NHS

Norfolk and Suffolk

Integrated Care Board

Commissioning Intentions 2026/27 to 2030/31

March 2026 v1.0

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1. Start Well

1.1. Perinatal

Senior Responsible Officer: Executive Nursing Director

Outcome: All babies in Norfolk and Suffolk are born healthy and given the best start in life so they can thrive.

Outcome measures:

1. Reduce and maintain smoking use during pregnancy below the national ambition of 6% by 2026/27 and from April 2027 aim for a reduction of smoking in pregnancy to below 5%.
2. Reduce and maintain rates of low birth weight and preterm birth rates to below the national ambition of 6%.
3. Neonatal Deaths within 28 days are reduced to below 1.63 per 1,000 babies based on 2023 ONS data.

Immediate priorities (Years 1&2 2026/27 and 2027/28):

1. Acute trust contracts and maternity service specifications

By March 2027, refresh and agree the acute Trust contracts and maternity service specifications, incorporating findings from national investigations into maternity and neonatal services. This will describe assurance requirements from providers and measured through agreed outcome metrics for babies, mothers, and birthing people.

2. Assurance on Health Inequalities

From April 2027, implement contract performance management to ensure Trusts are addressing health inequalities in maternity population. This will be measured through:

- Full implementation of the Saving Babies Lives Care Bundle and commencement of the Maternal Care Bundle quality assurance reporting.
- Quarterly reporting to the ICB on LMNS Equity & Equality action plans, triangulated against national inequalities data.
- Reduction of smoking in pregnancy rates below 5% in Norfolk and Suffolk.
- Evidence of effective maternity discharge processes and postnatal care plans aligned with MBRRACE-UK (2025) recommendations.

3. Maternity and Neonatal Voices Partnership's (MNVP)

During 26/27, commission MNVP across Norfolk and Suffolk in line with national guidance, to ensure local communities are represented and working in partnership

with perinatal care providers. This will be subject to business case development and approval.

4. Neonatal Outreach Services

By March 2028, track and ensure acute providers implement neonatal outreach services aligned with the British Association of Perinatal Medicine's Neonatal Outreach Service – A Framework for Practice (2025). This will be measured by providers demonstrating their services support families in their transition from hospital to home and their eventual transition to health visiting services. This is subject to additional funding, which may come via NHS England, and if not will be subject to a local business case.

Longer-term priorities (Years 3-5):

1. Norfolk and Suffolk Perinatal Quality and Safety Board

By April 2028, establish a Norfolk and Suffolk Perinatal Quality and Safety Board. This will determine compliance with contractual expectations, service user needs and national maternity and neonatal programme requirements, through systematic review of outcome and experience data.

2. National Maternity and Neonatal Intensive Support Team

From April 2028, we require all maternity and neonatal service acute providers in the national Maternity and Neonatal Intensive Support Team (formally Maternity Safety Support Programme – MSSP) to have exited the programme. Providers should evidence sustainability such that there are no new entrants.

1.2. Early Years

Senior Responsible Officer: Executive Nursing Director

Outcome: All children in Norfolk and Suffolk in their early years (0–5) will have the best possible start in life, supported by integrated, high-quality health, care, and early support services. This will enable every child to achieve optimal physical, emotional, and cognitive development, reduce health and developmental inequalities, and lay the foundations for lifelong health, wellbeing, learning and participation.

Outcome measures:

1. An increasing proportion of families with children in their early years (0–5) experience timely, proactive identification of needs, ensuring that those who may benefit from additional support are recognised and offered high quality support at the earliest opportunity.

2. Progress towards key national targets, including at least 75% of children achieving a good level of development by age 5, and by locally agreed outcomes developed in partnership with key system partners, including public health and children's services.

These intentions should be read in conjunction with community and neighbourhood health services commissioning intentions.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Strengthen proactive identification and case finding for CYP and their families requiring targeted early support.

By end of 2027/28 we will have worked with system partners to proactively identify families with children aged 0–5 who benefit from additional multiagency support. This includes developing and implementing population health management and case finding approaches to reduce unwarranted variation in access, experience or outcomes, using data, local intelligence, and system collaboration to ensure early identification of developmental, health, or social needs.

This will identify families who may not otherwise access services, with a particular focus on inequalities. Strong partnership work through the Families First Partnership Programme, and Best Start Family Hubs will ensure earlier, coordinated identification of needs and demonstrate joined up commissioning and delivery.

This will be measured through the number of multi-agency Early Identification Panels held, the attendance rate of core partners and number of families supported post identification. This builds on existing panels and current governance.

2. Strengthen early intervention for developmental needs to support good levels of development

By the end of 2027/28 we will have strengthened collaboration with system partners to jointly commission integrated pathways to enable early identification, assessment, and intervention for children aged 0-5 with developmental delays, SEND, neurodiversity, or additional needs.

This will ensure timely access to health, early years and local authority services, through reduced waiting times for developmental screening and speech language and communication assessments compared to March 2026. This supports early communication development and good level of development (GLD) attainment in line with national targets, the government's 'giving every child the best start in life' strategy and delivers NHS 10 Year Plan commitments. This will reduce fragmentation and duplication between services, build on existing partnerships and is supported by NHS planning guidance which encourages joint outcomes-based commissioning.

This will be measured through the number of partners contributing funding or resources into joint delivery models; the percentage of children 0-5 receiving early intervention who show measurable improvement in developmental or communication scores; and 75% of CYP achieving a GLD at the end of Early Years Foundation Stage by 2028 (specific targets for free school meals (FSM) eligible CYP for Norfolk and Suffolk in place to address health inequalities).

3. Enhance perinatal mental health and parent-infant relationship support

By the end of 2027/28 we will commission a comprehensive, integrated offer for perinatal mental health and parent-infant relationship support across Norfolk and Suffolk.

This will ensure expectant and new parents and infants (0–5) have timely access to evidence-based assessment, intervention, and ongoing support across health-commissioned pathways across all levels of need. This will build on existing resource and target gaps or inequity in provision across the Norfolk and Suffolk geography. It aligns to DHSC national priorities regarding Best Start: Healthy Babies, and national ambition for development and expansion of infant and young children's mental health provision.

This will be measured through increased access to MH support in 0-5 age group, meeting the community perinatal MH access target, and NHS Talking Therapies outcomes for the perinatal pathway specifically.

Longer-term priorities (Years 3-5):

1. Develop integrated neighbourhood multi-disciplinary teams for families with young children

By 2030, we will develop multi-agency integrated neighbourhood teams with clear referral pathways for families in Norfolk and Suffolk. This will include, but is not limited to, health visitors, midwives, GPs, early years practitioners, social prescribers, paediatricians, psychological support and community/voluntary sector partners.

This will provide coordinated support considering the needs of whole families, including establishing multi-agency MDTs (Families First Partnership Programme, Best Start Family Hubs and outreach in local communities) with a particular focus on families with children aged 0-5. It strengthens existing early footprints and planned legislative frameworks and delivers the joint integrated early years offer across health, education and community, supporting coordinated early intervention and shared care planning.

This will be measured through the teams operating in all family hub localities and MDT arrangements established in all agreed neighbourhood footprints across Norfolk and Suffolk.

2. Feel Well

2.1. Mental Health and Wellbeing

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcome: People of all ages can access timely, high-quality, and integrated mental health support delivered in community and hospital settings that promotes emotional wellbeing, is personalised, prevents crisis, and reduces health inequalities

Outcome measures:

1. Reduce the proportion of people reporting low life satisfaction, high anxiety, or low happiness
2. Reduce premature mortality because of severe mental illness
3. Reduce acute hospital ED attendance and emergency admission rates for people with severe mental illness

Local outcome and performance measures will be agreed through the commissioning process, and all national KPIs will be included.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Mental Health Urgent and Emergency Care (UEC) / Crisis Pathway

By 1 April 2027, review and recommission all Norfolk and Suffolk crisis and alternative mental health services to ensure people in crisis receive streamlined, consistent and purposeful interventions that are timely, appropriate and delivered in suitable environments.

By 1 April 2027, complete a review and needs assessment for the potential commissioning of Mental Health Assessment Centre(s) across Norfolk and Suffolk. This work will be aligned with any central NHS capital funding opportunities and will link NSFT and other providers with system partners.

Measured by:

- Completion of the review and recommissioning process by April 2027.

- Completion of a full business case for Mental Health Assessment Centre(s) by April 2027.
- Reduction in Emergency Department presentations and specialist admissions for mental health crises by April 2028.

2. Adult Specialist Placements

By April 2027, review Norfolk and Suffolk's approach to commissioning specialist mental health placements to understand patient cohorts and future commissioning requirements.

By April 2028, implement a single, unified model for commissioning adult specialist placements across both counties, ensuring that individuals receive clinically appropriate interventions close to home.

Measured by:

- Completion of comprehensive placement review by April 2027.
- Implementation of one agreed commissioning framework by April 2028.
- Reduction in the number of out-of-area specialist placements by 2028.

3. Children's Access and Mental Health Support Teams in Schools

Expand Mental Health Support Teams (MHSTs) in schools and colleges across Norfolk and Suffolk to increase access to early intervention and prevention support.

The aim is to:

- Achieve 77% coverage by 2027/28.
- 92% coverage by 2028/29, and
- 100% coverage by 2029/30.

Measured by:

- Percentage of schools and colleges with active MHST coverage annually.
- Increased early access and reduction in late-stage mental health presentations among children and young people.

4. Community / Neighbourhood Models

During 2026/27 and 2027/28, strengthen and expand community-based mental health services to achieve parity of esteem with physical health services and embed mental health in neighbourhood models of care. We will consider our support to Personality Disorder and Assertive Outreach as part of these new models of care

By March 2028, complete a full review and re-modelling of community mental health provision for 0–25-year-olds across the ICB geography to ensure timely, inclusive and outcome-focused support.

We will:

- Collaborate with Alliance Leads at place (including West Suffolk and Ipswich & East Suffolk early adopter sites) to integrate mental health with primary care, acute, social care and VCFSE partners.
- 0-25 years- review access routes and referral processes, assess diversity and efficiency of clinical delivery models within neighbourhoods, enhancing digital access and workforce productivity and reduce waiting times across under-18, and 18–25 (young adult) services.
- Use population health data to identify and reduce mental health inequalities across rural and urban areas in Norfolk and Suffolk.

Measured by:

- Inclusion of mental health within all neighbourhood delivery plans by April 2026.
- Documented reduction in identified health inequalities by 2028.
- Increased joint working between mental health, physical health and social care partners.
- Completion of service review and redesign plan by March 2028.
- Reduction in average waiting times and improved satisfaction scores by 2028.
- Improved service integration across age transitions (child to adult).

Longer-term priorities (Years 3-5 2028/29- 2030/31):

1. Mental Health Collaborative / Commissioning

Delivery on the objectives of a Five-Year Norfolk and Suffolk Mental Health and Emotional Wellbeing Strategy - completed April 2026 - that provides a clear framework for future commissioning and delivery.

The strategy will:

- Establish robust system governance to oversee mental health commissioning and provision.
- Commit to increasing life expectancy for people with Severe Mental Illness (SMI) in line with the general population by 2030/31.
- Identify and address mental health inequalities using a population health approach.

- Support a “left shift” in commissioning by transitioning a greater proportion of mental health funding to the VCFSE sector to promote early intervention and prevention by 2030/31.

Measured by:

- Completion and publication of strategy by May 2026.
- Annual progress reports on SMI life expectancy gap reduction.
- Year-on-year increase in VCFSE sector’s share of mental health commissioning spend (baseline to be established in 2026/27).

2.2. Trauma and abuse

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcomes:

- Children, young people and adults who have experienced domestic abuse, sexual violence, or sexual abuse will have equitable access to trauma-informed, culturally competent, and person-centred support that promote safety, healing, and empowerment, in line with Serious Violence Duty, 2022, The Domestic Abuse Act, 2021, The Care Act, 2014, Working Together to Safeguard Children, 2025, and The Victims and Prisoners Act 2024.
- The commissioning of these services will support recovery through multi agency collaboration and integrated care pathways, aligning with local Safeguarding and Community Safety Partnerships` priorities and workstreams.
- Trauma-informed practice will be embedded and evident across commissioning, service design and contract monitoring.

Outcome measures:

1. Increase in referrals to sexual violence and domestic abuse support services from healthcare settings.
2. Service user outcome measures of the efficacy of commissioned services will be developed to include the following:
    - evidence of person-centred assessments and empowered care/risk planning.
    - reduced re-traumatisation throughout care and treatment interventions.
    - Improved self-reported safety, wellbeing, and resilience.
    - reduced crisis presentations

Immediate priorities (Years 1 & 2, 2026/27 and 2027/28):

1. Sexual violence and domestic abuse support services

By April 2028, we will increase the number of referrals to sexual violence and domestic abuse support services from healthcare settings through staff proactively enquiring about sexual violence and abuse, to minimise late disclosures and provide early access to support and interventions.

This will build on existing provision and be supported by system working with partners such as OPCC, Social Care, Community Safety Partnerships, Police, Public Health and specialist VCFSE support. This supports ICB commitments to ensuring practical and specialist support in line with Serious Violence Duty, 2022, The Domestic Abuse Act, 2021, The Care Act, 2014, Working Together to Safeguard Children, 2025, and The Victims and Prisoners Act 2024.

This will be measured through evidence of increased numbers of individuals being referred to and service-user reported improvements in mental wellbeing following support by services

2. Early identification and support for children and young people affected by trauma and abuse

By April 2027, we will aim to commission services that offer flexible, needs-led support, avoiding arbitrary time limits, particularly for those affected by sexual violence/abuse and complex trauma so children, young people and families feel safe, believed, and supported throughout their recovery.

This focuses on delivering on early identification and support, recognises children and young people as victims in their own right, and as a high-risk, vulnerable group, as well as the significance of early identification and support for children and young people affected by trauma and abuse. This builds on existing provision and is supported by system working with partners such as OPCC, Social Care, Community Safety Partnerships, Police, Public Health and specialist VCFSE support. This also supports ICB commitments to ensuring practical and specialist support in line with Serious Violence Duty, 2022, The Domestic Abuse Act, 2021, The Care Act, 2014, Working Together to Safeguard Children, 2025, and The Victims and Prisoners Act 2024.

This will be measured through evidence of increased numbers of individuals being referred to and service-user reported improvements in mental wellbeing follow support by services.

Longer-term priorities (Years 3-5):

1. Recognising that serious violence is a major cause of ill health, poor wellbeing and inequalities, we will use a public health approach to develop an evidence

base to inform strategic and place-based commissioning of sufficient, effective trauma-informed support services for the most deprived communities and groups at high-risk of sexual violence, abuse and exploitation.

2. We will continue to work with public sector commissioners i.e. Police and Crime Commissioners, NHSE Specialist Commissioning, Local Authority Public Health Services and specialist VCFSE organisations to consolidate the commissioning of sexual violence and abuse support services across Norfolk and Suffolk, and explore opportunities for further integration of services, using our PHM data to address the inequalities faced by groups at high-risk of sexual violence/abuse such as children, women, older people, neurodivergent people, people who are LGBTQ+, disabled people, and ethnically minoritised communities.

3. Be Well

3.1. Learning Disabilities & Autism (LD&A)

Senior Responsible Officer: Executive Nursing Director

Outcome: All people with learning disabilities and autism experience improved health, wellbeing, and improved health outcomes.

Outcome measures: Reduce the mortality rate for people with learning disabilities and autistic people from causes considered preventable.

Immediate priorities (Years 1 & 2, 2026/27 and 2027/28):

1. Reduce reliance on mental health inpatient care

We will review current services and expand proactive community and crisis support in line with refreshed national service specifications, to reduce inpatient reliance for people with a learning disability and autistic people.

