Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 16 July 2025, 13:30 - 16:30

Agenda

13:30 - 13:30 (0 min)

Meeting agenda

- 00. Agenda for Part 1 ICB Board 16.07.25.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. DRAFT NW ICB Board Part 1 Minutes 21052025.pdf (15 pages)

13:30 - 13:30 (0 min)

4. Declarations of interest

- 04. Board Register of Interests.pdf (3 pages)

13:30 - 13:30 (0 min)

5. Chair's Action Log

- 05. Chairs Action Log July 2025.pdf (1 pages)

13:30 - 13:30 (0 min)

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

- 06. Action Log.pdf (2 pages)

13:30 - 13:30 (0 min)

7. Chair and Chief Executive's Report

13:30 - 13:30 (0 min)

8. ICB Transition

13:30 - 13:30 (0 min)

9. 10 Year Health Plan for England: fit for the future - ICP letter

- 09. 10 Year Plan - Letter cover paper.pdf (2 pages)
- 09.1 Letter from Karin Smyth MP to ICP Chairs and Co-Chairs 03072025.pdf (2 pages)

13:30 - 13:30 (0 min)

Strategy and Partnerships

13:30 - 13:30 (0 min)

10. Report from the Quality and Safety Committee

- 10. Quality and Safety Committee Report to Board.pdf (9 pages)

13:30 - 13:30 (0 min)

Commissioning, Delivery and Performance

13:30 - 13:30 (0 min)

11. Financial Report for Month 2 2025/26

- 11. ICB Finance Report - Month 02 202526 - Board.pdf (10 pages)

13:30 - 13:30 (0 min)

12. Report from the Finance Committee

- 12. Finance Commmittee Report to Board.pdf (4 pages)

13:30 - 13:30 (0 min)

13. Integrated Performance Report (IPR)

- 13. Performance report narrative.pdf (7 pages)
- 13.1 Performance Report.pdf (20 pages)

13:30 - 13:30 (0 min)

3.05 : Ten-minute Comfort Break

13:30 - 13:30 (0 min)

14. Report from the Commissioning and Performance Committee

- 14. C&P Committee Report to Board.pdf (10 pages)

13:30 - 13:30 (0 min)

15. Report from Primary Care Commissioning Committee

- 15. PCCC Committee Report to Board.pdf (7 pages)
- 15.1 FINAL Paper Board 16.07.25.pdf (2 pages)

13:30 - 13:30 (0 min)

System Oversight

13:30 - 13:30 (0 min)

16. Board Assurance Framework

- 16. Risk Management Report-Board-Pt1-BAF-July 25.pdf (3 pages)
- 16.1 Appendix 1-Board Assurance Framework-Board Pt1 July 25.pdf (14 pages)

13:30 - 13:30 (0 min)

17. Governance Handbook

- 17. Gov handbook updates.pdf (3 pages)

13:30 - 13:30 (0 min)

18. Amendment to the ICB Constitution

- 18. Amendment to the Constitution.pdf (2 pages)
- 18.1 App A NWConstitution v6 (draft).pdf (46 pages)

13:30 - 13:30 (0 min)

19. Report from the Audit and Risk Committee

13:30 - 13:30 (0 min)

Remaining Committees Reports and Questions from the public

13:30 - 13:30 (0 min)

20. Report from Patients and Communities Committee

13:30 - 13:30

21. Report from the Remuneration, People and Culture Committee Part 1 -

0 min **verbal.**

13:30 - 13:30 **22. Questions from the Public**
0 min

13:30 - 13:30 **23. Any other business**
0 min

Norfolk and Waveney
Integrated Care Board

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

Wednesday, 16 July 2025 1.30pm – 4.30pm

Chapman Room, Hethel Engineering Centre, Chapman Way, Hethel, Norwich, NR14 8FB

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 11 July 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 21 May 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. 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.	Chair and Ed Garratt
8.	1.55	**ICB Transition** Summary of what we know so far on the transition of ICBs both nationally and locally. Verbal update. Purpose: Information.	Ed Garratt Karen Barker

Item	Time	Agenda Item	Lead
9.	2.05	**10 Year Health Plan for England: fit for the future - ICP letter** Purpose: for information.	Andrew Palmer
		Strategy and Partnerships	
10.	2.15	**Report from the Quality and Safety Committee** Purpose: for information.	Cathy Armor
		Commissioning, Delivery and Performance	
11.	2.25	**Financial Report for Month 2 2025/26** To receive a summary of the financial position as at month 2. Purpose: to note.	Howard Martin
12.	2.35	**Report from the Finance Committee** Purpose: for information.	Hein Van Den Wildenberg
13.	2.45	**Integrated Performance Report (IPR)** To provide assurance to the ICB Board and highlight significant elements of the system performance reporting. Purpose: to note.	Matt Dooley
		3.05 : Ten-minute Comfort Break	
14.	3.15	**Report from the Commissioning and Performance Committee** Purpose: for information.	Hein Van Den Wildenberg
15.	3.25	**Report from Primary Care Commissioning Committee** Purpose: for information. • Independent Review into the organisational response to various primary care related matters. Purpose: for information.	Ian Wake/Hein Van Den Wildenberg/ Ed Garratt
		System Oversight	
16.	3.45	**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 approve.	Karen Barker
17.	3.55	**Governance Handbook**	Karen Barker

Item	Time	Agenda Item	Lead
		To present to the Board changes proposed by Committees in relation to the relevant terms of reference for review and approval. Purpose: to approve.	
18.	4.05	**Amendment to the ICB Constitution** To share the detail of mandated NHSE changes to the ICB Constitution. Purpose: to note.	Karen Barker
19.		**Report from the Audit and Risk Committee** Purpose: for information. No report submitted as the next scheduled meeting date is after the Board meeting and the Chair is not present to provide a verbal update.	David Holt
		Remaining Committees Reports and Questions from the public	
20.		**Report from Patients and Communities Committee** Purpose: for information. No report submitted as the next scheduled meeting date is after the Board meeting.	Cathy Armor
21.	4.10	**Report from the Remuneration, People and Culture Committee Part 1 - verbal.** Purpose: for information.	Cathy Armor
22.	4.15	**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
23.	4.25	**Any other business**	Chair
Date, time, and venue of next meeting: 1.30pm – 4.30pm, 24 September 2025 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 21 May 2025

PART 1 – Meeting in public

Council Chamber, Great Yarmouth Borough Council

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
- Steven Course (SC), Executive Director of Finance, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Executive Director of Nursing, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Stuart Keeble (SK), Local Authority Partner Member
- 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

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director Strategy and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Executive Director of Patients and Communities, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Executive Director of Digital, NHS Norfolk and Waveney ICB
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk
- Martin Keegan (MK), Adult Mental Health Senior Collaborative Lead NHS Norfolk and Waveney ICB and NSFT (item 11)

Attending to support the meeting:

- Jane Bacon (JB), Executive Assistant, NHS Norfolk and Waveney ICB (Minutes)

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting. Following the resignation of The Right Honourable Dame Patricia Hewitt, the Chair and the Board Members expressed their thanks and noted the significant influence she had in many changes and improvements in Norfolk	

	and Waveney, which will continue to be built upon. The Board noted she worked tirelessly on building close working relationships with a wide range of stakeholders across Norfolk & Waveney. Thanks were expressed to Hein Van Den Wildenberg for his hard work and Commitment inp the role of acting Chair in the interim period. The Chair noted that Tracey Bleakley has stood down from her role as CEO of Norfolk & Waveney ICB and thanks were expressed for her leadership and commitment to the ICB and wished her well for the future. Apologies were received from the following Board members: • Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services • Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB • Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB • Ian Wake (IW), Local Authority Partner Member	
2.	**Questions**	
	KB reported that one question had been received in advance from members of the public. The question has been circulated to Board members in advance of the meeting and relates to patient participation groups. The enquirer has been contacted in advance of the meeting and both the question and response will be published on the website following the meeting. MB commented that there has been no contractual change in requirements for general practice and Healthwatch in Norfolk and Waveney have asked to undertake a piece of work to look at a toolkit for practices. **Noted:** The question was discussed and noted.	
3.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 26 March 2025 were presented to the board for approval: Item 9, third paragraph – change word from ascent to descent. Following the above change the minutes of the meeting were approved as an accurate record.	
4.	**Declarations of interest**	

	The Chair noted that declarations of interest register was kept up-to-date and was available on the ICS's website. Cllr Whymark declared an interest in item 17 re Wave 4b. The Chair asked for a common conflict of interest to be noted for all colleagues in light of the proposed merger/restructuring. **Action:** KB to add a common conflict of interest to register for all parties.	**KB**
5.	**Chair's action log**	
	The Chair noted there were no Chair's actions to report. None to report.	
6.	**Action log**	
	The Chair reviewed all open actions with the Board. Page 3 of the minutes. States item 41 action remains open and not recorded on action log. It was noted that the item relates to dentistry. **Action:** Add action 41 to action log and carry forward to next meeting for an update.	
7.	**Chair and Chief Executive's Report**	
	Ed Garratt, CEO ICB welcomed everyone to the meeting and noted: • Excited to take up the role as interim CEO of Norfolk & Waveney ICB • Expressed thanks to the Rt Hon Patricia Hewitt, Tracey Bleakley and Hein Van Den Wildenberg for their work and commitment to the ICB and wished Tracey every success in her new role. • Acknowledged the professionalism and constructiveness of the staff in both ICBs. Staff were keen to collaborate and work together as the merger process starts. • Karen Barker is supporting as transition director for Norfolk & Waveney and Amanda Lyles from SNEE. • Decision made on Monday to end consultation for the Walk in Centre and Vulnerable adults service in Norwich and thanks were expressed for the support in taking the decision forward. • UEC – recognised the performance in Norfolk and Waveney and east of England on Ambulance response times has been the best since 2021 • Seeing a different approach to leadership at the ambulance trust with a strong focus on achieving response times, staff engagement. • Local development – 100% or practices now have delivery of digital in place. • Urgent dental treatment service in place providing 2,500 emergency appointments and looking to increase the numbers. • Health checks for LDA patients – have surpassed the target. • Medical Director Blog – pleased to see the information contained within the report. • The hospital group model for Norfolk & Waveney has been formed and expressed congratulations to those on their appointments. Looking forward to working productively with the new group model	

	• Recognised the heritage/history of Gt Yarmouth as the venue of the Board meeting. Acknowledged the health inequalities and is sponsoring a national network on improving health inequalities in communities across the country and includes Gt Yarmouth. Big focus for Norfolk and Suffolk in the future on reducing health inequalities of the population. **Noted:** The update was received and noted. The board was pleased to receive the positive updates and supportive of the approach going forward in reducing health inequalities across the region.	
8.	**ICB Transition**	
	EG reported that was approached by the principle of the Eastern education group who recognised the employment challenges being faced regionally and nationally. Was keen to work with the ICBs on supporting staff on employment challenges going forward. KB took paper as read. • Key thing from the document so far is the ICBs have a crucial role to play in the future of the health service • Debate around cluster arrangements – Option C in the paper - cluster will continue working as N & W ICB and SNEE ICB until at least April 2026. During period will be running 2 organisations as a cluster, with a single management team across the 2 organisations. • Will be working to build the new org to start 1st April 2026. • Karen Barker will be the local transition director for Norfolk & Waveney and will work alongside Amanda Lyes transition director for SNEE. • Work is taking place on designing the new structure with various meetings being set up to take forward. • Transition working group has been set up with the first meeting taking place on the 23rd May. • The published blueprint gives the lead for the way forward. **Noted:** The update was discussed and noted. **Agreed:** Transition update to be a standing item for future meetings. **Action:** Transition update – standing item for future meetings.	**KB**
	Learning from People, Staff, and Communities	
9.	**Prevention and screening**	
	PD'O introduced the item and noted that it is standing item within the board meetings. The presentation today focusses on the changes to community pharmacies to provide early interventions for patients and CVD Health Checks. Currently awaiting release of 10 year plan and PDO thanked everyone who contributed to the presentation.	

Comments from the Board:

- PD'O - Taking services to public more likely to get engagement.
- FW – Health check machine within store worked well
- FS – Situ station featured within video is more around raising awareness and not always linked to GP records. There is a wellness on wheels bus (WOW) and works in partnership providing health checks. Recently
- The WOW bus had been placed at NCFC and exploring placing the bus at Dereham Football club. The bus offers health checks, but can also help with GP registrations, vaccinations and many other things. Pharmacy first – there has been a lot of anxiety whether it would lead to an increased demand across primary care. Data has shown that just under 2% of pharmacy 1st consultations has led to a GP referral.
- EG – exciting work with relatively low investment and high impact – how do we scale up?
- SK – It is important we are targeting areas and getting into the communities. Both Norfolk and Suffolk are looking at the data to understand the impact of the work.
- DH – pharmacy and savings – how do we make sure we see impact of the work.
- AP commented – how we link to short term investment. How do we lead on prevention at the fore to bring longer term savings.

Following discussion, the board asked the Exec to come back with a proposal to the next meeting on scaling up the WOW bus.

Action: Proposal to next meeting on scaling up WoW Bus. **MB/FS**

- ER – need to give a thought to the cohort of patients that are banned from accessing community pharmacies – how do we reach that cohort of patients.
- FSe – need to include the harder to reach communities
- MB – The services are about improving outcomes for patients and gaining a stronger evidence base. There are still further opportunities for the WOW bus is not used 7 days a week and need to explore how to extend the service.
- PDO – LDA heath checks and the WOW bus – positively heartened by the conversation and commented on freeing up of time to take forward other opportunities. This has to be the principle for the new models of care going forward. Need to proactively engage with primary care to take the approach forward.
- EG has health checks been applied to prison health as an approach?
- PD'O responded no it hasn't but there are opportunities to strengthen the approach to the prison community and at the point of discharge – how do we prepare people in a better way for their discharge.
- FW – commented on the prisoners being discharges into the community – there has been a lot of work done in this area and the relation to homelessness and could link in with that work.

	Action: Proposal on how to prepare the prison community in regard to Health checks prior to discharge.. **Noted:** The board discussed the presentation, with support and endorsement for the actions arising from the item.	**PD'O**
	Strategy and Partnerships	
10.	**Report from the Quality and Safety Committee**	
	PD'O introduced the item highlighting key points from the report. • Discharge –work to be done on length of stay • Note work on NDD diagnostic space –. A deep dive was undertaken with an action for a business case to be developed on how to reduce the waiting lists. • Community wound infection pathway – this will work across the community practice settings and will have a significant impact on infection and control, ensuring best practice and consistency across the county. Comments from the Board: SK noted the joint quality and health impact assessments and would like to hear on the impact of this at a future meeting. **Action:** Briefing on quality impact assessments to a future meeting. **Noted:**he Board received and noted the report.	**PD'O**
11.	**Intensive and Assertive Outreach Review Presentation**	
	Martin Keegan – Senior collaborative lead employed by the Norfolk & Waveney ICB and NSFT in a dual role hosted by NSFT. MK gave an update on progress following the initial presentation to the ICB Board at the November meeting. Positive achievements so far are: • Cohort Identification - Norfolk & Suffolk Foundation Trust have identified their cohorts of people who meet the criteria for an Intensive and Assertive Outreach service which has been a significant piece of work. • Policy review. One of the first and significant requirements within the action plan was to review all operational policies within MH Trusts to ensure that people are not discharged based on 'DNA.' NSFT has updated 8 key policies. Both ICBs are assured that this is now complete. • Regular collaborative meetings between Norfolk and Waveney ICB, Suffolk & Northeast Essex ICB and Norfolk and Suffolk Foundation	

Trust have been established. These meetings have allowed discussion with wider system partners (e.g. Police & Adult Social Care) regarding the hard to engage SMI cohort.

All actions on the action plan are on track to be completed within the timeframe.

Key next steps are:

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

Comments from Board:

WP - how big is the cohort for Norfolk & Waveney? MK responded originally 478 patients were identified, which reduced to 112, with a second analysis bringing the list down to 60 patients.

ER asked reefercning a question asked at the last meeting on the engagement with VCSE sector collgeuas on identifying individuals who are known to the VSCE sector and have not ngaged with mental health services. She could not see this this captured within the data. MK responded that work is tsill underway on this and will reach out to adult social care leads on the process and will link in with VSCE to see how to capture this data accurately.

DH – commented that this is important work, noting that when ICBs go through the transition and resources are limited, where will this sit when decisions are made on priorities. It would be helpful to see a prioritisation list on the importance of work/services going forward so we can see what services we might have to stop doing as we go into the new world.

FSe – commented on the important work. This cohort of patients are demanding in terms of resources and time. This leada to a lot of escalated risk in all forms and needs looking at a system level. There is a gap between the strategic intent and operational capacity. This is not just a mental health provider challenge and needs to be looked at across Norfolk & Waveney and Suffolk and kept on radar by the Board on a regular basis.

SK – Commented on Population health management data and this will help feed into this work and there are some opportunities to link in PHM on the work.

	Following discussion and comments it was agreed to receive a detailed action plan to the July meeting. **Action:** Detailed action plan to July meeting. WP asked KB to link in with SNEE to check on the timeline for receiving the action plan to their board meeting. **Action:** KB to link in with SNEE to see when they are receiving the action plan. **Noted:** The board discussed and noted the update.	**MK-KB** **KB**
	Commissioning, Delivery and Performance	
12.	**Financial Report for Month 12 2024/25**	
	SC presented the Month 12 position noting it was a draft position as subject to internal audit. • At Month 12 (March 2025) the ICB delivered a surplus of £600k against a plan of £387k • This was achieved by offsetting the £8.1m of unidentified efficiencies with £1.2m of overperformance on efficiencies and £6.7m of non-recurrent mitigations. • Highlighted the underlying deficit position has increased to £122.4m due to the current impact of CHC packages due to demand and inflationary pressures and the removal of some of the non-recurrent savings found in year. • Strategic financial risk register – 2 key main risk: underlying deficit position and transformational development. • Financial position – good work taking place on the working capital and managing down some of the aged debts. • ICS financial summary position still in draft as subject to audit – Reported as a system reported a £36.2m deficit against breakeven plan. During the year 2 non-recurrent allocations was received for system support £21m in month 6 and £18m in year 11. • One trust reporting a deficit position – QEHKL £38.5m against plan – with other trusts reporting either a small deficit or small surplus giving an overall total of £36.2m adverse to plan. This money will need to be repaid in the following financial year giving an ongoing financial risk. • Efficiencies – plan in year to deliver £178.9m. • The efficiency position M12 YTD against plan is an adverse variance to plan of £37.7m. • The variance is mainly due to QEH £22.7m lower than planned, where anticipated efficiency savings have not materialised as expected. • JPUH, NNUH and the ICB have various CIP schemes that are not meeting plan due to slippage. • NSFT and NCH&C are on plan. • Recurrent efficiency delivery is £70.2m against the plan of £112.0m, £41.8m under and NR delivery is £71.0m against the plan of £67.0m,	

	£4.1m over, generating the net under delivery of efficiencies against plan of £37.7m. • Capital position - For CDEL & IFRS 16, M12 YTD variance to plan is an £0.4m overspend. Comments from the Board: EG asked on the financial position – what the lessons learned are for future years. SC responded that this year's position was supported on non-recurrent measures but makes the position harder in 25/26. A deep dive would be helpful to focus on how we can get into longer term sustainable recovery as a system to prevent this cycle happening again rather than relying on short term fixes. FSe commented it would be good to look at system wide efficiencies. **Noted:** The ICB Board received and noted the report and the learnings.	
13.	**Report from the Finance Committee**	
	HvdW presented the report and highlighted the following: • Underlying deficit positions for Norfolk & Waveney ICB of £122.4m and the Norfolk & Waveney system position of £230m and will be a challenge. • Financial plan submitted to NHSE with a significant risk that sits within the ICB of £35m • Total efficiency ask for the system is larger this year and will be a challenge to achieve. • Monthly finance meetings have been moved to bi-monthly, to allow for work to focus on the transistion and merger. The Chair and Deputy Cchair will meet on the intervening months to discuss any issues and manage risk. **Noted:** The ICB Board received and noted the report.	
14.	**Integrated Performance Report (IPR)**	
	MD presented the Integrated Performance Report. Key points to note are: • The report continues to develop with significant improvement and has been supported by auditors. • From July 2025 the ICB Board will receive a pack which includes performance from wider areas – Primary Care, People and Culture, and Finance. Additionally, the ICB Board will be provided with an equivalent report from the Quality and Safety Committee to represent the Quality Performance report Key metrics in the report:	

- Cancer: 28-day Faster Diagnostic Standard and 62-day treatment standard are in SPC special cause improvement.
- Diagnostics: is in common cause improvement
- Elective Care: 18-week and 52-week Referral to Treatment (RTT) standards are both in special cause improvement. Work remains ongoing to eliminate longer waiting times as per 24/25 ambitions. Reporting has begun against the 18-week standard for first appointment.
- Mental Health: three of the four standards are met, one (Talking Therapies first treatment) with confidence that the standard will be maintained.
  The fourth standard – 12-hour decisions to admit in A&E – is in common cause improvement.
- UEC: all areas saw common-cause improvement against target/trajectory. 111 call response times and Category-2 Ambulance response times recorded more significant improvement. A&E 4-hour and 12-hour standards recorded smaller gains in performance.

Comments from the Board:

- WP – asked on the summary assurance slides, only one metric was consistently meeting target. What does this tell us?
- MD responded this gives us a more focussed understanding on how we will identify areas that are not meeting targets.
- AP commented we need to maintain improvement. The report shows that the targets are not improving, but there are so many metrics behind the data and this is showing that the position is improving. Each trust has received a letter from NHSE on the focus for elective recovery and as Board look to focus more in 3 – 6 months' time to monitor performance.
- WP asked how as a Board are we assured on the performance?
- FS commented – as there are so many metrics have only chosen 14 metrics about which we are most worried. These areas are making good progress but are not delivering yet.
- FSe – commented on the inconsistency of targets and signals is a systemic issue and need to work through as a Board.
- DH – Data is an improvement on previous position. Would like to see a trajectory and would be helpful for the Board manage the position.
- EG asked with the new group model in place will we see improved metrics?
- JBa responded yes, with the new model in place will allow for a more holistic overview of the performance for the acute trusts through one lens and will lead to more focus in a consistent way.
- SC asked on the 52 week performance one of the route causes is due to financial restrictions. Need to remember that some of the areas where we have financial pressures could impact on quality and productivity and need more information on the route causes.
- PDO commented on the recovery action plan to drive further improvement and need to have conversations to support our Trusts to make sure they are aligned to improve targets.

