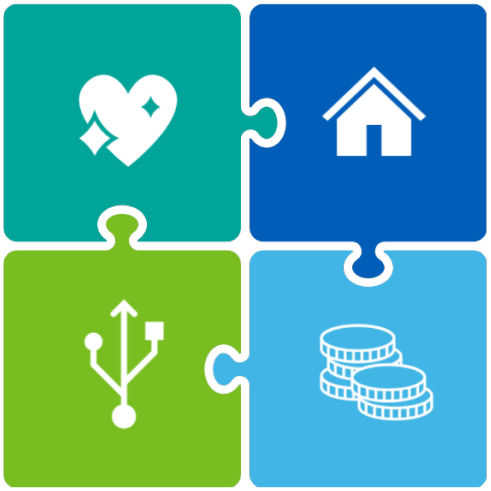
NHS
Norfolk and Suffolk
Integrated Care Board

Population Health and Commissioning Strategy 2026/27 to 2030/31



March 2026 v1.0

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1. Introduction and context

1.1. Foreword from the Chair and Chief Executive

The NHS Ten-Year Health Plan is a bold vision for a modern, sustainable health and care system that delivers better outcomes for everyone. Achieving a shift towards prevention and early intervention, bringing care closer to communities, and embracing digital innovation to improve access and equity requires a transformational change in the way in which NHS services are delivered.

For Norfolk and Suffolk, this vision means working as one system across health, social care, and the voluntary sector to enable healthier lives, reduce inequalities, and make the best use of our collective resources to improve access to services. This Population Health and Commissioning Strategy is our local response to the national ambition. It reflects our commitment to commission services that are proactive, person-centred, and shaped by the needs and aspirations of the people we serve.

Our goal is simple yet profound: to improve health outcomes for every resident of Norfolk and Suffolk. We want people to live longer, healthier, and happier lives, supported by safe, joined up, and compassionate care.

To achieve this, we will deepen our understanding of what drives health and wellbeing in our communities and design services that respond to those needs. This is reflected in our three core outcomes: improving healthy life expectancy, reducing health inequalities, and ensuring access to consistently high-quality care. Our clinical priorities will focus on interventions that will make the greatest difference to our citizens' quality of life.

To achieve these outcomes, we must work with NHS providers to achieve national standards in care, performance and quality, and ensure every pound spent delivers value. Too often, NHS services fall short of public expectations. Therefore, our focus must also be on recovery and sustained improvement as a foundation for transformation and improvements in population health outcomes.

The creation of a single Norfolk and Suffolk Integrated Care Board (ICB) is an opportunity to combine the best of both legacy organisations and build a strategic commissioning organisation with a culture of collaboration, innovation, and compassionate leadership. Our immediate priority is to create an environment where partnerships thrive, where every decision is driven by value and improvement, and where our workforce feels supported and empowered.

This five-year strategy is an ambitious but achievable vision for the future of health and care across Norfolk and Suffolk. It is shaped by the dedication of our workforce and the lived experience of our communities.

Professor Will Pope, Chair

Dr Ed Garratt OBE DL, Chief Executive

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

1.2. Scope of the Population Health and Commissioning Strategy

This Norfolk and Suffolk ICB Population Health and Commissioning Strategy (2026/27–2030/31) has been developed in response to NHS England's Ten-Year Health Plan, which sets out expectations for reshaping healthcare over the next five years. The NHS Planning and Strategic Commissioning Frameworks introduce a new planning model and define ICBs as strategic commissioners, requiring each ICB to produce a five-year Population Health and Commissioning Strategy.

This strategy sets out:

- The ICB's vision for improving health and healthcare by commissioning services that deliver priority outcomes
- How the ICB will operate as a strategic commissioner

It also outlines current and future health needs using an Integrated Needs Assessment, alongside insights from local people about their experience of NHS services. Current service quality, performance, and productivity are described to provide the context for the ICB's long-term ambitions and clinical priorities. The strategy highlights the importance of the interface between health and care in achieving shared goals.

This document provides the strategic foundation for a Population Health Improvement Plan, which will set out the ICB's detailed five-year commissioning intentions. Together, they establish an outcomes-based approach to healthcare commissioning across Norfolk and Suffolk.

1.3. National policy context

NHS England's Ten-Year Health Plan sets out three major shifts for the future NHS:

- Hospital to community – more care delivered locally and at home
- Analogue to digital – technology reducing admin and enabling people to manage their care
- Sickness to prevention – earlier intervention and supporting healthier choices

These shifts underpin this strategy and will run through our Commissioning Intentions in the Population Health Improvement Plan.

The Ten-Year Plan also introduces a new NHS operating model that moves power from the national centre to local systems. ICBs will take on greater responsibility, with more decisions passing to neighbourhood-level providers. The model includes fewer national targets, multi-year outcome-based budgeting, and more autonomy for high-performing organisations.

The Model Region and Model ICB Blueprints describe how responsibilities will be shared between regions and ICBs. The Model ICB Blueprint re-positions ICBs as strategic commissioners focused on population health, reducing inequalities, and ensuring value. The NHS Strategic Commissioning Framework further defines this role, which we respond to in section 4.1. A Model Neighbourhood Framework is expected in winter 2025/26. The Medium-Term Planning Framework for 2026/27–2028/29 is also a key driver.

Each year, providers and the ICB produce forward plans covering activity, performance, workforce and finance. A three-year financial settlement now enables longer-term planning, with improvement expectations across:

- Elective care, cancer and diagnostics
- Urgent and emergency care
- Primary care (GP, pharmacy, dental)
- Community services
- Mental health
- Learning disabilities, autism and ADHD

Our local response is described in the Population Health Improvement Plan, which sets out Commissioning Intentions linked to clinical priority outcomes and their relationship with NHS performance.

1.4. Local policy context

This strategy must also reflect local policy. Norfolk and Suffolk County Councils have each developed Health and Wellbeing Strategies that set shared priorities for improving health and reducing inequalities, based on their Joint Strategic Needs Assessments. These strategies guide how councils, the NHS and partners work together on prevention, early intervention and community wellbeing. The four common priorities - integration and partnership, prevention, reducing inequalities, and resilient communities - are embedded in this ICB strategy to ensure NHS commissioning supports local Health and Wellbeing goals.

This strategy also builds on existing work, including the two five-year Joint Forward Plans, the ICS Clinical Strategy, Population Health Management Strategy and Norfolk & Waveney's Health Inequalities Framework. Over time, the Population Health Improvement Plan is expected to replace the Joint Forward Plans, subject to legislation.

Figure 1 outlines local strategic arrangements. NHS Trusts and Foundation Trusts will produce five-year integrated delivery plans reflecting the NHS 10-Year Plan, ICB priorities, Integrated

Needs Assessment findings and Neighbourhood Health Plans. These plans will also set out key actions for delivering the new hospital developments in Norfolk and Suffolk.