This will be achieved through service reviews, targeted resource allocation, and development of community and crisis support pathways. This supports person-centred, community-focused care and reduces avoidable hospital stays.

This will be measured through a target of a 10% year-on-year reduction on mental health inpatient care for people with a learning disability and autistic people, evidenced through quarterly reporting.

2. Inpatient care oversight

Each year, we will strengthen oversight of mental health inpatient care, by ensuring that 100% of adult patients have a documented 12-point discharge plan and that

length of stay aligns with individual treatment plans for both adults and children, supporting timely, safe, and effective transitions to the community or alternative settings.

This will be achieved through strengthened clinical oversight, multidisciplinary coordination, and regular auditing of discharge plans. This supports safe, effective, and timely transitions from inpatient care, reducing delays and improving outcomes for patients.

This will be measured through quarterly reporting of discharge plan complete rates and alignment of length of stay with treatment objectives to reduce the number of people with a learning disability and autistic people in a mental health hospital with the longest lengths of stay.

3. Strengthen case management

Each year, we will strengthen case management by ensuring all people at risk of admission have up-to-date Care (Education) and Treatment Reviews (C(E)TRs) and are accurately recorded on Dynamic Support Registers (DSRs).

This will be achieved through improved governance, staff training, data quality initiatives, and cross-agency coordination. This will reduce avoidable admissions and ensure timely support for individuals with complex needs.

This will be measured through quarterly reporting of improvements in review completion rates, risk profiling, and intervention planning.

4. Annual health checks and health action plans

We will improve both the number and quality of Annual Health Checks for people with a learning disability so that by 2027/28, 85% receive an annual health check and each check includes a completed Health Action Plan.

This will help to address known health inequalities experienced by people with a learning disability, by strengthening preventative care and improving physical health outcomes. It will be achieved through improvement actions such as targeted GP support, patient outreach, awareness campaigns, and data quality improvements.

This will be measured through quarterly monitoring of annual health check and health action plan data.

5. Learning disability and autism mandatory training and awareness

We will promote and monitor learning disability and autism mandatory training as under section 181 of the Health and Care Act 2022. That introduces a requirement from the 1st of July 2022 that service providers registered with CQC must ensure

their staff receive training on learning disability and autism training appropriate to their role. It applies to all registered providers of health and social care in England.

This will improve capability across the system to meet the needs of people with a learning disability and autistic people through consistent, high-quality training. It will be achieved through awareness campaigns, targeted communications, and support for services will be implemented to increase training uptake.

This will be measured through quarterly reporting of progress against a target of 60% of the NHS workforce completing the training across Norfolk and Suffolk.

Longer-term priorities (Years 3-5):

We will:

1. Develop a comprehensive community model for enhanced community support and crisis response services.
2. Co-produce commissioning strategies and service design with people with lived experience, families, and carers.
3. Embed integrated, multidisciplinary pathways across health, social care, and voluntary sectors.
4. Achieve sustained reductions in health inequalities and premature mortality.
5. Support workforce development to ensure a skilled, compassionate, and workforce across all sectors.

3.2. Healthy Choices and Behaviours

Senior Responsible Officer: Executive Medical Director

Weight Management, Obesity and Physical Activity

Outcome: Adults and children across Norfolk and Suffolk are supported in reducing the serious health concerns relating to obesity through improved, integrated access to weight management and obesity services with targeted work to tackle unwarranted variations in access, experience and outcomes for Core20PLUS5 communities.

There is strengthened equity of access and participation in physical activity for those facing the greatest inequalities to support prevention, proactive treatment and management of long-term conditions.

Outcome measures:

1. By March 2028, 80% of people completing support programmes through the Weight Management and Complex Obesity Service (WMCOS) will demonstrate weight loss on leaving the programme.
2. By March 2028, fewer CYP require specialist weight management services, as a result of a reduction in childhood and young people's (CYP) obesity prevalence and associated health inequalities from an established Norfolk and Suffolk wide plan.
3. By March 2031, improvement in the proportion of people from Core20PLUS5 communities completing WMCOS programmes who achieve weight loss compared to the baseline established in years 1-2.
4. By the end of March 2027, we will have reduced unwarranted variation in the take up of physical activity offers, particularly within Core20PLUS populations and Health Inclusion Groups, and developed forward plans to make further improvements in physical activity levels.

[To note that the pace of mobilisation for weight management and obesity depends on obtaining external innovation funds]

Immediate priorities (Years 1 & 2, 2026/27 and 2027/28):

1. Work towards full mobilisation of WMCOS across Norfolk and Suffolk commencing with a Single Point of Access (SPoA) to streamline referrals and triage for adults with severe overweight and obesity, ensuring timely equitable patient access and consideration of increasing eligible cohorts. Ensure that SMI / LD patients are supported – August 2026. We will develop a range of evidence-based obesity management services for children and young people with provision to transition to adult services, by the end of December 2027.

- Expand the SPoA to ensure all-age access by the end of December 2028.
- Apply consistent proactive case finding to maximise uptake of national weight management programmes for those with less severe obesity, we will target 6,000 patients per year, with targeted approaches for Core20PLUS5 communities to ensure equity of access to interventions.
- Establish robust data flows to monitor outcomes and support decision-making, sharing learning to embed, evaluation will be undertaken with early feedback by September 2027. This will include capturing demographic data and experiences for Core20PLUS5 communities to monitor targeted interventions and improving health outcomes.
- Ensure increased capacity for bariatric surgical pathway provision by December 2026.
- Review and align the commissioning of the Norfolk and Suffolk activity models i.e. Active NoW in Norfolk (which is a referral-based programme provided by Active Norfolk that supports people to be more physically active), and the Suffolk Feel Good service. We will align this with key programmes and pathways including WMCOS.

Longer-term priorities (Years 3-5):

1. From 2028/2009 our focus is on scaling accessible obesity management and physical activity pathways. This is about integrating prevention and long-term condition strategies through PHM methodologies, and embedding sustainable models via optimised commissioning, strong community partnerships, outcome monitoring, longitudinal research and system-wide incentives. Also, supporting targeted outreach and proactive interventions for Core20PLUS5 communities to ensure equity in access, outcomes and experience.

Tobacco and Alcohol Care

Outcome: Reduce smoking and alcohol-related harm through equitable access to high-quality treatment, improving population health, tackling unwarranted variation in access, experience and outcomes for Core20PLUS5 communities and supporting NHS Net Zero goals from a baseline of March 2026.

Outcome measures: 75% of inpatients referred to in-house tobacco treatment services across Norfolk and Suffolk are supported to attempt to quit smoking by March 2028.

Immediate Priorities (2026/27–2027/28)

1. From 2026 Tobacco Dependency reduction will be further developed across inpatient and mental health settings, with targeted community-based interventions for higher risk groups with the worst outcomes including Core20PLUS5 communities and joint work with Public Health to embed support within emergency departments.
2. During 2026 we will review access to recommended pharmacotherapy and nicotine replacement products across the NHS tobacco dependency pathways to establish agreed service provision levels.
3. In 2026/27 we will collect and review demographic data and insights to support equitable access for Core20PLUS5 populations to tobacco dependency pathways.
4. In 2026/27 we will review smoking cessation incentive schemes and digital support offers.
5. Monitor prevalence of alcohol dependency in inpatient services in Norfolk and Suffolk and by end of March 2027 we will ensure that the support from mental health services, community providers and charities and support groups is accessible to patients.
6. By March 2028 we will have improved uptake rates of inpatient, mental health and maternity tobacco dependency reduction support offers amongst eligible cohorts, tackling unwarranted variation in access by Core20PLUS5 communities.

Longer-Term Priorities (Years 3–5)

1. We will advance tobacco and alcohol dependence support in line with the NHS 10-year plan ambitions, shifting the focus from treatment to prevention and population-level interventions.

Cardiovascular Disease (CVD) – Secondary Prevention

Outcome: Reduce premature mortality from CVD, unwarranted variation in treatment, uptake of care processes and disparities of outcomes among high-risk groups with the poorest outcomes including Core20PLUS5 populations. We will do this by improving detection and management of hypertension, atrial fibrillation (AF), and high cholesterol across Norfolk and Suffolk.

Outcome measures:

1. Increase the proportion of adults with controlled blood pressure (CVDPREVENT Indicator CVDP007HYP) to 80% by March 2028 (national target) including targeted interventions for Core20PLUS5 populations.
2. Increase the percentage of patients on optimal lipid-lowering therapy to 65% by March 2028, aligning with NG238 including targeted interventions for Core20PLUS5 populations to support health equity.
3. Improve AF detection and anticoagulation rates to match national prevalence expectations and increase anticoagulant therapy to 95% by March 2028 including targeted approaches for Core20PLUS5 populations to improve health equity and health outcomes.
4. Reduce emergency admissions for stroke and myocardial infarction by 5% from the 2024/25 baseline by March 2028, measured via SUS and HES data including targeted interventions for Core20PLUS5 populations.

Immediate Priorities (2026/27–2027/28)

1. By the end of March 2027, implement systematic blood pressure checks in GP practices and community settings, including pharmacies, outreach clinics, and workplaces, to improve early detection and aligning closely with local public health teams to boost uptake of NHS Health Checks.
2. Expand the use of digital tools for ABC risk assessment, for consistent monitoring and intervention by the end of March 2027.
3. Deliver targeted approaches to address unwarranted variation for Core20PLUS5 populations with the poorest outcomes, experience and access through tailored materials, community engagement, and partnerships by the end of March 2027.
4. Standardise care pathways for hypertension and lipid management across GP practices, supported by shared decision-making tools and clinician training by

end of March 2027 for a universal offer and proportionate approaches for Core20PLUS5 populations.
5. Roll out local case-finding and optimisation pathways/services in Norfolk and Suffolk aligned with CVDPREVENT indicators through a system-wide commercial collaboration of industry partners, developing the first joined up, digitally integrated care pathway for hypertension and lipid optimisation by the end of March 2027.
6. Ensure the incorporation of the NHS CVD Modern Service Framework recommendations, once available in 2026.

Longer-Term Priorities (Years 3–5)

We will embed population health management approaches (segmentation work) to identify high-risk groups and Core20PLUS5 communities with the poorest outcomes, experience and access. This will help to address unwarranted variation by targeting interventions effectively through the development of integrated digital dashboards for monitoring AF, BP and cholesterol metrics, supporting real-time performance improvement by the end of 2028.

Chronic Kidney Disease (CKD)

Outcomes: Improve early detection and management of CKD to reduce progression to advanced stages and associated cardiovascular and kidney failure risk. Reduce unwarranted variations in uptake of treatment and disparities of outcomes amongst Core20PLUS5 communities with the worst outcomes, experience and barriers to access.

Outcome measures:

1. Reduce the percentage of high-risk patients without CKD coding, as defined by patients whose last two eGFRs are less than 60ml/min/1.73m2 (uncoded CKD), who do not have a record of GP recorded CKD (G3a to G5) to 0.2% by March 2028.
2. Increase the proportion of patients who are coded with GP recorded CKD, who are monitored annually with urinary ACR and eGFR to 55% and 95% respectively by March 2028 and take a proportionate approach to monitor this improvement in Core20PLUS5 communities.
3. Reduce progression to stage 4/5 CKD by 5% within a 12-month period from the 2024/25 baseline by March 2028.

Immediate Priorities (2026/27–2027/28)

1. Embed CKD screening (ACR and eGFR) and coding in CVD and diabetes reviews by end of March 2027.

2. Introduce prompts in clinical systems for eGFR and ACR testing to standardise practice and reduce missed opportunities for diagnosis and increase home testing of urine albumin by end of March 2027, using demographic data to target interventions for Core20PLUS5 communities.
3. Develop education resources for clinicians and patients on CKD risk factors, lifestyle changes, and e-medication adherence with consideration of health literacy and targeted approaches for Core20PLUS5 communities. Agree, disseminate and utilise the regional CKD protocol by the end of March 2027.
4. Align renal pathways with CVD prevention initiatives to deliver integrated care for shared risk factors by the end of March 2027.
5. Roll out the 'Coding is Caring' CKD case-finding service to incentivise practices and optimise coding for probable CKD stage 3a and above by September 2026.

Longer-Term Priorities (Years 3–5)

1. We will implement integrated renal and cardiovascular care models to reduce fragmentation and improve outcomes by the end of March 2029 with targeted interventions for Core20PLUS communities to address unwarranted variation in outcomes, access and experience. We will expand virtual monitoring for CKD to support self-care and reduce unnecessary hospital visits by the end of March 2029.

4. Stay Well

4.1. Cancer

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcome: Cancer is diagnosed earlier, improving survival rates with reduced variation in outcomes for in Core 20PLUS communities.

Outcome measures:

1. Achieve the national survival ambition of achieving at least a 20-percentage point increase in early diagnosis above the 2019 level by 2035, including a reduction in associated unwarranted variation.
2. Reduce inequalities in the under 75 mortality rate from cancer considered preventable in Core20PLUS communities.
3. Increase the percentage of people with cancer surviving 5 years or more.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

Cancer is diagnosed earlier with improved survival rates and unwarranted variation identified and addressed

1. Increase early diagnosis through screening and awareness

Building on the learning from the planned strategic review of outreach into Core20PLUS communities for preventative activity, increase uptake and coverage of bowel and cervical screening and awareness of cancer symptoms by March 2027.

This will be supported by community focused Service Development Funding in partnership with the VCFSE sector and neighbourhood teams.

To support the national ambition of increasing the proportion of cancers diagnosed at stage 1 or 2, building on the regional Screening and Innovation Fund bids and ICB Early Diagnosis work. This will support approaches to increase equity of access and outcomes in areas of deprivation, rurality and for targeted intervention for Core20Plus communities for lung cancer screening/liver health engagement. PHM informed work will raise awareness for bowel and cervical screening, alongside improved health literacy to support informed choices and improved recognition of the symptoms.

This will be measured by achieving up to a four-percentage point increase in screening uptake in the lowest quintile IMD areas by March 2028 (N&W current screening stats: Bowel 76.9-81.6%, breast 62.7-74.4% and cervical 64-68%. Suffolk current screening stats: Bowel 76.18%, breast 79.72% and cervical 75.4%). The ICB will evaluate impact annually through 2026/27 and 2027/28.

2. Reduce unwarranted variation in urgent suspected cancer referrals and improve diagnostic access, with targeted approaches for our Core20PLUS communities

The ICB will commission a cancer decision making support tool to improve referral quality in line with Get it Right First Time (GIRFT) recommendations and facilitate local achievement of cancer waiting times standards/expand direct access/self-referral pathways for urgent suspected cancer. This supports phased implementation starting 2026/27 with full rollout by end of 2027/28 and aligns with NHS England's digital-first and neighbourhood health ambitions. Specifically:

- for gynae, this will include direct access to Trans Vaginal Ultrasound and pilot of self-referral for Post-Menopausal Bleeding and Unscheduled Bleeding on Hormone Replacement Therapy.
- for dermatology, this will include the extension of tele dermatology across care settings, with image optimisation clinics in primary care.
- for breast cancer, this will include the introduction of a breast pain pathway.
- for upper gastrointestinal this will include the direct access pilot of capsule sponge for early detection of oesophageal cancer.

This work will be in partnership with the regional Children and Young Adult Cancer Networks to ensure pathways for children and young people are timely, equitable and aligned with national service specifications.

This will be measured through reduced unwarranted variation in urgent suspected cancer referral rates for targeted populations across neighbourhoods by 20% and increase direct access diagnostics by 15% by March 2030.

3. Timely diagnosis and treatment of cancer

- We will meet and sustain cancer waiting time standards, with reduced variation in waiting times for Core20PLUS communities

We will collaborate with providers to fully implement diagnostic and treatment pathways using the nationally defined best practice timed pathways and associated milestones, which include transitional plans for business as usual. This directly supports national cancer waiting time targets and elective recovery ambitions. This will include:

- The development of nurse/allied health professionals (AHP) led Local Anaesthetic Transperineal Prostate Biopsy for the prostate pathway and new ways of working supported by AI and automation
- Monitoring and improving children and young people’s cancer waiting times in partnership with Operational Delivery Networks.