	• JG commented on the route cause and workforce challenges – is there data available on workforce challenges? • MD responded that there are shared challenges reagdring workforce which are impacting improvmnet targets. **Action:** JG to follow up Impact of workforce challenges with HRD colleagues and update at next meeting. AP commented that we need to do a deep dive on the performance targets looking at the data behind to understand the reasons. It was felt that the Commissioning and Performance committee could undertake a deep dive into the performance targets at its next meeting. **Action:** C&P committee to undertake a deep dive into performance targets at its next meeting. HvdW – commented on the performance report and that it needs to stay as a live document and needs to include a system view. **Noted:** The Board noted the report. Whilst being assured by the data the board were not assured on the progress being made this year.	**JG** **HvdW**
15.	**Report from the Commissioning and Performance Committee**	
	HvdW took paper as read and highlighted the following. • Many of risks looked at by ICB are covered by the Commissioning Performance Committee. • Highlighted the Elective recovery risk – further discussions have taken place as to whether the risk rating is appropriate – current scoring is 12 and will look at further. • Performance – following comments at today's meeting will ensure that the performance narrative includes how it will meet the trajectory for the current year going forward. • The Committee supported the planned submission and triangulation of information between finance, performance, and workforce. • Organisation changes within ICB and around the system will put stress on the delivery of plans **Noted:** The Board received and noted the report.	
16.	**Primary Care Recovery Plan Report**	
	MB presented an update on the Primary Care Recovery Plan and took the paper as read. The plan has a particular focus on digital, expansion of clinical services leading to community pharmacy and incentivising GPs to work at scale, with these key aspects leading to long term prevention.	

	Key outcomes expected for the second half of 2024/25 included: • Progress against our interface programme of work and delivery across four key areas • Increased sign up to and usage of the NHS App together with ongoing support for educational events • Completion of cloud-based telephony system upgrade programme for GP surgeries • Support programme for GP surgeries (*General Practice Improvement Programme – GPIP)* to manage workload and better respond to patient needs through the adoption of *Modern General Practice* principles • Promote a culture of quality improvement across primary care, harnessing the power of technology where appropriate to support this Comments from Board: EG – noted the excellent report and commented on the national conversation re the NHS app and is pleased to see it is doing well. Can we think about how it can be pushed out further. Test sites talk about continuity of care as the difference in outcomes for patients is enormous, but the difference in staff satisfaction/retention is large. Would be good to have a metrics piece of work this. FS – Messaging from primary care colleagues is around the administrative burden and the shared work between secondary and primary care. Continuity of care and the shift of work are the clear messages being shared by colleagues. MB – agreed with comments – will need time to deliver continuity of care within the resources we have more effectively. FSe – keen to look at the use of the NHS app in relation to front door re crisis and NSFT services. **Action:** FSe/MB/IR to discuss the usage of NHS App in relation to Mental health services. ER - asked to be included in the conversation on the use of the NHS APP and the cohort of patients that are digitally excluded from the app. SK - commented that there needs to be joined up approach on the NHS App in respect of patient inequalities. **Noted:** The Board discussed and noted the progress being made.	**FSe/MB/ IR**
17.	**Primary Care Commissioning Committee**	
	HW introduced the report and took the paper as read: Points highlighted:	

	• Dentistry – approved the year 2 of the long term dental plan which builds on the success from previous year. • Dental is biggest risk within primary care. All local dental/pharmaceutical committees have raised the increased risk of national insurance costs and the implications on staffing. • GP contract 25/26 and noted that Pharmacy 1st has been extended. • Quarterly estates update – sevenNorfolk & Waveney surgeries to benefit from national funding and builds on Wave 4b hub investment. • Meds Optimisation – pleasing to note this was a major contributor to the efficiency schemes and delivered more than t – contributor to efficiency schemes delivering more than £2m in savings. **Noted:** The Board acknowledged the work of the Medicines Optimisation teams in achieving the savings. Comments from Board: JBa – As we start to look at the shift of activity from acute to primary, which will involve a change in the commissioning arrangements. The activity shift will be critical for the new hospitals programme. Is there a role for the PCCC committee to have oversight of the work, to provide the Board with the required assurance. HvdW – it is important indeed we monitor the new partnership working (neighbourhood health). Will need some thought which committee is best placed to give assurance to the **Board** Cllr Whymark – need to include care system. Could invest in community hubs and need to think and look outside of the health care system as there are a lot of opportunities. FSe commented on the new GP contract which has been paused at a national level. This doesn't mean it has been paused at a local level and we need to think about the relationship between the ICB Board and primary care and the risks this poses and how this is taken forward over the coming months. MB – commented on the opportunities and the approach we need to take reading how we work with GPs and Primary care to take the opportunities forward within the context of the financial challenges. **Noted:** The Board discussed and noted the report.	
	System oversight	
18.	**Board Assurance Framework**	
	KB presented the Board Assurance Framework, which sets out the strategic risks and have all been reviewed in line with the process. There are 8 strategic objectives and felt it would be useful to spend time at a future meeting reviewing the objectives.	

	The report summarises the changes and includes a summary sheet and noted that there is still further work to be done. Comments from the Board: WP asked on risk 27 - achieved 24/25 financial plan. Is this correct? KB responded that when discussing Month 12 still talking about the risk for 24/25. At the next meeting, the risk will change to 25/26. HvdW commented do we need to include a risk on the BAF relating to the restructuring? KB responded that other ICBs within the region are drafting a risk relating to the restructuring. Will use that information to come up with some common wording on the risk to be shared across the boards. **Action:** KB to provide an update on the common risk re the restructuring to June meeting. AP commented on the strategic ambitions which are linked to the Joint Forward plan. Maybe need to wait to see how it links with the 10 year plan before reviewing the strategic objectives. **Noted:** The Board discussed and noted the report.	**KB**
19.	**Report from the Audit and Risk Committee Verbal**	
	DH gave a verbal update from the Audit and Risk Committee: • Internal audit opinion for 24/25 is reasonable and the ICB was given the recommendation by the auditors as a Going Concern. • Received a presentation at the meeting on the Freedom to Speak Up Guardian (FTSU). It was noted that the ICB had struggled to get a resource in place to manage the process. There is now a mechanism in place for staff to speak up but now need to encourage staff to report any issues/concerns. A report will be presented to the July board meeting in public. Quarterly reports will be presented to the audit committee on its progress for assurance. Comments from Board: FSe – good progress has been made within NSFT on FTSU and following learning NSFT are now in a much better position. **Noted:** The Board noted the verbal update.	
	Remaining Committees Reports and Questions from the public	
20.	**Report from Patients and Communities Committee**	

	MB gave a verbal update from the meeting held on the 19th May 2025 and the items discussed. • Review of 2 BAF risks and had reduced in score • Deep dive at the meeting focussed on place and the work taking place across Norfolk & Waveney and echoed the strength of partnership working and health inequalities • Discussion on Walkin centre with positive feedback on the decision to keep on • Process in place following the Learning from Deaths report – Presentation took place on the processes and the opportunities for sharing learning • Received assurance from prevention workstream • Information governance – how difficult it is to share information between statutory and non-statutory bodies • Healthwatch Norfolk – discussion on long waits • VSCE – update from assembly and the risks within the community **Noted:** The Board noted the update.	
21.	**Report from the Remuneration, People and Culture Committee**	
	Nothing to report.	
22.	**Questions from the Public**	
	There were no questions from the public.	
23.	**Any other business**	
	Constitution Amendment **Noted:** The Board noted that the constitution amendment was approved at its meeting in private on the 30th April 2025. EG recorded his thanks to Karen Barker for the progress on the work around the clusters.	

Date, time, and venue of next meeting:

13:30 – 16:30, Wednesday 16 July 2025 venue tbc

Any queries or items for the next agenda please contact:
nwicb.corporateaffairs@nhs.net

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

Dorey, Heidi
10/07/2025 08:47:35

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	Brundall Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Educational Association			X		Trustee, Workers Educational Association	des-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Council, Norwich University of the Arts			X		Chair of Council, Norwich University of the Arts	2024		
		Evolution Academy Trust			X		Trustee, Evolution Academy Trust	2022		
		Cambridge University Press Pension Schemes		X			Trustee, Cambridge University Press Pension Schemes	2018		
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust			
Jon Barber	Partner Member	Broadland St Benedicts			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group. No direct interest although conflicts of interest noted if necessary		Present	Although risks are minimal this will always be declared as with Trust Board declaration of interests
		James Paget University Hospitals NHS FT	X	X	X	Direct	Director of Acute Trust – commissioning decisions could impact my employer.		Present	Decisions impacting the allocation of resources etc to providers would require me to declare an interest not vote on the decision
		Great Yarmouth & Waveney		X		Direct	Place Chair – Gt Yarmouth & Waveney Place Board. No direct interest although conflicts of interest noted if necessary.		Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Acle Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			X	indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	To date	Will withdraw from any discussions and decision that might directly involve the department or discipline that relates to the declared conflict.
		Norfolk Deaf Association	X			direct	I am the Chief Executive Officer of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB	2010	To date	Not involved in any discussions and decisions that might benefit Hear for Norfolk
		Derrett Consultancy Ltd	X			indirect	I am the Director of Derrett Consultancy Ltd	2018	To date	Low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		Norfolk & Waveney MIND	X			indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	To date	Not involved in any discussions and decisions that might benefit N&W Mind
		Lakers Games Ltd	X			indirect	I am the Director of Lakers Games Ltd	nov-24	To date	Very low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		St Stephens Gate Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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

* Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal college of Nursing			X	Indirect	Professional Body - RCN Union			
* 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	Deputy Lieutenant for Suffolk	sep-23	Present	To be declared as appropriate
		NHS Suffolk & North East Essex ICB		X		Direct	Chief Executive	mai-25		To be declared as appropriate
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Ministry of Defence	X			Direct	NED Audit & Risk Assurance Committee	2022	Present	
		Newberry Clinic				Indirect	Wife a Consultant Community Paediatrician	2023	jul-24	
		Sole Bay Health Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Stuart Keeble	Director of Public Health and Communities for Suffolk and member elect of Norfolk and Waveney ICB	Director of Public Health Suffolk County Council		X			Commissions and funds services		Present	Remove himself from relevant conversations at N&W
* Andrew Palmer	Deputy Chief Executive Officer, Norfolk and Waveney ICB	Beccles Medical Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		James Paget University Hospital		X			My wife works at the JPUH, in a non-decision making role		Present	Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the decision will be taken in the best interests of the system with the necessary due-diligence taking place prior to final decision being made.
William Pope	Interim Chair	Chair of NHS Suffolk & North East Essex Integrated Care Board		X	X	Direct	Chair of the Integrated Care Board	2022	Present	Both Boards have appropriate governance management processes and systems
		Co-Chair of the Suffolk & North East Essex Integrated Care Partnership			X	Direct	Co-Chair of the Integrated Care Partnership	2022	Present	Both Boards have appropriate governance management processes and systems
Emma Ratzer	Partner Member - VCSE	Norfolk & Waveney Integrated Care Board	X			Direct	My employing organisation holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
* Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Long Stratton medical partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Norwich University Hospital			X	Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Multiple patient charities			X	Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		British Medical Association			X	Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Better Help, and VCSE provider: St Martin's Housing Trust	X			Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE provider: St Martin's Housing Trust	2022	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by St Martin's Housing Trust or Better Help
Ian Wake	Executive Director of Adult Social Services	Norfolk County Council		X		Direct	Executive Director of Adult Social Services, Norfolk County Council	14.10.2025	Present	
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with 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	mai-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 & WAVENEY ICB Interim Chairs Action Log - Wednesday 16 July 2025				
Date	**Matter**	**Details of discussion**	**Decision**	**Date Reported to ICB Board**
16-jul	Extension of terms for Non- Executive Members	Under section 3.12.7 of the Consitution the Chair is permitted to approve the re-appointment of a Non– Executive up to a total of 3 terms of 3 years. The Non-executives have each served one term of 3 years and the extension is now for one further year to 30 June 2026 inlight of the proposed changes to ICBs.	To extend the term for three Non Executive Members to 30 June 2026. These members are Cathy Armor, Hein Van den Wildenberg and David Holt. David and Cathy's appointment had been approved by the acting Chair, this is noted by the interim Chair. Hein's appointment is approved by the interim Chair.	16-jul-25

NHS
Norfolk and Waveney
Integrated Care Board

NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD
ACTION LOG

Actions arising at the meeting held on 29 January 2025:

Agenda Item	Action	Lead	Update	Target Date
29 January 25	Focus on strategic alignment and collaborative approach of Including young people's perspective in integrated neighbourhood teams as part of the prevention agenda.	Tricia D'Orsi	Paper to come to Board to focus on strategic alignment and collaborative approach. Action closed as this collaborative approach is now part of business as usual.	Propose closure of action.

Actions arising at the meeting held on 21 May 2025:

Agenda Item	Action	Lead	Update	Target Date
Conflict of Interest Register	A common conflict of interest to be noted for all colleagues in light of the proposed merger/restructuring.	Karen Barker	Complete. Wording included on the register to highlight those conflicted in terms of merger.	16 July 2025
ICB Transition update	Transition update to be a standing item for future meetings.	Karen Barker	Complete	16 July 2025
Prevention and screening	Following discussion, the board asked the Exec to come back with a proposal to the next meeting on scaling up the WOW bus.	Mark Burgis Dr Frankie Swords	Paper presented at the Development session. Complete	16 July 2025
Prevention and screening	Proposal on how to prepare the prison community in regard to Health checks prior to discharge.	Tricia D'Orsi	Paper being presented to EMT/EC on 04.08.25. Update to be shared at September meeting	24 September 2025
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 September meeting and a note has been made on the forward plan.	24 September 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.	24 September 2025
Intensive and Assertive Outreach Review Presentation	KB to link in with SNEE to see when they are receiving the action plan.	Karen Barker	See above SNEE also will receive this at the September Board meeting. Complete.	24 September 2025
Integrated Performance Report (IPR)	JG to follow up Impact of workforce challenges with HRD colleagues and update at next meeting.	Jacqui Grice	JG to update meeting.	16 July 2025
Integrated Performance Report (IPR)	C&P committee to undertake a deep dive into performance targets at its next meeting.	Hein Van Den Wildenberg	C&P update report to Board this month covers the work undertaken by the C&P Committee. Complete.	16 July 2025
Primary Care Recovery Plan Report	FSe/MB/IR to discuss the usage of NHS App in relation to Mental health services. ER - asked to be included in the conversation on the use of the NHS APP	FSe/MB/IR/ER	Update to meeting.	16 July 2025

	and the cohort of patients that are digitally excluded from the app.			
Board Assurance Framework	Provide an update on the common risk re the restructuring to June development meeting	Karen Barker	Complete. This is now on the ICB BAF for review on today's agenda.	16 July 2025

Agenda item: 09

NHS
Norfolk and Waveney
Integrated Care Board

Subject:	**10 Year Health Plan for England: fit for the future**
Presented by:	**Andrew Palmer, Deputy Chief Executive** **Executive Director of Performance, Transformation & Strategy**
Prepared by:	**Tom McColgan, Governance and Risk Manager, Suffolk and North East Essex ICB**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

To update the Board in relation to the publication of the '10 Year Health Plan for England: fit for the future' and to note that a further report addressing the implications for Norfolk and Waveney will follow in September.

Executive Summary:

1. Background

1.1. On 3 July 2025 the Government published the 10 Year Health Plan for England: fit for the future. The 10 Year Health Plan for England intends to *'create a new model of care, fit for the future. It will be central to how we deliver on our health mission. We will take the NHS's founding principles - universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagine how the NHS does care so patients have real choice and control over their health and care'*. The Plan sets out *'3 radical shifts'* that will reinvent the NHS: hospital to community, analogue to digital, and sickness to prevention.

1.2. A further report will come to the September meeting of the Board which will begin to draw out the local implications of the 10 year plan and how Norfolk and Waveney will support its delivery.

1.3. Following the publication of the 10 Year Health Plan, Karin Smyth MP wrote to all Integrated Care Partnership (ICP) Committee Chairs to set out the Government's intention to remove the requirement for all Integrated Care Systems to maintain an ICP Committee. The letter states that the Government's expectation is that ICP Committees will be abolished.

Appendix A: Letter from Karin Smyth MP to ICP Chairs and Co-Chairs.

Recommendation to Board:

That the Board notes the publication of the ‘10 Year Health Plan for England: fit for the future’ and notes that a the a further report, addressing the implications for Norfolk and Waveney will be presented at the September Board meeting.

Key Risks	
Clinical and Quality:	
Finance and Performance:	
Impact Assessment (environmental and equalities):	
Reputation:	
Legal:	
Information Governance:	
Resource Required:	
Reference document(s):	
NHS Constitution:	
Conflicts of Interest:	
Reference to relevant risk on the Board Assurance Framework	

Department of Health & Social Care

Karin Smyth MP
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

ICP Chairs and Co-Chairs

Sent via email

03 July 2025

Dear all,

Today marks a significant moment in the history of our NHS, as the government publishes its 10 Year Health Plan. The Plan sets out how we will help the NHS recover, deliver seismic changes in its operation to make it fit the future, and transform the country's health for generations to come. I know many of you will have played a significant role in the Plan's development, drawing on your expertise and experience to share ideas for delivering the change required. I extend my thanks to you all.

As you know, integrated care partnerships (ICPs) were created by the Health and Care Act 2022, with the purpose of bringing together system partners concerned with the care, health, and wellbeing of the local population. The current broad membership of ICPs reflects the ambition of system partners to work together to improve the health and wellbeing of their residents, and the important role that you as chairs and co-chairs have played as system convenors.

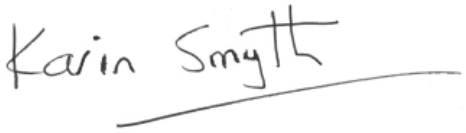
I extend my thanks to you and your members for fulfilling the core statutory duty of ICPs and developing integrated care strategies, setting the overall strategic direction for your systems and detailing how the local population's health needs are to be met by your integrated care board (ICB) and its partner local authorities. Despite the significant pace at which these strategies were first produced, they were developed in close collaboration with local partners and stakeholders and reflected real ambition to improve population health and wellbeing. These strategies often transcended a focus on frontline health services, to include consideration of the wider determinants of health and broader socioeconomic development conducive to improving the local population's health and wellbeing. Local residents are at the heart of every integrated care strategy which seek to encourage system partners to work in new and radical ways, drawing on what is already working well, and hold each other to account for progress.

ICPs are however currently operating in a confusing landscape, amidst a plethora of plans, strategies and committees. This means despite your hard work and dedication, and that of the members of your ICPs, there is too often confusion leading to frustration, siloed working, and inaction. We wish to harness the enthusiasm and creativity you and your colleagues have brought to ICPs in a more effective way that removes the inhibitors you have encountered. Therefore, the 10 Year Health Plan sets out our proposals for a simplified landscape, with greater clarity on roles, functions and accountabilities. In this new landscape, ICPs will no longer be a statutory requirement and therefore abolished. As we remove the statutory prescription, we are keen that the learning, energy,

partnership and leadership that many of you have sought to bring to ICPs continues to play a strong role in supporting partnership working, particularly in the development of neighbourhood health and in supporting ICBs to become effective strategic commissioners. The abolition of ICPs is not intended to diminish partnership arrangements between the NHS, local government and wider system partners. Instead, it is intended to allow these partnerships to flourish in more impactful ways. Our 10 Year Plan sets out the importance of partnership working, particularly in the development of neighbourhood health plans, and I am thankful for the enthusiasm and energy I know you and your colleagues will bring to this endeavour.

I reiterate my thanks to you all for your helping to shape our 10 Year Plan, and for the commitment you and your colleagues have shown to date. As we move forward now towards implementing our Plan, I trust your skill, commitment and experience will ensure our success and in achieving our goal of better health for all.

Kind regards,



KARIN SMYTH MP
MINISTER OF STATE FOR HEALTH

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Quality and Safety Committee Report**
Presented by:	**Cathy Armor, Quality and Safety Committee Deputy Chair**
Prepared by:	**Evelyn Kelly, Quality Governance & Delivery Manager**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 21 May 2025 to 16 July 2025.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett (Deputy Chair Cathy Armor)
Meetings since the previous update:	05 June 2025,14:00 – 17:00 (chaired by Deputy Chair) 03 July 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:	**05 June 2025** • Risk Deep Dive: CYP Mental Health Waiting Lists and Care Coordinator Allocations • Pharmacy, Optometry, and Dental Quality Programme • N&W LMNS Assurance Report • ICB Research & Innovation Annual Report • ICS Learning from Deaths Annual Report • N&W System Quality Group Assurance Report • ICS Quality Strategy 2026 Planning Discussion **03 July 2025** • Risk Deep Dive: CYP Speech and Language Therapy and CYP Skill Mix (NSFT) • Mental Health Transformation Report • Palliative Care & Hospice Report • Health Inequalities and Health Inclusion Report • Patient Safety Healthcare Inequalities Reduction Framework
BAF and any Board Operational risks relevant / aligned to this Committee:	**Risk 011: Continuing Healthcare** Risk remains at 16, reflecting the challenges in sourcing appropriate care due to care market capacity, particularly in relation to specialised care for people with complex needs. This creates risk in relation to quality and experience of care, as well as increased financial cost of sourcing care. **Risk 012: EEAST Response Time and Patient Harms** Risk remains at 20, reflecting the pressures in our urgent and emergency care system, with delays in handover of patients into hospital impacting on ambulance response times to calls in the community. This is a dynamic risk reflects ambulance response time trends. **Risk 034: Surge Capacity to Support Acute Trusts** Risk reduced to 12, reflecting the improved position and reduction in the exceptional requirement for corridor care. Committee noted that the risk is very dynamic, and in the week running up to the meeting there was some increased congestion requiring the opening of additional escalation beds following a busy Bank Holiday and Half Term. The risk will continue to be monitored closely. **Risk 035: Community Nursing Unallocated Visits** Risk remains at 16, reflecting the current challenges in demand and capacity, which creates risk in relation to the

	quality and experience of care as well as moral injury to staff and resilience across the wider community services. A deep dive is planned to return to Committee in the next quarter. **Risk 038: CYP Mental Health Case Manager Allocation** Risk remains at 16, reflecting the challenges in meeting demand for case management allocation, which in turn creates risk in relation to quality and experience of care and the potential for poorer long-term outcomes. Committee undertook a deep-dive discussion which is shared later in this report. **Risk 039: CYP Mental Health Waiting Lists** Risk remains at 16, reflecting the challenges in demand and capacity, which creates risk in relation to delayed treatment which impacts on the long-term outcomes for children and young people as they move into adulthood. This is also a potential area of moral injury to staff and resilience across the wider mental health pathways. Committee undertook a deep-dive discussion which is shared later in this report. **Risk 040: CYP Speech and Language Therapy** Risk remains at 16, reflecting the fact that NCC, as lead commissioner, are not currently assured of service delivery against some of the provider's key performance measures. This creates risk in relation to accessibility, quality and experience of care and outcomes for children and families. Committee undertook a deep-dive discussion which is shared later in this report. **Risk 042: Children's Mental Health Team Skill Mix** Risk remains at 16, reflecting the Trust's challenge in accessing available trained staff to deliver its services for babies, children, young people, and families, which creates risk in relation to delayed treatment and long-term outcomes for children and young people. Committee undertook a deep-dive discussion in July. **Risk 044: Care Provider Capacity System-Wide Impact** Risk remains at 15, reflecting local social care market capacity, and the risk of providers terminating care provision or closing due to failure to comply with statutory regulations. The national NI increase is also understood as a risk to small business resilience; ICB and local authority market engagement will continue to support and monitor impact. The risk has the potential to impact hospital discharge activity as well as LD&A hospital admissions.

