS England. Put simply, the recurrent cost of the ICB's business is compared to the recurrent allocations that the ICB receives at any given month. This is an established process and has been the basis

	for reporting the ULP to boards and committees since at least the formation of the Norfolk and Waveney CCG. In August 2025, NHS England issued a new ULP return and the accompanying guidance stated that ICB's should consider all non-recurrent allocations as recurrent. This represents a fundamental shift in the calculation process previously employed. The expectation is that this process will be adopted for the forthcoming Medium Term Financial Plan. - This could see the ICBs reported underlying deficit reduce by some £40-60m. This change has no impact on the ICBs cash position. - Other topics covered: o The committee considered elective activity levels in acutes this year (year to date, and forecast outturn) seen through the lens of impact on financial outturn and Elective Recovery Funding. o The September committee heard on update on the Medium Term Planning process. o The September committee heard an update on the ICBs efforts to minimise void space and improve utilisation of bookable space. o The September committee reviewed the delayed annual assessment of the finance committee.
Items for escalation to Board:	1. Month 6 results at system and ICB level. Current assessment of reasonable assurance that NHS entities in N&W ICS will meet their financial plans, whilst recognising the risk profile outside the reported position. 2. Deficit support funding is released on a quarterly basis and depends on credible progress against financial and efficiency plans. So far 3 of the 4 tranches that make up the total of ca £51m have been allocated 3. Significant change in reporting Underlying Financial Position and therefore Underlying Deficit for Norfolk & Waveney, following NHSE instructions.

	NHS entities in N&W ICS, including ICB	**N&W ICB**
Month 6 (September 2025)	Actual: Deficit of £(15.2)m vs Plan of £(7.3)m, i.e. a	Actual: Break-even vs Plan of Break-even

		shortfall of £(7.9)m.	
	Underlying Deficit *(* Basis of 2025/26 Financial Plans)*	NHSE has updated definitions resulting in a substantial lower Underlying Deficit than hitherto reported. Exact numbers tbc	NHSE has updated definitions resulting in a substantial lower Underlying Deficit than hitherto reported. Exact numbers tbc
	Efficiency delivery	Year to Date £83.9m Plan £86.4m Delivered Full Year £201.7m Plan	Year to Date £ 32.5m Plan £ 33.6m Delivered Full Year £86.3m Plan
Items requiring approval:	None		
Confirmation that the meeting was quorate:	Both 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.

Norfolk and Waveney
Integrated Care Board

Agenda item: 20

Subject:	**Medium Term Planning update – 2026/27**
Presented by:	**Designate Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning – NHS Suffolk and North east Essex Integrated Care Board and NHS Norfolk and Waveney Integrated Care Board**
Prepared by:	**Liz Joyce, Head of System Transformation**
Submitted to:	**ICB Board**
Date:	**26 November 2025**

Purpose of paper:

To update the Board on Medium-term Planning, including:

- Development of an ICB Population Health and Commissioning Strategy for the proposed NHS Norfolk and Suffolk ICB, based on an Integrated Needs Assessment (INA)
- Development of an ICB Population Health Improvement Plan for the proposed NHS Norfolk and Suffolk ICB, including commissioning intentions
- Submission of a 3-5 year operational planning submission

The Board is asked to endorse the approach being taken to develop the Integrated Needs Assessment, Population Health & Commissioning Strategy and the Population Health Improvement Plan within the context of the national timelines set out within the Framework(s).

Executive Summary:

The following guidance been published:

- The Planning Framework for the NHS in England
- The Medium-Term Planning Framework – Delivering Change Together 2026-27 to 2028-29
- The Strategic Commissioning Framework (SCF)

These policies combined aim to operationalise the new NHS England 10 Year Health Plan

This paper briefly summarises the guidance and what it means for the ICB in its role as a strategic commissioner. Additionally, the paper summarises work undertaken so far and the Committee is asked to endorse the overall approach.

Operational planning targets for 2026/27 are included in the report. They are an extension of targets in previous years, with a continued focus on elective recovery, urgent and emergency care and access to primary care.

A proposed timeline is set out within the report, including anticipated points in the governance when Board assurance and sign off will be required in December, January and March.

The **Planning Framework for the NHS in England** was published in September. The Framework introduces principles for effective integrated planning and defines planning responsibilities across Providers, ICB's, NHSE regions and the NHSE national team. The initial priorities for the ICB include:

- Developing an Integrated Needs Assessment (INA)
- Developing an ICB Population Health and Commissioning Strategy that reflects NHS operational priorities, the priorities in the NHS 10-Year Plan and local priorities
- Having evidence-based discussions with providers on multi-year Commissioning Intentions to form the basis of both the Strategy, and ICB Population Health Improvement Plan (PHIP)

The publication of this Framework was the signal for the ICB and system partners to start the work to refresh existing operational and clinical strategies.

In October, the **Medium-Term Planning Framework – Delivering Change Together 2026-27 to 2028-29** was published. It sets out a view of what effective medium-term planning looks like and reinforces the integrated approach and priorities that have been jointly agreed nationally.

This umbrella framework will be underpinned by the numerical plans covering workforce, finance and performance trajectories and Board assurance statements.

Within the Medium-Term Planning Framework are the 2026/27 and 2028/29 targets for operational performance and transformation covering:

- Elective, cancer and diagnostics
- Urgent and emergency care
- Primary Care
- Community health services
- Mental Health
- Learning Disabilities, Autism and ADHD
- Workforce

The detail can be found on pages 26-35 of the Framework. At the time of drafting this paper, the submission timetable and functional templates were not available, but the timeline is being brought forward relative to previous years, with a draft submission date expected to be in December and final submission in January/February. As in previous years, submission of triangulated plans that meet all the planning requirements will be at the forefront of the review process.

Provider and ICB Boards will be expected to undertake a maturity assessment covering areas including operational and strategic plan delivery, financial stewardship, performance against key standards, governance and compliance, quality and safety of care and system-wide transformation and integration. This is required at first and full submission stage.

In November, the **Strategic Commissioning Framework** (SCF) was published. This clearly defines the ICB's role as strategic commissioner with a set of clear expectations and timelines. It sets out a four-stage approach of:

1) Understanding the context
2) Developing a long-term population health strategy
3) Delivering the strategy through the payor function (allocating resources to incentive outcomes)
4) Evaluating impact

The SCF sets out a requirement for ICB's to:

- Develop an Integrated Needs Assessment (INA) by March 2026 at the latest
- Set an overall 5-year Strategy by January 2026
- Develop a 5-year Population Health Improvement Plan (PHIP) by January 2026 which will support the delivery of the Strategy and the requirement of each ICB to have a JFP

These three outputs will be refreshed at least annually and will reflect the development of the commissioning approach across for example, pan Norfolk and Suffolk, at System level and at Neighbourhood and Place.

The PHIP will include clear Commissioning Intentions (CI). These will describe the outcome we want to achieve (based on evidence), what outcome measures we are going to adopt, and then what the ICB intends to do in the short and longer term to achieve the outcome. These will be SMART and transparent in their approach and written in a way that providers will be able to respond to them. The aim is that they are used to further develop strong and trusted working relationships with providers. Draft CIs will be shared with providers for feedback and then finalised and written up as the PHIP for Board approval in January/February, subject to the national timetable.

Guidance from the Department of Health & Social Care on Neighbourhood Plans has not yet been published.

Progress so far

To update the Board as to current work and next steps, this paper sets out a summary of the work that the ICB has been progressing at pace in response to the national requirements:

1) **Developing an Integrated Needs Assessment**, with the Norfolk and Suffolk Public Health teams and wider intelligence around the current workforce, quality, performance and finance challenges and opportunities - this has been completed and shared with Providers as a draft to inform their Integrated 5 Year Plans and with Commissioners to inform the development of Commissioning Intentions. This has directly informed the clinical priority areas and the suggested outcomes.
2) **Refreshing existing Strategies and Plans** to develop a combined Norfolk and Suffolk Population Health and Commissioning Strategy. This work is well underway. The purpose of the Strategy is to be clear about the intent to improve population health outcomes, reduce inequalities and improve access and deliver the three shifts set out within the NHS 10-year plan. The Strategy will adopt a life course approach across six clinical domains, with each of the domains having a clinical priority and suggested outcome for consideration. Adults and Children & Young People are being considered within all the domains apart from two which are age specific. The Strategy will be socialised with Healthwatch, the two Health and Wellbeing Boards and other key system groups and partners and is work in progress.
3) **Developing detailed Commissioning Intentions** to feed into the PHIP - ICB Commissioners have worked up CI's that are mapped to the clinical priorities that were identified through the Integrated Needs Assessment. These will be shared with Providers, other key system stakeholders and the ICB Board and an internal review session is planned for December. The purpose of the PHIP is to set out interpretation of the Strategy into a series of deliverable outcomes for providers and Neighbourhood to respond to.
4) **Regular fortnightly provider forum** to align the Strategy and draft Commissioning Intentions with Provider 5-year Integrated Plans – these have been meeting since September, and an outline of the emerging Strategy has been shared with the group for feedback.
5) The ICB has set up an **internal planning group** with NHSE, who will interface directly with Providers this year for their template submissions for activity and performance, workforce and finance. This group will oversee the template submission for the ICB and triangulation, and preparation for the Board assurance. The cadence and pace of this group will need to increase once the planning templates have been received. Work is underway to forecast activity and performance trajectories using Provider year to date information.

Proposed Timescales

These timescales are subject to change with the publication of further guidance or information, and the Board is asked to note the evolving position. There is still considerable work to be undertaken at pace and the Board is asked to note the tight timescales.

The approach to the Strategy development and relationship with the Health and Wellbeing Strategies was socialised at the Suffolk Health & Wellbeing Board on 13th November. The same report will be shared at the Norfolk Health and Wellbeing Board on 3rd December.

The Strategy and PHIP will be shared with the ICB Board on 28th January 2026 for sign off.

A timeline for publishing the PHIP and the Integrated Needs Assessment is being worked through and is likely to be March 2026.

Recommendation to the Board:

The Board is asked to endorse the approach being taken to develop the Integrated Needs Assessment, Population Health & Commissioning Strategy and the Population Health Improvement Plan within the context of the national timelines set out within the Framework(s).

Key Risks	
Clinical and Quality:	None identified at this stage
Finance and Performance:	None identified at this stage
Impact Assessment (environmental and equalities):	This will be undertaken once the documents are in draft stage
Reputation:	None identified at this stage
Legal:	None identified at this stage
Information Governance:	None identified at this stage
Resource Required:	No additional resource required at this stage
Reference document(s):	Planning Framework for the NHS in England – September 2025 Medium Term Planning Framework - Delivering Change Together-2026-27-to-2028-29 – October 2025 Strategic-Commissioning-Framework – November 2025
NHS Constitution:	N/A
Conflicts of Interest:	N/A

Reference to relevant risk on the Board Assurance Framework	BAF03 Ambition 3: Improving Services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS) *Risk Title: Barrier to the full delivery of the MH transformation programme (children).* BAF04 Ambition 4: Transforming Mental Health Services *Risk Title: Barriers to full delivery of the MH transformation programme (adults).* BAF06 Ambition 6: Improving Urgent & Emergency Care *Risk Title: System/Urgent & Emergency (UEC) pressures.* BAF07 Ambition 7: Elective Recovery and improvement *Risk Title: Elective Recovery.*

Governance

Process/Committee approval with date(s) (as appropriate)	The Strategy and PHIP will be approved by the ICB Board and the operational planning submission is subject to an assurance process that will be described in the operational planning guidance when published.