This work will be supported by the provider-led redesign of the cancer workforce in alignment with the Aspirant Cancer Career and Education Development Programme (ACCEND).

This will be measured through achieving and sustaining the cancer waiting times standards: 80% for 28-day Faster Diagnosis Standard, 94% for 31-day treatment standard, 80% for 62-day treatment standard by March 2027. Performance will include all-age monitoring to ensure children and young people’s pathways meet national standards. Targets are to be met by March 2027 and sustained through 2028.

4. Better treatment and holistic support for people affected by cancer.

We will expand access to personalised and genomic cancer care.

During 2026/27 we will implement Lynch syndrome testing and surveillance pathway and support workforce redesign. This supports NHS ambitions for personalised and precision medicine and supports early diagnosis, utilising existing genomics infrastructure and leadership.

This will be measured through 100% of eligible patients offered Lynch testing by March 2027 as well as workforce capability metrics tracked via ACCEND key performance indicators.

5. Improved equity of access to positive patient experiences and personalised support

We will use National Cancer Patient Experience Survey insights to co-produce services and standardise support offers across settings. We will aim for full

implementation by 2028 with annual progress reviews, with targeted approaches to gain insights and to improve equity of access and experience for Core20PLUS groups.

Pathway redesign will link to closer to home treatment (e.g. chemotherapy) and support models wherever possible to improve patient experience. It builds on Macmillan Integrated Care learning and quality-of-life approaches and aligns with NHS focus on patient experience and personalised care.

This will be measured through achieving a ≥8.0 average rating on NCPES by 2028 and reduced unwarranted variation in experience scores.

6. Strengthen specialist commissioning and oncology models

With milestones set for each year through 2028, we will realign paediatric oncology shared care units (POSCUs), plan radiotherapy capacity, and establish oncology hub-and-spoke models. This work will include closer to home treatment (e.g. chemotherapy) and support wherever possible, with consideration for our Core20PLUS communities so they have equity of access to new models of care. This supports system transformation and neighbourhood care models and leverages collaboration with specialised commissioning and acute providers.

This will be measured through completion of a lung pathway deep dive and radiotherapy capacity plan by March 2027 and implementing an oncology hub-and-spoke model by March 2028.

Longer-Term Priorities (Years 3–5)

1. Use population health approaches for horizon scanning and early adoption of new innovations. This work will include the continued implementation of the action plan to deliver the themed areas of the early cancer diagnosis review. This will incorporate adults, children and young people's cancer priorities focusing on early recognition and transition with consideration of equity of access for areas of deprivation, rurality and Core20PLUS communities.
2. Development of collaborative provider delivery models – e.g. oncology hub and spoke
3. Population-based radiotherapy capacity planning

4.2. Elective care and diagnostic

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcome: People of all ages receive timely referral and access to high quality diagnostic and elective care in a clinically appropriate setting

Outcome measures: Planned care is delivered to national standards as set out in NHS England planning guidance, with improved equity in referral rates and waiting times across specialties and with focus on the Core20PLUS and Inclusion Health groups. These intentions are enablers to achieving economic growth and social mobility.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. An Optimal Referral Management and Outpatient model

Aligned to national guidance, we will commission providers to implement a streamlined Advice-to-Refer model which will include a single point of access per specialty for elective referrals and Advice & Guidance (A&G). Using the nationally mandated e-RS platform, we will work to implement each specialty when they are made available.

From 2027/28 we will engage with opportunities to implement the new NHS On-line hospital service that is being launched by NHS England. This will improve quality of services, enable patient empowerment and improve experience, and increase productivity towards national standards. The work will be mindful of all elements of patient pathways and interdependencies.

Success will be measured by providers achieving the following:

- By the end of March 2027, the number of referrals received through GP practices will have reduced, against the 2025/26 baseline.
- Increased utilisation of e-RS system and improved Turnaround Times. Job planning for A&G included within rotas.
- Reduction in follow up outpatient appointments, such that each provider improves by at least one quartile on Model Health System (ratio of follow-up: first appointments (outpatients)) from Q4 2025/26 baseline by March 2028.
- Increase in patient initiated follow up (PIFU) uptake to 20% across all high value low complexity (HVLC) specialties by March 2028.
- Reduction in rates of discharge at first outpatients without procedure (specialty baseline to be confirmed and target to be agreed with each provider by March 2026).
- Continuous reduction in overall waiting list size, aligned to national performance targets.

Process measures:

- 100% of referrals for the 10 specialties agreed between ICB, NHSE and providers to have the biggest impact on waiting times will flow through e-RS, in an Advice-to-Refer approach in line with nationally mandated timelines.

- Using best practice, standardised (e.g. GIRFT) outpatient templates across all specialities by the end of June 2026.
- Implementation of the NHS On-line hospital service, subject to further details being made available nationally.

2. Accelerate Diagnostic Capacity and Community Access

Aligning to national guidance and best practice, we will commission services to ensure more patients wait less time to receive a diagnosis - driven by findings and recommendations from the developing Norfolk and Suffolk Diagnostic Strategic Plan. This is expected to include expanding and maximising delivery through Community Diagnostic Centres (CDCs), improving productivity and innovating new delivery models, and reducing use of tests with limited patient benefit – the 'Right Test, Right Time' model. Expansion of CDC activity may include transfer of activity from acute or main sites to CDCs or other community settings where there is a clear benefit and requisite resourcing.

Commensurate with opportunities that arise, we will prepare robust businesses cases which include evaluation, through appropriate governance, to secure appropriate investment, building on existing infrastructure and connection with workforce planning so the right staff with the right skills are available to provide services. Diagnostic pathway development will explicitly include access needs of all, including children and young people, those with neurodiversity, cognitive impairment, or frailty. This will ensure equitable access across, improve experiences across settings and enable delivery of national standards.

Success will be measured by providers achieving the following:

- Reduction in diagnostic waits so that no more than 20% of patients wait >6 weeks by March 2027 and there is a minimum 3% improvement in by March 2027
- No more than 1% of patients wait >6 weeks by March 2029
- Full utilisation of CDC capacity, delivering to at least planned levels.

Process measure:

- Implementation of agreed straight-to-test pathways for the 10 largest specialties (largest by volume) by March 2028, and expanding to all clinically appropriate specialties by March 2029.

3. Improve access in key specialties to support delivery of 18-week RTT

We will improve access and performance in key specialties to support delivery of the 18-week RTT standard, including through commissioning a shift of clinically-appropriate services from hospitals to community-based provision – this will be

aligned to the emerging Neighbourhood Health Model. The first six specialities we will focus on across Norfolk and Suffolk are listed below. These have been chosen as they are high volume pathways with capacity and or pathway issues that are impacting on performance and patient experience:

- Dermatology: We will implement agreed recommendations from dermatology service reviews, including piloting self-referral pathways and the extension of tele dermatology across care settings, with image optimization clinics in primary care to increase the productivity of acute based dermatology clinics. This will be completed by September 2026.
- Urology: We will review and create a joint action plan to improve incontinence services and closer to home support for people with a blocked catheter by September 2028.
- Women's health/gynaecology: We will revise the bleeding on HRT, post-menopausal bleeding pathways and endometriosis pathways, implement self-referral pathways for low-risk women and extend neighbourhood-based women's health hubs to bring care closer at home by March 2027.
- Ear Nose & Throat (ENT) and Audiology: We will review and redesign audiology pathways to provide a closer to home care model, with particular focus on services for children and young people by April 2028. The pace of delivery also depends on being successful in securing funding through a regional bid.
- Eye care: We will commission a new eyecare integrated community service, including a single point of access (SPoA) where patient choice is applied when clinically appropriate to do so. The new service will be mobilised in the second half of 2026/27.
- Pain Management: We shall review and recommission pain management services to develop a more holistic core offer with improved earlier intervention, patient experience, equity of access, safe prescribing and closer to home care by September 2028.

Where relevant, the above reviews will include paediatric pathways and transition points to ensure continuity of care for children and young people, in line with the NHS Long Term Plan commitments for CYP elective and specialist services.

Success will be measured by providers achieving the following:

- Provider performance and reduction in speciality waiting times and backlogs aligned to planning.
- Achievement of the 2% annual productivity improvement.
- Improved patient experience, metrics to be agreed by end June 2026.

4. Improve the patient engagement and experience during elective waits

In line with commitments in NHS England's elective care reform plan and the Medium-Term Planning Framework, we will work in collaboration with patients, carers and our population to seek and respond to their experience of services. This will include local insights and feedback through reports such as the Healthwatch people's experience of waiting for planned care report. This will enable the ICB and providers to better understand the issues faced and to act on these insights. Patient-led access to information and two-way communications will be primarily digitally enabled through provider Patient Engagement Portals (PEPs) and empower individuals to better manage their own care and their own health and wellbeing while waiting for services. The ICB will ensure the communication and engagement needs of all population groups are met i.e. children and young people, those not digitally enabled and groups experiencing barriers to feeding back their experiences.

Success will be measured by providers achieving the following:

- Annual improvement in provider patient satisfaction scores.
- By the end of March 2028, all elective patients will have been given the opportunity to manage their care through a PEP, with a minimum target of 70% uptake.

Process measures:

- In partnership, the ICB will lead work across the system to ensure an annual engagement exercise is undertaken to capture the experience of waiting for care, and to measure the effectiveness of actions taken to date.
- By the end of Sept 2026, we will have a robust plan to mitigate the risk of digital exclusion – recognising that all NHS acute providers will have an Electronic Patient Record in place from April 2026.

5. Embedding Population Health Management and reducing Health Inequalities

In line with the national direction to reduce local inequalities and unwarranted variation, the ICB will work with providers and patients through 2026/27 to develop robust approaches that identify and monitor risk and opportunity through dynamic analysis of waiting lists. We will commission providers, from 2027/28 at the latest, to use these systematic processes to identify and address inequity in access (e.g. DNAs and waiting times), unwarranted variation and identify high risk groups (e.g. frailty, Children & Young People, Core20PLUS population). From 2027/28 providers will be expected to report on this analysis and develop plans that proactively reduce inequalities, variation and risk.

This data will inform the services needed, including within the Neighbourhood Health Model, to support patient self-care and support. This will both reduce risk and better enable people to wait well for planned care.

Success will be measured by providers achieving the following:

- Increased equity of access for agreed population cohorts, including those in the Core20PLUS and Inclusion Health groups, by at least 15% from the agreed baseline by end 2027/28.

Process measures:

- Agreement between the ICB and providers of the population health management approach to analyse waiting lists, by end of September 2026. Subsequent commissioning intentions to be informed by this data, by December 2026.
- Delivery of analytic reports and action plans by providers from Quarter 1 2027/28 at the latest.

Longer-term priorities (Years 3-5):

In line with NHS England priorities, evidence-based practice, and local population need, we will further invest in new models of elective care, particularly in community settings. We will continue to work with partners to identify opportunities to improve end-to-end pathways and quality of planned care aligned to national standards for children and adults. Success will be measured by:

1. Full implementation of straight-to-test pathways for 10 largest specialties by March 2029.
2. No more than 1% of patients are waiting over 6 weeks for a diagnostic test (within DM01).
3. Delivery of more elective care that is harmonious with Neighbourhood Health Models.
4. At least 92% of patients are waiting 18 weeks or less for treatment.
5. Innovation in use of data, digital/technology, workforce and associated ways of integrated working.

4.3. Neurodevelopmental Disorders

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning, and the Executive Nursing Director

Outcome: Neurodivergent people will experience improved health, wellbeing, and life outcomes, empowering them to achieve their potential, participate fully in society, and lead fulfilling lives. This will be achieved through equitable, timely, and high-quality assessment, diagnosis, and ongoing support that is accessible to all

Outcome measures:

1. By April 2028, reduce long waits for neurodiversity assessment to ensure that no individual waits more than 45 weeks for a diagnostic assessment.
2. By April 2027, 100% of patients referred for neurodiversity assessment in Norfolk and Suffolk will have access to structured pre, mid, and post assessment support offer, with uptake and satisfaction monitored to ensure at least 75% of patients report the support as helpful and accessible.

Immediate Priorities (Years 1&2, 2026/27 and 2027/28):

1. Review and recommission Adult ADHD and Autism services

By April 2027, complete a comprehensive review and recommissioning of Adult ADHD and Autism services across Norfolk and Suffolk, including an evaluation of the current service offers, development of new service models, and clear integration with wider assessment provision, with the final report and recommended commissioning decisions formally approved by system partners. This ensures ADHD and Autism services are effective, integrated, and aligned.

2. Diagnostic support

By April 2027, implement and make accessible pre, mid, and post diagnostic support offer for adults with autism and/or ADHD across Norfolk and Suffolk.

This supports adults through the assessment and diagnostic process, improves engagement and outcomes, and provides individuals and families with knowledge and resource to self-manage. It builds on existing resources and planned pathway implementation.

This will be measured through uptake and satisfaction, which will be monitored quarterly to ensure at least 75% of patients report the support as helpful and accessible.

3. National ADHD Taskforce recommendations

By April 2028, implement the National ADHD Taskforce recommendations across Norfolk and Suffolk, ensuring that all commissioned ADHD services adopt the recommended assessment, treatment, and support standards, with compliance monitored quarterly and at least 90% of services meeting the agreed standards by the target date.

This ensures ADHD services meet national best practice, improving outcomes for adults, children and young people and their families, and is based on existing service frameworks and commissioning oversight.

This will be measured through quarterly compliance monitoring against a target of ≥90% of services meeting standards by April 2028.

4. Identifying and meeting NDD needs of CYP and their families

By April 2028, implement a collaborative, system-wide approach (including education) to identifying and meeting neurodevelopmental (ND) needs of children, young people (CYP) and their families across Norfolk and Suffolk. Support for families will include early screening, structured pre-diagnostic guidance, and post-diagnostic interventions, including access to local community and educational resources. Education settings will be better equipped to support neurodivergent children with a focus on creating a more inclusive environment. All Support will be consistent, equitable, and joined-up with education, social care, and VCFSE partners.

This supports CYP and families through the assessment and diagnostic process, improves engagement and outcomes, and provides individuals and families with knowledge and resource to self-manage. It aims to strengthens system working for CYP with special educational needs and disabilities and builds on existing resources and planned pathway implementation.

This will be measured through reducing waiting times for assessment to no more than 45 weeks, aiming for equitable waiting times across all pathways by April 2028. CYP and families will report that they have experienced co-ordinated support.

5. Digital support offers

By April 2028, complete a comprehensive review of the digital support offers available to neurodivergent CYP and families across Norfolk and Suffolk to determine the potential for the introduction of a digital tools, including collaborative screening approaches, to work alongside existing pathways. Further develop the Norfolk digital support offer and expand to encompass Suffolk CYP and families.

This supports CYP and families through the assessment and diagnostic process, improves engagement and outcomes, and provides individuals and families with knowledge and resource to self-manage. This focuses on the shift from analogue to digital and will enhance holistic support for neurodivergent CYP and their families.

This will be measured through numbers of visits to the resource and the number of screens undertaken by digital means.

Longer-term priorities (Years 3-5):

1. Focus on outcomes such as employment, education, relationships, mental and physical health, and reduction in risk behaviours.
2. All individuals can access assessment, diagnosis, and treatment that meets their needs using the stepped care model approach

3. Promote seamless coordination across services, with care pathways designed around the individual and their family/carers.
4. Expand local services and ensure ongoing support to maintain health, wellbeing, and independence.
5. Provide accessible information, signposting, and digital tools to navigate services, support self-management, and enhance service user experience.