	Risk 047: Tuberculosis Service Provision Risk remains at 12, reflecting the recent extension to existing capacity, while the long-term model for local TB services is explored and developed. An element of risk remains around increasing demand and complexity of cases and inequity in the service offer across the system, which may impact on patient safety, quality of care and public health protection. **Risk 048: 12hr DTA Mental Health Breaches** Risk remains at 16, reflecting the impact of 'decision to admit' breaches where a specialist mental health bed cannot be found in a timely way. This causes extended waits for service users in busy A&E departments, which raises the risk of poor experience of care and exacerbation of symptoms in a clinically unsuitable environment. **Risk 058: Public Trust and Reputational Damage** Risk remains at 15, reflecting the impact of poor patient experience and patient harms in respect of delayed ambulance conveyance. This is a dynamic risk reflects ambulance response time trends and operational pressures in the system. **Risk 060: Specialist Palliative and End of Life Care** Risk reduced to 9 at the June 2025 meeting, reflecting the breadth of work taking place at a transformational level and the mitigations put in place by the Acute Hospitals to support patient pathways. **Committee agreed to de-escalate the risk to the Planned Care Team Risk Register.** **Risk 061: CYP MH Responsible Clinicians** Risk remains at 16. NSFT is currently reviewing its crisis pathways, which will include consideration of an all-age psychiatric liaison that will cover these roles. In the interim, the Trust is using community resources to mitigate the gaps. **Risk 080: Instrumental Assessment for CYP Dysphagia** Risk remains 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. This has the potential to impact on lung health, speech and language development, nutrition and aversion to eating and drinking which could have long term consequences.

	Risk 085: Provision of Paediatric Audiology (QEHKL) New risk opened at the July 2025 meeting, to reflect 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. QEHKL has flagged concerns relating to staffing levels, processes and waiting list and has taken the step to close their local service to new referrals while an improvement action plan is being prioritised. NNUH are supporting patients in West Norfolk whilst QEHKL focus on recruitment and backlog. **Committee agreed escalation of this new risk to Committee oversight at a score of 15.**
Key items for Board to take note of:	**Risk 038: CYP Mental Health Case Manager Allocation** Committee noted that the number of children waiting for case managers has reduced by 123 since October 2024, currently standing at 446. Efforts are ongoing to further reduce waiting times and improve service delivery. Committee's NSFT partner highlighted the internal transformation programmes aimed at enhancing the flow of the treatment pathway. These programmes focus on improving the allocation process and ensuring timely access to case managers. Committee reflections highlighted the importance of communication with these children and their families as well as their wider community networks. The importance of the Care Navigator role was emphasised. An action was taken to review the mechanisms for involvement of primary care in relation to managing risk for children and families awaiting case manager allocation. **Risk 039: CYP Mental Health Waiting Lists** Committee noted that the current waiting list has been reduced from 4,400 to 2,845 children, which has been achieved through early intervention offers, including mental health support teams in schools, community youth work, and professional therapeutic pathways. These initiatives have helped to meet increasing demand and support over 16,000 children in Norfolk and Waveney. NSFT has made considerable progress in reducing their waiting lists, with the new integrated front door ensuring that individuals are referred through to appropriate pathways

	early. Committee noted that the waiting lists for VCFSE organisations have increased, due to higher referral rates. Committee reflected on the challenge to meet the increased demand, emphasising the importance of aligning funding with new pathways, to ensure that children receive timely support and to build resilience in services. Committee noted the increased utilisation of VCFSE which has helped to reduce referrals for statutory services, where support and care can be better delivered elsewhere e.g. the LGBT+ Project, which has met the needs of young people needing a safe and accepting space to explore questions about their gender or sexuality, which has then reduced the need for a more 'clinical' mental health response. Committee highlighted the value of collaborative working in this space and the focus on early help and prevention. **ICB Research & Innovation Annual Report** Committee reviewed the annual report, highlighting key achievements, including income generation through research capability and innovation funding, and plans to support future research following patient journeys and developing research in priority areas. Committee noted the success of the Elsa study on type 1 diabetes screening in children. Committee reflected on the team's efforts to increase the diversity of research participants by working closely with voluntary sector organisations and through delivery of community training and engagement. An example of this is recent work with Opening Doors to address barriers to research participation for people with learning disabilities, aiming to reduce health inequalities through inclusive research. The report emphasised the importance of a confident and capable workforce in research and innovation. The team is working on creating a system dashboard to help collectively address skills gaps and provide more system-level training opportunities. **Risk 040: CYP Speech and Language Therapy** Committee noted the challenge for the provider to deliver commissioned activity due to exceptionally high demand. Committee noted that access and waiting times are improving and discussed the transformation that has taken place to support service delivery since 2023. This includes cross-organisational work with partners to meet children's

	communication needs. Video consultation methods and joined up working with schools and pre-school professionals have supported access and family experience. While there has been no identified quality impact yet, the ICB continues to work closely with the lead commissioner (NCC) to manage the risk and develop the long-term model of sustainable commissioning. The ICS AHP Faculty is working to publicise the work of Speech and Language Therapists and improve the student pipeline. **Mental Health Transformation Report** Committee were briefed on key areas where transformation has taken place, focusing on system priorities of early intervention and prevention, eating disorder, primary care interface and crisis response and support. The adult team emphasised positive work around talking therapies, supporting prevention and early intervention, outreach, and engagement. The new model has a more trauma-informed approach, and the Place-based delivery model supports access. Community redesign work includes pathway development work around dementia, dual diagnosis, and de-prescribing, as well as embedding the local Avoidant Restrictive Food Intake Disorder pathway. Crisis alternatives and home treatment have remained a focus and collaborative working between NSFT and VCFSE partners has supported non-admission options. The Trust's inpatient programme is aligned to national quality priorities. Review of the NSFT ADHD pathway and broader system framework to support 'right to choose' is ongoing. In the children's space, the expansion of mental health support in schools is a system focus, building on the success of the nationally funded programme and developing a plan to increase provision within a local financial envelope for the year ahead. The Advice and Support model is helping healthcare professionals and families to navigate the mental health system and help facilitate the right support at the right time. NSFT is embarking on a redesign of its Children and Families community model to align the Suffolk and Norfolk models. The ICB hosted Mental Health Care Navigators continue to have a significant impact, demonstrating improved patient experience and admission avoidance. **Palliative Care & Hospice Report** Committee noted the challenges in variation of access / quality, hospice funding inequality, workforce development and pipeline. A new dashboard is coming online to identify variation and target transformation work. Current priorities

	for the commissioning team include development of a system service specification for hospice care with SNEE ICB, PEOLC workforce mapping and implementation of the Electronic Palliative Care Co-ordination System (EPaCCS). Community asset and resource mapping is taking place to help patients and professionals navigate available resources. Committee noted the opportunities to improve transition for children moving between CYP-Adult services, including link sessions for families to experience both settings. The ICB is working with SNEE ICB to expand the local CYP PEOLC Forum to cover the Norfolk and Suffolk footprints. Members reflected on the shifting nature of PEOLC, with younger people and higher complexity and noted the need to develop a longer-term funding plan for hospice care. Committee requested additional consideration of the community care offer, which also meets the needs of many people in their last days of life. **Patient Safety Healthcare Inequalities Reduction** Committee received an update on the five elements of the new national framework: 1. **Access to information; translation and interpretation services.** The ICB is currently reviewing services in line with the new national framework. This involves service user engagement and involvement in procurement activities. 2. **Training and resources for staff.** The local framework for action includes development of a system training / resource hub. The ICB is developing its own training programme, and the Primary Care Team has included EDI and health inequalities in their recent training needs analysis project. 3. **Collection and use of diversity data.** A local task and finish group has been set up with an initial focus on Primary Care, as a common 'first contact' for service users. 4. **Involvement of diverse communities and coproduction.** The ICB uses its Community Insights Bank, hosts innovation and engagement events and the development of its QIA/EHIA supports good practice in commissioning.

	5. **Research and improvement.** The ICB is engaged with regional work and the Research and Innovation Team has coordinated training with community groups on 'research readiness'. Opportunities for translation of documentation etc. is also being put in place to improve access to research for underserved communities. **CYP Experiencing a Deprivation of Liberty** Committee received a report on options for the ICB to respond to the needs of children aged 16-17 who meet criteria for MCA/DOLS but fall between child and adult legislation. Committee recommended an approach that strengthens governance and puts a clear process in place. This will be discussed further at OMB for collective approval of the approach and its financial and quality implications. **<u>Committee Approvals for this period:</u>** **ICB Research & Innovation Annual Report (June)** Committee approved the annual report for publication. **ICB Safeguarding Children Policy (July)** Committee approved the updated policy, which reflected key statutory changes, covering FGM Mandatory Reporting and MCA/DOLS for Children Aged 16-17.
Items requiring formal approval of Board:	Committee proposed a minor revision of the Committee TOR, to reflect the inclusion of LD&A provider partners.
Confirmation that the meeting was quorate:	The June and July 2025 meetings were quorate, as defined in the Governance Handbook.

Improving lives together

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

May 2025

(Month 02 2025/26)

ICB Board – Part One: 16th July 2025

Contents

1. Executive Highlights

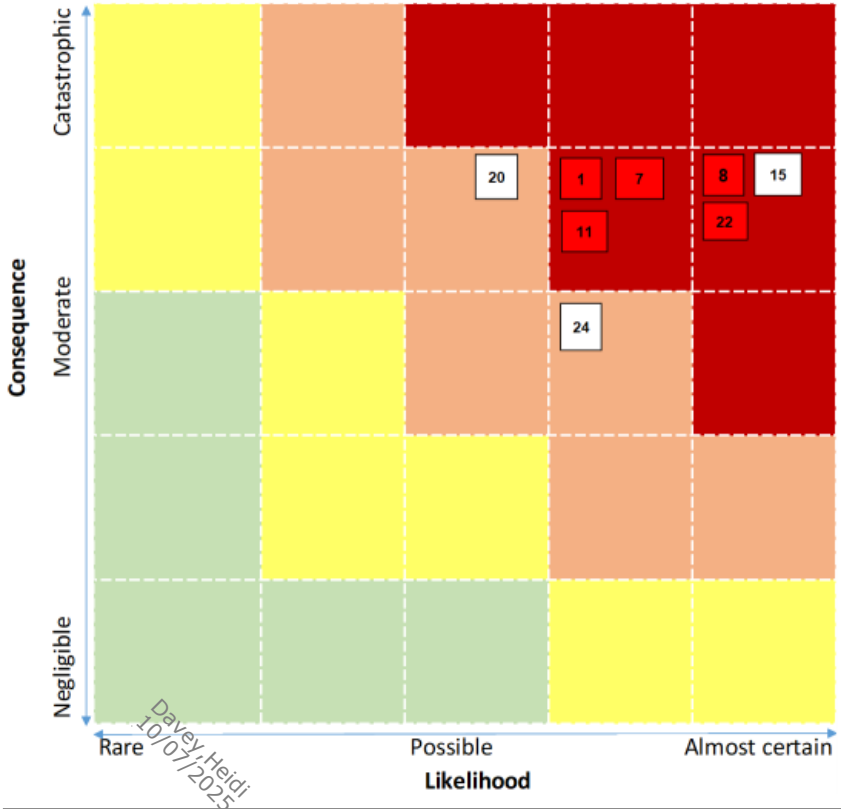
- The following report is based on the financial plan submitted to NHSE on 30 April 2025, which included a breakeven position.
- This report represents the **M02 May 2025** year-to-date position of the ICB as part of the 2025/26 Financial Year.
- The ICB has reported a breakeven **year-to-date position**,
- 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 2 position, there was a requirement to forecast achievement of sustainable commissioning efficiencies of £31.5m (including £3.4m year to date). These efficiencies are not yet at the delivery stage, so this does represent a risk to the ICB's financial position. This assumption has been captured in the ICB's risk reporting. On a year-to-date basis the ICB anticipates being able to cover this risk with potential prior-year benefits, the same assurance can not be provided for the full year forecast risk.
    - £0.3m of emerging pressures relating to Property Void costs.
    - £(0.3)m of Non-Recurrent mitigations arising from contract negotiations and investment slippage.
- 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. The ICB were the only member of the ICS to report a net risk position in financial plans.

- As at M02, the £34.7m net planning risks were reassessed to £30.6m, which are excluded from the forecast. **Total net risks, including new risks and mitigations in addition to planning risks, total £33.6m**. This is a reduction of £1.1m from the submitted plan, which is primarily due to delivery of a sustainable commissioning efficiency project, being partially offset with an emerging risk with Patient Choice for Neurodevelopmental Disorders (NDD).
- The **underlying full year forecast deficit remains on plan at £70.7m**, this is at risk of deteriorating significantly in-light of efficiency delivery risks.

2. Strategic Financial Risk Register

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

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



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

Extreme	2	2	5
High	9	9	3
Moderate	0	0	0
Low	0	0	0
Total Risks	**11**	**11**	**8**

As at M02 (May), 8 Key Financial Risks remain open of which 5 are considered Extreme relating to the Achievement of the in-year Financial Plan, the ICB Underlying Deficit, the ICB Organisational Change Programme, Independent Activity management and delivery against the Efficiency programme.

Against the M12 closing position of 2024/25, three risks have been closed as they are considered to be not relevant for the new financial year (risk 17 inflationary pressures), or 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, 20 and 16 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.

3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st May 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. The £17.3m balance is made up of aged debtors of £1.4m (including Norfolk County Council £0.8m & NNUH £0.2m), prepayments & accrued income of £4.6m, dental under delivery of £13m and a bad debt provision against aged debtors & dental under delivery of £1.7m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee.

Current liabilities
Total current liabilities has increased by £1.5m since March 2025, driven principally by ICB and system invoice accrual timing. The £171m balance is made up of trade creditors of £2m, Prescription Pricing Authority & dental accruals of £27m, payroll costs including GP pensions of £3m, deferred income of £4m, and ICB and system invoice accruals of £135m. 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 £4.9m. All invoices raised outside of the contractual conditions against which the ICB made a full and final settlement on remain on-hold.

Long Term liabilities
The non-current lease liabilities balance includes the right of use liabilities for the lease of the premises at King's Lynn and Norfolk County Council, following implementation of IFRS16 in April 2022.

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 31/05/25
ASSETS EMPLOYED		
Non-Current assets		
Right-of-use Assets	1,005	1,005
Accumulated Depreciation	(524)	(556)
Total non-current assets	481	449
Current assets		
Trade and Other Receivables	20,440	17,291
Cash and Cash Equivalents	693	6,992
Total current assets	21,133	24,283
Current liabilities		
Trade and Other Payables	(169,721)	(171,228)
Lease Liabilities	(239)	(194)
Provisions for liabilities and charges (including non-current)	(11,719)	(11,712)
Total current liabilities	(181,679)	(183,134)
Long Term liabilities		
Non-Current Lease Liabilities	(278)	(229)
Total non-current liabilities	(278)	(229)
Net assets employed	(160,343)	(158,631)
FINANCED BY TAXPAYERS EQUITY		
General fund	(160,343)	(158,631)
Total taxpayers equity	(160,343)	(158,631)

4. ICS Financial Summary: Revenue

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

Revenue surplus/(deficit) £m	Month 2 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(2.2)	(2.7)	(0.6)	(0.0)	0.0	0.0
NNUH	(2.8)	(4.6)	(1.7)	0.0	0.0	0.0
QEH	(2.3)	(2.9)	(0.6)	0.0	0.0	0.0
NSFT	(1.1)	(1.1)	0.0	0.0	0.0	0.0
NCH&C	(0.6)	(0.6)	0.0	0.0	0.0	0.0
Provider Subtotal	**(9.0)**	**(11.9)**	(2.9)	**(0.0)**	**0.0**	0.0
ICB	0.0	0.0	0.0	0.0	0.0	0.0
N&W System Total	**(9.0)**	**(11.9)**	(2.9)	**(0.0)**	**0.0**	0.0

- The position M2 YTD is a £11.9m deficit, which is £2.9m adverse against plan. This is a deterioration of £0.1m from M1 when the position was £2.7m off plan.

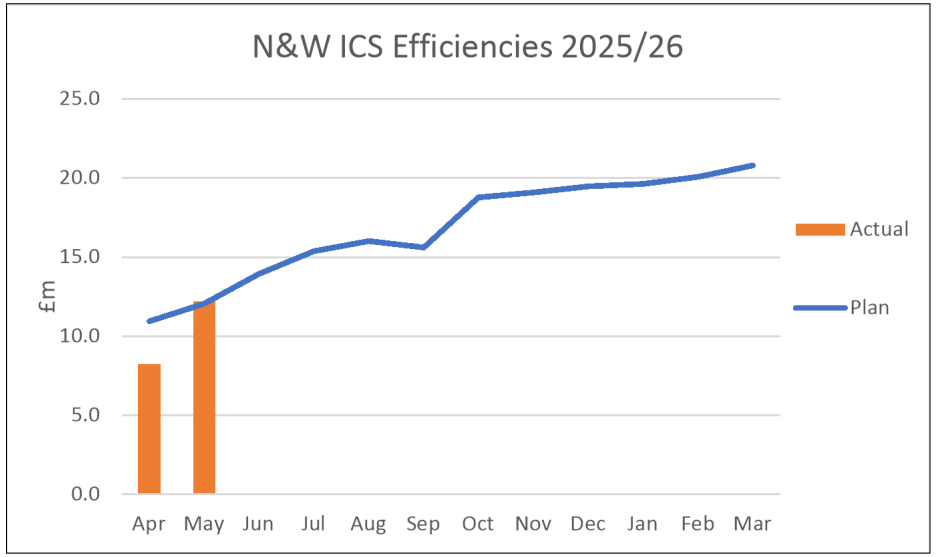
- The forecast outturn for the system is breakeven per the plan, however there is a net risk of £56.1m being reported against the FOT position.

- The following slides provide detail by organisation.

5. ICS Financial Summary: Efficiency and Transformation

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

System Efficiencies £m	Month 2 YTD			Forecast Outturn			Forecast Outturn	
Organisation	Plan	Actual	Variance fav/(adv)	Plan	Actual	Variance fav/(adv)	Recurrent	Non-recurrent
JPUH	3.6	3.2	(0.3)	25.9	25.9	0.0	18.2	7.7
NNUH	4.8	1.9	(2.9)	43.7	43.7	0.0	36.6	7.1
QEH	1.5	1.3	(0.2)	18.3	18.3	0.0	17.6	0.7
NSFT	2.9	3.6	0.8	18.7	18.7	0.0	10.9	7.8
NCH&C	0.6	0.7	0.1	8.8	8.8	0.0	4.7	4.1
Provider Subtotal	**13.4**	**10.8**	(2.6)	**115.4**	**115.4**	0.0	**88.0**	**27.4**
ICB	9.6	9.6	0.0	86.3	86.3	0.0	79.3	7.0
N&W System Total	**23.0**	**20.4**	(2.6)	**201.7**	**201.7**	0.0	**167.3**	**34.4**



N&W ICS efficiency plan for 2024/25 is to deliver £201.7m of efficiencies.

Year-to-date:

- The efficiency position M2 YTD against plan is an adverse variance to plan of £2.6m.
- Recurrent efficiency delivery is £13.9m against the plan of £18.2m, £4.3m under and NR delivery is £6.6m against the plan of £4.8m, £1.8m over, generating the net under delivery of efficiencies against plan of £2.6m.
- JPUH, NNUH, and QEH have various CIP schemes that are not meeting plan due to slippage.
- NSFT, NCH&C and the ICB are on plan.

Full year forecast:

- Full year efficiency programme forecast is £201.7m, per the plan.

6. ICS Financial Summary: Capital

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

System CDEL £m	Forecast Outturn @ Mth 2											
	System CDEL					IFRS 16			Total System Performance			
Organisation	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance	
		Inc./(Dec)			(Under)/Over			(Under)/Over			(Under)/Over	
JPUH	8.1	0.0	8.1	8.1	(0.0)	1.3	1.3	0.0	9.4	9.4	(0.0)	
NNUH	15.2	0.0	15.2	15.2	0.0	7.9	7.9	(0.0)	23.2	23.2	(0.0)	
QEH	9.3	0.0	9.3	9.3	0.0	0.3	0.3	0.0	9.6	9.6	0.0	
JPUH												
QEH												
Subtotal Including RAAC	**43.6**	**0.0**	**43.6**	**43.6**	**(0.0)**	**13.1**	**13.2**	**0.0**	**56.8**	**56.8**	**(0.0)**	
Adjustments												
Operational UEC Prior Year Q4 Performance	2.0	0.0	2.0	2.0	0.0				2.0	2.0	0.0	
Fair Share Allocation Adjustment	(0.9)	0.0	(0.9)	(0.9)	0.0				(0.9)	(0.9)	0.0	
N&W System CDEL Total	**44.7**	**0.0**	**44.7**	**44.7**	**(0.0)**	**13.1**	**13.2**	**0.0**	**57.9**	**57.9**	**(0.0)**	

Other Programmes £m	Forecast Outturn @ Mth 2											
	CDEL					IFRS 16			Total System Performance			
	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance	
		Inc./(Dec)			(Under)/Over			(Under)/Over			(Under)/Over	
Central Programmes Including RAAC			102.7	102.7	0.0				102.7	102.7	0.0	
Return to Constitutional Standards			56.2	48.7	(7.5)				56.2	48.7	(7.5)	
2025/26 Estates Safety			10.1	10.1	0.0				10.1	10.1	0.0	
2025/26 Mental Health: Reducing Out of Area Placements			1.9	1.9	0.0				1.9	1.9	0.0	
N&W Total Capital Programme			**215.8**	**208.2**		**13.1**	**13.2**		**228.9**	**221.4**		

- M2 combined system CDEL performance FOT is per plan.
- NNUH are planning to use the £2m UEC additional funding therefore this has been included in forecast.
- SCB will manage the slippage required in year to meet the £0.9m allocation reduction.
- In addition to system CDEL & IFRS 16 funds, there is other programme funding of £163.5m making the total capital resource for N&W ICS £221.4m.
- Return to constitutional standards programme is forecasting an underspend due to the JPUH UEC scheme being reviewed.

