NHS
Norfolk and Suffolk
Integrated Care Board

Population Health Improvement Plan (PHIP) 2026/27 to 2030/31

March 2026 v1.0

Contents

1. Introduction

The Population Health Improvement Plan (PHIP) sets out how the Norfolk and Suffolk Integrated Care Board (ICB) will deliver its five-year strategic priorities and meet the health and care needs of the local population. It outlines the ICB's commissioning intentions in line with the priorities in its Population Health and Commissioning Strategy.

Both the Strategy and the PHIP are grounded in the Integrated Needs Assessment (INA), which summarises population health outcomes, identifies major local health challenges, and highlights effective interventions. The Strategy translates the INA's insights into a clear vision for improving outcomes and ensuring equitable access, defining how the ICB will prioritise and allocate NHS resources and its role as a strategic commissioner.

The PHIP details how this strategic direction will be delivered, setting commissioning intentions for 2026/27 to 2030/31. It provides clarity for providers on resource allocation and expected outcomes, balancing immediate operational pressures with longer-term aims to improve population health.

Developed in the context of national direction, including the NHS 10-Year Health Plan, and current operational priorities, the INA, Strategy, and PHIP together provide a clear line of sight from population need to strategic intent, commissioning, and delivery.

2. How we will work – our enablers of strategic commissioning

The NHS Strategic Commissioning Framework sets out the key enablers for effective strategic commissioning, including:

- Clinical and care professional leadership to ensure population health expertise informs all commissioning and decision-making.
- Meaningful user involvement so services are co-designed with communities, especially underserved groups, from planning to review.
- Digital capability to harness technology and innovation for better outcomes, patient experience and integrated working.
- Healthcare intelligence to provide the analytical foundation for decision-making, place-based planning and system transformation.
- Estates that support service integration and ensure care is delivered in the right place.
- Procurement expertise to secure high-quality, value-for-money services within regulatory frameworks.
- Research and Innovation (R&I) to meet statutory duties on promoting research, evidence use and innovation in care.

- Workforce development to build a sustainable, agile workforce aligned with evolving population needs.

We will strengthen ICB leadership, skills and organisational capability so all functions contribute effectively to strategic commissioning. This includes developing competencies in:

- System leadership for population health, enabling collaborative working across health, care, VCFSE and local government.
- High-quality data and analytics to support insight-led population health management and innovation.
- Health economics and provider performance intelligence to inform resource allocation, market management and evaluation.
- Partnership with local government for joint planning, co-commissioning and action on wider determinants of health at neighbourhood level.

The following sections set out how the ICB will deliver these enabling functions.

2.1. Clinical leadership

Clinical leadership is central to the PHIP, ensuring commissioning reflects local needs and is grounded in credible clinical insight. Clinical Stewards will translate population health data into targeted action across Norfolk and Suffolk, bridging strategy and frontline delivery. By combining analysis of outcomes, variation, inequalities and population segments with insights from patients, communities and clinicians, they will help ensure priorities are evidence-based and focused on reducing inequalities.

Clinical Stewards will also provide expert oversight of service quality, value for money and system integration, offering constructive challenge to ensure services are robust and person-centred. Their leadership will support pathway redesign, stronger prevention and early intervention, better integration with social care, and the effective use of digital technologies to improve access and efficiency. This clinically led approach promotes earlier intervention, more care outside hospital, smarter digital use and closer partnership working on wider determinants of health.

Strong clinical leadership also underpins effective clinical governance. By monitoring outcomes, identifying risks and promoting continuous improvement, Clinical Stewards help ensure commissioning remains responsive to changing population needs. Their leadership is key to strategic commissioning that improves health outcomes and reduces inequalities across Norfolk and Suffolk.

2.2. Coproduction and Engagement

This approach strengthens transparency, trust and engagement by ensuring the ICB makes decisions with people who use services. We aim to embed lived experience, community insight and voluntary, community, faith and social care (VCFSE) expertise throughout the planning, design, delivery and review of services, enabling the commissioning of fair, effective and transparent care.

We will coproduce an evidence-based Partnerships, People and Communities Policy and continue developing a systemwide coproduction methodology. This will include:

- Face to face and digital participation.
- Collection of qualitative insights (e.g., Community Voices).
- Codesign and codelivery of engagement tools.
- Use of the Care Quality Commission (CQC) framework on engaging communities to address inequalities.
- Oversight from VCFSE and People and Communities Assemblies.
- Large scale coproduction approaches such as the 45-degree Insight and Oversight Group model.

These methods will support people, communities and VCFSE organisations to act as equal partners with the ICB, enabled through clear governance, fair remuneration and a shared commitment to reducing health inequalities.

Every ICB directorate will be supported to embed coproduction and engagement as a “golden thread” throughout commissioning cycles, giving commissioners a fuller understanding of lived experience.

Aligned to the ICB’s four strategic ambitions, coproduction and engagement will:

1. Sickness to prevention: Involve people early to design proactive, preventive care and enable self-management.

2. Care closer to home: Support neighbourhoods and providers to co-produce accessible, inclusive local care models.

3. Analogue to digital: Co-design digital tools and address barriers to access and confidence.

4. Social and economic development: Bring partners together as equals to address wider determinants of health and unlock community potential.

Across all ambitions, we will champion strong community voice and genuine partnership, ensuring the PHIP delivers what matters most to local people.

2.3. Digital

Digital supports the design and delivery of modern services that are accessible, safe, and responsive to the needs of our population. This includes the development and implementation of digital infrastructure, platforms for data sharing, care solutions and tools that empower people to manage their own health.

The ICB Digital function provides system-wide leadership for digital strategy, architecture, assurance and improvement. It sets clear digital direction, defines standards, and ensures safe, resilient and high-quality digital services across the system through strong partnerships with providers. Alongside its strategic role, the function maintains a small internal delivery and enablement capability to support ICB-led digital programmes, the safe adoption of automation and artificial intelligence (AI), digital skills development, and responsive expertise for both internal teams and frontline services

The function is made up of four elements:

- Digital Strategy and Development: Focuses on digital strategy, innovation, transformation delivery, and workforce capability. Its purpose is to drive forward the digital transformation agenda, build digital capability, and ensure alignment with system priorities.
- Digital Partnerships and Assurance: Combines digital contracting, partnerships, assurance, benefits management, and cyber resilience. Its purpose is to strengthen governance and performance management of digital delivery, ensuring value and accountability across all digital investments.
- Technical, Cyber and Architecture: Focuses on system architecture, technical design, interoperability, and assurance of data integrity. Its purpose is to maintain technical standards and alignment, ensuring safe, secure, and interoperable systems across the region.
- Neighbourhood and Digital Primary Care Enablement: Focuses on digital adoption, optimisation and frontline enablement across neighbourhood teams, PCNs and primary care providers. Its purpose is to strengthen digital enablement in primary care and neighbourhood teams by driving safe, sustainable adoption of digital tools and workflows.

By embedding digital into the commissioning cycle, the ICB can drive innovation, reduce inequalities, and create a more connected and resilient health and care system.

2.4. Intelligence

Our intelligence function will build a deep, dynamic understanding of the local population using joined-up, person-level data and intelligence. This includes linking health and care datasets, integration of public health and healthcare insights, measuring activity, performance, and outcomes against plans and strategies, and

advanced analytics for forecasting and modelling. The function will support market insight analysis to assess productivity and resource utilisation, health economic insights and evaluation analysis to assess service impact patient experience.

Strategic commissioning will be enabled with support from three teams:

- Data Engineering: responsible for building and maintaining the data architecture, engineering and cloud infrastructure that underpins the ICB's analytical capabilities.
- Commissioning Analytics: responsible for producing high-quality analysis and insights that inform strategic planning, commissioning, market management and performance improvement.
- Population Health Insight: responsible for generating insights that support proactive, preventative, and targeted approaches to improving population health. An economics, evidence and evaluation team will support evidence informed commissioning decisions.

The following resources will be available to support the strategic commissioning function:

- Norfolk and Suffolk Data Hub: a cloud-based data platform designed for fast, flexible, and scalable analytics.
- Norfolk and Suffolk Insight Hub: An online hub that includes a report directory to give commissioners access to timely, dynamic data visualisations, and an analyst hub that brings into one place resources for local data professionals.
- Norfolk and Suffolk Intelligence Function: The Population Health and Insight team will partner with Local Authority analysts to form an ICB-LA integrated Intelligence Function. This will focus on specialist analytical projects to support transformation and advanced analytics projects such as statistical forecasting and demand modelling.

2.5. Estates and Sustainability

The estates function provides strategic oversight of all NHS funded premises, ensuring the local estate is used effectively to support multidisciplinary teams and integrated care.