4.4. Urgent Emergency Care (UEC)

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcome: People of all ages in Norfolk and Suffolk with an urgent or emergency health need have access to timely and clinically appropriate care, first time, every time.

Outcome measures:

1. Urgent and emergency care is delivered to national standards as set out in NHS England planning guidance.
2. Year-on-year, more people access and receive clinically appropriate frailty, long-term condition management and/or urgent care through improved community-based services aligned to the emerging Neighbourhood Health Model including the Care Management Service. This will be measured by a differential growth rate in activity, from hospital-based services to community/neighbourhood provision.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. In line with national guidance and evidence-based practice, the ICB will continue to strengthen urgent care services to ensure more people receive clinically appropriate care in community-based settings aligned to the emerging Neighbourhood Health Model. Annually, our aim is to reduce the total non-elective admissions and bed days, with a specific focus on frail older people, given rising demand pressures. This will allow acute emergency care to be safeguarded for those who will benefit from it most, while unified and more efficient urgent care is delivered in the community for those where this offers the best health outcomes.

To achieve this, the ICB will:

- Expand the commissioned services within Unscheduled Care Co-ordination Hubs towards becoming a Single Point of Access by March 2028. This will include commissioning additional frailty healthcare professional expertise. The service will be required to increase its annual productivity by a minimum of 2%.
- Annually increase investment in urgent community response capacity and capability aligned to population need. Providers will be required to increase

their annual productivity by a minimum of 2%. By October 2027, Community Service Commissioners will have assessed total resources spent on those living with frailty and shift a proportion of those resources to better community provision, to ensure safe and effective care away from an acute hospital setting wherever possible, and to short-stay frailty attuned care when people do require admission.

- Commission an integrated pathway to ensure all clinically appropriate urgent care demand received by the East of England Ambulance Service is transferred and managed by our Integrated Urgent Care Service (NHS 111 +). This will include EEAST C3-5 calls by 1 April 2026, extending to agreed C2 codes by 1 July 2026.
- Procure a new Integrated Urgent Care service aligned to the ICBs associated Strategic Plan with the new service live by 1 April 2028.
- Commission more urgent dental care provision to deliver the ICB's share of the appointment target every year through to 2028/29.

2. In line with national guidance and evidence-based practice, the ICB will commission providers to deliver strengthened acute-hospital based UEC services to achieve improved quality of care and patient experience, reduce unwarranted variation, greater productivity and the elimination of unwarranted ambulance to handover delays.

To achieve this, the ICB will:

- Commission a 'UTC-first' model of care by default for patients who are less likely to require admission. This will include the requirement for pathways for children that support more rapid assessment and treatment, with the aim that these cohorts of patients are treated within the 95% standard by March 2027. This will include commissioning Urgent Treatment Centres (UTC) in Norfolk and Waveney during 2026/27. Mobilisation of additional UTCs at the Norfolk hospitals will be phased, with the overall aim that all UTCs across Norfolk and Suffolk will be operating and fully compliant with the national specification by end March 2028 (including direct booking provision).
- Commission providers to adopt practice in line with NHS England's Model Emergency Department and clinical operational standards for the first 72 hours in hospital. By July 2026, all acute Trusts will have agreed implementation plans that have been assured by the ICB.
- Commission 24/7 Same Day Emergency Services (SDEC) (or equivalent straight-to-specialty) aligned to national guidance (including direct referral by agreed partners inc. the ambulance service) by July 2026.
- Commission a "Hospital at Home" service in Norfolk and Waveney that builds on and strengthens existing Virtual Wards already in place. This supports "left shift" and integration strategies to achieve better outcomes for patients who

can be safely and appropriately managed at home by community teams with support from acute SDEC type facilities and aligns with the integrated approach in Suffolk.
- Embed ‘digital first’ care into urgent care provision by commissioning providers to bring relevant individual services (to be agreed and include Virtual Ward) together to form one ‘Hospital at Home’ service to support clinically appropriate care out of hospital by March 2028.

In line with the outcomes of audits, insight and inspections, the ICB will continue to engage with patients, carers and our population, and work in partnership with providers to seek and respond to their experience of UEC services to improve the quality of care. This will include sustained delivery of agreed system action plans in response to inspections of providers by the Care Quality Commission (CQC), as well as publication of an annual report that reflects ‘You said, We have’ in response to contacts received by Patient Advice and Liaison Services across ICB commissioned services.

This will be measured by:

- Our average 4-hour A&E performance is 82% for the year with annual increase towards 85% by 2028/29 by the end of March 2027.
- Achieving a year-on-year % increase in patients admitted, discharged and transferred from ED within 12 hours.
- Our average C2 mean response time is 25 mins with annual improvement towards 18 minutes, with 90% of calls responded to within 40 minutes by 2028/29 by the end of 2026/27.
- Year-on-year, more people (inc. High Intensity Users) access and receive clinically appropriate frailty, long-term condition management and/or urgent care through improved community-based services aligned to the emerging Neighbourhood Health Model including the Care Management Service. This will be measured by a differential growth rate in activity, from hospital-based services to community/neighbourhood provision in line with national expectations (approximately 3% nationally per year).

Longer-term priorities (Years 3-5):

In line with NHS England priorities, evidence-based practice, and local population need, we will:

1. Appropriately invest in urgent and emergency care, particularly in community settings, in line with 10-Year Health Plan objectives.

The scale and nature of investment and service redesign will be heavily informed by the evidence-based impact of the emerging Neighbourhood Health Model (inc. Care Management Service) – transferring services from acute-based settings and

eliminating the current capacity gap in urgent community response services by March 2031. The self-care and preventative focus of services delivered by the Neighbourhood Health Model is expected to materially reduce UEC demand, thereby preserving ambulance and acute-based services for people most in need.

2. Continue to collaborate with partners to identify opportunities to commission improved pathway access and quality of unscheduled care aligned to national standards for children and adults.

Our commissioning approach will accelerate the transition towards a more productivity, digital-first UEC model which is simpler for people to access and navigate. Together, this will further support delivery of the right urgent and emergency care, first time, every time thereby improving patient experience and health outcomes, quality of care, and better use of resource.

4.5. Stroke & Neurorehabilitation

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcome: The aim is to support the people in Norfolk and Suffolk to avoid having a stroke (see Be Well section), survive stroke, live well after stroke, and prevent complications through tertiary prevention.

Outcome measure: Increase the proportion of people in Norfolk and Suffolk who receive timely, high-quality, integrated stroke prevention, acute care, and rehabilitation—demonstrated by improved SSNAP performance, reduced incidence of preventable strokes, improved survival, and increased functional independence at 6-months post-stroke.

Our commissioning intentions focus on delivering care in line with the Integrated Community Stroke Service (ICSS) model and achieving performance standards set by the Sentinel Stroke National Audit Programme (SSNAP).

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Reduce variation in access to community stroke care, and eliminate unwarranted variation in access, model and outcomes in community stroke care.

By 1 April 2027, review and re-commission (if required) community stroke rehabilitation services following a comprehensive needs assessment to ensure stroke survivors have consistent access to care regardless of geography. Where gaps are identified, implement commissioner-led actions including updating Service Development Improvement Plans, revising commissioning specifications, and developing business cases for investment to tackle health inequalities. This includes

introducing community-based solutions to support 7-day flow in response to increased mechanical thrombectomy access.

By 1 April 2028, complete a comprehensive needs assessment to determine requirements for expanding community stroke rehabilitation services following April 2027 review and foundations built. This assessment will inform the development of a robust business case for a responsive, seven-day, needs-based model of care that incorporates six-month post-stroke reviews and embeds vocational rehabilitation in line with the Integrated Community Stroke Service (ICSS) framework.

Measured by:

- SSNAP Performance metrics i.e. consistent rating across geographies.
- Completion of the review process for April 2027
- Completion of a full business case for expansion of Community Stroke Rehabilitation by April 2028.

2. Increase rehabilitation intensity - harness technologies to increase intensity and access to acute and community rehabilitation

By March 2028, develop and implement a technology-enabled stroke rehabilitation model as a standard component of care. This should optimise the use of digital tools such as telerehabilitation platforms, mobile apps, wearable sensors, and virtual rehabilitation systems to deliver dose-matched, task-specific sessions remotely (both synchronous and asynchronous). The aim is to increase therapy contact time, reduce travel barriers, and maintain continuity of care. Assessments and referral handovers must incorporate patient preferences for modality (in-person, virtual, or hybrid). Address inequalities in access through device provision or loan schemes, alongside onboarding and technical support.

Measured by:

- Community Services Data Sets and SSNAP will evidence increased therapy provision delivered through technology-enabled interventions (including telerehabilitation platforms, mobile apps, wearable sensors, and virtual rehabilitation systems), alongside higher therapy hours per patient. Target: 10% of total therapy hours delivered through technology mediums Year 1, 15-20% Year 2.
- Baseline established by April 2026. Rollout plan developed and commenced by August 2026. Full delivery by August 2028.

3. Increase rehabilitation intensity - Expand group therapy to deliver needs-led, intensive community rehabilitation

By March 2028, develop and finalise the rollout plan and supporting materials for the implementation of group community therapy rehabilitation across all disciplines

(Physiotherapy, Occupational Therapy, Psychology, Nursing, and Speech and Language Therapy) with some early delivery commencing from October 2026 in Norfolk. This initiative will be supported by NHS England East of England Stroke Quality Improvement Rehabilitation funding and enabled through collaborative provider arrangements, maximising shared resources and leveraging multidisciplinary skill mix.

Measured by:

Community Services Data Sets and SSNAP will evidence increased therapy provision via group sessions and higher therapy hours per patient. Target: 10% of total therapy hours delivered through group sessions within Year 1, 15-20% Year 2.

Longer-term priorities (Years 3-5):

1. Shift in line with the 10 Year Plan to neighbourhood-based stroke prevention, rehabilitation, and reintegration models.
2. Optimise the configuration of acute stroke services to ensure timely, equitable access to hyperacute interventions and best practice care, reducing unwarranted variation and improving outcomes across the system.
3. Ensure stroke care across hyperacute, acute, and community settings is delivered by specialist teams, underpinned by expanded advanced practice roles and a clear workforce succession plan to secure long-term capability.

Neurorehabilitation

Outcome: People of all ages in Norfolk and Suffolk experience improved neurological health and recovery through earlier detection, reduced disability, faster access to high-quality personalised neurorehabilitation, equitable access to self-management support, and seamless transitions across the life course, enabling them to live longer, healthier, and more independent lives.

Outcome Measures:

- Reduce under-75 mortality and long-term disability from acquired brain injury and preventable neurological conditions.
- Develop standardised, outcome-based neighbourhood neurorehabilitation models for all ages, integrating physical, cognitive, psychosocial recovery and clinical psychological support.
- Reduce diagnostic and therapy wait times by transitioning to digitally enabled neuro-assessment and rehab planning.
- Expand equitable access to neuro self-management and recovery programmes across age, deprivation, and digital inclusion.
- Ensure smooth transitions between paediatric and adult neurorehabilitation services with shared goals, joint handovers, and family-centred planning.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Early Identification and Referral

By February 2027, launch neuro assessment clinics for adults and children/young people (CYP), embed case-finding prompts in clinical systems, and update referral templates.

Measured by:

- Clinic and referral volumes, prompt activations, training uptake, and conversion rates from referral to assessment.

2. Harness Digital Technology to improve care and efficiency

Between December 2027 and March 2028, deploy wearables and virtual ward integration for patients with acquired brain injury (ABI) and progressive neurological conditions. Embed multidisciplinary team (MDT) oversight and escalation protocols to ensure safe, effective monitoring and timely interventions.

Measured by:

- Number of patients onboarded to wearable monitoring and virtual ward platforms
- Proportion of therapy sessions delivered remotely.
- Percentage of escalation protocols activated within agreed timeframes.
- Additional indicators will include reductions in avoidable admissions, improvements in therapy intensity metrics, and patient-reported experience measures (PREMs).

3. Personalised Care & Transitions

By December 2027, commission and implement joined-up care planning that supports personalised neurorehabilitation and ensures smooth transitions between paediatric and adult services. This will include embedding shared goals, joint handovers, and family-centred planning, alongside the introduction of experience measures to capture patient and carer feedback.

Measured by:

- Number of personalised care plans initiated.
- Proportion of paediatric-to-adult transitions supported with documented joint handovers.
- Improvements in patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). Feedback-led improvements will be tracked to ensure that changes are informed by lived experience.

Longer-Term Priorities (Years 3–5: 2028–2031)

1. Strengthen joined-up pathways across primary care, VCFSE, and education using ICS-aligned digital tools, by December 2029.
2. Boost digital access and self-management, with 75% of users actively using digital tools, ensuring digital inclusion is considered and health literacy is improved for Core20PLUS communities, by March 2030.
3. Extend anticipatory and palliative care to all progressive neurological conditions, by March 2030. Embed a dedicated FND pathway with follow-up support, by March 2030.
4. Embed sustainable MDT models and expand capacity with 7-day services and shared records, by March 2031.

4.6. Long-term conditions

Senior Responsible Officer: Executive Director of Strategy, Digital and Commissioning

Outcome: Adults and children and young people with long-term conditions live longer, healthier, and more independent lives through early intervention, self-management support, and equitable access to high-quality, integrated care.

Outcome measures:

- Mortality rates for under 75-year-olds from diseases that are considered preventable.
- Healthy life expectancy at condition diagnosis and post-diagnosis.
- Health inequalities and variation in care, measured by narrowing gaps in outcomes.

Diabetes Care (All Age)

Diabetes is a major contributor to morbidity and mortality, with significant impact on population health and healthcare resources. By 2031, we aim to improve diabetes prevention, care and treatment, reducing diabetes complications and striving for activity and outcomes better than England averages as reported in National Diabetes Audits.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

From April 2026, improve health literacy. Optimise the use of preventative patient support programmes aligned with the varying needs of Norfolk and Suffolk populations, including an accessible digital platform for all diabetes education programmes. Increase case-finding and patient engagement with type 2 diabetes prevention and remission programmes, linking with the development of an Obesity Single Point of Access to reduce the prevalence of Type 2 diabetes.

From April 2027, develop and commission local primary and community care with leadership roles and accountability, to enable delivery of integrated shared diabetes

models of care in Norfolk and Suffolk. The aim is to improve performance on treatment targets and care processes that will exceed national averages and reduce inequalities through targeted actions. The West Suffolk's National Neighbourhood Health Implementation Programme will be an enabler to transition around 80% of diabetes care and support into the community.

From April 2027, improve care for children and young adults with equitable age-appropriate services to ensure seamless transition through paediatric and adult services.

Measured by:

1. By March 2027 - Completion of all care processes – Norfolk and Waveney Adults all 8 Types 1 >60% and Type 2 >65%. Suffolk 65%.
2. By March 2027 - Achievement of all treatment targets Norfolk and Waveney Adults all 3 Type 1>31% and Type 2 >45%. Suffolk 45%.
3. By March 2027 - Access to diabetes technologies – Children and Young People (CYP) to 75%, Adults to 20%.
4. By April 2027 - Improve access to structured education, type 2 prevention and remission programmes 10% above baseline for both newly diagnosed and established patients, from baseline 2025/26 data.
5. By April 2030 - 5% reduction in emergency admissions for diabetes-related complications (cardiovascular disease (CVD), diabetic ketoacidosis, hypoglycaemia).
6. Rates of major diabetes complications (lower limb amputations, end-stage renal disease, sight loss) Current diabetes amputation data rates per 1,000 population - Major Norfolk & Waveney 2.55 SNEE 1.50, Minor Norfolk & Waveney 4.63 SNEE 4.95.

Longer-Term Priorities (Years 3–5)

1. Implement integrated diabetes provision supported by better collaboration between services and multi-disciplinary workforces. Embed clinical education, ensuring seamless care across all services, increasing access to more specialised care closer to home.
2. Develop and commission specialist care provision to deliver agreed integrated shared diabetes models of care. This includes transformation of footcare services and access to diabetes technologies.