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: 12

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Director of Commissioning Finance**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 24th of June 2025.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 21.05.2025. Subsequent Meetings: 24.06.2025
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 2** results, i.e. per May 2025.* Much information regarding Month 2 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 2 reporting:

	- At **Month 2 (May 2025)** the NHS entities in the N&W ICS show a deficit of £(11.9)m vs a Planned deficit of £(9.0)m, i.e. a shortfall of £(2.9)m in the acute group of hospitals. Efficiency schemes delivered a saving year to date of £20.4m against a Plan of £23.0m a shortfall of £2.6m savings. The Plan for the year is break-even including deficit support funding of ca. £ 51m which is wholly dependent on the delivery of the financial plan. At Month 2 there is £56.1m of net risk outside the reported position. - At **Month 2 (May 2025)** the ICB shows a break-even position against a planned break-even position. Efficiency schemes delivered a saving year to date of £9.6m, in line with plan. The Plan for the year is break-even. At Month 2 there is £33.7m of net risk outside the reported position which is a minor improvement over the opening planned net risks of £35.9m. - Year to Date CDEL (**Capital** Delegated Expenditure Limit) expenditure as of Month 2 (May 2025) was £3.3m, £5.0m below plan. The forecast system CDEL & IFRS 16 capital expenditure is £57.9m, in line with the plan. - Other topics covered during the June 24 meeting: o The committee received a system workforce update and its financial implication. At Month 1 (April 2025) - total staff use (substantive + bank + agency) was below plan, driven by lower than planned substantive and agency use. Bank use remains above plan at NCHC, NSFT and JPUH. The committee heard of the workforce reduction plans in trusts, as well as regional and national scrutiny of delivery against workforce plans. o Committee received a verbal update on key points discussed in the Financial Recovery Board. o Committee received an update from matters discussed at recent Strategic Capital Boards.

	○ Committee discussed the net risks outside reported position (£56.1m per Month 2) in greater detail. At this early stage in the financial year, it is too early to provide an assurance level on meeting the financial plans. As per earlier reports to and discussions in Board, the efficiency ask for 2025/26 is very significant, both at system level, as well as ICB level. On the latter (ICB level), the committee noted that a significant part (ca. 35%) of the efficiency ask is high risk and/or not yet worked up or defined within the Sustainable Commissioning efficiency portfolio. The committee noted also, that the deficit support funding will be supplied on a quarterly basis in arrears, and is dependent on credible delivery against the financial plan trajectory and efficiency plans. Lastly the net risk of £56.1m outside the reported position is higher than the end of April plan position. Following a discussion, the committee decided to increase the risk rating to 20 for the BAF8 risk "Achieve the 2025/26 (ICB) financial plan", with a likelihood score of 5 and impact score of 4.
Items for escalation to Board:	1. Month 2 results at system and ICB level, as well as net risk outside the reported position 2. Deficit support funding is released on a quarterly basis and depends on credible progress against financial and efficiency plans. 3. Increase in BAF8 risk score "Achieve the 2025/26 (ICB) financial plan" from 16 to 20.

	NHS entities in N&W ICS, including ICB	**N&W ICB**
Month 2 (May 2025)	Actual: Deficit of £(11.9)m vs Plan of £(9.0)m, i.e. a shortfall of £(2.9)m.	Actual: Break-even vs Plan of Break-even
Underlying Deficit *(* Basis of 2025/26 Financial Plans)*	£(230.7)m *	£(122.4)m Exit U/L Deficit £(70.7)m Planned U/L Deficit

	Efficiency delivery	Year to Date £23.0m Plan £20.4m Delivered Full Year Forecast £201.7m Plan	Year to Date £ 9.6m Plan £ 9.6m Delivered Full Year Forecast £86.3m Plan
Items requiring approval:	None		
Confirmation that the meeting was quorate:	Confirmed that meetings were quorate.		

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

Agenda item: 13

NHS
Norfolk and Waveney
Integrated Care Board

Subject:	**Integrated Performance Report Assurance**
Presented by:	**Matt Dooley, Executive Director for Commissioning and Performance**
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:	**16 July 2025**

Purpose of Paper:

To provide assurance to the ICB Board on metrics associated with elective care (including cancer), mental health and urgent and emergency care. The paper will:

- highlight key successes
- draw attention to areas of concern
- describe remedial actions for areas of concern

Executive Summary:

Board are asked to note:

1. **Cancer**: Improvement in the 28-day Faster Diagnostic Standard (FDS) but 62-day treatment standard not being met across the system.
   Assurance level: concerning

2. **Elective**: Improved position for diagnostics waiting times, though with some significant variation across specialties. Notable improvements are seen in elective care waiting times: both 18-week and 52-week standards from referral to treatment. However, current performance does not give assurance that targets / trajectories will be met consistently, and 65-week waits will not be eliminated by 30.06.2025.
   Assurance level: average.

3. **Mental Health**: areas of delivery to be noted. 12-hour decision to admit (in A&E departments) is a focus as part of the wider crisis pathways and management of acute / urgent care.
   Assurance level: average.

4. **UEC**: some areas show common cause improvement, however, there is currently not assurance that trajectories spanning 1st April to 30th June will be met.
   Assurance level: concerning

All assurance levels were reviewed in Commissioning and Performance (C&P) Committee, 19th June 2025, and agreed as appropriate.

BORR: Board Operational Risk Register
ORR: Operational Risk Register

Report

1. Cancer

Overall Level of Assurance

Assurance Level	Supporting Statement
Concerning	The 28-day Faster Diagnostic Standard (FDS) is showing an improvement across the system. Continued efforts are required via cancer improvement/action plans and national tiering focus to sustain the result. The 62-day performance is not showing consistent improvement due to delays earlier in the pathway (such as diagnostics), clinical complexity and workforce capacity challenges to treat patients in a timely manner. Across areas of delivery there is continued reliance on insourcing – an approach where Trusts provide additional activity to see/treat more people within their own infrastructure. The key challenge around workforce is being raised with the People Board to support appropriate visibility and action.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	Board Assurance Framework 07 (InPhase 010) (BORR) 043; (ORR) 057; 050; 051
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	Metric(s) connected to this concern (references to the metric in the C&P committee data pack)	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
High referral levels impacting on waiting times for 28-day performance.	28-day FDS standard (C&P-1)	Y	Y	N
Delays in diagnostic testing and workforce constraints.	DM01: 6-week diagnostic (C&P-7)	Y	Y	Y
Backlog of long wait patients delaying treatment start dates.	Acute Trust Cancer Waiting Lists and trajectories.	Y	Y	N
Oncology workforce challenges.	62-day standard (C&P-4)	Y	N	N

Key success(es) - description	Metric(s) connected to this success
Two-month improvement in 28-day performance due to utilisation of insourcing, weekend working and CDC utilisation. Also targeted support for histopathology and the continual embedding of best practice timed pathways and associated milestones.	Cancer Waiting Times 28-day FDS target (77%) Diagnostic (DMO1) performance.

BORR: Board Operational Risk Register
ORR: Operational Risk Register

2. Elective Care and Diagnostics

Overall Level of Assurance

Assurance Level	Supporting Statement
Average	Performance is showing improvement across the reported diagnostic and treatment waiting times. However, there is not yet assurance that NHS Norfolk & Waveney will consistently meet the trajectory and operational insights indicate Q1 (the period 1/4/25 – 30/6/25) will see a more challenged position. There is a substantial risk to achieving the national target of clearing 65-week waits by 30.6.25, with one Trust planning not to meet this objective. Action plans and updated trajectories have been requested an provided as relevant per Trust. Significant work is required to meet 2025/26 plans – this includes with the Norfolk and Waveney University Hospital Group, Independent Sector Providers and other NHS Trusts outside of Norfolk and Waveney where Norfolk and Waveney residents seek and are provided care and treatment.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	Board Assurance Framework 07 (InPhase 010) BORR 076; 077
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	Metric(s) connected to this concern (references the metric number in committee / programme board data packs)	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
Variation across diagnostic area in Diagnostics waiting times (DM01)	DM01: 6-week diagnostic target (C&P-7)	Y	Y	N
Impact of delayed diagnostics and treatment – patient outcomes and experience, and reputational impact.	DM01: 6-week diagnostic (C&P-7) Referral To Treatment standards (C&P-9/13/14)	Y	Y	N

Key success(es) - description	Metric(s) connected to this success
Diagnostic and treatment waiting times are improving, with 3 of 4 standards reported in special cause improvement.	DM01: 6-week diagnostic (C&P-7) Referral To Treatment standards (18 & 52-week) (C&P-9/13) First appointment in 18-week (C&P-14)

BORR: Board Operational Risk Register
ORR: Operational Risk Register

3. Mental Health

Overall Level of Assurance

Assurance Level	Supporting Statement
Average	Significant work continues to address the variations in Inappropriate Out of Area Placements and the 12-hour A&E decision to admit breaches. These are complex, multifaceted issues involving system level and provider level factors.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	Board Assurance Framework 006 (InPhase 007) (BORR) 048
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	Metric(s) connected to this concern (references the metric number in committee / programme board data packs)	Remedial Actions in Place	Recovery Trajectory	Contractual Escalation
12-hour A&E decision to admit breaches – whilst the latest data shows an improved picture, the current variation is not considered acceptable and we are working 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.	C&P11	N	N	N

Key success(es) - description	Metric(s) connected to this success
NHS Talking Therapies performance in respect of first treatment within 18 weeks continues to overperform with 99.8% against a target of 95%.	C&P 2
Early Intervention in Psychosis (EIP) referrals seen within 2 weeks are at 85.7% against a target of 60%	MHITDG 3
The numbers of people accessing specialist community Perinatal Mental Health and Maternal Mental Health services in a rolling 12-month period is also above target at 1,150 (target 1,018)	MHITDG 7

BORR: Board Operational Risk Register
ORR: Operational Risk Register

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. Performance is showing improvement in some areas however there is no assurance that Norfolk & Waveney will meet the trajectory in Q1.

Risks	
Are any performance risks recorded?	Yes
Risk Reference No(s)	Board Assurance Framework - 003
Committee with Risk Oversight	Commissioning & Performance

Key concern(s) - description	Metric(s) connected to this concern (references the metric number in committee / programme board data packs)	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&P6, Ambulance Response times.	In development	In development	N
Recovery plans are required where performance is not achieving plan or contractual standards.	All where performance is of concern.	In development	In development	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&P6, Ambulance Response times.
Virtual ward strategic review has taken place, with an outcome of all providers signing up to a new model workshop.	

Recommendations to ICB Board:

- Note new report format which includes assurance levels, as per *Making Data Count*
- Note areas of concern and support actions that improve / recover performance
- Support development of recovery plans and trajectories where required and not in place

Governance

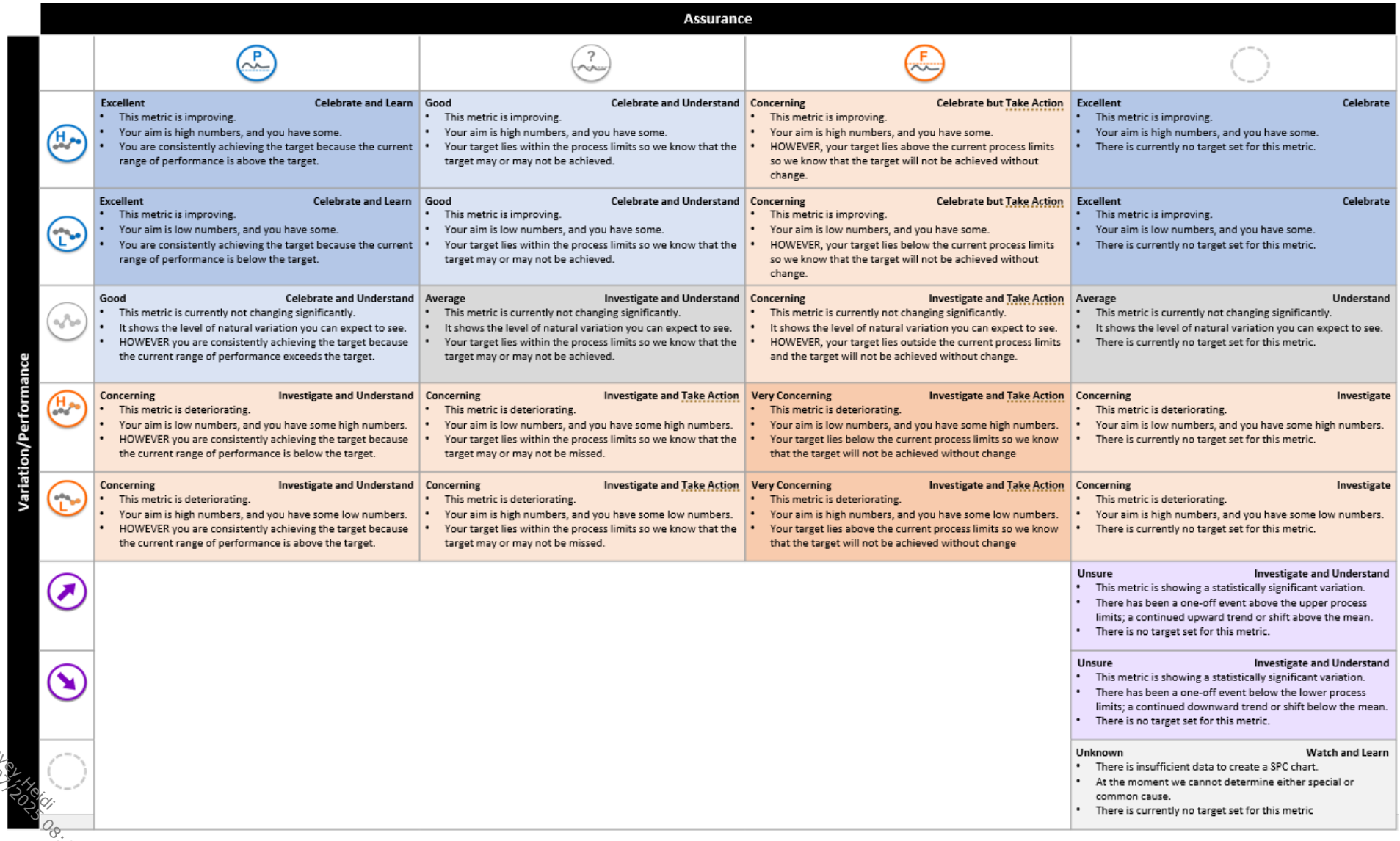
Board Approval	ICB Board Agenda Item: Date: 16th July 2025

BORR: Board Operational Risk Register
ORR: Operational Risk Register

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.



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Norfolk and Waveney ICB Board

View in Power BI

Last data refresh:
11/06/2025 19:05:06 UTC

Downloaded at:
12/06/2025 10:53:24 UTC

Commissioning and Performance Committee

Report Overview

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

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

Navigating the Report

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

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

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

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

Information Governance Notes

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

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

Report Version History

Date	Version	Change Notes
18/03/25	1.00	Initial Deployment
06/06/25	1.01	Transformed Reporting date to start of month to fix axis alignment issues.

Data Source: Various

Produced by: N&W ICB Business Intelligence

Email: nwicb.bi@nhs.net

Commissioning and Performance Committee

SPC headlines for core 15 Commissioning and Performance Committee metrics: May 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

Common Cause - No significant change

Special cause of concerning nature or higher pressure due to **H**igher or **L**ower Values

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

Commissioning and Performance Committee

SPC headlines for core 15 Commissioning and Performance Committee metrics: March 26

Search:

Search

Variation

- Common Cause
- Concern (High)
- Concern (Low)
- Improvement (High)
- Improvement (Low)

Assurance

- Capable
- Not capable
- Unreliable

Davey, Heidi 10/07/2025 09:47:35

Metric No.	Metric Name	Latest Date	Result	Target	Target Type	Variation	Assurance	Metric Data Source
1	Cancer - 28 Day FDS Performance - ICB	Mar 25	79.6%	78.0%	Trajectory	H	F	National
2	Talking Therapies - First Treatment Within 18 Weeks - ICB	Mar 25	99.8%	95.0%	Target	L	P	National
3	UEC - 111 Calls Answered within 60 secs (%) - ICB	Mar 25	87.6%	95.0%	Target		F	Provider Submission
4	Cancer - 62 Day Combined Performance - ICB	Mar 25	61.7%	70.8%	Trajectory		F	National
5	Mental Health - E.A.5 Active Inappropriate Adult Acute Mental Health Out Of Area Placements - ICB	Mar 25	0	0	Trajectory	L	F	National
6	UEC - Mean C2 Ambulance Response Times (Mins) - ICB	Apr 25	38.53	30.0	Target		?	Provider Submission
7	Diagnostics - DM01 Performance - ICB	Mar 25	73.9%	99.0%	Target	H	F	National
8	UEC - Total A&E 4hr Performance - Provider	Apr 25	72.2%	71.7%	Trajectory	L	F	National
9	RTT - 18 Week Performance - ICB	Mar 25	55.0%		Trajectory	H	F	National
10	UEC - 12 hour A&E DTA breaches - Provider	Apr 25	810	0	Target		F	ECDS
11	Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB	Apr 25	28	0	Target		F	ECDS
12	Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB	Mar 25	76.9%	80.0%	Target		?	National
13	RTT - 52 Week Performance - ICB	Mar 25	4.1%		Trajectory	L	F	National
14	RTT - 18 Week First Performance - ICB	May 25	61.8%	61.0%	Trajectory		F	National

Commissioning and Performance Committee

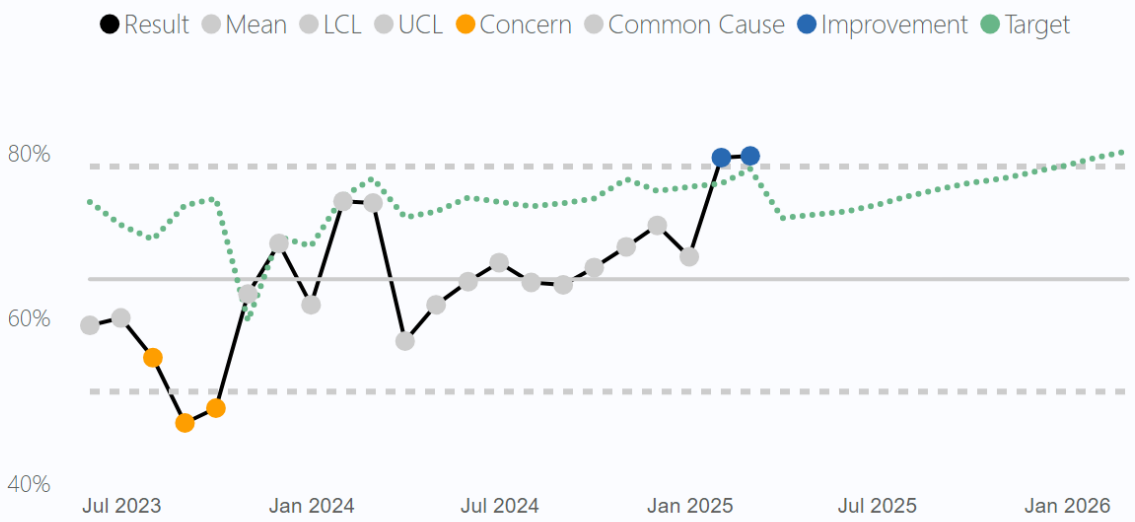
Cancer - 28 Day FDS Performance - ICB

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
Mar 25	National	79.6%	78.0%		

Daveya Saidi 10/07/2025 08:47:35

System Position - Summary and Context

Performance for the 28-day FDS reached 79.6% in March 2025, which is above the 78.0% target. The SPC indicates special cause improvement following a period of concern, demonstrating a positive shift in delivery.

Root Causes and Contributing Factors

- High referral volumes continue to increase pressure on diagnostic services, especially in skin, colorectal, urology.
- Delays in diagnostic testing and reporting, particularly in radiology, histopathology, and endoscopy, impacting timely decision-making.
- Workforce constraints across key diagnostic modalities (e.g. radiology, pathology, physiology), affecting turnaround times and list availability.

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/DM01 performance

Key Actions and Risks to Actions

1. Expand diagnostic capacity through insourcing, weekend working, and CDC utilisation
2. Implement and embed Best Practice Timed Pathways (BPTPs) across priority tumour sites
3. Targeted support to histopathology turnaround, with focus on skin and breast pathways

Cancer Transformation Oversight Group, Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026

Commissioning and Performance Committee

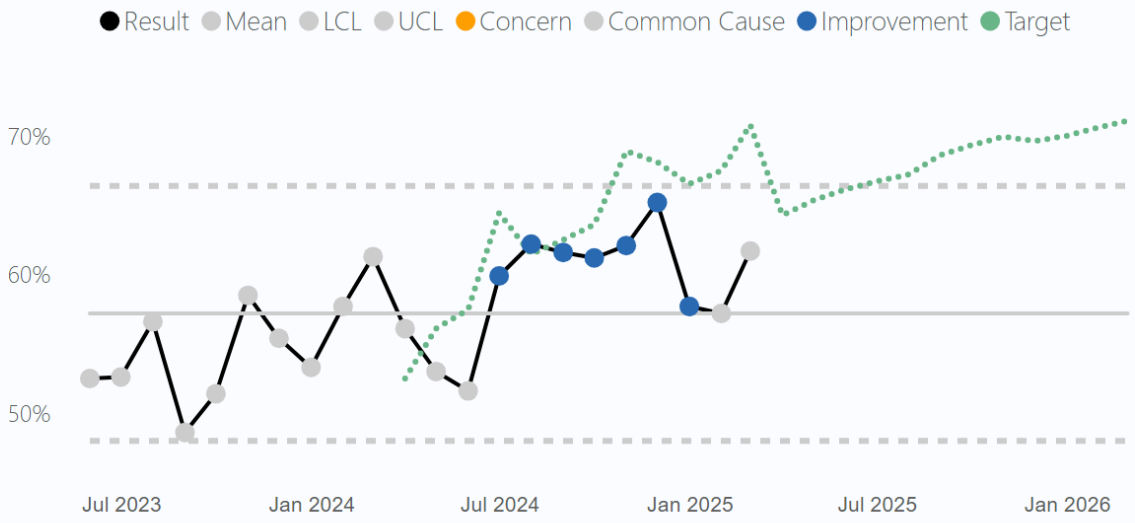
Cancer - 62 Day Combined Performance - ICB

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
Mar 25	National	61.7%	70.8%		

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System Position - Summary and Context

Performance for the 62-day cancer standard was 61.7% in March 2025, remaining below the 70.8% target. The SPC chart shows common cause variation, with sustained improvement since mid-2024. However, continued variation and recent fluctuations mean there is not yet assurance of consistently meeting the standard.

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 radiology, endoscopy, and histopathology are compressing the treatment window.
- Workforce shortages (e.g. anaesthetists, diagnostic staff, oncologists) are limiting capacity.
- Late tertiary referrals and theatre access issues are impacting provider ability to treat within 62 days.
- Patient choice and clinical complexity contributing to delayed starts.

Associated Metrics, Insights and Impacts

28-Day FDS performance directly influences 62-day outcomes, as delays earlier in the pathway compress the treatment window.

Theatre and diagnostic capacity constraints continue to impact delivery timelines.

Patient outcomes and experience may be negatively affected by treatment delays, particularly for fast-progressing cancers.