Working with NHS Trusts, local authorities (including One Public Estate), and voluntary and private sector partners, we will develop estate strategies that align infrastructure planning with population health needs and the Population Health and Commissioning Strategy. By maximising utilisation, attracting investment and ensuring leases and capital decisions reflect long term priorities, the estates function supports system wide financial sustainability.

Alongside commissioners, the team will map population needs, demand and existing capacity to target investment where it delivers the greatest improvements in access, outcomes and equity. This will enable modern, flexible facilities that support integrated neighbourhood teams and place-based models of care, including Neighbourhood Health Centres and Hubs.

The estates and digital teams will jointly deliver digitally enabled buildings that help staff and patients adopt new technologies and support programmes such as the New Hospital Programme.

The ICB's strategic commissioning role is perfectly positioned to join health and sustainability issues together and deliver sustainable value. The ICB's Green Plans set out how we will drive change to address health inequalities, environmental improvements and use resources sustainably. This will be approached through the sustainable care principles lens which is about prevention, patient self-care and/or empowerment, being lean and using environmentally friendly and lower carbon alternatives.

The ICB will aim to deliver what it describes as 'three up, three down' outcomes which reduce carbon emissions, air pollution, and waste while increasing/improving nature (including green spaces and water), climate resilience, and social value (to tackle inequalities). We will achieve this through delivering our Green Plans underpinned by our impact assessment process, training, partnership work and engagement. This approach aims to maximise opportunities to reduce emissions and improve population health when planning and commissioning NHS services.

2.6. Procurement

The procurement function works collaboratively to bring together teams and individuals, including services users, to review potential provider capacity, capability and service proposals.

Its core purpose is to:

- Propose and deliver flexible, innovative and proportionate processes using the Provider Selection Regime (PSR) and Procurement Act 2023 to select providers.
- Use market management and procurement mechanisms to focus on quality, value for money and delivery of improved outcomes.

The team will support with the delivery of the PHIP and strategic commissioning by:

- Ensuring procurement processes follow best practice and innovate through learning and research.
- Continuing to support co-production of services with the involvement of service users and and/or their representatives in procurement processes.

- Developing a better understanding of existing and potential provider markets to ensure all options are understood and available to commissioners when reviewing existing and future provision.
- Ensuring procurement strategies consider the entire range of potential providers, including new entrants, collaborations and innovation.
- Ensuring processes include requirements for providers to support a net zero NHS, building resilient communities, addressing wider determinants of health and reducing inequalities.
- Delivering training and support to internal subject matter experts and external organisations to better understand procurement and how to be involved successfully from both a potential provider and commissioner perspective.
- Further embedding a digital process for procurement which improves access and reduces administrative burdens.

2.7. Research and Innovation

Our research and innovation (R&I) function enables research to take place closer to where people live, supporting studies in primary care, care homes, schools and prisons, and strengthening community involvement through research hubs. Working with VCFSE organisations, regional research infrastructure and academic partners, we expand opportunities for local people to participate in research. Early engagement between researchers and communities ensures studies are inclusive, reflect local needs and generate evidence commissioners can confidently use.

A core role of R&I is connecting researchers and commissioners at the design stage of both research and services. This ensures research addresses local priorities and helps commissioners draw on the latest evidence and academic expertise in areas such as women's health, obesity, addiction and health inequalities. Through this collaboration, we identify knowledge gaps that require further study and support long term planning. The ICB already hosts £19 million of National Institute for Health and Care Research (NIHR) funded research with university partners, and we will continue supporting new funding bids aligned to local needs, including dementia, multimorbidity prevention and medicines optimisation.

Innovation will be translated into commissioning impact through a structured approach: developing an innovation pipeline, strengthening industry partnerships, supporting adoption in provider organisations, evaluating real world impact and building capability through training and shared learning. We will prioritise innovations that support prevention and care closer to home, underpinned by strong needs analysis, horizon scanning and coproduced pathways with communities, clinicians and partners. Digital and data driven technologies will be harnessed to improve

efficiency, access and outcomes, with a focus on reducing inequalities and strengthening the local innovation ecosystem.

Systemwide collaboration will ensure shared innovation priorities, aligned investment and coordinated adoption. Partnerships with Health Innovation East, NHS England InSites and the National Innovation Accelerator will support rapid scaling of proven solutions.

2.8. Workforce

The workforce function supports partners to build a sustainable, skilled and agile workforce that can meet changing population needs. This includes addressing shortages in high-risk areas and strengthening compassionate, agile leadership. We will promote a positive, inclusive culture where staff feel valued, safe, healthy and supported to learn and progress.

The team enables the ICB to meet its statutory duty to promote education, training and career development across the health and care system. It provides expertise and system intelligence to support an integrated workforce delivering care in the right place, at the right time. Working with health, social care, local government and education partners, the team will also help establish the system as an “Anchor System,” supporting local communities and economic growth.

Over the next 5 years, we will build a sustainable workforce pipeline by expanding training routes and apprenticeships that attract diverse talent and reflect community needs. We will continue improving staff experience through flexible working, wellbeing support and strong opportunities for development. A compassionate, inclusive culture with equitable opportunities, diverse leadership and reduced bullying and harassment will remain central.

We will work with training hubs and primary care to underpin neighbourhood hubs and community-based services. Workforce redesign will support new models of care, enabling staff to work at the top of their licence and improving productivity. Collaboration across health, care and the VCFSE workforce will be strengthened through a Workforce Collaborative Forum. Data-driven workforce planning, robust impact assessments and targeted recruitment, including apprenticeships, will ensure the right skills are available in the right places while supporting wider social and economic goals.

3. Approach to our commissioning intentions

Our commissioning intentions set out how healthcare resources will be allocated and what outcomes are expected. They translate the ICB’s Population Health and

Commissioning Strategy into tangible, evidence-based actions that improve health outcomes, reduce inequalities, and are value for money.

The commissioning intentions provide clarity for providers, guide service development and support financial planning and resource allocation, while promoting transparency and collaboration across the local system, including with the public. They are the core content of the PHIP, ensuring that strategic ambitions are turned into practical, measurable improvements.

Our commissioning intentions aim to deliver the ICB's three priority outcomes - improve healthy life expectancy for all, reduce health inequalities, improve access to consistently high-quality services. Our commissioning intentions are also aligned with our four cross-cutting ambitions – sickness to prevention, care closer to home, analogue to digital, and social and economic development. Our approach to reducing inequalities and prevention is described here.

We have organised our commissioning intentions into a life course approach – the Live Well framework. Within this, there are six Clinical Domains, each with a small number of Clinical Priorities. Each Clinical Priority focuses on the achievement of health outcomes. Some cross-cutting themes span all Clinical Domains.

Other than Start Well, which focusses on conception to 5 years old, the Live Well Clinical Domains encompass commissioning of services for all ages. For policies relating to special educational needs and disability (SEND) services across all domains, Children and Young People refers to the age group 0-25 years old.

3.1. Reducing health inequalities

One of the strategic outcomes in the Strategy is to reduce health inequalities and the ICB is serious about this commitment.

The PHIP sets out a robust plan to reduce health inequalities in line with statutory requirements. The plan builds on the local 10-year Health Inequalities Strategic Framework for Action, aligning with national policy drivers such as the Core20PLUS5 framework which targets the most deprived communities and high-risk groups.

Commissioners will:

- Adopt proportionate universalism, ensuring services are available to all but with support scaled to disadvantage.
- Engage communities to ensure lived experience and co-production inform decisions.
- Develop health inequalities impact assessments for all commissioning proposals.
- Embed clear outcomes, data requirements, and cultural competence in service specifications and contracts.

- Strengthen procurement scoring for health inequalities, prevention, population health management, and social value.

Operationalising these commitments means:

- Ensuring all commissioning intentions are reflective of the commitment to tackle health inequalities at every opportunity.
- Embedding oversight of inequalities metrics into governance arrangements and contractual oversight.
- Requiring programmes to evidence how they are “closing the gap” for Core20PLUS populations.
- Publishing annual Health Inequalities Statements, analysing variation in access, experience, and outcomes, and demonstrating actions taken to improve data quality and inform commissioning.

Commissioners must:

- Use population segmentation and risk stratification to tailor interventions.
- Collect, analyse, and publish disaggregated data (by deprivation, ethnicity, age, sex, disability, inclusion health status) to identify and address unwarranted variation.
- Set annual gap-closure targets and include equity key performance indicators (KPIs) in all contracts.
- Ensure digital inclusion, cultural competence, and reasonable adjustments are standard practice.

By embedding these principles and standard clauses across all commissioning intentions, commissioners can drive measurable reductions in health inequalities, ensuring equitable access, experience, and outcomes for all communities.