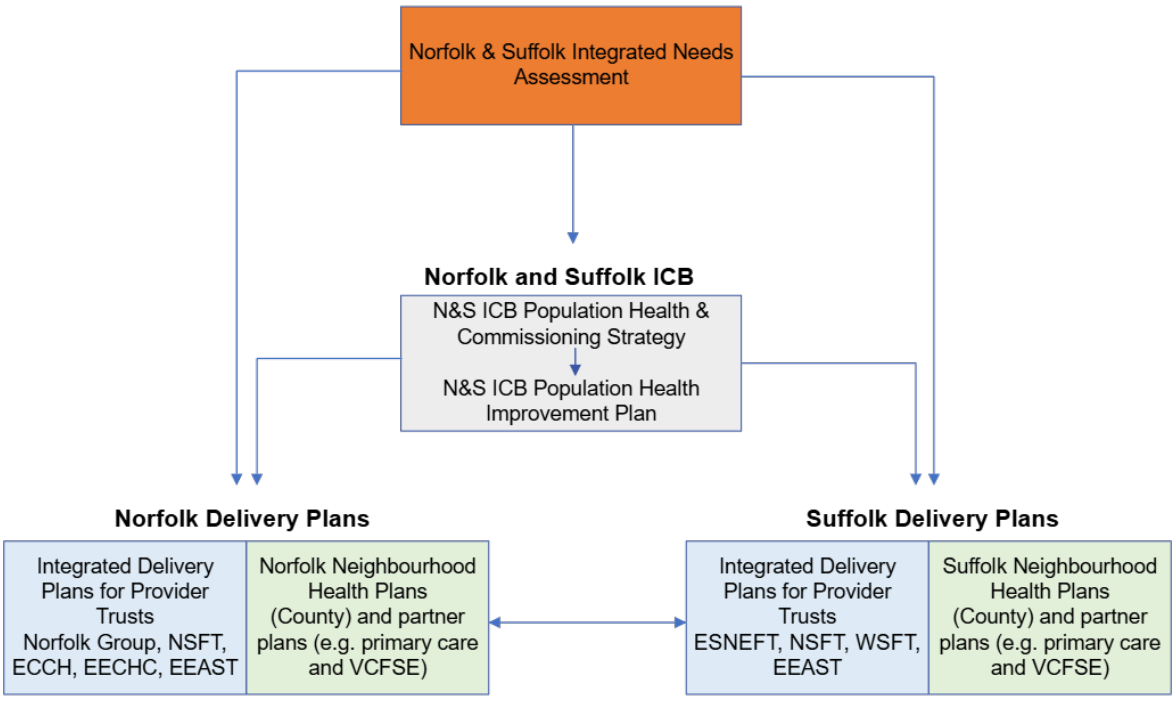

Figure 1 The Norfolk and Suffolk strategic arrangements

The final part of the local strategic arrangements is Neighbourhood Health Plans. These are for local determination by Local Authorities, ICBs, and NHS providers, under the oversight of the Norfolk and Suffolk Health and Wellbeing Boards. A Framework was published in March 2026.

1.5. The role of the ICB

The Health and Care Act 2022 established ICBs as statutory bodies, replacing CCGs and taking on their commissioning functions. ICBs are responsible for local NHS spending and performance, bringing partners together to plan and deliver services that improve population health and wellbeing. The ICB Board is accountable to NHS England, the Department of Health and Social Care, and the Ministry of Housing, Communities and Local Government.

Norfolk and Suffolk's NHS include primary care, hospitals, ambulance, community and mental health services, alongside Local Authorities and the VCFSE and independent sectors, all of whom support patients, carers and families.

The NHS England Strategic Commissioning Framework defines ICBs as strategic commissioners - responsible for designing and purchasing services through contracts and partnerships to improve population health. ICBs will do this with a smaller organisational structure and are accountable for:

- Setting NHS strategy for Norfolk and Suffolk
- Allocating resources fairly to improve health and access
- Setting commissioning intentions and desired outcomes
- Designing services and working with partners to deliver integrated care

These responsibilities underpin our Mission Statement.

Table 1 The ICB's Mission Statement

Norfolk and Suffolk Integrated Care Board Mission Statement:
We commission healthcare services in Norfolk and Suffolk to improve population health, reduce health inequalities, and improve equitable access to consistently high-quality healthcare.

2. Evidence base

2.1. Population needs

2.1.1. Our population

Norfolk and Suffolk have 1.7 million residents, with populations that are older and less ethnically diverse than England overall. Large rural and coastal areas shape access to services, and half the population lives in rural or coastal communities. Around 219,000 people live in the 20% most deprived areas, mainly in major towns such as Great Yarmouth, Ipswich, Lowestoft, Norwich and Thetford. Deprivation affects health outcomes significantly, with early deaths around 70% higher in the most deprived communities.

The region’s economic landscape includes clean energy, agritech, digital and tourism. Rurality, older age, and coastal isolation contribute to complexity in service access and require tailored approaches to health and care delivery.

2.1.2. Findings from public engagement

Engagement across both ICBs and national Change NHS feedback shows that people want a more compassionate, connected and person-centred NHS. While local priorities are supported, the public is unsure how improvements will be achieved, particularly around access, integration, continuity and workforce capacity.

Key messages include:

- Desire for a “one front door” experience, preventing people from falling between services.
- Strong emphasis on relationships, collaboration with social care and the VCSE sector, and investment in staff.
- Support for technology but concerns around digital exclusion and loss of personal connection.
- Call for meaningful action on prevention, health education and early help, especially for children and families.

Overall, people are optimistic but pragmatic, asking for an NHS that listens and works in partnership with communities.

2.1.3. Integrated Needs Assessment (INA)

To inform our strategy, Norfolk and Suffolk Public Health teams produced a “Norfolk and Suffolk Integrated Needs Assessment”. This summarises information in the Joint Strategy Needs Assessments (JSNAs) and from local datasets to provide an overview of the health and wellbeing of the population, including analysis of population demographics, health outcomes, and inequalities, as well as key trends in morbidity, mortality, and wider determinants of health. This created a shared understanding of the health and wellbeing needs of Norfolk’s and Suffolk’s population as the basis for the development of the ICB’s strategy. Key findings include:

- Life expectancy is slightly better than England; however, men in the least deprived areas live 7 years longer, and women 6 years longer, than those in the most deprived.
- Top drivers of inequality: cancer, circulatory and respiratory disease.
- Main causes of ill health include heart disease, dementia, stroke, COPD, chronic pain, diabetes and falls.
- Over 30 years, disease burden has shifted from mortality to morbidity, reflecting longer life and rising long term conditions.
- Dementia and learning disability prevalence is significantly above national levels.
- Priority focus areas include:
  - Healthy ageing and long-term condition support
  - Targeting services in high deprivation areas
  - Health behaviours (obesity, smoking)
  - Screening and immunisation
  - Mental health and social wellbeing
  - Addressing geographical barriers to access

These areas shape the strategy’s clinical priorities and population health outcomes

2.2. NHS services in Norfolk and Suffolk

2.2.1. NHS Productivity

Productivity has declined since the pandemic, locally mirroring national trends. Costs have grown faster than activity, and the NHS aims for 2% annual productivity growth over the next three years.

Local analysis identifies a need for 2.5–6% annual productivity improvement across providers. Some gains are expected through workforce efficiency, reduced temporary staffing and better corporate service models. Productivity varies widely across acute providers, from –9.9% to +3.8%.

The ICB will prioritise monitoring productivity, aligning resources to value, and supporting financially sustainable models of care.

2.2.2. NHS Quality

National assessments show rising demand, workforce shortages and fragmented care. Inequalities persist, affecting quality and outcomes - for example, dental extractions in deprived children and maternal mortality for Black women.

Local concerns raised through complaints include:

- Access to primary care and dentistry
- Weight management services
- Outpatient waiting times and communication
- CHC processes
- Vaccination access for housebound patients

Key quality challenges for local Trusts include ambulance delays, maternity safety, fundamental standards of care (falls, nutrition, frailty), long waits for neurodevelopmental assessments and SEND related service pressures. Improving quality is therefore a central strategic priority.

2.2.3. NHS Operational Performance

National reviews highlight worsening access and infrastructure pressures. Locally, challenges mirror national patterns but with some improvements.

Key trends include:

- Primary care appointments have increased 7-14% over three years.
- Cancer: Faster diagnosis has improved, but fewer people start treatment within 62 days.
- Diagnostics improving overall, but with provider variation.
- Elective: No provider has achieved the 18-week standard since 2021, though very long waits are reducing.
- Urgent care: Four-hour A&E standard unmet since 2020; attendances up 42% since 2017/18.
- Mental health: Standards for crisis follow up and talking therapies are being met; CYP, perinatal and employment support access has improved.

- Community: 52 week waits increasing, especially in NDD; virtual ward utilisation rising.

2.2.4. Workforce

Norfolk and Suffolk's combined health and care workforce totals 113,000 FTE, including 46,000 in healthcare and 68,000 in social care. The VCSE sector is large and active, with tens of thousands of volunteers.

Secondary care providers expect a 400 FTE reduction by 2026 despite small increases in nursing, midwifery and AHP staff.

Key workforce challenges:

- Recruitment and retention pressures, especially for clinical support, nursing and AHP roles.
- High temporary staffing use in some acute services.
- Declining staff engagement scores and concerns about bullying, discrimination and inequity in career progression, including under representation of BME staff in senior roles.

These issues impact quality, productivity and patient experience.

3. Population Health Strategy

3.1. Vision and outcomes

Our vision is that Norfolk and Suffolk residents live longer, healthier, happier lives with access to safe, joined-up, patient-centred care.

This reflects our commitment to improving both the quality and experience of care, as well as the need to enhance the overall health and wellbeing of the communities we serve. Achieving this vision requires a commitment to tackle the drivers of health and healthcare inequalities and placing our citizens at the heart of decision-making.

