

Strategic Commissioning Intentions 2027–30

The ICB's statement of intended outcomes, service changes and future commissioning approach.



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1. Executive summary

1.1. Building on Our Way – strategy to delivery

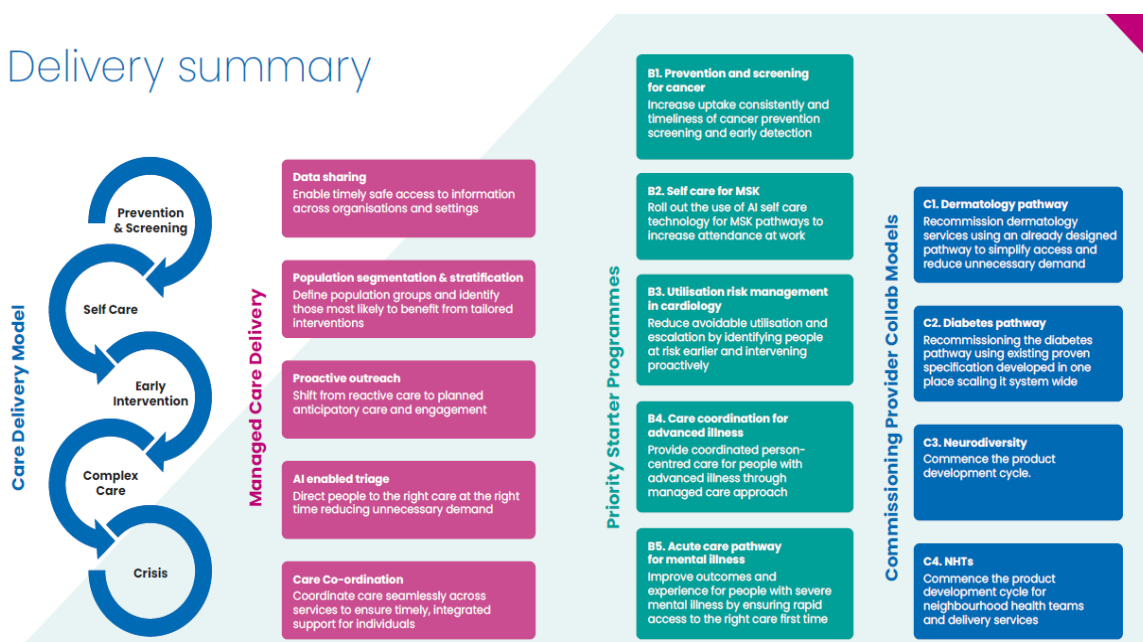
Our Way - strategy to delivery, published in April 2026, is the ICB's guiding five-year strategy. Building on Our Way, the purpose of our Central East ICB Commissioning Intentions 2027-30 is to communicate the following to providers and partner organisations:

- the outcomes and service changes the ICB intends to pursue to deliver the Our Way strategy
- new development areas – for example based on population health insights, work arising from our 2026/27 Delivery Plan, policy changes, service challenges
- contractual payment or provider-model changes
- areas for early dialogue before detailed specifications, business cases or procurement decisions

We have made good progress on the Our Way care delivery model and priority programmes during the first half of 2026/27 and will continue to work on them for the remainder of this year. For example:

- We are rolling out AI triage enabling self-care for patients with lower back pain across Central East.
- We are testing and improving a Care Coordination Hub for end-of-life care, with a view to scaling up.
- We have developed a specification to roll out a transformed care model for dermatology.
- We have engaged with hundreds of stakeholders to shape our diabetes pathway re-design.
- We have developed a new frailty specification based on best practice and stakeholder engagement.
- We will begin working with GP practices and partners to develop AI triage linked to the NHS App.

Delivery summary



1.2. Commissioning intentions - principles

The Commissioning Intentions are designed to help achieve constitutional standards and are based on a set of principles aligned to Our Way including population benefit; quality as the guiding strategy; prevention; and neighbourhoods by default. It also includes a principle on effective healthcare utilisation, productivity and value:

We will commission and actively manage services to ensure resources are used appropriately, consistently and in line with evidence based best practice. Providers will be expected to deliver care in accordance with GIRFT recommendations, agreed clinical standards and utilisation benchmarks reducing unwarranted variation, low value activity and avoidable demand.

Consistent with the Institute for Healthcare Improvement's Quintuple Aim, we will commission services that improve population health, patient experience and equity, support workforce wellbeing and make best use of available resources. This provides a framework for balancing quality, outcomes and sustainability in all commissioning, investment and service redesign decisions.

1.3. Working as a strategic commissioner

Central East ICB inherited several thousand contracts with service providers, but as a strategic commissioner we are not best placed to drive joined up front line delivery. To implement the care model vision set out in Our Way, between now and end of 2029/30, we will change how we operate. This means:

- delegating, through new contractual arrangements, responsibility for integrating care for local people at a local level to Neighbourhoods with a common operating model adapted to meet local need;
- commissioning a new 'integrator' function to coordinate delivery across neighbourhoods;
- commissioning provider collaboratives and lead provider arrangements across Central East where this will deliver better outcomes for patients and more sustainable services.

We will work collaboratively with ICB's across England through a new compact to build effective strategic commissioning and deliver measurable improvements for our populations. Our initial focus will be on a small number of measures (see section 1.10), and frailty specifically.



We will also work with the Office of Pan ICB Commissioning (OPIC, East of England) to coordinate our approach on areas such as delegated specialised commissioning, ensuring that there is a joined-up approach to assure quality and sustainability.

1.4. Population health insights

We have refreshed Central East Population Health Insights, based on analysis of a wide range of demographic, health and inequalities data, and briefly summarised in the diagram below. The work

reinforces the Our Way priorities, and two resulting recommendations have been incorporated into our Commissioning Intentions:

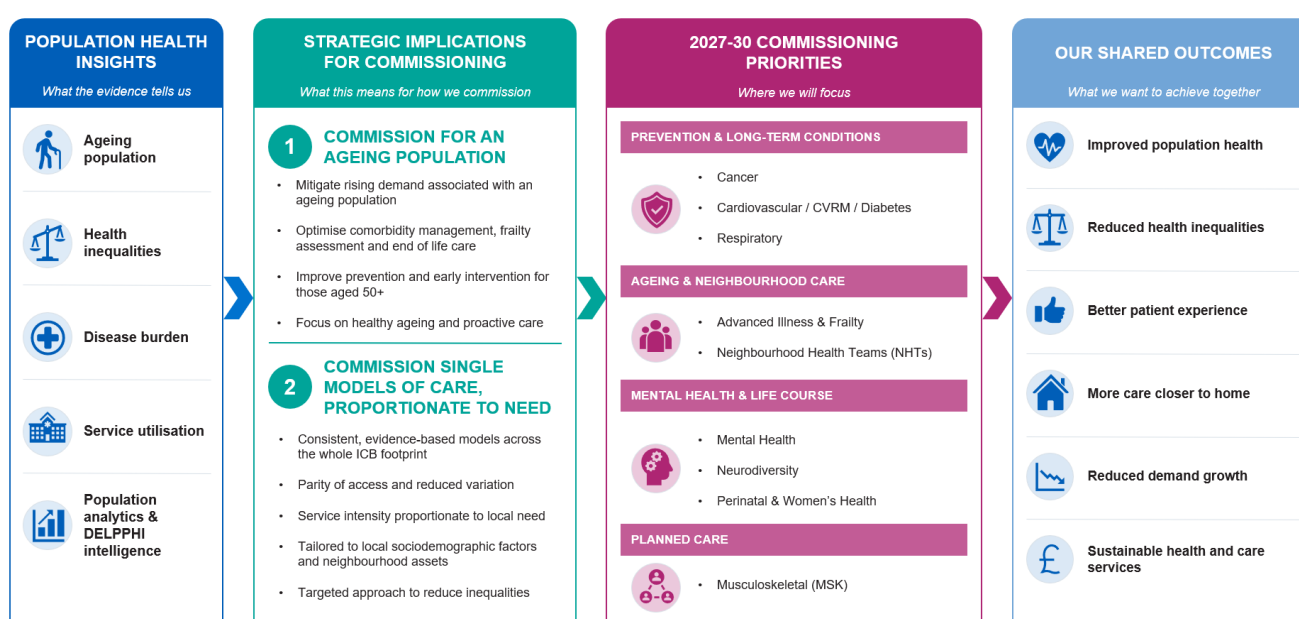
Recommendation 1: The ICB should commission integrated service models of care for key **long-term conditions, frailty and end of life** that cut across the stages of intervention set out in Our Way and in line with the ICB role as a strategic commissioner.

Recommendation 2: To reduce unwarranted variation and enable parity of access, commissioning must enable **consistent, evidence-based models of care across the whole ICB footprint**. Service intensity should be **proportionate to local needs and** tailored to local sociodemographic factors and neighbourhood assets.

The data and evidence lead to the introduction of new priorities for 2027-30:

- Respiratory illness as a major driver of healthcare utilisation and reversible risk.
- Perinatal care including maternity

Population health insights



1.5. Neighbourhood health

We recognise that delivery happens at place. To strengthen local partnerships, we will use **upper-tier local authority geographies as our common unit for place** and work towards having capitated budget transparency, integrated neighbourhood delivery and commissioning arrangements accordingly. The Commissioning Intentions set out the next steps for 2027-30 detailing how we will work with partners (see **Appendix B**) to develop Neighbourhood Health Teams working to a common operating model adapted to meet local needs, commission the new integrator function and **introduce the new frailty specification**. It will also involve aligning incentives over time including revision of the PCN Directed Enhanced Service (DES) contract.

Several related programmes will help build our wider Neighbourhood Health delivery model, including end-of-life care coordination, a managed care model for patients with long term conditions such as diabetes. Starting this year and continuing into 2027/28 we will test and evaluate AI enabled triage for primary care linked to the NHS App, digital prevention and patient reported health data to transform

how residents access and interact with services. We will also roll out proven innovative technology such as the PocDoc Healthy Heart Check.

2027–30 intention	Summary	Evidence of progress
Neighbourhood health: prevention & proactive care	a) Commission for Single and multi-neighbourhood arrangements, including integrator specification, based on a set of design principles. b) New frailty specification (multi-organisation) c) Continue long-term condition programmes (e.g. diabetes, heart failure), introduction of new priority programme for respiratory illness d) Align incentives including revised PCN Directed Enhanced Service. e) Population health management using CE ICB wide data system (DELPPHI) f) Enhance primary care access: develop and evaluate digital front door test bed pilots via the NHS App for AI triage, remote monitoring and prevention. g) Review Better Care Fund arrangements h) Community Services Coordinated Commissioning Review: implement CE ICB-wide specifications for urgent care services including Urgent Care Coordination Hubs, Urgent Community Response, Virtual Wards.	Consistent frailty-first neighbourhood teams; stronger care coordination; more care at or closer to home.