Key Actions and Risks to Actions

1. Expand diagnostic and treatment capacity through insourcing, WLIs, and improved use of CDCs
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

Cancer Transformation Oversight Group, Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026

Commissioning and Performance Committee

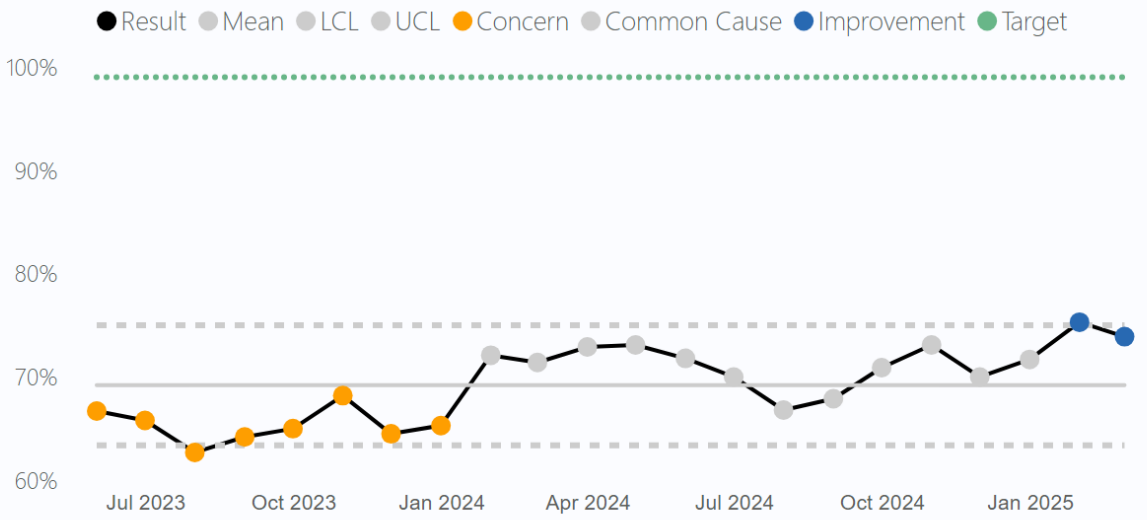
Diagnostics - DM01 Performance - ICB

Metric Description

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

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Mar 25	National	73.9%	99.0%		

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System Position - Summary and Context

Performance continues to improve, with common cause improvement evident from Jan-25. The March-25 result of 73.9% remains below target, and there is currently no assurance that the target will be met consistently.

While recent data shows positive movement, the system remains under pressure, and further sustained improvement is required to close the gap. Consistency and resilience in delivery remain key concerns despite the upward trend and best performance for 12+ months.

Root Causes and Contributing Factors

- Workforce shortages due to sickness, vacancies, and limited uptake of additional sessions
- Capacity constraints, including loss of insourcing, delayed CDC infrastructure, and equipment issues
- Operational inefficiencies in booking, underutilised lists, and lack of standardised scheduling
- Data quality issues, especially around NCDR submissions and inconsistent performance tracking
- Growing demand from urgent and cancer pathways reducing capacity for routine diagnostics

Associated Metrics, Insights and Impacts

- Diagnostic delays may lead to poorer outcomes and increase clinical risk, particularly for cancer/urgent care
- Prioritisation is being made in some areas of diagnostics such as Cancer pathways.
- Waiting times for children and young people are being monitored in key areas such as Audiology.
- Interconnected Metrics: DM01 compliance and breach volumes/all Cancer Standards / RTT standards

Key Actions and Risks to Actions

1. Recruit and upskill diagnostic staff (radiographers, endoscopists, audiologists)
2. Optimise booking and maximise list utilisation with revised templates and session planning
3. Use of insourcing, WLI, and CDCs to increase capacity
4. Prioritise diagnostics for cancer and long-wait patients

Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026

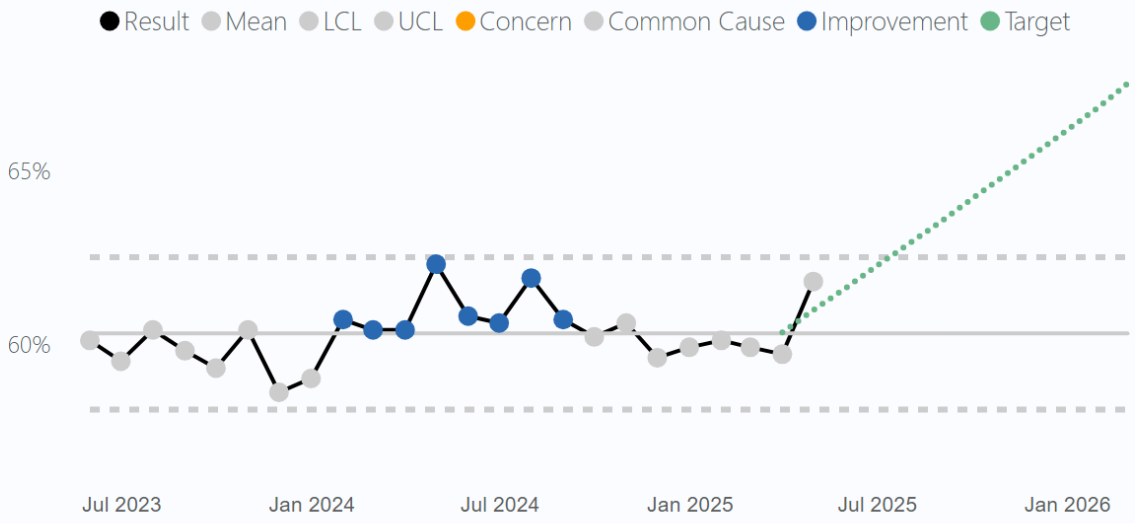
Commissioning and Performance Committee

RTT - 18 Week First Performance - ICB

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

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
May 25	National	61.8%	61.0%		

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System Position - Summary and Context

May performance is common cause improvement, with 2.1 percentage-point increase and 0.8 above the target. There is not yet consistency to provide assurance on performance.

JPUH is in special cause improvement delivering 61.8%. NNUH performance is in common cause improvement, delivering 59.5%.

QEH is improving however remains in special cause concern, while delivering 62.8%.

Root Causes and Contributing Factors

- High referral demand in key specialities.
- Workforce constraints, including shortages in outpatient clinic staffing and diagnostics.
- Diagnostic bottlenecks delaying onward clinical decision-making and treatment pathways.
- Tighter financial controls on vacancies and the triple lock process as part of financial turn-around.

Associated Metrics, Insights and Impacts

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

Key Actions and Risks to Actions

1. Demand and Capacity: Diagnostics working group standing up from April '25; Insourcing; CDC moving to 7/7 working from May. Trusts monitoring activity against plan by specialty. Demand Management working group in formation, with key connection to A&G and pathway management and national Validation Sprint
2. Activity constrained by finance: risks identified; productivity working group.
3. Workforce challenges: Recruitment ongoing; Locum cover; upskilling; insourcing.
4. Demand management: work is developing at pace to agree a demand management programme of work.

Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026.

Commissioning and Performance Committee

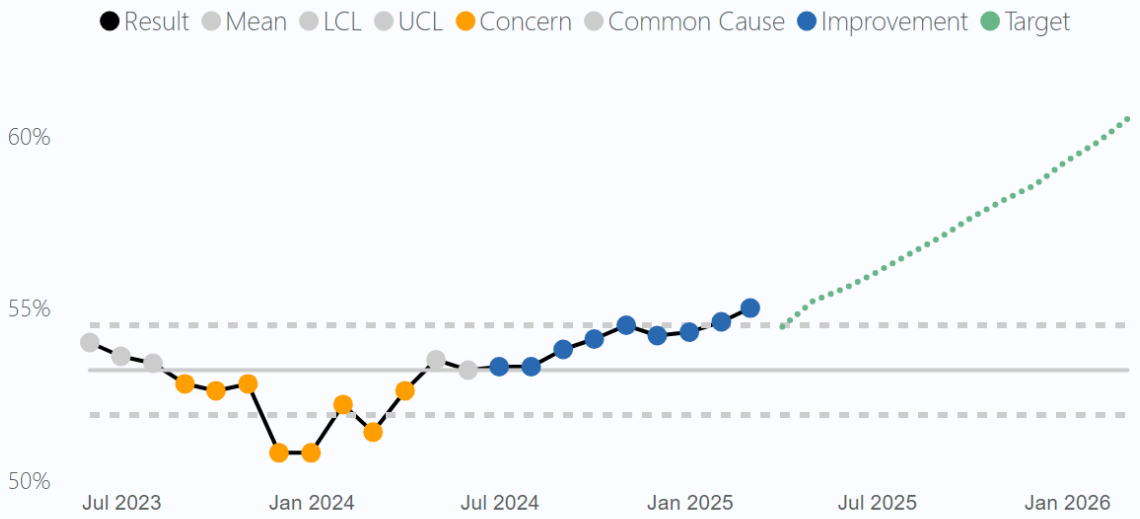
RTT - 18 Week Performance - ICB

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
Mar 25	National	55.0%			

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System Position - Summary and Context

March is the 9th month of special cause improvement. The improvement seen, however, is within narrow upper and lower limits. March reporting shows: NNUH delivered 53%; JPUH delivered 54.7%; QEH delivered 57.9% - QEH is in special cause concern despite achieving the highest performance.

Improvement is evident though some specialties are challenged and the trajectory is ambitious. Validation Sprint through Q1 is expected to impact performance due to reducing the numbers waiting early in pathways.

Root Causes and Contributing Factors

- Workforce - recruitment and sickness
- Financial challenges and changes to activity available
- Demand into elective pathways

Associated Metrics, Insights and Impacts

- Diagnostics and 52-week Referral to Treatment (RTT) standards.
- 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.
- Harm reviews are in place for those on waiting lists.

Key Actions and Risks to Actions

1. Productivity working group standing up to drive efficiency opportunities - delayed from anticipated April start.
2. Demand Management programme in formation, with key connection to national and local initiatives
3. Activity modelling and tracking of activity across all elective areas is in development (June 2025)

Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026.

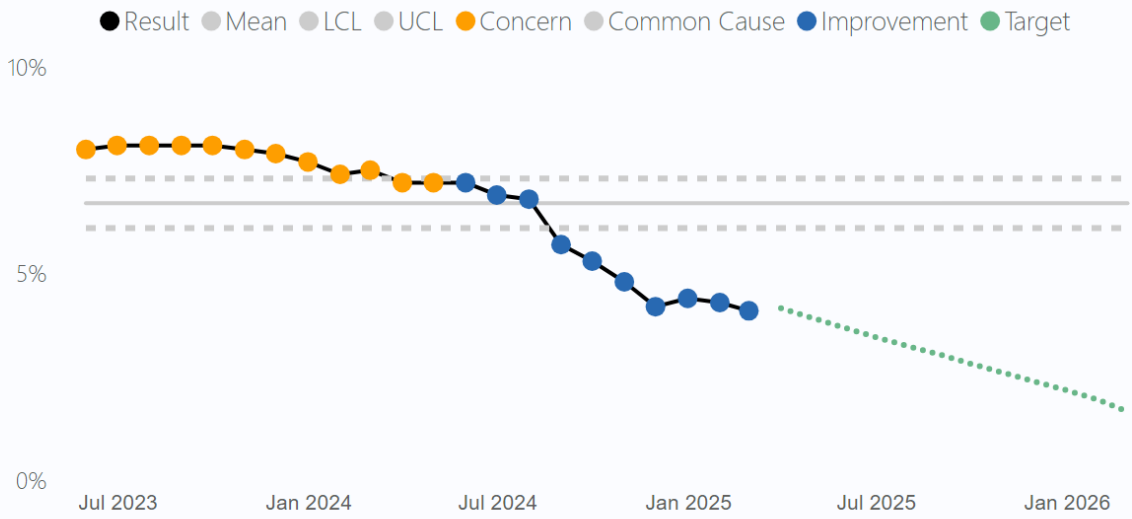
Commissioning and Performance Committee

RTT - 52 Week Performance - ICB

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

BAF

BAF07



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Mar 25	National	4.1%			

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System Position - Summary and Context

March saw a continuation of the sustained improvement seen since mid-2024. This improvement is seen across all three acute hospitals in Norfolk and Waveney, and all are now under 5% of their waiting list waiting 52-weeks or more. The numbers of people waiting over 65-weeks is of key focus in parts of our system with plans shared for delivering '0' 65-week waits by 30th June, however there is concern that some specialties may not achieve this.

Root Causes and Contributing Factors

- Financial constraints and controls impacting additional capacity being utilised e.g. in/outsourcing.
- Workforce shortages in key clinical areas, impacting the ability to deliver elective care at required levels.
- Elective capacity constraints and cancellations, often due to pressures from UEC demand.
- Increasing patient complexity, including comorbidities and higher acuity, which extends treatment times and reduces throughput - particularly 52- and 65-week waits

Associated Metrics, Insights and Impacts

- Diagnostic waiting times (DM01)
- RTT Incomplete Pathways
- Cancer pathways
- Theatre utilisation and cancellation rates, validation and developments of Advice & Guidance.

Key Actions and Risks to Actions

1. Participation in 2025/26 NHSE Validation Sprint.
2. System collaboration to support challenged pathways, use of the Group Model
3. ICS working groups focused on Productivity and Demand Management standing up from May 2025.
4. Forward look to view risks in waiting lists and support sustainable improvement.

Scheduled Care Board and Commissioning and Performance Committee oversee these actions, to run to 31/03/2026.

Commissioning and Performance Committee

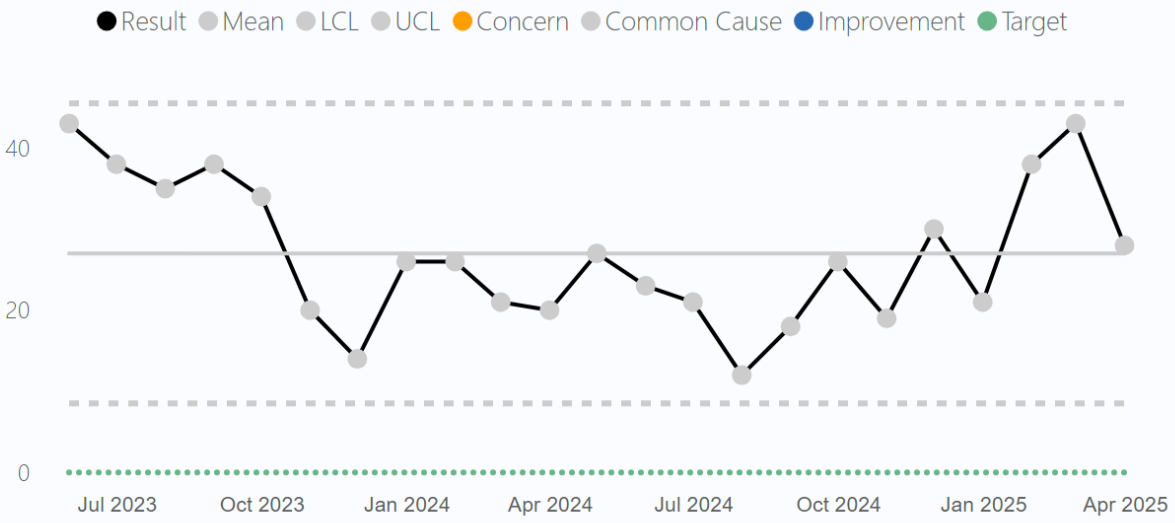
Mental Health - 12 Hour A&E Decision To Admit Breaches - ICB

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
Apr 25	ECDS	28	0		

System Position - Summary and Context

During the current reporting period, there were 28 12-hour DTA breaches, where the target remains zero. This is an improvement from last month.

The current variation is not considered acceptable, and improvement actions have been triggered. Benchmarking data (where available) shows that this level of breach is comparable to or slightly better than the national average, where mental health bed pressures and demand challenges are also contributing to breaches.

Root Causes and Contributing Factors

The breaches can be attributed to a combination of increased demand, bed capacity limitations, and workforce pressures within both the local provider and 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

Commissioning and Performance Committee

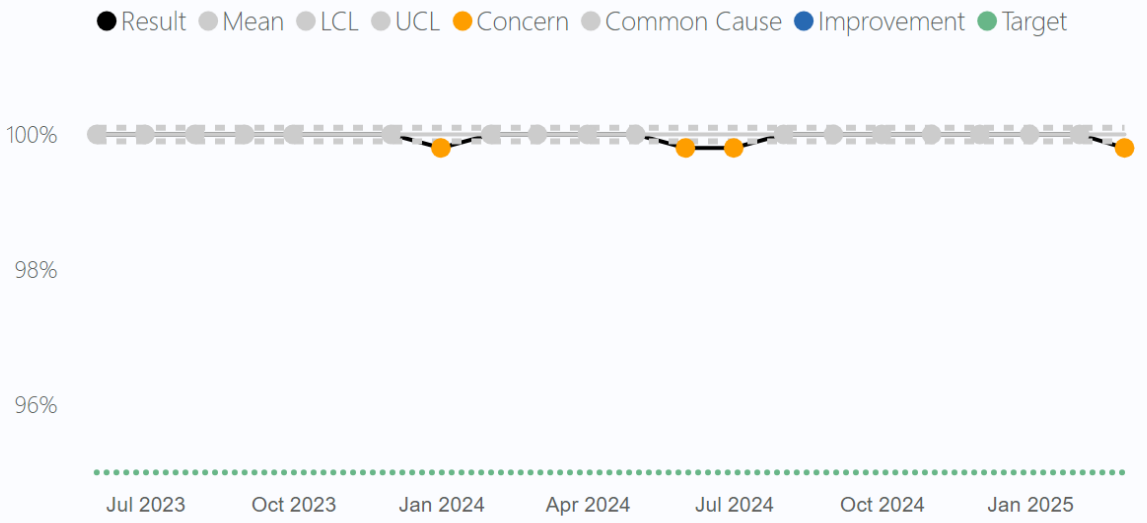
Talking Therapies - First Treatment Within 18 Weeks - ICB

Metric Description

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

BAF

None



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Mar 25	National	99.8%	95.0%		

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System Position - Summary and Context

Performance remains strong and consistently above target, with the latest reporting period achieving 99.8% against the 95% national standard. SPC shows the process is in statistical control, with no concerning variation. This provides assurance of sustained delivery.

Root Causes and Contributing Factors

No systemic constraints currently impacting this metric.

Associated Metrics, Insights and Impacts

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

Key Actions and Risks to Actions

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

Commissioning and Performance Committee

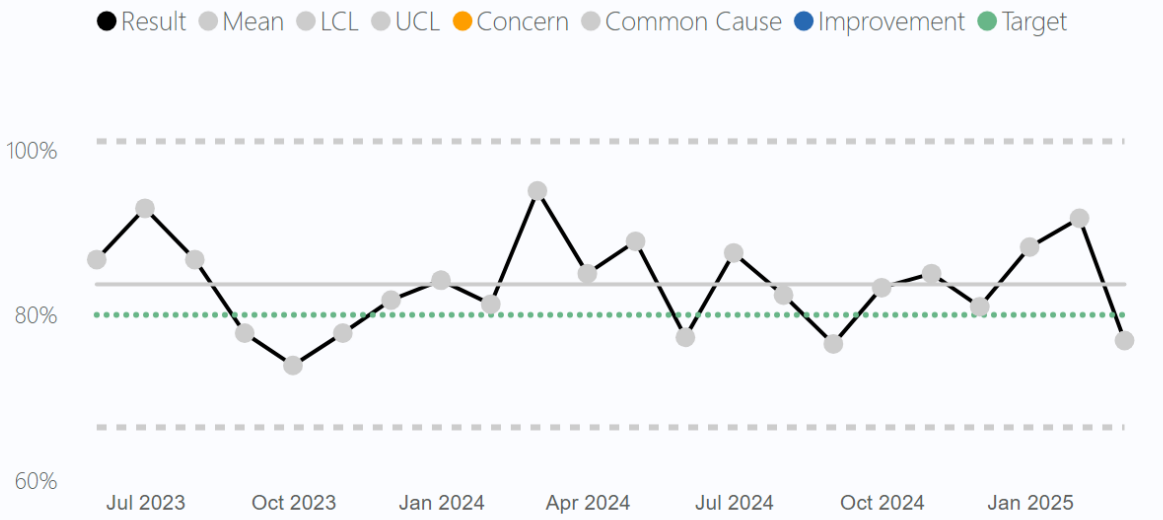
Mental Health - Acute Discharges Followed Up Within 72 Hours - ICB

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
Mar 25	National	76.9%	80.0%		

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System Position - Summary and Context

This section reflects a dip in performance (76.9% vs. target of 80%), acknowledges minor variations that are within acceptable limits, and compares the Trust's position with national/regional benchmarks. It also notes that the SPC chart provides assurance that the Trust is consistently meeting the target, with some acceptable variations during certain periods.

Root Causes and Contributing Factors

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

Associated Metrics, Insights and Impacts

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

Key Actions and Risks to Actions

The key actions outlined focus on enhancing discharge planning, increasing capacity in community teams, improving communication between inpatient and community services, and targeting high-risk patients for follow-up. These actions are designed to sustain the positive performance of 91.7% 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.

Commissioning and Performance Committee

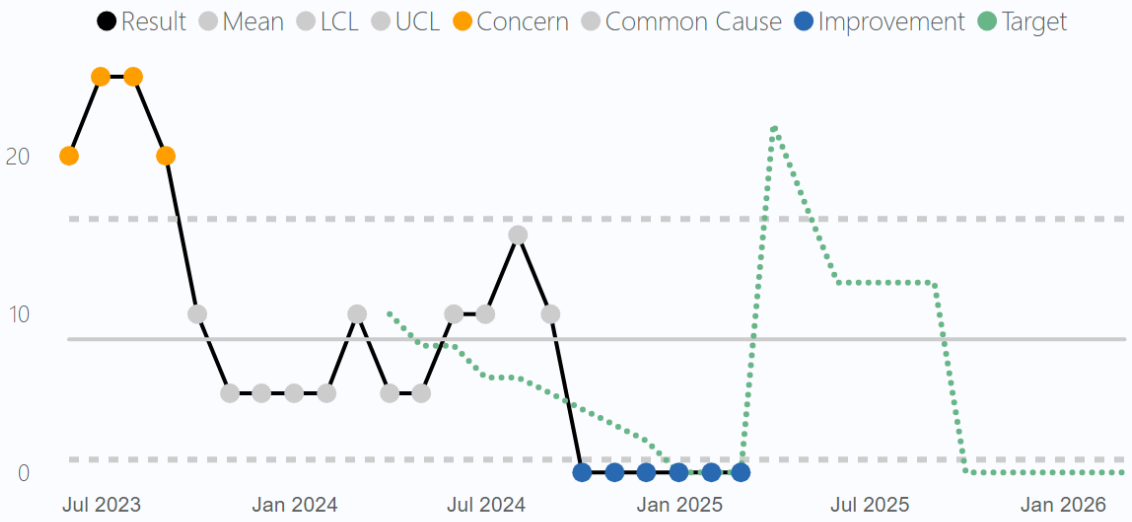
Mental Health - E.A.5 Active Inappropriate Adult Acute Mental Health Out Of Area Placements - ICB

Metric Description

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

BAF

None



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

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System Position - Summary and Context

There continues to be significant challenges in maintaining inappropriate out-of-area placements against a target of zero. The target has been maintained for 5 consecutive months with SPC showing 'improvement' in this time, though the challenge of a 'zero' target should be recognised.