We will know we have been successful in achieving our vision if we see improvements in our three outcomes – improving healthy life expectancy for all, reducing health inequalities, including in equality in life expectancy, and improving access to consistently high-quality services, such as by reducing waiting times for care.

Table 2 The ICB's Vision and Outcomes

Our Vision	Norfolk and Suffolk residents live longer, healthier, happier lives with access to safe, joined-up, patient-centred care		
Outcomes	Improve healthy life expectancy for all	Reduce health inequalities	Improve access to consistently high-quality services

To improve access to consistently high-quality services, we will focus on:

- Reducing waiting times for elective diagnostics and treatments, including for cancer care
- Reducing waiting times for urgent and emergency care, including average ambulance response times and waiting times in Emergency Departments
- Increasing appointments across primary care, including primary medical care, pharmacy consultations and dental appointments
- Reducing waiting times in Community Health Services and improving response times of urgent community response services
- Improving access to mental health support teams and reducing the longest waiting times for mental health care

Healthy life expectancy is 62.5 and 63.3 for males in Norfolk and Suffolk respectively and 62.9 and 63.6 for females (2021-23). We will improve this by focusing on the clinical priorities that have the greatest impact on quality of life and by reducing health inequalities.

Figure 2 shows our strategy on a single page, illustrating the linkages between our outcomes, ambitions, long-term clinical priorities and more immediate priorities.

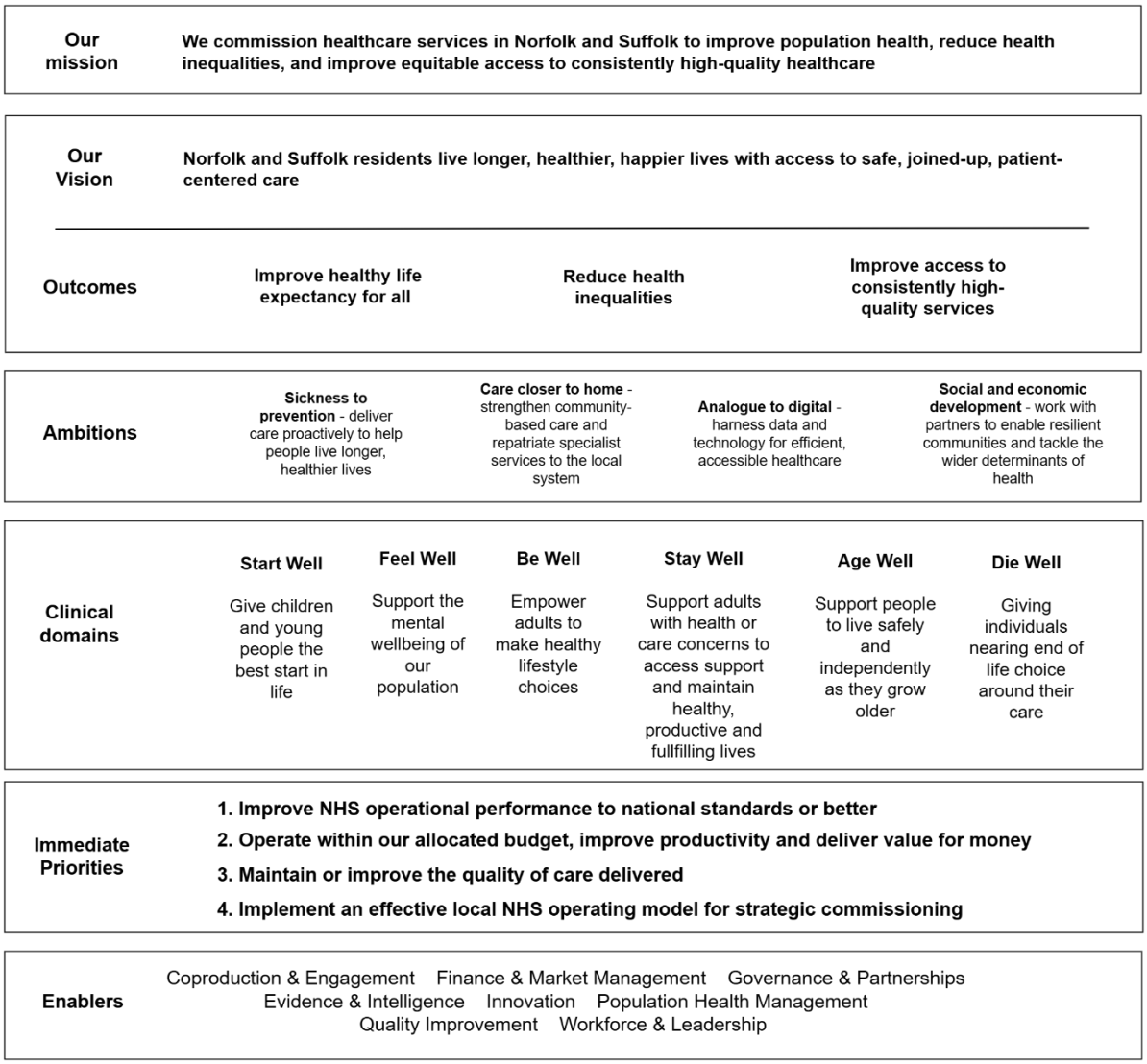

Figure 2 The Norfolk and Suffolk ICB strategy on a page

3.2. Reducing health inequalities

The ICB has a statutory duty to reduce health inequalities under the Health and Care Act 2022, the NHS Constitution and the Public Sector Equality Duty. To fulfil this, we will adopt clear policies, measurable standards, and routine commissioning processes that ensure tackling health inequalities is embedded in every commissioning and assurance activity we undertake.

Our approach to reducing inequalities will build on existing policies across Norfolk and Suffolk, including the10 year Health Inequalities Strategic Framework for Action. This sets a vision and guiding principles to tackle inequalities and their root causes.

Our commitment is to come together with system partners to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities,

prioritising prevention and by acting together, making health inequalities everybody's business.

The ICB will use the Core20PLUS5 approach to target resources in deprived communities and at high-risk groups. This will include assessment of unwarranted variation and targeted action in maternity, mental health, respiratory disease, cardiovascular disease, cancer, vaccination, smoking cessation and children and young people's services.

The Core20 refers to the 20% most deprived communities in England, defined using the Index of Multiple Deprivation (IMD). Our Plus groups will include:

- Ethnic minority communities
- Inclusion health groups (homeless people, asylum seekers, Gypsy, Roma, traveller communities)
- People with learning disabilities or autism
- Armed forces communities, including veterans
- Young carers and looked after children

Policies adopted by the ICB will include:

- Proportionate universalism in all service models - services will be available to all, but the scale and intensity of support will be proportionate to levels of disadvantage
- Mandatory health inequalities impact assessments for all commissioning proposals
- Embedding inequalities outcomes, data requirements and cultural competence expectations in service specifications and contracts
- Strengthened procurement scoring on health inequalities, prevention, population health management (PHM) and social value
- Engagement with communities to obtain insight on lived experience and ensure co-production

To make this business as usual, the ICB will:

- Embed oversight of inequalities metrics into commissioning governance and quality committees
- Require each relevant programme to evidence how it is "closing the gap" for Core20PLUS populations
- Publish annual progress and align practice to the Health Inequality Assurance Framework

As part of its Annual Report, the ICB will publish an annual Health Inequalities Statement demonstrating:

- A comprehensive understanding of inequalities in health care need across Norfolk and Suffolk
- Analysis of variation in access, experience and outcomes for different population groups
- Actions taken to improve data quality
- How insights on inequalities are informing commissioning, resource allocation and service redesign

To measure progress, we will monitor life expectancy across Norfolk and Suffolk, aiming to reduce the current life expectancy gap between the most and least deprived areas over the five-year period of this strategy. Additionally, we will measure progress across the range of metrics described in NHS England's statement on information on health inequalities measurement framework.

These actions will ensure the ICB drives measurable reductions in access, experience and outcomes gaps across Norfolk and Suffolk.

3.3. Our ambitions

We will realise our vision and outcomes by commissioning our services in a manner consistent with four ambitions.

Table 3 The ICB's Ambitions

	Sickness to prevention	**Care closer to home**	**Analogue to digital**	**Social and economic development**
Ambitions	Focus more on preventing illness and supporting people to stay healthy for longer.	Improve care in local communities and bring more specialist services back into the local health system.	Use data and technology to make healthcare more efficient and easier to access.	Work with partners to build stronger communities and tackle the wider factors that affect health.

