NHS
Central East
Integrated Care Board

Our Way – Strategy to Delivery

April 2026

Our promise

Our purpose

Our purpose is simple: to do what best serves our population. Everything we do is guided by this. We are responsible for managing the clinical and financial risk for 3.5 million people, and for making sure the NHS can continue to support you now and in the future.

Our focus is on outcomes, quality, and accountability, with collaboration used to strengthen delivery. We will continue to learn, adapt, and improve so that the NHS can support you better today and for years to come.

What you can expect from us

We promise to focus on what makes the biggest difference to people's lives. This means acting earlier to prevent illness and detect disease, making care easier to access, and ensuring people receive the right care in the right place. We will work to reduce unnecessary pressure on hospitals, help people closer to home wherever possible, and improve experience as well as outcomes.

We will be clear about our priorities and open about how we are doing. We will measure ourselves against a small number of meaningful outcomes and share progress honestly, including where improvement is slower than we want.

How we will make decisions

We promise to make decisions based on evidence, insight, and lived experience, not on organisational convenience. We will do less of what does not add value and more of what does. We will focus on reducing health inequalities, prioritising those communities who experience the poorest access, outcomes, and experience.

We will need to make tough choices. We cannot do everything, and not every service or intervention can continue unchanged. When we make difficult decisions, we will explain why, how we reached them, and how they support the long-term interests of the population.

How we will listen and respond

Your voice matters. We will listen widely to communities and work more deeply with people who have lived experience of services, using this insight alongside clinical and performance data to improve quality and reduce risk. We may not always be able to act on everything we hear, but we will acknowledge it, explain what has changed as a result, and be open when it has not.

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Contents

"This is how we will work over the next five years: principled in intent, disciplined in execution, and relentless in our focus on improving outcomes for our population."

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Purpose of this document

This document sets out a five-year approach for how the Integrated Care Board will improve health outcomes, experience, and sustainability for our population. It is not a detailed operational plan, but a principles-led strategy that provides a clear direction of travel and a consistent way of working over the medium term.

The approach is driven by a small number of core principles and strategic choices, with delivery achieved through the life-cycle described in this document—bringing together commissioning, continuous improvement, and service development into a single, disciplined operating model. This will ensure that strategy translates into action, learning is embedded, and what works is scaled systematically.

The strategy applies to all residents, across all ages, and spans the full breadth of providers involved in delivering health and care. This includes NHS organisations, primary care, community and mental health services, voluntary and community sector organisations, and local authority partners. It reflects our role as commissioners of a 'population-capitated' budget - linked to the size of our population - and our responsibility to steward resources on behalf of that population.

By setting out clear priorities, expectations, and ways of working, this document provides a shared framework for decision-making, investment, improvement, and assurance. It is intended to support consistent delivery over time, while remaining flexible enough to respond to emerging need, evidence, and national direction.

In short, this is how we will work over the next five years: principled in intent, disciplined in execution, and relentless in our focus on improving outcomes for our population.

Part 1
Strategy

Our population

Our Population at a Glance

3.53 million GP-registered patients across Cambridgeshire, Peterborough, Bedford, Central Bedfordshire, Luton, Milton Keynes, and Hertfordshire

16.4% aged 65+ (rising); **9.6%** live in most deprived quintile nationality

4.9 years male/3.8 years female life expectancy gap between healthiest and least healthy areas

15% with multimorbidity overall (43.8% in 60+)

The Central East ICB serves approximately 3.5 million people across Cambridgeshire, Peterborough, Bedfordshire, Luton, Milton Keynes, and Hertfordshire. The population is living longer but with a growing challenge of long-term illness, widening inequalities linked to deprivation.

Understanding the leading causes of death and disability

Cancer, cardiovascular disease, and respiratory disease remain the leading causes of death. Across the population, poor mental health has the biggest impact on quality of life and disability, accounting for 23.1% of years lived with disability. Musculoskeletal conditions also have a significant impact on quality of life and disability, accounting for 19.5% of years lived with disability. The impact of mental health on disability and quality of life highlight a critical commissioning gap. While we invest extensively in high-mortality conditions, we must also focus on those conditions which have the biggest impact on quality of life.

KEY INSIGHT:

A dual focus on both mortality AND quality of life is essential. Mental health disorders and musculoskeletal conditions drive 43% of years lived with disability and should receive proportionally more commissioning focus.

Rank	Causes of Death	Causes of Disability
1	Cancer (32.1%)	Mental health disorders (23.1%)
2	Cardiovascular disease (27%)	Musculoskeletal conditions (19.5%)
3	Respiratory disease and infections (13.8%)	Unintentional injuries (8.4%)
4	Neurological disorders (10.2%)	Neurological disorders (7.9%)

Long-term conditions and multimorbidity: the clustering challenge

Analysis of primary care data reveals where there is a high prevalence of long-term conditions across Central East. Hypertension (11.5–15.1%) is the most common condition, highest in Bedford and Central Bedfordshire. Diabetes prevalence is particularly concerning in Luton (10%), which is notable given its relatively young population, signalling decades of future complications for those affected.

Obesity is severely under-recorded (8.6–14.1% in primary care data vs around 25–30% in population surveys), masking the primary modifiable risk factor driving condition accumulation. New cases of depression (0.8–1.3% annually) is below England average (1.5%), reflecting variation in both population need and under-identification.

Multimorbidity: Long-term conditions rarely exist in isolation. Local analysis reveals extensive clustering: 65% of people with diabetes also have hypertension, 21% have coronary heart disease, and 18% have depression. Common mental health conditions co-occur with physical long term conditions in 13–28% of cases locally, yet we are recording fewer new cases of depression each year than the national average, suggesting under-diagnosis (0.8-1.3% locally compared to 1.5% nationally). This under-identification means that many of our residents with physical long-term conditions have unrecognised mental health needs that complicate their care and worsen their outcomes.

Research on patients across England shows that people who live in the most deprived areas tend to develop multimorbidity earlier than people living in the least deprived areas. **Modifiable risk factors drive this:** Obesity, smoking, high blood pressure, and physical inactivity are all contributing to worsening health, particularly in our more deprived areas. Obesity reduction and smoking cessation would deliver greatest benefits to the most deprived populations.

KEY INSIGHT:

Across people with multimorbidity in England, the median age of onset decreased from 56 in 2004 to 46 in 2019, with much earlier onset for people living in deprived communities. Common mental health conditions co-occur with physical long term conditions in 13-28% of cases, yet we identify fewer new cases of depression than other areas. Even a 3-5 year delay transforms lifetime healthcare utilisation.

Health Inequalities

The 4.9-year male and 3.8-year female life expectancy gap between our best and worst areas reflects earlier multimorbidity onset, decades of living with preventable conditions, and premature death. Three conditions account for more than half (52–62%) of this gap: circulatory disease (17–26%), cancer (15–21%), and respiratory disease (12–20%). The healthy life expectancy gap is even wider (9.8–10.9 years), meaning that our most disadvantaged residents spend more years living with an illness or disability.

Indicator	Best outcomes	Poorest outcomes	Gap
Life expectancy	Cambridgeshire, Herts	Peterborough, Luton	4.9 yrs (M), 3.8 yrs (F)
Healthy life expectancy	Herts, Central Beds	Luton, Peterborough	9.8 yrs (M), 10.9 yrs (F)
Preventable Under 75 mortality	Hertfordshire	Luton, Peterborough	54% higher
Cardiovascular Disease mortality	Hertfordshire	Peterborough	32% variation
Respiratory mortality	Cambridgeshire	Luton	31% variation
Cancer mortality	Hertfordshire	Peterborough	18% variation

KEY INSIGHT:

Circulatory disease (17–26%), cancer (15–21%), and respiratory disease (12–20%) drive over half the life expectancy gap—yet all three share the same modifiable risk factors. The healthy life expectancy gap is even wider (9.8-10.9 years), meaning disadvantaged residents spend more years disabled by the same conditions, reducing their quality of life and driving up hospital costs.

Self-Reported Health

Self-reported health remains broadly positive, with over 82% of residents describing their health as good or very good. However, this varies by area, with residents in more deprived places more likely to report fair, bad or very bad health. This mirrors the known links between deprivation and long-term conditions, disability and life expectancy.

Future Projections

Population projections indicate substantial growth overall over the next 5 years. This is most marked in older age groups (age 65 and over) and will be sustained through to 2047. As the population ages, the number of people living with frailty is expected to increase. Based on local data, the number of people with severe frailty is expected to increase by 55% by 2047, to approximately 35,500 people. As frailty and multimorbidity are closely associated with age, service planning must anticipate this growth.

Frailty Status	Current Estimate	Growth by 2031	Growth by 2047
Mild frailty	164,516	+12%	+40%
Moderate frailty	40,715	+16%	+51%
Severe frailty	20,603	+17%	+55%

Strategic Implications

In summary, the key challenges are a high and growing burden for our population and our system of long-term and disabling condition, persistent inequalities driven by deprivation, and a rapidly ageing population. Addressing these issues will require sustained focus on prevention, tackling inequalities, and supporting people to live well with long-term conditions, alongside planning for increasing demand in older age groups.

Population Health - further detail

Further detail on Central East Population Health, our priorities and the evidence-base are set out in a supporting document.

Our purpose

We need to be clear about the purpose of the ICB. Our role is to manage the clinical and financial risk for the 3.5 million people we serve, ensuring that the right health interventions are in place to improve lives, reduce avoidable harm, and use public resources responsibly. Everything we do needs to be driven by one question: what best serves our population?

The ask of the new ICB as the system commissioner is to focus relentlessly on what matters most to people and to the system.