1.6. Strategic healthcare utilisation and transformation

Strategic healthcare utilisation and transformation programmes cover next steps for Our Way priorities, and measures designed to effect rapid change. These include structural reform, use of GIRFT standards, protocols and benchmarks, setting clear expectations for pathway development and clinical standards. It also covers transformation and scaling of evidence-based services.

Providers will be expected to focus on improving healthcare utilisation, reducing unwarranted variation and aligning with GIRFT. We expect to see development of asynchronous triage for outpatients. We will work with NHSE on opportunities to maximise the benefits of NHS Online for patients.

2027–30 intention	Summary	Evidence of progress
Strategic healthcare utilisation & pathway transformation	a) Develop lead provider and collaborative models to rationalise ICB commissioning arrangements. b) Ensure that Providers deliver in line with GIRFT, including standardised follow up out-patient protocols. c) Develop models for asynchronous out-patient triage. d) Introduce contract schedule setting out expectations for referrals, pathway developments and clinical standards (see Appendix C). e) Re-procure new dermatology specification, pathway transformation. f) Embed and expand AI triage across Central East ICB	Reduced unwarranted variation, duplication and avoidable use; improved access and flow

	providers for community musculoskeletal physiotherapy for back pain. g) Work with NHSE to maximise benefits from NHS Online. h) Improve diagnostics services including Community Diagnostic Centre utilisation and new capacity. i) Progress medicines optimisation programme. j) Work with NHSE to assure National Maternity Investigations recommendations & 10-point plan, and specific ICB perinatal quality improvement, including focus on Maternal Care Bundle Element 1. k) A phased transition to transform and delegate most All Age Continuing Care functions.	
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1.7. Mental health, learning disability & autism

We will continue to progress the Our Way Mental Health Crisis and In-patient pathways programme through our standard lifecycle sequence, and build on 2026/27 work to improve access to neurodevelopmental services in a sustainable way. We will also review Mental Health Services for Children & Young People, with a focus on strengthening early help and prevention including digital options.

2027–30 intention	Summary	Evidence of progress
Mental health, learning disability and autism	a) Continue Our Way Mental Health Crisis and In-patient programme. b) Develop CE Neighbourhood Mental Health Framework c) Build on Our Way Neurodevelopmental programme to develop an integrated model (improved access, prevention & early intervention) d) Review CYP Mental Health services; strengthen early help, prevention including digital options. e) Review of section 117, specialist hospital placements and joint commissioning.	Reduce avoidable admissions and out of area placements

1.8. Finance, commissioning and contracting approach

Planning assumptions will recognise the likely impact of demographic growth, population need and increasing complexity including the need to support primary care, neighbourhood health and preventative models of care. Providers should not assume automatic growth in activity, capacity or funding, and will be expected to maximise productivity, improve healthcare utilisation and work with the ICB to reduce unwarranted variation and avoidable demand.

Community, mental health, primary care and neighbourhood services will be expected to play an increasing role in prevention, proactive care and pathway transformation, supported by service redesign, productivity improvements and investment where justified by a robust case. Where there is national policy or direction, including development of Modern Service Frameworks and Prevalence Reviews, these will be considered as part of our overall commissioning and contracting approach.

We will continue the block deconstruction work across **community and mental health providers**. The work will provide a clearer basis for reviewing service models, productivity, investment and

disinvestment. The ICB will **recast the acute deconstruction** exercise following the 2026/27 contracting round: any movement towards a target contract value will be managed and phased. In the acute sector, the ICB will review the use of **local prices** where these do not adequately reflect an agreed service model, pathway or local cost base. Further detail on our contracting, activity and payment approach is set out in **Appendix D**.

2027–30 intention	Summary	Evidence of progress
Finance, commissioning and contracting approach	a) Differential growth to support primary and community services delivery, whilst maintaining acute services performance. b) Build on community and mental health block de-construction to inform service reviews, productivity and investment decisions c) Continue phased adjustments based on acute block de-construction. d) Review of local prices to ensure they are evidence-based, transparent and well-defined. e) Development of year-of-care payment approach for testing in specific services or patient cohorts.	Funding better aligned to outcomes, pathways and population need rather than historic activity

1.9. Major projects and estates investment

The ICB will continue to develop its pipeline for investment in Neighbourhood Health Centres, support development of Mental Health Emergency Departments and Neighbourhood Mental Health Centres. We will also continue to work with providers to right size and ensure strategic coherence for major projects.

2027–30 intention	Summary	Evidence of progress
Estates and capital projects	a) Continue investment pipeline for Neighbourhood Health Centres b) Support development of Mental Health Emergency Departments and Neighbourhood Mental Health Centres. c) Progress major projects for hospital re-development including Mount Vernon Cancer Centre re-location; Watford General Hospital re-development; Hinchingsbrooke Hospital re-development; Bedford Hospitals Elective Care Centre; Cambridge Children's Hospital; Cambridge Cancer Research Hospital; Milton Keynes University Hospitals programme.	Modern fit for purpose estates

1.10. Outcomes and key performance metrics

The Commissioning Intentions are based on (1) continuation of the 9 Our Way measures (2) delivering our national planning commitments (3) taking account of National Oversight Framework metrics. During 2027-30 Central East ICB will be working collaboratively with other ICB's across England to align, learn and leverage collective approaches where appropriate.

As part of the emerging national collaborative approach with other ICBs we are proposing to add four metrics which align to the Our Way Care Model as follows:

- Reduce clock starts per 100,000 people
- Reduce the average length of stay for people aged 65 and over
- Increase access to dentistry so every child can receive dental care
- Increase access to same-day urgent primary care appointments

1.11. Engagement

Communication and engagement on the Commissioning Intentions 2027-30 will take place mainly via established networks and channels with our providers and partners.

More broadly, lived experience and community insight will be treated as a core input to our improvement system, not a separate engagement activity. Broad community engagement will be used to identify patterns, themes, and emerging risks that shape priorities.

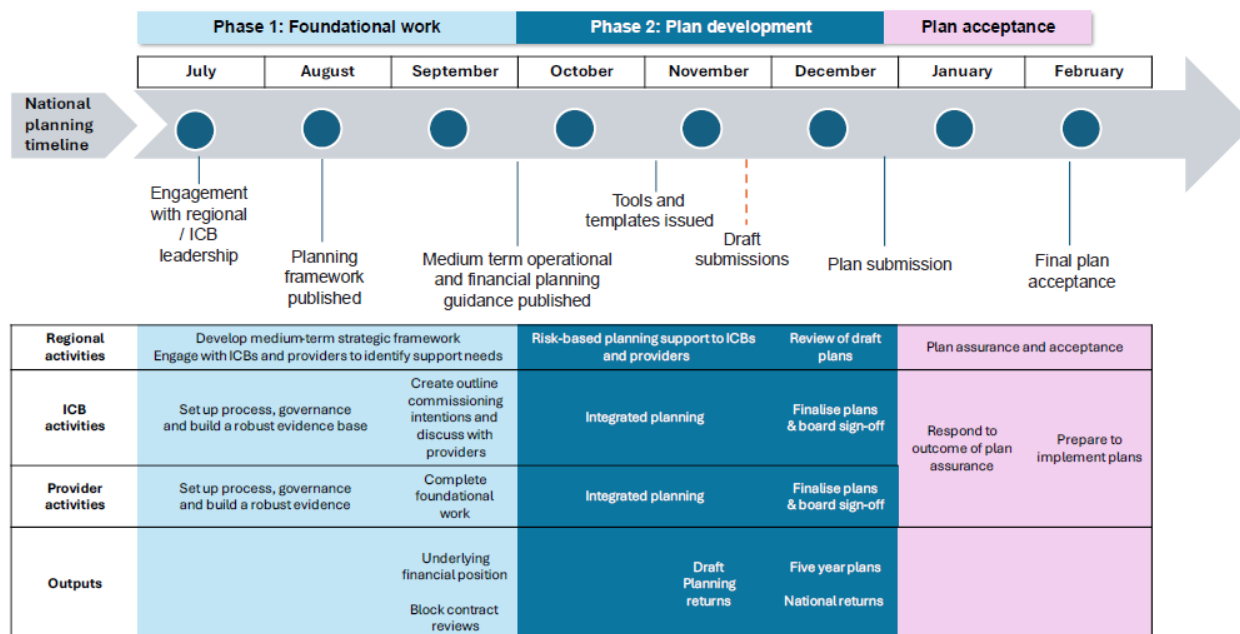
Greater involvement of people with lived experience will be focused where we are designing interventions, testing changes, or assessing reliability - ensuring insight influences decisions early, not retrospectively. Insight from communities experiencing the poorest access, experience, and outcomes will be prioritised to inform targeted PDSA (quality improvement methodology, Plan Do Study Act) cycles and assess whether changes are reducing, rather than reinforcing, unwarranted variation. 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.

1.12. Planning process

Pending national guidance, we will work with providers and partners on the assumption the planning process will be similar to last year as shown in the NHSE diagram below. Our Five-Year Strategic Commissioning Plan – Our Way Strategy to Delivery – will remain fundamentally unchanged, but we will update it in line with these Commissioning Intentions. We are working on the activity, performance and financial modelling in anticipation of technical planning submissions in the autumn, but also to inform contracting for 2027-30.

Planning Framework for the NHS in England

Indicative timetable for 2026/27 – across two phases



What does this mean for system partners?

Sector	Expected impact and contribution
Residents and communities	More coordinated care, clearer access routes, greater involvement in service design and more support to stay well.
Primary care	A central role in neighbourhood delivery, with incentives increasingly consolidated around additional, measurable outcomes.
NHS trusts	Greater alignment of workforce and pathways to neighbourhoods, population outcomes and agreed transfers of care.
Sector	Closer alignment of health, care and wider public services, including joint planning and pooled or aligned resources where appropriate.
Hospices and VCFSE	A more explicit role in prevention, personalised care, community resilience, end-of-life care and reducing inequalities.

2. Purpose, context and commissioning implications

Strategic Aim: To provide a clear and concise basis for joint planning, service redesign, market development and contracting conversations for 2027–30.

Our Way - strategy to delivery, published in April 2026, is the ICB's guiding five-year strategy. The purpose of these commissioning intentions is to communicate our main priorities for delivering Our Way in 2027-30, improving quality, transforming patient experience and achieving financial sustainability.

The document is intended to:

- set a common strategic direction for providers and partners;
- help achieve constitutional standards;
- describe the outcomes and service changes the ICB intends to pursue;
- signal where contractual payment or provider-model changes may be required;
- support early dialogue before detailed specifications, business cases or procurement decisions;
- provide a consistent framework for prioritisation, delivery and assurance.

The NHS 10-Year Plan continues to provide a strong foundation for our work, while we also consider more recent national policy and guidance such as the National Cancer Plan for England, and Modern Service Frameworks.