1. **Sickness to prevention - Deliver care proactively to help people live longer, healthier lives.**

We will prioritise services and programmes that focus on prevention and earlier intervention. Within this, we will prioritise action in members of our population included in our plus groups (see paragraph 3.2), and on those areas known to have the greatest impact on inequalities: maternity, mental health, respiratory disease, cardiovascular disease, cancer, vaccination, smoking cessation and children and young people's services.

This will reduce inequalities and enable residents to maintain their own good health and reduce the likelihood of avoidable deterioration in health, and unplanned or urgent care needs. Commissioning decisions will target 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). This will include actions to promote screening uptake, better management of long-term conditions, more proactive care for

individuals with high complexity care needs, and improving uptake of annual health checks and subsequent health plans for people with SMI and LD&A.

We will work with Public Health to prevent illness at the whole population level (primary prevention) including through immunisation, lifestyle support, and actions to promote and maintain good health. Here we will focus our efforts on risk factors that have the greatest impact on health such as smoking and drug and alcohol abuse.

2. **Care closer to home - Strengthen community-based care and repatriating specialist services to the local system**

We will prioritise commissioning decisions for physical and mental health services that contribute to a shift in care being closer to our citizen's homes, including care delivered at home where possible, and development of a Neighbourhood NHS. We will prioritise investment in integrated community services, ensuring residents have access to timely, high-quality care without unnecessary hospital visits. In line with the ambitions of the NHS England 10-Year Health Plan, we expect this to result in a gradual increase in the proportion of resource prioritised within out of hospital settings. Where appropriate, we will also repatriate specialist services to local areas. This will benefit our citizens' by improving continuity of care and reducing the need for travel to distant centres.

3. **Analogue to digital – harness data and technology for efficient, accessible healthcare**

Across all our commissioning decisions we will look for opportunities for data and technology to enhance care quality, efficiency and value for money, improve care coordination, reduce duplication, and enhance patient access. We will maintain a strong focus on digital innovation as well as digital inclusion. Additionally, we will leverage data and analytics to embed PHM into commissioning activities, enable

evidence-based decision-making, and drive a shift towards proactive, personalised care. We will align local policy with the national digital and data agenda - taking advantage of national infrastructure and tools where appropriate - whilst keeping Norfolk and Suffolk residents at the centre of every decision. Key projects driving this transformation will include:

- Cyber Security - Protect resident data and ensure system resilience.
- Data Analytics – Our Intelligence Function and Data Hub will provide more predictive analytics (e.g. risk stratification), evaluative analytics (e.g. impact analysis) and health economic analysis.
- Digitising Social Care Record – Administrative tasks will be streamlined, information accessed quickly, accuracy improved, communication enhanced, and care integrated, creating a more efficient, connected system.
- Electronic Patient Record (EPR) Rollouts - Streamline workflows and reduce administrative burden, enabling earlier interventions and better management of long-term conditions to drive up life expectancy and gain better insights from data. Maximising EPR interoperability given the range of current and future EPRs across NHS services.
- Expand the use of patient portals through the NHS App or other digital means, to empower people to understand and manage their own health and healthcare.
- Digital innovations, such as use of wearable devices for long-term condition management and automation to reduce time spent by clinicians on administrative tasks.
- Integrated Neighbourhood Team working - Provision of information to enable multidisciplinary teams to coordinate care around the needs of each resident.
- Shared Care Records – Provide healthcare professionals with a single, comprehensive view of each resident's health and care information, so that people tell their story only once, offering seamless support and ensuring safer, more coordinated, and truly person-centred care.
- Virtual Care - Expand access and choice, supporting early intervention and self-management.

4. Social and economic development – work with partners to enable resilient communities and tackle the wider determinants of health

We recognise that health is shaped by factors beyond healthcare as evidenced in the Marmot Review (2010)[1] and the follow up report in 2020[2], and are proud to be part of the UK Marmot Place programme in West Norfolk and East Suffolk. Through our partnership with local authorities, NHS providers, and the VCFSE, we will

[1] Marmot, M. Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. (2010)
[2] Health equity in England: the marmot review 10 years on. Institute of Health Equity (2020)

contribute to ensuring housing, education, employment, social support, and environmental factors are arranged to enable good health. Through partnership with Local Authority Offices of Data Analytics, we will link healthcare data to that held by Local Authorities to improve intelligence on wider determinants of health and inform actions taken by Public Health. By tackling these wider determinants of health, we will strengthen community resilience and reduce health inequalities, supporting long-term improvements in population wellbeing. Good health will also provide a solid foundation for a strong local economy.

3.3.1. Work and Health

Work and Health are critical priorities for ICBs, with health conditions being the leading cause of economic inactivity; in Norfolk and Suffolk, 6% of our working age population is economically inactive due to health needs. One in five working-age adults has a work-limiting condition, with rising comorbidities and long-term conditions threatening workforce sustainability over the next five to ten years. “Good”, safe, and secure work supports health and wellbeing and is a critical wider determinant of health. This underpins the ICB’s ambition of contributing to the economic development of our communities.

Through implementation of the Fit for Work, Fit for Life strategy and health and work plans, the ICB will contribute systems leadership and leverage our role as a strategic commissioner to:

- Improve population health by tackling the underlying factors that affect people’s health and limit their ability to work;
- Support people who are currently facing health barriers to enter employment, providing personalised support programmes; and,
- Support employers and employees to remain well and in employment where someone has a disability or health need which impacts them at work

This will be embedded within our policies and strategic plans and delivered through neighbourhood and primary care interventions, integrated partnerships and pathways, and strategic commissioning.

3.4. Our roadmap to success

Our strategy must strike a balance between focussing on the commissioning activities that will best support achievement of population health outcomes in the longer-term (by five years) and those activities that will support addressing immediate challenges (within the next two years). Therefore, our priorities are set out in a two-stage, five-year plan, though this will be a continuum of work.

This focusses on early recovery and rapid stabilisation in the first two years to address urgent quality, performance, and financial pressures, thereby laying the

foundations for sustainable improvements. The first two years also focus on designing and delivering and/or commissioning new care models, including secondary prevention care models, to lay the foundations of a neighbourhood healthcare service and identifying the major transformation opportunities that will improve population health, including the financial frameworks that will support this sustainably. It is anticipated that SNEE and N&W ICB's will come together into one ICB in 2026/27. We will develop the strengths from both organisations and build the capabilities that are needed to deliver this strategy most effectively.

Improving population health outcomes demands transformational changes in how healthcare services are delivered. This change will be achieved over the longer-term (years three to five) through realisation of our ambitions to achieve the three shifts in care - sickness to prevention, care closer to home, analogue to digital – whilst building resilient local communities. This requires extensive system integration through a neighbourhood healthcare service, redesigned care models to shift more care into the community, and greater emphasis prevention, all of which must be underpinned by digitally led innovation and change.