Norfolk and Waveney
Integrated Care Board

Agenda item: 21

Subject:	Integrated Performance Report Assurance
Presented by:	Richard Watson, Designate Deputy Chief Executive and Executive Director of Strategy, Digital and Commissioning – NHS Suffolk and North East Essex Integrated Care Board and NHS Norfolk and Waveney Integrated Care Board
Prepared by:	ICB Collaborative Commissioning and Performance Team with contributions from teams working in subject areas.
Submitted to:	Norfolk and Waveney ICB Board meeting
Date:	26 November 2025

Purpose of Paper:

To provide assurance to the ICB Board of performance against plan. The paper will:

- highlight key successes
- draw attention to areas of concern
- describe remedial actions for areas of concern

Executive Summary:

Committee are asked to note:

1. **Cancer**: FDS (28day) and 62-day combined standards are not being met across the system and are below planned position. There is variation across modalities / cancer sites and there is no assurance that performance will meet plans.
   Assurance level: concerning

2. **Elective**: Diagnostics and referral to treatment (RTT) times are off the planned position (negatively) – noting the report shows some areas remain in special cause improvement recovery to the planned position for 2025/26-year end will be significantly challenging. There is significant variation across specialities. Urgent and cancer cases, and those who have been waiting the longest times are being prioritised, further impacting some treatment time standards.
   The ICB and NHSE are providing oversight and support as appropriate.
   Contractual escalations have been made with JPUH and NNUH regards 65-week waiting times.
   Assurance level: concerning.

3. **Mental Health**: Acute discharges followed up within 72 hours performance has slightly decreased but remains above target.
   Since March 2025 there had been a reduction in the average length of stay, whilst this increased in August, the system is performing within expected limits,
   12-hour decision to admit is a focus as part of the wider crisis pathways and management of acute / urgent care. **Assurance level: average.**

4. **UEC**: 111 call response times shows continued improvement. Category 2 ambulance response times have increased through August and September. There is currently no assurance that trajectories will be met.
   Assurance level: concerning

5. **Primary care:** In September, data for general practice appointments recorded shows 655,285, exceeding the 2025/26 operational plan by 49,600 appointments. The ICB remains confident that practices will continue to meet or surpass planned activity levels. Quarter 3 data (October–January) will be critical in assessing the impact of the 1 October contractual changes, which aim to ensure consistent online access for patients. This data will support understanding of whether these changes influence how patients choose to access care (e.g., online versus traditional routes) and of any impact on overall appointment delivery across general practice.
   Assurance level: Good

6. **Dental**: activity delivery for general dental activity has been higher month on month this year compared to the same period last financial year. There is confidence that overall practices will deliver their activity however there will be variation between individual practices with some under-delivering.
   Activity for orthodontic services is on target to deliver 100%. A number of orthodontists have accepted the offer to reduce waiting lists with increased activity up to 110% this year.
   Assurance level: Good

Report

1. **Cancer**

Overall Level of Assurance

Assurance Level	Supporting Statement
Concerning	Cancer delivery is behind planned positions for August. The 28-day FDS remains in special cause improvement, while one provider met their in-month plan. There is variation across Trusts and cancer body sites, due to a range challenges with some key themes such as: diagnostic delays; workforce challenges; demand profile changes. Cancer 62-day performance is in common cause variation, with improvement for 4 months returning the position to that at April-25 One Trust met their in-month plan. Early (stage 1 and 2) Cancer diagnosis rates are behind plan.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	BAF07 (InPhase reference; 010) (BORR) 043; (ORR) 057; 050; 051; 075
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	Metric(s) connected to this concern	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
High referral levels impacting on waiting times and backlogs.	28-day FDS standard (C&P-1), 62day Combined Performance (C&P-2)	Y	Y	N
Delays in diagnostic testing and workforce constraints.	DM01: 6-week diagnostic (C&P-3)	Y	Y	Y
Backlog of long wait patients delaying treatment start dates.	Acute Trust Cancer Waiting Lists and trajectories.	Y	Y	N
Oncology workforce shortages.	62-day standard (C&P-2)	Y	N	N

Key success(es) - description	Metric(s) connected to this success
Implementation of the BMS guidance for women on HRT or with unscheduled bleeding on gynae pathways. This shall free up capacity on the USC pathway.	Gynae FDS performance.
N&W ICB have agreed to commissioning the Lynch pathways to consent patients for testing for the syndrome and potential onward referral for genetic counselling. This will lessen wait times for genetic counselling.	Genetic counselling waiting times.
NNUH have maximised their use of teledermatology within their current capacity.	Skin FDS performance.
Rapid Cancer Action Team pathway reviews to commence in Lung and Prostate which will focus on the 62-day metric and associated improvements.	62 Day performance.

2. Elective Care and Diagnostics

Overall Level of Assurance

Assurance Level	Supporting Statement
Concerning	**Diagnostics** (DM01): The confirmed performance for Aug-25 shows common cause concern, with all providers below planned position. Trust-level reporting identifies variation across providers as well as across test type. Providers have significant plans in place to recover the position, primarily through additional activity (through both insourcing and outsourcing) through to the end of 2025/26. **Referral to first outpatient appointment:** The confirmed position in Oct-25 is 6.5 percentage points below plan, continuing the under-delivery to plan from June-25. This performance is in special cause concern. Current focus on long waits and cancer pathways will challenge recovery in the immediate term, and any non-delivery of 2025/26 standards will add further work to future years in order to meet the constitutional 18-week standard by 31st March 2029. **Referral to treatment** (RTT): The Aug-25 position for 18-week and 52-week RTT, for the system and all providers in Norfolk and Waveney, is negative to the planned position. In addition, the system,

	and 2 Trusts within the system, continue to work to eliminate 65-week waits. Providers have provided remedial action plans to NHSE and the ICB with trajectories that outline recovery – James Paget University Hospital has outlined that more deliverable actions are required to return to the planned position and eliminate 65week waits by the end of 2025/26. There remains a significant reliance on additional capacity – through internal staff processes or the purchase of additional capacity through insourcing or outsourcing to achieve year-end plans. This reliance on additional capacity places some risk on the deliverability as the additional capacity cannot be guaranteed. Plans into 2026/27 will further challenge the system and require robust and sustainable delivery.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	BAF07 (InPhase 010) BORR 076; 077
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	**Metric(s) connected to this concern**	**Remedial Actions in Place**	**Recovery Trajectory**	**Contractual Escalation**
Modality variation in Diagnostics waiting times, with reliance on routes for additional capacity that may not be deliverable (e.g. availability of insourcing) to achieve recovery.	DM01: 6-week diagnostic (C&P-3)	Y	Y	N
Impact of delayed diagnostics and treatment – patient outcomes and experience, and reputational impact.	DM01: 6-week diagnostic (C&P-3) RTT standards (C&P-4/5/6)	Y	Y	N
Long waiting times (65-week RTT) has not yet been eliminated and there is risk that the system will not achieve the revised national elimination ambition.	RTT standards (C&P-4/5/6)	Y	Y	Y
Delivery of the 2025/26 planned elective standards may not be achieved as a system	RTT standards (C&P-4/5/6)	Y	Y	N

Key success(es) - description	**Metric(s) connected to this success**
The three acute provider Trusts in Norfolk and Waveney are utilising the newly formed Group model to support challenged areas across the system and seek collective solutions.	DM01: 6-week diagnostic (C&P-3) RTT standards (C&P-5/6) First appointment in 18-week (C&P-4)

3. Mental Health

Overall Level of Assurance

Assurance Level	Supporting Statement
Average	Acute discharges followed up within 72 hours performance has slightly decreased but still remains above target. Since March 2025 there had been a reduction in the average length of stay, whilst this increased in August, the system is performing within expected limits. Significant work continues to address the 12-hour A&E decision to admit breaches. However, these are complex, multifaceted issues involving system level and provider level factors.12-hour decision to admit is a focus as part of the wider crisis pathways and management of acute / urgent care.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	BAF - 006 BORR - 048
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	Metric(s) connected to this concern	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
12-hour A&E decision to admit breaches – the latest data shows a downward trend following months of an improved picture. The current variation is not considered acceptable, and we continue to work closely with NSFT as part of their clinical transformation work priority pillar to support improved performance. Whilst there is no recovery trajectory this is being continuously monitored and is affected by system pressures. Benchmarking data does show that this performance is comparable to or slightly better than the national average.	C&P12	N	N	N

Key success(es) - description	Metric(s) connected to this success
Talking Therapies performance in respect of first treatment within 18 weeks continues to overperform or meet target.	C&P12

4. Urgent and Emergency Care

Overall Level of Assurance

Assurance Level	Supporting Statement
Concerning	The focus of the UEC Programme Board for 25/26 is based around the national priorities to improve patient outcomes. For UEC this is

	to improve A&E waiting times and ambulance response times compared to 2024/25. The 60 second response time to 111 calls is maintaining special cause improvement, and with latest data showing 1.7 percentage points off the 95% target. Category 2 Ambulance response times shows special cause improvement, as performance is within the control limits, however times have increased through August and September, ahead of winter. There is currently no assurance that NNHS Norfolk & Waveney will meet the planned trajectory.

Risks	
Are any performance risks recorded?	Y
Risk Reference No(s)	BAF - 003
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	**Metric(s) connected to this concern**	**Remedial Actions in Place**	**Recovery Trajectory**	**Contractual Escalation**
Ambulance turn-around times are impacting on wider performance areas and poses a risk to patient safety (in the community and at the ED front doors) and quality of care.	C&P8, Ambulance Response times.	In progress	In progress	N
Recovery plans are required where performance is not achieving plan or contractual standards.	All where performance is of concern.	In progress	In progress	N

Key success(es) - description	**Metric(s) connected to this success**
Work within UCCH and 111 validation rates continues to be high, meaning less C3-C5 ambulance are sent which allows additional capacity within community for higher acuity calls.	C&P8, Ambulance Response times.
Virtual ward strategic review has taken place, with an outcome of all providers signing up to a new model workshop. Task and finish groups are in early stages to support this work.	

5. Primary Care

Overall Level of Assurance

Assurance Level	**Supporting Statement**
Good	Delivery is to plan.

Risks	
Are any performance risks recorded?	
Risk Reference No(s)	BAF – 032 BORR – 023, 025, 029, 056 ORR - 053, 054, 055, 071
Committee with Risk Oversight	Primary Care Commissioning (PCCC)

Key concern(s) - description	Metric(s) connected to this concern	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
Nil				

Key success(es) - description	Metric(s) connected to this success
Nil noted – see Primary Care report to ICB Board	

6. Dental

Overall Level of Assurance

Assurance Level	Supporting Statement
Good	Activity delivery month on month is higher than the same period last year, an additional 64,000 units of activity delivered in first six months. Discussions are underway to rebase contracts that have underperformed year on year to free up funding for investment in NHS dental services, either with providers who can deliver or through new contracts and a tender process in areas of greatest need. Providers have been offered the opportunity to deliver up to 110% of their activity linked to new patients if they can.

Risks	
Are any performance risks recorded?	
Risk Reference No(s)	BAF02
Committee with Risk Oversight	Primary Care Commissioning (PCCC)

Key concern(s) - description Resilience of dental practices and ability to recruit workforce to deliver NHS dental services	Metric(s) connected to this concern	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
Nil noted				

Key success(es) - description	Metric(s) connected to this success
Year on year improvement in activity achieved and increase in number of new patients being seen Delivery of 21,520 additional urgent dental appointments as share of national target of 700,000.	Activity target and number of patients seen split by children and adults

Recommendations to ICB Board:

- Recognition of the achievements in Dental services.
- Recognition of key areas of achievement in mental health.
- Challenges in delivery of Cancer targets and impact on patient care
- Challenges in diagnostic and RTT delivery, and notably the position at JPUH, who have submitted revised plans to the end of 2025/26 to NHSE that are below the plans submitted at the start of the financial year. This may see the system position not achieved as planned.
- The position in UEC as winter period of pressures starts.