These commissioning intentions set out the ICBs strategic direction for 2027-30. They signal areas where services, pathways, activity, provider arrangements or payment mechanisms may change. They are not a contract and do not commit the ICB to a particular service model, activity level, price, payment mechanism or funding arrangement. Detailed requirements will be confirmed through the appropriate commissioning, procurement and contracting processes, subject to the applicable national rules, statutory duties, affordability and formal ICB approval.

2.1. Population health insights

Since publication of Our Way in April 2026, the Central East ICB Strategic Value Unit has further developed and refined population health insights as set out in the diagram below, with two key recommendations for Commissioning Intentions.

Appendix A provides a summary of the Population health insights that have been developed across Central East; a full set of insights is available on request. Based on these insights, a clear strategic narrative emerges which strongly aligns with Our Way by reinforcing the need to shift from reactive, hospital-based care towards proactive, preventative, neighbourhood-centred models that improve outcomes, reduce inequalities and ensure long-term sustainability.

Insight headlines:

Ageing population

- Our ageing population is significantly increasing demand for health and care services, requiring a stronger focus on prevention, healthy ageing, frailty management, end of life care planning and proactive support for people with long-term conditions.

Variation

- Variation in outcomes, access and healthcare utilisation persists across Central East, requiring evidenced-based models of care that can be adapted to meet the differing needs of local populations.

Health inequalities

- Health inequalities remain a cross-cutting challenge, with pockets of poor outcomes often masked by system-wide averages, necessitating targeted investment and proportionate universalism approaches.

Long-term conditions

- Preventable long-term conditions continue to drive avoidable demand, particularly cardiovascular disease, respiratory illness, mental health needs and musculoskeletal conditions, reinforcing the case for neighbourhood-based prevention and integrated care models.

Early identification and intervention

- Early identification and intervention offer the greatest opportunity to improve outcomes, including through screening, diagnostics, frailty services, mental health support, and end-of-life care planning.

These insights firstly reinforce the Our Way strategic approach, underlining the need to commission integrated service models of care for key **long-term conditions, frailty and end of life** that cut across the stages of intervention set out in Our Way and in line with the ICB role as a strategic commissioner. The Insights signal tackling **respiratory illness** as an emerging priority area for 2027-30, in addition to the existing Our Way programmes.

Secondly, the insights highlight the need to reduce unwarranted variation and enable parity of access, commissioning must enable **consistent, evidence-based models of care across the whole ICB footprint**. Service intensity should be **proportionate to local needs and** tailored to local sociodemographic factors and neighbourhood assets.

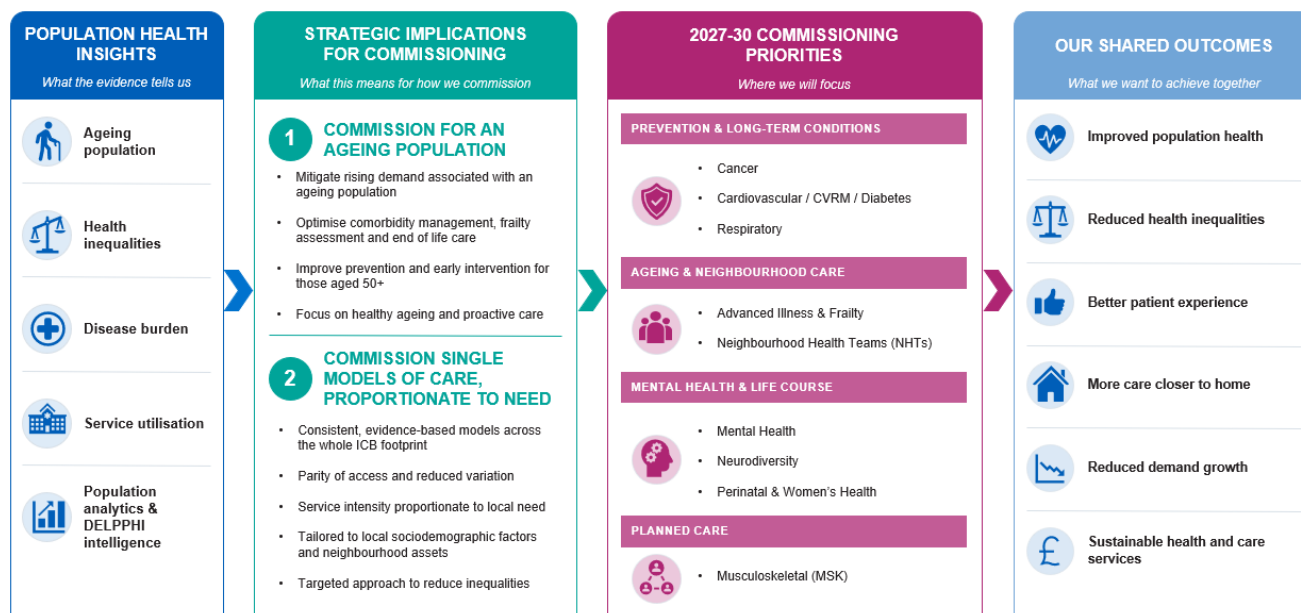
The Insights review of priorities also flags neonatal and maternity care as a further emerging priority for 2027-30 based on data, patient experience and national policy priorities.

2.2. Commissioning implications and priorities

The analysis highlights that our most significant challenge over the next decade will be the impact of a rapidly growing and ageing population, with emergency admissions and bed day demand projected

to increase substantially. At the same time, considerable variation exists in health outcomes, disease burden, deprivation, digital exclusion and service utilisation across places and neighbourhoods, demonstrating that a uniform approach to service delivery will not meet the needs of all communities.

Population health insights



The insights reinforce the need for integrated neighbourhood health models that focus on prevention, early intervention and personalised support, particularly for people living with long-term conditions, frailty, multimorbidity and complex needs. The evidence highlights significant opportunities to improve outcomes through earlier identification and management of cardiovascular disease, cancer, respiratory illness, smoking-related harm, mental health conditions and frailty, while reducing future demand on acute services through strengthened community-based care and prevention programmes.

Population health analysis demonstrates that pockets of deprivation, poorer health outcomes and barriers to access exist across all places, often masked by system averages. This reinforces the need for consistent evidence-based models of care across Central East, while tailoring the scale, intensity and delivery mechanisms of services to the needs of local populations and neighbourhoods. The variation observed in cancer screening uptake, cardiovascular outcomes, smoking prevalence, childhood emergency attendances, mental health service utilisation and digital exclusion strengthen the arguments for targeted interventions which focus on communities experiencing the greatest disadvantage.

Finally, our insights reinforce the strategic importance of population health intelligence, linked data and predictive analytics as enablers of strategic commissioning. The emerging DELPPHI data platform and the planned use of predictive modelling provide the foundations for commissioning decisions that are increasingly evidence-based, outcomes-focused and responsive to future population need.

This supports Our Way's ambition to make best use of resources, target interventions where they will have greatest impact and commission integrated pathways that deliver better health, improved patient experience and greater value for the population of Central East.

2.3. Engagement

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.

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.

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.

3. Our commissioning principles

Strategic Aim: Apply a consistent set of principles to all commissioning, investment, disinvestment and service redesign decisions.

The principles below have evolved from last year, but retain an intended focus on population benefit, prevention, evidence, quality, collaboration, value, accountability and appropriate delegation, while reflecting a shift of emphasis to neighbourhood working, provider stability and outcome-based commissioning.

1. Population benefit and proportionate universalism	We will start with population need, inequalities, lived experience and future risk, and apply greater intensity where need and exclusion are greatest.
2. Quality is the strategy	We will design safety, effectiveness, experience, access and equity into commissioned services from the outset, whilst supporting workforce wellbeing and ensuring stewardship of public resources consistent with the IHI's quintuple aim. National standards are the minimum, not the limit of our ambition.
3. Prevention and neighbourhoods by default	We will prioritise prevention, early intervention and proactive care, delivering support at home, digitally or in neighbourhood settings where clinically appropriate. Hospital care will be used where its specialist capability is required.
4. One population, one pathway, shared accountability	We will commission around people and pathways rather than organisational boundaries, reducing hand-offs, duplication and repeated assessment. Responsibilities, clinical accountability, information flows and escalation routes will be explicit.
5. Effective healthcare utilisation, productivity and value	We will commission and actively manage services to ensure resources are used appropriately, consistently and in line with evidence-based best practice. Providers will be expected to deliver care in accordance with Get It Right First Time (GIRFT) recommendations, agreed clinical standards and utilisation benchmarks, reducing unwarranted variation in service delivery, eliminating low-value activity, and ensuring people receive the right care, in the right setting, at the right time.
6. Evidence, intelligence and evaluation	We will use population health, utilisation, quality, finance, workforce, research and resident insight; establish baselines and evaluate impact.
7. Stewardship, value and sustainable provision	We will treat public funding, workforce, estates and environmental resources as one system resource. Investment and disinvestment will reflect outcomes, affordability and provider-market sustainability, not historic arrangements alone.
8. Co-production, partnership and subsidiarity	We will work with residents and system partners to take decisions at the most local level capable of delivering the desired outcome, with delegation matched by capability, assurance and accountability.
9. Transparency, delivery and earned autonomy	We will set clear and measurable expectations, owners and consequences. Greater freedom will follow demonstrated capability and delivery.

4. System outcome measures

Strategic Aim: To create a unified outcomes framework that aligns local ambitions with national priorities to measure population impact, system transformation and delivery of our commissioning intentions.

To ensure our commissioning intentions deliver improved health outcomes and we make best use of available resources across the health system for the population of Central East, the ICB will continue to monitor the nine measures as set out in Our Way. We will also work with other ICB's across England to align, learn and leverage collective approaches where appropriate.

The Commissioning Intentions are based on (1) continuation of the 9 Our Way measures (2) delivering our national planning commitments (3) taking account of National Oversight Framework metrics. During 2027-30 Central East ICB will be working collaboratively with other ICB's across England to align, learn and leverage collective approaches where appropriate.

As part of the emerging national collaborative approach with other ICBs we are proposing to add four metrics which align to the Our Way Care Model as follows:

- Reduce clock starts per 100,000 people
- Reduce the average length of stay for people aged 65 and over
- Increase access to dentistry so every child can receive dental care
- Increase access to same-day urgent primary care appointments

Additionally, rather than creating a separate performance mechanism, we will bring together existing local, operational and national measures into a single outcomes framework that provides a clear line of sight between our long-term strategic ambitions, annual delivery priorities, the care delivered, and national accountability requirements. By aligning these frameworks, our aim is to strengthen consistency across the system, ensure local action contributes to national objectives and create a balanced, evidence-based approach to monitoring progress and impact through to 2030.

The outcome framework will evolve alongside emerging national guidance and system priorities, with measures focused on the areas where our commissioning intentions seek to deliver the greatest change:

- establishing effective neighbourhood models of care;
- improving population health and reducing inequalities, including for people with mental health, learning disabilities and autism needs;
- shifting care closer to home;
- transforming priority clinical pathways; and
- securing sustainable, high-quality services within available resources.