Root Causes and Contributing Factors

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

Associated Metrics, Insights and Impacts

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

Key Actions and Risks to Actions

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

Commissioning and Performance Committee

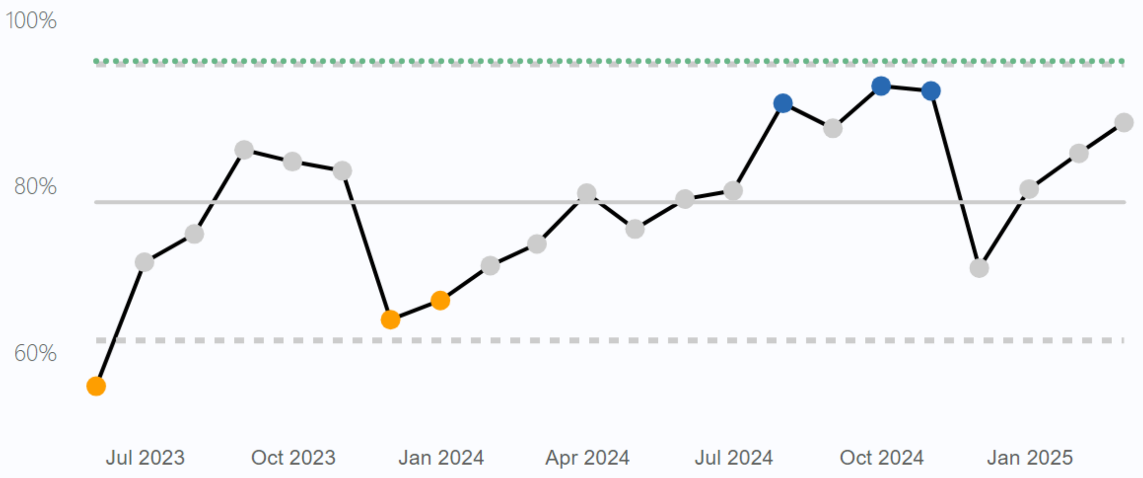
UEC - 111 Calls Answered within 60 secs (%) - ICB

Metric Description

The percentage of 111 calls answered within 60 seconds of the calle being available out of all 111 calls answered.

BAF

BAF06



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Mar 25	Provider Submission	87.6%	95.0%		

System Position - Summary and Context

February has seen an increase in call answering performance of 3% compared to January. A low abandonment rate reduced further from January which was 1.62% and 1.22% in February, wit March data continuing to show this positive trend.

Root Causes and Contributing Factors

February remains a pressured month for our 111 provider with it being in the winter period, higher rates of respiratory infections and dental issues are being seen within this month. Staff sickness was over 11% in February which would have had an impact on their call answering performance through the month.

Associated Metrics, Insights and Impacts

Our 111 provider remains within the to quartile of national providers for calls answered within 60 seconds and their abandonment rate remains below national average, both of which are positive outcomes for the month.

Key Actions and Risks to Actions

Although provider is not achieving 95% a weekly recovery trajectory is in place with improvements being seen. This is monitored weekly with the ICB and provider to work through challenges which are being faced.

Commissioning and Performance Committee

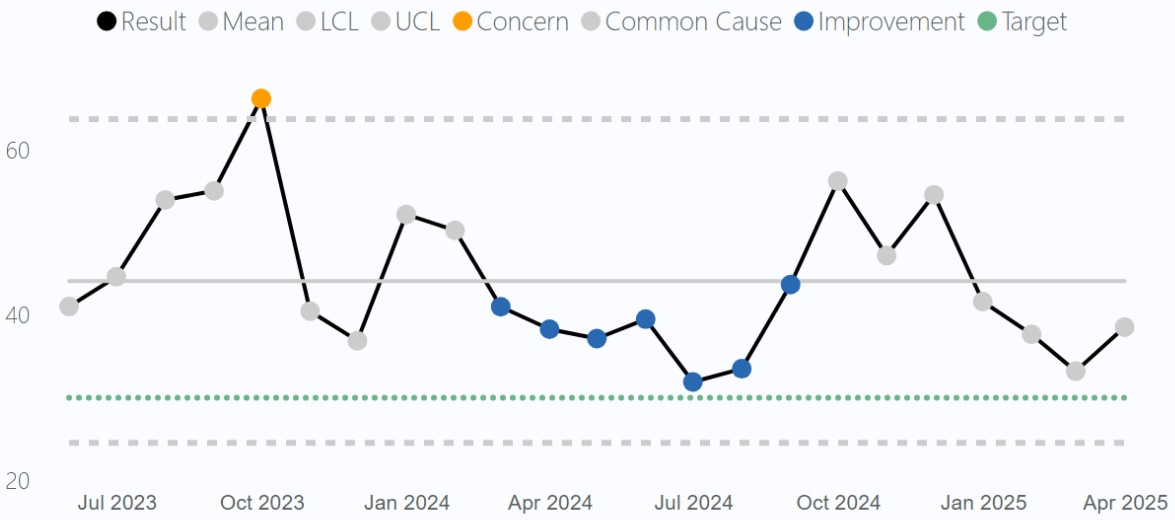
UEC - Mean C2 Ambulance Response Times (Mins) - ICB

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
Apr 25	Provider Submission	38.53	30.0		

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System Position - Summary and Context

C2 response times for March have decreased to 33.28 which is the closest we have been as a system to the target of 30 minutes since July 24.

Root Causes and Contributing Factors

Turn around delays 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 despatch element of C3-C5. Call before convey has increased into UCCH from the previous month.

Work continues within the acutes with QEH and NNUH both signed up to handover in 30 minutes and JPUH to handover in 45.

60% of validation work from our 111 provider are downgraded away from an ambulance.

Commissioning and Performance Committee

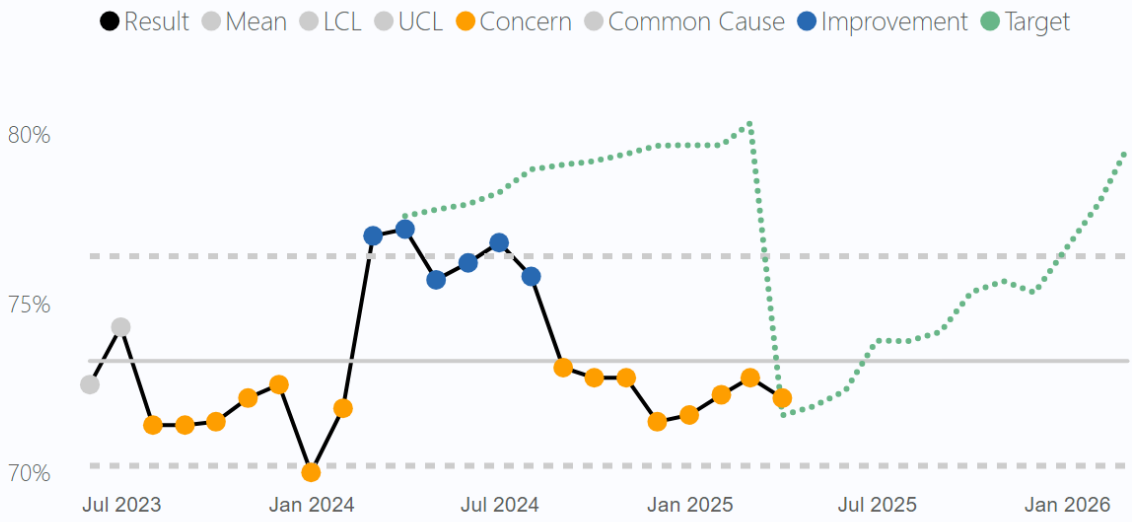
UEC - Total A&E 4hr Performance - Provider

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
Apr 25	National	72.2%	71.7%		

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System Position - Summary and Context

A further increase towards the target of 80.3% was seen in March, broken down by acute to:

NNUH - 81.7%

JPUH - 63.1%

QEH 52.8%

Root Causes and Contributing Factors

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

Associated Metrics, Insights and Impacts

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

Key Actions and Risks to Actions

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

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

Commissioning and Performance Committee

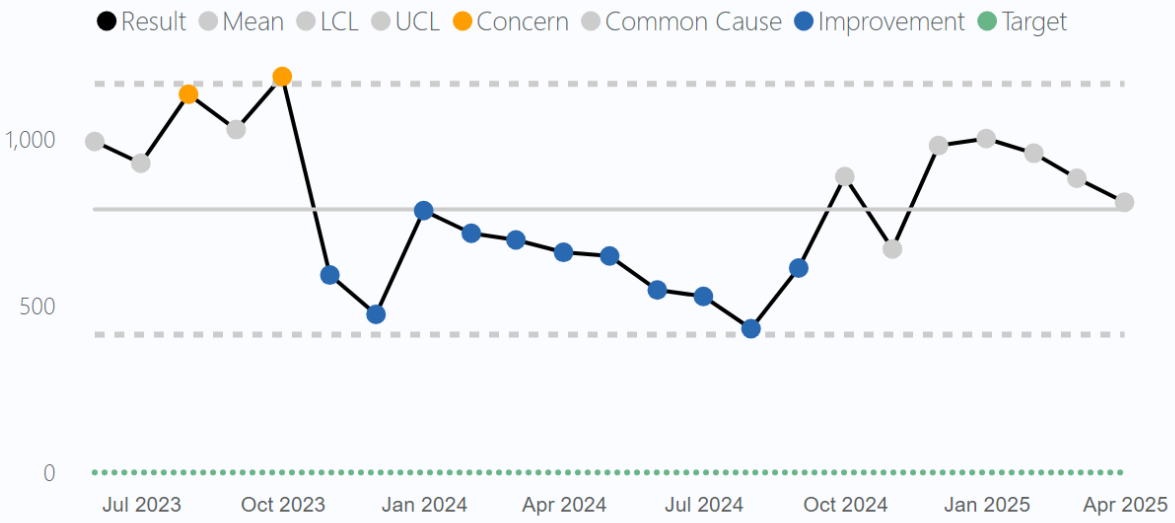
UEC - 12 hour A&E DTA breaches - Provider

Metric Description

The total number of patients who spend more than 12 hours from a decision to admit being made until departure in A&E.

BAF

BAF06



Latest Date	Metric Data Source	Result	Target	Variation	Assurance
Apr 25	ECDS	810	0		

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System Position - Summary and Context

As a system 882 12 hour breaches were seen this is broken down by acute:

NNUH 281, JPUH 458, QEH 143

This is a further decrease from February.

Root Causes and Contributing Factors

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

Associated Metrics, Insights and Impacts

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

Key Actions and Risks to Actions

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

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

Commissioning and Performance Committee

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	3941	Talking Therapies - First Treatment Within 18 Weeks - ICB	Percentage of people who attend their first treatment contact in the reporting month with 18 weeks from referral (RTT)	Numerator: Number of referrals who had their first treatment contact within 18 weeks from referral. Denominator: Number of referrals who had their first treatment contact within the reporting period.
3	1021	UEC - 111 Calls Answered within 60 secs (%) - ICB	The percentage of 111 calls answered within 60 seconds of the calle being available out of all 111 calls answered.	Numerator = Calls answered within 60 secs (B01).Denominator = Number of calls answered (A03).
4	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.
5	3855	Mental Health - E.A.5 Active Inappropriate Adult Acute Mental Health Out Of Area Placements - ICB	A count of patients that are currently in an out of area acute mental health bed and placed for inappropriate reasons (OAP) as of the last day of the reporting month	A count of active inappropriate placements captured at midnight on the last day of the reporting month. Rounded to the nearest 5 with values below 5 being suppressed
6	10273	UEC - Mean C2 Ambulance Response	The average minutes taken for all Category 2 ambulance dispatches from the clock start time to the time the first	Average response times for C2 priority Numerator: Total Response Time (Mins) Denominator: Total Call Outs

Commissioning and Performance Committee

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 URL
Cancer	Cancer	Provides an overview of the monthly Cancer Waiting Times (CWT) dataset including: Total Activity, number Compliant, Breaches, Performance and Waits.	
DM01	Diagnostics - DM01 & CDC	Provides an overview of Diagnostic waiting lists and activity over time, information is available with a commissioner view & by provider, as well as by treatment function. Data is sourced from national datasets.	
Outpatients	Specialist Advice Activity Dashboard	This dashboard provides system reporting on a number of Outpatients metrics. Note access to this page on NHS futures has to be requested	
Planning	Planning Metrics	This report providers a simplistic overview of the current position of the ICB/ICS against the Operational Planning Metrics. The data shows the latest position of either Nationally Validated Submissions or data provided by local ICB teams to BI directly.	
PTL	PTL Waiting List	Provides an overview of weekly national patient tracking list including RTT 18 week performance, Open pathways & Breaches. Information is available as a commissioner view and by provider, as well as by specialty. Data is sources from national waiting list dataset.	
RTT	Referral to Treatment (RTT)	Provides an overview of monthly Referral to Treatment waiting times including 18 week performance, Open pathways, Breaches, Closed Pathways & Clock starts. Information is available as a commissioner view and by provider, as well as by specialty. Data is sources from national RTT datasets.	
UEC	Emergency Department	Interactive dashboard for analysis of activity trends in Emergency Department/A&E	
UEC	Urgent Community Response Dashboard	Interactive dashboard detailing Urgent Community Response activity and performance.	
UEC	UEC Summary Dashboard	This dashboard gives a summary level of key activity for UEC areas. This is covers all of the main contact areas but does not go into performance level detail of the areas.	
UEC	Ambulance	Interactive dashboard for analysis of activity trends for Ambulance	
UEC	Virtual Ward	Provides an overview of Virtual Ward activity across Norfolk and Waveney providers, with metrics for Current Patients, Capacity, Admissions and Discharges to show the current system position and trends over time.	
UEC	Emergency Admissions Dashboard	Interactive dashboard for analysis of activity trends in Emergency admissions	

Norfolk and Waveney
Integrated Care Board

Agenda item:14

Subject:	**Commissioning & Performance Committee (CPC) Report**
Presented by:	**Hein van den Wildenberg, Non Executive Member**
Prepared by:	**Diane Smith, Head of Collaborative Commissioning and Performance**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

To provide the Board with an update on the work of the Commissioning and Performance Committee (CPC) for the period since the last Board meeting in Public on 21st May 2025.

Committee:	Commissioning and Performance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update on 21st May 2025	Meeting held in private on 19th June 2025 09:00 – 11:30
Overall objectives of the committee:	• To make financial decisions / recommendations about business cases for commissioning and decommissioning, within the value of its delegated responsibilities as set out in the terms of reference. This forum is where decisions will be made about commissioning, other than for primary care which has its own committee. • To consider and make decisions on clinical policies as recommended by the Clinical Policy Development Group. • To consider and make decisions on recommendations from the medicines optimisation programme board. • To oversee and gain assurance on the operational arrangements that support the commissioning of services. • Oversee the process of any further delegation of commissioning responsibilities from NHS to the ICB. • Provide oversight to the Individual Funding Request panel. • Conduct and lead the oversight of NHS system and commissioned provider performance, directing improvement

	resources and ensuring learning is implemented. This includes coordinating with regulators where formal improvement is required. • Ensure that innovation, best practice, evidence and evaluation and the impact on health inequalities consistently informs our commissioning decisions. • Approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation.
Main purpose of meeting:	The Committee exists to provide assurance and oversight and make decisions (within its delegations) on the commissioning and performance of services to ensure better outcomes for the population of Norfolk and Waveney. It will also consider the management of risk in all its work.
BAF and any significant Board Operational Risks relevant / aligned to this Committee:	The following risks are the responsibility of this Committee, which will be making commissioning decisions and managing performance: Board Assurance Framework (BAF) • BAF03 – Barriers to full delivery of the mental health transformation programme (Children and Young People) • BAF04 – Barriers to full delivery of the Mental Health Transformation Programme (Adults) • BAF06 – System Urgent & Emergency Care (UEC) pressures • BAF07 - Elective Recovery These are the risks that are part of the reviewed BAF, signed off by the ICB public Board in July, and aligned to the 8 ambitions in the Joint Forward Plan. **BAF07:** The Committee reviewed and discussed the risk ratings for BAF07 to consider the description, mitigated score and tolerated / target risk rating. Discussion took place following review by and support from Provider Performance and Planning Oversight Group (PPPOG) and Scheduled Care Board (SCB). As a result, C&PC support the following changes in BAF07: • Description amended to: *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.* This description remains aligned to the Joint Forward Plan (JFP) • Mitigated risk is raised from 12 to 16 (4x4) – increasing the likelihood score from 'possible' to likely'. This is recommended due to 25/26 planning submission not meeting national / constitutional standards, and because of the current performance position and risk to delivering key

	standards across diagnostics, elective and cancer care. Committee noted, however, that the submission of 25/26 plan that did not meet all performance targets is a control. • Tolerated risk lowered from 12 to 9 (3x3) – this is reducing the consequence score from 'major' to 'moderate'. This reflects the ambition to have a lower risk associated with the significant areas of work No new risks were raised to C&PC. The following risk has been recommended for closure, due to substantive funding being identified: (074) Familial Hypercholesterolaemia Board Operational Risk Register (BORR) • (030) Neuro-Developmental Service (NDS) Children and Young People • (045) Risk to CYP health due to long waiting times at NNUH for paediatric podiatry surgery • (046) System wide gaps in Speech and Language Therapy Provision • (049) ICB application of sustainable commissioning and compliance with procurement regulations • (077) Diagnostic 6-week standard – March 2025 • (076) Referral to Treatment (RTT) standard – March 2025 • (079) ICB not submitting a Standards Met DSPT – April 2025 • (072) Loss of JPUH alcohol care team service due to lack of confirmed funding – NEW added March 2025 • (043) Delayed decision making re ICB business case for the Lynch Syndrome testing and surveillance pathway - transferred from Quality and Safety Committee March 2025 Operational Risk Register (ORR) • (037) Tier 3 and 4 weight management. • (057) System failure to meet access standards for cancer diagnosis and treatment • (050) Histopathology delays affecting cancer pathways • (051) Insufficient acute medical staffing in oncology across system providers to meet current demand • (052) Hypnotics and anxiolytics prescribing (primary care) Risk deep dive: The planned deep dive of Cancer risks was deferred to July due to agenda pressures and the shortened meeting timeline. Elective care and diagnostics reviewed the 3 risks of: BAF07, 077 (diagnostic 6-week standard) and 076 (RTT standard). The deep-dive recommendation that the committee was asked to support:

	i. Connection with the People and Culture Committee/People Board to support workforce challenges. This will be taken forward to the appropriate committee support. Remaining recommendations were supported but required no specific action by C&PC.
Key items for Board to take note of:	**1. Performance:** The June meeting of the Committee received the revised Integrated Performance Report (IPR), aligning performance assurance with the governance structure reporting to CPC: Most data and narrative in the report reviewed was the validated position for March 2025. The narrative report now states assurance levels for each programme of work; the committee reviewed these and agreed with them. The assurance levels utilise the NHSE Making Data Count programme. These are detailed in the performance narrative, included in the pre-read.

Programme area	**June assurance level[1]**
Elective and diagnostics	Concerning
Cancer	Average
Mental Health	Average
Community	- Not provided, data in development
UEC	Concerning

a) **Elective and diagnostics**:
Performance is showing improvement across the reported diagnostic and treatment waiting times. However, there is significant variation across specialties and not yet assurance that NHS N&W will consistently meet the trajectory – committee noted that consistency in delivery is key.
Operational insights indicate Q1 will see a more challenged position – associated with April bank holidays and operational / workforce challenges at the start of the financial year. Work continues to focus on both elimination of the longest waits, especially that of those waiting 65-weeks, while driving performance on new 52-week and 18-week standards. There is a significant risk to clearing 65-week waits by 30.6.25 – this reflects a very high risk at JPUH and a highly ambitious plan to achieve '0' at NNUH.
National validation sprint is being repeated for Q2 (July – Sept).
Diagnostics discussion noted Histology position has improved significantly and with a robust plan to continue this improvement, with a better position presented as the QEH histology service moves. Joint work across the trust, supported by the group model, presents opportunities to

[1] Note the assurance levels and definitions have been utilised from the NHSE Making Data Count programme.

	address key workforce challenges – non-imaging diagnostic specialties are experiencing especially significant workforce challenge. Focus task and finish groups are being established in diagnostics specialties to identify root causes and actions. The assurance level was specifically checked with committee for the elective and diagnostic programme. Committee acknowledged that several approaches are needed to deliver the long-term elective care plan to achieve 18-week waits: 1. System demand & capacity modelling – with view to achieving 2029 elective care targets 2. Contracted recovery plans to accompany trajectories **Actions include** (further to above)**:** i. Working groups established with focuses on diagnostics, productivity and demand management – actioned by PPPOG ii. NHSE tiering support – in place fortnightly with all N&W Acute Trusts. iii. Ensuring robust connection with workforce plans to ensure elective recovery view – Committee to connect with workforce leads and plans through the ICB People and Culture Committee and the People Board a) **Cancer**: The 28-day Faster Diagnostic Standard is showing an improvement across the system, however, a dip from this position should be expected in April data at the next reporting point. Continued efforts are required via cancer improvement/action plans and national tiering focus to sustain the result, focused on acute trusts. The 62-day performance is not showing consistent improvement due to delays earlier in the pathway, including backlogs, clinical complexity and workforce capacity/fragility – there remains continued reliance on insourcing. Improvements are more robust in some areas, with some fragility noted Cancer pathways are being prioritised over elective care and in some instances the demand in cancer pathways is consequently impacting on elective care capacity. It should continue to be noted that NNUH plans for 25/26 identified that the Trust do not plan to meet the NHSE standard for cancer 62-day. b) **Mental health**: significant work underway with mental health flow, including Multi-Agency Discharge Events (MADE) events. Committee noted that MH 12-hour decisions to admit in A&E and Inappropriate Out of Area Placements are a symptom of flow and discharge

challenges. It was noted that there will be a need for whole system input to support some aspects of flow. Urgent care aspects of mental health services remain a key focus for internal and system improvement work, with rapid improvement actions established.
CYP noted that there has been a decline of performance against eating disorders referral to treatment, and this has been a consistent position – pending data to be reflected in the performance report.