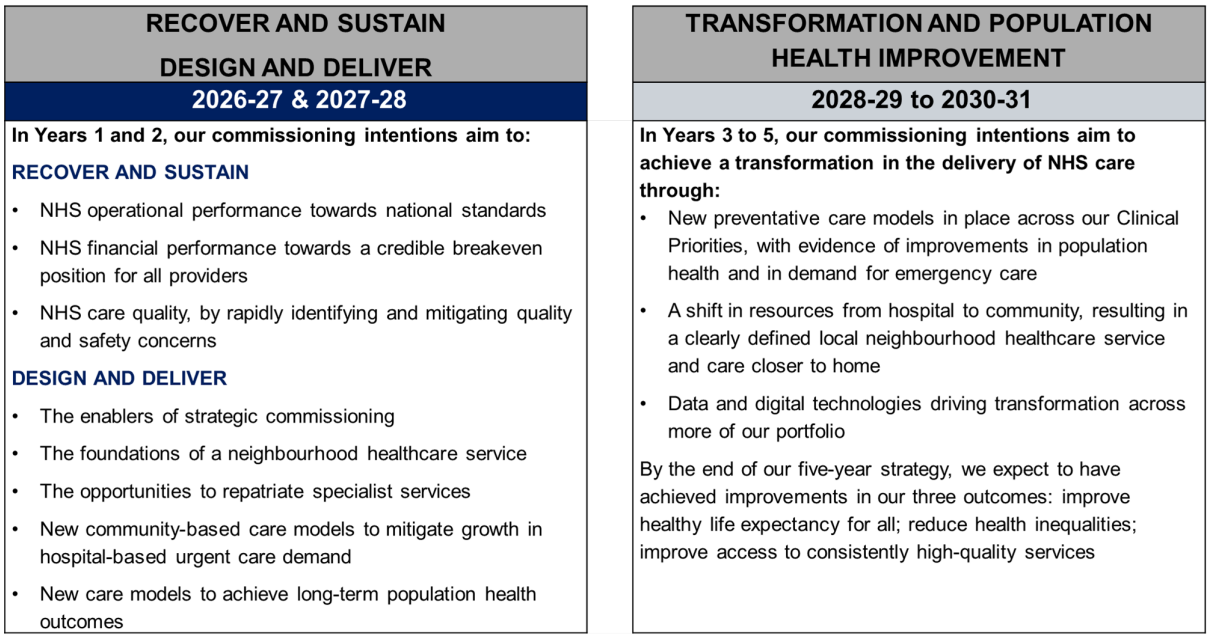

Figure 3 Our five-year roadmap

3.5. Our long-term Clinical Priorities and the Live Well Framework

Through this strategy we marry commissioning activity with the Clinical Priorities that we need to focus on to achieve our vision and outcomes by the end of this five-year strategy (Table 4). Our Clinical Priorities are structured by a life course approach called the "Live Well" Framework (Table 4).

Within this framework there are six Clinical Domains, each with a small number of Clinical Priorities. Each Clinical Priority focuses on the achievement of health outcomes, in line with the ICB's shift to outcome-focussed strategic commissioning. We aim to see improvements in these outcomes by the end of the five-year period of

this strategy or sooner which in turn will support our achievement of our overall three outcomes and through that our vision. Several themes span the Clinical Domains.

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

Table 4 Clinical Domains and Clinical Priorities

Clinical Domain	Clinical Priorities
Start Well Giving children and young people the best start in life, including pre-conception	• Early Years • Pre-conception, maternity and perinatal
Be Well Empowering our population to make healthy lifestyle choices	• Learning disabilities and autism • Healthy choices and behaviours
Feel Well Supporting the mental health and emotional wellbeing of our population	• Mental Health & Emotional Well-Being • Trauma & abuse
Stay Well Supporting our population who have health or care concerns, to access support and maintain healthy, productive and fulfilling lives	• Cancer • Elective & diagnostics • Neurodevelopmental disorders • Urgent & emergency care • Stroke • Long-term conditions
Age Well Supporting people to live safely and independently as they grow older	• Ageing Well • Dementia
Die Well Giving everyone nearing end of life, choices around their care	• End of life and palliative care
Cross-cutting themes	• General Practice • Dental, vaccinations, pharmacy & optometry • Medicines Optimisation • Neighbourhood healthcare • Community services • Specialised commissioning • Work and health

	• Health protection

Our clinical priorities form the basis of how we have arranged our commissioning intentions in the Norfolk and Suffolk Population Health Improvement Plan (PHIP).

3.6. Our Immediate Priorities

3.6.1. Performance

We know from public engagement that NHS performance is important to our population and the amount of time it takes to be seen and treated is of concern. Therefore, the ICB aims to commission services to achieve all standards in the Medium-term Planning Framework, in line with trajectories and targets set by NHSE.

The Population Health Improvement Plan describes in full what and how the ICB will commission and how it will work with providers to achieve performance improvements.

Achieving this improvement across the breadth of priority services will be extremely challenging for our providers and we will work with them to develop our local response. Our key performance priorities include (not a complete list):

- Elective, Cancer and Diagnostics – reform the way elective care is delivered to increase productivity and ensure 92% of patients are treated within 18 weeks of their referral by 31 March 2029.
- Urgent and emergency care – improve Ambulance category 2 performance to an average of 18 minutes by 2028, with 90% of calls responded to within 40 minutes; 1-hour psychiatric liaison standard; 24hr face to face crisis assessment; zero inappropriate out of area placements
- Primary care and community services – ensure 90% of clinically urgent patients are seen on the same day, subject to consultation with the profession on this aim
- Mental Health, Learning Disabilities and autism - children and young people access standard and adult and older persons length of stay.

3.6.2. Quality

Our vision is for a fully integrated and collaborative approach to quality across all health and care services within Norfolk and Suffolk. This will be through a single, shared understanding of quality, enabling all providers to use and report agreed measures and outcomes to demonstrate the quality of their services. We will make quality an integral part of the ICB's strategic commissioning model. The ICB will:

- Have a clear and credible strategy for improving quality, including defined governance and escalation processes which ensure that quality risks are managed effectively, based on the National Quality Strategy.
- Expect all relevant providers, as part of their contractual responsibilities, to submit quality reports that demonstrate evidence of how patient and public

experience data are collected and analysed across their care pathways and services.

- Expect all providers to provide the ICB with an indicative plan for Quality Improvement (QI) activities which align with key risk and quality priorities as set within their Quality Accounts and National Quality Board guidance. This includes provider implementation of new Modern Service Frameworks and National Care Delivery Standards as they are launched nationally.
- Respond to all emerging concerns raised about commissioned services by using the Norfolk and Suffolk Early Warning Framework, which sets out the ICB's approach to identifying and responding to concerns regarding the quality of care.
- Assess procurements from a quality perspective, monitor quality as part of contracts, to drive quality improvement, proactively manage risks and ensure that all service changes have supporting Quality Impact (QIA) and Equality and Health Inequalities Impact (EHIA) Assessments that are in line with the National Quality Board guidance (2025).
- Embed clinical quality and oversight in the initiation phase of all new projects or programmes of work within Norfolk and Suffolk ICB, supported by a Quality Oversight Checklist by March 2027.
- Confirm its accountabilities and responsibilities for quality assurance and oversight with NHS East of England's Regional Quality Team, thereby ensuring a reduction in duplication and clarity of expectation for providers.
- Make full use of patient experience and outcome measures (PROMS and PREMS) as they are captured, including as part of the National Neighbourhood Implementation programme.

4. Commissioning Strategy

4.1. The Strategic Commissioning Framework (SCF)

NHS England published the Strategic Commissioning Framework[3] in November 2025. This explains the national expectation for how ICBs will operate as strategic commissioners. This sets ICBs a clear focus on improving population health, reducing health inequalities and ensuring access to services. We have adopted these aims as the three outcomes we will deliver through this Strategy.

The Framework defines strategic commissioning as "a continuous evidence-based process to plan, purchase and monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare".

A key change is the significant focus on data and analytics for assessing population health need and evaluation, as well as the greater focus on health economic

[3] NHS England » Strategic Commissioning Framework

principles for resource allocation. The Norfolk and Suffolk ICB will use the Framework as a guide to change our approach to commissioning.

4.2. Our approach to Strategic Commissioning

The four stages of Strategic Commissioning are:

1. Understanding the context
2. Developing long-term population health strategy
3. Delivering through payor functions
4. Evaluating impact

We will apply these stages through a set of tangible activities that will underpin how we will work, including:

- Using linked patient-level data to identify population cohorts, drivers of cost, poor outcomes, and understand who are facing barriers to access
- Embed population health management as a total continuous improvement process through all that we commission
- Prioritisation of investments to maximise allocative efficiency and align resource allocation with strategic intent
- Deliver our strategy through enforceable contract management that describes that ICB's expectations on activity volumes, price, standards and productivity
- Develop market management policies that challenges underperformance, rewards achievement of high standards, and is underpinned by a policy of commissioning to improve value
- Track delivery to monitor performance and evaluate impact
- Investing in the enablers of strategic commissioning
- Working with our partners through constructive dialogue to triangulate finance, workforce, and performance
- Working with our partners to create the conditions to identify and deliver transformations in how care is delivered

4.2.1. Understanding the context

The foundational stage of Strategic Commissioning is a deep understanding of the current and future healthcare needs of the local population. To achieve this, we will:

- Work with Public Health Teams to produce, refresh each year and publish an Integrated Needs Assessment
- Establish a Norfolk and Suffolk Intelligence function that is ICB and Local Authority-Integrated to extract insights from data and inform strategic planning and population health management.
- In our Data Hub, expand person-level linked datasets across the Norfolk and Suffolk geography