Together, these measures will provide a shared framework for assessing progress across Central East, supported by annual trajectories and delivery metrics through the ICB's 2027/28, 2028/29 and 2029/30 delivery plans, ensuring the ICB's strategic intent is translated into demonstrable improvements in outcomes, experience and value for our population.

5. The health and care landscape we are working towards

Strategic Aim: To create an integrated provider landscape in which neighbourhoods organise proactive care, pathways operate across organisations and provider collaboratives deliver at the most effective scale.

5.1. Our three-year vision

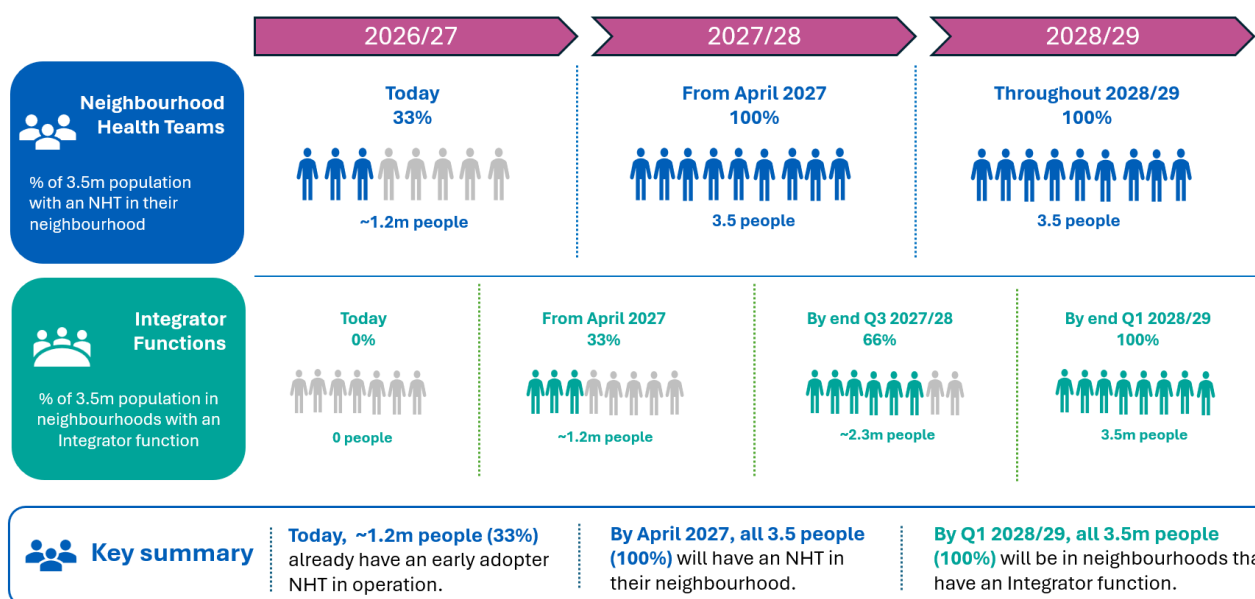
By the end of 2029/30, residents should experience a more coherent health and care system, regardless of which organisation employs the professional delivering their care. The intended landscape has three connected levels:



Central East ICB will develop and test the Integrator Function at an appropriate place or Unitary Authority level recognising this is a natural footprint to coordinate multiple neighbourhoods, organise common capabilities and support collective accountability. This approach also supports the continuing evolution of local government structures and the opportunities presented by Local Government Reorganisation (LGR) over time. We anticipate a number of first-wave Integrators being ready for April 2027 supported through a fast-track route where sufficient capability, maturity and provider alignment already exist, enabling earlier implementation and learning ahead of wider rollout.

Population Impact Over Time – 3.5m People

Progress towards all Londoners benefiting from Neighbourhood Health Team (NHTs) and Integrator Functions



Over time, Integrator responsibilities are expected to evolve and may include population health management, service coordination, improvement support, workforce development, digital and data infrastructure, and, where maturity permits, delegated resources or contracts.

Lead providers and provider collaboratives will be used selectively where they simplify accountability, improve pathway integration, strengthen resilience or provide a more efficient platform for delivery. The ICB will retain strategic commissioning, statutory accountability, quality oversight and assurance.

5.2. Development approach

- Define the common integrator specification, eligibility and readiness criteria, by March 2027.
- Assess local maturity, provider alignment, governance, information and financial capability.
- Use first-wave arrangements to test and evaluate the model before wider adoption.
- Ensure that delegated responsibility is matched by explicit accountability, risk controls and transparent outcomes.
- Align and expand VCFSE commissioning to enable the sector to play an important role in the delivery of preventative support for people with mild frailty, helping maintain independence, reduce social isolation and delay progression to more complex need
- Align new models with local government reform and established place partnerships.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Lead and participate in neighbourhood delivery, with access to shared infrastructure and clearer escalation routes.
Acute providers	Focus specialist capability while supporting pathway redesign, advice, diagnostics and transfer of appropriate care closer to home.
Community and mental health	Increased focus on scaled models of care: complex care, rehabilitation and hospital avoidance.

Sector	Expected impact and contribution
Hospices	Contribute specialist palliative and end-of-life expertise, coordination and community-based support.
VCFSE	Operate as a strategic and delivery partner providing preventative elements of neighbourhood planning and delivery.
Local authorities	To collaborate and identify opportunities to better align social care, public health and wider determinants with neighbourhood priorities.

6. Priority 1: Neighbourhood health, prevention and proactive care

Strategic Aim: To make neighbourhood health the primary operating model, beginning with frailty and building reusable capability for other priority cohorts.

Central East ICB is committed to making neighbourhood health the primary model for delivering health and care across our 3.5 million population. Aligned to **Our Way**, the **NHS 10-Year Health Plan** and the **Neighbourhood Health Framework**, we will organise care around neighbourhood populations, shift care closer to home, strengthen prevention and proactive care, and improve outcomes through integration across primary care, community, mental health, acute, social care and VCFSE partners.

Frailty is the first priority cohort and will provide the foundation for future neighbourhood models for other population priorities, which may include children and young people, SEND, mental health, multiple long-term conditions, end-of-life care and other priority populations. Over time, decision-making, accountability and resources will increasingly be aligned around population outcomes, experience and value.

6.1. Neighbourhood commissioning intentions

To guide this transformation, and to provide a consistent reference point for future commissioning, contracting and service redesign decisions, Central East ICB has adopted 10 Neighbourhood Health Design Principles (see **Appendix B**). These principles define the outcomes and behaviours we will prioritise, the risks we are prepared to take, and the future state we are collectively working towards with our providers, local authority partners and neighbourhood communities.

Underpinned by our design principles, Central East ICB will implement a phased three-year approach to establish consistent **Neighbourhood Health Teams (NHTs)** in every neighbourhood through a common Frailty First model, while developing **Integrator Functions** across Unitary Authorities subject to the outcome of Local Government Reorganisation (LGR).

From April 2027, the ICB intends to commission single Neighbourhood Health Teams through a **local PCN DES Variation, or equivalent contractual mechanism**, establishing a consistent neighbourhood operating model focused initially on frailty and creating the infrastructure, leadership, workforce and data capability required for future cohorts.

In parallel, the ICB will develop and test Integrator Functions at Unitary Authority level. During 2026/27 this will include a common specification, eligibility framework, readiness assessment and expression of interest process, with a small number of early adopters expected from April 2027.

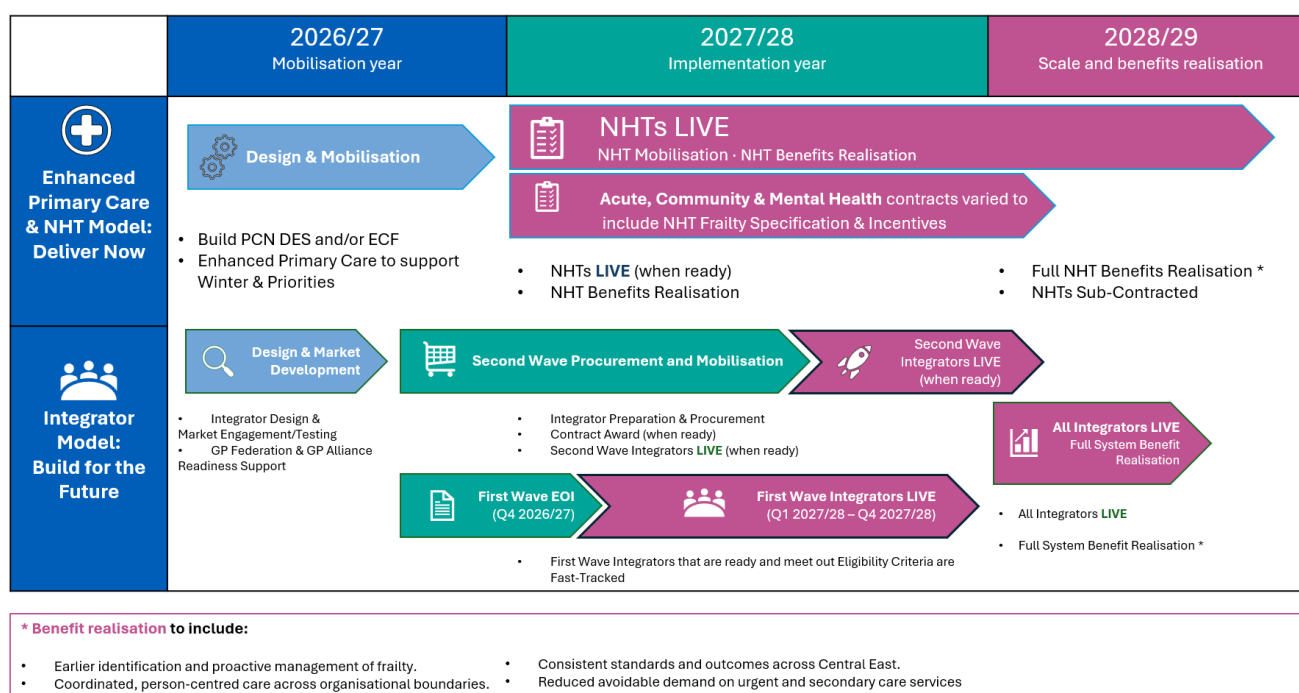
Recognising variation in local maturity and readiness, implementation will be phased, allowing more mature systems to progress faster while supporting others to build capability. Over time, Integrators may evolve from coordinating improvement, analytics and infrastructure functions towards greater responsibility for population health management, shared outcomes, aligned resources and neighbourhood-facing services. This will support the gradual transfer of activity and resources from hospital-based care into neighbourhood delivery models.