3.2. Prevention

Delivering our strategic outcomes depends on achieving our ambition of moving from sickness to prevention. In the short term, our priority is to prevent growth in avoidable hospital admissions particularly through urgent and emergency care, by improving productivity and shifting resources into community provision, ensuring timely access to care closer to home. However, prevention opportunities exist in every clinical and care pathway and in the longer-term we aim to improve population health across all six clinical domains. Embedding prevention across everything we commission and working with providers to deliver preventative interventions will mean fewer people die from preventable causes, health inequalities are reduced, and everyone has the chance to live a long, healthy life.

Our commissioning intentions prioritise initiatives that prolong life and aim to prevent complications in established disease (tertiary prevention) and earlier identification and intervention to reduce the impact of disease that has already occurred (secondary prevention). We have put significant emphasis on addressing risk factors that have the greatest impact on health, including smoking and drug and alcohol abuse. We also focus our prevention efforts in areas known to have greatest impact on health inequalities which are maternity, mental health, respiratory disease, cardiovascular disease, cancer, vaccination, smoking cessation and children and young people's services. Our broader prevention aims to prevent illness at the whole population level (primary prevention) will be achieved through our work to support system partners. We will:

- Work with system partners, particularly Public Health teams, to tackle health behaviours: i.e. support people to stop smoking, eat healthily, reduce alcohol harm, and increase physical activity. We will commission high-value NHS services that enhance existing offers. As broad themes that influence many aspects of health, these are foundational to delivering improvements across all our Clinical Priority outcomes.
- Work with healthcare providers to maximise every patient interaction: Use contacts across all settings to deliver brief interventions and refer to community-based support services.
- Improve screening and immunisation: Increase uptake of cancer screening and routine vaccinations, with targeted outreach in populations where take up is lowest.
- Detect risk early and intervene: Use population health management and digital tools to identify risk factors and early-stage disease and take action to prevent progression and complications.

We will take an evidence-led approach on prevention priorities. For secondary prevention, we will focus on early identification and optimisation of treatment pathways for priority conditions, as identified in the Integrated Needs Assessment:

- Cardiovascular disease (hypertension, cholesterol, atrial fibrillation)
- Cancer
- Diabetes
- Dementia
- Frailty

We will also embed approaches to prevent, identify, and treat infections early across all settings. We will work with local authorities, the VCFSE, and communities to address the wider determinants of health such as housing, active travel, access to

green spaces, good health at work, and place-based initiatives that create healthier environments.

We will make sure we have the healthcare intelligence and digital tools, including shared care records, that enable commissioned services to follow a population health management approach including targeting of interventions, monitoring of activity, and evaluating impact. Health coaches, social prescribers, and community navigators will all play a key role in delivering prevention at scale.

We will measure progress in achieving our outcomes and we will report on progress in reducing health inequalities. We will shift resources from reactive care to prevention over time, ensuring sustainable delivery and improved outcomes.

The second part of our PHIP describes our Commissioning Intentions in detail, reflecting our three Outcomes and four Ambitions, organised into our six priority clinical domains.

4. Summary of commissioning intentions for 2026/27 - 2030/31

4.1. Start Well

4.1.1. Perinatal

Perinatal Outcome:

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

Outcomes Measures:

- Smoking in pregnancy below 6% (2026/27) and below 5% (from April 2027)
- Low birth weight and preterm birth rates below 6%
- Neonatal deaths <1.63 per 1,000 births

Immediate priorities:

- By March 2027, refresh acute and maternity contracts and service specifications, embedding national maternity and neonatal findings and strengthening outcome-based assurance.
- From April 2027, delivery of national care bundles, improved equity reporting, lower smoking in pregnancy rates, and better postnatal discharge and care.
- In 2026/27, commission a Commission Maternity and Neonatal Voices Partnership (MNVP): across Norfolk and Suffolk to ensure community representation, subject to business case approval.
- By March 2028, ensure providers implement BAPM-aligned neonatal outreach services to support families' transition from hospital to home, subject to funding.

Longer term priorities:

- Establish Perinatal Quality and Safety Board: By April 2028, set up a Norfolk and Suffolk board to oversee compliance with contracts, service user needs, and national maternity and neonatal requirements.
- From April 2028, ensure all local maternity and neonatal providers have exited the National Maternity and Neonatal Intensive Support Team programme and can demonstrate sustained improvement.

4.1.2. Early Years

Early Years Outcome:

- All children aged 0–5 have the best possible start in life, supported by integrated, high-quality health and early-years services.

Outcome Measures:

- Increased early identification of needs.
- Progress towards 75% achieving Good Level of Development (GLD).

Immediate priorities:

- Improve early identification and case finding: By 2027/28, work with partners to proactively identify families with children aged 0–5 needing targeted support, reducing inequalities through data-led, multi-agency approaches and coordinated delivery via Family Hubs and Families First.
- Strengthen early intervention for development: By 2027/28, jointly commission integrated pathways for children 0–5 with developmental delays, SEND or additional needs, reducing waiting times, improving early outcomes, and increasing the proportion achieving a good level of development.
- Enhance perinatal mental health and parent-infant support: By 2027/28, commission an integrated perinatal mental health and parent-infant relationship offer across Norfolk and Suffolk, improving equitable access to evidence-based support and meeting national access and outcomes targets.

Longer term priorities:

- Develop integrated neighbourhood MDTs: By 2030, establish multi-agency neighbourhood teams across Norfolk and Suffolk with clear referral pathways to provide coordinated, whole-family support for families with children aged 0–5, measured by full coverage across all family hub localities and neighbourhood footprints.

4.2. Feel Well

4.2.1. Mental Health and Wellbeing

Mental Health and Wellbeing Outcome:

- Timely, high-quality and integrated mental health support promoting wellbeing and reducing inequalities.

Outcome Measures:

- Reduce low wellbeing scores (life satisfaction, anxiety).
- Reduce premature mortality due to severe mental illness (SMI).
- Reduce emergency department (ED) attendances and admissions for SMI.

Immediate priorities:

- Recommission mental health crisis pathways: By April 2027, review and recommission crisis and alternative mental health services to ensure timely, consistent and appropriate care, alongside completing a needs assessment for Mental Health Assessment Centre(s) across Norfolk and Suffolk.
- Adult specialist placements: By April 2027, review commissioning of specialist mental health placements to understand need, and by April 2028 implement a single, unified model across Norfolk and Suffolk to deliver appropriate care closer to home.
- Expand MHSTs in schools: Expand Mental Health Support Teams across Norfolk and Suffolk schools and colleges to improve access to early intervention and prevention, with links to Personality Disorder and Assertive Outreach support where appropriate.
- Strengthen community mental health models: During 2026–28, expand neighbourhood-based mental health services to embed parity of esteem, and by March 2028 review and remodel 0–25 years community provision to ensure timely, inclusive and outcome-focused support.

Longer term priorities:

- Mental Health Strategy & Commissioning: Implement the Five-Year Norfolk and Suffolk Mental Health Strategy (from April 2026) to strengthen governance, reduce inequalities, improve SMI life expectancy, and shift funding toward early intervention and VCFSE-led prevention by 2030/31.

4.2.2. Trauma and Abuse

Trauma and Abuse Outcome:

- Equitable access to trauma-informed and person-centred support for victims of domestic/sexual abuse.

Outcome Measures:

- Increase referrals from healthcare.
- Evidence of person-centred assessments.
- Reduced re-traumatisation.
- Improved safety and wellbeing.
- Reduced crisis presentations.

Immediate priorities:

- Increase referrals to sexual violence and domestic abuse services: By April 2028, boost healthcare-initiated referrals to support services for earlier access to interventions, working with partners and measuring uptake and improvements in service-user wellbeing.
- Early support for children affected by trauma/abuse: By April 2027, commission flexible, needs-led services for children and young people affected by trauma or abuse, ensuring safety, belief, and ongoing support, measured by referral numbers and reported wellbeing improvements.

Longer term priorities:

- Public health approach to serious violence: Use evidence-based, trauma-informed strategies to commission effective support services for high-risk and deprived communities.
- Integrated commissioning of sexual violence services: Work with public sector and VCFSE partners to consolidate and integrate services across Norfolk and Suffolk, targeting inequalities for high-risk groups using PHM data.

4.3. Be Well

4.3.1. Learning Disabilities and Autism (LD&A)

Learning Disabilities and Autism (LD&A) Outcome:

- People with LD&A experience improved health, wellbeing, and health outcomes.

Outcome Measures:

- Reduction in preventable mortality.

Immediate priorities:

- Reduce inpatient reliance: Expand community and crisis support for people with learning disabilities and autism to reduce avoidable hospital stays, targeting a 10% year-on-year reduction in inpatient care by 2027/28.
- Strengthen inpatient oversight: Ensure 100% of adult patients have 12-point discharge plans and stays align with treatment goals, supporting timely, safe transitions and improved outcomes, monitored quarterly.