Actions:

i. NSFT to share update to transformation plans to next Committee (plan due to complete Q3).
ii. Committee requested a recovery plan for performance MH 12hr decisions to admit in A&E.
iii. Redesign of Crisis Resolution Home Treatment teams underway within NSFT and due to complete Q3.

c) **Community**: work continues to ensure accurate and informative reporting of community performance position. The Committee noted long waits are known in wheelchair services in central and west Norfolk and adult Speech and Language Therapy

Action:

i. Review is underway of inequity of services available between the two providers for Norfolk and Waveney

d) **Urgent & Emergency Care (UEC)**: committee noted performance at the end of Q4 (period Jan – March) is an expected period of challenge for UEC services. All areas reported on are in common cause improvement, except for 4-hr A&E target which is in concern however on trajectory and is being monitored daily - the greatest challenge noted at QEHKL. N&W is in the top quartile of services nationally for *111* performance, though below target and a recovery trajectory is in place with the provider. Category 2 ambulance performance has a national and regional focus, as well as forming part of the NHSE support through tiering – committee noted that the 30min target is an interim target.

Actions include:

i. NHSE tiering support
ii. Committee to task UEC Board to outline for Committee the recovery plan where performance is off track.

e) **Primary Care:** the committee noted the report on performance and recovery from the Primary Care Commissioning Committee and will not duplicate but consider this position within the overarching system performance view.

	2. Audit outcome: Performance Management and Data Quality The repeated audit by our internal auditor TIAA found an improved level of assurance to 'reasonable assurance'. Committee received the report and a cover paper that outlined the key areas of action. Most areas have been addressed through: i. Revised templates for escalation and reporting ii. Minor amendments to the Integrated Performance Management Framework, which the committee later approved iii. More robust and clearer recording in committees of root causes, actions and timeframes and owners for actions of corrective action. Committee were asked to support the further action of ensuring senior reinforce key responsibilities and timescales associated with performance oversight and assurance arrangements. **3. Specialised Commissioning:** The committee noted the paper shared from the regional specialised commissioning team, regards performance, finance and risk. The TIAA internal audit of delegated specialist commissioning was presented. This identified the overall assessment was that there is reasonable assurance. The audit did question if there is anything from the specialised commissioning risk register that requires reflecting in local ICB risk registers, and if so, where would these be handled and held. Committee noted that there is appropriate oversight of providers delivering specialised services, and there are formal and legal arrangements between N&W ICB and the team managing these services on our behalf. Committee therefore agreed that regular receipt and review of the risk register held by the specialised commissioning team to identify any risks that do require a local reflection remains appropriate. **4. Escalation reports** i. **Digital Strategy Steering Group:** The committee noted the paper shared, particularly around the Acute Electronic Patient Record (EPR) programme and the plans to replace the current order comms system to external primary and community providers in the ICS (currently provided with the *ICE* system but planned to be replaced by the Meditech system). There had been significant feedback from the Local Medical Council, primary care, and community regarding the planned changes and the identified risks as Meditech potentially

	does not integrate as seamlessly with GP and community solutions as the current system does. The EPR programme is developing several ideas on how this might work and potentially deferring the integration work until later in the program. ii. **Clinical Transformation & Planned Care**: A verbal update was given ahead of a written report. - Terms of Reference for the Therapeutics Advisory Group has been reviewed but requires further review following feedback from LMC. - The implementation plan has been approved and published for the Hybrid Closed Loop (HCL) provision for diabetes care – HCL systems link continuous glucose monitoring (CGM) with insulin pump technology to monitor blood glucose and automatically adjust the amount of insulin given through a pump to people living with type 1 diabetes. National Institute for Health and Care Excellence recommended (Dec 2023) that HCL technology should be rolled-out in a phased implementation. - Pharmacy foundation placements have been increased from 20 in 2025/26 to initial plans in 2026/27 for 38 (to be confirmed by national). - A new regional anti-microbial stewardship dashboard has demonstrated significant improvement for N&W. - Tirzepatide funding has been approved and prescribing will start on 23rd June in Primary Care – a national requirement with standard national criteria. iii. **Scheduled Care Board**: key conversation to highlight is regards legal advise to actions when a clinical policy change is made – a report and discussion will follow on this in the July meeting. Committee members will support all Programme Boards to submit reports. **5. Tracking system activity:** following the submission of activity plans as part of the 25/26 planning process and the subsequent development of Indicative Activity Plans (IAPs) in provider contracts, the ICB is working up a format and data flow to track against these plans – monitoring for under and over activity. The ICB has been working with the acute Trusts in system to develop this and to ensure tracking against plans as they are nuanced week-by-week. The first draft was shared and walked through with the committee and it was highlighted that this report is based on non-validated activity and is to enable a timelier review and reaction to activity position. Committee appreciated the view this provides and how it will enable tracking of finances that connects with activity. Committee were asked to support in ensuring all Trusts engage through sharing plans and reviewing the approach.

	Committee also keen to see a similar tracking for independent providers and for system workforce. 6. **Contracts and sustainable commissioning process:** The initial work has taken place to review contracts 25/26 and 26/27. A paper will be brought to C&PC in July 2025. 7. **NHSE review of the ICB in July:** Committee noted that the upcoming quarterly review by NHSE of the ICB will be purely focused on performance, with a key elective care / recovery focus. This will not duplicate NHSE tiering but supplement it and inform further system performance improvement work. 8. **Clinical policy – Varicose Veins**: The NHS N&W clinical threshold policy for Varicose Veins has been reviewed, to remove tighter restrictions which were introduced during COVID19 and to bring it further in line with NICE guidance – the case presented identified that this will support reduced system costs through secondary prevention. It was noted that the activity this change will bring must be managed within the existing activity plans and resourcing, and not present a cost /activity pressure in the system. 9. **Escalations for ICB Board to be aware of** i. There remains very high risk that NHS Norfolk and Waveney will not achieve the 65-week standard of '0' by 30.6.2025. ii. Changes approved to the Varicose Veins clinical threshold policy and the identification this activity must be managed within the existing activity plans. iii. Committee approved changes to the BAF07 risk – *Elective Recovery* iv. Updated Performance narrative to provide more clarity on assurance assessments, and key actions pursued.
Items requiring formal approval of Board:	None
Confirmation that the meeting was quorate:	Yes.

Key Risks – of performance that falls short of expected national or local standards, constitutional requirements and/or plans	
Clinical and Quality:	The impact of commissioning decisions on Clinical and Quality are integral part of decision making, and a clear process of assessing this impact is in place. Performance which falls short of expected national or local standards, constitutional requirements and/or plans

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

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:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

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

Committee:	Primary Care Commissioning Committee
Committee Chair:	Ian Wake, Local Authority Member
Meetings since 21 May 2025	8 July 2025
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, and since 1 April 2023 the commissioning of dental, pharmaceutical and optometry services under a Delegation Agreement with NHS England.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks relevant / aligned to	**BAF02 – Primary Care Resilience and Transformation Current mitigated score – 5x4=20**

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.
Key items for assurance/noting:	Members received reports on the following areas: • **Delivery group reports** for the Dental Services, Dental Delivery and General Practice and Community Pharmacy Delivery Groups were noted. As part of the

	process to commission a new interpreting and translation service, the team was asked to ensure they engaged with primary care providers as well as service users. • **A strategic finance report** was noted. Month 2 was showing a £0.3m overspend on the GP and prescribing budget, projected to be £3m at year end. This was mainly due to unidentified efficiencies in general practice against the required budget reduction applied, with £500k identified through the reduction applied to APMS contracts and the remainder being worked up through the financial recovery work.
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 impact of national insurance increases across all 4 primary care contractor groups will continue to be monitored in relation to the resilience risks. It was noted all four local representative committees had raised concerns about the impact of increased national insurance contributions on the financial resilience of their contractors. • The **Strategic Primary Care Workforce Recruitment and Retention Programme Report** was approved. This included approving funding to the value of £2.8m following Triple Lock approval, to deliver the GP, Dental and Optometry Retention Programmes with the aim of increasing and stabilising Primary Care workforce across Norfolk and Waveney, supporting patient access to primary care services, and noting the operational delivery plan to support sustainability and resilience of the Primary Care workforce. It was noted the funding allocation from NHSE had reduced slightly this year and that there was increasing demand for non-clinical training, which was not permitted from CPD (continuous professional development) budgets. The team had successfully attracted grant funding for this. • The **Strategic Framework for Primary Care** was approved. The framework had been developed following feedback from PCCC in March and incorporated further conversations with stakeholders as requested by Committee Members. The next steps would be to move to implementation planning.

	The adoption of the framework and workstreams would see a focus across four key areas for the remainder of the 2025/26 financial year: o Primary Care Input into System Planning and Decision Making o Understand resource, demand and capacity o Role of Primary Care in Tackling Health Inequalities o Future Models of Primary Care • Committee members noted an **update on operational planning**, including the new requirement to submit a **GP Action Plan**. A proposal to provide regular updates being added to the forward planner for scrutiny against performance to provide assurance against delivery was approved and a new standing item was agreed. The overall aim of the primary care headline submission was to improve access, efficiency, and integration within the broader healthcare system. The recently published NHS Oversight Framework would be reviewed and included in future performance reporting for primary care, alongside measures in the ICB's Integrated Performance Report and the planning submission. • Committee members noted the **TIAA audit report** (Assurance Review of Primary Delegated Commissioning) and its reasonable assurance rating and supported its management recommendations. The 2025 TIAA audit into delegated commissioning follows on from the previous audit of April 2024 which reviewed the implementation of transition plans for these services with a key focus on risks.
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: Hein van den Wildenberg, ICB Board non-executive member, Deputy Chair Karen Watts, deputising for Patricia D'Orsi, executive director of nursing, ICB James Grainger, deputising for Steven Course, 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

Norfolk and Waveney
Integrated Care Board

Agenda item:
15.1

Subject:	**Independent Review into the organisational response to various primary care related matters.**
Presented by:	**Ed Garratt, Interim Chief Executive**
Prepared by:	**Ed Garratt, Interim Chief Executive** **Karen Barker, Executive Director of Corporate Affairs**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

To update the Board on work that is in progress with regard to an independent review relating to the ICB's organisational response to various primary care related matters.

Executive Summary:

The ICB has commissioned Verita to undertake an independent review that will specifically concentrate on the following matters.

1. A governance review relating to the ICB's organisational response relating to the Additional Roles Reimbursement Scheme ("ARRS") funding.
2. A review of the learning from the Independent Review into Norfolk & Waveney ICB's commissioning role in how the impact of the collapse of One Norwich Practices Ltd was managed and any lessons learned.
3. Consideration of how the ICB currently works with primary care and in particular GP Federations and what can be learned from this.

The independent governance review will identify learning in the round from both the ARRS and One Norwich and any other related governance issues.

Verita is an independent company which carries out objective investigations and reviews and provides expert advice to organisations in the UK, particularly regulated organisations and those in the public sector.

Report

The ICB has commissioned Verita to undertake this independent governance review. This work will be overseen by a working group chaired by Christine Outram. Christine is an NHS leader with over 30 years' experience as a Chair and Chief Executive, having worked in a wide range of health service settings.

The current intention is that the independent governance review's findings will be presented along with the independent review of One Norwich as set out above, to the PCCC at its meeting in the autumn 2025.

Recommendation to the Board:

To note this report and that the independent governance review relating to the ICB's organisational response to various primary care related matters, as well as the independent governance review into Norfolk and Waveney's commissioning role and One Norwich is intended to be presented in the autumn 2025.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	
Impact Assessment (environmental and equalities):	N/A
Reputation:	It is important that a thorough independent review is undertaken so that transparent learning can be applied throughout the organization and any reputational risks mitigated accordingly.
Legal:	It is important that a thorough independent review is undertaken so transparent learning can be applied throughout the organization and any legal risks and mitigated accordingly..
Information Governance:	N/A
Resource Required:	Independent governance review
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	The review will consider conflicts of interest
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information- September 2025.

Agenda item: 16

Norfolk and Waveney Integrated Care Board

Subject:	**Risk Management**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Agnes Earl, Corporate Governance & Risk Management Senior Officer**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 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 May 2025. Since then, many teams have been reviewing and updating their risks.

Please find attached a copy of the following (as at 3 July 2025):

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

Attention is directed towards the following notable changes:

Board Assurance Framework (BAF)

- BAF07 (Ref 10) – Mitigated score increased, Target score decreased, and risk description amended
- BAF02 (Ref 32) – Not reviewed in month

Risk	Changes/actions required
BAF01 (Ref 8): Health inequalities and Population Health Management	•
BAF02 (Ref 32): Primary Care Resilience and Transformation	• Risk not reviewed in month
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	• Mitigated score increased to 16 from 12 • Target score reduced from 12 to 9 • Risk description amended
BAF08 (Ref 27): 2025/26 financial plan	•

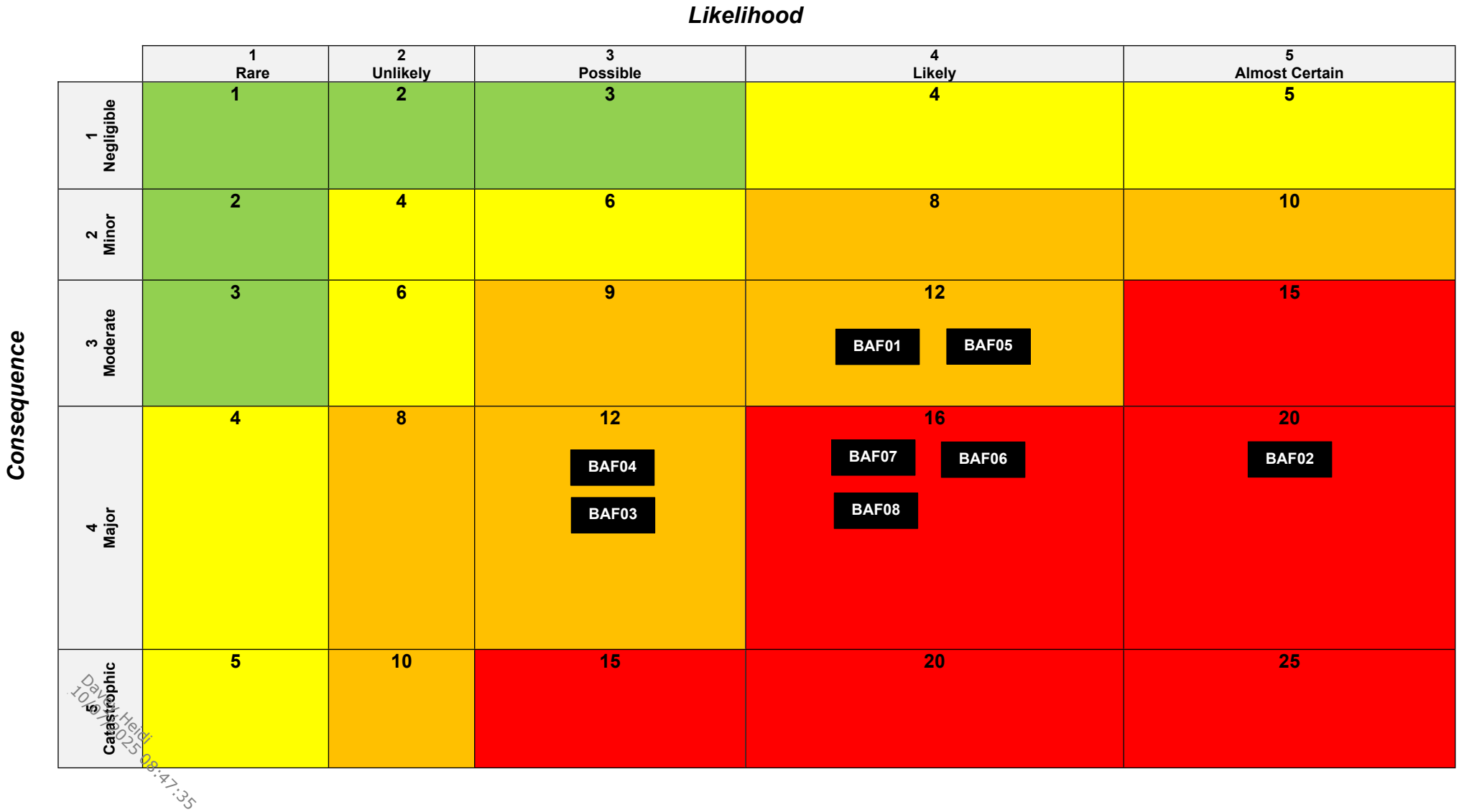
Recommendation to the Board:

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 03 July 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	4	12	12	12	12								
Ambition 2: Primary Care Resilience and Transformation																		
32	Primary Care Resilience and Transformation	Mark Burgis	Primary Care Commissioning Committee	29-Aug-24	31-Mar-27	12	20	20	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)	Jocelyn Pike	Commissioning and Performance Committee	01-Jul-22	30-Nov-24	8	16	16	12	12								
Ambition 4: Transforming Mental Health Services – Adult Mental Health																		
6	Barriers to delivering equitable, safe and consistent care in adult mental health	Jocelyn Pike	Commissioning and Performance Committee	01-Jul-22	31-Mar-26	8	12	12	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								
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								
Ambition 7: Elective recovery and Improvement																		
10	Elective Recovery	Matt Dooley	Commissioning and Performance Committee	01-Dec-22	31-Mar-29	12	12	12	16	16								
Ambition 8: Improving Productivity and Efficiency																		
27	2025/26 financial plan	Steven Course	Finance Committee	10-May-23	31-Mar-26	12	12	12	16	16								

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**	**03/06/25**
Risk type	Health inequalities		

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

- 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								
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	Sadie Parker	Primary Care
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**29/08/24**	**31/03/27**	**28/05/25**
Risk type	Transformational		

Risk Scores

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

Controls

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

Actions

Date opened	Action	Owner	Target completion
28/10/24	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 • The national DDRB uplift for dental contractors has yet to be confirmed and applied adding to the concerns about the impact on practice incomes in April 2025. There may be an increased risk of contract terminations. • 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**
29/05/25	The framework has been refreshed to reflect the changes to ICBs and the recently published ICB Blueprint. The updated document will be discussed and approval sought at July PCCC	Sadie Parker	**31/07/25**

Visual Risk Score Tracker – 2025/26

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	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**
Jocelyn Pike	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**	**13/06/25**
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**

Visual Risk Score Tracker – 2025/26

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	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**
Jocelyn Pike	Commissioning and Performance Committee	Mark Payne	Mental Health & LD
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**01/07/2022**	**31/03/2026**	**19/06/25**
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								
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**	**13/06/25**
Risk type	Workforce & people		

Risk Scores

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

Controls

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

Actions

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

Visual Risk Score Tracker – 2025/26

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	15	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**	**09/06/25**
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	Discussions being undertaken with system partners to reach agreement for UCCH to take on role of trusted assessor for UCR and virtual ward. The trusted assessor model is now in place for West, so all West patients are triaged through UCCH.	Rebecca Richards	**31/10/25**
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.	Rebecca Richards	**10/07/26**

Visual Risk Score Tracker – 2025/26												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16								
Change	-	-	-	-								

Davey, Heidi
10/07/2025 08:47:35

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**
Matt Dooley	Commissioning and Performance Committee	Diane Smith	Commissioning & Performance
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**01/12/22**	**31/03/29**	**02/06/25**
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 (30/06/2025) o JPUH (2025) - June forecast: 190. July forecast: 99 however the Trust have highlighted challenges which place severe risk against clearance of 65-ww by end Q1 o NNUH (2025) - June forecast: 28. July forecast: 0 with some risk associated QEH reporting 0	Diane Smith	**31/08/25**

	Significant risk noted to achievement of 65ww. ICS forecast date to reach 0 is 31/05/2025.		
01/04/24	The 52 week forecast position across the ICS (30/06/2025): April confirmed position: - NNUH: 4.6% (plan end 25/26: 2.2%) - JPUH: 4.9% (plan end 25/26: 1.0%) - QEH: 2.2% (plan end 25/26: 1.0%) - ICB: 4.1% (plan end 25/26: 1.7%) • NNUH (2025) - July forecast: 3,288 - • JPUH (2025) - July forecast: 1,594 • QEKL (2025) - July forecast: 435	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	Diane Smith	**31/07/25**
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. Leads and initial meetings set for 2/3. Pending agreement of SRO for demand management	Diane Smith	**31/07/25**
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	Diane Smith	**31/07/25**

Visual Risk Score Tracker – 2025/26

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

BAF08

Risk Title	**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**
Steven Course	Finance Committee	Emma Kriehn-Morris	Finance
Risk programme board	**Date Risk Identified**	**Target Delivery Date**	**Date risk last reviewed**
N/A	**10/05/23**	**31/03/26**	**01.07.25**
Risk type	Financial		

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

- 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
1.04.25	Review of all mitigations and recovery actions to support the financial delivery to plan.	Emma Kriehn-Morris	**31/03/26**
01/04/25	Review of monthly and year to date performances and assess forecast out-turn evaluated risks and mitigations.	Emma Kriehn-Morris	**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								
Change	-	-	↑	-								

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Governance Handbook – Proposed changes**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICB Development**
Prepared by:	**Nikki Bartrum, Corporate Governance Senior Manager**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting Part 1**
Date:	**16 July 2025**

Purpose of paper:

For approval.

Executive Summary:

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 10. The changes made to the document are detailed below:

Section	Proposed change
1–4	No change
5	No change
6 and 7	No change
8	**Conflicts of Interest Policy** This Policy has been updated to reflect the implementation of electronic declaration forms for COI and gifts and hospitality. The changes have been made and are now included within the next version of the policy (V3). The Conflicts of Interest Committee approved the proposed updates at their meeting on 6 February 2025. The changes are shown in italics text below: **Appendix A: Declaration of Interest Template** *PLEASE NOTE: The template below has been replaced by an electronic version of the form. A link to the electronic form can be found on the Corporate Affairs intranet page and should be used for all new declarations made from 1 April 2025. A separate form should be submitted for each interest declared.* *Before submitting the form, individuals will be asked to confirm that the declaration has been discussed and agreed with their line manager.* *For new starters, the Recruitment Team will send a Declaration from to candidates as part of the pre-employment checks. The Declaration should be reviewed by the recruiting and/or line manager and interview panel.* **Appendix D: Register of Gifts and Hospitality Form** *The paper declaration from has now been replaced with an electronic form. A link to the form can be found on the Corporate Affairs intranet page and should be used for all new declarations made from 1 April 2025.*

	A new form should be submitted for each declaration made. *The following information is required:* • *Recipient name* • *Position* • *Date of offer* • *Date of receipt (if applicable)* • *Declined or accepted?* • *Supplier/offer or name and nature of business* • *Details of gift/hospitality* • *Estimated value* • *Details of previous offers or Acceptance by the Offer or/Supplier* • *Reason for Accepting or Declining* • *Details of the officer reviewing and approving the declaration made and date* • *Other comments* *Before submitting the form, individuals will be asked to confirm that the declaration has been discussed and agreed with their line manager.*
9-13	No change
Appendix D	**Patients and Communities Committee Terms of Reference** The annual Risk Management Audit, undertaken by Tiaa in March 2025, highlighted that the Terms of Reference for this Committee did not make reference to risk management. In response to the recommendations made by Tiaa, Section 2 (Purpose) and section 6 (Responsibilities of the Committee) have been updated to include responsibilities in relation to risks assigned to the Patients and Communities Committee. The proposed changes to the current terms of reference, that were agreed by the Committee at its meeting on 19 May 2025, are shown in italics below: **1. Purpose 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. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit *and will also consider the management of risk in all its work.* **2. Responsibilities of the Committee** ***Risk Management*** • *Provide oversight and scrutiny of risks assigned to the Committee.* • *Provide assurance, through regular reports to the ICB Board, that risks are being identified, monitored and managed appropriately.*
Appendix G	**Quality and Safety Committee Terms of Reference** A minor amendment has been made to the Members section of the Terms of Reference to reflect inclusion of Learning Disabilities & Autism partner provider attendance (Hertfordshire Partnership Foundation Trust). The change is shown in italics below:

	Members The Members attending Part 1 and Part 2 meetings of the Committee are as follows (please see Section 6 below with regard to Part 1 and Part 2 meetings): • Non-Executive Member (Chair) • Non-Executive Member (Deputy Chair) • ICB Executive Director of Nursing or nominated deputy • ICB Executive Medical Director or nominated deputy • ICB Primary Medical Services Partner Member The following attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations): • Acute, Community, Mental Health, *Learning Disabilities & Autism* and Ambulance Service Chief Nurses or nominated deputies • 2 Local Authority attendees (Norfolk and Suffolk) • 1 VCSE Assembly attendee • 1 Independent Provider Partner • 1 Hospice Provider Partner

RECOMMENDATION

The Board is asked to approve the changes to the Governance Handbook 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 it's 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.