6.2. Our 2027-29 roadmap

- **Commission neighbourhood teams through primary care-led arrangements** using a PCN DES Variation or equivalent contractual mechanism.
- **Develop and test Integrator Functions** across multiple neighbourhoods.
- **Align primary care incentives** around neighbourhood health, prevention and resilience.
- **Strengthen prevention and proactive care** through population health management and targeted intervention.
- **Embed VCFSE and local authority partners** as core neighbourhood delivery partners.

Neighbourhood Health – Delivery and Integrator Timeline

Phased approach: NHTs deliver now, Integrators build for the future



Success will be evidenced through consistent neighbourhood delivery models, improved coordination, shared outcomes, reduced duplication, earlier intervention and a stronger focus on prevention and reducing inequalities.

The following sections describe what this means for different provider sectors and how provider roles, responsibilities and contractual expectations will evolve between now and 2029/30.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	• The ICB intends to commission NHTs through a local PCN DES Variation or equivalent contractual mechanism, making primary care the lead delivery vehicle for neighbourhood health.

Sector	Expected impact and contribution
	• Transitional funding and outcome-based incentives may support mobilisation and delivery of the Frailty NHT Specification. • Primary care will increasingly lead population health management, care coordination and neighbourhood delivery, initially for frailty and subsequently for other priority cohorts. • Incentives will increasingly align to neighbourhood outcomes, system priorities and resilience.
NHS Trusts (Acute, Community, Mental Health and Ambulance)	• Providers will be expected to align workforce, services and pathways to neighbourhood populations and support delivery of the NHT model. • Funding arrangements will increasingly support outcomes, activity shift and risk / gain share approaches that enable care to move into neighbourhood settings. • Providers will be expected to participate in Integrator arrangements, and where appropriate this will be reflected in contractual changes. • Community services will be progressively aligned around consistent specifications, outcomes and neighbourhood delivery models.
VCFSE sector	• VCFSE organisations will become core partners in neighbourhood delivery, particularly for prevention, wellbeing and tackling wider determinants of health. • Future NHT and Integrator arrangements will more systematically embed and commission VCFSE provision.
Local authorities	• Local authorities will be key partners in the design, governance and delivery of neighbourhood health. • Neighbourhood teams will increasingly operate across organisational boundaries to support joined-up health, care and wider public services. • Local authorities will help shape future Integrator arrangements and place-based reform.

6.3. Enhanced Primary Care and PCN DES variation

The ICB intends to use a local **PCN DES Variation, or equivalent contractual mechanism**, to commission Enhanced Primary Care as the lead delivery vehicle for Neighbourhood Health Teams from April 2027. The initial focus will be delivery of the Central East Frailty NHT Specification, including proactive identification, multidisciplinary working, care coordination and personalised care planning.

Over time, primary care incentive schemes will be simplified and aligned into a neighbourhood framework focused on outcomes, prevention, population health and reducing inequalities. PCNs will retain flexibility in local delivery arrangements provided they meet agreed service standards, outcomes and assurance requirements.

These intentions represent a deliberate shift from organisation-centred delivery towards integrated neighbourhood-based care, with accountability, resources and decision-making progressively aligned around population need.

The following sections have been identified as areas that remain strategically relevant to neighbourhood health and the preventative managed care model we will continue to build. Through risk stratification, personalised planning and multidisciplinary coordination, responsibility and resources will progressively follow population need.

6.4. Community Services: A coordinated commissioning review

Building on the previous work of the three legacy ICBs, Central East ICB will focus on coordinated commissioning of community-based services that enable community providers to increasingly focus on complex care, rehabilitation, hospital avoidance and care shifted from acute settings.

The ICB will begin with reviewing urgent and emergency care and community-based services across the ICB footprint. Our aim will be to commission at-scale integrated models of care that support neighbourhood team delivery. Initial areas will include urgent care coordination, urgent community response, virtual wards, hospital at home, end of life services and wider community provision. Reviews will consider consistency, integration, utilisation, outcomes, workforce, affordability and opportunities for collaboration.

What does this mean for system partners?

Sector	Expected impact and contribution
Acute providers	More consistent alternatives to admission and clearer transfer, escalation and discharge pathways.
Community providers	Greater responsibility for coordinated urgent response and care closer to home, supported by clearer specifications and baselines.
Primary care	Simpler access to advice and community response, with reduced administrative hand-offs.
Residents	Faster access to the right response and fewer avoidable transfers between services.

6.5. Cardiovascular, renal and metabolic diseases (CVRM)

Strategic Aim: Commission integrated cardiometabolic pathways across primary, community and secondary care that support prevention, early intervention and proactive management of cardiovascular disease, diabetes and related conditions to improve population health outcomes, reduce inequalities and unwarranted variation, and deliver high-quality care aligned with national best practice.

Diabetes

The ICB will strengthen diabetes services through the implementation of integrated pathways spanning primary care, neighbourhood teams, community services, specialist care, and VCSE partners. For Type 1 diabetes, this will include equitable access to continuous glucose monitoring, hybrid closed-loop technology, structured education, psychological support, and coordinated care across key life stages including transition, pregnancy, and adulthood. For Type 2 diabetes, the ICB will implement an enhanced integrated diabetes model aligned to national best practice, supporting delivery of NICE-recommended care processes, reducing variation in outcomes, and improving prevention and management of complications.

The ICB will also develop new neighbourhood-based approaches to cardiometabolic health, bringing together diabetes, obesity, cardiovascular disease, hypertension, lipid management, and kidney disease within a single preventative pathway. Particular emphasis will be placed on reducing diabetes-related foot disease, supporting wellbeing and self-management, improving care for people living with frailty, and ensuring services are informed by population health intelligence, shared accountability, and continuous improvement. VCSE partners and people with lived experience will play a central role in co-designing services, supporting peer networks, and shaping future models of care.

Cardiometabolic prevention

The ICB will commission and evaluate innovative population health technologies, including the use of digital solutions for point of care testing such as the PocDoc Healthy Heart Check, to enhance cardiovascular risk identification, improve access to preventative care for underserved populations, and support the development of integrated cardiometabolic care bundles that enable earlier intervention and better long-term outcomes.

Cardiology

The ICB will work with pathology providers, primary care and cardiology services to implement a standardised laboratory-based NT-pro BNP testing pathway across Central East, replacing historic local arrangements where appropriate. The overall objective is to provide the following benefits:

- improve equitable access to heart failure diagnostics and support improved pathways including related to earlier diagnosis and treatment
- reduce unwarranted variation, enhance the patient experience
- secure improved value for money through a lower-cost diagnostic model

The pathway will incorporate standardised reporting and referral guidance to support timely access to echocardiography and specialist assessment where clinically indicated.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Deliver consistent achievement of NICE care processes and treatment targets, reduce unwarranted variation, and support proactive identification and management of people at risk of cardiovascular, renal and metabolic diseases.
Neighbourhood and community services	Provide coordinated multidisciplinary support, strengthen self-management and prevention, and deliver integrated cardiometabolic care closer to home.
Acute and specialist providers	Deliver specialist expertise, technology-enabled care, structured education, and integrated pathways for people with complex diabetes needs.
VCSE partners	Support co-production, community engagement, peer support, and targeted interventions to improve access, experience, and self-management.
Residents	Benefit from earlier intervention, more personalised and coordinated care, improved access to support and technology, and better long-term outcomes.

6.6. AI triage, NHS App and digital prevention

Strategic Aim: To support the delivery of Neighbourhood Health through the adoption of AI-enabled triage, digital prevention and remote monitoring technologies that empower residents, strengthen self-care and enable clinicians to intervene earlier

The care delivery model set out in Our Way includes AI enabled triage to direct people to the right care, redirecting demand to the most appropriate destination. Based on joint work with the National NHS England digital teams, our intention is to pilot, test, evaluate and scale (where appropriate) the following:

- AI triage
- Prevention functions
- Patient-entered data using wearables and connected devices

Commencing this year and continuing into 2027/28 we will pilot AI-enabled triage for primary care, digital prevention services and patient-reported health data to transform how residents access and interact with health and care services, creating a more proactive, personalised and sustainable model of care.

Through a programme of testing, evaluation and adoption, Central East ICB will use the NHS App as the principal digital front door to support prevention, improve access, optimise healthcare utilisation and direct resources towards higher-value care, while reducing unwarranted variation and improving outcomes for our population.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Tested triage and prevention tools intended to improve direction, access and workload management.
Providers	Clearer digital referral routes and integration requirements across pathways.
Residents	Simpler navigation and digital access, with non-digital routes retained and equality impacts evaluated.

7. Priority 2: Strategic healthcare utilisation and pathway transformation

Strategic Aim: Improve access, experience and sustainability by redesigning end-to-end pathways, reducing unwarranted variation and using the most appropriate setting of care.

Pathway transformation will combine healthcare-utilisation analysis, clinical evidence, resident insight, demand and capacity planning, workforce, digital capability, quality and financial impact. Changes will identify effects on every part of the pathway and avoid unmanaged transfer of workload, clinical risk or cost. Pathway changes will balance improved outcomes, access, healthcare utilisation, patient experience, and value with the need for clinically and financially sustainable services.

For each priority pathway, the ICB will establish a clear baseline covering population need, activity, cost, price, outcomes and variation. Proposals will identify the intended service change, implementation requirements, financial and contractual implications, impact across the whole pathway and how any released capacity or resources will be realised.

7.1. **Single Point of Access (SPoA), specialist advice and asynchronous consultations**

Single Point of Access (SPoA)

The ICB will continue to expand clinically led SPoA pathways as a key enabler of elective care reform and pathway transformation, ensuring patients are directed to the most appropriate service first time. Working with providers, the ICB will implement national SPoA requirements across consultant-led specialties to improve referral quality, reduce unwarranted variation, support elective recovery, enhance productivity and deliver a more consistent and timely experience for patients and referring clinicians.

The ICB will continue to work with providers to align local SPoA implementation with national e-RS functionality and Directory of Services (DoS) developments, ensuring SPoA services are clearly defined, accessible and embedded within referral pathways. This will support a consistent digital front door for elective referrals and Advice & Guidance requests, enabling improved pathway coordination and greater transparency of referral routes. Whilst the scope of the current national SPOA programme is NHS healthcare providers, the ICB intends to capitalise on the benefits for patients wherever appropriate & possible through an extension of implementation to independent sector providers (ISPs).

Patient Initiated Follow-Up (PIFU)

The expansion of clinically appropriate PIFU pathways is a core component of outpatient transformation, supporting the shift to a more personalised, digitally enabled and patient-led model of care, promoting self-management, shared decision-making and greater choice. Providers will be expected to maximise the use of clinically appropriate PIFU pathways and demonstrate sustained growth in PIFU utilisation as a key enabler of reducing unwarranted follow-up activity and delivering outpatient transformation; it is expected that PIFU use will increase across all appropriate specialties and pathways and the ICB will be commissioning services on this basis.