- Strengthen case management: Ensure all at-risk individuals have up-to-date Care (Education) and Treatment Reviews and are recorded on Dynamic Support Registers, reducing avoidable admissions through improved governance and cross-agency coordination.
- Annual health checks: By 2027/28, 85% of people with learning disabilities will receive an annual health check with a Health Action Plan, improving preventative care and physical health outcomes.
- Mandatory learning disability and autism training: Ensure NHS staff complete role-appropriate training (target 60% by 2027/28) to improve capability in meeting the needs of people with learning disabilities and autism.

Longer term priorities:

- Develop community crisis support: Build comprehensive community models for enhanced support and crisis response.
- Co-produce services: Involve people with lived experience, families, and carers in commissioning and service design.
- Integrate pathways: Embed multidisciplinary pathways across health, social care, and voluntary sectors.
- Reduce inequalities & mortality: Achieve sustained reductions in health inequalities and premature deaths.

4.3.2. Health Choices and Behaviours: Weight Management

Healthy Choices and Behaviours: Weight Management Outcome:

- Improve obesity-related health outcomes and increase equitable access to physical activity.

Outcome Measures:

- 80% of weight management and complex obesity service (WMCOS) completers lose weight by 2028.
- Fewer children and young people (CYP) requiring specialist weight services.
- Increased weight-loss success in Core20PLUS5 groups.

Immediate priorities:

- Mobilise WMCOS: Launch a Single Point of Access (SPoA) by August 2026 for adults with severe obesity, ensuring timely, equitable access, including SMI/LD patients, and expand to all ages by December 2028.
- Develop obesity services for children and youth: Provide evidence-based interventions with smooth transition to adult services by December 2027.
- Maximise programme uptake: Target 6,000 patients/year, using proactive case finding and equity-focused approaches for Core20PLUS5 communities.

- Strengthen data, surgery, and activity alignment: Establish robust outcome monitoring, increase bariatric surgery capacity by December 2026, and align Active NoW and Suffolk Feel Good programmes by March 2027.

Longer term priorities:

- Scale and integrate obesity and activity pathways: From 2028, expand accessible services, embed prevention and long-term condition strategies, strengthen community partnerships, monitor outcomes, support research, and ensure equity for Core20PLUS5 communities.

4.3.3. Healthy Choices and Behaviours: Tobacco and Alcohol Care

Healthy Choices and Behaviours: Tobacco and Alcohol Care Outcome:

- Reduce smoking and alcohol-related harm.

Outcome Measures:

- 75% inpatient quit attempts supported by 2028.

Immediate priorities:

- Expand tobacco dependency support: From 2026, strengthen inpatient, mental health, and community interventions, targeting high-risk and Core20PLUS5 groups, including emergency department support.
- Review access and treatments: In 2026, assess availability of pharmacotherapy, nicotine replacement, digital tools, and incentive schemes across NHS pathways.
- Monitor equity and outcomes: In 2026/27, collect demographic data to ensure equitable access and review alcohol dependency support across services.
- Increase uptake by 2028: Improve participation in tobacco dependency reduction for inpatient, mental health, and maternity services, reducing Core20PLUS5 disparities.

Longer term priorities:

- Shift to prevention: Advance tobacco and alcohol dependence support, focusing on prevention and population-level interventions in line with 10-year ambitions.

4.3.4. Healthy Choices and Behaviours: Cardiovascular Disease (CVD) (Secondary Prevention)

Healthy Choices and Behaviours: Cardiovascular Disease (CVD) (Secondary Prevention) Outcome:

- Reduce premature mortality and unwarranted variation in CVD outcomes.

Outcome Measures:

- 80% blood pressure (BP) control.
- 65% optimal lipid therapy.
- 95% anticoagulation in atrial fibrillation (AF).
- 5% reduction in stroke/myocardial infarction (MI) admissions.

Immediate priorities:

- Expand BP checks and NHS Health Checks: By March 2027, implement systematic blood pressure screening across GP, community, workplace, and pharmacy settings, boosting early detection and Health Check uptake.
- Digital tools and standardised pathways: Roll out ABC risk assessment tools, standardise hypertension and lipid care pathways, and provide clinician training to ensure consistent care and shared decision-making.
- Target Core20PLUS5 populations: Use tailored materials, community engagement, and partnerships to reduce inequities in outcomes, access, and experience.
- Integrated CVD prevention: Develop joined up, digitally integrated hypertension and lipid optimisation pathways aligned with CVDPREVENT and NHS CVD Modern Service Framework recommendations.

Longer term priorities:

- Embed population health management: By 2028, use segmentation and digital dashboards to identify high-risk and Core20PLUS5 groups, monitor AF, BP, and cholesterol, and target interventions to reduce unwarranted variation.

4.3.5. Healthy Choices and Behaviours: Chronic Kidney Disease (CKD)

Healthy Choices and Behaviours: Chronic Kidney Disease (CKD) Outcome:

- Improve CKD detection and reduce progression.

Outcome Measures:

- Reduce uncoded CKD to 0.2%.
- Increase Albumin-to-Creatinine Ratio (ACR) monitoring to 55% and estimated Glomerular Filtration Rate (eGFR) monitoring to 95%.
- 5% reduction in progression to CKD stage 4/5.

Immediate priorities:

- Embed CKD screening and coding: By March 2027, include ACR and eGFR in CVD/diabetes reviews, using system prompts and home testing to improve diagnosis, targeting Core20PLUS5 populations.

- Education and protocol: Develop clinician and patient resources on CKD risk, lifestyle, and medication, and implement the regional CKD protocol.
- Integrated care pathways: Align renal pathways with CVD prevention for shared-risk management.
- Optimise case-finding: Roll out the ‘Coding is Caring’ CKD service by September 2026 to improve coding for CKD stage 3a+.

Longer term priorities:

- Integrated renal and cardiovascular care: By March 2028, implement joined-up care models with targeted Core20PLUS5 interventions and expand virtual CKD monitoring to improve outcomes and reduce hospital visits.

4.4. Stay Well

4.4.1. Cancer

Cancer Outcome:

- Cancer is detected earlier, improving survival and reducing inequalities.

Outcome Measures:

- 75% diagnosed at Stage 1 or 2 by 2028.
- Reduced under-75 preventable cancer mortality.
- Increased 5-year survival.

Immediate priorities:

Earlier cancer diagnosis and improved survival, with unwarranted variation reduced.

- Increase early cancer diagnosis through improved screening uptake and symptom awareness.
- Expand bowel and cervical screening, particularly in Core20PLUS communities, by March 2027.
- Deliver community-focused interventions through VCSFE partnerships and neighbourhood teams.
- Achieve the national survival ambition of achieving at least a 20% increase in early diagnosis above the 2019 level by 2035
- Reduce inequalities by targeting deprived and rural areas, including lung cancer screening, liver health engagement and improved health literacy.

Reduce unwarranted variation in urgent cancer referrals and improve diagnostic access, particularly for Core20PLUS communities

- Introduce a cancer decision-support tool to improve referral quality, support Get It Right First Time (GIRFT) recommendations and meet waiting time standards.

- Expand digital, direct access and self-referral pathways from 2026/27 to 2027/28, aligned with neighbourhood health ambitions.
- Deliver targeted pathway improvements across gynaecology, dermatology, breast and upper gastrointestinal (GI) cancers.
- Work with regional Children and Young Adult Cancer Networks to ensure timely, equitable care aligned to national specifications.

Meet and sustain cancer waiting time standards, reducing variation for Core20PLUS communities

- Implement best-practice diagnostic and treatment pathways, supporting national targets and elective recovery.
- Introduce nurse/AHP-led local anaesthetic prostate biopsies and AI-supported workflow improvements.
- Monitor and improve children and young people's cancer waiting times in collaboration with Operational Delivery Networks.
- Support workforce redesign through the ACCEND programme.
- Expand personalised and genomic cancer care, including Lynch syndrome testing and surveillance during 2026/27, supported by workforce redesign to enable early diagnosis and precision medicine.

Improve equity of access and personalised support using patient survey insights, with full implementation by 2028

- Redesign pathways to enable closer-to-home treatment and holistic care, building on Macmillan Integrated Care and quality-of-life approaches.
- Measure success via National Cancer Patient Experience Survey (NCPES) scores (≥8.0) and reduced variation in patient experience.

Strengthen specialist commissioning and oncology models, including paediatric oncology, radiotherapy planning, and hub-and-spoke care

- Expand closer-to-home treatment and ensure equitable access for Core20PLUS communities.
- Measured via lung pathway review, radiotherapy plan (by March 2027), and hub-and-spoke implementation (by March 2028).

Longer term priorities:

- develop a long-term population health strategy for cancer, focusing on early diagnosis, innovation and equitable access across all ages.
- Implement collaborative provider delivery models, including oncology hub-and-spoke arrangements.
- Undertake population-based radiotherapy capacity planning.

4.4.2. Elective Care and Diagnostics

Elective Care and Diagnostics Outcome:

- Timely referral and access to high-quality elective and diagnostic care.