- Work with Local Authority insight teams, including Offices of Data Analytics, to expand insights on the wider determinants of health
- Work with Local Healthwatch organisations (and their successors) and the VCFSE to capture and understand “lived experience” as well as the views of independent voices from patients and the public, including seldom-heard voices.
- Develop deep insights into health inequalities and unwarranted variation
- Collate evidence on high impact, high value healthcare interventions and innovation opportunities
- Put in place data and analytical tools that are accessible to neighbourhood care providers to support the use of insights in delivery of proactive care.
- Embed our segmentation model (Figure 4) and risk stratification tools to enable identification of priority population cohorts and align strategy with delivery, including supporting identification of care for high intensity users
- Build skills across the organisation in interpreting and using analysis

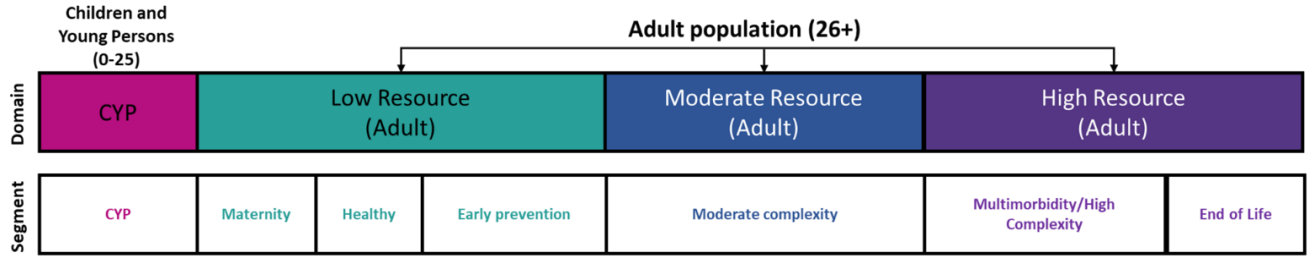

Figure 4 The Norfolk and Suffolk population segmentation model

4.2.2. Developing long-term population health strategy

To ensure we retain a focus on setting long-term population health strategy for the local NHS system, we will:

- Review, update and publish each year our five-year Population Health and Commissioning strategy
- Align our Commissioning Intentions to health outcomes
- Build our strategy from a compelling case for change, as set out in the Integrated Needs Assessment
- Align our strategy to both national and local policy drivers
- Align our strategy with Neighbourhood Health Plans, ensuring consistency in prioritisation from system to neighbourhood and strategy to care delivery
- Develop a five-year Population Health Improvement Plan which will set out our SMART Commissioning Intentions that enables providers to respond to the ICB’s priorities and to enable success to be measured
- Enhance the organisation’s capabilities in healthcare strategy and strategic planning development and design of new care models
- Establish a coproduction methodology
- Embed coproduction into our commissioning processes across all we do

4.2.3. Delivering the strategy through payer functions and resource allocation

4.2.3.1. Market Management

The Provider Selection Regime (PSR) requires the ICB to act with a view to securing the needs of the people who use the services whilst improving quality and efficiency in the provision of the services, whilst acting transparently, fairly and proportionately. To achieve this, the ICB will shape, manage and develop provider markets through a policy for market management based on the following principles:

- Operate within a defined financial envelope while transitioning from block contracts to activity-based funding, linking resource allocation decisions to value-for-money and improved patient outcomes.
- Align commissioning decisions with system performance targets

The policy requires an informed and structured approach to allocating funding across NHS and independent sector providers. We will develop, implement, test and refine a funding allocation framework that will:

- Establish annual budgets and allocate resources by service area / speciality based on prevalence, waiting list size, productivity, and required performance.
- Sustain the necessary NHS trust capacity for critical services
- Distribute remaining funds to providers proportionally, with adjustments informed by patient choice alongside provider performance, quality, and efficiency.

To manage dynamic markets, in particular for Right to Choose services, we will:

- Maintain a contingency fund for in-year accreditation of new providers, ensuring patient choice without destabilising the system.
- Incorporate newly accredited providers into future annual planning cycles.
- Use performance metrics such as outcomes, productivity, and patient experience to inform future allocations and incentivise improvement.

To achieve this approach the ICB will better understand and manage markets by:

- Undertaking structured market analysis with early provider engagement to develop a joint understanding of future need versus future capability
- Monitor new policies, developments and innovations to inform the appropriate scale for commissioning
- Undertake ongoing, risk-based assessment of contracts, which stratifies contract management approaches
- Support and develop new and existing providers to further stabilise the system to allow the devolution of commissioning responsibilities as appropriate.

We will develop, implement, test and refine these processes and policies through 2026-27 with transparency and provider engagement, aiming for full integration into business-as-usual by 2027/28.

4.2.3.2. Prioritisation

The ICB will apply a structured, multi-criteria decision analysis to ensure that investment decisions are transparent, evidence-based, and aligned with the immediate and longer-term aims of this strategy. This approach will balance immediate operational needs with long-term sustainability, enabling us to allocate resources where they deliver the greatest value.

This will provide fairness and transparency, ensuring that all investment proposals are judged against the same criteria. It will enable the ICB to make difficult trade-offs in a resource-constrained environment. The process will also foster strategic alignment, ensuring that local commissioning decisions contribute to national ambitions such as prevention, care closer to home, and digital transformation.

By embedding this prioritisation framework, the ICB ensures that commissioning decisions are equitable, clinically sound, financially responsible, and socially valuable.

4.2.3.3. Health economics

Health economics principles and methodology will be embedded throughout all the ICB's commissioning activities, to ensure that decisions are evidence-based, equitable, and deliver the greatest value for our population. However, this will play a key role in ensuring that the ICB's finite resources are allocated and used to maximum effect to improve population health.

When making commissioning decisions we will aim to develop a robust understanding of cost-effectiveness, allocative efficiency, and the opportunity cost for each investment. This approach strengthens our ability to assess need, develop strategy, evaluate options, and invest resources where they will have the most impact on health outcomes and inequalities.

4.2.3.4. Workforce planning

Workforce planning and re-design will be a core enabler of this strategy, ensuring that the system inspires, attracts and retains the right people with the right skills, knowledge, behaviours and values to deliver the health and care services needed now and the future. To support integration and maximise efficiency, we will encourage a system-wide approach to workforce planning and re-design. We will work with education providers, professional bodies, and system partners to transform and create sustainable supply pipelines and career pathways, enhance staff wellbeing and resilience, and embed equality, diversity, and inclusion across all workforce initiatives such that the workforce reflects the populations served. We will work with partners to address workforce shortages through innovation and reform such as new roles or upskilling and digital solutions.

Utilising the evidence base we will support the re-design of multi-disciplinary teams at neighbourhood level, particularly focussing on change management and organisational development interventions.

By integrating workforce planning into strategic commissioning, we will ensure that service transformation is underpinned by a resilient, skilled, and adaptable workforce capable of meeting future health and care demands supported by strong, compassionate and agile leadership.

4.2.4. Population Health Management

The Integrated Needs Assessment shows that population health and care needs are changing, requiring a more proactive approach to prevent widening inequalities. Population Health Management (PHM) supports this by shifting care from reactive to proactive and strengthening strategic commissioning through better use of data, resource allocation and evaluation. Using integrated data, segmentation, risk stratification and demand modelling, PHM identifies groups at risk and informs preventative care models, workforce planning and contracting. We will embed PHM across planning, commissioning, resource allocation and learning.

By combining health data with wider determinants such as housing, employment and finances, Integrated Needs Assessments and JSNAs help identify the factors driving poor outcomes and support more coordinated action.

Through PHM we will:

- Understand current and future needs and inequalities
- Identify at-risk groups through analytics and predictive modelling
- Implement evidence-based, person-centred interventions
- Strengthen enablers of long-term preventative care
- Evaluate outcomes, impact and value

This ensures care is proactive, data-driven and equitable, with strong partnership working, including the VCFSE sector. We will apply PHM across all clinical priorities. To ensure consistency, we will bring together the strongest local approaches from Suffolk and Norfolk to create a unified system-wide PHM model.

We have experience embedding PHM through training, resources and practical tools. Existing "How-To" guides and evaluation frameworks will be aligned into a single toolkit, and wider access to PHM data will be expanded. Linked datasets will play a central role, enabling proactive case finding and earlier intervention for high-risk groups. Existing programmes show how proactive case finding can reduce variation, improve access for underserved communities and support earlier treatment, so we will establish a consistent system-wide approach focused on high-impact cohorts.