Cardiac Care (Adults)
Cardiovascular disease causes a quarter of annual deaths and widespread morbidity. By 2031, we will optimise the cardiac pathway across Norfolk and Suffolk, exceeding national/regional audit averages. We will do this by improving cardiac rehabilitation, heart failure, acute coronary syndrome (ACS), and non-ST-Elevation Myocardial Infarction (NSTEMI) pathways.

Please also refer to the inter-dependent Commissioning Intention "cardiovascular disease – Secondary Prevention" within Healthy Choices and Behaviours, Be Well

domain.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Heart failure will be the focus of the Ipswich and East Suffolk National Neighbourhood Health Improvement Programme.
2. By March 2028 - Improve Cardiac Rehabilitation services, by ensuring cardiac rehabilitation is offered to all patients, expanding face-to-face, group and digital options, and improving patient outcomes through integrated service delivery and innovation. Where possible we will explore options for shared rehabilitation programmes within Long Term Condition programmes.
3. By March 2028 - Reform the heart failure pathway, by expanding Multidisciplinary Team (MDT) capacity, levelling up community provision, and reducing avoidable admissions through integrated care, workforce investment, and equitable service access. Access currently varies across the region. This intention will include rehabilitation services for heart failure patients and will be aligned with the rehabilitation objective above.
4. By March 2028 - ACS / NSTEMI pathway improvements by reducing inter-hospital transfer delays from the James Paget Hospital, optimising Norfolk Cath Lab capacity, and embedding a networked pathway model to deliver equitable treatment within 72 hours.

Measured by:

1. By March 2028 - Increase cardiac rehab uptake: measure % of eligible patients enrolled and benchmarked against National Audit and quarterly metrics. Targets: HF rehab 20% (from 10%), acute coronary symptom (ACS) rehab 70% (from 45%)
2. By March 2028 - Reduce cardiac readmissions to 19% (from current EoE average of 24%) and average Length of Stay (LOS) to 8.2 days (from current EoE average of 9.2 days) benchmarked against regional baseline and national standards, monitored quarterly via NHS Digital and local audit.
3. By March 2028 - Reduce Heart Failure (HF) admissions by 10% and average LOS to 8.2 days across Norfolk and Suffolk, benchmarked against regional baselines and national HF audit, monitored quarterly. Increase Virtual Ward use to support.
4. By March 2028 - Improve timely and accurate HF diagnosis across Norfolk and Suffolk. Aiming for a reduction of echocardiogram waits greater than 6 weeks, benchmarked against national HF audit and monitored quarterly, to 30% from the current 50%. Reduce the detection gap of patients with HF by 5% by March 2027.
5. By March 2028 - Ensure ACS/Non-ST-elevation myocardial infarction (NSTEMI) patients receive percutaneous coronary intervention (PCI) within 72 hours and optimal secondary prevention, benchmarked against national audit

standards, monitored quarterly across Norfolk and Suffolk. Boost NSTEMI treatment time attainment to 55% from current 50% average.

Longer-Term Priorities (Years 3–5):

1. Assess further local need through assessments with cardiac care providers across the region.

Respiratory Care (All Age)

Respiratory disease affects one in five people in England and is the third biggest cause of death. Respiratory diseases are a major factor in winter pressures faced by the NHS.

By 2031 we aim to improve respiratory care and treatment, tackle variations in access, experience and outcomes, reduce respiratory complications and strive for activity and outcomes better than averages as reported in national/regional audits.

This will include support for people with Asthma, Chronic Obstructive Pulmonary Disease (COPD) and community-acquired pneumonia to live more independent lives through accurate diagnosis, early intervention, equitable access to high-quality, integrated care and self-management support across the life course and taking targeted approaches with Core20PLUS populations.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. From April 2027 - Respiratory diagnostics and risk detection**.** Increase equitable, early, accurate timely diagnosis using technology, case finding and embedding clinical education. This will include recommissioning and expanding spirometry services, roll out further of N-Tidal and home-based diagnostic tools, PHM tools, embedding respiratory case finding into NHS Health Checks, school health programmes, outreach services for targeted populations and LTC reviews.
2. From April 2028 - Integrated community respiratory care. Develop a neighbourhood respiratory health care model that ensures equitable access to standardised, outcome focussed and evidence based coordinated care across Norfolk and Suffolk. Target Core20PLUS populations to support equitable access and improve outcomes. This will include strategic commissioning of clinically led, virtual MDT's and structured pathways, delivering virtual ward models for high-risk patients and supporting transitions between paediatric and adult services.
3. From April 2027 - Respiratory rehabilitation and self-management**.** Improve equitable access and completion of age-appropriate respiratory support. This will include pulmonary rehabilitation, commissioning of age-appropriate rehabilitation through the life course and accessible education programmes, considering outreach into communities as appropriate. Delivering pharmacy-led inhaler optimisation and switch programmes and school/community

interventions. Ensure Clinical education for medical staff is available and on-going.

4. By March 2027 - Improving rates of respiratory-specific vaccination uptake amongst eligible cohorts, tackling variations in Core20PLUS communities with targeted approaches at neighbourhood level.

Measured by:

- By March 2028 - Diagnostic spirometry wait times and utilisation of digital technology, targeting inequality in access for key population demographics by March 2027. 30% reduction in diagnostic wait times against 2025/26 baseline.
- By March 2028 - Short stay admissions (0-1 day) for asthma and COPD. 5% average reduction in line with regional average.
- By March 2028 - Access and completion rates for respiratory rehabilitation and self-management programmes. 80% of routine pulmonary rehabilitation patients commence within 100 days. 70% of patients complete Pulmonary Rehabilitation programme, targeting variations in access, experience and outcomes from Core20PLUS communities.

Longer-Term Priorities (Years 3–5):

1. Enhance respiratory diagnostic provision across ICB utilising latest AI technology.
2. Clinically led, integrated breathlessness health provision, engaging with local populations to consider Core20PLUS communities. Embed anticipatory care planning and palliative support for advanced COPD and improved experience scores across all age groups.
3. Extend age-appropriate rehabilitation and education programmes. Co-design culturally appropriate, supporting health literacy and self-management resources for all age groups.

<u>Children and Young People specific long term condition priorities – asthma and epilepsy</u>
Individuals with long-term conditions live longer, healthier, and more independent lives through early intervention, self-management support, and equitable access to high-quality, integrated care. We will work collaboratively across health, education, and community partners to improve the prevention, early identification, and management of long-term conditions in children and young people with a particular focus on asthma, epilepsy and diabetes.

Immediate Priorities (Years 1&2, 2026/27 and 2027/28):

1. Expand specialist epilepsy nursing by March 2027 to ensure equitable provision across Norfolk and Suffolk, supporting children and young people with epilepsy through timely access to specialist advice, care coordination, and education support.

2. Quality Personalised Asthma Action Plans (PAAPS) for all diagnosed CYP, recorded and accessible to clinicians.

Measured By:

- By end March 2028 - Achieve specialist epilepsy nursing ratio in line with The Royal College of Paediatrics and Child Health (RCPCH) recommendation.
- By end March 2028 - All CYP with epilepsy have access to named specialist epilepsy nursing support.
- % of CYP without an up-to-date asthma review reduced from 72% to 60% by end of March 2027, and by end March 2028 reduced by a further 15%.

Longer-Term Priorities (Years 3–5):

By March 2030, deliver integrated, family-centred models of care that aims to reduce avoidable hospital admissions, improve quality of life, and supporting and empowering families to manage conditions confidently at home. Full implementation across all localities.

5. Age Well

5.1. Ageing Well including frailty

Senior Responsible Officers: Executive Primary Care and Neighbourhood Health Director (Norfolk) and Executive Primary Care and Neighbourhood Health Director (Suffolk)

Outcome: Older people in Norfolk and Suffolk stay active and independent for longer, with fewer falls and fractures that require unplanned care.

Outcome measures:

Reduction in emergency admission rate due to falls among people aged 65+, and reduction in emergency admission rate for people with frailty.

Immediate Priorities (Years 1 & 2 2026/2027 & 2027/2028):

1. High quality frailty care

We will implement standardised frailty pathways across all Alliances. We will grow and expand a community model with community geriatricians aligned to neighbourhoods.

By the end of March 2028, we will be using the frailty toolkit to guide identification, assessment, and proactive management within integrated multi-disciplinary teams. This will be supported through shared digital infrastructure across acute, community, and primary care settings.

This will be measured through an increase by March 2027 in the proportion of identified frailty patients who have completed, recorded, and shared Comprehensive Geriatric Assessment (CGA) and/or Rockwood frailty tool across care settings. By March 2028, we will ensure that My Care Choices Register (MCCR) is updated to improve the utilisation of Advance Care Plans (ACP) and ReSPECT documentation. By the end of 2027, we will demonstrate consistent use of the Frailty Rockwood Scale across INTs and PCNs. By end of March 2028, frailty pathways and the frailty attuned care will be fully implemented, improving early identification and personalised care planning and outcomes.

2. High quality falls care

By the end of March 2028 at the latest, we will implement a standardised falls prevention and management service aligned to national best practice and guidelines, incorporating the use of technologies, where appropriate.

This will be achieved by incorporating this into the community services review, aligning it with integrated neighbourhood working to proactively identify individuals at risk and delivery of an increased number of falls assessments. Our initiatives will use the Core20PLUS5 approach, to address unwarranted variations in treatment target attainment, increase the uptake of falls assessments and reduce disparities of outcomes among high-risk groups.

This will be measured through a reduction in falls-related A&E attendances including hip fractures by 2027/2028.

3. Carer identification & support

By the end of 2027/28 we will increase the identification of paid and informal carers to provide support. This will be enabled within Integrated Neighbourhood Teams through training and support. It will be aligned with the VCFSE carers strategy and detailed within our action framework.

This will be delivered through co-commissioned support of Carers Matter Norfolk and Suffolk Family Carers.

This will be measured through an increase in the number of carers identified on the GP register to 5% by the end of 2027/28.

We will promote the completion of Carer Impact Assessments for all new services that move care closer to home, to ensure understanding and mitigation of any adverse impacts on family carers.

4. Carers strategy development

As outlined above, we will utilise and adopt the existing All-Age Carers Strategies published by our VCFSE partners to establish our strategic direction and inform future commissioning action frameworks. This builds on the review of the current All-Age Carers Strategy (2022–2027) and aligns with NHS Personalised Care and Integration priorities.

5. Integrated support to Care Homes

The ICB will develop a dedicated Care Homes commissioning framework for the Suffolk and Norfolk system covering residential and nursing homes, which explicitly aligns the work of care home support teams-, community service-, primary care networks (PCNs), pharmacies, falls prevention providers and management services, EEAST and social care co-commissioning partners and providers.

This will be monitored through an increase in the number of care homes, and care homes residents supported to stay well at home and avoid unplanned hospital attendances. The framework will be published by the end of March 2027.

These Commissioning Intentions will be underpinned by co-produced county-wide “Ageing Well” campaigns tackling loneliness, isolation, and physical inactivity.

Longer-Term Priorities (Years 3–5)

With consideration for Core20PLUS communities, we will:

1. Continuously monitor the benefits and outcomes of the Commissioning Intentions in Years 1 and 2, to assess impact against existing and forecast population health needs and consider further strategic commissioning plans which may be required for the period 2028-2031 and beyond.
2. Ensure full coverage and continuous development to maturity of Integrated Neighbourhood Teams by March 2030.

5.2. Dementia

Senior Responsible Officers: Executive Primary Care and Neighbourhood Health Director (Norfolk) and Executive Primary Care and Neighbourhood Health Director (Suffolk)

Outcome: People living with dementia in Norfolk and Suffolk are supported through timely, high quality care planning that reduces the likelihood of avoidable hospital care.

Outcome measures:

1. Achieve the 12-week waiting time standard for Memory Assessment Services by end of 2027-28.

2. An increase in the number of individuals with a dementia care plan who have received a review in the past 12 months by the end of 2027/2028.
3. Reduce the rate of unplanned hospital admissions for people with dementia.

Immediate Priorities (Years 1& 2 2026/2027 & 2027/2028)

1. Deliver timely dementia diagnosis

With consideration for Core20PLUS communities, we will take action to address unwarranted variation in access experience and outcomes, to reduce the time from referral to diagnosis by improving Dementia Assessment Service capacity, productivity and capability, introducing more robust triage, and enabling diagnosis of advanced dementia through local advisory pathways. We know that proactive identification of dementia can help support the reduction in episodes of delirium through improved education and training.

We will do this by building existing Memory Assessment Service transformation work and integrate primary and community pathways with consideration for the needs of our Core20PLUS communities.

This will be measured through a phased reduction in waiting times from 2026/27, achieving the 12-week standard across all localities by the end of 2027/2028, with targeted initiatives to reduce waiting times.

2. Improve quality of care through service-user feedback

We will ensure that service user and carer feedback informs continuous improvement across all commissioned dementia services, measured against the Dementia Charter, with person-centred care, systematic data collection and transparent reporting, including promoting registration on My Care Choices Register (MCCR).

We will measure this through feedback responses that are received and associated actions (You said - We did), rating services as “good” or “excellent”; feedback gathered annually from a target of 10% of service users as a minimum, number of people affected by Dementia who are registered on MCCR. Data collection will be consistent by the end of 2027.

3. Reduce dementia-related hospital admissions and length of stay considering target approaches for Core20PLUS populations

We will decrease avoidable dementia admissions to secondary care and reduce the average length of hospital stay through enhanced community support and prevention pathways and tackle unwarranted variation in Core20PLUS communities.

We will do this by strengthening the neighbourhood health model to include dementia support, expand admission-avoidance models, and utilise AI tools and ICB Business Intelligence to analyse admission drivers and support improved co-ordination of community support. We will commission the continuation of dementia and delirium training to support raised awareness.

We will set a baseline in 2026/27 and achieve a sustained reduction in admissions and length of stay by March 2028, with further improvement through 2031. We will ensure this work is linked to programmes commissioned through the Better Care Fund.

4. Increase annual dementia care plan reviews

We will ensure that individuals living with dementia receive an annual, high-quality, person-centred review of their care plan that reflects their evolving needs and preferences. In doing, we will consider the needs of people living in Core20PLUS communities.

We will achieve this by training clinicians in personalised care planning and promote use of the MCCR.

This will be measured though an increase in the number of individuals with a dementia care plan to have received a review within the past 12 months by the end of 2027/2028, sustained annually thereafter.

Longer-term priorities (Years 3-5):

1. Respond to innovation and integration opportunities e.g. advances in Dementia Modifying Treatments and Blood Bio-markers
2. Increase AI enabled community support, including use of VCFSE services.
3. Streamline processes, utilising awareness campaigns and place-based plans to support those with a suspected or confirmed dementia diagnosis.
4. Ensure that individuals with dementia are enabled to complete their advance care plan as early as possible, to support their future care, linking to AI/digital enabled Right Care, Right Time packs and Yellow Folders – aligned to the MCCR.
5. Integrate the Dementia Intensive Support Teams where they exist to form part of our general offer for Urgent Community Response and align proactively with our neighbourhood model for health and social care

We will give particular consideration to addressing unwarranted variation in access to dementia diagnosis and support services and outcomes, and co-produce approaches, which will enable improvements.

6. Die Well

6.1. End of Life

Senior Responsible Officers: Executive Primary Care and Neighbourhood Health Director (Norfolk) and Executive Primary Care and Neighbourhood Health Director (Suffolk)

Outcome: People of all ages with life-limiting conditions or who are at the end of life, and their families, experience timely identification and proactive care planning, enabling high-quality, dignified, and coordinated care that reflects their holistic needs and preferences.