Norfolk and Waveney
Integrated Care Board

Agenda item: 18

Subject:	**Amendment to the ICB Constitution**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Submitted to:	**NHS Norfolk and Waveney ICB Board Meeting**
Date:	**16 July 2025**

Purpose of paper:

To note an amendment to section 3.5 (CEO) of the NHS Norfolk and Waveney ICB Constitution.

Executive Summary:

NHSE has mandated clustering ICBs to make changes to section 3.5 (CEO) of their constitution.

The track changes are included in Constitution (V6) as Appendix A to this paper.

This paper is to update the Board that the mandated changes will be finalised and implemented following this meeting and the updated version uploaded to the ICB website.

Recommendation to the Board:

To note the mandated changes.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

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

Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Date Approved by NHS England	Effective date
V1.0	N/A	1 June 2022	1 July 2022
V2.0	27 September 2022	4 October 2022	4 October 2022
V3.0	27 November 2024	17 December 2024	17 December 2024
V4.0	14 March 2025	19 March 2025	19 March 2025
V5.0	30 April 2025	1 May 2025	1 May 2025
V6.0	16 July 2025	N/A	16 July 2025

CONTENTS

1. Introduction

1.1 Foreword

NHS England has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

Our Integrated Care System

The Norfolk and Waveney Integrated Care System ("the ICS") is made up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. The ICS is comprised of an NHS Integrated Care Board working with an Integrated Care Partnership committee formed jointly with local authority partners.

Over and above everything else we want to achieve, we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

The partners in our ICS work together at 'system' level across Norfolk and Waveney, more locally at 'place' and 'neighbourhood' levels, and through our primary care networks and provider collaboratives.

Our Integrated Care Board

NHS Norfolk and Waveney ICB ("the ICB") was formed on 1 July 2022 and covers the same area as the former Norfolk and Waveney CCG previously did. The ICB brings the local NHS together to improve population health and care. The responsibilities of the ICB include developing a plan to meet the population's health needs and arranging for the provision of health services.

As with all NHS bodies that plan and commission services in England, NHS Norfolk and Waveney ICB and our local NHS trusts and foundation trusts are subject to the triple aim duty, and as such consider the effects of their decisions on:

- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

Our Integrated Care Partnership

Our Integrated Care Partnership ("the ICP") brings together the local NHS, local authorities, the voluntary, community and social enterprise sector and other partners that have an impact on the wider determinants of health. The ICP is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. The ICB is required to have regard to the ICP's Integrated Care Strategy when making decisions, commissioning and delivering services. The ICP is a statutory committee of the ICB, Norfolk and Suffolk County Councils.

The membership of the ICP is the same as the Norfolk Health and Wellbeing Board and includes representatives from Suffolk County Council and Waveney. The partners involved are the ICB, providers of health and care services, our county, district, borough and city councils, voluntary, community and social enterprise sector organisations, Healthwatch, the Constabulary and the Office of the Police and Crime Commissioner.

This Constitution for the ICB and the terms of reference for the ICP are aligned to ensure that our governance arrangements are clear, and more importantly, that all partner organisations are working toward the same aim and goals.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Norfolk and Waveney Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is set out in the map below. The ICB covers the whole of the area covered by Norfolk County Council. The ICB also covers part of Suffolk but not all of the area covered by Suffolk County Council. The area covered by the ICB also includes the following local government areas: the District of Breckland, District of Broadland, Borough of Great Yarmouth, Borough of King's Lynn and West Norfolk, District of North Norfolk, City of Norwich, District of South Norfolk and also part of the District of East Suffolk.

1.3.2 All of the Lower Super Output Areas in the District of East Suffolk which are covered by the ICB are set out in Appendix 1.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.improvinglivesnw.org.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the

statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England, which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; or
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive of the ICB can propose a change to the Constitution by notifying the board in writing with at least 7 days' notice.
b) The Chair of the ICB will be consulted on any proposed changes.
c) The board of the ICB must approve any changes to the Constitution in accordance with its standing orders.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing Orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map** – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
   - The above documents a) – c)
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.7.2

e) **Key policy documents -** which should also be included in the Governance Handbook or linked to it:
   - Standards of business conduct policy
   - Conflicts of interest policy and procedures
   - Policy for public involvement and engagement

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.improvinglivesnw.org.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing
b) At least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.1.1 The ICB has 5 Partner Members:

a) 2 Partner members: NHS trusts and foundation trusts
b) 1 Partner Member: primary medical services
c) 2 Partner Members: local authorities

2.1.2 The ICB has also appointed the following further Ordinary Members to the board:

a) 2 Non-executive Members
b) Member from the Voluntary Community and Social Enterprise Assembly Board
c) Member from the Integrated Care Partnership

2.1.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 2 Partner members NHS trusts and foundation trusts
d) 1 Partner member primary medical services
e) 2 Partner members local authorities
f) 4 Non-executive Members (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair and one of which, who may be the Deputy Chair or the Audit and Risk Committee Chair, will be appointed the Senior Non-executive Member
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) Member from the VCSE Assembly Board
k) Member from the Integrated Care Partnership.

2.1.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.1.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

3.3 Regular Participants and Observers at board meetings

2.1.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.1.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

a) Executive Director of Strategy and deputy Chief Executive
b) Executive Director of Patients and Communities
c) Executive Director of Corporate Affairs and ICS Development
d) Executive Director of Strategic Transformation
e) Executive Director of Digital and Data
f) Executive Director of Commissioning and Performance
g) Director of Public Health for Norfolk County Council (unless they are one of the local authority Partner Members)

h) Director of Public Health for Suffolk County Council (unless they are one of the local authority Partner Members)

Further system Directors may be invited to participate as relevant by the Chair.

2.1.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

a) Healthwatch Norfolk
b) Healthwatch Suffolk
c) Norfolk and Waveney Local Medical Committee

2.1.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders

3 Appointments process for the board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:
a) Comply with the criteria of the "fit and proper person test"
b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—
a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the

Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A Health Care Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.

b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be a maximum of 3 years and the total number of terms a Chair may serve is 3 terms.

3.4 Deputy Chair and Senior Non-executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit and Risk Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-executive Member is to be appointed from amongst the Non-executive Members by the board subject to the approval of the Chair.

4 1.1 Chief executive

5 1.1.1 The chief executive will be appointed by the chair of the ICB in accordance with any guidance issued by NHS England.

6 1.1.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

7 1.1.3 The chief executive must fulfil the following additional eligibility criteria:

8 a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

9 1.1.4 Individuals will not be eligible if:

10 a) any of the disqualification criteria set out in 3.2 apply

11 b) subject to clause 3.5.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board

~~**3.5 Chief Executive**~~

~~3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.~~

~~3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England~~

~~3.5.3 The Chief Executive must fulfil the following additional eligibility criteria~~

~~a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act~~

~~3.5.4 Individuals will not be eligible if:~~

~~a) Any of the disqualification criteria set out in 3.2 apply~~

~~3.6~~11.2 Partner Member(s) - NHS trusts and foundation trusts

~~3.6.1~~11.2.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition.

- James Paget University Hospitals NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust

~~3.6.2~~11.2.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an Executive Director of one of the NHS Trusts or FTs; or
b) Be an Executive Director of East Coast Community Healthcare CIC within the ICB's area; and
c) Any criteria set out in NHS England's guidance from time to time; and
d) One member is to have particular knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness, and of community services
e) One member is to bring particular knowledge and experience in acute hospital services; and
f) Senior level operational expertise.

~~3.6.3~~11.2.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any exclusion criteria as set out in NHS England guidance applies

~~3.6.4~~11.2.4 These members will be appointed by a panel subject to the approval of the Chair.

~~3.6.5~~11.2.5 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation listed at 3.6.1.a will be invited to make nominations.
   - The nomination of an individual must be seconded by one other eligible organisation.
   - Eligible organisations may nominate individuals from their own organisation or another organisation
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval:
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~3.6.6~~11.2.6 The term of office for these Partner Members will be 3 or 4 years, as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

~~3.7~~11.3 Partner Member - providers of primary medical services

~~3.7.1~~11.3.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

~~3.7.2~~11.3.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

~~3.7.3~~11.3.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Any criteria set out in NHS England's guidance from time to time;
b) This member must be a Health Care Professional, either a partner or employee, actively working within a practice in the Norfolk and Waveney ICB area; or
c) A locum that is active for the majority of their time within a practice in Norfolk and Waveney ICB area.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role and person specification.

~~3.7.4~~11.3.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any criteria as set out in NHS England guidance applies.

~~3.7.5~~11.3.5 This member will be appointed by a panel subject to the approval of the Chair.

~~3.7.6~~11.3.6 The appointment process will be as follows:

a) Joint Nomination:
    - When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make nominations.
    - The nomination of an individual must be seconded by three other eligible organisations.
    - Eligible organisations may nominate individuals from their own organisation or another organisation.
    - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c):
    - The full list of nominees will be considered by a panel convened by the Chief Executive.
    - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4
    - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
    - A fit and proper person test will also be undertaken on the preferred candidate before appointment
c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~3.7.7~~11.3.7 The term of office for this Partner Member will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms in the case of a 3 year term, and 1 term in the case of a 4 year term.

~~3.8~~11.4 Partner Member(s) - local authorities

~~3.8.1~~11.4.1 These Partner Members are jointly nominated by the local authorities responsible for the provision of social care whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Norfolk County Council
b) Suffolk County Council

~~3.8.2~~11.4.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.8.1; and
b) Any criteria set out in NHS England's guidance from time to time.

~~3.8.3~~11.4.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.8.4~~11.4.4 This member will be appointed by the panel subject to the approval of the Chair.

~~3.8.5~~11.4.5 The appointment process will be as follows:

a) Joint Nomination:
    - When a vacancy arises, each eligible organisation listed at 3.8.1.a will be invited to make nominations.
    - Eligible organisations may nominate individuals from their own organisation or another organisation
    - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until a consensus is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c):
    - The full list of nominees will be considered by a panel convened by the Chief Executive.
    - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3
    - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

- A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval:
The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~3.8.6~~11.4.6 The term of office for these Partner Members will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

~~3.9~~11.5 Medical Director

~~3.9.1~~11.5.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

~~3.9.2~~11.5.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria set out in NHS England guidance applies.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

~~3.10~~11.6 Director of Nursing

~~3.10.1~~11.6.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

~~3.10.2~~11.6.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.10.3~~11.6.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

~~3.11~~11.7 Director of Finance

3.11.111.7.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Any further criteria as set by NHS England from time to time; and
c) Meet the criteria as set out in the person specification for the role.

3.11.211.7.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.11.311.7.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.1211.8 Four Non-executive Members

3.12.111.8.1 The ICB will appoint four Non-executive Members.

3.12.211.8.2 These members will be appointed by a panel subject to the approval of the Chair.

3.12.311.8.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee
d) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration, People and Culture Committee
e) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Finance Committee.
f) Another shall have specific knowledge, skills and experience with regard to the people and the community of Norfolk and Waveney.
g) Any other criteria as set out by NHS England's guidance.

3.12.411.8.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area; and
c) any criteria as set out in NHS England's guidance applies.

3.12.511.8.5 The term of office for a Non-executive Member will be 3 years and the total number of terms an individual may serve is 3 terms, after which they will no longer be eligible for re-appointment.

3.12.611.8.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire

on the date that the individual they replaced was due to retire in order to provide continuity.

~~3.12.7~~11.8.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

~~3.13~~11.9 Other Board Members

VCSE Assembly Board member

~~3.13.1~~11.9.1 This member is nominated by the Norfolk and Waveney Voluntary, Community and Social Enterprise (VCSE) Assembly Board.

~~3.13.2~~11.9.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role in one of the VCSE sector legal entities in Norfolk and Waveney; and
b) Any criteria set out in NHS England's guidance from time to time

~~3.13.3~~11.9.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.13.4~~11.9.4 This member will be appointed by a panel subject to the approval of the Chair.

~~3.13.5~~11.9.5 The appointment process will be as follows:

a) Joint Nomination:
    - When a vacancy arises, each member of the Norfolk and Waveney VCSE Assembly Board will be invited to make nominations.
    - The nomination of an individual must be seconded by one other eligible member of the Norfolk and Waveney VCSE Assembly Board.
    - Eligible members may nominate individuals from their own organisation or another organisation
    - All eligible members of the Norfolk and Waveney VCSE Assembly Board will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c):
    - The full list of nominees will be considered by a panel convened by the Chief Executive.
    - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.13.2 and 3.13.3

- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
- A fit and proper person test will also be undertaken on the preferred candidate before appointment

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

Integrated Care Partnership Board Member

~~3.13.6~~11.9.6 This member is nominated by the Norfolk and Waveney Integrated Care Partnership.

~~3.13.7~~11.9.7 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a member of the Integrated Care Partnership Committee; and
b) Any criteria set out in NHS England's guidance from time to time

~~3.13.8~~11.9.8 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.13.9~~11.9.9 This member will be appointed by a panel subject to the approval of the Chair.

3.13.10 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each individual member of the Integrated Care Partnership Committee will be invited to make nominations.
- The nomination of an individual must be seconded by one other member of the Integrated Care Partnership Committee.
- Eligible members may nominate individuals from their own organisation or another organisation
- All members will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.13.7 and 3.13.8
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

- A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~3.14~~11.10 Board Members: Removal from Office

~~3.14.1~~11.10.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

~~3.14.2~~11.10.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 90% of the meetings to which they are invited, including ICB Board and Committee meetings, unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

~~3.14.3~~11.10.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.14.2 apply.

~~3.14.4~~11.10.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

~~3.14.5~~11.10.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

~~3.14.6~~11.10.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's Chief Executive; and
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

~~3.15~~11.11 Terms of appointment of Board Members

~~3.15.1~~11.11.1 With the exception of the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration, People and Culture Committee in line with the ICB remuneration policy and any other relevant policies published at www.improvinglivesnw.org.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by the Board. Any discussions about remuneration for the Non-executive Members will be held without the Non-executive Members present.

~~3.15.2~~11.11.2 Other terms of appointment will be determined by the Remuneration, People and Culture Committee.

~~3.15.3~~11.11.3 Terms of appointment of the Chair will be determined by NHS England.

412 Arrangements for the exercise of our functions

4.1 Good governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a standards of business conduct policy which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB standards of business conduct policy can be found on our website at www.improvinglivesnw.org.uk.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full at www.improvinglivesnw.org.uk

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published at www.improvinglivesnw.org.uk.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a) Submit regular decision or assurance reports to the board
b) Comply with any internal audit findings of the ICB
c) Conduct annual committee effectiveness reviews
d) Submit their term of reference for board approval.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the Standing Financial Instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit and Risk Committee will be chaired by a Non-executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration, People and Culture Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration, People and Culture Committee will be chaired by a Non-executive Member other than the Chair or the Chair of the Audit and Risk Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further

information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook.

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website at www.improvinglivesnw.org.uk

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) The ICB acts in the public interest at all times
b) Avoiding undue influence
c) Transparency and Accountability.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers of the interests of:
- a) Members of the ICB
- b) Members of the board's committees and sub-committees
- c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website at www.improvinglivesnw.org.uk.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
- a) act in good faith and in the interests of the ICB;
- b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
- c) comply with the ICB's Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests
- Key policies

The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the "Joint Forward Plan"). The plan will, in particular:

a) describe the health services for which the ICB proposes to make arrangements in the exercise of its functions
b) explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards), and sections 223GB and 223N (financial duties).

c) set out any steps that the ICB proposes to take to implement the Norfolk and Waveney joint local health and wellbeing strategies·

d) set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

e) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and decision making

7.3.1 At least three Non-executive Members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Seven Principles of Public Life (the Nolan Principles) and meet the criteria described in the fit and proper person test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Complying with existing procurement rules until the provider selection regime comes into effect.

b) evidencing that it has properly exercised the responsibilities conferred on it by the regime, once this is published, by:
- publishing the intended selection approach in advance.
- publishing the outcome of decisions made and the details of contracts awarded.
- keeping a record of decisions made under the regime, including evidence that all relevant issues and criteria have been considered and that the reasons for any decision are clearly justified.
- recording how conflicts of interest were managed.

c) monitoring compliance with this regime via an annual internal audit process, the results of which will be published.

d) including in the annual report a summary of contracting activity as specified by the regime.

e) ensuring that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions and that any such representations are considered fairly and impartially within the timescales prescribed.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)

b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)

c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration, People and Culture Committee which is chaired by a Non-executive Member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration, People and Culture Committee is determined by the board. No employees may be a member of the Remuneration People and Culture Committee, but the board ensures that the Remuneration People and Culture Committee has access to appropriate advice by:

a) The Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee
b) Meetings may also be attended by the following individuals, who are not members of the committee, for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:
- The ICB's most senior HR Advisor or their nominated deputy
- The Director of Finance or their nominated deputy
- The Chief Executive or their nominated deputy, and
- Executive Director of Corporate Affairs and ICS Development or their nominated deputy

8.1.4 The board may appoint independent members or advisers to the Remuneration People and Culture Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration People and Culture Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the ICB's Governance Handbook.

8.1.6 The duties of the Remuneration People and Culture Committee include for the Chief Executive, Members of the Board and other Very Senior Managers:

a) Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
b) Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

a) Determine the ICB pay policy, including the adoption of pay frameworks such as Agenda for Change;

b) Oversee contractual arrangements;
c) Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For Clinical Advisors:

a) Determine ICB pay policy
b) Oversee contractual arrangements

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the ICB
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) All consultation proposals will be formally agreed by the ICB and will be shared with a range of key stakeholder prior to the start of any consultation process to ensure that the proposals are robust and representative.
b) Work with Healthwatch Norfolk and Healthwatch Suffolk to ensure patient and public voice is embedded into the work of the Norfolk and Waveney Integrated Care Board, embracing co-production and co-design wherever possible.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

g) Use community development approaches that empower people and communities, making connections to social action.

h) Use co-production, insight and engagement to achieve accountable health and care services.

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements, include:

a) Working with patients and members of the public across the ICS to ensure patients and members of the public are involved in helping to shape services at a local level.
b) Strengthening Patient Participation Groups, supporting them to embrace new ways of reaching out to local communities and feeding these views into local alliances.
c) Working with the Norfolk and Waveney Communications and Engagement Group (including NHS, local authorities, both Norfolk and Suffolk Heathwatch, and VCSE) to consider as part of Norfolk and Waveney wide campaigns, communication and engagement activities.
d) Working with the Integrated Care Board to include patient stories at their meetings, linked to and focussed on highlighting the importance of patient and public views and voices to help inform decision making.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
Place-based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

	• the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of the Norfolk and Waveney Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 17 December 2024.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Executive Director of Corporate Affairs and ICS Development, will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1. Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board.

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, then the Deputy Chair of the ICB shall preside over the meeting of the board in the Chair's stead. The Deputy Chair shall be appointed by the board.

4.2.3. If both the Chair and the Deputy Chair are absent, or are disqualified from participating by a conflict of interest, then the board may appoint a temporary deputy to preside over meetings of the board.

4.2.4. The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.improvinglivesnw.org.uk.

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak but may not vote on their behalf.

4.5.2. The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1. The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the board will be 10 members, including:

a) Either the Chief Executive or the Director of Finance
b) Either the Medical Director or the Director of Nursing
c) At least one Independent member (which can include the Chair) except where non-executive remuneration is being considered, in which case this section 4.7.1 (c) can be disregarded if the Chair is absent in exceptional circumstances.
d) At least one Partner Member.

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.
c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board.

4.7.3. For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies and defects in appointments

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- For a limited period the quorum will be reduced by one per vacancy.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. Where necessary or helpful, the board may draw on third party support such as peer review or support from NHS England.

Urgent decisions

4.9.4. In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5. The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in

the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit and Risk Committee for oversight.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2. The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members,

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

6.1. The common seal of the ICB shall be kept by the Executive Director of Corporate Affairs or a nominated manager by them in a secure place.

6.2. Register of Sealing

6.2.1 The Executive Director of Corporate Affairs shall keep a register in which they, or another manager of the ICB authorised by them, shall enter a record of the sealing of every document.

6.3. Use of the Seal

6.3.1 Please refer to the Governance Handbook for who may authorise its use, and when use of the Seal will be triggered.

Appendix 3: Lower Super Output Areas covered by Norfolk and Waveney ICB

District of East Suffolk

Lower Super Output Areas covered by Norfolk and Waveney ICB in the District of East Suffolk
East Suffolk (PARTIAL) including LSOAs: E01030240, E01030241, E01030242, E01030259, E01030260, E01030261, E01030262, E01030277, E01030279, E01030281, E01030266, E01030267, E01030271, E01030278, E01030280, E01030246, E01030248, E01030249, E01030250, E01030264, E01030265, E01030255, E01030263, E01030270, E01030289, E01030290, E01030233, E01030235, E01030268, E01030269, E01030288, E01030247, E01030254, E01030256, E01030258, E01030276, E01030257, E01030274, E01030275, E01030287, E01030291, E01030234, E01030236, E01030237, E01030238, E01030223, E01030224, E01030225, E01030227, E01030228, E01030226, E01030286, E01030292, E01030293, E01030294, E01030239, E01030251, E01030252, E01030253, E01030272, E01030273, E01030230, E01030231, E01030232, E01030285, E01030282, E01030283, E01030284, E01030295, E01030229, E01030243, E01030244, E01030245