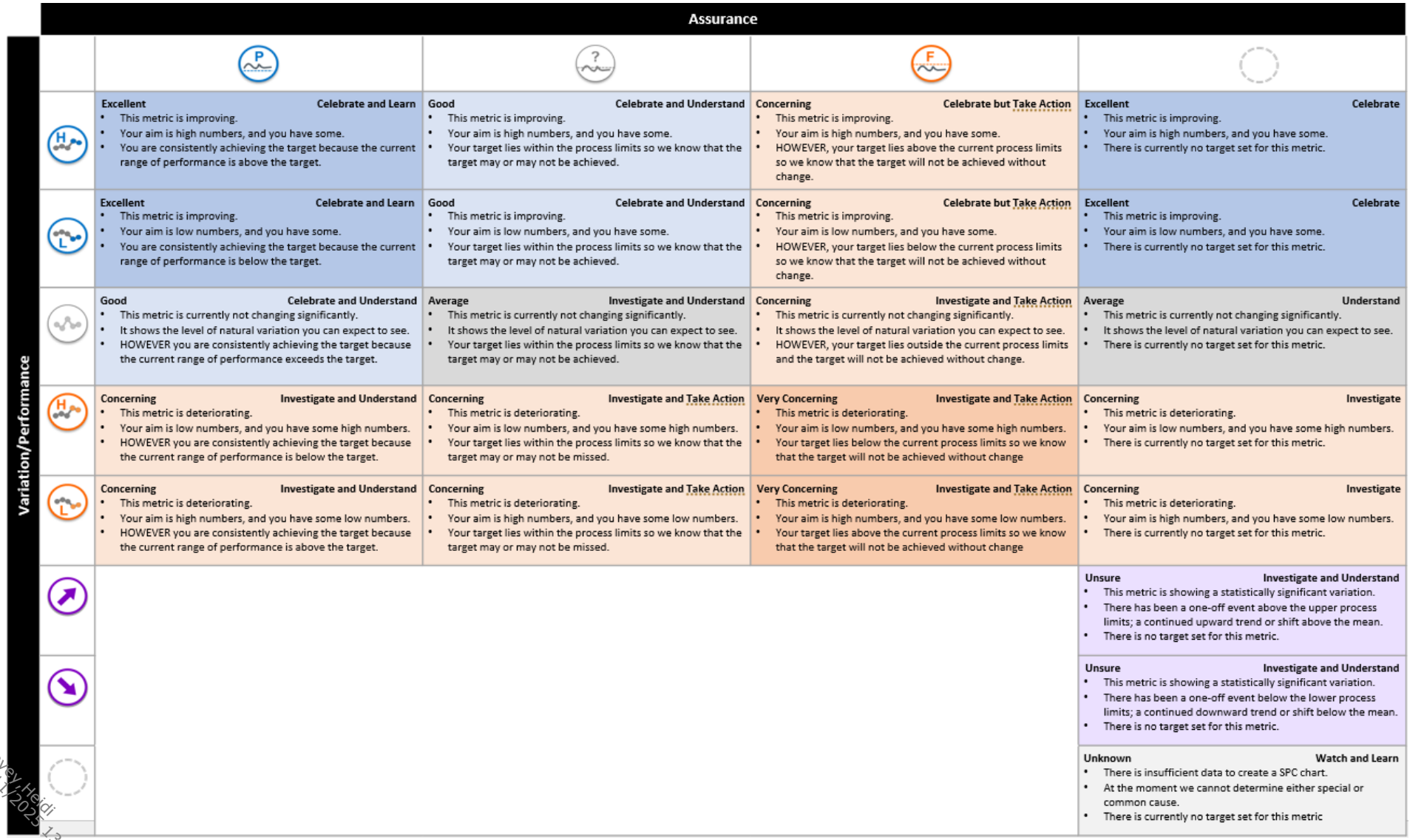
Governance

Board Approval	Norfolk and Waveney ICB Board Agenda Item: Date: 26th November 2025

Reference Document
Summary MDC Icons and How to Interpret Them
[Making Data Count link]

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart, you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers, but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers, but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers, and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers, and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits, then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction,** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction,** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.



Norfolk and Waveney ICB Board – **Board Performance Pack**

November 2025

View in Power BI

Last data refresh:
16/11/2025 20:01:06 UTC

Downloaded at:
17/11/2025 08:37:19 UTC

Improving lives **together**
Norfolk and Waveney Integrated Care System

ICB Board Report

Report Overview

The ICB Board Report has been created to support the oversight of key metrics by providing actionable information.

The metrics have been agreed by the ICB Board & 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

ICB Board

SPC headlines for core 15 ICB Board metrics: October 25

	Variation indicates consistently **P**assing the target	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently **F**alling short the target	No Target
Special Cause of Improving nature or lower pressure due to **H**igher or **L**ower Values		Cancer - 28 Day FDS Performance - ICB UEC - Mean C2 Ambulance Response Times (Mins) - ICB	RTT - 18 Week Performance - ICB	
Common Cause - No significant change		Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB	Cancer - 62 Day Combined Performance - ICB UEC - Total A&E 4hr Performance - Provider Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB	Dental - % of Units of Dental Activity (UDA) delivered - ICB Dental - % of Units of Orthodontic Activity (UOA) delivered - ICB Primary Care - Total GP Appointments - ICB
Special cause of concerning nature or higher pressure due to **H**igher or **L**ower Values				

ICB Board

SPC headlines for core 15 ICB Board metrics: March 26

Search:

Search

Variation

- Common Cause
- Concern (High)
- Concern (Low)
- Improvement (High)
- Improvement (Low)

Assurance

- Capable
- Not capable
- Unreliable

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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	Aug 25	71.2%	74.7%	Trajectory	H	?	National
2	Cancer - 62 Day Combined Performance - ICB	Aug 25	60.1%	67.2%	Trajectory		F	National
3	UEC - Mean C2 Ambulance Response Times (Mins) - ICB	Sep 25	40.69	30.0	Target	L	?	Provider Submission
4	UEC - Total A&E 4hr Performance - Provider	Oct 25	75.1%	75.3%	Trajectory		F	National
5	RTT - 18 Week Performance - ICB	Sep 25	54.4%	57.1%	Trajectory	H	F	National
6	Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB	Sep 25	86.4%	80.0%	Target		?	National
7	Mental Health - E.H.37 Average LOS In Adult Acute MH Beds - ICB	Sep 25	67.0	60.9	Trajectory			National
8	Finance - FOT Surplus/Deficit - ICB	Oct 25	£0	£0	Target			Other
9	Primary Care - Total GP Appointments - ICB	Sep 25	655,285	605,659	Trajectory			GPAD
10	Dental - % of Units of Dental Activity (UDA) delivered - ICB	Jul 25	25.8%		Target			National
11	Dental - % of Units of Orthodontic Activity (UOA) delivered - ICB	Jul 25	19.4%		Target			National
12	Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB	Sep 25	31	0	Target		F	ECDS

ICB Board

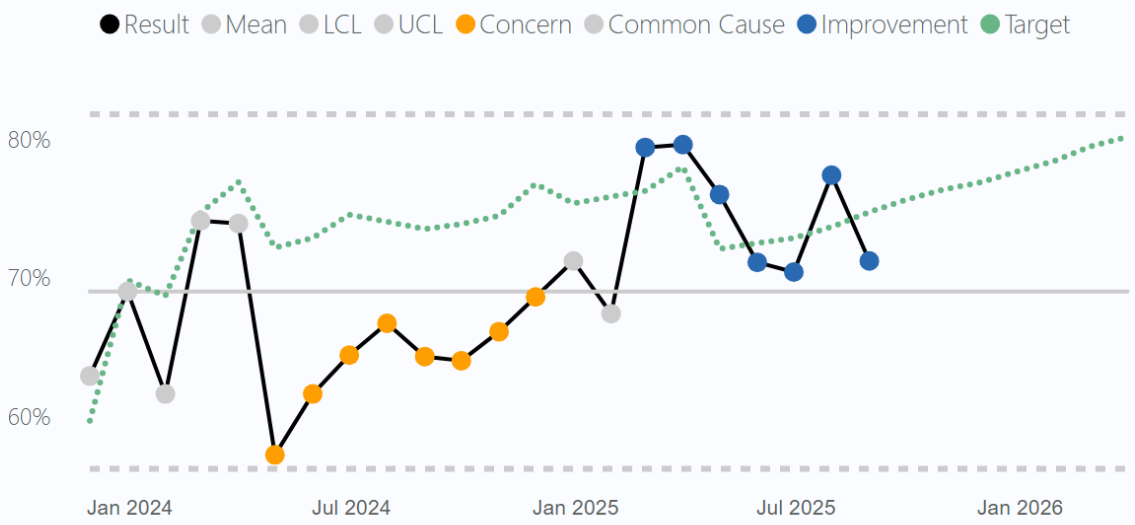
Cancer - 28 Day FDS Performance - ICB

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
Aug 25	National	71.2%	74.7%		

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System Position - Summary and Context

Aug-25 performance was 71.2%, which is 3.5 percentage points behind plan. The chart continues to show special cause variation of improvement. The Norfolk & Norwich University Hospital were the only provider in Norfolk and Waveney to deliver on plan in the month. Nationally performance in Aug-25 was 74.6%

Performance, however, remains fragile due to diagnostic delays, workforce constraints, and high referral volumes impacting timely cancer pathway progression.

Root Causes and Contributing Factors

- Diagnostic delays in endoscopy, radiology, and histopathology - shortening the pathway time for treatment.
- Workforce shortages (consultants, diagnostic staff) and sickness leading to reduced capacity.
- High referral volumes across key tumour sites (skin, colorectal, urology, gynaecology) driving backlog growth.
- Capacity constraints in plastics, urology, and lung pathways limiting timely first appointments.
- Operational pressures – admin tracking gaps and ERS processes impacting booking and pathway flow.

Associated Metrics, Insights and Impacts

Delays in achieving a diagnosis can increase patient anxiety, impact timely treatment initiation, and contribute to poorer clinical outcomes, particularly for aggressive or fast-progressing cancers.

Interconnected Metrics: Cancer 62-day; Diagnostics (DM01); Early (Stage 1 and 2) Cancer diagnosis.

Key Actions and Risks to Actions

1. Provide additional diagnostic capacity through multiple routes such as additional clinics and weekend working, and Community Diagnostic Centres utilisation, with a focus on histology recovery.
2. Implement and embed Best Practice Timed Pathways (BPTPs) across priority tumour sites.
3. Grow one-stop and nurse-led clinics (e.g. triage) to streamline patient flow.
4. Apply productivity analysis and external partner support to optimise internal processes.
5. Maintain grip through weekly/bi-weekly Patient List reviews.

Oversight: Cancer Transformation Oversight Group to Commissioning & Performance Committee to 31/03/2026.