Outcome measures:

1. Improve identification of people at end-of-life by increasing the number of people registered on My Care Choices Register to at least 1% of the population by 2028.
2. Reduce avoidable hospital admissions for people at end of life by reducing the rate of emergency admissions for people in the last three months of life each year, addressing inequalities in Core 20 and Plus groups.
3. Improve end-of-life outcomes by ensuring 90% of eligible patients have a documented care plan in place (including preferred place of death) by 2028.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Refresh and align commissioning for specialist palliative and end of life care to national standards

We will implement refreshed commissioning arrangements for Specialist Palliative and End of Life Care across Norfolk and Suffolk by April 2028. This will reduce variation and align with national standards and the SNEE hospice model, including specialist paediatric palliative care and Children's Hospice services for children/ young people with life-limiting and life-threatening conditions.

This will be achieved by building on existing hospice grant arrangements and use shared learning to inform a Norfolk and Waveney commissioning refresh. It supports the NHS Planning Framework objectives on integration, productivity, and equitable access to personalised, high-quality care and the principles identified by Together for Short Lives.

This will be measured through the establishment of long-term grant agreements with hospices by 2027 and reduce unwarranted variation in access and quality across the ICB. A new commissioning model will be implemented and aligned across Norfolk and Suffolk by April 2027.

2. Improve early identification and advance care planning

By March 2027 we will train and support care teams to proactively identify those nearing end of life (targeting 1% of practice populations) and record preferences using the newly commissioned My Care Choices Register (MCCR). This work will be in alignment with wider Primary Care commissioning intentions re Proactive Care and Care Homes.

This will be achieved by building on the Future Care Planning Enhanced Service and MCCR implementation, supported by data monitoring and clinical training. This work will include engagement with Core20PLUS communities with consideration of specific personalised support needs and Ageing Well groups. This work will align with the SNEE locally co-produced ‘10 outcomes that matter’ to personalise care and reduce avoidable hospital activity. This work will include reasonable adjustments to those groups that may struggle with digital access.

This will be measured through a target of 90% of eligible patients having a documented care plan by 2028, which is aligned with aim of 1% of the population registered on MCCR. Through the MCCR these patients will have advance care plans and ReSPECT forms which define their preferred place of care/death. The MCCR system will also measure patient feedback. The implementation of MCCR will also impact positively on unwarranted variation in access and avoidable admissions/acute bed-days for people in the last 3 months of life with considered approaches for NHS Core20PLUS5. Approval has been given that this work will be underpinned by an ICB wide primary care enhanced service.

3. Redesign NHS Continuing Healthcare (CHC) Fast Track provision

We will transform CHC Fast Track pathways into a fully integrated, proactive end-of-life model offering coordinated 24/7 support. This will align with existing waking night support services in Norfolk and Suffolk, with a new integrated model that will be implemented by end of March 2027. We will do this by aligning Fast Track Provision with CHC, new models of community care within our neighbourhoods, contracting, and finance, building on learning nationally.

This will be measured through a reduction of inappropriate acute admissions in the last weeks/days of life.

4. Address inequalities in end-of-life care outcomes

We will address inequalities in end-of-life outcomes by using the text response survey and other forms of feedback, as appropriate, across the ICB to ensure more equitable access to advance care planning across all neighbourhoods and increasing access to palliative and end of life care for children, young people and adults with life limiting illnesses. More children, families and adults from Core20PLUS5 groups with palliative/end of life care needs will receive appropriate support.

This will be measured using MCCR and population health data, considering unwarranted variation in access, patient experience, and outcomes by diagnosis, deprivation, and ethnicity. We will complete an initial analysis of the data following implementation of MCCR. We will also apply Population Health Management tools and PHM dashboards to monitor equity metrics quarterly.

5. Work in partnership with providers to enable staff to provide outstanding care by providing training to allow identification and care for people at the end of their lives

We will continue to train appropriate health and social care staff to identify people at end of life and provide outstanding person centred and individualised care. This aligns with the ambition 5 “All staff are prepared to care” within the NHS Ambitions for Palliative Care and End of Life framework.

We will achieve this by seeking funding to commission VCFSE partners to deliver compassionate community-based training about the benefits of advance care planning and ReSPECT facilitation. We will extend the proven Care Choices model to all Integrated Neighbourhood Teams once in place with considered approaches to NHS Core20PLUS5 to address unwarranted variation. We will commission the recruitment and training of Hospice Neighbours and consider opportunities to expand VCFSE and compassionate community services across Norfolk and Suffolk.

Our measurement will be through the numbers of individuals engaged in training and qualitative and quantitative evaluation of training during 2026/27.

Longer-term priorities (Years 3-5):

Taking into consideration the needs of Core20PLUS communities we will:

1. Use the Shared Care Record (ScR) to co-ordinate the wishes of people who are at end of life and move away from the MCCR
2. Further progress single points of access, treatment escalation planning and frequent, co-ordinated touch points for people at the end of life, with clinicians and community-based integrated services within neighbourhoods
3. Continue to align Specialist Palliative and End of Life Care commissioning arrangements across Norfolk and Suffolk and work towards national recommendations
4. Commission services that reflect that more children and young people with life-limiting conditions are living longer and transitioning into adult services.
5. Ensure age-appropriate, seamless and equitable care across community, hospice and specialist settings in accordance with national guidance and neighbourhood health models

7. Cross Cutting

7.1. Community

Senior Responsible Officers: Executive Primary Care and Neighbourhood Health Director (Norfolk) and Executive Primary Care and Neighbourhood Health Director (Suffolk)

Outcome: People stay well in their communities and when support is needed individuals experience personalised, joined-up physical, mental health and care services

Outcome measures:

1. Reduction in rate of emergency admissions to hospitals (reduction in crisis situations). Prior to April 2026, a trajectory for reducing unplanned emergency admissions for the next two years will be established.
2. Increase in activity delivered by community services. Greater numbers of people have access to and are supported by activity outside of statutory services and care closer to home through Place/Neighbourhood commissioning.
3. Increase in the community services productivity. Resources in the delivery of community-based health and care support are used more efficiently in line with further expected national community productivity guidance. Trajectories will be established by April 2026.
4. Reduction in the average total price per person per year of delivering a patient's healthcare needs across primary and secondary care. The ongoing costs of supporting people are reduced as people's independence is increased.

We are aiming for consistent access requirements and patient outcomes across the Norfolk and Suffolk system. The commissioning intentions align with the NHS guidance on Standardising Community Health Services and the NHS Medium Term Planning Framework 2026/27 to 2028/29, focusing on the three strategic shifts: From treatment to prevention, from analogue to digital from hospital to community. The commissioning intentions set out below are aligned and integrated with our local authorities and Alliance/Place partners.

These intentions should be read in conjunction with those included within all other domains and primary care.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Community Contract Review and Redesign

Both Norfolk and Suffolk will be commissioning new community contracts within the next 2 years. The ambition is to continuously improve the prevention of ill health, proactive and joined up care, with a widening of services within communities and increase consistency access for patients. This review and redesign will consider all elements of service delivery; outpatients, mental health, children and young people services, physical health, VCFSE aligned to Social Care and specifically include:

- On-going public engagement about the design of new models of care and with preventative health and wellbeing measures within each Place
- Further plans for expansion of community-based services with integrated neighbourhoods, enabled by place-based commissioning, pooled budgets trials
- Building further VCFSE services for resilient communities
- Systematic review and progression towards appropriate co-location of services in line with national guidance for Neighbourhood Health Centres
- Integrated workforce development and exploration of flexible ways of working
- Development of commissioning principles that explore collaborative commissioned models with partners that focus on integration and outcomes-based accountability

The opportunities and constraints of the New Hospital Programme provide important context for this review and forward planning.

2. Shared service delivery of Integrated Care, Urgent Community Response into neighbourhoods.

Aligned to the NHS 10-year plan, we will progress shared service models for Integrated Care and Urgent Community Response within neighbourhoods. We will seek to build and/or advance, as appropriate to each Place, models which improve outcomes through integrated, proactive, planned and urgent care within our communities, delivered by multi-disciplinary primary, community and secondary care teams to reduce avoidable admissions and accelerate safe discharge.

3. Neighbourhood-based community model

By March 2028, implement and expand a neighbourhood-based community model that includes:

- Aligned community geriatrician support
- Frailty Assessment Based services (FAB) - Please refer to our intentions described within the Age Well Domain).
- An increase in Virtual Ward utilisation to support admission avoidance and discharge from hospital in line with national targets and GIRFT guidance

- Delivery of Homefirst support and Independent Wellbeing practitioner services,
- Integration of community hospice services, ensuring coverage across 100% of neighbourhoods (please refer to our intentions described within the Die Well Domain).

The ICB will support partners in undertaking Place based reviews to reduce discharge delays to national expected levels, removing unwarranted variation. This will include improving in-hospital discharge processes making best use of community capacity (home based and bedded), and increasing home-based intermediate care including urgent community response, ensuring 90% of UCR referrals are responded to within 2 hours.

Together these intentions will strengthen neighbourhood working, build continuity of care across services in communities, and enrich knowledge and skills within community teams to improve personalised and holistic care.

We will continue to embed robust governance at place, e.g. Alliance Committees to promote the efficient, economic and effective use of our collective resource inclusive of the Better Care Fund (BCF), ensuring we work in partnership (including with VCFSE) to target our efforts to people in greatest need (i.e. Core20Plus5). We will monitor and evaluate BCF funded schemes in early in Quarter 4 each year to support future commissioning in line with the ICB and council business planning periods. Health and Wellbeing Boards will continue to consider and approve Better Care Fund investment plans.

During 2026/27, the ICB will work with providers to agree how we measure the impact of neighbourhood health in line with national requirements and take remedial action if non-elective demand in the frail older population group increases over plan.

4. Addressing variation in capacity, provision and long waiting times of core community provision.

By 31st March 2027, at least 78% of planned community health service activity will happen within 18 weeks. This will be achieved by: -

- Undertaking system capacity and demand modelling to understand current and potential future demand for community health services to inform future commissioning.
- Continue to standardise core service provision as defined in Standardising Community Health Services.
- Actively managing long waits for community health services, reducing the proportion of waits over 18 weeks and developing an action plan to eliminate all 52-week waits.
- Identifying and act on system-wide productivity opportunities.

- Identifying and acting on innovation opportunities e.g. digital therapeutics for MSK treatment with appropriate regulatory approval.

5. Analogue to digital: further development of virtual wards and hospital at home model in neighbourhoods.

We will work to ensure consistent availability and occupancy of Virtual Wards and bed bases as per NHSE guidance, ensuring monthly monitoring of utilisation and annual progress reviews to support the analogue to digital transformation, improve clinical efficiency, support admission avoidance and early discharge from acute and community settings. We will explore the use of a care planning module on the shared care record as a single patient record for neighbourhood teams to enable further improvements in joined up care and productivity. As noted above, forward planning and monitoring will have vital regard to the opportunities and constraints of the New Hospitals Programme.

6. National Neighbourhood Health Implementation Programme requirements and enabling healthy communities

The NNHIP is a national accelerator programme, delivering large scale change to develop a neighbourhood health service as described within the 10-year plan. There are pilot sites in West Suffolk and Ipswich and East Suffolk.

In 2026 the West Suffolk will design and implement an integrated community diabetes care model that delivers holistic, person-centred care closer to home by collaborating with local healthcare providers, community organisations, and public health teams to co-design and pilot the model using existing resources and funding streams. The model will level up the diabetes treatment targets and care processes with an aspiration that all practices reach at least 65% of the 8-care process performance by 27/28. This model will be monitored and evaluated with an intention to spread and adopt to Ipswich and East Suffolk from 2027 onwards.

In 2026, in Ipswich and East Suffolk, the focus of the National Neighbourhood Implementation Programme will be to test and learn of the Care Management Service in West Ipswich prior to commissioning Suffolk wide, together with a focus on patients at risk of heart failure. Ipswich and East Suffolk will continue to develop holistic Population Health Management informed approaches to risk assessment and proactive care management for a wider cohort of 5% of the population currently in receipt of the highest levels of health and care services.

The Care Management Service (CMS) will support the identified 1% of the population who account for 61% of emergency admission bed days and include individuals generally over 70 years of age, with three or more long term conditions, many of whom are housebound, require social and palliative care. This will be achieved by focusing on proactive, co-ordinated, multi-disciplinary care supported by

a dedicated care co-ordinator in line with NHS Planning guidance and 10-year plan. Although initially this will be a stand-alone commissioned service the long-term ambition is to incorporate the CMS into the Neighbourhood Health Service. The test and learn Service within Ipswich West will inform the expected reduction in non-elective admissions and bed days. The implementation of the N-CMS will take place within 2026/27, with the benefits starting to be realised by March 2028.

In Great Yarmouth and Waveney, West Norfolk and Central Norfolk, collaborative models of Neighbourhood Health and Care will be further advanced at pace and in partnership, building on the assets of each Place and informed by Population Health Management approaches.

7. High Intensity Users

We will continue to commission or enable bespoke services / interventions for people that are high users of health and care services, who may have unmet need related to wider determinants of health or where further co-ordination of care is needed. Through this we would anticipate a reduction of 25% in the first 12 months of an intervention and a 10% improvement of wellbeing after 6 months.

8. Community Therapy Services

Through the GIRFT MSK Community work taking place in 25/26, we will further monitor and review the demand and community physiotherapy capacity, to ensure urgent requests are responded to within 2 weeks and routine within 5 weeks. The potential to commission Community Assessment Days will be explored for delivery throughout the 2-year period of 26/27 and 27/28.

A single point of access and Musculoskeletal Assessment and Triage Service (MATS) is now in place for almost all areas in Norfolk and Waveney. From January 2025, all patients will receive the same MSK provision, except those registered with a group of five GP practices who currently access physiotherapy via QEH only. The commissioning intention is to ensure these patients can access the full benefits of the new and consistent Norfolk and Waveney MSK pathway.

We will also complete an action plan to implement recommendations of the adult speech and language therapy provision in Norfolk and Waveney.

Longer-term priorities (Years 3-5):

1. Each Commissioning Intention set out above requires significant ICB and partner commitment, which respects the different levels of development on Neighbourhood working within each Place to date. We will develop plans with partners to ensure an ambitious pace of change which respects differences in

communities' needs and removes unwarranted variation in access, experience and outcomes.

We will further:

2. Ensure ongoing monitoring and evaluation of the performance of the new community contract by implementation of a structured monitoring framework including quarterly performance reports and annual evaluations to ensure delivery against agreed KPI's.

- Further service development based on requirements of the NHS Long Term Plan and annual operational planning guidance.
- Establish clear trajectories for reduction in acute activity delivered through transfer of services to community and primary care settings within neighbourhoods.
- Further progress our digital opportunities to utilise shared digital records and optimise workforce tools across integrated partners as well as in the delivery of proactive care.
- Publish and share learning from the National Neighbourhood Implementation Programme.
- Continue scrutiny of community waiting lists to ensure at least 80% of activity is occurring within 18 weeks, developing plans to address backlogs or change in demand if required.
- Continue work to support the shift from acute to community to support the new hospitals programmes in Norfolk and Suffolk.

7.2. General Practice

Senior Responsible Officers: Executive Primary Care and Neighbourhood Health Director (Norfolk) and Executive Primary Care and Neighbourhood Health Director (Suffolk)

Outcome: Patients receive timely and equitable access to high-quality general practice that is integrated with other primary and secondary care services, including as part of a strengthened neighbourhood health model, which results in improved patient access and experience.

Outcome measures:

1. Ensure 90% of clinically urgent patients are seen on the same day (face-to-face, phone, or online), (subject to NHS England GMS contract negotiations), working with primary care providers to quantify the challenge in 2025/26.
2. Reduction in unwarranted variation in access across practices.