This blueprint embeds PHM across planning, commissioning and delivery, creating a unified, proactive, data-driven and equitable system across Norfolk and Suffolk that anticipates need, prevents ill health and improves outcomes for every community.

4.2.5. Evaluating impact

Central to our role as a strategic commissioner is the ability to evaluate the performance and impact of the services we commission from a quality, operational and financial perspective to ensure we are obtaining the best outcomes for our population. ICBs need to understand how services perform as part of contract management as well as to inform future service design. We will consider the evaluation of impact at all stages of the strategic commissioning cycle to determine the most appropriate approach; ensure service aims are clearly linked to outcomes, and to confirm the availability and quality of outcome data (both quantitative and qualitative) as an integral part of service development.

Two principal approaches will be used to evaluate the impact of the services we commission:

1. Performance monitoring: key performance indicators (KPIs) will be routinely used to monitor the performance of a service. They will form a key part of contracts with providers.
2. Detailed evaluation: involving a systematic assessment of a project or service to determine its effectiveness or impact.

We will utilise the existing evidence base, population health data and qualitative insight to determine which approach is taken early in the commissioning cycle. We will draw on the evidence base from other ICBs, where appropriate, to determine the need for detailed evaluation and avoid duplication of existing work.

We will use different approaches to evaluation (formative, process, summative and economic) either individually or in combination, depending on the nature of the intervention, the rationale for evaluating it and the resources available to do so.

Across Norfolk and Suffolk, we have strengths in formative and process evaluation approaches. Summative evaluation (where we establish causal linkage between services and outcomes) and economic evaluation will be enhanced moving forward. To achieve the full mix of evaluation capability, we will establish three approaches to evaluating impact for services or pathways that we commission:

1. We will support the development of strategic commissioners within the ICB to understand evaluation and enable them to frame and conduct these, where appropriate.
2. For services of particular significance/importance, we will work with external evaluation providers (e.g. Health Innovation Networks, academia, consultancy) to deliver specific evaluations.

3. For other commissioned services we will include an evaluation requirement as part of a contract for a particular service or pathway.

Each service or pathway will have a clear method of evaluating impact as part of the commissioning process. The outputs from each evaluation will feed directly into the next stage of the commissioning cycle where it will used as evidence alongside population heath data and insight to determine next steps.

5. NHS Operating Model for Norfolk and Suffolk

5.1. Approach to Place and Neighbourhood

The ICB will build on recognised strengths of commissioning at Place and neighbourhood levels. The five Places will be West Norfolk, Great Yarmouth and Waveney, Central Norfolk, West Suffolk, and Ipswich and East Suffolk. The ICB will give all due consideration to the implications of Local Government Reform.

Each Place will have an Alliance - a group of partners with common purpose - to advance the vision, objectives and outcomes developed for their area within the context of the overarching ICB's Population Health and Commissioning Strategy.

Each Alliance will be a partnership of equals with representatives of all relevant partners within the Place.

The ICB will delegate accountability for the commissioning of community and wider 'out of hospital services', end of life care and neighbourhood commissioning, to a Committee for Norfolk and Waveney and East and West Suffolk. This includes accountability for the service's financial, quality and operational performance. The Committees will comprise representatives of each of their constituent Alliances. The Committees will further delegate responsibility for commissioning these services to Place Alliances, with a budget aligned to these services. The level of assurance which each Committee chooses to seek from the Alliances will depend on their maturity. The ICB retains accountability for primary care services (general practice, dental, optometry and pharmacy services), in line with the legal delegation agreement with NHS England. Some contractual agreements for pharmacy and optometry with another host ICB in the eastern region are in place. We will work within these agreements and with other organisations to enable discretionary funding to be delegated wherever possible, to support the development of Alliances.

Each Alliance will establish a clear forward plan for the quantifiable progression of holistic (physical and mental), all age Neighbourhood Health within their Places, to enable implementation of the Ten-Year Plan and achievement of the three ICB outcomes. The Alliances will ensure that plans are informed by quantitative information (e.g. population segmentation and risk stratification) and qualitative insights, with services being co-produced with communities and partners to address specific local health and wellbeing needs. This will ensure there is a relentless focus on:

- reducing health inequalities
- enabling people to stay well (preventing ill health and addressing the wider determinants of health also)
- ensuring (at least) national standards of access to and experience of safe, high-quality care are met, and unwarranted variation is addressed; and
- enabling joined up care within neighbourhoods, when people need it

Alliances will ensure that neighbourhoods are enabled by the digital, workforce, information governance and estates support including the potential of Neighbourhood Health Centres.

5.2. Partnering for impact: people, communities and strategic relationships

The ICB cannot achieve its objectives alone and is committed to partnering with people and communities, NHS providers, local government, the VCSFE sector, the private sector, and other strategic partners. These relationships are foundational to creating an inclusive, equitable, and responsive health and care system. They are critical to the ‘left shift’ towards prevention, reducing health inequalities, delivering New Hospital Programmes, and developing Neighbourhood Health. All partners need to be empowered to contribute to collaborative system leadership, whilst committing to coproduction and ongoing engagement with people and communities.

Health outcomes are shaped by clinical, psychosocial, and economic factors. Local authorities bring expertise in housing, education, public health and social care; VCSFE organisations offer insight into lived experience and social determinants; the private sector creates opportunities to influence health and socio-economic ambitions; and communities themselves hold the knowledge and assets that make change sustainable. By partnering effectively, we can design and commission services that reflect real needs, reduce inequalities, and deliver on our shared ambition for healthier lives.

The ICB will:

- Embed partnership as core practice: Make working in partnership, co-design and ensuring an equitable voice for people, communities, and VCSFE a requirement for all teams and supported by practical tools and a co-produced partnerships policy.
- Harness Place and neighbourhood working: Strengthen collaboration and co-production with communities and strategic partners at every level, empowering local partnerships to deliver local priorities.
- Start with seldom-heard voices: Apply the CQC engagement framework and NHS 10 Principles of Working with People and Communities to establish a baseline, identify barriers, and implement best-practice solutions.
- Build on existing strengths: Further develop VCSFE and People & Communities Assemblies and expand the impactful tools already in place.
- Encourage collaboration: Through commissioning practices, encourage partnerships and collaborative working to meet the needs of the population
- Ensure accessibility and inclusion: Address language, interpretation, digital inclusion, and health literacy to enable meaningful engagement.
- Consider and address the wider determinants of health: Through strong partnerships we will deliver the social and economic ambitions of the ICB
- Monitor and evaluate: Understand the impact of ICB decisions and ways of working on wider system partners, including its impact on VCSFE sector sustainability.

Through these actions, the ICB will embed co-production and partnership at the heart of strategic commissioning, ensuring decisions are inclusive, evidence-based, and focused on improving outcomes for all.

5.3. Governance and delegated commissioning

The ICB Board will have a committee structure to delegate decision making and oversight responsibility for many of the ICB's functions Figure 5. The Executive Committee will be responsible for the day-to-day operation of the organisation, with decision making responsibility across the ICB's remit. The Strategic Commissioning; Finance, Workforce and Performance; and Quality Committees also have delegated responsibilities that cross the ICB footprint. Committee membership includes a range of relevant stakeholders from providers and partner organisations, to bring wider perspectives into the ICB's oversight and decision-making processes.

The Board also works collaboratively with Local Authorities, sitting as part of the Health and Wellbeing Board to manage expenditure through the Better Care Fund. The Board also collaborates with the Health and Wellbeing Board and wider Local Authorities governance structures on the commissioning of Children's Services and in areas where social care and health interact.

The Board has also delegated commissioning and oversight responsibility for Community Services and Primary Care to Norfolk and Waveney East and West Suffolk Committees, as well as responsibility for specific services that fall under the

Ageing Well and Die Well Clinical Domains. These Committees have further delegated some commissioning to neighbourhood level through the five Places which cover Norfolk and Suffolk.

The ICB Board will work closely with Health and Wellbeing Boards on delivery of Neighbourhood Health Plans and with providers for delegated commissioning to applicable providers.