ICB Board

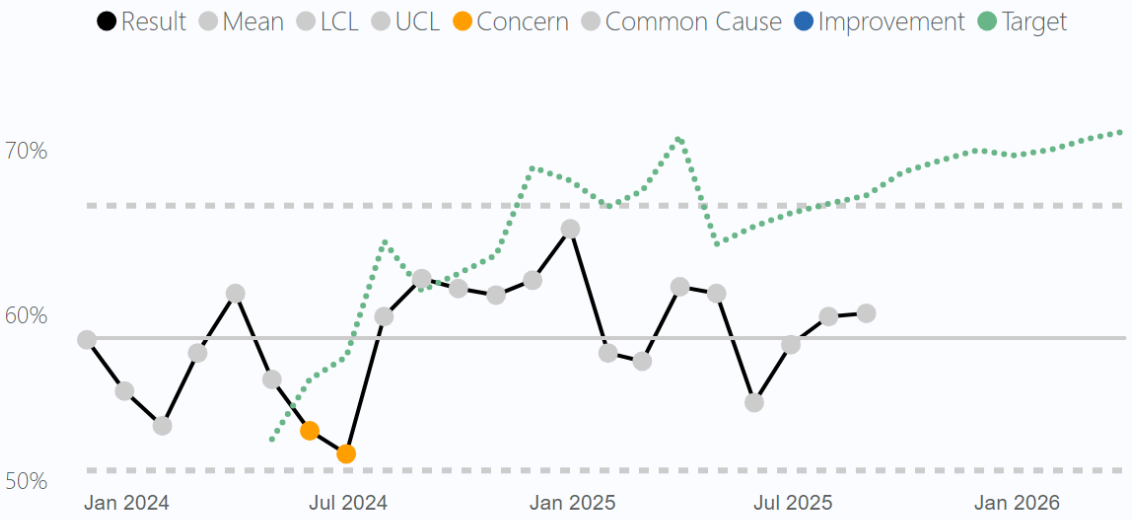
Cancer - 62 Day Combined Performance - ICB

Metric Description

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

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Aug 25	National	60.1%	67.2%		

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System Position - Summary and Context

Aug-25 performance was 60.1%, a 0.2 percentage point improvement from July but remains 6.6 percentage points below the target for the month. Variation is seen across providers in Norfolk and Waveney and by cancer body site.

The Statistical Process Control chart shows common cause variation. There is no assurance of sustained delivery at this point.

Root Causes and Contributing Factors

- Backlog of long-wait patients in key tumour sites (urology, colorectal, lung, gynaecology) continues to delay treatment starts.
- Diagnostic delays in histopathology, radiology, and endoscopy(notably lower GI, upper GI, and head & neck pathways) are compressing the treatment window.
- Workforce shortages (e.g. oncologists, anaesthetists, diagnostic staff) are limiting treatment and diagnostic capacity.
- Late tertiary referrals and restricted theatre access are reducing ability to treat within 62 days.
- Patient choice and clinical complexity continue to contribute to delays.

Associated Metrics, Insights and Impacts

Diagnostics and 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

1. Additional diagnostic capacity through additional staffing, clinics and maximising system capacity
2. Implement and embed Best Practice Timed Pathways (BPTPs) across high-pressure tumour sites
3. Targeted histopathology and endoscopy recovery support, including backlog clearance and recruitment
4. Strengthen tumour site PTL oversight and escalation for patients approaching breach and prioritising
5. Whole system work on key specialities of challenge

Oversight: Cancer Transformation Oversight Group to Performance Committee oversee these actions, to run to 31/03/2026

ICB Board

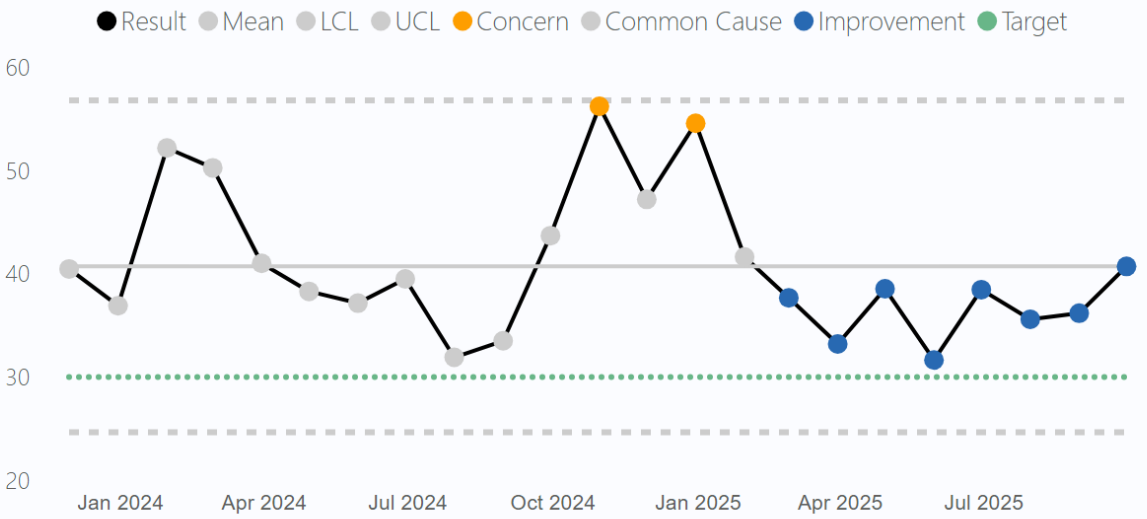
UEC - Mean C2 Ambulance Response Times (Mins) - ICB

Metric Description

The average minutes taken for all Category 2 ambulance dispatches from the clock start time to the time the first ambulance arrives on scene.

BAF

BAF06



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Sep 25	Provider Submission	40.69	30.0		

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System Position - Summary and Context

C2 response times have increased for a 3rd month in a row with Septembers result being 40.69, this moves N&W further from the 30 minute target.

Root Causes and Contributing Factors

Turn around delays and activity continue to have an an impact on C2 performance as this reduces 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 continues to work on pre dispatch element of C3-C5. Call before convey has increased into UCCH and hear and treat rates are above 20%.

Our 111 provider continues to validate lower acuity ambulances and reduce as many as possible, with over 60% downgraded away from an ambulance.

ICB Board

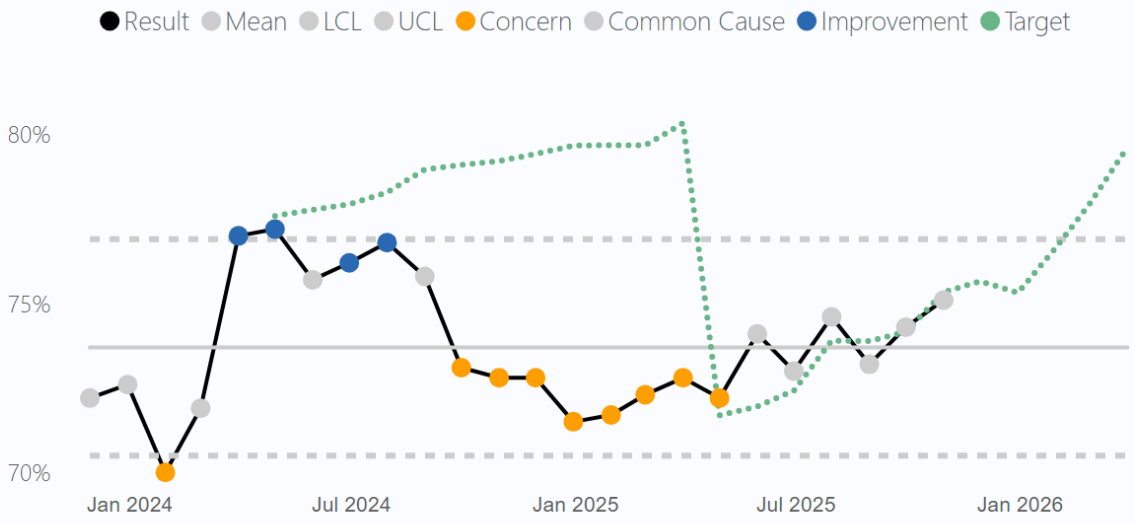
UEC - Total A&E 4hr Performance - Provider

Metric Description

The percentage of A&E attendances across all department types that spend less than 4 hours from arrival to departure.

BAF

BAF06



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Oct 25	National	75.1%	75.3%		

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System Position - Summary and Context

An increase has been seen in 4 hour performance across the ICS to 74.3% which is slightly above the trajectory of 74.2%

Broken down by acute this is: NNUH - 80.4%, JPUH - 67.5%, QEH -65.8%. NNUH and JPUH remain above their trajectories, with QEH below theirs, however improvements have been seen within QEH performance compared to August.

Root Causes and Contributing Factors

Ambulance activity remains static however minors activity remains high. UCCH and NHS111 consistently reviewing patients to ensure only patients that need to be there are coming into ED's and alternative pathways are used wherever possible.

Capacity within the community remains 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 submitted their operational plans for 25/26 and how they expect to perform throughout the year work has commenced on working towards their individual targets.

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 and implementing their plans for 25/26 to support acute in hospital programmes of work.

ECIST as part of Tier 1 have visited sites and reports are expected with recommendations to support service delivery.

ICB Board

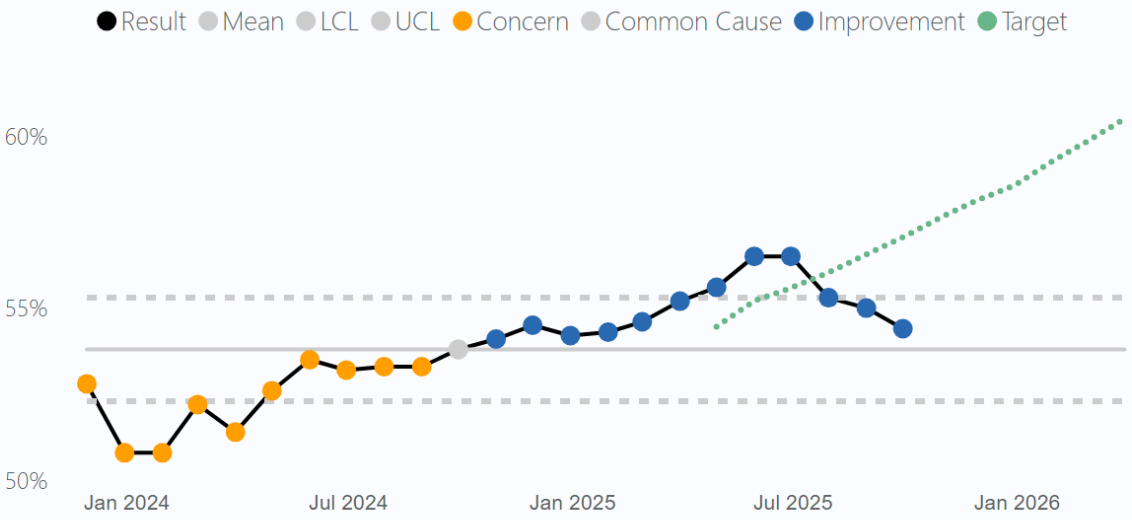
RTT - 18 Week Performance - ICB

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



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Sep 25	National	54.4%	57.1%		

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System Position - Summary and Context

Aug-25 performance was 55.0%: an increased gap between plan and performance, though the SPC chart continues to show special cause improvement. All local system providers are below plan (by 2.2 to 3.3 percentage points) and under the 61.0% National performance for Aug-25. Current forecasts return delivery to plan by end Dec-25 for 2 of 3 providers. Further mitigation's are required to return the whole system to plan.

Root Causes and Contributing Factors

- Workforce shortages, vacancies, and sickness reducing capacity - including in diagnostics at the start of pathways.
- Activity year-to-date is below plan in key elective areas with financial pressures limiting recovery activity.
- Referral/demand profile changes in pressured specialities - to be investigated further.
- Outpatient transformation and productivity improvements (including national validation).