Outcome Measures:

- Delivery of national planned care standards.
- Improved equity in referral and waiting times.

Immediate priorities:

- An Optimal Referral Management and Outpatient model: Implement a streamlined Advice-to-Refer model with a single point of access per specialty for elective referrals and Advice & Guidance, using the nationally mandated e-RS platform, to improve quality, patient experience and productivity in line with national standards.
- Accelerate diagnostic capacity by expanding Community Diagnostic Centres, improving productivity and adopting the 'Right Test, Right Time' approach, supported by robust business cases and workforce planning to ensure equitable, timely access for all.
- Improve 18-week referral to treatment (RTT) performance by redesigning high-volume specialty pathways and shifting appropriate care from hospitals to community settings, aligned to the Neighbourhood Health Model, to improve access, productivity, patient experience and equity (including for children and young people).
- Enhance patient engagement and experience during elective waits through patient feedback, digital engagement portals and inclusive communication, enabling people to better manage their care while ensuring equitable access for all groups.
- Embed population health management to reduce inequalities by using dynamic waiting list analysis to identify risk and unwarranted variation, with providers required from 2027/28 to act on and report progress, supporting equitable access and helping people to wait well for planned care.

Longer term priorities:

- Invest in community-based elective care and improved end-to-end pathways, aligned to NHS standards, with success measured by straight-to-test pathways in major specialties, reduced diagnostic waits, improved RTT performance, alignment with Neighbourhood Health Models, and innovation in data, digital, workforce and integrated working.

4.4.3. Neurodevelopmental Disorders (ND)

Neurodevelopmental Disorders (ND) Outcome:

- Improved health and life outcomes for neurodivergent people through equitable, timely assessment and support.

Outcome Measures:

- Zero waits >45 weeks by April 2028.
- 100% access to structured pre-/mid-/post-assessment support.

Immediate priorities:

- By April 2027, review and recommission Adult ADHD and Autism services to ensure effective, integrated, and aligned care across Norfolk and Suffolk
- By April 2027, provide accessible pre-, mid-, and post-diagnostic support for adults with ADHD and autism, improving engagement, and outcomes, and self-management, with at least 75% patient satisfaction monitored quarterly.
- By April 2028, implement National ADHD Taskforce recommendations across Norfolk and Suffolk, ensuring ≥90% of services meet national assessment, treatment, and support standards, monitored quarterly.
- By April 2028, implement a system-wide approach to identify and meet neurodevelopmental needs of children and young people, providing early screening, pre- and post-diagnostic support, and equipping education settings to deliver inclusive, consistent, and equitable care.
- By April 2028, review and expand digital support for neurodivergent children and young people, introducing tools like collaborative screening to enhance engagement, outcomes, and self-management alongside existing pathways.

Longer term priorities:

- Focus on holistic outcomes including health, education, employment, relationships, and reduced risk behaviours.
- Ensure accessible assessment, diagnosis, and treatment through a stepped care model.
- Promote coordinated, person- and family-centred care pathways.
- Expand local services with ongoing support to maintain wellbeing and independence.
- Provide accessible information, signposting, and digital tools to support self-management and enhance experience.

4.4.4. Urgent Emergency Care (UEC)

Urgent Emergency Care (UEC) Outcome:

- Timely and clinically appropriate urgent and emergency care.

Outcome Measures:

- Delivery of national UEC standards.

- Increased community-based urgent care activity.

Immediate priorities:

Strengthen urgent care by expanding community-based services aligned to the Neighbourhood Health Model, reducing non-elective admissions and bed days, particularly for frail older people.

- Develop a Single Point of Access via Unscheduled Care Coordination Hubs and increase community response capacity, with annual productivity gains of ≥2%.
- Ensure all clinically appropriate urgent care from East of England Ambulance Service is managed through Integrated Urgent Care (NHS 111+) by mid-2026.
- Procure a new Integrated Urgent Care service by April 2028 and expand urgent dental care to meet annual targets through 2028/29.

Strengthen acute hospital urgent and emergency care to improve quality, patient experience, productivity, and reduce ambulance handover delays.

- Implement an urgent treatment centre (UTC) first model, fully compliant by March 2028, including rapid assessment pathways for children and direct booking.
- Adopt NHS Model ED standards for first 72 hours by July 2026 and provide 24/7 Same Day Emergency Care.
- Expand “Hospital at Home” and Virtual Ward services, embedding digital-first care to safely manage patients at home by March 2028.

Patient Feedback and Service Improvement

- Continue to engage patients, carers, and the public to improve urgent and emergency care, acting on CQC inspections and feedback, and reporting annually through a “You said, we have” update.

Longer term priorities:

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

4.4.5. Stroke

Stroke Outcome:

- Avoid stroke, survive stroke, recover well, and prevent complications.

Outcome Measures:

- Increased timely access to integrated stroke care.
- Improved Sentinel Stroke National Audit Programme (SSNAP) performance.
- Reduced preventable strokes.
- Increased functional independence at 6 months.

Immediate Priorities:

- By April 2027, review and re-commission community stroke rehab services to ensure consistent, equitable access, addressing gaps and health inequalities.
- By April 2028, complete a needs assessment to expand services, support 7-day care, six-month post-stroke reviews, and embed vocational rehabilitation in line with ICSS standards.
- Review and re-commission services by April 2027 for equitable access.
- Expand services by April 2028 with 7-day care, post-stroke reviews, and vocational rehabilitation.
- Implement multidisciplinary group therapy for community stroke rehab by March 2028, with early rollout from October 2026 in Norfolk, supported by collaborative providers and NHS Stroke Quality Improvement funding.

Longer term Priorities:

- Shift to neighbourhood-based stroke prevention, rehab, and reintegration.
- Optimise acute stroke services for timely, equitable hyperacute care and improved outcomes.
- Deliver specialist stroke care across all settings, supported by advanced practice roles and workforce planning.

4.4.6. Stroke: Neurorehabilitation

Stroke: Neurorehabilitation Outcome:

- Improved neurological recovery and independence across the life course.

Outcome Measures:

- Reduced under-75 neuro mortality/disability.
- Standardised neighbourhood neurorehabilitation models.
- Reduced diagnostic/therapy waits.
- Equitable access to self-management support.
- Improved paediatric–adult transition.

Immediate Priorities:

- By February 2027, launch neuro assessment clinics, embed case-finding prompts, and update referral templates for adults and CYP.

- By March 2028, deploy wearables and virtual ward integration for ABI and progressive neurological conditions, with multi-disciplinary team (MDT) oversight and escalation protocols for safe, timely care.
- By December 2027, deliver personalised neurorehabilitation with seamless transitions between paediatric and adult services, informed by patient and carer feedback.

Longer term priorities:

- Strengthen integrated pathways across health, VCFSE and education using ICS-aligned digital tools by 2029.
- Increase digital access and self-management to 75% uptake, addressing digital inclusion and health literacy for Core20PLUS communities by 2030.
- Expand anticipatory and palliative care to all progressive neurological conditions and embed a functional neurological disorder (FND) pathway by 2030.
- Embed sustainable MDT models, expanding capacity with 7-day services and shared records by 2031.

4.4.7. Long Term Conditions (LTCs)

Long Term Conditions Outcome:

- Longer, healthier, more independent lives for people with LTCs.

Outcome Measures:

- Reduced under-75 preventable mortality.
- Improved healthy life expectancy.
- Reduced inequalities.

<u>Diabetes Care (all age)</u>

Immediate priorities:

- Focus on improving health literacy and expanding tailored prevention, education and digital support across Norfolk and Suffolk. Case-finding and engagement with Type 2 diabetes prevention and remission programmes will increase, aligned with the development of an Obesity Single Point of Access.
- From April 2027, integrated primary and community diabetes services with clear leadership and accountability will be commissioned to improve outcomes, reduce inequalities, and exceed national benchmarks. The West Suffolk National Neighbourhood Health Implementation Programme will support the shift of up to 80% of diabetes care into community settings.

- From April 2027, equitable, age-appropriate services for children and young people will ensure smooth transition between paediatric and adult care.

Longer term priorities:

- Deliver integrated diabetes care through stronger collaboration and multidisciplinary working, supported by embedded clinical education, to provide seamless services and improved access to specialist care closer to home. This includes commissioning specialist provision to deliver shared models of care, transforming footcare services, and expanding access to diabetes technologies.

Cardiac Care (Adults)

Immediate priorities:

- Heart failure as a priority within the Ipswich and East Suffolk National Neighbourhood Health Improvement Programme.
- Improve cardiac rehabilitation so it is offered to all patients, with expanded face-to-face, group and digital options, and improved outcomes through integrated delivery and innovation (by March 2028).
- Reform the heart failure pathway by expanding MDT capacity, strengthening community provision, reducing avoidable admissions, and improving equity of access, aligned with rehabilitation services (by March 2028).
- Improve ACS/NSTEMI pathways by reducing inter-hospital transfer delays, optimising catheter lab capacity, and embedding a networked pathway to ensure equitable treatment within 72 hours (by March 2028).

