NHS
Norfolk and Suffolk
Integrated Care Board

Strategic Plan for Mental Health 2026-2031

V1.6
June 2026

Table of Contents

1. Introduction

1.1. Purpose of this Strategic Plan

The purpose of this strategic plan is twofold. First, it sets out the ICB's priorities for emotional wellbeing and mental health for the period 2026-2031, and gives an overview of how they will be delivered. Its focus is on the areas that the ICB has responsibility for and which we will lead; it is not intended to be a comprehensive, whole-system plan that considers all elements of emotional wellbeing and mental health.

Second, while this is very much an ICB plan, it outlines how – in our view – the wider system might in future collaborate to best effect. This is in recognition of the fact that no one organisation's plans exist in isolation – improving mental health outcomes for local people requires partnerships, alignment of plans and, in many cases, integrated delivery.

This strategic plan sits under the ICB's overarching Population Health and Commissioning Strategy[1], and its more detailed Population Health Improvement Plan. It is intended to be the first of a series of ICB service focused strategic plans, reflecting the particular importance attached to mental health within the new organisation.

While the ICB is a new organisation, its predecessor bodies had mental health plans and work programmes for both Norfolk and Suffolk, which have been reviewed and, where there is alignment, built into this document. Alongside this, the current and emerging plans of partners locally have been considered, reflecting our wider objective to – where possible - align plans and priorities.

1.2. Scope of this Strategic Plan

This strategic plan considers the ICB's priorities along a spectrum from prevention and early intervention (such as perinatal services) through to more specialist clinical interventions (such as supporting people in crisis). It also takes an all age approach, spanning perinatal, children and young people and adults.

This plan does not consider in any detail two other important areas that are relevant to wider emotional wellbeing and mental health. These are services for people with a learning disability and/or autism or who are neurodiverse, and support for people with dementia. In the case of the former, there are other partnership based plans that set out collective planning arrangements and shared priorities; and in the case of the latter, developing a responsive and integrated approach to supporting people with dementia is being progressed at a local, Alliance based level, reflecting the different issues and challenges across the footprint.

[1] https://www.norfolkandsuffolk.icb.nhs.uk/documents/population-health-and-commissioning-strategy/

1.3. Structure of this Strategic Plan

There are four main sections to this plan:

- Strategic context, which summarises the national and local environment within which this plan was developed
- The ICB priorities, which sets out the main areas of focus for the ICB over the next five years
- Delivery arrangements, which considers what form future system-wide mental health collaborative arrangements might take
- Next steps, which gives and overview of how this strategic plan will move into the delivery phase.

2. Context

This section sets out the national and local context within which we have developed, and will be implementing, our strategic plan for mental health.

2.1. National Context

In 2025 NHS England published its Ten-Year Health Plan[2], which outlined three main shifts for the future NHS, each of which is highly relevant to mental health:

- Hospital to community – with more care delivered locally and at home
- Sickness to prevention – helping people to make healthier choices and where required earlier intervention
- Analogue to digital – using technology to enable people to manage their care and to increase efficiency

At the same time, the role, configuration and capacity of ICBs has undergone significant change. ICBs have, in general, consolidated, resulting in fewer organisations covering larger geographic areas. As outlined in NHS England's Strategic Commissioning Framework[3], the focus of ICBs has been recast, positioning them primarily as strategic commissioners focused on population health, reducing inequalities and ensuring value. And, alongside these changes, ICB running costs have reduced by up to half, significantly reducing their capacity. Taken together, these changes reframe ICBs' role in the local system.

In recent months NHS England has also published other national frameworks that are highly relevant to this strategic plan. This includes detailed guidance on neighbourhood health, which considers the structure and composition of the new neighbourhood health centres. Work is also progressing nationally on the development of mental health specific modern service frameworks, such as supporting people with severe mental illness.

Finally, as well as changes to NHS structures, the Government is progressing a major reorganisation of local government. These changes are an important consideration in the development of this strategic plan, as local authorities are central partners in supporting the emotional wellbeing and mental health of local people. In Norfolk and Suffolk, this reorganisation is likely to result in the existing two county and 12 district and borough councils being replaced by six new unitary authorities, three in Norfolk and three in Suffolk.

2.2. Local Context

Norfolk and Suffolk Integrated Care Board

In April 2026 the new Norfolk and Suffolk ICB was formally established, replacing the two previous organisations. The new ICB has recently published both its overarching strategy (the Population Health and Commissioning Strategy, 2026/27-2030/31), and

[2] https://www.england.nhs.uk/long-term-plan/

[3] https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

the more detailed Population Health Improvement Plan[4], which covers the same period. Both of these documents build on and reflect plans developed by the legacy ICBs, as well as key local strategies such as the two county-based Health and Wellbeing Strategies, the refreshed Norfolk and Suffolk NHS Foundation (NSFT) strategy and other partners' plans.

The ICB's Population Health and Commissioning Strategy articulates the new organisation's overall mission and vision, as well as its ambitions and the six main clinical domains that provide the framework within which our work is organised. It also sets out local thinking about strategic commissioning and how the new organisation will approach its core future function, including the central role clinical leaders from all disciplines – medical, nursing and therapies – will have.

The more detailed Population Health Improvement Plan describes the ICB's commissioning intentions for the five-year period and, in doing so, sets out how the wider ambitions and outcomes identified in the Population Health and Commissioning Strategy will be delivered. This plan describes the priorities within the "Feel Well' domain, which largely focus on mental health, and as such sets the main priorities that now form the principal focus of this strategic plan for mental health.

Although the new ICB is a single organisation, much of its work is at 'place' level (also known as Alliances). There are five places across the footprint:

- West Norfolk
- Great Yarmouth and Waveney
- Central Norfolk
- West Suffolk
- Ipswich and East Suffolk

Needs Assessment – Mental Health in Norfolk and Suffolk

Both Norfolk and Suffolk County Councils have recently produced comprehensive mental health needs assessments[5]. These are invaluable resources for the wider system, helping all local organisations and partners, including the ICB, to focus their work on the right issues and areas. Together, the needs assessments provide a single, central source of evidence that can support the increasing alignment of all partners' strategic plans.

The needs assessments provide a thorough analysis of key elements of mental health locally, including:

- Almost 15% of adults locally have a diagnosis of depression

[4] https://www.norfolkandsuffolk.icb.nhs.uk/about/governance/population-health-and-commissioning-strategy/

[5] http://www.healthysuffolk.org.uk/JSNA

[6] http://www.norfolkinsight.org.uk/JSNA

- Adults with a severe mental illness locally experience particularly poor outcomes; people in this group are almost five times more likely to die before the age of 75 than the general population
- Mental health need among children and young people is high and increasing
- There are concerns over the emotional wellbeing of almost half of all children who are looked after
- About 1 in 100 people registered with a GP have a diagnosis of schizophrenia, bipolar affective disorder or other psychoses
- The prevalence of perinatal mental health conditions is high, at approximately 26%
- The rates of admission among children as a result of self-harm is higher than average, particularly in Suffolk.