An increase in the adoption of safe, equitable and digitally enabled PIFU models, including through the NHS App, will reduce unnecessary follow-up appointments, improve patient experience, release outpatient capacity and support elective recovery and productivity improvements. In order to achieve the maximum benefit for the population of Central East, it is the ICB's intention that this important transformation will be realised in all NHS funded care that it commissions and will be working with independent sector providers (ISPs) accordingly.

Asynchronous consultations

We will work with providers to explore the potential role of asynchronous consultation models within outpatient pathways, assessing the benefits, risks and suitability across different specialties. This will include understanding how digitally enabled approaches could improve access, reduce avoidable follow-up activity, optimise clinical capacity and provide patients with greater flexibility in how they access care.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Greater use of Advice and Guidance and SPoA pathways, with clearer and more consistent referral routes and timely access to specialist input. PIFU and asynchronous models should provide clearer routes for patients to re-access specialist care while reducing avoidable demand associated with traditional follow-up arrangements.
Acute providers	Implement clinically led SPoA and referral-triage arrangements across appropriate specialties; increase the safe and equitable use of PIFU, including digital PIFU; and work with the ICB to assess and develop asynchronous consultation models where these improve access, productivity and use of clinical capacity.
Community providers	Work with the ICB to extend the benefits of SPoA and PIFU across NHS-funded care where appropriate, supporting consistent referral routes, access arrangements and pathway expectations.
Residents	Faster and more consistent access to appropriate specialist care, fewer unnecessary outpatient appointments, greater flexibility and control over follow-up, and increased support for self-management and care closer to home.

7.2. Diagnostics

Strategic Aim: To improve provision and parity of access to diagnostic services for residents across Central East.

Diagnostics are a core component of clinical pathways and associated improvements are therefore intended to deliver improvements more broadly in the quality of health care and health outcomes for our population. This will have a positive impact on the time that patients wait from referral to definitive treatment (RTT) and it will be felt by our local population as a tangible improvement in the quality of the healthcare they receive. The ICB will shape the future provision of diagnostic services to:

- Address existing pressure points, including non-obstetric ultrasound and paediatric audiology services
- Ensure alignment with future population health needs
- Facilitate the left shift in healthcare provision
- Support the evolution of neighbourhood services and help reduce health inequalities

As part of improving local diagnostic services, the ICB will identify expansion opportunities in primary care direct access to diagnostic tests (and which reflects the wider group of healthcare professionals that now make up primary care teams such as first contact physiotherapists) and straight to test pathways.

The ICB will develop a Central East Diagnostics Strategy and Year 1 delivery roadmap, principally focused on identifying and realising the opportunities that exist in delivery through Community Diagnostic Centres.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Shape responsive diagnostic pathways through referral and patient experience insight.
Acute providers	Inform diagnostic improvement through insight on capacity, demand and pathway performance.
Community diagnostic centres	Identify variation and opportunities to improve access and productivity.
Residents	More consistent, equitable and sustainable access to diagnostic services will result in more timely diagnoses, treatment and better health outcomes.

7.3. Dermatology

Strategic Aim: Establish a standardised, whole-pathway dermatology model that improves access, outcomes, primary care support and sustainability.

The ICB intends to reshape the provision of dermatology services from April 2027 through a standardised whole-pathway model designed to improve access, outcomes and value. The details of the pathway will be set out in a new service specification. The new model will incorporate a single referral management and triage function, expanded Advice and Guidance, greater use of tele-dermatology and AI-enabled triage, and the transfer of appropriate activity from acute to community settings.

Delivery of the new pathway will necessitate changes to way some aspects of dermatology services are currently being provided by system partners. The ICB's ongoing engagement with local healthcare providers will help ensure the changes being made are right for the population we serve and that implementation aligns with the programme timeline. In turn, patients will benefit from a better quality service as quickly as is feasible. This transformation will strengthen support to primary care, improve collaboration across healthcare provider interfaces, reduce waiting times, improve patient experience and outcomes, and deliver a more sustainable and cost-effective dermatology service across Central East.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Improved advice, consistent referral routes and stronger clinical support
Acute providers	A more clearly defined specialist role and managed transfer of appropriate activity.
Community providers	Potential expanded diagnostic and treatment responsibility under a standard pathway
Residents	Reduced waits, fewer unnecessary appointments and better access to care closer to home where appropriate.
VCFSE	Opportunities to support preparation, navigation, self-management and recovery.

7.4. Cancer

Strategic Aim: To improve cancer outcomes through earlier diagnosis, equitable access and sustainable, digitally enabled pathways that support prevention, reduce inequalities and deliver high-quality care closer to home.

The ICB intends to commission sustainable, equitable and digitally enabled cancer services that improve early diagnosis, reduce health inequalities, and deliver timely access to high-quality care. Continuing with colorectal cancer as a priority initially as set out in 'Our Way', we will expand neighbourhood-based prevention and early diagnosis, increasing screening uptake and strengthen primary care awareness. We will also support innovative risk-stratified pathways such as FIT@80 and ColoFIT, support the initial roll-out of the Lung Cancer Screening Programme, and strengthen case-finding approaches to identify cancers earlier.

The ICB will also continue to reduce unwarranted variation in access, treatment and outcomes, expand personalised cancer care and stratified follow-up models, and support the adoption of digital solutions that improve pathway efficiency, patient experience, and clinical outcomes. Commissioning decisions will be informed by population health intelligence and aligned to the NHS Cancer Plan, Cancer Waiting Time standards, and the strategic shift towards prevention, community-based care and digital transformation

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Increased focus on cancer screening promotion, proactive identification of non-responders, improved coding and data quality, targeted case finding, and strengthened referral quality.
Acute providers	Increased proportion of cancers identified at an earlier stage, improving treatment outcomes and reducing demand associated with late-stage disease.
Community providers	Greater involvement in prevention, awareness raising, community outreach and supporting underserved populations to access screening and diagnostic services,

Sector	Expected impact and contribution
VCSFE	Key role in engagement, education and targeted outreach activities to improve screening uptake among communities with historically lower participation rates and poorer outcomes.

7.5. MSK self-care: lower back pain

Strategic Aim: Commission a digital self-care pathway for lower back pain where currently unavailable to allow people to access timely, evidenced-based care and appropriate clinical support.

We will commission a digitally enabled MSK service that embeds and increases self-referral, digital triage, and digital self-management as core access routes, building on the ICB priority programme. Through this approach, we aim to reduce unnecessary GP front-door activity, improve referral quality and patient outcomes. In 2027/28, this work will move into stages 'E' (assure, learn and optimise) and 'F' (evolve or sunset) of the commissioning lifecycle, as set out in Our Way, to ensure the service continues to deliver value and adapts where appropriate.

We will commission services in line with the national MSK specification to deliver consistent standards, improved access, better outcomes, and more efficient use of system capacity across primary, community, and planned care. We will require digital pathways to be fully integrated within existing service models and informed by the views and experiences of local residents.

7.6. Perinatal care

Strategic Aim: To improve outcomes, experience and equity for women, babies and families by developing integrated maternity pathways that promote prevention, earlier intervention and personalised care.

The ICB will adopt a population health and strategic demand management approach to maternity services, ensuring women receive the right care, in the right place, at the right time whilst delivering sustainable use of healthcare resources.

A key priority will be the implementation of the recommendations arising from the National Maternity Investigations and Inquiries, and ensuring the ICB's approach aligns with the provider implementation of the associated 10 Point Plan. Through commissioning levers, we will focus on:

- **Safety** - strengthening safety-critical services such as Maternal Medicine Network (MMN) provision, Perinatal Pelvic Health Service (PPHS),
- **Service utilisation** - effective triage and community-based models, for example explore the potential for a Central East wide maternity triage service.
- **Retain strategic commissioning**, and **quality assurance** within the ICB.

The ICB will also prioritise delivery of Maternal Care Bundle Element 1, which focuses on risk assessing all pregnant women at the earliest opportunity. The ICB will continue to ensure appropriate emphasis on commissioning services that fully support safe and timely preconception, antenatal and postnatal care, including prevention and management of conditions associated with increased maternal morbidity and mortality. An example of this is specific work regarding maternal obesity and preconception care. Digital solutions will be explored as a key enabler for change.

This preventative approach will support earlier intervention, reduce avoidable complications and improve long-term outcomes for women and babies. Delivery will be underpinned by population health management, digital innovation, health inequalities reduction, and robust demand and capacity planning to improve maternal and neonatal outcomes, enhance women's experience, and ensure long-term service sustainability

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Stronger preconception support, earlier identification of risk and timely access to antenatal, specialist and personalised care.
Acute and maternity providers	Consistent delivery of safe, evidence-based maternity pathways, strengthened specialist provision and improved triage, flow and healthcare utilisation.
Community and mental health providers	More integrated community-based antenatal, postnatal, pelvic health and perinatal mental health support, with clearer referral and escalation pathways.
Local authorities and public health	Joint action to support healthier pregnancies, improve early access and reduce inequalities in maternal and neonatal outcomes.
VCFSE	Targeted engagement, advocacy and support for women, babies and families experiencing poorer access, experience or outcomes.
Residents	Earlier intervention, more personalised and coordinated care, fewer avoidable complications and improved experience and outcomes.

7.7. Children and young people

Strategic Aim: To improve outcomes, experiences and life-chances for children and young people

The ICB will prioritise the transformation of children and young people's services through earlier intervention, improved access and more integrated pathways that deliver better outcomes and experiences for children, young people and families. Key priorities for 2027–30 include redesigning neurodevelopmental pathways to reduce waiting times and improve experiences, expanding diagnostic capacity, modernising hearing services, strengthening joint commissioning with local authorities, improving neurorehabilitation provision, and enhancing support for children affected by complications of excess weight, codifying and scaling existing opportunities where appropriate.

The ICB will also support the development of integrated care models linked to the new Cambridge Children's Hospital and establish Lead Commissioner arrangements to secure sustainable children's hospice provision across the East of England.

These priorities will be underpinned by a system-wide Healthier Together digital platform to support prevention, self-care, health literacy and consistent clinical pathways. Collectively, they will support a strategic shift towards prevention, early intervention and integrated care, improving outcomes and patient experience while delivering greater productivity, value for money and long-term sustainability.

What does this mean for system partners?

Sector	Expected impact and contribution
Children and families	Earlier, needs-led support and fewer organisational hand-offs.
Providers	Greater alignment around common pathways, standards and outcomes.
Local authorities and education	Stronger joint commissioning and shared approaches for complex need and SEND.
Hospices and VCFSE	Clearer roles in sustainable provision, family support and community delivery.

7.8. All age continuing care

Strategic Aim: To transform All Age Continuing Care into an integrated, outcome-focused model that delivers better experiences, greater independence and sustainable value through community-based delivery, innovation and strong system governance.

The ICB intends to transform All Age Continuing Care from a predominantly transactional assessment and funding function into an integrated, outcome-focused model embedded within neighbourhood and community services.