Longer term priorities:

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

Respiratory care (all age)

Immediate priorities:

- Expand respiratory diagnostics and risk detection to enable earlier, accurate diagnosis through enhanced spirometry, digital and home-based diagnostics, case-finding, and embedded clinical education.
- Develop integrated community respiratory care through neighbourhood-based models delivering standardised, evidence-based care, virtual MDTs, virtual wards for high-risk patients, and improved transitions between paediatric and adult services, with a focus on Core20PLUS populations.
- Improve respiratory rehabilitation and self-management by expanding equitable access to age-appropriate pulmonary rehabilitation,

education programmes, pharmacy-led inhaler optimisation, and community and school-based interventions, supported by ongoing clinical education.

- Increase respiratory vaccination uptake among eligible populations, using targeted, neighbourhood-level approaches to address inequalities, particularly within Core20PLUS communities.

Longer term priorities:

- Enhance respiratory diagnostics across the ICB using AI-enabled technology.
- Deliver clinically led, integrated breathlessness services, with targeted support for Core20PLUS communities, embedding anticipatory care planning and palliative support for advanced COPD to improve experience across all ages.
- Extend age-appropriate rehabilitation and education programmes, co-designing culturally appropriate resources to support health literacy and self-management across the life course.

CYP long term condition priorities (asthma and epilepsy)

Immediate priorities:

- Expand specialist epilepsy nursing to ensure equitable access for children and young people, providing timely advice, care coordination, and education (by March 2027).
- Ensure quality Personalised Asthma Action Plans (PAAPs) are in place for all diagnosed CYP and accessible to clinicians.

Longer term priorities:

- Deliver integrated, family-centred care by March 2030 across all localities.
- Reduce avoidable hospital admissions and improve quality of life.
- Support and empower families to manage conditions confidently at home.

4.5. Age Well

4.5.1. Ageing Well / Frailty

Ageing Well / Frailty Outcome:

- Older people stay active and independent for longer.

Outcome Measures:

- Reduction in admissions due to falls.
- Reduction in frailty-related admissions.

Immediate priorities:

- High-Quality Frailty Care: Implement standardised frailty pathways across all Alliances, expanding neighbourhood-based community geriatrician models and MDT working supported by shared digital systems. By 2028, frailty tools, CGA, ACP/ReSPECT and consistent Rockwood use will be embedded to improve early identification, personalised care planning, and outcomes.
- High-Quality Falls Care: By March 2028, implement a standardised, evidence-based falls prevention and management service, aligned to neighbourhood working and using technology where appropriate. This will target Core20PLUS5 groups, increase falls assessments, and reduce falls-related A&E attendances, including hip fractures.
- Carer Identification & Support: By 2027/28, increase identification of paid and informal carers within Integrated Neighbourhood Teams, aligned with the VCFSE strategy. Support will be co-commissioned with Carers Matter Norfolk and Suffolk Family Carers, aiming for 5% of carers on GP registers and completion of Carer Impact Assessments for new services.
- Carers Strategy Development: We will adopt existing All-Age Carers Strategies from VCFSE partners to guide strategic direction and future commissioning, aligned with NHS Personalised Care and Integration priorities.
- Integrated Support to Care Homes, by March 2027, develop a Suffolk and Norfolk Care Homes commissioning framework linking care home teams, PCNs, community services, pharmacies, EEAST, and social care.

Longer term priorities:

- Monitor Years 1–2 Commissioning Intentions to assess impact and inform future strategic plans and ensure full coverage and maturity of Integrated Neighbourhood Teams by 2030.

4.5.2. Dementia

Dementia Outcome:

- People with dementia receive timely, high-quality care reducing avoidable hospital use.

Outcome Measures:

- 12-week MAS waiting time standard.
- Increased annual care plan reviews.
- Reduced unplanned admissions.

Immediate priorities:

- Deliver Timely Dementia Diagnosis: Reduce referral-to-diagnosis times by 2027/28 through expanded Memory Assessment Service capacity, improved

triage, and integrated primary-community pathways, addressing Core20PLUS needs and supporting early identification to reduce delirium.

- Improve Quality of Care through Feedback: use service user and carer feedback to drive continuous improvement in dementia services, measured via the Dementia Charter, annual feedback from at least 10% of users, MCCR registration, and “You said – We did” actions by 2027.
- Reduce Dementia-Related Hospital Admissions, by March 2028, reduce avoidable dementia admissions and hospital stays especially in Core20PLUS communities through enhanced community support, admission-avoidance models, AI-driven analysis, dementia training, and strengthened neighbourhood health teams, building on Better Care Fund initiatives.
- Increase Annual Dementia Care Plan Reviews, by 2027/28, ensure all people with dementia, including those in Core20PLUS communities, receive annual person-centred care plan reviews, supported by clinician training and MCCR use, with this maintained annually thereafter.

Longer term priorities:

- Respond to innovation and integration opportunities, e.g., dementia-modifying treatments and biomarkers.
- Expand AI-enabled community support, including voluntary sector services.
- Streamline processes and raise awareness to support those with suspected or confirmed dementia.
- Enable early completion of advance care plans, linked to digital tools and Right Care, Right Time packs.
- Integrate Dementia Intensive Support Teams into Urgent Community Response and neighbourhood health and social care models.
- Address variation in access and outcomes through co-produced approaches.

4.6. Die Well

4.6.1. End of Life

End of Life Outcome:

- People at end-of-life experience coordinated, dignified, high-quality care aligned with preferences.

Outcome Measures:

- 1% of the population registered on MCCR.
- Reduced emergency admissions in last 3 months of life.
- 90% have documented care plan.

Immediate priorities:

- Specialist Palliative and End of Life Care: Refresh and align palliative and end-of-life care commissioning across Norfolk and Suffolk by 2027–28 to reduce variation, improve quality, and ensure equitable access, including children's services.
- Improve early identification and advance care planning by 2027, training care teams to proactively identify patients nearing end of life, record preferences via the My Care Choices Register, and personalise care to reduce hospital admissions and variation in access.
- Redesign CHC Fast Track by March 2027 to create a fully integrated, 24/7 end-of-life care model, reducing inappropriate acute admissions and aligning with community and neighbourhood services.
- Address Inequalities in End-of-Life Care: Improve equitable access to advance care planning and palliative care for all, especially Core20PLUS5 groups, using feedback, MCCR, and population health data, with equity monitored quarterly via PHM tools.
- Enable Staff to Deliver Outstanding End-of-Life Care: Train health and social care staff to provide person-centred end-of-life care, using VCFSE-led community training, ReSPECT facilitation, and the Care Choices model, with focus on Core20PLUS5 groups. Success measured by staff trained and training evaluations in 2026/27.

Longer term priorities:

- For Core20PLUS communities, enhance end-of-life care by using the Shared Care Record, expanding coordinated neighbourhood support and single points of access, aligning specialist commissioning with national guidance, and ensuring seamless, age-appropriate care for children transitioning to adult services.

4.7. Cross Cutting Domains

4.7.1. Community

Community Outcome:

- People stay well in their communities with personalised, joined-up care.

Outcome Measures:

- Reduced emergency admissions.
- Increased community-delivered activity.
- Increased productivity in community services.
- Reduced total cost per person.

Immediate priorities:

- Norfolk and Suffolk will commission new community contracts within two years to improve prevention, joined-up care, and consistent access through expanded community services. The review will cover all service areas, including mental health, children and young people's services, physical health, and VCFSE aligned to social care. It will focus on public engagement, integrated neighbourhoods and place-based commissioning, strengthened VCFSE provision, service co-location, integrated workforce development, and collaborative, outcomes-based commissioning. The New Hospital Programme will shape the context for this work.
- Shared delivery of Integrated Care and Urgent Community Response in neighbourhoods
  Aligned to the NHS 10-Year Plan, shared service models will be developed across neighbourhoods to deliver integrated, proactive, planned and urgent care. Place-based, multidisciplinary teams across primary, community and secondary care will improve outcomes, reduce avoidable admissions, and support faster, safer discharge.
- By March 2028, a neighbourhood-based community model will be implemented and expanded, including aligned community geriatrician support, frailty assessment services, increased use of virtual wards, Home First and independent wellbeing practitioner support, and full neighbourhood coverage of community hospice services.
- The ICB will support place-based reviews to reduce discharge delays, improve in-hospital discharge processes, maximise community capacity, expand home-based intermediate care and urgent community response, and ensure 90% of UCR referrals are met within two hours.
- Robust place-based governance, including Alliance Committees and Better Care Fund arrangements, will ensure effective partnership working, targeted investment for those most in need (CORE20PLUS5), and ongoing evaluation to inform future commissioning.
- Addressing variation, capacity, and long waits in core community services
  By March 2027, at least 78% of planned community activity will be delivered within 18 weeks. This will be achieved through system-wide demand and capacity modelling, standardisation of core services, active management of long waits (including elimination of 52-week waits), productivity improvements, and adoption of approved innovations such as digital MSK therapies.
- Analogue to digital: virtual wards and hospital at home
  Virtual wards and hospital at home models will be expanded across neighbourhoods in line with NHSE guidance, with regular monitoring of utilisation to improve efficiency, admission avoidance, and early discharge. Shared care record functionality, including a single care planning module for neighbourhood teams, will be explored to strengthen joined-up care and productivity, informed by the opportunities and constraints of the New Hospitals Programme.