The needs assessments highlight the strong link between deprivation, inequality and higher levels of mental health need, with a particular focus on local places including Lowestoft and Kings Lynn. They also identify a range of underlying factors that profoundly affect mental health, including:

- The importance of strong family and wider societal relationships as a protective factor
- The impact of socioeconomic and environmental factors, with poverty and low quality or insecure housing both being associated with poor mental health
- The key role of health behaviours, such as diet, physical activity, sleep and screen time, in influencing an individual's mental health
- The importance of psychological factors, such as people's sense of identity, belonging, resilience and ability to overcome setbacks
- The clear inter-relationship between multiple factors such as physical illness, deprivation and environment in negatively affecting mental health

Taken together, the needs assessments highlight the following areas as priorities for action by partners across the local system:

- Reduce inequalities in mental health need through targeted, place based approaches
- Strengthen early intervention and crisis prevention for children and young people
- Reduce premature and excess mortality by addressing physical health inequalities for people with severe mental illness
- Improve mental health support for care-experienced children and families
- Improve early identification and support for people with common mental health conditions
- Plan for the mental health needs of an aging population
- Improve mental health intelligence and data integration

The needs assessments include the development of a small number of recommendations for action, many of which have informed the development of the strategic plan.

Service User Voice and Experience

The voices of people with lived experience, together with perspectives from families and carers, offer invaluable insights into where the mental health system functions effectively and where improvements are needed.

In developing this strategic commissioning plan, our approach has been to review and assimilate what we already know about service users, families and carers' priorities and preferences, and have woven this information into our priorities. This approach was shared with, and supported by, a number of representative groups locally.

In common with partners from across the system, the ICB shares a commitment to coproduction – designing the detailed programmes that will flow from this strategic plan in concert with service users, families and carers.

Based on the extensive coproduction and engagement work of the predecessor ICBs, as well as local initiatives such as the Mental Health Charter and evidence from other local partners, the following are some of the key themes and learning:

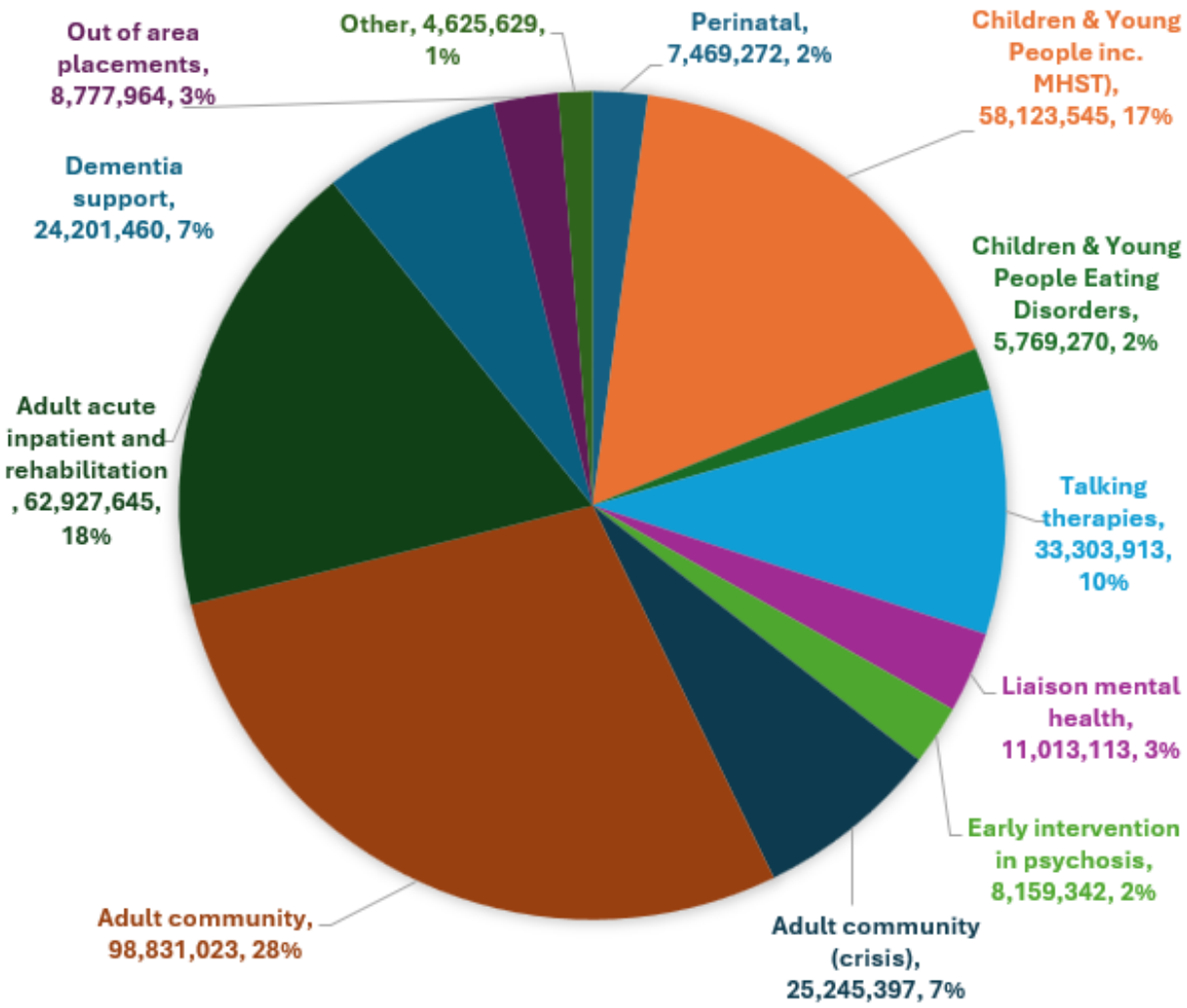
- Access and navigation: people want to be able to access the right help at the right time, are often uncertain about how to access support, especially out of hours, and often face difficulties navigating complex service pathways
- Waiting for support: people are concerned about long waits, and describe the period between seeking help and receiving treatment as particularly challenging
- Kindness and compassion: people want to be listened to respectfully, and to be able to have safe, sensitive conversations in environments that are appropriate
- Shared decision-making: people don't want to be 'done to', they want genuine, respectful involvement in all elements of care planning
- Young people's experiences: children and young people emphasise the importance of accessible support in schools and communities as well as of having trusted adults who can listen and offer guidance
- Carer experiences: carers supporting people with serious mental illness regularly highlight the need for clearer information, better communication with services and more involvement in care planning

Mental Health Provision – Current Landscape

Last year, the predecessor ICBs spent approximately £348m on mental health services across Norfolk and Suffolk (excluding specialist, prescribing and continuing health care).

Within this, the largest areas of expenditure were adult community mental health, excluding crisis services (£98m), adult acute inpatient and rehabilitation (£63m) and children's community services, including mental health support teams (£58m):

Breakdown of N&W and SNEE ICB MH expenditure, 2025-26



Service Area	Spend (£m)
Adult community mental health	98.8
Adult acute inpatient and rehabilitation	62.9
Children and young people services	58.1
Talking therapies	33.3
Crisis services	25.2
Dementia support	24.2
Other mental health services*	46.1

*Includes liaison mental health, early intervention in psychosis, perinatal mental health, eating disorder services, out-of-area placements and other services.

The pie chart and table highlight how approximately £348 million of mental health funding was spent across Norfolk and Suffolk in 2025/26. The largest areas of expenditure were adult community mental health services (£98.8m), adult acute inpatient and rehabilitation services (£62.9m), and children and young people's services including Mental Health Support Teams (£58.1m). Smaller areas of expenditure included talking therapies, crisis services, dementia support, liaison mental health, perinatal mental health, eating disorder services, early intervention in psychosis, out-of-area placements and other services

In 2025/26, about 80% of the two ICBs' total expenditure on mental health was invested in services provided by Norfolk and Suffolk Foundation Trust (NSFT), the main NHS provider locally.