Through a phased transition of operational delivery to a provider-based model, while retaining strategic commissioning, quality oversight, performance management and financial governance within the ICB, we will strengthen integration across health, social care and specialist services, improve workforce sustainability, and support earlier intervention for people with complex needs.

We will harness digital and AI-enabled approaches to improve the quality, consistency and timeliness of decision-making, use population health intelligence and learning from complex casework to inform future commissioning, and deliver person-centred care that promotes independence, inclusion, quality of life and long-term outcomes within a sustainable and financially robust operating model.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Improved coordination of care for individuals with complex needs, with clearer pathways and stronger links to community-based support and proactive management.
Community providers	Operational delivery, creating opportunities to integrate Continuing Care within wider community, neighbourhood and specialist services.
Community health services	Closer integration between Continuing Care, community nursing, therapies and specialist services.
Mental health, learning disability and autism services	Stronger alignment of pathways and shared management of complexity to improve outcomes and reduce fragmentation of care
Local authorities	Greater collaboration around assessment, care planning, transitions and person-centred support.

Sector	Expected impact and contribution
Residents, families and carers	Simpler pathways, improved communication, more coordinated support and faster, more consistent decision-making focused on quality of life and outcomes.

7.9. Palliative and end-of-life

Strategic Aim: To establish a sustainable, integrated and outcomes-driven palliative and end-of-life model.

The ICB will strengthen its strategic commissioning of palliative and end of life care through a population health-based approach that aligns service provision, workforce, activity, quality and investment with the current and future needs of local communities. Building on the emerging NHS England Modern Service Framework for Palliative Care and End of Life Care, the ICB will undertake a comprehensive assessment of need, demand, utilisation and outcomes to inform future commissioning decisions and ensure services are designed around the needs of patients, families and carers.

The ICB will work with hospices, community providers, primary care, acute trusts, local authorities and voluntary sector organisations to develop a more integrated model of care that supports earlier identification of palliative needs, proactive care planning, seamless transitions between services and greater coordination across Place and neighbourhood teams. Particular focus will be placed on reducing unwarranted variation in access, experience and outcomes, improving equity for underserved populations, and ensuring people are able to receive care in the setting most appropriate to their needs and preferences.

In line with NHS England guidance, the ICB will 1) transition hospice commissioning away from short-term grant arrangements towards NHS contracts and 2) move towards three place-based commissioning arrangements for hospice care over 2027-30 to support quality improvement and provider sustainability. Commissioning arrangements will support collaborative system working, strengthen outcome measurement and provide a more sustainable platform for service development and workforce planning across the hospice and specialist palliative care sector.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Earlier identification of people with palliative care needs, improved care planning, stronger coordination with community and hospice teams, and greater use of personalised care approaches.
Acute providers	Closer integration with community and hospice services, improved discharge and care coordination, reduced unwarranted hospital use at end of life, and a greater focus on shared outcomes.
Community providers	Increased responsibility for delivering coordinated neighbourhood-based palliative care, supporting people at home where appropriate, and working alongside hospices to provide seamless care.
Local authorities	Enhanced partnership working around care coordination, carers' support, social care provision and wider determinants of wellbeing for people approaching end of life.

Sector	Expected impact and contribution
VCSFE	Greater involvement in supporting personalised care, bereavement support, community engagement and reducing inequalities in access to end of life services.

7.10. Medicines utilisation

The ICB expects all commissioned providers to demonstrate safe, evidence-based and best-value use of medicines.

During 2027/28, the ICB's intention is to prioritise

- High-risk medicine monitoring
- Medication review for high-risk and frail patients
- Reduction of harmful oversupply
- Reliable implementation of medicines-safety alerts
- Coordinated management of shortages
- Effective use of the NHS Discharge Medicines Service
- Clinically appropriate adoption of best-value biological medicines

Where these requirements are already included in legislation, professional standards or existing contracts, the ICB will use assurance, improvement support and contractual performance management.

Additional investment will be reserved for clearly evidenced service gaps, additional capacity or outcomes beyond the existing baseline.

8. Priority 3: Mental health, learning disabilities and autism

Strategic Aim: To improve outcomes for people with mental health needs, learning disabilities, autism and neurodevelopmental needs by shifting support earlier, reducing reliance on hospital care, tackling inequalities and creating the conditions for providers and partners to work together more effectively across Central East.

The ICB will focus on six strategic commissioning priorities underpinned by the need for providers, local authorities, primary care and VCSFE partners to collaborate across pathways and geographies to improve outcomes for our population and tackle unwarranted variation in access, experience and outcomes.



8.1. Mental health crisis, inpatient care

Strategic Aim: To develop a modern mental health crisis and acute care system that supports people closer to home, reduces avoidable admissions and improves outcomes.

The ICB will use the Our Way Mental Health Acute and Crisis Priority Programme to test, evaluate, codify and scale best practice across crisis and acute mental health pathways. This will inform the development and commissioning of:

- **A Central East Crisis Care Specification**, setting out the model for prevention, early intervention, crisis response, crisis alternatives and neighbourhood-based support.
- **A Central East Acute Mental Health Pathway**, establishing a consistent approach to admission avoidance, inpatient care, discharge, recovery and flow.

Together, these programmes will support the shift from reactive and inpatient-based care towards earlier intervention, stronger community support and more effective crisis response, reducing avoidable admissions, lengths of stay and out-of-area placements whilst improving outcomes for people experiencing mental ill health.

There will be opportunities for providers and groups of providers to take the lead in this work and the ICB will explore opportunities for commissioning lead-providers and from provider collaboratives commencing 27/28.

8.2. Learning disabilities and autism

Strategic Aim: To improve outcomes for autistic people and people with learning disabilities through stronger community support, reduced reliance on restrictive care and a more coordinated approach to meeting complex needs.

The ICB will commission a consistent Central East community learning disability service specification, defining the core offer, access arrangements, multidisciplinary support, outcomes and partnership expectations.

To support this, the ICB will undertake a comprehensive review of learning disability services across the three legacy systems to identify variation, unmet need, service gaps and future commissioning opportunities, informing the development of a consistent Central East model aligned to population need. We will provide strategic oversight and assurance of Dynamic Support Registers, Care (Education) and Treatment Reviews, and wider admission avoidance arrangements across all ages. Working with provider partners and system colleagues, we will use performance information, quality intelligence and system insight to identify risks, support improvement and promote community-based alternatives to hospital admission, helping to reduce unnecessary admissions, lengthy hospital stays and reliance on out-of-area placements.

The ICB will develop and implement a consistent Central East autism commissioning framework, providing strategic direction for autism-informed services and support across the life course. This will include commissioning arrangements that promote reasonable adjustments within mainstream services, strengthen community-based support, improve transitions between children's and adult services, and enhance crisis prevention and admission avoidance pathways. The framework will support the development of learning disability and autism crisis accommodation and other community-based alternatives to inpatient care and align with the implementation of Mental Health Act reforms. Through this approach, the ICB will improve access, experience and outcomes for autistic people, reduce inequalities, and deliver more personalised, coordinated and sustainable care closer to home.

8.3. Neurodevelopment transformation

Strategic Aim: To develop a consistent, sustainable and needs-led neurodevelopmental model that improves access, reduces inequalities and delivers better outcomes for people with neurodevelopmental conditions across Central East.

The ICB will develop a single Central East neurodevelopmental commissioning model and strategic framework, with an immediate focus on identifying, codifying and scaling best practice, particularly in children and young people's neurodiversity assessment and support. This will reduce unwarranted variation in pathways, access and waiting times across the three legacy systems and establish an integrated neurodevelopmental pathway spanning assessment, pre- and post-diagnostic support and ongoing care. By strengthening links between neurodevelopmental services, mental health, primary care, education and community services, the ICB will improve access to evidence-based support, reduce inequalities and deliver a sustainable model focused on prevention, early intervention and effective management of future demand.

8.4. Community and neighbourhood mental health

Strategic Aim: To establish a clear Central East model for neighbourhood mental health services that promotes prevention, recovery and coordinated care closer to home.

The ICB will use the findings from the mental health service reviews undertaken across the three legacy systems to develop and commission a Central East Neighbourhood Mental Health Centre specification as part of the wider Neighbourhood Health model. The specification will establish a consistent neighbourhood mental health offer across Central East, with peer support, recovery and co-production as core principles. It will include access, care coordination, assertive outreach, intensive community support and recovery-focused interventions, whilst strengthening integration between mental health services, primary care, local authorities and VCSE partners. Through this approach, the ICB will support earlier intervention, reduce inequalities and deliver more personalised, coordinated and community-based care closer to home.

8.5. Children and young people's mental health

Strategic Aim: To deliver a consistent, integrated and preventative model of Children and Young People's Mental Health Services (CYPMHS) that improves access, outcomes and experience for children, young people and their families across Central East

The ICB will develop and commission a consistent Central East Children and Young People's Mental Health Service (CYPMHS) model aligned to the i-THRIVE framework, establishing a clear and integrated pathway of support across the three legacy systems. Informed by best practice and a review of CYPMHS services and investment across Central East, the model will define a consistent core service offer, including early help and preventative interventions, Mental Health Support Teams in Schools (MHSTs), digital early intervention, specialist CAMHS provision, crisis support and transition arrangements. Through stronger integration between health, education, social care and VCSE partners, this approach will improve access to support, reduce unwarranted variation, promote earlier intervention and ensure children and young people receive coordinated, needs-led care that improves outcomes and reduces inequalities.

8.6. s.117, specialist hospital placements and joint commissioning reform

Strategic Aim: To establish a sustainable, equitable and consistent approach to Section 117 aftercare, specialist hospital placements and joint commissioning that improves outcomes, supports delivery of neighbourhood health and maximises the effective use of public resources across Central East.

The ICB will set out and implement a consistent Central East framework for Section 117 aftercare, specialist hospital placements and joint commissioning, establishing clear governance, funding responsibilities, discharge pathways and decision-making arrangements across the three legacy systems. The framework will support implementation of Mental Health Act reforms, improve oversight of people with the most complex mental health, learning disability and autism needs, and provide a sustainable approach to commissioning and financial accountability.

Working with local authority partners, the ICB will strengthen strategic market management and housing planning to support the development of appropriate community-based accommodation, reduce barriers to discharge and improve access to local support for people with complex needs. Section 75 agreements and pooled budget arrangements will be reviewed to determine where they remain necessary and where alternative arrangements may better support improved outcomes, reduced complexity and effective partnership working. Through this approach, the ICB will strengthen community-based alternatives, improve discharge pathways, reduce reliance on institutional and out-of-area care, and deliver a more coherent and sustainable commissioning model across Central East.

What does this mean for system partners?