1. **Improve access** to care so that services are easier to navigate, more local where possible, and feel simpler and more joined up from a person's perspective. If access feels complicated or fragmented, we need to change how care is organised. **We want to see patient-reported satisfaction with primary care rise.**
2. Make the **NHS financially sustainable and more productive.** This means using resources where they deliver the greatest value, reducing low-value activity, and supporting different ways of working rather than relying on incremental growth. Doing less of what does not add value and more of what does is essential if we are to create the headroom needed to improve care over time. **We want to flatline average NHS spend per resident.**
3. **Support people to stay in work and remain economically active** wherever possible. Good health underpins independence, employment, and wellbeing, and we need to design care that helps people recover, manage long-term conditions, and continue to participate in society. **Decreasing the average number of days residents spend on waiting lists** is key to this ambition.

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Meeting these challenges requires focus, consistency, and resolve. We need to hold the line on our role: managing risk, setting direction, and assuring outcomes, while working with our partners to enable delivery. By staying anchored on the question of what best serves our population, and by being clear about where effort adds value, we can make a meaningful difference to people's lives and ensure the NHS remains viable for the future.

Owning the commissioning role

As an Integrated Care Board, we are the commissioners. We hold a population-capitated budget and a statutory responsibility to use it to secure the best possible outcomes for our population. Commissioning is not a background function—it is a central mechanism through which quality, equity, and value will be delivered.

To do this, we will work differently. We will be explicit about what we are commissioning for, the outcomes we expect, and how delivery will be assured. Our approach will be grounded in the following improvement principles: clear priorities, disciplined use of data and insight, rapid testing and learning, and a relentless focus on whether services are delivering reliably for our population. This is how we translate strategy into delivery and accountability.

Given the scale of change ICBs have been asked to deliver, alongside a significant reduction in staffing capacity, we must be disciplined about where we spend our time and effort.

We will be empathetic to the pressures facing partners across the system, but we will also be clear about boundaries.

Providers will be expected to work directly with each other to resolve operational issues and manage day-to-day delivery. NHS England regional teams will continue to fulfil their oversight and support role. Local authorities will be critical in leading on public health, prevention, and addressing the wider determinants of health.

By maintaining this clarity of focus, we will create the conditions for the whole system to function more effectively, reducing duplication, avoiding blurred accountability, and ensuring that effort is directed where it adds the most value. The ICB will remain firmly anchored on the role only we can play: stewarding public resources, shaping services around population need, and holding the system to account for delivering quality, outcomes, and value. The emergence of Integrated Health Organisations as a contract-based delivery method is compatible with this approach.

Quality is the strategy

For too long, commissioning has been passive, without actively shaping, assuring, or challenging delivery. The Dash Review of Patient Safety Across the Health & Care Landscape (July 2025) is clear that this lack of grip on quality is not unique to providers: across the system there is too little routine use of meaningful quality data, too slow a response to known variation, and insufficient clarity about what "good" looks like in practice. In Year 1, we must therefore be clear and transparent about why certain services are not delivering in line with expectations - and explicit about what will change as a result.

Our improvement philosophy will be anchored in the principles of continuous improvement, embedding it at the heart of everything we do. The Dash Review highlights that while the NHS generates vast quantities of data, much of it is retrospective, burdensome, and poorly linked to improvement. To address this, we will adopt proven methodologies such as Plan–Do–Study–Act (PDSA) cycles, use timely, decision-ready data to inform action, and foster a culture with a continuous expectation of improvement. This directly responds to the report's conclusion that sustainable quality improvement depends less on inspection and assurance, and more on local capability to test, learn, and adapt at pace.

This shift positions us to deliver meaningful change, improve population health outcomes, and restore confidence in commissioning as an active, strategic function—one that shapes quality rather than simply reports on it.

- **Embed quality at the core** - Commissioning teams must position quality as the central driver of strategy, not an afterthought. The Dash Review found that quality is often fragmented across safety, effectiveness, and experience, with no single line of sight for leaders. Our approach will integrate these dimensions into a coherent commissioning narrative, ensuring quality is designed in from the outset.
- **Use data-driven feedback loops** - Real-time metrics and rapid PDSA cycles enable swift identification and remediation of underperformance. The review emphasises that long reporting cycles delay action and blunt accountability. By shortening feedback loops, we move from retrospective explanation to prospective improvement.
- **Align stakeholders around outcomes** We will engage providers, residents, and communities in co-creating targets and testing improvements. The Dash Review stresses that quality improves fastest where patients and frontline teams are actively involved in defining what matters and measuring progress.
- **Distinguish between process tuning and full redesign** - As demonstrated in models such as the Nuka healthcare system in Alaska, we will use rapid-cycle methods for local process improvement and reserve full recommissioning for systemic issues. This reflects the review's finding that not all quality problems require structural change—many require disciplined execution of well-designed processes.

A process can only be considered effective if it operates successfully 95% of the time, and achieving that level of reliability requires rigorous testing and multiple iterations before confidence is established. The Dash Review highlights that the NHS often accepts far lower reliability as "normal", leading to unwarranted variation and avoidable harm. This discipline will therefore become a cornerstone of our assurance framework.

Rather than requesting lengthy plans that describe actions without demonstrating impact, we will focus on evidencing the reliability of processes and achieving outcomes. By embedding this expectation into our commissioning approach, we will shift from activity-based reporting to outcome-based assurance, ensuring that what is promised is not just delivered once, but delivered consistently for our population.

Resident & community insights

Lived experience and community insight will be treated as a core input to our improvement system, not a separate engagement activity. Alongside quantitative performance and outcome data, insight from our residents will provide early intelligence on variation, risk, and failure demand—often identifying problems such as poor access, avoidable harm, low-value activity, and widening inequalities before they are visible in formal metrics.

We will use insight to inform Plan–Do–Study–Act (PDSA) cycles, helping us define problems accurately, test changes quickly, and understand whether improvements are working in practice. Rather than repeatedly collecting new feedback, we will draw more systematically on the insight already available across the system to support timely improvement decisions. We will use modern, digital mechanisms as a default, including, wherever possible, the NHS app.

Listening will be purposeful and proportionate, aligned to where we are in the improvement cycle. Broad community engagement will be used to identify patterns, themes, and emerging risks that shape priorities. Deeper involvement of people with lived experience will be focused where we are designing interventions, testing changes, or assessing reliability—ensuring insight influences decisions early, not retrospectively.

In priority pathways and populations, quality improvement will be explicitly co-produced. People with lived experience will work alongside commissioning and quality teams to design measures, test changes, and interpret results, with appropriate support and payment for their expertise. This ensures that improvement efforts reflect what matters to people, not just what is easiest to measure.

Health inequalities will guide where we focus our improvement effort and our listening. Insight from communities experiencing the poorest access, experience, and outcomes will be prioritised to inform targeted PDSA cycles and assess whether changes are reducing, rather than reinforcing, unwarranted variation.

Finally, insight will be built into our assurance and learning loops. What we hear will directly inform risk discussions, reliability testing, and decisions about whether processes are fit for purpose or require redesign. We will close the loop by being explicit about what has changed because of insight, where it has not, and why—ensuring transparency and reinforcing a culture of continuous improvement and accountability.

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Our care model

Our strategy is underpinned by a single, consistent care model that applies across all pathways and populations. This model sets out how care should be delivered, where effort should be focused, and how resources should be used to maximise access, quality, and value. Every pathway we commission and assure is expected to reflect this model.

The model is built around five interconnected layers, each of which is essential to reducing avoidable demand, managing risk earlier, and ensuring that clinical expertise is focused where it adds the greatest value.

1. **Prevention and screening** - The foundation of the model is prevention, early detection, and risk reduction. This includes population-level prevention, targeted screening, vaccination, and early identification of emerging need. The aim is to reduce future morbidity, avoidable deterioration, and unwarranted demand on NHS services.

2. **Supported self-care** - Where people can safely manage their own health, the system should enable and support them to do so. This includes clear information, digital access, remote monitoring, and advice services that build confidence and capability, reducing unnecessary clinical contact while improving experience and outcomes.

3. **Proactive outreach and risk mitigation** - Rather than waiting for people to present in crisis, we will prioritise proactive outreach to individuals and groups at risk of deterioration or avoidable service use. This includes identifying missed opportunities for intervention, addressing gaps in care, and acting early to reduce escalation and unplanned demand.

4. **Care coordination for complex needs** - For people with multiple conditions, frailty, or complex needs, care is actively coordinated around the individual. This includes multidisciplinary working, personalised care planning, and continuity of oversight, ensuring care is joined-up, proactive, and focused on outcomes that matter to the person.

5. **Crisis response and recovery** - When crises do occur, services must respond rapidly and effectively, minimising harm and avoiding unnecessary admissions where possible. Crisis care is time-limited, closely linked to recovery and step-down support, and feeds learning back into earlier layers of the model to prevent recurrence.

This care model is enabled by a managed care system that segments and stratifies the population according to risk and need, allowing interventions to be targeted at the right people, at the right time, and at the right intensity. Care is coordinated proactively across pathways, with clear accountability for oversight and outcomes.

Digital access tools—including online entry points, remote monitoring, and AI-enabled triage—are used to reduce friction for patients and remove avoidable volume from the clinical workforce. This ensures clinical time is focused on people who most need it most, while improving access, consistency, and experience for the wider population. In line with the 10 Year Health Plan, the NHS App will expand functionality over time as the main digital 'front door' to the NHS. Traditional means of access such as the telephone will remain open for those who prefer it, and improve as digital access takes increasing volumes of enquiries and contacts.