Although the majority of the ICBs' mental health expenditure was with NSFT, there are a very wide range of organisations that provide mental health support and wider wellbeing services to people across Norfolk and Suffolk. Some of these – for example a number of children's services in Norfolk - are directly commissioned by the ICB to provide services, while others are funded in a different way, for example by the county councils, via their own fundraising or through sub-contracts.

Pathways for mental health support vary considerably both across and within the two counties, and also by age group. The needs assessments completed by the two county councils both describe current provision and highlight key issues to be addressed across pathways.

3. The ICB Priorities for Mental Health

3.1. Delivering the ICB's Vision and Outcomes

In our Population Health and Commissioning Strategy, we outlined a simple vision – to improve health outcomes for every resident of Norfolk and Suffolk. We also identified three overarching outcomes which will help to make this vision a reality and which will guide our activity. These are:

- Improving healthy life expectancy
- Reducing health inequalities
- Ensuring access to consistently high quality care

Improving emotional wellbeing and mental health for people across Norfolk and Suffolk will be central to successfully meeting each of these over-arching outcomes.

Improving healthy life expectancy must encompass mental as well as physical health. For example, we know that around 15% of the adult population have a diagnosis of depression – so if we are to improve 'healthy life', we need to do more to develop models of care that help to prevent depression, diagnose it early and provide effective interventions.

Similarly, health inequalities in mental health are stark. For example, we know that people with a severe mental illness will, on overage, die ten years younger than the wider population. So, if we are to reduce overall inequalities, this must be an area of focus.

Finally, we know that specialist, evidence-based interventions for people who need them are highly effective in improving mental health, but services can sometimes be difficult to access and/or are not of uniformly high quality. Improving access to, and guaranteeing the quality of, mental health services must therefore be a priority.

As outlined above, our new organisation is increasingly focused on our role as a strategic commissioner, and our capacity is greatly reduced compared with predecessor bodies. Therefore, we know we cannot do everything. The priorities set out below form the main elements of our change programme for mental health for the coming years, and have been selected on the basis that, delivered in partnership with others, they will make a significant contribution to meeting our three primary outcomes.

3.2. Our Priorities for Mental Health

We recently outlined our broad strategic commissioning priorities in the Population Health Improvement Plan, which covered all service areas, including mental health. These flow from and build on the direction set out in the Government's 10 Year Plan for the NHS.

There was extensive engagement with partners on this plan, and the wider Population Health and Commissioning Strategy, while the ICB was operating in shadow form.

The ‘Feel Well’ element of the Population Health Improvement Plan set out our three high-level ambitions for mental health:

- Reduce the proportion of people (of all ages) experiencing low life satisfaction, high anxiety or low happiness
- Reduce premature mortality of people with severe mental illness
- Reduce attendance at hospital emergency departments, and subsequent admission rates, for people with severe mental illness

Making progress toward meeting these outcomes was a key factor in determining our strategic priorities for mental health. In the following, we confirm our priorities, explain why we selected them and set out our high-level plans for delivering each commitment.

These are the commitments that that we, the ICB, will lead, working alongside colleagues from across the system. We fully recognise that this is only one part of our wider system’s work on mental health, and that in addition to leading some elements, we have a key role both in helping to ensure our plans are aligned with others, and in supporting partners to progress their priorities and improvement plans.

In addition, work in a number of other important areas will continue to be developed, outside the specific priorities that are highlighted below. These include strengthening employment support for people with severe mental ill health, improving therapeutic support for survivors and victims of domestic abuse, the procurement of an ICB-wide all-age eating disorder service, and strengthening the contribution of mental health practitioners in primary care.

Although this is plan for a five-year strategic period, inevitably there is more detail for the coming two to three years. This is partly because the ICB is developing as a new organisation, and also because there are a number of national Modern Service Frameworks (MSF) for mental health under development, the requirements of which this plan will need to reflect. For example, the Severe Mental Illness (SMI) Modern Service Framework is due to be published in Autumn 2026, which will help to establish clear, evidence based quality standards and end unwarranted variation in adult mental health care.

One area that is not highlighted in this section as a separate work programme is prevention, early intervention and the wider determinants of mental health. This is for two reasons: first, prevention is of such importance that it is woven into almost all of the ICB’s work (for example on neighbourhoods) and is a key part of our wider strategic objective to deliver a ‘shift left’; and, second, prevention and early intervention is a shared responsibility across many system partners, not for the ICB to lead on its own. As such, it is one of the suggested areas of focus for the whole system mental health Network outlined in section 4 of this plan.

Our approach to mental health is age inclusive, recognising that there are a number of key stages of transition (for example from young person to adult, and adult to older person) that require the support and services our system offers to be flexible and focused on individual need, rather than constrained by rigid age boundaries.

Nevertheless, in developing this strategic plan we have chosen to take a ‘life course’ approach, as this helps to ensure there is clarity on the priorities identified as well as being aligned with approach taken in the mental health needs assessments that have been completed across both counties. The main areas are:

- Perinatal
- Children and Young People
- Adults (including older adults)

Perinatal

Why this is a priority

We know that good perinatal mental health is a key factor that influences not just the health of expectant and new parents, but also of the wellbeing of the infant and young child. A positive start in life is also one of the key determinants of future life chances, and can have a significant bearing on narrowing inequalities.

We also know that prevalence of perinatal mental health conditions locally is high, with an estimated rate of 26% - more than one in four – and that early identification (through maternity care) is key. Our data suggests that currently access to specialist perinatal mental health services is limited, relative to estimated need, and our access rates are below target across both counties.

Our commitment

At present there are gaps and inconsistencies across Norfolk and Suffolk in the support we commission for expectant and new parents as well as infants. To address this, our commitment is that by April 2028 we will commission a comprehensive, integrated offer for perinatal mental health and parent-infant relationship support.

How we will deliver this commitment

We plan to phase delivery of this commitment over the first part of this strategic plan. Our initial focus in 2026/27 will be on identifying gaps by comparing local provision with national standards and recommendations, together with an evaluation of outcomes, This will enable a clear picture of the quality and effectiveness of the current service to be formed. Our immediate aim is to ensure that there are equitable standards across Norfolk and Suffolk, and to make our commissioning approach consistent across both counties.

We will work with local service providers, the East of England Provider Collaborative, place partnerships, maternity services, safeguarding and colleagues from local authorities and the voluntary, community, faith and social enterprise (VCFSE) sector to map current pathways and to identify future delivery requirements and options for improvement. This will encompass specialist perinatal mental health services, parent–infant relationship support (including for fathers) and universal services, ensuring that there is alignment with emerging neighbourhood models of care as well as new local authority-led Best Start Family Hubs.

Our priorities will likely include improving continuity between inpatient Mother and Baby Units and community services; strengthening outreach and step-down support; and using population health and inequalities data to better target access and investment. We will also consider the support provided to women who experience miscarriage, as well as Sudden Infant Death (SID).

Informed by this work, we will develop an integrated perinatal mental health pathway to support future commission intentions, with a view to strengthened arrangements being in place by April 2028.

Children and Young People

Why this is a priority

There is clear evidence that childhood experiences have a profound impact on mental health in later life, and we know that the signs of poor mental health as an adult are often evident in childhood (up to half of all mental health conditions experienced by adults were identifiable by the age of 14). Therefore, focusing on and seeking to improve childhood emotional wellbeing and mental health is a priority both for the ICB and the wider system – as well as being vital for individual children, it is a critical element of wider efforts to prevent future ill health and to narrow inequalities.