3. Improve patient experience year-on-year (measured via ONS Health Insights Survey).
4. Make 95% of appointments available via the NHS App after triage.

These intentions should be read in conjunction with those listed in the Live Well Domains as well as Community and Neighbourhood Services in particular.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Strengthen access and capacity in general practice: Improving access, tackling unwarranted variation across General Practice and improving patient experience

We will support and facilitate at scale working and collaboration across practices to enable more consistent service availability to meet clinical demand.

We will support Practices to continue to evolve and embed the modern general practice access model to ensure 90% of clinically urgent appointments are seen on the same day (face-to-face, phone, or online), subject to NHS England contract negotiations. This will link closely with the work to embed and develop Pharmacy First as part of an integrated neighbourhood health approach.

We will support Practices to deliver the 2025/26 and 2026/27 GP contractual requirements, identifying Practices where demand exceeds capacity and providing tailored support to Practices. We will work with Quality colleagues and in collaboration with Primary Care Networks/ Neighbourhoods, Local Medical Committees, emerging Primary Care Collaboratives and GP Federations, ensuring consistent quality and access standards across all practices, enabling Practice transformation and supporting workforce wellbeing and development (recruitment, retention and training). Specific workforce approaches will be developed in rural, deprived and coastal areas where there are known challenges to recruitment.

We will work with digital colleagues to deliver digital advancements in the NHS App and evolution of online consultation functionalities within the modern general practice access model.

We will work with Practices to support continuity of care processes within General Practice, increasing the percentage of patients who can see their preferred healthcare professional, where clinically appropriate.

2. Enhance integration with wider health and care systems: Delivering Integrated Neighbourhood working, including implementation of the Neighbourhood Health Model, successfully establishing Neighbourhood Health Centres across Norfolk and Suffolk

We will commission services that strengthen collaboration between general practice and other primary care partners such as community pharmacy, optometry, dentistry, community care, and voluntary sector partners. Working with NHS England as part of the National Neighbourhood Health Implementation Programme and the PCN Pilot Programme, we will support the delivery of the NNHIP across Suffolk and in Great Yarmouth and Waveney in 2026/27.

We will use learning from both programmes to inform future development and wider expansion across Norfolk and Suffolk into 2027/28.

We will further our commitment to joined up care for individuals, their families and carers in creating or advancing Integrated Neighbourhood Teams, with primary care leadership and services. We will give specific focus to the provision of primary care involvement, community and mental health services, MDT working and risk stratification/ segmentation as the basis for integration. We will see integration across primary care, as well as with community and mental health services.

We will develop and deploy the Care Management Service to all neighbourhood teams in Suffolk.

We will consider future national guidance and contract reform alongside digital integration and an optometry first approach to improve access to urgent eye care services and ensuring same day access for clinically urgent eye conditions. To enable equitable access, we would look to develop clear referral pathways from optometry into ophthalmology and other specialities using advice and guidance principles.

3. Continue to develop the Primary Secondary Care interface

We will continue to support the work of local system partners to develop the primary and secondary care interface to improve patient experience with a focus on the areas identified through the Red Tape Challenge report.

We will continue to identify opportunities and act to further improve the clinical partnership, pathways and processes required to enable productive working between primary and secondary care teams to deliver joined up, efficient and effective care, including effective mechanisms for resolving interface issues. This will support the release of clinical capacity. We will develop direct access to diagnostics for specific specialties, aligned to neighbourhoods, supporting patients to access care closer to home, in the right place, first time, enabling patients to be managed within the community without the need for referral.

We will prioritise the use of A&G (Advice and Guidance) in general practice prior to, or instead of, a planned care referral, flowing through a single point of access. We will work in an integrated way across ICB teams to ensure this work aligns with

changes to outpatient services and supports the ambitions of moving from hospital to community and from treatment to prevention.

4. Improve our approach to commissioning services from general practice to improve quality and consistency of services, and to reduce health inequalities

We will review all locally commissioned enhanced services across Norfolk and Suffolk, undergoing a commissioning assessment to ensure services are commissioned at the most appropriate scale to safely meet the needs of the local communities we serve, support the development of neighbourhood services and the resilience of primary care, reduce health inequalities and to provide best value in public service delivery.

We will consider and implement improvements to Local Enhanced Service commissioning to reduce variation in access and outcomes for patients and decrease bureaucracy for practices. We will be informed by the experience of practices, together with national benchmarking and good practice.

We will align with the new hospital programme and the commissioning of community services across Norfolk and Suffolk in developing the best approach to commissioning services under new neighbourhood contracts, when they are published. We will commission in a way which supports delivery of the NHS 10 Year Plan, align resources appropriately and develop neighbourhood health services, addressing the three shifts.

Longer-term priorities (Years 3-5):

1. Further develop our primary care estate to address known capacity issues and provide for neighbourhood health, where possible.
2. Offer Practice Level Support that enables continuous improvement across General Practice and evolves alongside the changing model of general practice, while supporting integration within neighbourhoods.
3. Work with local communities to design and develop their local services to address health inequalities and service gaps.
4. Further develop our workforce focusing on recruitment, retention, training and wellbeing.
5. Implement national primary care contract changes, as required.
6. Develop digital opportunities to harness new technologies within primary care services and move towards a digital first primary care service.

7.3. Medicines Optimisation

Senior Responsible Officer: Executive Medical Director

Outcome: To align safety, quality and cost-effective prescribing across the Integrated Care System (ICS) enabling everyone in Norfolk & Suffolk to 'Live Well'.

Outcome measures: Reduction in unwarranted variation in prescribing across Norfolk and Suffolk.

[Proxy measure: ASTRO-PUs are used to weight prescribing information to allow comparison across different practices based on practice populations; cost is another measure.]

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Develop a system-wide medicines optimisation strategy

We will develop a system-wide medicines optimisation strategy in line with national priorities and aligned with commissioning intentions.

This will be undertaken through engagement with senior pharmacy leaders, non-pharmacy stakeholders and patients, with the aim of clearly setting out the areas of focus for Years 3 – 5. It will be led by the ICB Director of Medicines Optimisation & Pharmacy and approval via the System Prescribing Committee (or equivalent).

This will be measured through the publication of an agreed system-wide medicines optimisation strategy by March 2028.

2. Harmonise all existing medicines governance processes

We will implement a revised structure to ensure that the approval of medicines-related policies/guidelines and commissioning of medication (including adopting those recommended by NICE TA) across the system is streamlined, promoting a smooth and efficient decision-making pathway.

The measurement of achievement is that all existing medicines governance processes are harmonised by April 2027.

3. Supply of medication to patients – secondary care

We will work with secondary care to update existing contractual arrangements so that patients are supplied with 28 days' medication on discharge and in the outpatient setting, where clinically appropriate. This is in line with Getting It Right First Time (GIRFT) recommendations.

This work will be led by the Interface Medicines Optimisation Lead(s) with approval via Contracts governance process and assurance provided via the System Prescribing Committee (or equivalent). Where required, patients will be referred to and supported by the Discharge Medicines Service, an Essential Service within the Community Pharmacy Contractual Framework. Engagement will therefore include local Community Pharmacy Leads.

Secondary care contracts will be updated to this effect by April 2027 at the latest.

4. Commission local medicines optimisation incentive schemes

We will continue to commission local medicines optimisation incentive schemes to drive financial sustainability and quality improvement in primary care/neighbourhoods and community pharmacy aligned with commissioning intentions.

A review of existing schemes across the two predecessor ICBs will be undertaken to inform a harmonised approach. This single, harmonised approach will be from 2027/28.

5. Adoption of biosimilars

We will continue to promote and ensure the adoption of all biosimilars with a focus on ensuring rapid uptake of nationally prioritised biosimilars which offer substantial savings opportunities.

We will implement this through engagement with clinicians, co-development of effective medicines pathways moving from treatment to prevention, and using contractual arrangements, to enhance cost-efficiency and therapeutic outcomes.

Unless otherwise stated, we aim to meet the national ambition of 100% of new patients requiring biological medicines will be initiated on the best value biological, where clinically appropriate, within 3 months following its launch at least 80% of existing patients will be on the best value biological medicine within 10 months of its launch.

6. Other priorities

- We will continue to collaboratively focus on medicines safety to address national, regional or local safety issues that arise, ensuring a system-wide response.

- We will continue to prioritise antimicrobial stewardship across the system with the expectation that appropriate antimicrobial prescribing will improve across a range of metrics aligned to national, regional and local requirements.
- We will continue to promote the safe deprescribing of medicines (polypharmacy) aligned to national, regional or local guidance working with system partners using recommended tools to achieve this including reducing medicines waste wherever possible.

Longer-term priorities (Years 3-5):

1. Further embed the use of population health data to inform and drive targeted medicines optimisation initiatives to reduce health inequalities and improve outcomes for people living in Norfolk and Suffolk.

2. Establish a unified medicines formulary across the ICS working together with system stakeholders to reduce variation and improve appropriate prescribing.
3. Complete the harmonisation of all medicines-related policies/guidelines within the system to reduce variation and improve appropriate prescribing and outcomes for people living in Norfolk and Suffolk.
4. Embed pharmacogenomics where available into local prescribing pathways where this is to further optimise medicines use for patients in key areas, e.g. antiplatelet prescribing.
5. Work with the system to implement the Electronic Prescription Service. This has the potential to transform the current medicines supply model for outpatients and discharge and improve patient experience.

7.4. Dental, Vaccinations, Pharmacy and Optometry

Senior Responsible Officers: Executive Primary Care and Neighbourhood Health Director (Norfolk) and Executive Primary Care and Neighbourhood Health Director (Suffolk)

Outcome: Children and adults are able to access timely, high-quality services in settings close to home, reducing unwarranted variation and improving health outcomes. This coordinated access supports Core20PLUS5 populations, enhances understanding of good oral health, ensures equitable uptake of vaccinations, and reduces demand on Emergency Departments by providing alternatives through primary and out-of-hours care.

Outcome measures:

1. A year-on-year increase in the number of children and adults accessing NHS dental care and delivery of the ICB share of the additional 700,000 urgent dental appointment target in England every year.
2. A reduction in waiting times across community and hospital dental care services.
3. Achievement of national immunisation uptake targets and a reduction in variation in Core20 and PLUS groups.
4. Increase in people accessing community pharmacies and optometrists.
5. Increase in people accessing out-of-hours pharmacy first services.

Immediate priorities (Years 1&2, 2026/27 and 2027/28)

1. Access to dental care

We will review and update our dental commissioning plan by June 2026, to ensure we deliver a year-on-year increase in the number of children and adults accessing

care. This includes urgent care and routine dental care, supporting people's oral health to stabilise and focus on prevention.

This will be achieved by:

- Successful implementation of the national dental contract reforms expected to be in place from April 2026. It is anticipated these new reforms will include a requirement to support the delivery of some new Key Performance Indicators/ outcome measures.
- A robust dental workforce development plan.
- A communications and education plan to support people to maintain good oral health by using effective prevention strategies to reduce the risk of dental diseases.

We will proactively collaborate with providers and the dental market to achieve full deployment of the NHS dental budget into patient care, including dialogue on performance levels, rebasing contracts where needed, procurement targeted at reducing health inequalities and optimum use of non-recurrent resources.

This will be measured through a year-on-year increase in the number of children and adults accessing NHS dental care, especially from Core 20 and Plus groups (target to be defined), and delivery of the ICB share of the additional 700,000 urgent dental appointment target in England every year from 2026/7 to 2028/29.

2. Access to oral health care in the appropriate setting

We will review and update the dental commissioning plan by September 2026, to support the shift from hospital-based care to community and primary care settings, through integrated working across the dental system. This will include the commissioning of local clinical pathways that are responsive to the needs of the population.

This will be measured through the increase in the capacity and utilisation of intermediate care services. These are services which are provided by a clinician outside of hospital who has enhanced skills and experience. In addition, we expect to see a reduction in waiting times across community and hospital dental care services and an improvement in dental workforce recruitment and retention.

Other measures are to be determined and based around the expected improvements further to the new contract reforms; for example, supporting more people to have a protective coating of fluoride varnish applied to their teeth to strengthen them and prevent decay.

3. Access to vaccinations

We will support people to access vaccinations within their communities, leading to improved health outcomes and reduced health inequalities – achieving a reduction in unwarranted variation in access to vaccines, focussing on prioritising health optimisation and prevention.

This will be achieved by delivering vaccinations through Neighbourhood Health Models, successfully establishing Neighbourhood Health Centres across our system to offer and increase uptake in vaccines in identified underserved communities. We will review and update the vaccinations delivery plan by June 2026 to ensure we continue to strengthen access to vaccinations, and reduce unwarranted variation in some areas such as Lowestoft, Thetford, Kings Lynn, and central Ipswich/Norwich.

We will also support the rollout of the HPV vaccination available at community pharmacies for women and young people who missed out on vaccination at school.

We will manage the transfer of commissioning responsibility for vaccinations and immunisations from NHS England to Integrated Care Boards expected from April 2027 and integrate this within our wider vaccination programme.

We will measure achievement through national immunisation uptake targets.

4. Embed a 'Pharmacy First' and 'Optometry (eye care) First' approach.

We will embed a 'Pharmacy First' approach as a core urgent care pathway, reducing pressure on GP practices and Emergency Department services.

This will be achieved through good relationships between general medical practice and community pharmacy. We will expand the integration to wider neighbourhood teams by introducing sustainable 'Peer Ambassador' roles for community pharmacy to strengthen inter-agency working within neighbourhood/place.

We will introduce prescribing-based services into community pharmacies to support access to primary care, medicines optimisation and tackling inequalities. We will expand the role of pharmacy technicians to use Patient Group Directions and introduce independent prescribing from community pharmacists, using Population Heath Management tools to design services.

We will consider future national guidance and contract reform alongside digital integration and an optometry first approach to improve access to urgent eye care services and ensuring same day access for clinically urgent eye conditions. To enable equitable access, we would look to develop clear referral pathways from optometry into ophthalmology and other specialities using advice and guidance principles.

This will be measured through an increase in people able to directly access healthcare and successfully resolve their issues in community pharmacies or optometrists.

5. Primary care access out of hours, at weekends and bank holidays

Where need is identified, we will commission additional primary care to meet demand out-of-hours and over surge periods including bank holidays and weekends. We will also develop enhanced access arrangements for community pharmacy to improve capacity in primary care and to help protect Emergency Departments for the most unwell patients and address crowding in Urgent and Emergency care settings.

This is underpinned by adopting a Pharmacy-First approach. We will use Population Health Management tools to identify inequalities and underserved populations. We will review existing provision and ensure capacity is commissioned to match the health needs. We will commission enhanced access arrangements, co-produced with local Health & Wellbeing Boards. We will support the system's pharmacy workforce strategy to facilitate capacity across organisational/sector boundaries.

This will be measured through and increase community pharmacy capacity during extended hours and bank holidays, and an increase in Pharmacy First service delivery during those hours.

Longer-term priorities (Years 3-5):

We will:

1. Expand the Pharmacy First approach to optimise a walk-in pharmacy first service.
2. Enable appointment booking systems in community pharmacies.
3. Maximise the use of existing primary care estate to include community pharmacy.
4. Support the integration of community pharmacy with the NHS Single Patient Record (SPR).
5. Establish community pharmacies as Acute Respiratory Infection hubs to support NHS winter pressures.

7.5. Specialised Commissioning

Senior Responsible Officer: Managing Director of Specialised Commissioning for the East of England region

Outcome: Improved access to specialised services to improve patient outcomes and provide care closer to peoples' homes.

Outcome measure: Increase timely access to specialised care with measurable improvements in pathway-specific clinical outcomes, demonstrated through reduced waiting times, and increased delivery in appropriate settings.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Renal Services

We will commission additional renal services to address predicted increase in demand for dialysis of at least 5% per annum. For delivery by March 2028, we will work with partners to procure new capacity and work with the Renal Network to increase home dialysis to a minimum of 20%. Our commissioning will be informed by national standards and using data dashboards and toolkits to support best practice.