By operating proactively, coordinating care across settings, and using digital tools intelligently, the model aims to reduce unwarranted variation and avoidable utilisation, increase access and satisfaction, and deliver more consistent outcomes. It provides a common framework for commissioning, delivery, and assurance—ensuring that every pathway contributes to a sustainable, high-quality system of care.

Disease priorities

We will begin by focusing on a small number of priority disease areas and groups of care where the need is greatest, the opportunity for improvement is clear, and the potential to reduce avoidable utilisation is significant. These priorities reflect the health needs of our population and provide the greatest opportunities for improving outcomes, experience, and value through the care model.

These pathways will act as early exemplars for how we apply proactive, coordinated, and digitally enabled care—demonstrating how quality improvement, population management, and contractual incentives come together to deliver measurable impact.

Cancer remains a leading cause of morbidity and mortality, with outcomes highly sensitive to early detection, timely access, and coordinated pathways. Variation in screening uptake, diagnostic timeliness, and post-treatment support contributes to avoidable emergency presentations and poorer outcomes. Our focus will be on strengthening cancer prevention and screening, improving access to diagnostics, and proactively supporting people during and after treatment to reduce unplanned admissions and crisis presentations. Coordinated pathways across primary, community, and specialist care will improve experience and outcomes while reducing avoidable acute utilisation.

Musculoskeletal (MSK) conditions are among the highest drivers of outpatient activity, imaging, and elective demand, with significant variation in access, intervention rates, and outcomes. Many people experience long waits and repeated contacts that do not add value. MSK is the second leading cause of economic inactivity in England. By prioritising supported self-care, digital access, early triage, and proactive management, we can reduce unnecessary referrals and investigations, improve flow, and ensure specialist input is targeted at those who will benefit most. This pathway offers early opportunities to demonstrate how proactive care and digital tools can significantly reduce demand while improving satisfaction.

Cardiovascular Disease is a major contributor to premature mortality, health inequalities, and emergency admissions. Much of this burden is predictable and preventable, with clear opportunities for early identification, risk stratification, and proactive management. This pathway will focus on prevention, population-level risk management, and proactive outreach to people at highest risk. Coordinated management of long-term conditions will reduce avoidable hospital admissions, improve outcomes, and narrow inequalities, while making better use of clinical capacity.

People with advanced illness often experience fragmented care, repeated crises, and high levels of unplanned hospital use—frequently in ways that do not align with their preferences or improve quality of life. By prioritising early identification, proactive care planning, and coordinated support across health and care services, we can reduce avoidable admissions, improve experience for people and families, and support care closer to home. This pathway directly aligns with our care model's emphasis on proactive coordination and crisis prevention.

Mental health crisis care has a significant impact on individuals, families, and wider services, including emergency departments and ambulance services, and is a high-pressure, high-cost area. Our focus will be on strengthening early intervention, proactive outreach, and coordinated crisis response, ensuring people receive timely support in the most appropriate setting. Improving flow, continuity, and follow-up will reduce repeat crisis presentations, avoid unnecessary admissions, and improve outcomes and experience.

Priority areas summary

Together, these five pathways account for a disproportionate share of healthcare utilisation, including emergency attendances, admissions, outpatient activity, and diagnostic demand. They also reflect areas of greatest variation in access, experience, and outcomes across our population.

By starting here, we can:

- Apply the care model at scale where it will have the greatest impact
- Demonstrate how proactive, managed care reduces avoidable utilisation
- Improve outcomes and experience for large sections of the population
- Build confidence in new contracting, data, and delivery models

These priority areas will be used to test and refine our approach before extending it to other pathways over time, ensuring that change is focused, evidence-based, and deliverable—while delivering early benefits for our population and the system.

Measuring what matters

To ensure that our strategy translates into real change in experience, utilisation, and outcomes, we will be clear on how we will measure impact. Key measures will be deliberately few, to ensure focus and prioritisation are made easier.

Our performance framework measures whether the strategy is delivering what it is intended to achieve: better quality, lower avoidable utilisation, and a financially sustainable NHS. Rather than a long list of disconnected indicators, we operate a layered model that links frontline delivery, organisational behaviour, and long-term population impact. The framework distinguishes between:

- **Three top-level system outcomes**
- **Four critical pathway indicators**
- **One population early intervention measure**
- **One organisational enabler**

Together these nine measures will provide a mix of leading indicators (signals of change in progress) and lagging indicators (evidence of sustained system impact). Shifting the dial in these areas will be the central focus of every decision we make.

Measures	Why they matter
System outcomes	
Increase patient-reported satisfaction with access to primary care	These indicators show whether the system has fundamentally shifted toward better access and sustainable delivery
Decrease the average number of days residents spend on waiting lists	
Flatline average NHS spend per resident	
Critical pathway indicators	
Decrease type 1 & 2 A&E attendances per 100,000 population	These are early utilisation signals. When they move in the right direction, they predict future improvement in waiting times, cost, and patient experience
Decrease the average length of stay for mental health inpatient admissions	
Increase support for children and young people's mental health and wellbeing	
Reduce the average number of emergency admissions for people in their last six months of life	
Population early intervention measure	
Increase the proportion of cancers diagnosed at early stages stage 1 and 2 - starting with colorectal cancer	Earlier diagnosis improves patients' treatment outcomes and survival rates, reduces downstream utilisation, and demonstrates that the prevention layer of the care model is functioning
Organisational enabler	
We will measure: Whether at least 95% of ICB staff agree with the NHS Staff Survey statement that "the care of patients/service users is my organisation's top priority	This is a leading indicator of organisational health and will indicate whether ICB staff agree with the principle that quality is our strategy

Why this layered approach matters

This framework will ensure that we are not waiting years to understand whether our strategy is working.

- Top level system outcomes confirm structural utilisation shift.
- Critical pathway indicators show whether behaviour is changing.
- Population early intervention measures demonstrate long-term impact.
- Organisational enablers show whether our culture supports delivery.

Every programme and contract must contribute to these layers. This creates a single line of sight from neighbourhood delivery to Board accountability.

These measures will be used consistently across commissioning, contracting, and assurance. They will provide a shared definition of success, helping us stay focused on long-term improvement rather than short-term activity management. Most importantly, they will ensure that every programme, pathway, and investment decision contributes to the same overarching goals: better outcomes, better experience, lower avoidable utilisation, and a sustainable system for our population.

Neighbourhood health strategy

Our strategy is grounded in a simple but ambitious intention: to deliver brilliant care locally, bringing the National Neighbourhood Health Strategy to life for our communities in a way that is tangible, consistent, and meaningful. National policy sets the direction, but improvement is realised in neighbourhoods—through relationships, trust, and coordinated delivery by organisations that know their communities best.

Neighbourhood Health provides the operational level at which our care model, quality approach, and population-based commissioning come together. It is where prevention, proactive care, coordination, and crisis response are integrated around people and places, rather than organisations or individual services.

We will rely on the full breadth of our provider landscape to do this well. This includes small and specialist voluntary and community sector organisations, primary care, community providers, local authority services, and large NHS trusts. Each brings distinct strengths, reach, and expertise. Our role as commissioners is to align these contributions into a coherent neighbourhood offer, with clear outcomes and shared accountability, joining up services for our residents.

Voluntary and community sector organisations will play a critical role in prevention, early intervention, social support, and addressing the wider determinants of health. Their trusted relationships and deep community insight are essential to improving access, experience, and equity—particularly for communities least well served by traditional models of care.

Primary and community health services will act as the anchor of neighbourhood delivery, providing continuity, proactive management of long-term conditions, and coordination across pathways. We are working with partners to develop Neighbourhood Health plans, alongside more detailed Primary Care Action Plans which we will publish in Spring 2026.

Local authorities will be central partners in public health, prevention, and place-based working, ensuring health and care are integrated with wider support for housing, employment, and wellbeing.

Larger NHS providers will continue to deliver specialist and acute services, but increasingly as part of neighbourhood-connected pathways, supporting earlier intervention, smoother transitions, and rapid step-down from hospital-based care. This alignment is essential to reducing avoidable utilisation while improving outcomes and experience.

Neighbourhood delivery will be enabled by the managed care infrastructure described earlier: shared data, digital access tools, and proactive coordination that support neighbourhood teams to act early and consistently. Contracting and financial models will reinforce this approach, using provider collaboratives and lead provider arrangements to minimise fragmentation and support shared responsibility for outcomes at neighbourhood level.

By focusing on excellent local delivery, we will ensure that national policy translates into real benefit for residents. Neighbourhood Health becomes not a programme, but the way care is organised and delivered—bringing together our diverse providers around a shared purpose: improving outcomes, reducing inequalities, and delivering sustainable, high-quality care for every community we serve.

The critical role of primary care

A sustainable and high performing NHS depends on a strong Primary Care foundation. Primary Care – which includes general practice, community pharmacy, dental and optometry services, is uniquely positioned to focus on prevention, early intervention and proactive management of long-term conditions, reducing unnecessary hospital admissions and outpatient activity. This is central to reducing overall utilisation.

Strong Primary Care underpins patient satisfaction. Increased access, continuity of care, trusted relationships and holistic, person-centred support improve experiences and outcomes, particularly for people with more complex needs.

Our Way acknowledges general practice, community pharmacy, dentistry and optometry as the cornerstone of reform across Central East.

Improve, codify, and scale

> **We will test small, learn fast, and scale what works.**
>
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> Chief Executive Officer,
> Central East ICB

Our approach to transformation is deliberately disciplined. We will test small, learn fast, and scale what works—rather than attempting large-scale change without evidence. Improvement will begin in real settings using established improvement methods to demonstrate that a model works in practice, delivers benefit, and can be implemented reliably.