We also know that locally there are growing numbers of children and young people who are experiencing anxiety, depression and emotional distress, and that demand for mental health support is rising sharply. In addition, our data shows that inequalities emerge early, with higher levels of need and service uptake in deprived areas, and that in our system we have unusually high rates of admissions for children who have self-harmed.

Addressing these issues, and ensuring as many children as possible experience a positive, secure childhood and develop key life-course skills such as resilience, involves parents, families, schools, social care, the NHS as well as wider communities. Our contribution is to be an active partner to a wider coalition.

Our commitments

<u>Early years</u>
Early years (approximately 0-5) are key years in every child's physical, emotional and cognitive development. There is strong evidence of the relationship between experiencing childhood trauma and adverse events and future emotional wellbeing, school attendance and self-harm.

As such, with partners we will develop new ways of proactively identifying families with children aged 0-5 who would benefit from targeted, trauma-informed multiagency support. This will seek to identity families who may not be currently accessing services, with a particular focus on inequalities. Supported by this intelligence, we will jointly commission integrated pathways of support, including for children with developmental delay, Special Educational Needs and/or neurodiversity. We anticipate that this work will take us until April 2028 to complete.

Over the longer term (to 2030), we will collaborate with partners to establish integrated neighbourhood teams for families with young children. This will simplify access to services, and better integrate support provided by midwives, health visitors, GPs, early years practitioners and VCFSE partners.

School-aged children

Most children spend the majority of their time either at home or at school. As a result, the mental health advice and support that the NHS provides to schools, teaching staff, partners and individual students is a key component in promoting emotional wellbeing and good mental health.

During the period covered by this strategic plan, we will expand the coverage of our Mental Health Support Teams to all schools, including those in the independent sector and further education colleges. By April 2028, we plan to have 77% coverage, and by April 2029 this will have risen to 92%, reaching 100% coverage by April 2030.

This is a significant investment in new capacity, which will enable more children to be supported earlier, with the potential to help alleviate pressure (such as long waiting times) in other parts of the system.

How we will deliver these commitments

We will deliver these commitments through continued close partnership working across health, education, local government and the VCFSE sector, recognising the importance of integrated, place-based approaches across the life course.

Early years

During 2026/27 we will work with place partnerships and providers to develop a collective approach to using shared intelligence to support earlier identification of need, particularly in the early years. Alongside this, we will work with existing partnerships to develop more integrated pathways for children and families, including looking at the potential to develop different models of commissioning and provision that are tailored to local needs.

School-aged children

For school-aged children and young people, we will support the phased expansion of Mental Health Support Teams, ensuring alignment with the proposed Young Futures Hubs[6], wider neighbourhood working and other community-based mental health services.

Working within the national framework, we will tailor delivery models across Norfolk and Suffolk to best meet the needs of children and schools. We will seek to build on existing local learning such as the children's hub currently operating in Kings Lynn (as part of a national pilot) as well as ensuring that these new teams that are fully aligned with other children's services.

To inform this work, during 2026/27 we will complete a review of the current delivery of MHSTs, with a focus on identifying areas of inequity or variation in access. We will draw on this baseline to develop, in concert with partners, a three-year delivery plan,

[6] https://www.gov.uk/guidance/young-futures-hubs

ensuring that by April 2030 all schools (including in the independent sector) and colleges have an MHST in place.

Over the medium term we will, with partners, strengthen transitions and seek to reduce fragmentation across all children's provision through aligned commissioning, engagement with children and families, and, where required, targeted procurement activity. As this new capacity is introduced, will also ensure that there is a sharper focus on preventing crisis and on self-harm, both areas highlighted in the recent needs assessments.

Adults

For adults, we will focus on four main areas:

- Embedding community mental health in neighbourhood models of care
- Redesign of alternative pathways for people in crisis
- Support for people with complex needs
- Introduction of a single unified model for commissioning specialist mental health placements

Why these are priorities

Embedding mental health in neighbourhoods

NHS England's Ten Year Health Plan sets out three major shifts for the future of the NHS, one of which is a move from hospital to community, with more care delivered locally and at home. A key component of this shift is the establishment of neighbourhoods, which bring together and integrate many services at a local level, including mental health.

As well as being a national priority, there are important local drivers for embedding community mental health in our neighbourhoods. For example, we know that many people experience physical and mental health difficulties at the same time, indicating that we need to be able to support early diagnosis and access to suitable, integrated pathways.

Similarly, we know that targeted, place based approaches are key to reducing premature mortality for people with a severe mental illness, as evidence-based interventions largely relate to physical health, such as improved uptake of health checks, targeted smoking cessation programmes and cardiovascular risk management.

Finally, it is clear that a neighbourhood approach will be key in reducing inequalities in mental health. We know from the recent needs assessments that there is strong correlation between poor mental health and deprivation and coastal communities, and that addressing these issues requires a highly localised, cross-partner approach.

We have considerable learning and experience locally that will support the further development of this model. This includes the two Alliances in Suffolk, which have been operating a partnership model for many years, the current Integrated

Neighbourhood Teams (INTs), which support the delivery of integrated services, and primary care networks, which bring together local GP practices.

Support for people with complex needs

As outlined in the previous section, people with severe mental health conditions have a lower life expectancy than the general population, and reducing premature mortality in this group is one of the three priority mental health outcomes for the ICB.

Some people with severe mental health conditions benefit from a community-based intensive and assertive support service, particularly for those individuals where engagement is a challenge. At present, there gaps and inconsistency in this support, and as well as strengthening services, there are opportunities to better involve partners from the VCFSE sector.

A further priority group is supporting people with complex emotional needs (personality disorder). At present, support in Norfolk and Suffolk is primarily provided through the NHS and local mental health charities. Pathways include specialised community mental health teams and psychoeducational recovery courses for traits like Borderline/ Emotionally Unstable Personality Disorder (BPD/EUPD).

Across the ICB, there is currently a lack of consistent, stabilising and relationally continuous support for this group of people, who often struggle to engage with community treatment leading to repeated crisis service use, reactive and repeated inpatient care.

Alternative pathways for people in crisis

We know that across the two counties we do not yet have a consistent, evidence based approach to supporting people who are experiencing a mental health crisis or who require urgent support. Too often the pathways are complex, fragmented and not responsive enough.

We also know from partners in acute hospitals that too many people experiencing a mental health crisis attend their emergency departments, which is rarely the most appropriate place for them. Further, a proportion of these people are then admitted, often not because an acute hospital is the right place to meet their needs, but because capacity in more appropriate facilities is lacking. Finally, we know that in some places there is insufficient focus at an early enough stage on planning and delivering rehabilitation and reablement.

Mental health specialist placements

For many years, our local system has reactively purchased placements for individuals outside the two counties, either when there is no capacity locally and/or where appropriate services are not available. Although there have been improvements recently, we do not yet have a consistent ICB-wide, evidence based model for commissioning these placements that ensures all people receive clinically appropriate care that is as close to home as possible. We also know that there are opportunities to better align and integrate work with local authority colleagues in the way post discharge (Section 117) support is provided.

Our commitments

Embedding mental health in neighbourhoods

As we develop neighbourhood models of care we will, with partners, ensure that community based mental health services are, for the first time, fully embedded. By the end of the period covered by this strategic plan, mental health practitioners will be included as core members of Integrated Neighbourhood Teams in every locality. We will ensure that this is reflected in all our neighbourhood delivery plans.

Our broad approach to neighbourhood development is all age, although we recognise (as outlined above) there will need to be flexibility and pragmatism to ensure services are fully aligned with those of partners (for example, the children's zones in Norfolk).