Associated Metrics, Insights and Impacts

- Diagnostics and 52-week Referral to Treatment (RTT) standards and long waiting times of 65-weeks.
- RTT analysis for key groups is being undertaken routinely. Recent analysis of data as part of the NHSE Statement on Information on Health Inequalities will further inform actions. Specialty level analysis is being undertaken to exclude skewing.
- Harm reviews are in place for those on waiting lists.

Key Actions and Risks to Actions

1. Productivity plans within each provider, supported by specialist advisers as needed.
2. Demand management programme in place, aligned with national/local initiatives.
3. Outpatient and theatre capacity expanded through WLIs, insourcing, and enhanced waiting list management.

Performance and improvement is vulnerable at speciality and to key dependencies such as workforce.

Risks: Recruitment delays, variable WLI/insourcing uptake, and financial constraints.

Oversight: Scheduled Care Board and Commissioning & Performance Committee oversee to 31/03/2026.

ICB Board

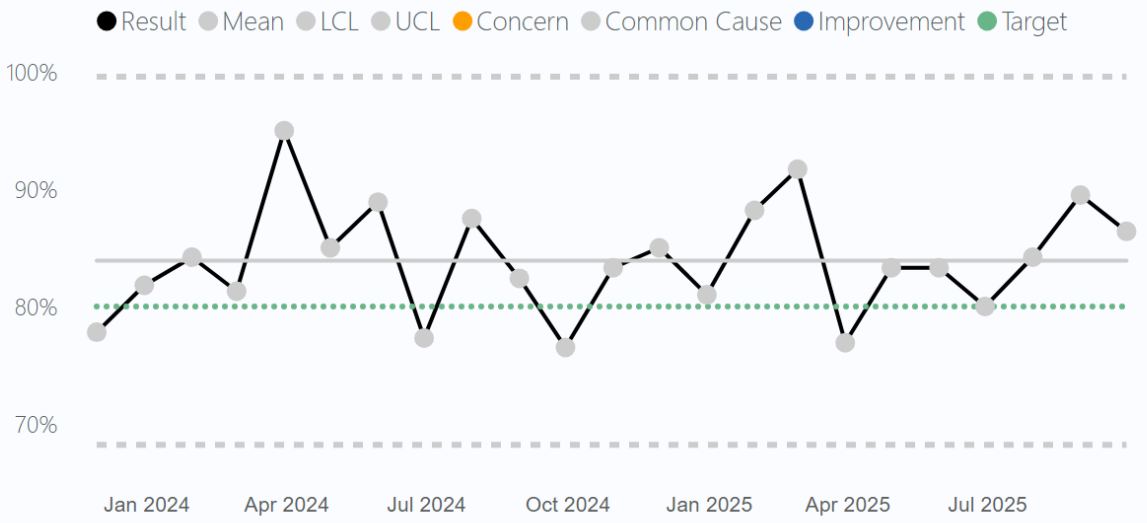
Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB

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
Sep 25	National	86.4%	80.0%		

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System Position - Summary and Context

This section reflects a increase in performance which has gone up to 89.5%. We met the target last month where the Trust's position was in line with national/regional benchmarks. It also notes that the SPC chart provides assurance that the Trust is 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 80% 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.

ICB Board

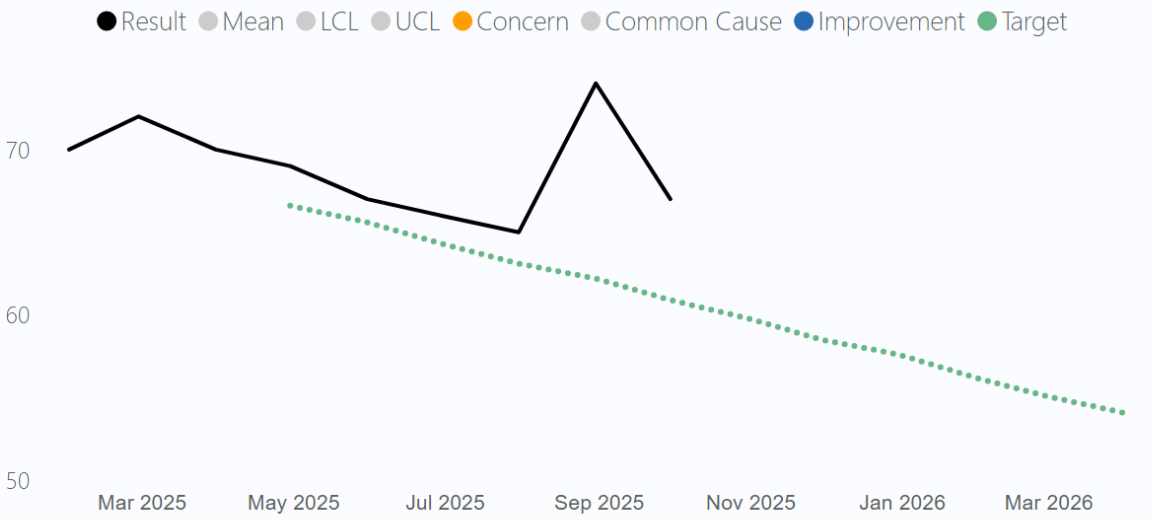
Mental Health - E.H.37 Average LOS In Adult Acute MH Beds - ICB

Metric Description

Rolling 3 month figure showing the NHSE calculated average length of stay (LOS) for those aged 18 and over in Adult, Older Adult and PICU Mental Health Beds. Average is the total bed days for these discharges divided by total discharged inpatient spells where final ward is Adult, Older Adult or PICU

BAF

None



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Sep 25	National	67.0	60.9		

System Position - Summary and Context

There has been a continued reduction in average length of stay, from March 2025 (72) , down to 65 last month bringing performance closer to target levels and broadly in line with national and regional benchmarks. However, this month has seen an increase up to 74. The SPC chart provides a level of assurance, indicating that the current performance is stable with some expected, acceptable variation. There is no indication of special cause variation, suggesting the system is performing within expected limits.

Root Causes and Contributing Factors

The length of stay in adult acute mental health beds is influenced by a range of system-level and provider-level factors. Key drivers include high demand for inpatient beds, delays in discharge planning, and workforce challenges across both inpatient and community settings. Inconsistent availability of step-down and community support services contributes to prolonged admissions, as does variation in access to housing, social care, and appropriate follow-up support. Regional disparities and patient-level complexities, such as social or clinical needs that cannot be quickly met, also play a significant role. Tackling these issues will require improved coordination across the system, enhanced community provision, and a focus on timely, person-centred discharge pathways.

Associated Metrics, Insights and Impacts

Length of stay has a direct impact on quality of care, patient safety, and experience. Extended admissions can lead to increased risk of institutionalisation, delayed recovery, and reduced bed availability. Overly short stays may compromise stability and readiness for discharge. Health inequalities are evident, with some groups. This metric is closely interconnected with others, including bed occupancy, delayed transfers of care, community follow-up, and readmission rates, all of which influence and are influenced by the average length of stay.

Key Actions and Risks to Actions

1. Strengthening discharge planning processes – multi-agency discharge planning from the point of admission.
2. Expanding community capacity – investment in crisis response, home treatment, and step-down services
3. Improving flow through acute pathways – enhancing bed management and reducing internal delays, particularly through digital tools and real-time tracking.
4. Targeted support for complex discharges – introducing dedicated roles or panels to address housing, social care, and legal barriers.

All of which are in place.

ICB Board

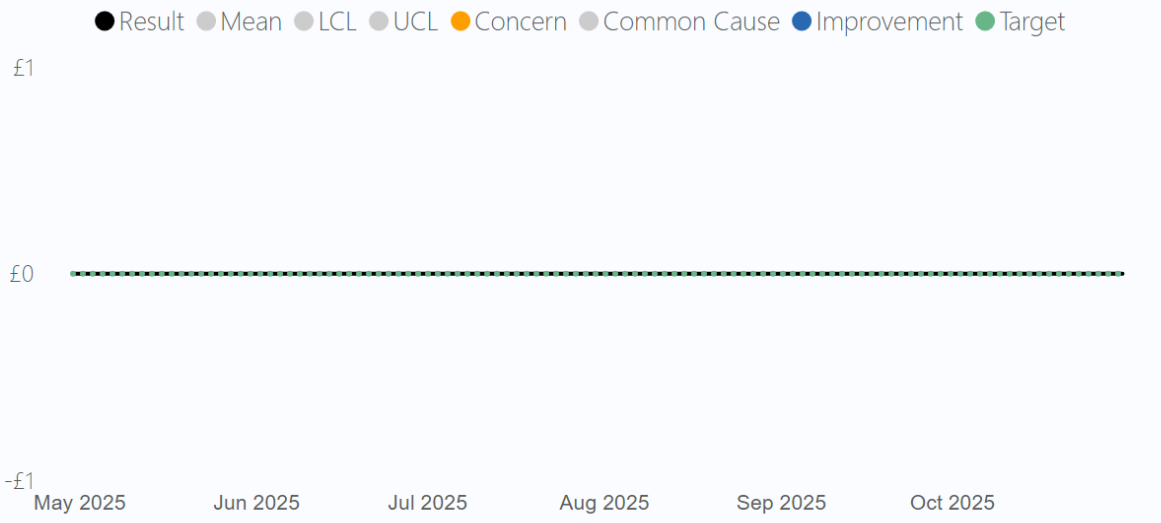
Finance - FOT Surplus/Deficit - ICB

Metric Description

N&WICB Forecast Outturn (FOT) Surplus/Deficit. Full year forecast position, updated monthly.

BAF

BAF08



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Oct 25	Other	£0	£0		

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System Position - Summary and Context

The ICB is reporting a break even on plan position at M7, both YTD and FOT.

YTD under delivery of sustainable commissioning efficiencies are offset by additional operational efficiencies and Prior Year Benefits.

Root Causes and Contributing Factors

N/A

Associated Metrics, Insights and Impacts

N/A

Key Actions and Risks to Actions

In order to deliver a breakeven position the oragnisation needs to maintain a firm grip on the efficiency programme and ensure there is no further slippage.

ICB Board

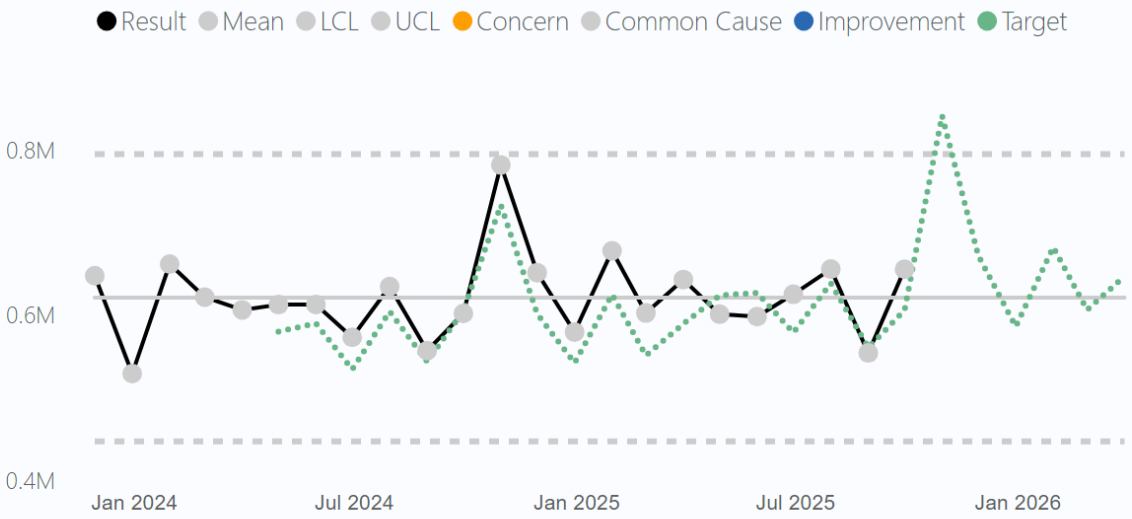
Primary Care - Total GP Appointments - ICB

Metric Description

Total number of General Practice Appointments per Practice

BAF

BAF02



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Sep 25	GPAD	655,285	605,659		

System Position - Summary and Context

September saw an over delivery of 49,600 appointments compared to target. All 5 areas of N&W saw a year on year increase in appointments with the biggest being a 12% increase in Yarmouth & Waveney. This may well be due to the timing of flu clinics. To date, against the plan, we are running at around 75k above the plan. The trends for the % of face to face appointments; appointments with a GP; same day appointments has remained consistent (around 70%; 33% and 40%) throughout the year.