Where innovation is required, we will not reinvent the wheel. We will make full use of national NHS accelerator and innovation programmes to test and evidence impact at pace, allowing us to adopt proven models without duplicating effort or delaying delivery.

Once a model has been shown to work -either locally or through credible national evidence - we will move quickly to codify it into a standard, evidence-based service model. This means clearly defining the core components, outcomes, workforce, digital requirements, and delivery expectations so that it can be replicated consistently.

We will then commission once at scale across our 3.5 million population, limiting the number of providers we contract with and using lead provider models to ensure clarity of accountability, consistency of delivery, and effective risk management. This approach reduces fragmentation, simplifies commissioning, and supports high-quality, reliable delivery at scale.

We describe this as “improve it, then codify it, then scale it.” Codification is intentional. We are not asking each local area to redesign services from scratch. Just as you would not expect every branch of a national retailer to invent its own core product, we expect proven models to be delivered consistently because that is what drives quality, efficiency, and reliability.

We recognise that not everything will work everywhere. Local context matters. However, we will apply an 80:20 principle: the core model should be followed as standard, with local variation only where there is a clear, evidence-based reason to do so. Deviations must be explicit and justified, not assumed.

This approach balances innovation with discipline. It allows learning and creativity at the front end, while ensuring that once something works, it is delivered consistently and at scale—supporting better outcomes, reduced variation, and sustainable use of public resources across the system.

Health, work and economic participation

Health and economic participation are inseparable. A sustainable NHS is not only about managing illness; it is about supporting people to live well enough to participate in education, employment, and community life.

For many residents, particularly younger adults, ill health is now a major barrier to economic activity. Over 9 million people aged 16-64 in the UK are economically inactive (approx. 700,000 more than in 2019). 2.8 million of those (30%) are economically inactive due to long-term sickness. The biggest drivers of national economic inactivity are mental ill health, a musculoskeletal condition such as arthritis or back pain, and cardiovascular disease (circa 1.6m combined). This is reflected in our own disease priorities.

As commissioners, we recognise that the NHS is one part of a wider system that supports people back into economic activity. We will work in partnership with employers, employee assistance programmes, Jobcentres and employment services, and wider public, private and social care partners to design care that supports participation wherever possible.

In practical terms, this means:

- Considering how access to care can be made flexible around work and education.
- Supporting reasonable workplace adjustments where health is a barrier.
- Aligning neighbourhood delivery with employment and social support pathways.

Supporting people to return to work or education improves wellbeing, reduces long-term demand on health services, and strengthens the economic resilience of our communities.

Financial strategy

The financial strategy for Central East ICB is built on a simple principle: every pound we spend must deliver demonstrable value and a measurable improvement in outcomes for our population. Financial decisions are inseparable from our quality and improvement approach and from the five-layer care model that underpins all pathways. Resources will be directed toward prevention, early intervention, reliable delivery, and the reduction of unwarranted variation, while maintaining systemstability and sustainability.

We are planning on the basis that future funding growth from NHS England will be modest, with most ringfencing removed to provide greater flexibility. At the same time, efficiency and productivity requirements are expected to continue year on year. This means we cannot rely on growth funding to meet rising demand and must instead focus on using resources more effectively. This includes taking a more active approach to the approximately £1bn of health spend invested outside Central East, ensuring it contributes to improved NHS utilisation for our population.

We will support innovation and transformation by setting aside a proportion of our yearly funding allocation for time-limited investment in service change that supports priority programmes and national shifts toward prevention, early intervention, and care closer to home. These investments will be targeted, evidence-based, and subject to clear expectations about their impact.

We will continue to operate within our fair share of available resources, aligning funding with healthcare need and avoiding cost pressures being displaced across the system. Financial sustainability is not about doing less for the population, but about using resources where they deliver the greatest benefit and stopping activity that does not improve outcomes.

From 2026/27, we will increasingly align resource allocation with outcomes and population need, rather than historic patterns of spend. This approach will evolve in line with national guidance and business rules as they are confirmed. Where block contracts remain, NHS England guidance and pace-of-change thresholds will be applied to support a managed transition away from them, recognising the need to maintain stability.

We will continue to operate within national financial frameworks, including the use of blended payment models in areas such as urgent and emergency care and radiotherapy. Elective and other variable activity will continue to be paid on a cost and volume basis, in line with national tariffs, best practice pathways, and prescribing guidance.

All proposals for service development or new investment will be considered in the context of system priorities, the care model, and the direction set by the national NHS 10 Year Health Plan. Decisions will be transparent, evidence-based, and consistent with long-term financial and clinical sustainability.

Contracting strategy

Our contracting approach is a core lever for delivering quality, outcomes, and value. We will use contracts deliberately to support the care model, reinforce collective accountability, support data sharing, and reduce unwarranted variation. We are moving away from activity-led contracting toward a value-based approach, where payment and incentives are aligned to improved quality of life, better experience, and reduced inequalities.

Contracts will increasingly be let with groups of providers working in collaboration, including the use of lead provider models, to minimise fragmentation and reduce the overall number of contractual relationships the ICB needs to manage. These models will enable clearer accountability for end-to-end pathways, support coordination across settings, and allow risk to be managed at the level where it can be most effectively controlled.

Outcomes will be measurable, transparent, and shared across collaborating providers. Success will be defined by collective achievement, not organisational performance in isolation. Tackling health inequalities will be embedded as a core contractual requirement, shaping how services are designed, delivered, and improved.

Contracts will focus on what matters most: relationships, experience, and outcomes. This supports a relational delivery model, where continuity of relationships—alongside continuity of care—is foundational to place-based delivery. We will keep contracts high trust and low burden, avoiding excessive KPIs and compliance-heavy processes. Specifications will be clear but not overly prescriptive, allowing professional judgement, innovation, and local adaptation within agreed outcomes.

Shared financial risk and reward will be a defining feature. Through blended payments, pooled budgets, and pathway-based envelopes, contracts will pass both upside and downside risk to provider collaboratives, incentivising early intervention, proactive care, and utilisation management in line with the five-layer care model. Multi-year, place-based contracts will give providers the flexibility to reinvest within an agreed financial envelope as needs change.

High-quality, timely data will be non-negotiable. Contracts will set firm expectations for data sharing, data quality, and transparency, recognising that reliable data underpins quality improvement, financial rigour, and assurance. Data is not an administrative add-on—it is a core enabler of improvement and accountability.

Our contracting models will evolve over time. We will use a range of approaches—from fee-for-outcomes arrangements linked directly to measurable improvements, to bundled pathway or population-based contracts held by a lead provider—scaling complexity as confidence and capability grow. This flexibility allows us to start simple while remaining focused on value and outcomes.

Capital strategy and major projects

As commissioners, we hold accountability for ensuring that the right services are available in the right place to meet the needs of our population. To achieve this, we must have robust planning and clarity in how we manage capital resources.

As an Integrated Care Board (ICB), we receive a relatively small capital funding allocation (~£20m in 2026/27). Any capital allocated to us will be fully directed toward delivering ICB priorities and enhancing health outcomes at the neighbourhood level.

Where a provider seeks our support for estates development, we will offer support in principle if the proposal demonstrates clear value to the population and aligns with our Central East Strategic Commissioning Strategic Plan aims. This includes ensuring that the provider has clarity on revenue streams to sustain the development.

We will not incur costs that do not add measurable value to our population. While we will assist providers in engaging with wider stakeholders to enable successful capital management, the responsibility for capital investment remains with the provider. They must have confidence in their ability to fund and manage these developments.

Major capital investment is being progressed through an established pipeline of schemes reflecting prior decisions and existing commitments. These programmes will continue to advance in line with agreed approvals, confirmed funding arrangements, and relevant national requirements.

As an ICB we have very limited discretionary capital. This means we must be highly selective about how future capital is prioritised and ensure that investment directly supports our care model, neighbourhood delivery, and population outcomes. Large, acute-based schemes alone will not deliver the shift toward prevention, proactive care, and care closer to home that our strategy requires.

Over the next five years, we will work with NHS England and the Department of Health and Social Care to establish a stronger pipeline of community-based capital schemes, aligned to neighbourhood health and integrated care delivery. This will include working with a wide range of providers - primary care, community services, mental health providers, voluntary and community sector organisations, and local authority partners—to identify opportunities where capital investment can unlock better access, coordination, and utilisation reduction.

Our focus will be on practical, scalable community infrastructure that enables:

- Prevention, early intervention, and proactive outreach
- Care coordination for people with complex needs
- Delivery of services closer to home and outside hospital settings
- Better use of digital and flexible space

We will take a collaborative and phased approach, supporting providers to develop schemes that are deliverable, affordable, and aligned with system priorities. Capital proposals will be assessed not just on readiness, but on their contribution to outcomes, utilisation reduction, and long-term sustainability.

By strengthening the community capital pipeline over time, we ensure that future investment decisions are better balanced, more aligned to neighbourhood delivery, and more effective in supporting the shift of care that our population needs.

Part 2

ICB Operating Model

Building an effective organisation of professionals

The Central East Deal

The simple test

Does this best serve our population?

What I will do

- **Know what we are trying to achieve for our population** and prioritise delivering it.
- **Take responsibility** and raise issues early
- **Use my judgement and act** within the agreed boundaries
- **Work as one team** and collaborate across roles
- **Learn, innovate and improve**
- **Treat people with respect** and act with integrity

What the organisation will do

- Be clear about **direction and priorities**
- Set **simple governance** so people can act
- Invest in **skills, development, and wellbeing**
- Create a s**afe and inclusive environment**
- Hold **everyone to the same standards**
- **Be honest** about what we cannot deliver

Starting a new organisation with a clear strategy requires more than structures and plans; it requires shared purpose, consistent professional behaviour, and a culture that enables people to act with confidence and responsibility. Our organisational development approach is designed to support this from the outset, grounded in clarity, trust, and high professional standards.