Our aim in developing neighbourhoods is to ensure that our local model:

- Provides accessible and simplified support
- Enables a focus on prevention and early intervention
- Embeds VCFSE provision
- Helps to prevent crisis and escalation to acute services

One recent development that we believe can accelerate this work is the development of new community mental health hubs across Norfolk and Suffolk. Led by NSFT, these will be facilities that could form a physical walk-in base for a wide range of VCFSE, primary care, community, hospital and local authority services. The development of these hubs is an opportunity to 'reimagine' how some community mental health services are provided locally, testing a range of new delivery models.

Although not led by the ICB, we are keen to roll out the first of these hubs in the most deprived parts of the two counties, as we know from the needs assessment that people living in these areas are more likely to experience poor mental health, and that this is one if the key factors that drives inequality.

Support for people with complex needs

As a priority, we will support NSFT with the development of a business case to provide a consistent, comprehensive community-based assertive and intensive outreach response service for Norfolk and Suffolk. We will ensure that this is a partnership-based approach, with the Trust working alongside partners from the VCFSE sector in order to make sure that the service is as accessible as possible, making best use of all local experience and capacity.

Our aim is to ensure that there is timely, accessible support for this group of people. Over time, we would expect this to result in improved outcomes, including in improved life expectancy, and a reduction in the need for crisis and emergency support.

In addition, during 2026/27, we will work with NSFT and system partners to develop a business case to review and refresh our service offer for people with complex

emotional needs, with the aim of ensuring there is consistent, evidence based provision across the two counties.

Alternative pathways for people in crisis

As outlined above, we need to ensure that across Norfolk and Suffolk there is a consistent, evidence-based approach to supporting people in crisis or that have an urgent mental health need, and that access to these pathways is both straightforward and timely. By further developing these alternative pathways, our aim is to reduce pressure and reliance on acute services.

To deliver this, by April 2027 we intend to, with the involvement of system partners and service users, review and then recommission all relevant alternative crisis pathways. This encompasses about £6m of ICB expenditure, encompassing existing crisis hubs/sanctuary houses, steam cafes and community connectors. We are currently developing a detailed business case to progress this element of our programme.

Alongside strengthening these crisis pathways, we will work in partnership with NSFT and other system partners to design and implement two new Mental Health Emergency Departments, ensuring that these new facilities form a seamless part of the wider urgent care pathway.

Mental health placements

By April 2027, we will complete a review of our current approaches to commissioning adult specialist placements, to ensure there is a clear picture need and likely future commissioning requirements. Building on this, by April 2028, we will implement a new, consistent ICB-wide model for commissioning all relevant adult placements across both counties.

How we will deliver these commitments

Delivery of our adult mental health priorities will focus on system leadership, our commissioning functions and close collaboration with place, NHS providers, VCFSE partners and service users.

Embedding mental health in neighbourhoods

As we develop neighbourhoods, we will ensure that relevant community mental health services are fully embedded. Starting in 2026, we will progress this work alongside partners, seeking to integrate statutory and VCFSE provision, targeting the areas of highest need and with a focus on prevention and early intervention.

Towards the end of 2026/27, we aim to have completed the procurement and mobilisation of the first phase of the mental health wellbeing hub approach, and in early 2027/28 we plan to introduce the single point of access.

We will monitor progress across four main domains:

- Improved access and navigation – more referrals through the single point of access, reduced waiting times
- Prevention – reductions in crisis presentations and increased utilisation of community pathways

- Integration – evidence of integration with INTs and hubs, increased population reach, including on underserved groups
- Experience and outcomes – service user feedback, reduction in crisis episodes

Alongside this, we will prioritise the development of the seven new community hubs across Norfolk and Suffolk, with a phased roll out that starts with the areas of highest deprivation and greatest need for mental health support (Kings Lynn and Lowestoft).

Support for people with complex needs

In the first quarter of 2026/27, we will review and decide whether to support the current business case for a consistent ICB-wide intensive and assertive outreach support service. The proposed model is a partnership involving NSFT, VCFSE, acute hospitals, local authorities and the police.

Subject to the business case, in late 2026/27 we will work with partners to codesign the detailed implementation of the model, including the development of standard operating procedures, with a view to the new service going live in early 2027/28.

In the first quarter of 2026/27 we will review and decide whether to support the business case for supporting people with complex emotional needs. Subject to agreement of the business case, we will work with partners to codesign the implementation of the new model with a view to the new service going live in early 2027/28.

Alternative pathways for people in crisis

During 2026/27 we will lead a system-wide review of existing pathways for people experiencing a mental health crisis, drawing on existing activity, outcomes and inequalities data. This will enable a clear baseline to be established, and for key gaps to be identified.

We will use this analysis to shape the development of consistent, evidence-based alternative pathways of care across the two counties, and to determine our approach to recommissioning services. Our aim is to ensure that new, ICB-wide pathways are mobilised in mid-2027.

A key consideration as we progress this work will be the establishment of Mental Health Emergency Departments in Norwich and Ipswich, ensuring they are fully aligned with local urgent care systems and alternatives to admission, and make a positive contribution to reducing pressure on main hospital emergency departments.

We will also consider how, as a system, we can improve and strengthen existing arrangements for the provision of Section 117 aftercare for people who have been admitted to hospital under relevant sections of the Mental Health Act

This work is being prioritised within the ICB (and the wider system), and we aim to have completed the review and the resulting recommissioning by April 2027.

Alongside this, we will continue to work closely with NSFT and other partners to develop and agree business cases to improve the way the system helps people with

complex emotional needs, and how intensive and assertive support is provided. A particular area of focus will continue to be on the support provided to the relatively small number of people that regularly use, or who are in frequent contact with, a range of local services (such as emergency admissions and the police).

Mental health specialist placements

We will complete a review of the current arrangements for commissioning specialist support during 2026/27. This will build in work on the recent Inpatient Delivery Plans, and will seek to remodel the offer for people who need specialist rehabilitation support, reducing the number of people who are not supported locally. Our work will include analysis of recent trends, utilising population health management data and close liaison with NSFT to identify service gaps and potential areas of service redesign.

We aim to have completed this work by April 2028, by which point there will be a consistent, ICB-wide approach which enables support locally to be the default, with non-local placements becoming the exception.

3.3. Commissioning approach

Delivery of most of the priorities set out above will require a partnership approach, in order to codesign services that are evidence based, aligned with other provision locally and that meet service users' needs and preferences.

In some instances, this codesign phase will be followed by a procurement process, which does not always sit comfortably alongside a partnership based approach. The framework within which the ICB operates is the Provider Selection Regime[7], which sets out when procurement is likely to be appropriate, and what form it might take. The ICB is currently finalising its own strategic commissioning toolkit, which aims to build on the PSR regulations to help the ICB to use its procurement function appropriately, sensitively and intelligently.

3.4. System and Partners' priorities

Shared system ambitions

Over time, we are keen to work with partners to test whether we can come together and act in concert to identify, agree and deliver a small number of shared objectives. We know from discussions with partners as we have developed this plan that there is interest in and support for this concept.

This idea been referred to as setting 'shared system ambitions'. This would involve collectively identifying two or three medium term priority outcomes that are ambitious, aligned with the key issues identified in the two needs assessments and that require multi-partner engagement to successfully deliver. Once agreed, one partner could, on behalf of the wider system, take the lead in delivery, convening partners as required and establishing a system-delivery plan.

[7] https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/

As well as focusing collective effort on key issues, a shared system ambitions programme would encourage the development of new ways of working and could result in a template for the future.