- National Neighbourhood Health Implementation Programme
  The NNHIP will accelerate neighbourhood health services in line with the NHS 10-Year Plan, with pilots in West Suffolk and Ipswich and East Suffolk. In 2026, West Suffolk will implement an integrated community diabetes model, aiming for all practices to reach at least 65% of the eight care processes by 2027/28, with wider rollout from 2027.Neighbourhood health and care models in Great Yarmouth and Waveney, West Norfolk and Central Norfolk will continue to develop through collaborative, place-based approaches.
- High Intensity Users: Bespoke services will continue to be commissioned for high users of health and care services with unmet needs or poor care coordination, aiming to reduce service use by 25% within 12 months and improve wellbeing by 10% within six months.
- Community Therapy Services: Following GIRFT MSK work in 2025/26, demand and community physiotherapy capacity will be reviewed to meet response times of two weeks for urgent and five weeks for routine care. Community Assessment Days will be explored in 2026/27–2027/28. A single point of access and consistent MSK pathway is now in place across most of Norfolk and Waveney, with commissioning intentions to extend full pathway access to the remaining GP practices.

Longer term priorities:

- Successful delivery of the commissioning intentions requires strong ICB and partner commitment, tailored to each Place's neighbourhood development. Plans will ensure ambitious progress while addressing community needs and reducing unwarranted variation.

4.7.2. General Practice

General Practice Outcome:

- Timely, equitable access to high-quality general practice as part of neighbourhood models.

Outcome Measures:

- 90% same-day urgent appointments.
- Reduced variation in access.
- Improved patient experience.
- 95% appointments via NHS App.

Immediate priorities:

- Strengthen access and capacity in general practice: Support practice collaboration to meet demand, embed same-day access for urgent appointments, integrate Pharmacy First, and ensure consistent quality.

Provide tailored support for contractual requirements, workforce development, and recruitment in hard-to-staff areas. Enhance digital tools and continuity of care to improve patient experience.

- Enhance integration with wider health and care systems: Commission services to strengthen collaboration between general practice, primary care partners, community services, and the voluntary sector. Deliver the Neighbourhood Health Model and Neighbourhood Health Centres, using learning from NNHIP and PCN Pilot Programmes to expand across Norfolk and Suffolk by 2027/28.
- Advance Integrated Neighbourhood Teams with primary care leadership, MDT working, risk stratification, and joined-up care across community and mental health services. Deploy the Care Management Service across Suffolk and improve urgent eye care access through digital integration, optometry-first approaches, and clear referral pathways.
- Support local partners to improve the primary–secondary care interface, streamlining pathways, processes, and clinical partnerships to enhance patient experience and release capacity. Expand direct access to diagnostics and Advice & Guidance (A&G) in general practice to enable care closer to home and reduce unnecessary referrals. Work will align with outpatient changes and the NHS 10-Year Plan, shifting care from hospital to community and from treatment to prevention.
- Improve commissioning from general practice to enhance quality, consistency and reduce health inequalities: We will review all locally commissioned enhanced services across Norfolk and Suffolk to ensure they are commissioned at the right scale to meet local needs safely, strengthen neighbourhood and primary care resilience, reduce health inequalities and deliver best value. We will improve Local Enhanced Service commissioning to reduce variation in access and outcomes and minimise bureaucracy, informed by practice experience, national benchmarking and good practice. Our approach will align with community and hospital commissioning, new neighbourhood contracts and the NHS 10 Year Plan, supporting neighbourhood health services and the three strategic shifts.

Longer term priorities:

- Develop a sustainable, neighbourhood-based primary care system by expanding estate capacity, strengthening and supporting the workforce, co-designing services with communities to reduce inequalities, implementing national contract changes, and embedding digital-first models of care.

4.7.3. Medicines Optimisation

Medicines Optimisation Outcome:

- Safe, high-quality, cost-effective prescribing.

Outcome Measures:

- Reduction in unwarranted prescribing variation.

Immediate priorities:

- We will develop and publish a system-wide medicines optimisation strategy aligned with national priorities and the ICB strategy, shaped by engagement with pharmacy leaders, wider stakeholders and patients. The strategy will be led by the ICB Director of Medicines Optimisation & Pharmacy, approved through the System Prescribing Committee, and published by March 2028.
- We will implement a streamlined, system-wide structure for approving medicines policies, guidelines, and commissioning decisions, including NICE TA adoption, to enable efficient decision-making. This will be led by the ICB Quality, Governance & Safety Medicines Optimisation Lead, with approval through the ICB Quality and Finance Committees, and completed by April 2027.
- We will update secondary care contracts to ensure patients receive 28 days' medication on discharge and in outpatient settings, where clinically appropriate, in line with GIRFT. This will be led by the Interface Medicines Optimisation Leads, approved through contracts governance with assurance via the System Prescribing Committee, supported by community pharmacy and the Discharge Medicines Service, and completed by April 2027.
- Commission local medicines optimisation incentive schemes: We will continue to commission medicines optimisation incentive schemes to support financial sustainability and quality improvement across primary care, neighbourhoods and community pharmacy, aligned with the PHIP. Existing schemes will be reviewed to develop a harmonised approach, led by the ICB Medicines Transformation Lead and approved through the Alliance Committees/System Prescribing Committee.
- We will promote rapid adoption of biosimilars, prioritising nationally identified products that deliver significant savings, through clinician engagement, pathway development and contractual levers. This will be led by the ICB High-Cost Medicines Lead with assurance via the System Prescribing Committee. We aim to meet national targets for initiating new patients and switching existing patients to best-value biological medicines, where clinically appropriate.
- We will maintain a system-wide focus on medicines safety, antimicrobial stewardship and safe deprescribing to address national, regional and local priorities, improve prescribing quality and reduce medicines waste. Delivery will be led by relevant ICB medicines optimisation leads, with assurance via the System Prescribing Committee.

Longer term priorities:

- Use population health data, a unified formulary, harmonised policies, pharmacogenomics, and the Electronic Prescription Service to optimise medicines use, reduce variation, improve outcomes, and address health inequalities across Norfolk and Suffolk.

4.7.4. Dental, Vaccination, Pharmacy, Optometry

Dental, Vaccination, Pharmacy, Optometry Outcome:

- Improved timely access to primary care services close to home.

Outcome Measures:

- Increased dental access & urgent appointments.
- Reduced dental waiting times.
- Achievement of vaccination targets.
- Increased pharmacy/optometry use.

Immediate priorities:

- We will update the dental commissioning plan by June 2026 to increase access for children and adults, covering urgent and routine care with a focus on prevention. This will be supported by implementing national contract reforms, developing the workforce, promoting oral health, and working with providers to maximise NHS dental resources and reduce inequalities.
- We will update the dental commissioning plan by September 2026 to shift care from hospitals to community and primary care through integrated pathways. Success will be measured by increased intermediate care capacity, reduced waiting times, improved workforce recruitment and retention, and enhanced preventive care, such as fluoride varnish application.
- We will improve vaccine access and reduce inequalities by delivering vaccinations through Neighbourhood Health Models and Centres, updating the delivery plan by June 2026, supporting HPV rollout in community pharmacies, and preparing for the transfer of commissioning to the ICB in 2027. Success will be measured against national immunisation uptake targets.
- We will make pharmacy and optometry first points of contact for urgent care to reduce pressure on GPs and emergency departments. This includes expanding community pharmacy roles, integrating services into neighbourhood teams, introducing prescribing services, and creating clear referral pathways for urgent eye care. Success will be measured by increased direct access and resolution of patient needs in these settings.
- We will commission additional primary care and enhanced community pharmacy access during evenings, weekends, and bank holidays to meet

demand, reduce ED pressure, and address inequalities. Success will be measured by increased pharmacy capacity and Pharmacy First service delivery during extended hours.

Longer term priorities:

- Expand Pharmacy First walk-in services, introduce appointment booking, integrate pharmacies with primary care estates and the NHS Single Patient Record, and establish pharmacies as Acute Respiratory Infection hubs to support winter pressures.