Root Causes and Contributing Factors

Work continues to build a common and collective understanding around the various different data sources and soft intelligence. This informs ongoing conversations between commissioning managers and providers around variations in the number and type of appointments being recorded. This work should put us in a good position to collectively identify and understand challenges with demand and capacity and agree plans and support required to address these.

Associated Metrics, Insights and Impacts

Metrics within the GP dashboard and soft intelligence are combined to support identification of where additional support to understand, and address, variation in experience and access is required.

Key Actions and Risks to Actions

Ongoing review of data, conversations to support coding/recording is happening to support conversations with GP surgeries to identify areas where systems can support effective working to ensure that appointment availability aligns with clinical need and supports a positive patient experience. This will be reported through GP Action Plan updates to the Primary Care Commissioning Committee

ICB Board

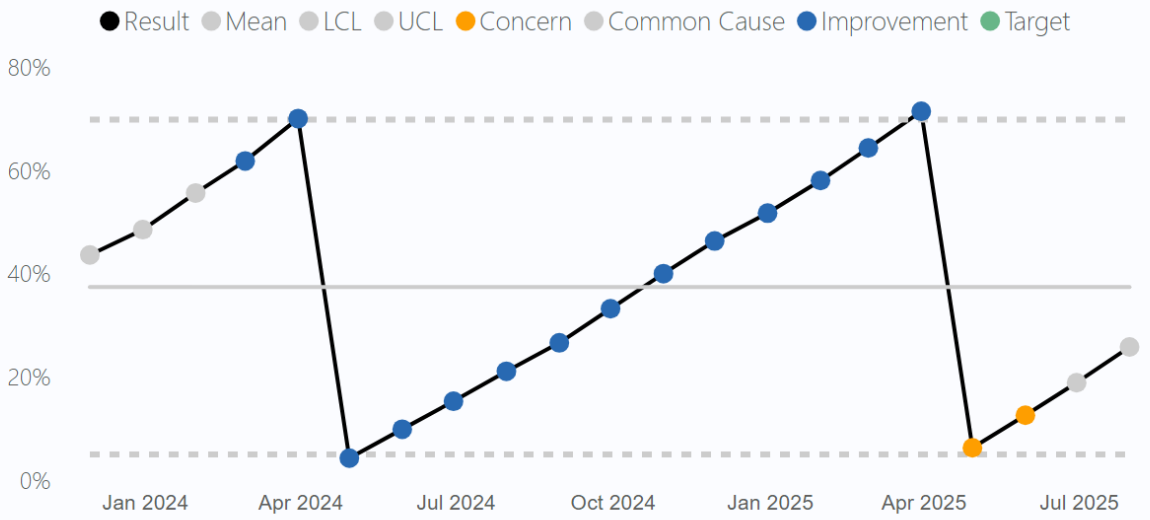
Dental - % of Units of Dental Activity (UDA) delivered - ICB

Metric Description

Percentage of units of dental activity (UDA) year to date delivered against the total annual contracted UDAs for the ICB.

BAF

BAF02



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jul 25	National	25.8%			

Daveyd Heidi 29/1/2025 13:38:45

System Position - Summary and Context

The ICB is on target to achieve a higher level of activity by year end, month on month activity is higher than the same months in 2024/2025. 64,000 units of activity delivered in first six months over and above the same period last year. Practices must achieve at least 30% of their contracted activity by September each year, the report highlights that the majority of practices will achieve this target.

ICB has agreed to fund up to 110% over-performance for contractors to see new patients.

Root Causes and Contributing Factors

Investment in dental workforce schemes and support to contractors, including the option to shift towards a mix of flexible commissioning and national contract activity is resulting in improved resilience and increased activity. Additional investment of £1.5m in 2024/2025 for new patients has also impacted increase in activity delivery this financial year.

Associated Metrics, Insights and Impacts

Unscheduled Care target to deliver additional 21,520 appointments in 2025/2026, new national scheme launched Oct 2025 has resulted in 29 additional providers signing up to deliver unscheduled care this year.

Increase in new patients seen by children and adults

Oral health needs data review

Key Actions and Risks to Actions

Delivery of Year 2 ICB Long Term Dental Plan

Rebase targeted underperforming contracts to release monies for reinvestment

Deliver dental workforce schemes for 2025/2026

Risk that workforce schemes may not deliver sufficient increase in workforce (dentists and dental care professionals)

Risk of increased costs for dental practices may result in unsustainable NHS dental services

ICB Board

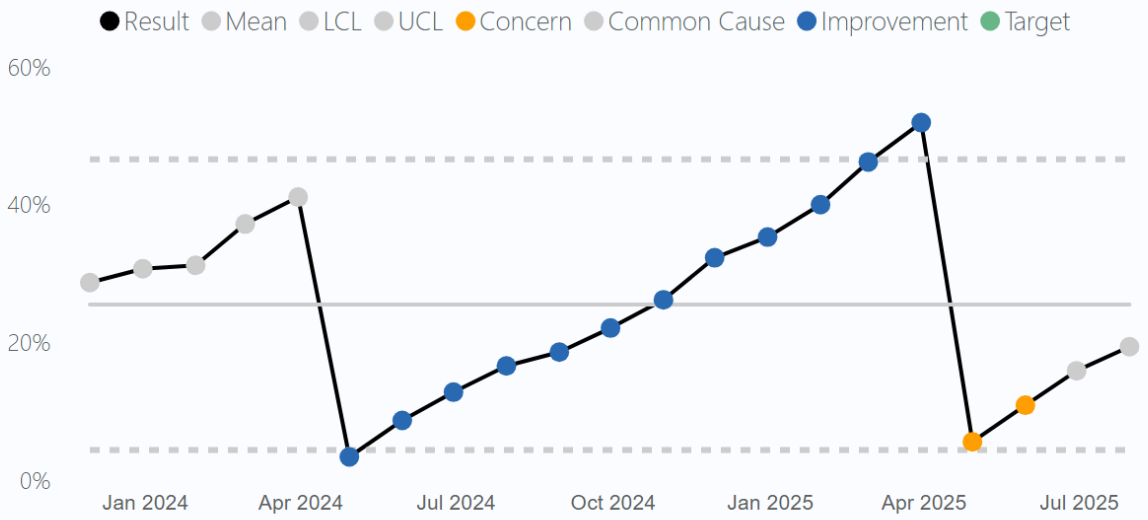
Dental - % of Units of Orthodontic Activity (UOA) delivered - ICB

Metric Description

Percentage of units of orthodontic activity (UOA) year to date delivered against the total annual contracted UOAs for the ICB.

BAF

BAF02



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Jul 25	National	19.4%			

System Position - Summary and Context

Orthodontic activity on target to deliver target trajectory by year end. The ICB has also agreed to finance up to 110% to enable orthodontic providers to reduce waiting lists, all providers have accepted the offer.

Root Causes and Contributing Factors

Orthodontic activity is claimed on commencement of treatment. Orthodontic contracts expire 31 March 2027 however treatment can take 18 - 24 months to complete.

Associated Metrics, Insights and Impacts

Increase in UDA dental activity. Lack of access to general dental services leads to a lack of shared care between general dentist and orthodontist whilst patient in active treatment and inability for individuals to be referred for orthodontic treatment start.

Orthodontic Needs Assessment completed September 2025.

Risk to orthodontic workforce sustainability in the long term without planned intervention.

Key Actions and Risks to Actions

Primary Care Commissioning Committee approved extension of 6 contracts up to 10 years in principle subject to Quality and Performance review of individual contracts.

NHS England approval received subject to completion of ICB governance. EMT and Board approval also required.

Commissioning and Performance Committee

Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB

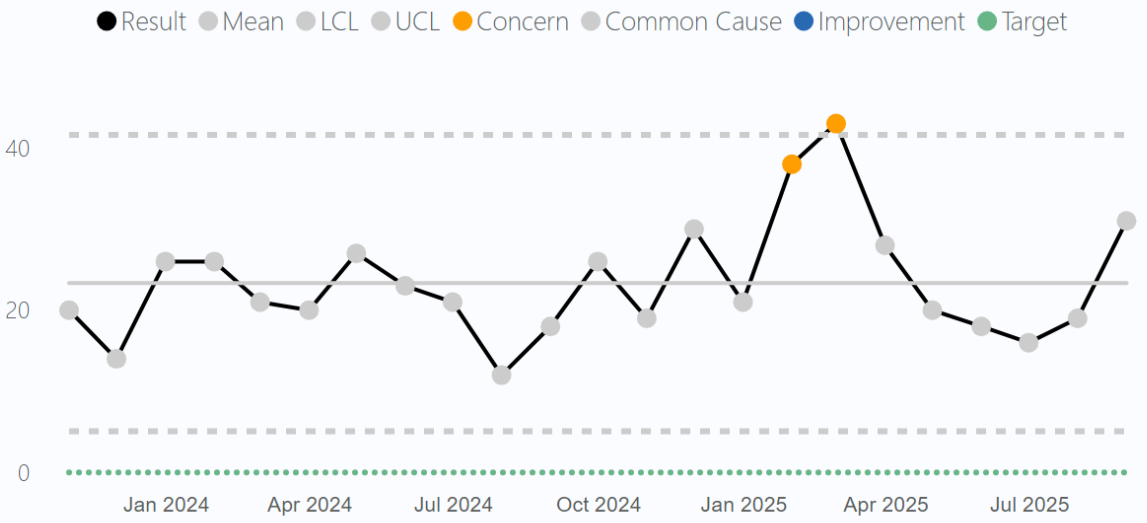
Supplementary

Metric Description

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

BAF

None



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Sep 25	ECDS	31	0		

System Position - Summary and Context

During the current reporting period, there were 31 12-hour DTA breaches, where the target remains zero. This is an increase from the last report.