Early examples of possible whole system ambitions are:

- Increase the life expectancy of people with severe mental illness
- Reduce the number of children and young people who are not attending school due to poor mental health
- Reduce the proportion of adults reporting low life satisfaction, high anxiety or low happiness

Progressing the shared system ambitions would form one of the core functions of the Norfolk and Suffolk mental health network that we propose in section 4.4.

Contributing to partners' plans and priorities

This section has largely focused on our priorities for mental health as a newly established ICB; it sets out the main areas of work that we will be responsible for leading and convening, involving partners as we do so.

Alongside this, we recognise that there are a wide range of other issues and priorities that need to be addressed if we are to improve wider wellbeing and mental health, and that many of these are led by that other partners. Examples include:

- Initiatives that focus on prevention, early intervention and wider determinants of mental health, including healthy workplaces
- County-based suicide prevention strategies
- Public health commissioned services such as health visiting
- County-led children's services such as early help
- Social care support for people with mental ill health

Our clear commitment, through this strategy, is to be an active partner in these areas, including where appropriate in key alliances such as the Children and Young People's Alliance in Norfolk. This is in recognition that although we have a leadership role in many (mostly NHS) priorities, we have an equally important role in supporting others in the delivery of theirs.

4. System Delivery

This section sets out some considerations on how the wider Norfolk and Suffolk system might collaborate to deliver priorities and shared outcomes for mental health, and increasingly align strategies and plans. This includes our view on what the ICB's role in these arrangements might be in the future.

4.1. Background

Promoting and enabling emotional wellbeing and good mental health is not the preserve of a single organisation. The underlying causes of poor mental health are varied and complex, as are the range of people and bodies that have a role in addressing them – from individuals, communities and VCFSE organisations through to statutory services provided by local authorities and the NHS.

Although the broad objectives of such a diverse consistency are widely shared – supporting good mental health – the priorities of partners inevitably differ. Larger statutory organisations (including the ICB) tend to have – and are often required to have – their own strategic plans that primarily focus on what they are directly accountable for delivering. In addition, there are a very large number of other organisations, including those in the VCFSE sector, who often provide support in very specific geographical areas or on particular topics, who will have their own priorities and plans.

In addition, leadership responsibility for mental health and wider wellbeing is widely distributed. Taken together, the number of stakeholders involved in mental health and the variety of leaders creates a challenge for the system: how best to collaborate and align plans in order to meet shared objectives.

4.2. Alignment of Strategic Plans

Creating a set of strategies and plans for emotional wellbeing and mental health that are fully aligned is likely to be an objective that takes many years to deliver, if it is possible at all. However, what is possible is for key partners to recognise this issue, and to agree to set a shared goal of increasingly aligning strategic and transformation plans. This would require each partner, as it develops its own internal ('vertical') plans, to simultaneously give careful thought to how they align with others' priorities (the 'horizontal').

In developing this ICB strategic plan, we have discussed the importance of alignment with a wide range of local partners, and there is a broad consensus supporting this direction of travel. We have tried to model this approach in the development of this strategic plan, by sharing and discussing the priorities we set out, as well as by considering how best to work together. We know that other partners – for example NSFT as part of the refresh of their strategic plan – are doing the same, which we welcome.

As a system there are other steps we can take to better align and integrate our activities, for example by: ensuring we all have regard to the refreshed needs assessments in determining our priorities; that where possible our plans are mutually

reinforcing; and that where it makes sense to do so we combine resources to deliver improvements.

4.3. Previous Mental Health Collaborative Arrangements

Because there is a clear need to share and where possible align work programmes, and to collaborative to deliver priorities, in recent years both the Norfolk and Suffolk systems have developed a range of collaborative arrangements for mental health. These arrangements seek to bring partners together to set shared goals, coordinate work and in some instances integrate delivery.

Previous arrangements

Arrangements for partnership working on mental health have evolved differently across the two counties.

In Norfolk, there is a separation between the arrangements for Children and Young People and those for Adults. In the former, the County Council has led the development of a shared system strategy ('Flourish'), and has convened an effective CYP Strategic Alliance, which has four principal objectives, including improving children's emotional wellbeing and mental health. Although there have been various system groups focusing on adult mental health in Norfolk, at present there is no standing adult-focused mental health alliance or collaborative in place.

In Suffolk, in 2023 an all-age mental health collaborative, led by the ICB, was launched. This collaborative brought together partners from across the system, and had delegated authority over the ICB mental health commissioning functions and budget. The 'core' collaborative, which was formally a sub-committee of the ICB to enable functions to be delegated, was supported by a range of sub-groups, including on service areas (e.g. crisis, community, children and young people), as well as service user experience and VCFSE partnership groups.

Learning from previous collaboratives and partnerships

One advantage of having had different arrangements locally is that there is an opportunity for learning, and to draw on this experience as we consider the options for new system-wide arrangements. The following points bear consideration:

- Having delegated authority over functions and budgets (as was the case in Suffolk) can be effective in raising the profile of a collaborative, securing senior engagements in forming the basis for a system-based approach to decision making
- Equally, other examples demonstrate that it is possible to have effective partnerships without formal delegation where there is a clear shared strategy and effective leadership, as demonstrated by the successful CYP Strategic Alliance in Norfolk
- Being clear about – and remaining true to – the purpose and scope of the forum is key, otherwise there is a tendency for the agenda to grow, diluting its impacts and creating a large and unwieldy membership

- Ensuring joint or collaborative arrangements are effective requires considerable management and leadership capacity – liaising with partners, setting priorities, ensuring the right issues go the right forum at the right time, curating meeting agendas and ensuring all papers are clear
- Getting the geography right can be challenging – for example, on occasion large collaboratives may be too removed from service delivery to really understand the more local issues within smaller geographic areas, while those on a smaller footprint can find their influence over decision making is limited.

4.4. Future Collaborative Arrangements

Approach

In developing this strategic plan, we engaged with partners to both review the existing collaborative arrangements, and to understand their views and perspectives on how we, as a system, might organise ourselves in the future. Understandably given how complex a topic this is, there are a range of perspectives.

Key considerations

In forming a view on what shape future collaborative arrangements could take, and crucially what the new ICB's role in them should be, there are a number of factors for the ICB to consider. These include:

- Added value – the degree of confidence that the collaborative arrangements will be purposeful: effective in delivering the priorities set out in this plan and, more broadly, in improving outcomes and services
- delegation and decision making – whether the new ICB is likely to be in a position to delegate some or all mental health commissioning responsibility to a system forum, or to another partner, either now or in the future
- geographic footprint – if there are to be one or more ICB-led partnership forums, what the footprint(s) should be, recognising the wide scope of the issues and services that need to be considered
- age – whether there should be an age split in order to have a strong focus on the different needs of children and adults, or if an all age approach may be preferable
- capacity – given the very significant reduction in ICB staffing levels, and the learning about the capacity required to lead effective partnership forums, the extent to which the ICB will have the bandwidth to effectively support one or more partnership forum(s)
- other partners' arrangements – the ICB is only one body with a role in mental health locally, and there are existing arrangements (such as the Strategic Alliance in Norfolk) which already work well. Therefore, consideration of which other organisations might continue to, or may in future take on, a leadership or convenor role, is key

As part of the work to develop this strategic plan, a number of potential options for future collaborative arrangements.

Options considered

Eight main options were considered as part of our analysis of partnership arrangements that could be led by the ICB.

Possible options for ICB-led collaborative arrangements

Option 1a – Norfolk and Suffolk Collaborative, with no delegation.
This option would involve a single forum for all partners, including providers, VCSE organisations and service user experience representatives. It would cover all ages, including children and young people, adults and older adults. The primary focus would be on aligning strategies and plans, with no formal delegation.