We will commission appropriate off site renal dialysis capacity in relation to the New Hospital Programme at Queen Elizabeth Hospital Kings Lynn (QEHKL), West Suffolk Hospital (WSH), and James Paget University Hospital (JPUH).

2. East of England Gender Services

In line with the national service speciation, we will engage with local systems to improve ongoing care. This will be achieved by March 2028 by: -

- Placement of GPs with Extended Roles (GPwER) across the region, working to a central service hub.
- Working with the responsible ICB to identify suitable community and/or primary care providers for ongoing prescribing responsibilities, following discharge from the service.
- Liaison with GP Practices on the provision of annual health checks.
- 400 new referrals per year, and deliver at least 1,500 first assessments per year, as well as correlating follow-up appointments.
- Reduced waiting times for adults and CYP.

3. Neuro-Rehabilitation Brain Injury Services

We will work with providers to establish a live dashboard showing where there is available bedded capacity and collaborate with system partners to establish clearer pathways and links to commissioners to facilitate timely rehab in an appropriate setting.

We will commission clinical facing trauma and rehabilitation coordinators in acute hospitals and additional service capacity to ensure equitable geographic coverage.

4. Paediatric Burns Services

To conclude by March 2028, NHS England (National Specialised Commissioning Team) will undertake a full options appraisal for the provision of Paediatric Burns in the London and South-East area, which will cover the medium- and long-term provision.

As an interim measure we will commission a joint, but virtual assessment, from the Paediatric and Neonatal Decision Support and Retrieval Service (PAND)R team for children who require single organ support for longer than the 24 hours, for the period of extended ventilation.

5. Mental Health
    5.1. Reduce reliance on inpatient care

The Specialised Mental Health Provider Collaborative will work to reduce reliance on inpatient admissions, reducing the number of patients being placed in inpatient settings far from home and their families where clinically appropriate.

This will be achieved with the transformation schemes in place, and those planned for implementation, working with local systems to prevent admission where appropriate, and expedite patients considered delayed in terms of discharge. This will be measured by the reduction in occupied bed days, less placements outside of natural clinical flow, and the increase in patients accessing non-in-patient care and treatment.

    5.2. Pathway delivery

Implementation of the NHS England's Children and Young People's Developmental service specification aims to provide better experiences for children, young people and their families and carers, with children and young people receiving equitable care closer to home. This will be achieved by developing more community-based alternatives to hospital admission, with stronger integration between community and specialised services.

We will do this by working closely with Health and Justice on the adult forensic population on expediting transfer to secure services where identified, and remitting back to prison where appropriate, providing advice and guidance to appropriately prevent admission and support their mental health during prison sentence. This will also support 'problem solving in a timelier manner (i.e. clinical disputes; establishing the responsible commissioner).

This will be measured by the number of prisoners referred for access to secure care, the timeframes associated and the numbers of prisoners remitted.

Longer-term priorities (Years 3-5):

1. Renal Services

The Specialised Commissioning Team will work with ICB partners to deliver the national Renal Services Transformation Programme. This advocates a system wide approach where commissioning and provision of renal services is joined up across care settings and promotes a whole patient / whole pathway approach. This will enable ICBs to reshape the patient pathway with greater emphasis on prevention, early identification and treatment of renal disease. It will also make transplantation more accessible.

2. East of England Gender Services

The Specialised Commissioning Team will work with General Practice to improve awareness and understanding of gender care, to reduce unnecessary delays in the provision of medical treatments to individuals and free up clinical time in the commissioned specialised provider.

3. Paediatric Burns Services

Implementation of the recommendation of the options appraisal so that all paediatric burns patients are treated within the London and South-East Burns Network (LSEBN) footprint to national standards at a burns unit co-located with a Paediatric Intensive Care Unit and Paediatric High Dependency Unit facilities.

4. Mental Health

Investing in end-to-end pathways, we will strengthen collaboration with system partners and providers to jointly commission integrated pathways to enable early identification, assessment, and intervention for children, young people and adults.

5. Workforce Redesign

Following a successful pilot, we will look to implement a locally agreed tariff for Trust’s to use to cover the costs of utilising the clinical homecare companies to deliver sub-cut chemotherapy/immunotherapy agents to the patient’s home for self-administration. This will be viable alternative to the patient on monotherapy sub-cut chemotherapy/immunotherapy from having to come into the hospital.

7.6. Health and Work

Senior Responsible Officer: TBC

Outcome: We will introduce best practice models of care which

1. Reduce the risk of people developing preventable health needs which impact their ability to access work.

2. Educate and support employers to be inclusive workplaces and offer personalised multi-agency support packages to people who are economically inactive or struggling to remain in work due to a disability and/or health needs.
3. Offer Children and Young People early identification and support for their health needs to reduce the risk of them becoming a barrier to education, employment or training (see Start Well section).
4. Offer working aged people access timely, high-quality, and integrated employment support delivered in their community which contributes to increased healthy life expectancy and reduces health inequalities.

Outcome measures:

- Halt the rising trend of people experiencing health related economically inactivity (people aged 16 – 66)
- Reduce the proportion of young people (16 – 24) not in education, employment or training
- Increase the healthy life expectancy and healthy working life expectancy of our residents

Local outcome and performance measures will be agreed through the commissioning process, and all national KPIs will be included.

Immediate priorities (Years 1&2 - 2026/27 and 2027/28)

1. Embed Work and Health agenda within all strategically commissioning services

From April 2026 all commissioned services will consider work and health implications within their service models and workforce development through the adoption of the ICB Fit for Work, Fit for Life strategic plan interpreted within all of the above commissioning intentions and specific work and health interventions below.

This will include supporting clinicians to embed the Royal Colleges Consensus Statement 2025 Healthcare Professionals' Consensus Statement for action on health and work - AOMRC and Promoting work as a health outcome: guidance for AHP leaders - GOV.UK within their clinical practice.

We will:

- Provide clinical pathways that have considered how to provide early and rapid intervention for patients who are absent from work or economically inactive (within the context of equality impact assessment).
- Provide staff training resources focused on work as a health outcome and the most common comorbidities seen with people who face barriers to accessing and/or remaining in work to provide brief advice and signposting to system support programmes.

- Create a single access point for information to refer patients to employment and skills support programmes.

Measured by:

- Workforce and Service user feedback
- Percentage of people with health needs who are economically inactive
- Work absence via fit note data
- Referral data from employment and skills providers
- Percentage of people who are assessed during a Work Capability Assessment as having “no work requirements” prior to receiving health assessment and intervention
- Proportion of young people (16 – 24) not in education, employment or training

2. Work Well Partnerships

By 1 November 2026 Work Well Partnerships will be established across Norfolk and Suffolk to enable integrated and holistic early intervention for work, health, and skills. A personalised assessment of the individual’s barriers to employment will be offered, and a multi-agency support package provided to assist:

- People to remain in work
- To manage their health condition to return to work or from sickness absence
- To start work

Measured by:

- Service user feedback
- Percentage of people with health needs who are economically inactive
- Number of fit notes for complete absence from work
- Percentage of people who are assessed during a Work Capability Assessment as having “no work requirements” prior to receiving health assessment and intervention
- Proportion of young people (16 – 24) not in education, employment or training

3. Economic Development

We will work collaboratively with fellow health Anchor organisations, VCFSE, DWP, Local Authorities (MCA in 2027 onwards) and a range of employers to support people with health needs into work and remain in work to reduce inequalities and promote economic development. We will collectively deliver the Get Norfolk and Get Suffolk Working plans and the ICB Fit for Work, Fit for Life strategic plan principles to improve individuals’ health, reduce health inequalities, and address workforce shortages across industries.

Measured by:

- Percentage of people with health needs who are economically inactive
- Number of fit notes for complete absence from work
- Percentage of people who are assessed during a Work Capability Assessment as having “no work requirements”
- Proportion of young people (16 – 24) not in education, employment or training
- Employment and economic inactivity rates of ≤80%
- Disability and gender disparity gaps in employment and economic inactivity
- Skills and employment gaps within economy

Longer-term priorities (Years 3-5)

1. Work and Health is an evolving area of practice nationally and internationally. We will continuously review the evidence base and population health to update our strategic plan accordingly. This will enable the five-year plan to remain current and agile to the health and economic needs of our communities. We will:
   - Analyse the outcomes of service users who have been supported by work and health programmes to inform the strategic commissioning of both primary and secondary prevention interventions, aimed at reducing need and demand post-retirement.
   - Review the needs of people with respiratory, women’s health, and neurological conditions who are in the “middle” cohort of economically inactive people due to health conditions and receivers of fit notes to establish is targeted programmes would support their needs better.
   - Work in collaboration with public health to establish the needs of people who permanently work at night, to reduce their health inequalities and improve their healthy work life expectancy.

7.7. Health Protection

Senior Responsible Officer: Executive Nursing Director

Outcomes: Community IPC support for health commissioned providers will reduce healthcare associated infections in Norfolk and Suffolk. Effective IPC measures improve patient outcomes, prevent admissions from sepsis and directly impact on system flow.

Reduce impact of Tuberculosis (TB) on populations in Norfolk and Suffolk by ensuring populations at risk of TB have access to resilient, high quality TB services.

Outcome measures:

Work towards reductions in community MRSA, E. coli and CDI cases with the aim of preventing increases in gram negative bloodstream infections from 2019-2020

baseline. Reduced rates of infection in the community will reduce prolonged hospital admissions and support system flow.

Strengthened TB services available for the diagnosis and management of TB in the community which are sustainable in the face of rising cases and high levels of patient complexity. Effective management of TB in the community will reduce TB related admissions and support system flow, reduce potential for drug resistant and multi-drug-resistant strains of TB and the associated costs of treating such cases.

Immediate priorities (Years 1&2, 2026/27 and 2027/28):

1. Infection Prevention and Control (IPC)

Reinforce community IPC support for health commissioned services in Central and West Norfolk and develop implement a community IPC resource for health commissioned services in Suffolk.

These should:

- Reduce healthcare associated infection rates among patients most at risk.
- Strengthen community-based care and improve patient safety.

2. Tuberculosis (TB) services

There is a need to stabilise Tuberculosis (TB) services in Norfolk and Waveney, in particular to support containment of the Lowestoft TB cluster, and to reinforce TB services in Suffolk (provided by WSFT and ESNEFT), and work towards the mobilisation of the community TB service in Suffolk.

These actions should:

- Support better patient health outcomes (preventable deaths) and cost saving benefits to the NHS in the long term because less transmission equates to fewer cases.
- Reduce drug resistant TB and facilitate rapid transition from acute to community healthcare and provision of supported, ongoing, community treatment.
- Reduce health inequalities in at-risk populations.
- Help close the current gap in TB provision by creating more resilience within the existing teams.

Longer-term priorities (Years 3-5):

We will focus on the following:

1. Infection Prevention and Control (IPC) and Health Protection

There is an opportunity to align and link available IPC and Health Protection resource to population health data, which would allow focus on areas within Norfolk

and Suffolk with high rates of infection and deprivation. Longer-term aspirations represent the development of a resilient provider-led health and local authority, multi-agency partnership model for IPC and Health Protection (akin to the Safeguarding partnership). This partnership would include all providers (acutes and community), and the local authority, district and borough councils.

The expected community services review, (refer to the cross-cutting Community Commissioning Intention), could be a catalyst for step change and facilitate the development of a comprehensive and resilient model for IPC and Health Protection across Norfolk and Suffolk.

2. Tuberculosis (TB) services

Longer-term aspirations for TB services in Norfolk and Suffolk are the development of a TB partnership model that delivers an integrated and responsive TB service which reflects the epidemiology and population health data around social risk factors for TB across both counties. The service would work collaboratively to improve the overall resilience and effectiveness of TB services and focus on areas within Norfolk and Suffolk with high rates of TB and social risk factors for TB.

8. Glossary

Term / acronym	Definition
A&G	Advice & Guidance (a mechanism for primary care to seek specialist advice—often via e-RS—without necessarily making a formal referral, supporting optimal referral and outpatient models).
ACCEND	Aspirant Cancer Career and Education Development Programme (a programme supporting cancer workforce development and career pathways).
CDC	Community Diagnostic Centre (a model to increase diagnostic capacity and provide tests closer to home, supporting faster access to diagnosis).
CMS	Care Management Service (a service model focused on proactive, coordinated care for people with complex needs and high service use, typically delivered through a dedicated care coordinator and multidisciplinary support).
Core20PLUS5	An NHS England approach to addressing health inequalities, focusing on the most deprived 20% of the population ("Core20"), plus additional local population groups ("PLUS"), and 5 clinical areas of focus ("5").
e-RS	NHS e-Referral Service (the national system used to create, manage and book referrals into specialist care, including Advice & Guidance functionality).
GIRFT	Get It Right First Time (a national programme that uses data and clinical review to identify unwarranted variation and improve quality and efficiency).
ICB	Integrated Care Board (the NHS statutory organisation responsible for planning and commissioning NHS services across an Integrated Care System).
ICS	Integrated Care System (a partnership of NHS organisations and local authorities that plan and deliver joined-up health and care services for a population).
ICSS	Integrated Community Stroke Service (a model of community-based stroke rehabilitation and support, intended to provide consistent access and outcomes across geographies).
MCCR	My Care Choices Register (a digital register used to record advance care planning information, including preferences and care plans, to support coordination—particularly for end-of-life care).
MDT	Multidisciplinary team

MNVP	Maternity and Neonatal Voices Partnership (a mechanism to ensure service users and communities are involved in shaping maternity and neonatal services).
MSSP	Maternity Safety Support Programme (a support and improvement programme for maternity services; referenced in the document as the former name of the Maternity and Neonatal Intensive Support Team).
Neighbourhood Health Model	A model of care that organises services around neighbourhoods to deliver integrated, proactive and personalised care (often through multidisciplinary teams), with a shift from hospital-based care to community-based support.
New Hospital Programme	A national programme to build and modernise hospital infrastructure; referenced in the document as a key context/constraint for community and neighbourhood service planning.
NHSE / NHS England	NHS England (the national body responsible for leading the NHS in England, including setting priorities and commissioning some specialised services).
NNHIP	National Neighbourhood Health Implementation Programme (a national programme to accelerate delivery of neighbourhood health services and test-and-learn approaches in selected sites).
PHM	Population Health Management (using linked data and intelligence to understand population needs, segment risk, target interventions and reduce inequalities).
PIFU	Patient Initiated Follow Up (a model where follow-up is initiated by the patient when needed, rather than routine scheduled follow-up appointments).
PREMs	Patient Reported Experience Measures (patient feedback about their experience of care and services).
PROMs	Patient Reported Outcome Measures (patient-reported outcomes, such as symptoms or function, usually collected via questionnaires).
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment (a process/form to record clinical recommendations for emergency care and treatment, reflecting patient preferences).
RTT	Referral to Treatment (the waiting time measure from referral to the start of consultant-led treatment; commonly referenced as the 18-week RTT standard).

SPoA	Single Point of Access (a single route for referrals/triage into a service, intended to streamline access, ensure appropriate routing and reduce variation).
SSNAP	Sentinel Stroke National Audit Programme (the national audit for stroke care, used to measure and benchmark stroke service performance).
UEC	Urgent and Emergency Care (services that provide care for urgent or emergency health needs, including urgent treatment centres, NHS 111 and emergency departments).
VCFSE	Voluntary, Community, Faith and Social Enterprise (organisations that are not-for-profit and provide community-based support and services).
WMCOS	Weight Management and Complex Obesity Service (a service that provides structured support for people with severe overweight/obesity, potentially including lifestyle interventions and pathways into specialist care such as bariatric services).