Improvement actions have continued. 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 the 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

NSFT clinical transformation work priority pillar is: Interface with Mental Health Liaison Service (MHLS) and acute hospitals (NSFT led):

Some of the key components are seeking clarity re roles and responsibilities between Crisis Resolution Home Treatment Team (CRHTT) and MHLS re crisis pathway (includes Children and CYP crisis)

Review of the MHLS across NSFT including age- appropriate support

Areas for improvement with acute hospitals and physical healthcare pathway

ICB Board
Metric Dictionary

The table below contains a further breakdown about the metrics contained within the report

Metric Order	Metric ID	Metric Name	Metric Description	Metric Technical Description
1	3009	Cancer - 28 Day FDS Performance - ICB	Percentage of N&WICB patients treated within 28 days following an urgent referral for Cancer	Per Cancer Waiting Times (CWT) N&WICB Data published by NHSE. Numerator: Number of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer, an referral for breast symptoms where cancer was not initially suspected or an urgent referral from an NHS Cancer Screening Service, within a given month. Denominator: Total number of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, following an urgent referral for suspected cancer, an referral for breast symptoms where cancer was not initially suspected or an urgent referral from an NHS Cancer Screening Service, within a given month.
2	3845	Cancer - 62 Day Combined Performance - ICB	Percentage of N&WICB patients treated within 62 days for Cancer first definitive treatment.	Per Cancer Waiting Times (CWT) N&WICB Data published by NHSE. Numerator: Number of patients receiving a first definitive treatment for cancer within 62 days of receipt of: an urgent GP (or other referrer) referral for urgent suspected cancer; a breast symptomatic referral; an urgent screening referral; or consultant upgrade, within a given month/quarter. Denominator: Total number of patients receiving a first definitive treatment for cancer following receipt of: an urgent GP (or other referrer) referral for urgent suspected cancer; a breast symptomatic referral; an urgent screening referral; or consultant upgrade, within a given month/quarter.
3	10273	UEC - Mean C2 Ambulance Response Times (Mins) - ICB	The average minutes taken for all Category 2 ambulance dispatches from the clock start time to the time the first ambulance arrives on scene.	Average response times for C2 priority Numerator: Total Response Time (Mins) Denominator: Total Call Outs
4	3806	UEC - Total A&E 4hr Performance - Provider	The percentage of A&E attendances across all department types that spend less than 4 hours from arrival to departure.	Percentage of all A&E attendances that left the department within 4 hours Numerator: The number of patients in all A&E department types that left within 4 hours Denominator: The number of patients in all A&E department types Data Source: NHS England: Monthly A&E Attendances and Emergency Admissions
5	3638	RTT - 18 Week Performance - ICB	Percentage of N&WICB patients at the end of the month who are waiting under 18 weeks against the RTT standard.	Percentage of N&WICB patients at the end of the month who are waiting under 18 weeks against the RTT standard. Numerator: Patients waiting for RTT treatment at month end with a weeks wait of 17 weeks and under. Denominator: Total number of patients waiting for RTT treatment at month end.
6	3938	Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB	Percentage of adult acute admissions discharged and eligible for a follow up contact seen within 72 hours	Numerator: Number of adult acute admissions discharged and eligible for a follow up contact seen within 72 hours. Denominator: Number of acute admissions discharged and eligible for a follow up contact

ICB Board
Additional Reporting

The table below contains links to additional reporting and analytics which provide further detail for relevant reporting areas to support the board.

Reporting Area	Report Name	Report Description	Report U
Previous Board Packs	ICB Board	A folder repository of previous board packs created	

Agenda item: 23

Norfolk and Waveney Integrated Care Board

Subject:	**Risk Management**
Presented by:	**Amanda Lyes, Executive Director of People, Governance and Corporate Services**
Prepared by:	**Agnes Earl, Corporate Governance & Risk Management Senior Officer**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**26 November 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 September 2025. Since then, many teams have been reviewing and updating their risks.

Please find attached a copy of the following (as at 17 November 2025):

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

Attention is directed towards the following notable changes:

Board Assurance Framework (BAF)

- BAF08 (Ref 27) score decreased to 8

Risk	Changes/actions required
BAF01 (Ref 8): Health inequalities and Population Health Management	
BAF02 (Ref 32): Primary Care Resilience and Transformation	
BAF03 (Ref 7): Barriers to full delivery of the Mental health transformation programme (CYP)	
BAF04 (Ref 6): Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	
BAF05 (Ref 31): Increasing numbers of older people with complex health needs in Norfolk & Waveney	
BAF06 (Ref 3): System / Urgent & Emergency Care (UEC) Pressures	

BAF07 (Ref 10): Elective Recovery	
BAF08 (Ref 27): Achieve the 2024/25 AND 2025/26 financial plan	• New Operational Lead – Colin Bright • Score decreased to 8

Suffolk and North East Essex (SNEE) currently report 16 risks on their Board Assurance Framework (BAF), while Norfolk and Waveney Integrated Care Board (NWICB) identify 8 strategic risks on theirs.

Of NWICB's 8 BAF risks, 6 align closely with those on SNEE's framework. It is noted that both organisations include high-scoring risks for Urgent and Emergency Care and Waiting List Targets, each rated at 16. However differences in scoring are seen in other areas:

- Finance Risk: SNEE assigns a score of 15, whereas NWICB rates it significantly lower at 8.
- Cyber Security: SNEE scores this risk at 15 on their BAF, while NWICB hold this on their Operational Risk Register (ORR) with a score of 6.
- RAAC Plank Risk: NWICB scores this risk at 20 on their ORR, compared to SNEE's score of 12 on their BAF.

SNEE's BAF includes several risks not reflected in NWICB's registers:

- SR29: Impact of Climate Change on Healthcare Capacity and Resilience
- SR35: ISFE2 – Finance Ledger System Implementation
- SR36: Impact of ESNEFT Epic EPR Implementation Across the ICS

NWICB's BAF includes risks not present on SNEE's framework, including:

- Health Inequalities and Population Health Management
- Increasing Numbers of Older People with Complex Health Needs in Norfolk and Waveney

(These may be captured within SNEE's operational risk register)

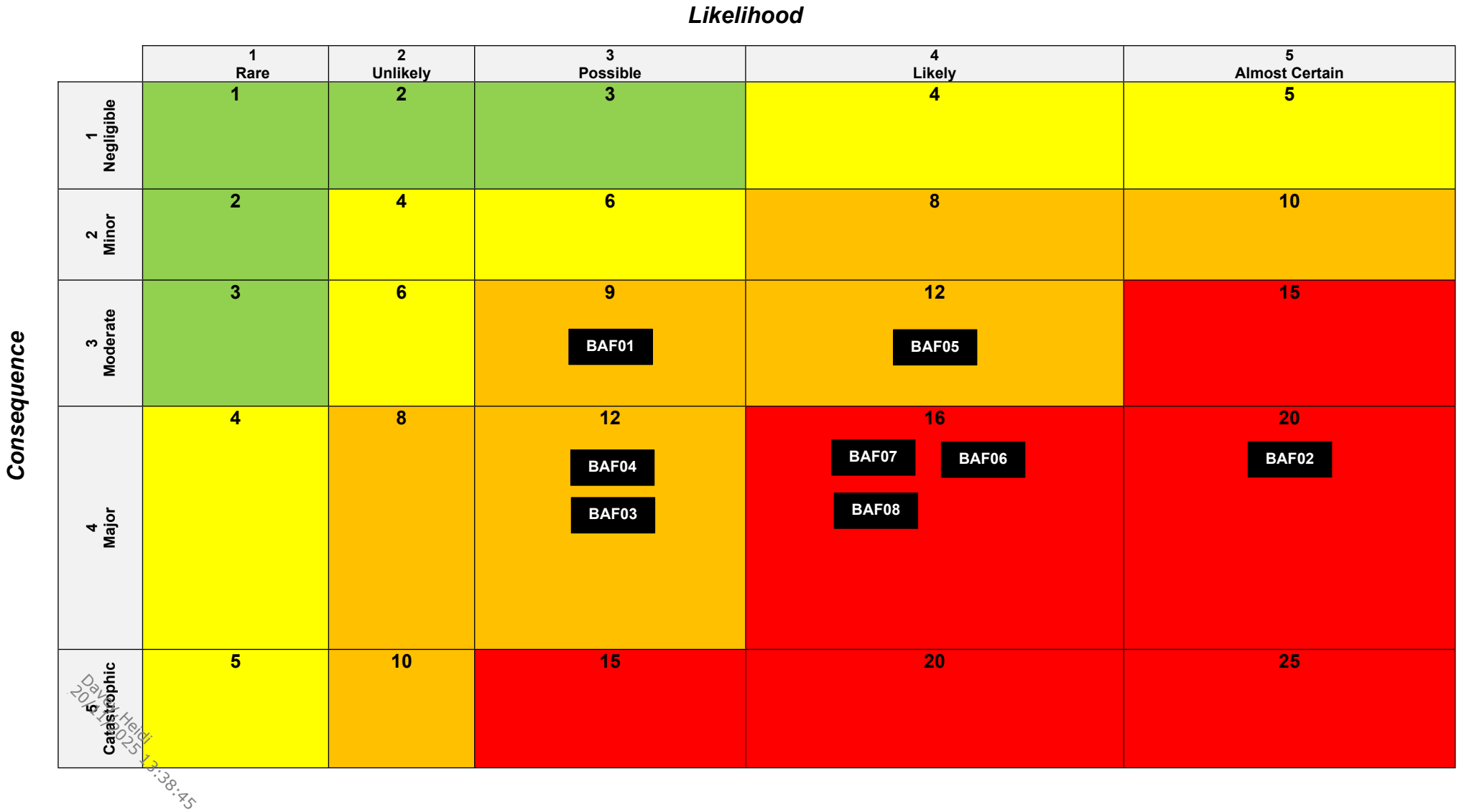
Recommendation to the Board:

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

Appendix 2: Risk visual

Board Assurance Framework risks
Board Operational Risk Register risks



NWICB - Board Assurance Framework Summary 17 November 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-26	8	12	12	12	12	9	9	9					
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	20	20	20	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)	TBC	Commissioning and Performance Committee	01-Jul-22	31-Mar-26	8	16	16	12	12	12	12	12					
Ambition 4: Transforming Mental Health Services – Adult Mental Health																		
6	Barriers to delivering equitable, safe and consistent care in adult mental health	TBC	Commissioning and Performance Committee	01-Jul-22	31-Mar-26	8	12	12	12	12	12	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	12	12	12	12	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	16	16	16	16	16					
Ambition 7: Elective recovery and Improvement																		
10	Elective Recovery	TBC	Commissioning and Performance Committee	01-Dec-22	31-Mar-29	12	12	12	16	16	16	16	16					
Ambition 8: Improving Productivity and Efficiency																		
27	Achieve the 2024/25 AND 2025/26 financial plan	Howard Martin	Finance Committee	10-May-23	31-Mar-26	12	12	12	16	16	16	16	8					

BAF01

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**	**31/03/26**	**30/10/25**
Risk type	Health inequalities		

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**3**	**9**	**2**	**4**	**8**
Risk appetite:					**Risk tolerated:**			

Controls

- 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

Visual Risk Score Tracker – 2025/26

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

BAF02

Risk Title	**Primary Care Resilience and Transformation**
Risk Description	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 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. 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. 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, 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.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Risk team**
Mark Burgis	Primary Care Commissioning Committee	Amanda Sear	Primary Care
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**29/08/24**	**31/03/27**	**20/10/25**
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. 2024/25 plan has now been completed, many objectives transferred to GP Action Plan and Operational Planning submission for primary care - delivery being monitored through PCCC.
- Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience.
- An overarching strategic vision and principles for primary care and a strategic framework for primary care have been agreed by PCCC and are posted on Connect NoW and are included in the relevant meeting packs/notes
- 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	Community Pharmacy • 10 June - all previous actions completed, risk to be reviewed and updated by end of August	Sadie Parker	**31/08/25**
28/10/24	Dental • 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. • 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 • 30/05/2025 Dental investment and Year 2 commissioning plans approved by Primary Care Commissioning Committee and through Triple Lock in May 2025 • 10 June - all actions complete, update will be given and risk reviewed by end of August	Sadie Parker	**31/08/25**
31/07/25	Red Tape Challenge published - discussed at September SIM to agree where oversight will come from. Implementation of recommendations incorporated into GP Action Plan monitored by PCCC. System Interface Group, led by ICB Medical Director, is where oversight of all things interface sites. PCARP not published.	Amanda Sear	**31/03/26**

Visual Risk Score Tracker – 2025/26

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20	20	20	20	20					
Change	-	-	-	-	-	-	-					