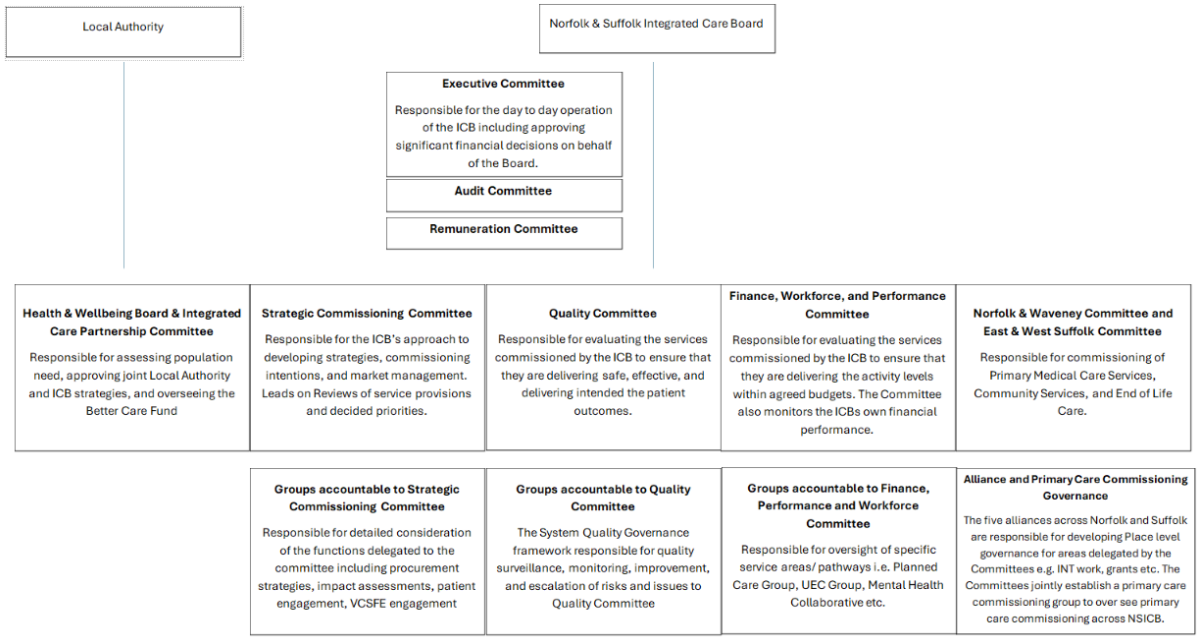

Figure 5 Suffolk and Norfolk Integrated Board Governance structure

5.4. Assurance and accountability

The ICB will publish an annual report in accordance with any guidance published by NHSE that sets out how it has discharged its functions and fulfilled its duties in the previous financial year. The ICB is held to account by NHSE for performance through the NHS Oversight Framework, which sets out a broad range of measures.

The ICB has adopted a range of population health outcome measures to assess success in achieving its strategy. This reflects the accountability the ICB has to improve the health of the local population. The ICB will measure success of the services it commissions through a range of performance measures, reflecting the accountability the ICB has to commission services that meet high standards.

Through this strategy and its population health improvement plan, the ICB has set local performance priorities that are important to the system's population. These metrics form the ICB's performance framework.

The ICB will establish effective arrangements via the delegation to committees and subsequent reporting cycles to enable the Board of the ICB to provide an effective

and timely account of its performance to key internal and external stakeholders and the public. The ICB will seek reports and assurance from directors and managers as appropriate, concentrating on the delivery of the key priorities and goals set out in this strategy, including integrated governance, risk management and internal control, together with indicators of their effectiveness. Reports will have consistent foundations based on underlying assurance processes that indicate the degree of achievement of the priorities and the effectiveness of the delivery and performance.

The Finance, Workforce and Performance Committee will be established by the Board to support managing improvement, development and performance. This will be a data-driven, evidence-based and rigorous committee that provides focus on supporting the spread and adoption of innovation and best practice between partners.

A regular assessment of delivery performance against the strategy, focussing on performance against population health outcomes, will be undertaken by the Strategic Commissioning Committee, with appropriate escalation to the ICB Board and an annual summary provided through the ICB's annual report.

Our Board Assurance Framework (BAF) will provide the ICB Board with a simple but comprehensive method for the effective and focused management of risk. Through the BAF the ICB Board will gain assurance that risks are being appropriately managed throughout the organisation.

5.5. Equality and Health Inequalities and Quality Impact Assessments

The ICB has the responsibility for ensuring that robust and thorough impact assessments inform and support all business cases as part of a sustainable, ethical and outcome-focussed strategic commissioning approach. This includes Quality Impact Assessments (QIA) and Equality and Health Inequalities Assessments (EHIA). QIA focuses on the quality of care delivered, looking at factors based on the National Quality Board definition of care quality as well as considering broader system resilience and workforce factors that may be impacted by changes in commissioning. EHIA focuses on impact across populations, including people with protected characteristics (age, sex, race, disability, religion or belief, sexual orientation, gender reassignment, marriage or civil partnership and pregnancy and maternity), and other communities, including inclusion health groups (e.g. homeless, sex workers, migrant communities), residents in Core20 areas of higher social deprivation, carers of all ages and our armed forces community.

Together, these assessments identify, explore and mitigate the risk of any unintended impacts of commissioning decisions, early within planning, and influence decision-making to ensure that quality, accessibility and equity of health outcomes remain central.

The ICB has a robust process for the completion of these assessments, and to ensure there is robust escalation and risk management in place.

6. Glossary

Acronym/term	Definition
A&E	Accident and Emergency services providing urgent hospital care.
BAF	Board Assurance Framework – the main tool used by the ICB Board to identify, manage and gain assurance on strategic risks.
CCG	Clinical Commissioning Group – former NHS organisations responsible for commissioning services prior to the creation of ICBs.
Core20PLUS5	An NHS England approach to reducing health inequalities by targeting the most deprived 20% of communities, plus specific inclusion groups and priority clinical areas.
CYP	Children and Young People, generally referring to ages 0–25 in NHS policy.
DHSC	Department of Health and Social Care, the UK government department responsible for health and social care policy.
EPR	Electronic Patient Record – a digital system that stores and shares patient health information.
EHIA	Equality and Health Inequalities Impact Assessment – an assessment to understand how decisions may affect different population groups and health inequalities.
ICS	Integrated Care System – organisations working together across health and care to improve population health and reduce inequalities.
ICB	Integrated Care Board – the statutory NHS organisation responsible for planning and commissioning NHS services within an ICS.
IMD	Index of Multiple Deprivation, the national measure of relative deprivation across small geographic areas in England.
INA	Integrated Needs Assessment – a combined assessment of population health needs using health, care and wider data sources.
JSNA	Joint Strategic Needs Assessment, produced by local authorities and the NHS to understand current and future health and wellbeing needs.
KPI	Key Performance Indicator, a measure used to assess performance against objectives or standards.
LD&A	Learning Disabilities and Autism.
MTFP	Medium-Term Planning Framework, setting national NHS priorities, standards and expectations over a multi-year period.
ND	Neurodevelopmental Disorders, including conditions such as autism and ADHD.
NHS	National Health Service, the publicly funded healthcare system in England.

NHSE / NHS England	The national body overseeing the NHS and holding Integrated Care Boards to account.
PHIP	Population Health Improvement Plan, setting out detailed commissioning intentions to deliver the Population Health and Commissioning Strategy.
PHM	Population Health Management, using data and insight to identify population needs, target interventions and improve outcomes.
Place	A geographic area within the ICS footprint where partners work together to plan and deliver services locally.
Proportionate universalism	Providing services to everyone, with the scale and intensity increased for those with greater need or disadvantage.
PSR	Provider Selection Regime, the national framework governing how NHS commissioners select service providers.
QI	Quality Improvement, systematic approaches to improving patient safety, experience and outcomes.
QIA	Quality Impact Assessment, assessing the potential impact of service changes on care quality and safety.
Right to Choose	A legal right allowing patients to choose certain providers for NHS-funded services.
Risk stratification	Analysing data to identify individuals or groups at higher risk who may benefit from targeted interventions.
SCF	Strategic Commissioning Framework, NHS England guidance defining how ICBs should operate as strategic commissioners.
SEND	Special Educational Needs and Disabilities.
Shared Care Record	A digital record that allows authorised professionals across health and care to access shared patient information.
SMI	Severe Mental Illness.
VCFSE	Voluntary, Community, Faith and Social Enterprise sector.
Neighbourhood Health / Neighbourhood Healthcare	Multidisciplinary health and care delivered at neighbourhood level, centred on the needs of local populations.
Neighbourhood Health Plans	Local plans setting out how neighbourhood partners will improve health outcomes and reduce inequalities.
Live Well Framework	A life-course approach structuring clinical priorities from early years to end of life.