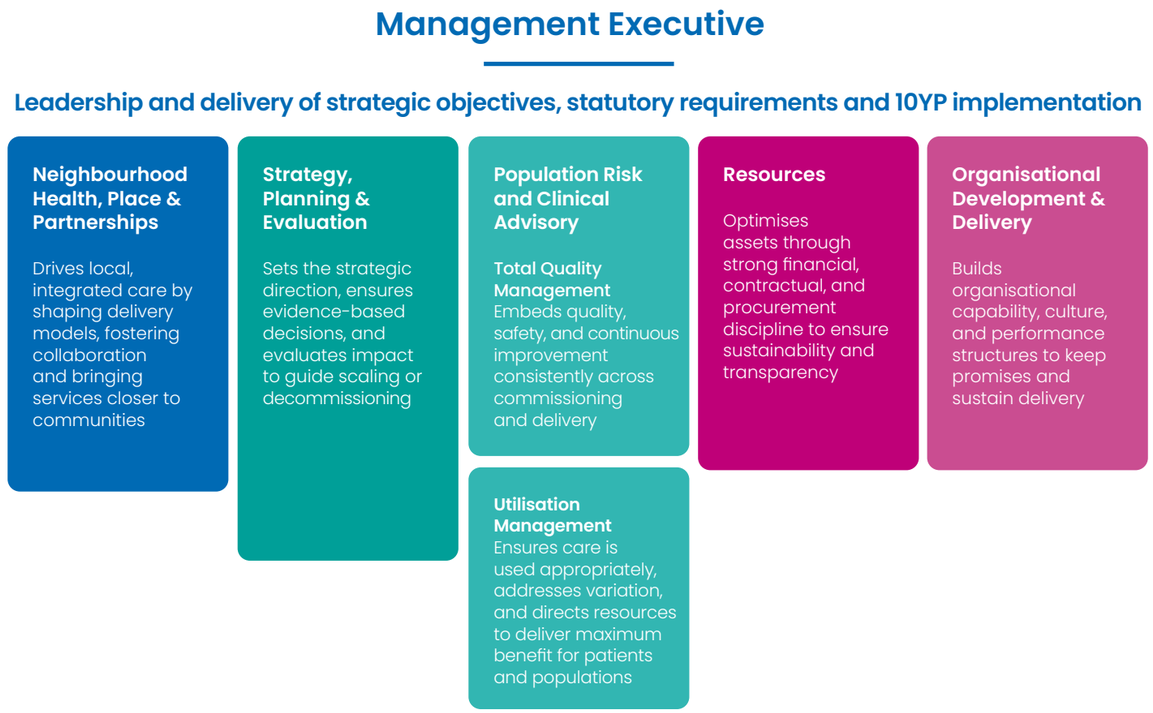
We will be guided by the Nolan Principles of Public Life in how we lead, make decisions, and behave as an organisation. These principles set clear expectations for integrity, accountability, openness, and leadership, and apply to everyone at every level. They provide a common reference point for how we work together and how we earn trust with partners, stakeholders, and the public.

We are committed to building a highly skilled organisation and will invest in training, development opportunities, coaching, and wellbeing support. In return, we expect people to take responsibility for applying their skills in practice and contributing to delivery. Our governance and delivery models have been deliberately designed to give people clarity about priorities, decision rights, and accountability, so they are able to act with confidence and pace rather than waiting for permission.

Everyone in the organisation is expected to understand the strategy and the outcomes it is designed to deliver. We will create time and space for this learning, recognising that clarity enables good judgement and consistent decision-making. We want every member of staff to understand how their role contributes to delivering our five key metric shifts, and to use our guiding question — what best serves our population? — to inform day-to-day decisions and actions.

Talent management will be a core discipline, not a compliance exercise. We will prioritise effective appraisals for all staff, including Executive & Non-Executive Directors. In addition, every member of staff will have regular monthly reviews focused on delivery and behaviours. These conversations will provide clarity on priorities, feedback on impact, and support for development, reinforcing high standards while enabling people to grow and perform at their best. By investing in skills, enabling action through clear governance, and maintaining high professional standards, we will create the conditions for our ICB to deliver its role effectively and make a meaningful difference for the population we serve.

Form of the ICB



Our organisational delivery model has been designed to respond directly to the new expectations placed on ICBs. If we are to meet our objectives, we need to be bold and unapologetic about the standards we set for ourselves. The scale of the challenge means that incremental change will not be enough; we need clarity of purpose, strong leadership, and high expectations of delivery.

We have therefore structured the organisation into five core teams. Each team has been designed deliberately, with clear intent, and has shaped its own internal structure to best deliver its role. While each team has a distinct focus, none operates in isolation. This is a matrix organisation by design, with shared ownership of outcomes and delivery across teams.

The **Neighbourhood Health, Place and Partnerships team** is the engine of our market management role. It leads our work to develop more localised, integrated care, working closely with providers, local authorities, and other partners. This team is responsible for shaping local delivery models, supporting collaboration, and ensuring that care is organised in ways that are more efficient, more joined up, and closer to communities.

The **Strategy, Planning and Evaluation team** is the brain of the organisation. Its role is to ensure we are focused on the right things, that our commissioning decisions are grounded in evidence and population need, and that we can evaluate whether interventions are delivering the benefits we expect. This team underpins the full life-cycle described earlier in this document, from prioritisation and business case development through to evaluation, learning, and decisions about scale or decommissioning.

The **Population Risk & Clinical Advisory Directorate** will provide strong clinical leadership and oversight, with a particular focus on Total Quality Management and Utilisation Management. Total Quality Management ensures that quality, safety, and continuous improvement are embedded consistently across commissioning and delivery. Utilisation Management focuses on ensuring that care is used appropriately, variation is understood and addressed, and resources are directed to where they deliver the greatest benefit for patients and the population.

The **Resources team** will ensure that we make the best possible use of all our assets. This includes having a strong grip on contracts, procurement, estates, and both strategic and operational finance. The team's role is to provide rigour, transparency, and discipline, enabling the organisation to remain financially sustainable while supporting delivery of the agreed priorities.

The fifth team is focused on **Organisational Development, Assurance, and Delivery Support.** This is where we concentrate on ourselves as an organisation: developing our people, embedding our culture, and maintaining a tight grip on delivery. This team supports the organisation to do what it says it will do, providing the structures, assurance, and support needed to sustain performance over time.

Across all five teams, the operating model is deliberately matrix-based. Delivery depends on collaboration, working across organisational boundaries to deliver complex programmes effectively. Clear Senior Responsible Owners (SROs) will be appointed for major work programmes, with accountability for outcomes that cut across multiple teams. This reflects best practice in system leadership, recognising that complex change requires shared ownership, clear accountability, and strong coordination.

By operating in this way, we create an organisation that is aligned to its purpose, clear about roles, and capable of delivering at pace. This model supports high standards, encourages collaboration, and ensures that strategy, delivery, and assurance are tightly connected in everything we do.

A single life-cycle for commissioning, improve, codify and scale

To ensure our strategy is delivered consistently and at pace, we will implement a single, end-to-end life-cycle that brings together the commissioning cycle, continuous improvement, and service (or "product") development. This life-cycle provides a shared operating model for how ideas move from identification through to scale, assurance, and - where appropriate - exit.

The life-cycle replaces fragmented approaches to improvement, transformation, and commissioning with a clear, disciplined pathway that aligns quality, outcomes, finance, and delivery. It ensures that we invest in what works, scale only when there is evidence of impact, and actively avoid service inertia.

Activity will enter the life-cycle through one of two routes:

- Strategic priority areas, such as those set out in this strategy (for example priority pathways, neighbourhood health teams, or re-procurements), where proactive change is required to deliver population outcomes.
- Quality-driven improvement needs, where data, assurance, or lived experience identifies unacceptable variation, risk, or underperformance that requires structured intervention.

This ensures the life-cycle is used both to deliver strategic change and to respond decisively where quality or safety improvement is required.

Strategic commissioning plan & statutory requirements

A	B	C	D	E	F
Identify & improve	**PDSA to product**	**Business & investment decision**	**Commission and mobilise**	**Assure, learn and optimise**	**Evolve or sunset**
Demonstrate the real problem can be improved in a real setting	Demonstrate the real problem can be improved in a real setting	Decide whether to invest at scale	Move from approval to controlled safe spread	Ensure the service continues to deliver value and adapt	Avoid service inertia make intentional decisions to adapt or stop
Improvement methodology	Demonstrate the real problem can be improved in a real setting	NHS business case discipline	Commissioning for quality and outcomes	Improvement and performance assurance	Strategic value and opportunity cost
Residents and partners with commissioner sponsorship	Demonstrate the real problem can be improved in a real setting	Commissioner	Commissioner with providers	Commissioner with provider	Commissioner
1. Clear problem statement and target population 2. Improvement aim and measures 3. Evidence of PDSA cycles in life settings 4. Early signal of benefit	1. Defined service model 2. Clear description of the solution 3. Workforce digital estates and dependency assumptions 4. Early cost envelope and capacity assumptions	1. Strategic case 2. Economic case 3. Financial case commercial and governance assumptions 4. Benefits realisation plan with measures	1. Commissioning route agreed 2. Mobilisation plan with milestones 3. Clear quality outcome and reporting requirements 4. Ongoing improvement expectations embedded in contract	1. Commissioning route agreed 2. Continuous improvement capability maintained 3. Active benefit tracking against the business case 4. Periodic strategic review (every two years)	1. Predefined review triggers 2. Options appraisal: evolve, replace, or stop 3. Managed transition plan 4. Learning captured for future services
DP0 Is it in the commissioning plan or statutory requirement?	**DP1** Is there enough evidence of benefit to justify investing and scaling this design?	**DP2** Is this service sufficiently defined and stable to justify a business case?	**DP3** Should this be commissioned as a standard offer?	**DP4** Is this service delivering at the expected scale?	**DP5** Is this still the right service in the right form?	**DP6** Do we recommission, redesign, or retire?