Option 1b – Norfolk and Suffolk Collaborative, with ICB delegation.
This option would involve a single forum for all partners, including providers, VCSE organisations and service user experience representatives. It would cover all ages, including children and young people, adults and older adults. This option would include full or partial delegated responsibility for decision making over ICB mental health funds.

Option 2a – Separate all-age county-based collaboratives, with no delegation.
This option would involve separate Suffolk and Norfolk forums for all partners, including providers, VCSE organisations and service user experience representatives. The primary focus would be on aligning strategies and plans, with no formal delegation.

Option 2b – Separate all-age county-based collaboratives, with ICB delegation.
This option would involve separate Suffolk and Norfolk forums for all partners, including providers, VCSE organisations and service user experience representatives. This option would include full or partial delegated responsibility for decision making over ICB mental health funds.

Option 3 – Separate county-based collaboratives, split by children and young people and adults.
This option would involve separate children and young people and adult forums across both Suffolk and Norfolk for all partners, including providers, VCSE organisations and service user experience representatives. The primary focus would be on aligning mental health strategies and plans.

Option 4 – Neighbourhood or alliance mental health collaboratives.
This option would involve multiple forums on a neighbourhood or place footprint, including all relevant local partners. The primary focus would be on aligning mental health strategies and plans.

The first two options (1a and 1b) both take the form of single, all of Norfolk and Suffolk, all age Collaborative. The key difference between the two options is that the first assumes there is no formal delegation of commissioning responsibilities by the ICB, while the second assumes there are delegated arrangements in place.

The next two options assume that there are separate county based, all age collaboratives. The first (2a) is a model where there is no formal delegation from the ICB, while the second (2b) is a delegated model, where ICB commissioning responsibilities are formally delegated into each of the county-based collaboratives.

The next option (3) is for separate county based collaboratives, split by age, with different groups for children and young people and adults. In this option, therefore, there are four collaboratives – separate children's and adults groups in Norfolk and in Suffolk. A variant of this option - the same arrangement but with ICB functions and budgets delegated into the four groups - was considered, but was not developed in any detail as it was felt to be unrealistic in the near term, due to the practical difficulties of disaggregating ICB functions and budgets in this way, and the complex governance arrangements that would be required (e.g. multiple sub-committees of the ICB).

The final option considered (4) takes a much more localised approach, and assumes that there are a number of mental health collaboratives on a much more local footprint – for example at ICB Alliance or at neighbourhood level. As in option 3, a variation of this model, which included delegation of ICB functions and budgets, was considered but was not developed in detail, for the reasons set out above.

Delegation of ICB functions to another partner

A further option we have looked at is whether the ICB might decide to formally delegate some of its mental health commissioning functions to another partner.

One model we considered in some detail is the potential for NSFT, as the main mental health provider locally and the only statutory organisation with the same footprint as the ICB, to take on some of the ICB's commissioning responsibilities. In this model, the ICB would delegate responsibility for the delivery of one or more outcomes or pathways and would, within a formal agreement, transfer the relevant commissioning budget to the trust.

NSFT would then be responsible for designing and implementing the delivery of the agreed outcomes or pathways, including directly commissioning other partners as required. This model (often referred to as a lead provider) is in operation in some other parts of the country in mental health to enable integration of services.

An alternative model, which is much less common, would be for the ICB to delegate responsibility for some of its mental health commissioning functions to a local authority partner. An example could be the commissioning of children's mental health services, if the objective were to fully integrate the commissioning (and potentially provision) of the key mental health, wider care and education services.

Analysis and conclusions

Each of the options set out was reviewed against the key considerations set out above to help determine which – if any - might be feasible and potentially effective.

A central factor in initially narrowing down the range of options was determining whether the ICB, as a new organisation operating on a new footprint, would

realistically be in a position to formally delegate commissioning functions and budgets into a new collaborative arrangements.

The conclusion reached was that this is unlikely in the near term, due to the likely practical difficulties associated with the disaggregation of functions and budgets, as well as the complex governance that would be required to enable it. There were also concerns over the ability of the ICB to effectively support potentially complex delegated forums given the significant reduction in its internal capacity. This removed two of the options considered (1b and 2b).

The next critical factor considered in assessing the options was factoring in the significant impact of the reduced capacity of the ICB. This resulted in a clear view that it would not be possible for the ICB to lead multiple collaboratives within its footprint. This led to options 2a, 3 and 4 being removed, due to the new ICB lacking the resources to be the lead partner or convenor (although other partners could establish or continue to lead partnership groups on these footprints, with the ICB as a contributor).

The option of the ICB delegating functions to another partner (such as NSFT or one of the two county councils) has clear potential advantages, including:

- promoting integration
- being better aligned with the new ICB's focus as a strategic commissioner
- helping mitigate the reduction in ICB capacity

As a result, this is a direction of travel that is broadly supported. However, in the short term there are disadvantages and potential risks that likely make this option challenging to progress.

In the case of NSFT (as their refreshed strategy recognises) while significant progress has been made in improving services and in putting strong foundations in place, there is more to do ensure that all core services are delivered to a consistently high standard. This needs to remain the trust's primary focus in the near future, rather than risking stretching capacity by adding in, on a large scale at least, new commissioning responsibilities.

A preferable approach is likely to be to support the development of these capabilities over time, with the trust increasingly taking a system leadership role in the implementation of relevant priorities set out in this plan. Elements of this approach are already in place, with for example the Trust taking a lead/system convenor role in a number of areas, including the:

- codesign and development of community mental health hubs
- preparation, with partners, of the business case for intensive and assertive outreach, for consideration by the ICB

In the case of both county councils, the delegation of ICB mental health commissioning functions is not likely to be a realistic option at this point. This is primarily due to the significant organisation change that is likely to result from the

Government's plans to restructure local government. This will result in the two county and 12 district and borough councils likely to be replaced by six new unitary authorities in 2027.

Finally, consideration was given to whether any of the models outlined above would be effective in helping to deliver the priorities set out in this strategic plan. On balance, the conclusion reached was that most of the options would not be, and that a different approach where partnerships are formed around specific priorities and programmes deliverables, might be required.

Taken together, the options appraisal suggests that the only model for an ICB led mental health collaborative that has the potential to add value to the system, and be that could potentially be supported within the ICB capacity constraints, would be a single, whole Norfolk and Suffolk all age collaborative (without formal delegation).

However, having assessed this possible option in greater depth and discussed it with partners, there are significant reservations over whether this is the right way forward. Particular concerns include:

- that a collaborative encompassing all issues of emotional wellbeing and mental health would have too broad a scope, potentially limiting its effectiveness
- that an all Norfolk and Suffolk footprint would be too large, making it less relevant for partners who have a more local focus
- that the membership would likely be very large, which could impede clear decision making
- that, if purely ICB led, the forum risks becoming a briefing or overly discursive (rather than action-orientated) meeting

As a result, we have been developing – and would like to propose -an alternative approach that focuses more on how the system collaborates to deliver partners' priorities and shared projects rather than on developing a standing collaborative architecture.

There are a number of features of this proposed approach:

- not having any standing, formal ICB-led mental health collaboratives
- instead, designing future partnership arrangements around specific programmes of work and priorities, convened by the organisation that has primary accountability for their delivery
- establishing a new, quarterly Norfork and Suffolk mental health network to agree shared priorities and design joint working arrangements where these are required

In additional to the above, within the available capacity we will continue to support, and actively contribute to, relevant mental health focused forums that are led by other partners, such as the CYP Strategic Alliance in Norfolk, and the parallel arrangement that is planned in Suffolk.