4.7.5. Specialised Commissioning

Specialised Commissioning Outcome:

- Improved access to specialised services closer to home.

Outcome Measures:

- Increased timely access, reduced waits, improved outcomes.

Immediate priorities:

- We will expand renal services to meet a 5% annual increase in dialysis demand, increase home dialysis to at least 20%, and commission off-site capacity linked to the New Hospital Programme at QEHKL, WSH, and JPUH, guided by national standards and data-driven best practice, by March 2028.
- By March 2028, we will improve ongoing care through GPwER (GP with Extended Role) placements, coordinated community prescribing, GP annual health checks, and service delivery of 400 new referrals and 1,500 first assessments per year, while reducing waiting times for adults and CYP.
- We will improve timely access to rehab by establishing a live bed-capacity dashboard, clear care pathways, trauma and rehab coordinators in acute hospitals, and additional service capacity for equitable geographic coverage.
- By March 2028, NHS England will complete an options appraisal for London and South-East paediatric burns provision. In the meantime, we will commission joint virtual assessments via the PANDR team for children needing extended single-organ support.
- We will reduce distant and unnecessary inpatient admissions by transforming care pathways, preventing admissions where possible, and speeding up delayed discharges. Success will be measured by fewer occupied bed days, fewer out-of-area placements, and increased access to non-inpatient care.
- We will implement NHS England's CYP Developmental service specification to provide equitable, community-based care closer to home, reduce hospital admissions, and improve integration with specialised services. For the adult forensic population, we will expedite transfers to secure services, provide

guidance to prevent admissions, and support mental health in prison. Success will be measured by referral numbers, transfer times, and remittances.

Longer term priorities:

- Deliver system-wide renal services with a focus on prevention, early treatment, and improved transplantation access; reduce delays and improve awareness in East of England Gender Services; ensure paediatric burns care meets national standards within the LSEBN footprint; strengthen integrated mental health pathways for early identification and intervention; and expand home-based delivery of subcutaneous chemotherapy/immunotherapy to reduce hospital visits.

4.7.6. Health and Work

Health and Work Outcome:

- Improve health-related economic activity and workplace inclusion.

Outcome Measures:

- Halt rise in health-related economic inactivity.
- Reduced NEET %.
- Increased healthy life expectancy & healthy working life expectancy.

Immediate priorities:

- From April 2026, all commissioned services will integrate work and health considerations, supporting clinicians to use national guidance, provide early intervention for patients absent from work, deliver staff training on work as a health outcome, and offer a single access point for employment and skills support.
- By November 2026, Work Well Partnerships will provide integrated early support across Norfolk and Suffolk, offering personalised assessments and multi-agency interventions to help people stay in, return to, or start work while managing their health.
- We will work with partners and employers to support people with health needs into and within work, reducing inequalities, improving health, and addressing workforce shortages through the Get Norfolk and Get Suffolk Working plans and the ICB Fit for Work, Fit for Life strategy.

Longer term priorities:

- We will keep the Work and Health strategy agile by reviewing evidence and population health, evaluating outcomes from programmes, and targeting interventions for economically inactive groups and night workers to reduce health inequalities and improve healthy work - life expectancy.

4.7.7. Health Protection

Health Protection Outcome:

- Reduce healthcare-associated infections through community IPC support, improving outcomes, preventing sepsis admissions, and supporting system flow across Norfolk and Suffolk.

Outcome Measures:

- Reduce community infections (MRSA, E. coli, CDI) to prevent bloodstream infections, shorten hospital stays, and support system flow.
- Strengthen sustainable community TB services to manage rising, complex cases, reduce admissions, and limit drug-resistant TB

Immediate priorities:

Infection Prevention and Control (IPC)

- Reinforce community IPC support in Norfolk and Suffolk for health-commissioned services.
- Reduce healthcare-associated infections, strengthen community care, and improve patient safety.

Tuberculosis (TB) Services

- Stabilise and strengthen community TB services in Norfolk and Suffolk.
- Reduce TB transmission and drug resistance, improve patient outcomes, and support transition from acute to community care.
- Address health inequalities and build resilience within existing TB teams.

Longer term priorities:

- Develop a resilient, provider-led, multi-agency partnership to target high-infection, high-deprivation areas.
- Use the community services review as a catalyst to create a comprehensive IPC and Health Protection model across Norfolk and Suffolk.
- Establish a TB partnership model that integrates services, aligns with population health and social risk factors, and strengthens resilience and effectiveness across both counties.

5. Statutory duties

Our Strategy, PHIP and overall strategic commissioning approach will support the discharging of the ICB's statutory duties as set out below:

- Describe the health services for which the ICB proposes to make arrangements. The commissioning intentions describe these services.
- Ensure that the financial capital and revenue resourcing use limits set by NHSE England are not exceeded, i.e. that the ICB does not spend beyond its means.
- Improve quality of services for those at home, in the community, seeking secondary care and those with long term conditions (LTCs).
- Commitment to ensuring the patient has the right to choice, can access the information they need to make that choice, and they are actively involved in decisions about their care.
- Commitment to obtaining appropriate advice to discharge our responsibilities with partner organisations, clinical and care professions and other subject matter experts.
- Reduce health inequalities by understanding the demographics of those most in need and taking targeted evidence-based action.
- Promote involvement of each person in their care by expanding the choices and control that people have over their own care.
- Ensure that needs of children and young people are met and they have the best start to life, as well as wider ICB responsibilities under the Children and Families Act 2014.
- Address the needs of victims of abuse by ensuring that the proper systems are in place and their voices are heard.
- Promote integration by working with system partners to align and integrate service delivery across sectors to create efficiencies in practice and improve outcomes for the local population.
- Consider the effects of our decisions on the ‘triple aim’ which is about people’s health and wellbeing, the quality of services and the sustainable and efficient use of resources.
- Support wider economic and social development. This includes for example the work and health agenda which is a specific commissioning intention.
- Develop the system approach to healthcare with partners. The focus on our four Ambitions in the strategy will further accelerate this and build on good progress to date.

Specific duties relating to digital and data, estates, involving the public, climate change, procurement and population health management, research and innovation, workforce and training are also mandated.

6. Glossary

Acronym / term	Definition
ABI	Acquired brain injury
ACP	Advance care planning
ACR	Albumin-to-creatinine ratio
ACS	Acute coronary syndrome
ADHD	Attention-deficit/hyperactivity disorder
AF	Atrial fibrillation
AHP	Allied health professional
AI	Artificial intelligence
BAPM	British Association of Perinatal Medicine
BP	Blood pressure
CDI	*Clostridioides difficile* infection
CGA	Comprehensive geriatric assessment
CHC	NHS Continuing Healthcare
CKD	Chronic kidney disease
Core20PLUS5	NHS England health inequalities approach focusing on (1) the most deprived 20% of the population (Core20), (2) “PLUS” inclusion health groups, and (3) five clinical areas
CQC	Care Quality Commission
CVD	Cardiovascular disease
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
eGFR	Estimated glomerular filtration rate
FND	Functional neurological disorder
GI	Gastrointestinal
GLD	Good Level of Development
GP	General practitioner
GPwER	GP with Extended Role
HPV	Human papillomavirus
ICB	Integrated Care Board
ICS	Integrated Care System
ICSS	Integrated community stroke service
INA	Integrated Needs Assessment
IPC	Infection Prevention and Control
JPUH	James Paget University Hospital Foundation Trust
LD&A	Learning Disabilities and Autism
LSEBN	London and South-East Burns Network
LTC / LTCs	Long term condition(s)
MAS	Memory Assessment Service
MCCR	My Care Choices Register
MDT	Multidisciplinary team
MHSTs	Mental Health Support Teams
MI	Myocardial infarction

MNVP	Maternity and Neonatal Voices Partnership
MRSA	Methicillin-resistant *Staphylococcus aureus*
NCPES	National Cancer Patient Experience Survey
ND	Neurodevelopmental disorders
NEET	Not in education, employment or training
NHS	National Health Service
NHS 111+	Integrated Urgent Care (accessed via NHS 111 and additional clinical assessment / referral functions)
NIHR	National Institute for Health and Care Research
NSTEMI	Non-ST elevation myocardial infarction
PAAPs	Personalised Asthma Action Plans
PANDR	Paediatric and Neonatal Decision Support and Retrieval Service
PCN / PCNs	Primary Care Network(s)
PHIP	Population Health Improvement Plan
PSR	Provider Selection Regime
QEHKL	The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
R&I	Research and Innovation
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RTT	Referral to Treatment
SMI	Severe mental illness
SPoA	Single Point of Access
SSNAP	Sentinel Stroke National Audit Programme
TB	Tuberculosis
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
VCFSE	Voluntary, Community, Faith and Social Enterprise
WMCOS	Weight Management and Complex Obesity Service
WSH	West Suffolk Hospital NHS Foundation Trust