DP **Decision Point**

How the life-cycle works in practice

A. **Identify and improve -** Work typically begins with a clearly defined problem grounded in population need, lived experience, quality data, and utilisation insight. Improvement starts in real settings using PDSA cycles to test whether the issue can be addressed in practice before committing to scale.

B. **PDSA to product -** Where local improvement shows promise, learning is translated into a replicable service model. This includes defining the service offer, workforce and digital requirements, dependencies, and early cost and capacity assumptions—turning improvement into something that can be commissioned and scaled.

C. **Business case and investment decision -** Once a model is sufficiently defined and stable, a decision is taken on whether to invest at scale using NHS business case discipline. This aligns quality improvement with financial sustainability and ensures resources are directed to interventions that demonstrate value.

D. **Commission and mobilise -** Approved models move into commissioning, using the approaches described earlier in this document—whole-pathway models, lead providers, and collaborative delivery. Mobilisation focuses on controlled, safe spread, with clear outcomes, reporting requirements, and improvement expectations embedded in contracts.

E. **Assure, learn, and optimise -** Once live, services are subject to routine outcomes and value monitoring, benefit tracking against the business case, and ongoing improvement. This aligns with our assurance approach and the eight core key performance indicators, (KPIs), focusing on reliability, experience, utilisation, and outcomes rather than activity alone.

F. **Evolve or sunset -** The life-cycle includes a formal point to decide whether services should evolve, be replaced, or stop. Pre-defined review triggers ensure we avoid cumulative commissioning and maintain active stewardship of resources.

Governance, timelines, and flexibility

The decision points within the life-cycle are fixed and are set out clearly in the governance section of this document. These decision gates provide consistency, transparency, and assurance, regardless of the size or origin of the work. We will regularly return to our governance model, checking and challenging its effectiveness.

However, the time taken to move through the life-cycle will vary depending on the scale, complexity, and risk of the project. Small, discrete improvements may progress rapidly, while large pathway redesigns or re-procurements will require longer development and mobilisation periods.

The starting point in the life-cycle will also vary. Not all work will begin at the improvement stage. For example:

- Some programmes may enter at the business case stage, where evidence already exists and the need is to make an investment decision.
- Others may begin at commissioning, where national requirements or pre-existing decisions apply.
- This flexibility allows the life-cycle to be applied proportionately, while maintaining a consistent approach to decision-making and assurance.

Why this matters

This life-cycle is how we will operate as an ICB. It:

- anchors commissioning decisions in quality, evidence, and population need
- aligns improvement activity with financial and contractual discipline
- supports delivery of the care model and neighbourhood health strategy
- enables clear, consistent governance without slowing delivery
- ensures we invest, scale, adapt, and stop services deliberately.

The ICB's core delivery functions

Building on this focus, we need to be explicit about the core delivery functions of the ICB and ensure that they are delivered to a consistently high standard, aligned with best practice and statutory requirements. In a context of reduced capacity, this means being disciplined about what sits within our business-as-usual responsibilities and being relentless about doing those things well, while supporting others to lead where they are best placed to do so.

At the heart of our role is being an effective commissioner and a good system partner. This means setting clear expectations, maintaining a strong grip on delivery, and providing assurance where it is required, rather than substituting for delivery or operational management elsewhere in the system. Our focus is on outcomes, quality, and accountability, with collaboration used to strengthen delivery.

Safeguarding

A fundamental priority within this is safeguarding. Maintaining a strong grip on safeguarding is non-negotiable and central to our statutory responsibilities. This includes ensuring effective oversight, assurance, and partnership working in line with best practice, and delivering our responsibilities under the Families First Partnership Programme. Safeguarding must be embedded across commissioning, contracting, and assurance, rather than treated as a standalone function.

Continuing healthcare

In Continuing Healthcare, our focus is on commissioning services that are more consistent, scalable, and sustainable, while continuing to meet individual needs. The intent is to reduce unnecessary variation, improve quality and experience, and ensure value for money, without compromising statutory entitlements.

Medicines utilisation

For medicines optimisation utilisation, our role is to provide assurance that prescribing across the system is safe, evidence-based, and clinically appropriate. This is not about running a medicines service, but about ensuring that providers are using the most effective treatments, managing risk, and adopting innovation where it delivers clear benefit. This approach aligns with the wider technology and innovation pipeline, particularly where developments in medicines have the potential to materially affect outcomes and utilisation.

Intelligence

Underpinning all of this is the need to build a world-class capability in data, intelligence, health economics, and evaluation. High-quality decision-making depends on timely, trusted insight into need, activity, outcomes, and value. This capability supports every part of the model: setting priorities, assessing business cases, assuring delivery, evaluating impact, and making informed decisions about scaling, adapting, or stopping interventions. It also enables the system to test whether changes are genuinely delivering agreed shifts in utilisation and experience metrics.

Taken together, this defines a clear and sustainable operating position for our ICB. By focusing on our core commissioning and statutory functions, maintaining a strong grip where it matters most, and building robust analytical capability, we will ensure that the ICB adds maximum value in a constrained environment. This clarity will support our partners to lead on delivery, enable innovation to be introduced in a controlled way, and keep the system focused on improving outcomes for our population.

Re-procurement

Our approach to re-procurement will be clear, proportionate, and aligned with the legal framework. We will comply fully with procurement law and national guidance, while exercising discretion to choose routes that are appropriate to the scale, risk, and complexity of the service.

Wherever possible, we will seek to reduce the cost and burden of procurement, avoiding unnecessary process, duplication, or disruption to services. Decisions will be guided by whether change is needed to improve outcomes, quality, value, or access for the population.

To support transparency and good governance, we will publish a forward view of contracts coming to an end through our Board papers. This will provide visibility of upcoming decisions, enable early consideration of options, and support informed discussion about priorities, risks, and opportunities well in advance of formal procurement activity.

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> Chief Executive Officer,
> Central East ICB

Building data foundations

Over the next one to three years, our data approach will focus on building a single, shared foundation that supports better decision-making, stronger commissioning, and improved outcomes for the population. The aim is to have a practical, unified view of data that helps us understand need, target intervention, track outcomes, and hold the system to account.

We will do this by bringing data and analytics together into one integrated platform, providing a consistent view across the system rather than multiple disconnected datasets. This will support core population health management activity, including identifying priority cohorts, modelling the impact of interventions, and tracking whether changes are delivering the agreed shifts in utilisation, outcomes, and experience. By standardising metrics and KPIs, we will ensure that performance is measured consistently and transparently, enabling clearer accountability across commissioning and delivery.

This unified approach will also improve efficiency. By reducing duplication of data infrastructure, tools, and effort, and by consolidating analytics capability, we can focus limited capacity on what adds the most value. We will strengthen our ability to link activity, quality, outcomes, and cost, which is essential for effective commissioning, contracting, and assurance, and for making informed decisions about scaling, adapting, or stopping interventions.

Improving interoperability and data quality is a core part of this work. Standard data models and better data linkage will make it easier to work with national systems and partner organisations, while also improving access to timely, trusted information. This will support service planning, utilisation management, and benchmarking, helping ensure decisions are evidence-based, equitable, and focused on improving care.

The approach is explicitly outcomes-led and focused on improvement and equity. By bringing together clinical, operational, and experience data, we can better understand variation, identify where inequalities exist, and target action where it will have the greatest impact. The platform will also provide a stable foundation for the responsible use of artificial intelligence (AI) and predictive analytics, supporting innovation where it can improve outcomes and align with the system's agreed priorities.

Strong governance and information standards will underpin the whole approach. Data will be managed securely and transparently, with clear accountability and proportionate controls. We acknowledge that effective information governance (IG) is a fundamental dependency for our ambition to turn strategy into delivery. We will prioritise working though IG issues in a safe and managed way, informed by expert advice.

By improving consistency, clarity, and access to information, we will also strengthen trust — with partners, providers, and the public — that decisions are being made fairly, openly, and in the best interests of the population.

The utilisation of healthcare

Our approach to utilisation management is focused on improving outcomes and quality by ensuring that care is used appropriately, consistently, and at the right point in a person's treatment pathway. Our aim is to reduce unwarranted variation, avoid harm, and ensure that limited resources are directed to where they deliver the greatest benefit for patients and the population.

We will start by developing a clear understanding of where variation exists and what drives it. This includes analysing differences in referral rates, admissions, length of stay, prescribing, diagnostics, and follow-up across pathways, places, and population groups. Variation will be explored alongside clinical evidence, population need, and lived experience to distinguish between appropriate differences and unwarranted variation that may indicate poor access, low-value activity, or quality and safety risks.

Best practice will be central to how utilisation management is applied. National guidance, evidence-based pathways, and clinical standards will be used as the reference point for what good looks like, with local adaptation where it improves outcomes. Clinical leadership will be critical in this work, ensuring that decisions are clinically led, transparent, and focused on improving care. Utilisation management will be embedded within commissioning, contracting, and quality assurance, rather than operating as a separate function.