Finally, there are a range of other system meetings – for example at Alliance level – that will bring together partners at a more local level and which will continue to consider mental health alongside physical health.

Developing a Norfolk and Suffolk Mental Health Network

Although we have concluded that there should not in future be permanent, ICB-led mental health collaboratives, it is nevertheless clear that delivering better emotional wellbeing and mental health support for local people requires coordination and for many partners to work closely together. Some mechanism for the system to come together is likely to be beneficial, as long as the potential disadvantages outlined above can be mitigated.

The shared challenge for the system is how to achieve this in way that is effective and that adds value and that helps partners to deliver priorities, without creating a planning infrastructure that is bureaucratic, time consuming for members or which requires significant capacity to maintain.

In our view, what is required is a flexible, dynamic arrangement that brings partners together to support and enable collaboration, focused on the issues and topics where partnership working is required. The proposed mental health network could fulfil this function.

We envisage that the proposed network would:

- meet approximately quarterly for half a day
- include all relevant statutory and non-statuary partners and stakeholders from across Norfolk and Suffolk
- be tasked with:
    - progressing work on the identification of a small number of shared system ambitions (as set out in Section 3.3)
    - coordinating work on system-wide issues where no one organisation has the lead, such as prevention and early intervention
    - mapping actions partners are taking to meet the recommendations of the new Norfolk and Suffolk needs assessments, including the identification of any gaps and how these will be filled
    - agreeing how, where required, partners might come together to deliver an outcome, objective or programme (such as the development of the new mental health hubs)
- support the ongoing alignment of partners' strategies and delivery plans
- provide an opportunity for updates on key topics
- offer a regular opportunity for strengthening relationships

For such a network to be effective and purposeful, it would need the right culture, with members being committed to using the forum to progress and coordinate the delivery of agreed priorities. It would also need to be flexible, with the ability to establish workstreams or sub-groups to develop specific pieces of work.

Ideally, this network should be co-sponsored by a broad range of partners, to ensure it is a collective endeavour that has a genuine system focus. This could be achieved by having rotating leads/chairs, by jointly setting agendas and ensuring there is distributed leadership, with different partners leading on different topics.

Therefore, while the ICB is willing to commit to mobilising and being the convenor of the proposed network initially, we would welcome a joint approach with other partners. We aim to hold the first meeting of the network in summer of 2026, with a likely focus on agreeing the scope and work plan for the network.

This proposed approach also reflects the sovereignty of individual organisations, each of which has their own strategies and plans in support of mental health and emotional wellbeing.

Contribution of partners from the VCFSE sector

Across Norfolk and Suffolk, there are several hundred organisations from the voluntary, community and social enterprise sector that make a vital contribution to supporting emotional wellbeing and mental health. As noted above, these organisations vary greatly in their scale, scope and geographic focus, and while in some instances VCFSE organisations are directly commissioned to provide services, many others do so by drawing on their own resources.

The value of this contribution is highlighted in the ICB's Population Health Improvement Plan, which sets an objective of moving "a greater proportion of mental health funding to the VCFSE sector to promote early intervention and prevention". There are already measures in place to support delivery of this objective, with for example a proportion of the potential funding for a recent business case developed by NSFT being 'ringfenced' for VCFSE led activity. We will continue to pursue this approach as we commission new, and recommission existing, services.

Alongside this, we will discuss with colleagues, including those in the VCFSE Assembly, what other mechanisms could be put in pace to enable an expanded role for VCFSE partners in supporting the emotional wellbeing and mental health of local people.

5. Next Steps

5.1. Approach to Delivery

Section 3 outlines the main priorities for the ICB over the period of this strategy, with seven key areas identified:

- commission a comprehensive, integrated support offer for perinatal mental health and parent-infant relationship support
- proactively identify families with children aged 0-5 who would benefit from targeted, multiagency support and develop more integrated models of commissioning and provision
- expand the coverage of Mental Health Support Teams to all schools, including those in the independent sector and further education colleges
- ensure that community based mental health services are fully embedded within new neighbourhood delivery models
- strengthen support for people with complex needs
- review and recommission all relevant crisis and urgent care pathways to ensure there is a consistent, evidence based approach
- implement a new, consistent ICB-wide model for commissioning all relevant specialist adult placements

Detailed implementation plans, including timelines and milestones, are being developed for each of the seven areas and will be shared with partners in order to:

- ensure that plans are clear, transparent and as far as possible aligned with partners' work and timescales
- enable joint working arrangements (for example on early years) to be developed
- establish a framework that enables progress to be tracked and shared

The proposed quarterly Mental Health Network is likely to be a key forum for sharing and iterating these implementation plans.

5.2. Provisional Delivery Milestones

Year	Quarter	Provisional Milestone
2026/27	Apr-Jun	• ICB Strategic Plan agreed by ICB Strategic Commissioning Committee • MHST – ICB approval of funding for expansion • Support for people with complex needs – review business case • Preparation of implementation plans for strategic priorities

Year *(cont.)*	**Quarter** *(cont.)*	**Provisional Milestone** *(cont.)*
2026/27	Jul-Sept	• Initial quarterly meeting of N&S MH Network • Support for people with complex needs – codesign of detailed service and review of business case • Mobilisation of implementation plans
2026/27	Oct-Dec	• MHST – market engagement and procurement • Neighbourhoods - embed integration of community mental health into neighbourhood plans • Support for people with complex needs – finalise standard operating procedures • Quarterly meeting of N&S MH Network
2026/27	Jan-Mar	• Perinatal – complete baseline review of existing service • Early years – agree collective approach to sharing intelligence • Neighbourhoods – mobilisation of first phase • Alternative crisis pathways – complete baseline review and recommissioning • Specialist placements – mapping and review of existing arrangements complete • Quarterly meeting of N&S MH Network
2027/28	Apr-Jun	• MHST – contract award • Neighbourhoods – single point of access go live • Support for people with complex needs – new service operational • Alternative crisis pathways – new services mobilised • Quarterly meeting of N&S MH Network
2027/28	Jul-Sept	• MHST – contract mobilisation • Quarterly meeting of N&S MH Network
2027/28	Oct-Dec	• Quarterly meeting of N&S MH Network • Support for people with complex needs – new service operational (complex emotional needs)
2027/28	Jan-Mar	• MHST – teams in place at 77% of schools and colleges • Perinatal – complete commissioning of integrated offer of support • Early years – jointly commissioned pathways in place • Specialist placements – consistent ICB-wide commissioning model in place • Quarterly meeting of N&S MH Network
2028/29	Apr-Jun	• Neighbourhoods – phased integration of community mental health services • Quarterly meeting of N&S MH Network
2028/29	Jul-Sept	• Quarterly meeting of N&S MH Network
2028/29	Oct-Dec	• Quarterly meeting of N&S MH Network

Year *(cont.)*	**Quarter** ***(cont.)***	**Provisional Milestone** ***(cont.)***
2028/29	Jan-Mar	• MHST – teams in place at 92% of schools and colleges • Quarterly meeting of N&S MH Network
2029/30	Apr-Jun	• Neighbourhoods – phased integration of community mental health services • Quarterly meeting of N&S MH Network
2029/30	Jul-Sept	• Quarterly meeting of N&S MH Network
2029/30	Oct-Dec	• Quarterly meeting of N&S MH Network
2029/30	Jan-Mar	• MHST – teams in place at 100% of schools and colleges • Quarterly meeting of N&S MH Network