BAF03

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**
TBC	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**	**31/03/26**	**22/09/25**
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

- 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
- Expansion of CBT informed therapy delivered by children's wellbeing practitioners offering additional capacity within early intervention offers.
- Providing earlier support in primary care and education.
- Additional early support - Expanded offer to 11 teams providing 55% coverage of all schools across Norfolk and Waveney. Aligning with Norfolk Children Services School and Community Zones to ensure effective utilisation of system resource and avoid duplication

Actions			
Date opened	**Action**	**Owner**	**Target completion**
06/11/22	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. Update 13.06.2025 New transformation team in place at NSFT. Some progress with recruitment but skills mapping still required as there are currently gaps in appropriate knowledge & skills	Rebecca Hulme	**31/03/26**
25/08/23	13.06.25 Following SPRG - NSFT formally requested to submit trajectories for RTA within 4 weeks and RTT within 18 weeks. Further request for information regarding ROTT rates, treatment start rates and action plans for longest waits	Rebecca Hulme	**30/09/25**
13/06/25	Expansion plan developed with required funding described and discussed with finance. Further discussion will be required following proposed paper to EMT	Rebecca Hulme	**30/09/25**
01/07/25	System clinical review of the quality, safety and efficiency of young people's journey through the mental health system. This pathway includes initial triage of requests for support (RfS) by the Children and Young People's Mental Health Advice, Support and Access Service (MHASA) delivered by Cambridge Community Service (CCS) and then subsequent assessments and treatments by Norfolk and Suffolk NHS Foundation Trust (NSFT), Mancroft Advice Project (MAP), Ormiston families (OF) or Talking therapies.	Rebecca Hulme	**31/10/25**
27/07/25	Review contracts with Children Services to explore opportunities for alignment and to ensure best value for money	Rebecca Hulme	**31/10/25**

Visual Risk Score Tracker – 2025/26

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

BAF04

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**
TBC	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**	**07/11/25**
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

- 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
03/07/25	NSFT have stood up their mental health transformation program ICB officers are embedded into the programs of work and are present at the clinical transformation group which oversees this program of work. Work is focussing on 5 key areas inpatients, UEC, community, older adults and CYP.	**Mark Payne**	**31/03/26**

Visual Risk Score Tracker – 2025/26

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

BAF05

Risk Title	**Increasing numbers of older people with complex health needs in Norfolk & Waveney**		
Risk Description	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. The risks are that: a) services will be unable to continue to meet the increasing demand and needs of our ageing population with complex health needs. b) costs associated with care of this population will increase significantly adding to financial pressures c) quality of care for older people may decline if a) and b) are not suitably mitigated		
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**	**21/10/25**
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	**31/10/25**

Visual Risk Score Tracker – 2025/26

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

BAF06

Risk Title	**System / Urgent & Emergency Care (UEC) Pressures**		
Risk Description	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. 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.		
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**	**25/10/25**
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:

- 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 7.09 days for non-elective pathway.
- The system continues to fall below the 78% threshold set within the national recovery strategy.
- 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. Work is continuing to enhance the UCCH initiative to support care homes and their residents to prevent unnecessary conveyance and admission to hospital, which began as part of the winter 24/25.

Hospital Admissions Avoidance:

- 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.

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 have agreed to the ambition and sign off has been received from NCH&C. Monthly oversight shared with UEC with metrics also reported to alliances.	Rebecca Richards	**31/03/26**
10/06/25	UCCH impact has reached the maximum level if focus continues to only be for C3-C5s. To make greater impact on admissions UCCH needs to be able to interact with more C2 calls pre-dispatch. Approval is being sought through EEAST Board to pilot C2 validation calls taking place in	Rebecca Richards	**31/03/26**

	UCCH with the MDT. If approved the proposal is to trial this for 6 months over winter.		

Visual Risk Score Tracker – 2025/26												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	**16**	**16**	**16**	**16**	**16**	**16**	**16**					
Change	-	-	-	-	-	-	-					

BAF07

Risk Title	**Elective Recovery**		
Risk Description	There is a risk that elective care in Norfolk and Waveney may not meet constitutional commitments or in-year planning ambitions, resulting in prolonged waiting times beyond national and local targets. If this happens, it may lead to increased clinical harm and poorer outcomes for patients awaiting diagnosis and treatment (including cancer), worsen existing health inequalities, and negatively impact patient experience.		
Risk Owner	**Responsible Committee**	**Operational Lead**	**Risk team**
TBC	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**	**15/10/25**
Risk type	Reputational		

Risk Scores

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

Controls

- Unified process of clinical harm review and prioritisation in line with national guidance.
- The Provider Productivity and Planning Oversight Group and the Scheduled Care Board have been established to to oversee all workstreams to improve performance and reduce harm, driving operational changes from Commissioning and Performance Committee.
  Workstreams include: Productivity; Diagnostics; Demand Management
- Independent Sector Providers (ISP) are being utilised to support capacity, with the use of Elective Recovery Funds (ERF).
  Insourcing and outsourcing opportunities being utilised to create capacity, with focus on challenged specialties."
- Cancer: Local engagement to raise awareness of signs/ symptoms of cancer and to encourage early presentation to Primary Care/linking with health inclusion groups and areas of deprivation. Non-Specific symptoms (NSS) pathway is in place via the system cancer Rapid Diagnostic Service and the “C the Signs” Primary Care Clinical Decision support tool to improve quality and reduce variation in urgent suspected cancer referrals.
- Mutual aid process agreed to enable patients to transfer to alternative providers using existing capacity. Within the ICS this 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
22/04/24	65 week position as per KLOE (09/10/2025) o JPUH (2025) - September forecast: 207; October forecast: 179 o NNUH (2025) - September forecast: 74; October forecast: 0 o QEH reporting - September forecast: 3; October Forecast: 0	Diane Smith	**31/12/25**

	Significant risk noted to achievement of 65ww by 21/12/25 as requested by NHSE. Risk is at JPUH and regards specialities: ENT, Urology, Gynaecology		
01/04/24	The 52 week forecast position across the ICS (09/10/2025): August confirmed position: - NNUH: 5.0% (plan: 3.8%) - JPUH: 5.1% (plan: 4.3%) - QEH: 2.0% (plan: 1.6%) - ICB: 4.3% (plan: 3.2%) Forecasts as at 9/10/25 • NNUH (2025) - end Oct forecast: 2594 (against plan of 2594) • JPUH (2025) - end Oct forecast: 1630 (against plan of 1099) • QEKL (2025) - end Oct forecast: 396 (against plan of 351)	Diane Smith	**31/03/26**
28/11/24	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 - workforce dependency	Diane Smith	**30/11/25**
31/05/25	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. Further clarity required as part of ICB changes.	Diane Smith	**30/11/25**
03/02/25	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. Shared with People Board chair and NED and further discussion in development. Pending feedback from People Board chair for best approach - People Board attendance delayed by Board scheduling	Diane Smith	**30/11/25**
01/08/25	65w RTT remedial action plans requested from both JPUH and NNUH, copies of NHSE Tier1 RAP's requested via contracting team.	Diane Smith	**30/11/25**

Visual Risk Score Tracker – 2025/26

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

BAF08

Risk Title	**Achieve the 2024/25 AND 2025/26 financial plan**		
Risk Description	IF the ICB does not deliver the 2025/26 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**
Howard Martin	Finance Committee	Colin Bright	Finance
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**10/05/23**	**31/03/26**	**17/11/25**
Risk type	Financial		

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	2	4	**8**
Risk appetite:					**Risk tolerated:**			

Controls

- Detailed plan for the current year 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.	Colin Bright	**31/03/26**
01/04/24	Review of monthly and year to date performances and assess forecast out-turn evaluated risks and mitigations.	Colin Bright	**31/03/26**

Visual Risk Score Tracker – 2025/26

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 24

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Audit and Risk Committee Chair**
Prepared by:	**Heidi Davey, Head of Corporate Governance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 November 2025**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee to 5 November 2025.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update:	*Bullet pointed details of the committee meeting held since the last report to Board, including dates and times.* • ***5 November 2025***
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	Main purpose of this meeting was to report on key areas to the Committee providing information and assurance. The focus was on the role of the Audit and Risk Committee in the transition process. The Designate Executive Director of People, Governance and Corporate Services attended as SRO for transition to provide an overview of the process to date: **ICB Transition Overview and Update** This presentation noted that the ICB is still awaiting a go live date from region NHSE on when we can commence the staff consultation. Planning is underway with draft structures being finalised. Morale amongst staff was very low, with staff beginning to feel demoralised as there is uncertainty around

	their future. Teams are working together across the two ICBs, confirmation of the consultation will help strengthen this approach. **Briefing by Executive Director of Finance** A briefing by the Executive Director of Finance covered key issues. **Organisational restructure** the ICB is still waiting of a definitive response from NHSE on a way forward. Options are being considered to take the restructuring process forward in the absence of national funding for redundancy costs. **Planning** ICBs have received a high-level strategy document from NHSE but are still awaiting information on the detailed allocations. Various groups have been formed across the ICB's looking at planning, funding, and cost improvements. **ISFE2 issues and resolutions** An update was presented to the Committee on the implementation of new finance system ISFE2 and the issues experienced. The new system was launched on 1 October 2025 and was rolled out to 42 ICBs across the country. There have been a number of issues since the system went live. The main concerns relate to workflow and the ability to report from the system. All ICBs have experienced these issues nationally. In addition, the Committee discussed the following items: *Internal Audit Progress Report* *Counter Fraud Service Progress Report* *External Auditor's Report* *Losses & Special Payments* ***Growth Monies*** *Information Governance Senior Information Risk Officer Report* *Board Assurance Framework* *Committee Terms of Reference* *Committee Annual Plan* The following items were presented to the Committee for information: o Conflicts of Interest Committee Update o Internal Audit Reports with reasonable assurance or above and advisory reports o Procurement update and Tender Waiver Briefing o Report on any urgent Board decisions and non-compliance with the Standing Orders o TIAA Client Briefing Notes
BAF and any Board Operational risks	BAF reference numbers and detail of any Board Operational Risks (BORR) set out here.

relevant / aligned to this Committee:	None
Key items for assurance/noting:	Presentations to Committee above
Items for escalation to Board:	N/A
Items requiring approval:	N/A
Confirmation that the meeting was quorate:	The meeting was quorate

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 25

Subject:	**Constitution and Governance Handbook - Proposed Changes**
Presented by:	**Heidi Davey, Head of Corporate Governance**
Prepared by:	**Nikki Bartrum, Corporate Governance Senior Manager**
Submitted to:	**ICB Board Meeting**
Date:	**26 November 2025**

Purpose of paper:

The ICB Board is being asked to approve amendments to the Constitution and Governance Handbook to include updates to job titles across both documents.

Executive Summary:

Introduction
The Governance Handbook is designed to support and supplement the ICB's Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The approved version of this document will become version 12.

Changes made to the Governance Handbook document are summarised below:

Sections 1 – 4	No change
Section 5	This section sets out the functions reserved to the Board, functions delegated to an individual or Committees and functions delegated to other bodies or to be exercised jointly. The following changes have been made to the Scheme of Reservation and Delegation: • Page 20: "Clinical Advisors" changed to "Clinical Stewards" • Page 30-31: Executive Director job titles updated to reflect new Designate Executive Director Structure.
Section 6-13	No Change

In addition, changes have also been made to the Constitution to update Executive Director job titles to reflect new Designate Executive Director Structure.

Recommendation to the Board:

The Board is asked to approve the amendments to the ICB Governance Handbook and Constitution as detailed in the report above.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining its reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	
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)	Board for approval