Quality and safety are fundamental to this approach. Utilisation management will be used to identify early signals of risk, avoidable harm, and missed opportunities for earlier intervention. Where change is needed, improvement will be co-designed with clinicians and informed by patient experience, with clear monitoring of impact on outcomes, access, and equity. By using utilisation management in this way, we aim to reduce unnecessary demand, improve consistency and quality of care, and support the sustainable delivery of services that best serve our population.

Strategic risk management

Our approach to risk management is deliberately focused on what matters most to our population. Risk management will help us to understand and actively manage the factors that would most undermine access, outcomes, experience, and system sustainability if we get them wrong.

We will continue to manage operational and transactional risks - such as the delivery of the financial plan, contractual compliance, workforce capacity, and statutory requirements. These are necessary controls. However, the most material risks facing the ICB are strategic and systemic.

If we fail to improve access, outcomes, and experience, people will wait longer, quality of life will decline, and inequalities will widen. If we do not shift care earlier and reduce low-value activity, the system will become increasingly financially unsustainable. The NHS today accounts for 38% of day-to-day government spending – a figure projected to rise 40% by the end of the decade. If we lack pace and discipline in delivery, population health outcomes will stagnate or worsen. These risks sit at the heart of this strategy and must be explicitly owned and managed at Board level.

A further critical risk is building a new organisation without clarity of role, purpose, and culture. This strategy—and the operating frameworks it sets out, including the care model, commissioning approach, and life-cycle—are designed to mitigate that risk from the outset.

Risk management will be integrated with strategy and delivery and risks will be assessed based on their impact on population outcomes, utilisation, financial sustainability, and public confidence. Mitigation will focus on clear decision-making, disciplined prioritisation, and timely action.

The Board plays a central role. Beyond assurance, Board members are responsible for shaping direction, testing assumptions, and challenging whether delivery is sufficient to achieve the outcomes we have committed to. Risk discussions should inform strategic choices and investment decisions, not sit alongside them.

We will work openly with auditors and regulators, using their insight to strengthen governance and learning. Issues will be identified early, learning captured, and decisions revisited where evidence shows change is needed.

This approach is underpinned by the culture described earlier in this document. Psychological safety, inclusion, and professional accountability are essential to managing risk well—enabling challenge, transparency, and learning while maintaining clear ownership and responsibility.

By embedding risk management into strategy, governance, and culture, we create an organisation that is honest about the challenges it faces and disciplined in addressing them - essential to delivering sustainable improvement for the population we serve.

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Operating environment

To deliver effectively as commissioners of a 'population-capitated budget', which is linked to the size of our population, we need absolute clarity about who is accountable for what. Our approach sets out a clear and disciplined way of working across the system, designed to remove ambiguity, reduce duplication, and keep the focus on improving outcomes for our population.

At the core is a clear distinction between commissioning and delivery. Commissioners are accountable for population-level outcomes. We are responsible for understanding population need, setting strategy, defining outcomes, shaping service models and markets, and contracting for delivery. Crucially, we remain accountable for assuring performance and whether agreed outcomes are being achieved.

Providers are accountable for operational delivery. Within the framework set by commissioning, they manage demand, capacity, access, flow, and day-to-day performance. Providers also lead pathway redesign and continuous operational improvement, using frontline expertise to improve quality, efficiency, and experience. While providers are held to account for delivery, they retain autonomy over how services are run.

Engagement with clinicians, patients, and system partners is essential, but it is deliberately distinct from delivery accountability. Stakeholders are involved through structured consultation and co-production at defined points—particularly in shaping strategy and service models—ensuring decisions are informed by expertise and lived experience without blurring responsibility for delivery.

Decision-making is guided by a small number of clear principles. The outcomes framework and RACI (Responsible, Accountable, Consulted, or Informed) are used to prioritise what matters most, support consistent assurance, and avoid reactive or ad hoc intervention except where safety or statutory requirements demand it. Performance is managed through contracts, KPIs, and agreed escalation routes, reviewed on a planned cadence.

The RACI below sets out how this works in practice:

Activity	Commissioner	Provider	Residents	System Partners
Population health strategy & outcomes framework	Accountable / Responsible	Consult	Consult	Consult
Needs assessment & service model design framework	Accountable / Responsible	Consult	Consult	Responsible (JSNAs)
Strategic procurement & market management framework	Accountable / Responsible	Inform	Consult	Consult
Contracting (terms, KPIs, outcomes, incentives)	Accountable / Responsible	Consult	Consult	Consult
Performance & outcomes assurance	Accountable / Responsible	Responsible	Consult	Consult
Outcomes ownership (population-level results)	Accountable	Responsible	Consult	Consult
Strategic Demand management	Accountable	Responsible	Consult	Consult
Demand management: referrals, flow, access	Consult	Accountable / Responsible	Consult	Consult
Capacity planning & rostering	Inform	Accountable / Responsible	Consult	Consult
Pathway redesign & operational improvement	Consult	Accountable / Responsible	Consult	Consult

This approach creates a stable operating environment in which roles are explicit, accountability is clear, and collaboration is purposeful. By holding the line on who owns outcomes, who delivers services, and how engagement is used, we strengthen our grip, reduce risk, and create the conditions for sustained improvement in quality and outcomes.

Governance

Effective delivery of this strategy depends on clear, proportionate, and disciplined governance. Our governance framework is designed to provide strong strategic oversight, timely decision-making, and clear accountability—while avoiding duplication, ambiguity, or unnecessary burden.

We operate a four-tier governance model, which applies across the organisation and all programmes. This framework aligns strategy, commissioning, improvement, and delivery, and is the mechanism through which life-cycle decision points are exercised.

Four governance tiers

Tier 1: ICB Board

The ICB Board is responsible for setting overall strategy, approving major decisions, and holding the organisation to account for delivery, quality, and financial sustainability. Decisions reserved to the Board are set out in the Governance Handbook. The Board retains ultimate accountability for outcomes, risk, and stewardship of public resources.

Tier 2: Board committees

Committees act under delegated authority from the Board and provide both decision-making and assurance functions. Decisions reserved to Committees are detailed in the Governance Handbook. Committees ensure that strategy is translated into robust plans and that delivery is progressing as intended.

There are six sub-committees of the Board:

1. Audit and Risk Committee
2. Remuneration and Workforce Committee
3. Utilisation management and quality improvement committee
4. Finance, Planning and Payer Committee
5. Neighbourhood Delivery Committee x 3
6. Executive Management Team Committee

Together, these committees provide focused oversight of quality, utilisation, finance, neighbourhood delivery, and organisational leadership.

Tier 3: Programme boards

Programme Boards are responsible for overseeing the delivery of specific programmes and pathways. They operate through delegation to the relevant Executive Director or Director, with delegations set out in the Governance Handbook and the Delegated Financial Limits document.

Programme Boards are accountable for progress through the life-cycle, delivery against agreed outcomes, management of risk, and escalation where decisions or support are required.

Tier 4: Working groups

Working groups are task-and-finish in nature. They do not hold decision-making authority. Their role is to complete defined actions, develop proposals, undertake analysis, and support delivery for Programme Boards and Committees.
How governance supports delivery

This four-tier structure ensures:

- Strategic decisions are taken at the right level
- Delivery is delegated appropriately and supported
- Assurance is consistent and proportionate
- Life-cycle decision points are clear and transparent.

The governance framework underpins the improvement life-cycle described earlier, with fixed decision points exercised at the appropriate tier, as set out in the Governance Handbook.

All staff are expected to work within this governance framework and comply with the Standing Financial Instructions, delegated authorities, and associated policies. This clarity enables faster decision-making, stronger assurance, and a shared understanding of how we operate as an organisation.

By maintaining clear lines of accountability and disciplined governance, we create the conditions for confident delivery—balancing pace with control, and innovation with assurance—over the five-year life of this strategy.

Aligned governance

The Board

Strategic direction, implementation of 10YP and meeting statutory accountabilities

Finance, Planning and Payer Function

Ensures financial sustainability and value base commissioning aligned with population health needs

Utilisation Management and Quality Improvement

Provides assurance on the quality, safety and performance of commissioned services

Neighbourhood Health Delivery x3

Delivering Neighbourhood health agenda. Improving health equality and enhancing local accountability transparency and engagement, in how services are delivered

Audit and Risk

Provide independent assurance on governance, risk management, internal control and financial reporting

Management Executive

Leadership and delivery of the strategic objectives, statutory requirements and 10YP implementation

Remuneration and Workforce

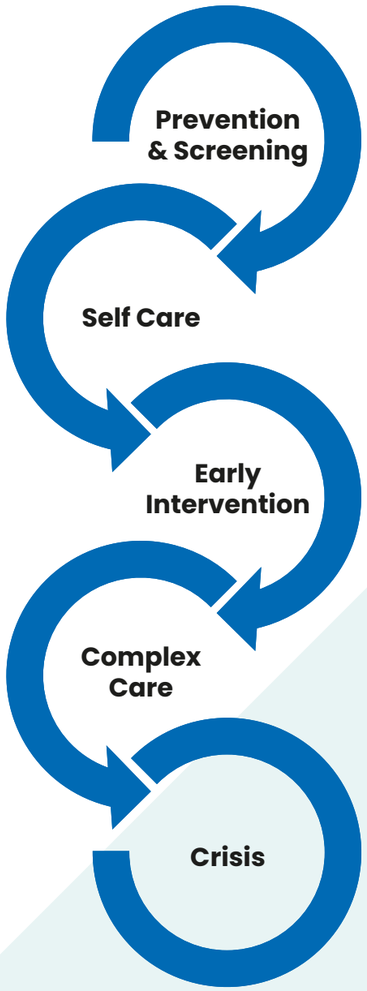
Oversee executive pay and ICB workforce transition

Part 3

Delivery Roadmap

Delivery summary

Care Delivery Model



Provides a blueprint for standardised care stages and interventions across all pathways to improve efficiency.

Managed Care Delivery

Data sharing
Enable timely safe access to information across organisations and settings

Population segmentation & stratification
Define population groups and identify those most likely to benefit from tailored interventions

Proactive outreach
Shift from reactive care to planned anticipatory care and engagement

AI enabled triage
Direct people to the right care at the right time reducing unnecessary demand

Care Co-ordination
Coordinate care seamlessly across services to ensure timely, integrated support for individuals

Managed care approach that leverages data and tools for population risk management and proactive coordination, reducing risk and improving patient satisfaction

Priority Starter Programmes

B1. Prevention and screening for cancer
Increase uptake consistently and timeliness of cancer prevention screening and early detection

B2. Self care for MSK
Roll out the use of AI self care technology for MSK pathways to increase attendance at work

B3. Utilisation risk management in cardiology
Reduce avoidable utilisation and escalation by identifying people at risk earlier and intervening proactively

B4. Care coordination for advanced illness
Provide coordinated person-centred care for people with advanced illness through managed care approach

B5. Acute care pathway for mental illness
Improve outcomes and experience for people with severe mental illness by ensuring rapid access to the right care first time

Launch starter programmes to build best-practice care stages using improvement methodology, creating a foundation that will expand as we learn

Commissioning Provider Collab Models

C1. Dermatology pathway
Recommission dermatology services using an already designed pathway to simplify access and reduce unnecessary demand

C2. Diabetes pathway
Recommissioning the diabetes pathway using existing proven specification developed in one place scaling it system wide

C3. Neurodiversity
Commence the product development cycle.

C4. NHTs
Commence the product development cycle for neighbourhood health teams and delivery services

Build a commercial and contracting framework to drive provider collaboration, standardisation, and market-led efficiency

Delivery at scale: from five programmes to a system pipeline

We will begin delivery with five priority programmes, recognising these as the small snowball at the top of the hill. They are deliberately chosen because they address major population needs, offer clear opportunities to reduce utilisation, and already have evidence or proven elements that can be improved, codified, and scaled quickly.

By applying the life-cycle and creating a disciplined delivery pipeline, these initial programmes will rapidly generate learning, standardised models, and reusable components. Over time, this allows us to move faster—not by constantly redesigning whole pathways, but by locking in proven elements and assembling them together, much like building blocks.

As best practice is established and scaled—for example in screening, digital self-care, or proactive risk identification—it becomes part of the standard system offer. Future pathway development can then focus on combining these proven components rather than starting again. This is how we reduce variation, increase reliability, and accelerate improvement across the system.

The five starting programmes

The initial programmes commencing immediately are:

What	How	Why
Prevention and Screening for Cancer	Improving uptake, equity, and early detection by strengthening proven screening approaches and scaling what works across communities.	Cancer is a leading cause of mortality and healthcare use across Central East ICB, including preventable premature mortality. Cancer is also a focus of the national NHS ten year plan. Diagnosing cancer earlier usually means better outcomes overall for patients. Cancer is responsible for 32% of deaths and 15–21% of the life expectancy gap.
Self-care for MSK	Digital self-care. Implementing and scaling evidence-based digital self-management to reduce unnecessary clinical contact, imaging, and referrals, while improving access and experience.	MSK disorders are the 2nd leading cause of years lived with disability in the East of England region (GBD, 2023) and 2nd leading cause of economic inactivity in England (646,000 on long-term benefits). Community MSK waits are the highest backlog in England (348,799). In Central East, MSK is one of the five leading causes of elective admission growth. 19.5% of disability burden; and 26.5M working days lost nationally.
Utilisation risk management in cardiology.	Proactive risk identification. Proactive identification and management of people at risk from hyperlipidaemia and hypertension, using population stratification and early intervention to prevent future events and reduce avoidable utilisation.	Circulatory disease is the second leading cause of death in the UK, causing 1 in 4 premature deaths. It is the biggest contributor of the gap in life expectancy across Central East. Underlying modifiable risk factors for CVD – smoking, obesity, high blood pressure, physical inactivity- are also modifiable risk factors for other leading causes of death such as cancer and respiratory disease. 27% of deaths; 17–26% of Life Expectancy gap.
Care Coordination for Advanced illness	Care coordination. Scaling an already proven health and care collaborative model to provide proactive, coordinated support, reduce acute admissions, and support people in the most appropriate setting.	Severe frailty +55% by 2047[NM1.1]. Multi-disciplinary team coordination reduces acute admissions. Approximately 50% of acute hospital beds are being used by patients in last two years of life.
Mental health crisis care	Improving, codifying, and scaling crisis care models to reduce repeat crises, avoid unnecessary admissions, and improve outcomes and experience for people in mental health crisis.	Mental ill-health is a leading cause of disability (23.1% of disability burden), premature mortality, & economic inactivity across the Central East (CE) Cluster. High demand for urgent and crisis mental health (MH) care, unwarranted variation in outcomes, and gaps in early intervention and continuity of care result in inconsistent, poorly coordinated support. Earlier proactive case management and integrated pathways will improve care coordination, reduce escalation, enhance quality of life, improve life expectancy and support participation in the workforce.

Each programme will follow the same life-cycle discipline: improve locally, codify what works, and scale through commissioning and lead provider models.

How we will drive delivery

All five programmes will commence immediately. Each will have a clear plan on a page, setting out objectives, measures, milestones, and early delivery actions. Formal reporting will begin in April 2026, and we expect each programme to demonstrate measurable progress within this financial year, consistent with their stage in the life-cycle.

As delivery progresses, we will work with the Board to ensure there is a clear, rolling pipeline of future programmes entering the life-cycle. This ensures focus is maintained, capacity is managed, and momentum is sustained.

Delivery will be held together through the ICB Delivery Unit, which oversees progress, interdependencies, and risk across programmes, working directly with the Chief Executive. This provides a single point of grip on delivery, ensuring alignment with strategy, quality, finance, and commissioning decisions.

Why this approach matters

This is how we move from isolated improvements to system-wide change. By starting with five programmes, building a pipeline, and reusing what works, we create a repeatable delivery engine—one that allows us to scale faster over time, reduce duplication, and steadily improve outcomes and utilisation across our 3.5 million population.

The result is not constant redesign, but continuous assembly of best practice - driving consistency, efficiency, and better outcomes for our communities.

Re-procurement and service redesign

Re-procurement is a critical commissioning lever for delivering our care model, improving outcomes, and reducing unwarranted utilisation. We will not pursue cumulative commissioning. Where new models are introduced, we will actively sunset legacy services and overlapping contracts, ensuring that commissioning decisions simplify the system rather than add complexity or duplication.

Our approach is to redesign and commission whole pathways, with clear accountability, aligned incentives, and a focus on proactive, coordinated care.

Diabetes and dermatology pathways

In 2026/27, we will decommission existing arrangements for diabetes and dermatology and re-procure these services on a whole-pathway basis, contracting with lead providers accountable for end-to-end delivery. These pathways have been prioritised due to high levels of activity, variation, and avoidable secondary care utilisation.

The new contracts will:

- Apply the five-layer care model, with strong emphasis on prevention, supported self-management, proactive outreach, and coordinated specialist input.
- Align incentives across primary, community, and secondary care to reduce unnecessary referrals, outpatient attendances, and escalation.
- Enable digital access, triage, and advice models to improve flow and experience.
- Hold a single lead provider accountable for quality, outcomes, and financial performance across the pathway.

As part of implementation, legacy and overlapping services will be formally decommissioned, ensuring clarity of accountability and avoiding parallel provision.

Procurement will take place during 2026/27, with new services going live within 12 months of contract award. Transition will be carefully managed to maintain continuity and safety for patients while enabling meaningful redesign.

Neighbourhood Health Teams

From 2027 onwards, we will begin commissioning Neighbourhood Health Teams, representing the next phase of our neighbourhood-based delivery model. These teams will be commissioned through networks of lead providers, bringing together primary care, community services, mental health providers, voluntary and community sector organisations, and local authority partners.

Lead providers will be accountable for coordinating delivery, managing shared resources, and delivering agreed outcomes at neighbourhood level. As with other re-procurements, this will involve rationalising and sunsetting existing contracts where they overlap or duplicate neighbourhood functions, avoiding cumulative commissioning.

Neighbourhood Health Team contracts will:

- Increase access by providing clear neighbourhood entry points, proactive outreach, and timely support closer to home.
- Reduce utilisation of reactive healthcare by identifying risk early, managing deterioration proactively, and preventing avoidable escalation to urgent and emergency services.
- Coordinate care seamlessly across organisations and disciplines, ensuring people experience joined-up, continuous support rather than fragmented services.
- Support people in the best place for their specific needs, enabling care at home or in community settings wherever possible and reserving specialist or acute care for when it is genuinely required.

Neurodiversity services

Between 2026 and 2028, we will re-commission neurodiversity services. There is currently no fixed service specification, and this will be developed through the full programme life-cycle—needs assessment, co-production, pathway design, and market engagement—ensuring the model reflects the needs of our population and best practice.

Once commissioned, services will go live within 18 months of specification approval. As with other areas, re-commissioning will be accompanied by the planned decommissioning of overlapping or legacy arrangements, creating a clearer, more coherent pathway.

While we work through the programme life-cycle, our expectation is that waiting lists will reduce, supported by improved triage, clearer pathways, and better use of existing capacity.

Through this approach, re-procurement becomes a tool for simplification, not accumulation—enabling clearer accountability, reduced variation, and delivery of care that is better aligned to our strategy, care model, and population needs.

NHS
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Integrated Care Board

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