Sector	Expected impact and contribution
Primary care	Stronger roles in prevention, early identification, physical healthcare and coordinated neighbourhood support.
Mental health, learning disability and autism providers	More consistent pathways, stronger community alternatives and clearer accountability for access, outcomes, flow and discharge. Opportunity to lead areas of service redesign through revised commissioning models and lead provider and provider collaborative type approaches.
Acute and community providers	Better integration of physical and mental healthcare, with clearer crisis, transfer and shared-care arrangements.
Local authorities and education providers	Stronger joint commissioning and coordinated support across social care, housing, education and complex-needs pathways.
Specialist providers	Increased oversight of placements, outcomes, value and discharge, with reduced reliance on institutional and out-of-area care.
VCSFE	Greater involvement in prevention, inclusion, recovery, family support and community-based alternatives.
Residents, families and carers	Earlier, coordinated and needs-led support, with fewer hand-offs and greater access to care closer to home.

9. Finance, commissioning, contracting approach

Strategic Aim: To use contracting as a strategic lever to improve population health outcomes, reduce inequalities, support neighbourhood health delivery and optimise healthcare utilisation, while providing the stability and certainty required to deliver transformational change and financial sustainability.

9.1. Finance approach

Our financial strategy is integral to delivering Our Way. It reflects our responsibility to steward public resources for 3.5 million people and to manage clinical and financial risk across the Central East population. Consistent with the principle that **quality is the strategy**, we will act as an intelligent payer: using population health intelligence, utilisation data, clinical evidence and resident insight to direct resources towards interventions that improve access, experience, outcomes and effectiveness.

Providers will work collaboratively with the ICB to reshape pathways; reduce unwarranted variation, avoidable demand and low-value activity; and secure measurable improvements in quality, productivity and financial sustainability. The financial settlement assumes:

- Low digit % growth allocation from NHS England with most funding ringfences removed to support flexibility.
- Continued efficiency and productivity requirements consistent with NHS England expectations on a recurrent basis.
- The ICB strategy is to increase the proportion of overall funding committed to driving the shift towards prevention, early intervention and in-community care.
- Investment should not automatically be regarded as additive. Where investment is intended to release capacity, reduce avoidable demand or improve healthcare utilisation elsewhere in the pathway, the identified resources should be redeployed.
- Continued financial sustainability, consuming only our fair share of available resources with funding aligned with healthcare need.

Our medium-term planning approach is based on the expectation of continued growth in healthcare demand and complexity, alongside a strategic shift towards prevention, neighbourhood health and care delivered closer to home.

- Planning assumptions will recognise the likely impact of demographic growth, population need and increasing complexity including the need to support primary care, neighbourhood health and preventative models of care.
- Providers should not assume automatic growth in activity, capacity or funding. Providers will be expected to maximise productivity, improve healthcare utilisation and work with the ICB to reduce unwarranted variation and avoidable demand.
- Community, mental health, primary care and neighbourhood services will be expected to play an increasing role in prevention, proactive care and pathway transformation, supported by service redesign, productivity improvements and investment where justified by a robust case.

These planning assumptions are intended to provide a consistent strategic framework for service planning and resource allocation. They do not represent contractual growth commitments, funding

guarantees or uniform savings requirements. Over time, the ICB intends that investment in prevention, neighbourhood health and pathway transformation will be accompanied by reductions in avoidable demand elsewhere in the system and opportunities to release, redeploy or repurpose resources to improve outcomes, healthcare utilisation and value

Each material commissioning proposal and provider plan will identify its baseline, expected demand, required capacity, productivity opportunity and impact on outcomes, inequalities and expenditure. Plans must also set out the period over which benefits will be delivered, the dependencies and risks, the consequences for other parts of the pathway, and how released capacity or funding will be redeployed. The assumption will be reviewed through the annual planning round as allocations, national payment rules and demand forecasts are confirmed.

The ICB will set its commissioning plans within the recurrent resources available for 2027-30, including notified allocations, delegated budgets and confirmed national funding streams. Resources will be deployed across the Central East footprint according to population need, health inequalities, clinical priorities and demonstrable value, rather than perpetuating historical organisational or geographical funding patterns. Where allocations remain uncertain, plans will identify the assumptions used, the associated risks and the actions required when funding is confirmed.

9.2. Commissioning approach

Shaping sustainable provision

Financial recovery will be pursued through fundamental transformation rather than short-term cost reduction alone. We will prioritise prevention, proactive care, neighbourhood delivery, digital enablement and the movement of appropriate care closer to home. Investment, disinvestment and service redesign decisions will be evidence-led and outcome-focused, drawing on population need, inequalities, clinical effectiveness, utilisation, productivity, affordability and measurable value. The ICB will use its strategic commissioning, procurement, contracting and market-management levers to shape sustainable provision, including collaboration across providers where this improves pathway outcomes and value.

Securing delivery

Delivery will be supported by a common set of financial strategy enablers: a single version of the truth across activity, cost, workforce, quality and outcomes; strengthened population health and healthcare-utilisation intelligence; service-line and pathway-level costing; clear investment and disinvestment criteria; robust benefits tracking; aligned clinical, operational and financial leadership; strategic procurement and market management; digitally enabled productivity; and consistent contract, performance and risk-management arrangements across the Central East footprint.

Planning assumptions

For 2027-30, providers and partners should plan on the basis that:

- new investment will be exceptional and will require a clear evidence base, a quantified benefits case, recurrent affordability and an agreed source of funding with a timeline for benefits realisation. Where investment is intended to release capacity or cost elsewhere in the pathway, the associated change and resource movement must form part of the approved plan;
- service developments must demonstrate how they reduce avoidable utilisation, improve outcomes and productivity or release capacity and recurrent cost elsewhere in the pathway. Proposals must identify the dependencies, implementation costs, impact on patients and workforce, and the mechanism for reallocating resources across organisational boundaries;

- financial growth will not, by itself, be accepted as the response to demographic, activity or cost pressures;
- low-value, duplicative or ineffective activity may be reduced, redesigned or decommissioned so that resources can be redirected to higher-value care;
- primary care local incentive schemes will be reviewed to ensure they are aligned with strategic commissioning priorities, neighbourhood delivery, population need and inequalities, and that payments are linked to clear, measurable and additional outcomes rather than activity or historical arrangements alone. The review may result in schemes being redesigned, consolidated, discontinued or resources being redirected to different interventions where these offer greater impact and value;
- the Better Care Fund will be reviewed jointly with local authority partners to ensure pooled resources support prevention, admission avoidance, timely discharge, independence and sustainable community capacity. Plans will include transparent baselines, quantified benefits, clear accountability and evidence of impact across health and care pathways. Subject to statutory requirements and agreement with partners, the review may result in funding being used differently from current arrangements, including redirecting resources towards interventions that better deliver agreed outcomes and value;
- contracts will increasingly use the payment mechanism best suited to the service and intended outcome, linking funding where appropriate to activity, outcomes, quality, productivity and value, with transparent baselines, agreed risk-sharing arrangements and consistent information across the Central East footprint.
- pathway transformation, neighbourhood health and service redesign are intended to improve outcomes, access and healthcare utilisation whilst maintaining clinically and financially sustainable services. The ICB does not assume that transformation requires additional recurrent investment and will expect proposals to identify opportunities to release, redeploy or repurpose resources where appropriate.

9.3. Deconstruction exercise

Community & Mental Health Services Block

We will continue the block deconstruction work across community and mental health providers, as well as other in-scope non-acute services, to establish transparent activity, cost, workforce, quality and outcome baselines that support accountability, transformation and value. This will include agreeing the services and funding within each contract, separating priced activity from legitimate fixed or non-activity-based costs, assessing the completeness and quality of activity and cost data, and identifying where local currencies or prices are required. The work will provide a clearer basis for reviewing service models, productivity, investment and disinvestment, and for determining whether resources should remain within existing contractual arrangements or be redirected across pathways to deliver better outcomes and value.

Acute Services Block

Alongside this work, the ICB will recast the acute deconstruction exercise following the 2026/27 contracting round. The recast will use the latest agreed contract envelopes and indicative activity plans, with a detailed breakdown of the fixed element into identifiable services and values. It will distinguish genuinely fixed service costs from planned variable, blended, pass-through and marginal activity payments, and will reconcile core ICB and delegated specialised commissioning funding where relevant.

Activity valuations will be based on the applicable NHS Payment Scheme. Where no national unit price applies, the activity valuation basis will be separately agreed in line with established and agreed local prices. Historic ERF-derived values or other reconciliation methodologies will not determine the valuation basis for 2027/28 onwards. This will provide a consistent comparison between current

baseline funding and the value of planned activity at applicable national or agreed local prices. Where a material funding difference is evidenced, any movement towards a target contract value will be managed and phased, taking account of national payment rules, affordability, service sustainability, demand growth, efficiency opportunities and the need to safeguard patient care.

Local Price Review

In the acute sector, the ICB will review the use of local prices where these do not adequately reflect an agreed service model, pathway or local cost base. Local prices will be evidence-based, transparent and subject to clear governance, with defined currencies, activity and cost assumptions, quality and outcome requirements, productivity expectations and risk-sharing arrangements. They will not be used simply to preserve historical funding. The review will be aligned with the acute block deconstruction work so that fixed, variable, blended and locally priced elements are consistently identified and reconciled against activity and applicable national payment rules.

9.4. Assurance and partnership

The ICB will work openly with providers, local authorities and other partners to agree realistic and internally consistent activity, workforce, quality and financial assumptions. Delivery will be monitored through an integrated assurance cycle using common data, pathway-level metrics, clear benefit ownership and agreed tolerances. Corrective action will be taken early where plans are off track, including the review of investment, contract mechanisms, capacity assumptions and delivery milestones. This disciplined approach will enable Central East to live within its means while creating headroom for transformation and directing resources to the services and populations where they will deliver the greatest benefit.

Success will be assessed through a balanced set of measures covering population outcomes and inequalities, avoidable utilisation, pathway productivity, delivery of recurrent efficiencies, release and redeployment of capacity, contract performance, investment benefits and the underlying recurrent financial position. Measures will be agreed at the outset of each priority programme and reported through a single quality, performance and finance view.

We expect to iterate these as required, subject to further guidance on NHS England financial frameworks and business rules applicable from 2027-30 onwards.

- We will apply NHS England guidance and any appropriate pace-of-change adjustment thresholds to progress with the deconstruction of block contracts.
- We intend to pay for elective and variable activity on a cost and volume basis, subject to applicable national payment rules and agreed contractual arrangements. In line with national tariffs and best practice clinical pathways and prescribing guidance. We will also agree and manage Indicative Activity Plans (IAPs) to ensure fixed resources can be aligned with activity plans.
- Historic reconciliation methodologies, monitoring arrangements or alternative pricing approaches will not, in themselves, determine future payment arrangements from 2027/28 onwards. Future arrangements will be established through the relevant commissioning and contracting processes and in accordance with NHS England direction and the NHS Payment Scheme.
- Other ICB allocations and contract values will be reviewed on a case-by-case basis to ensure alignment of resources to patient need and to support improved health outcomes. There should be a clear expectation that non-recurrent funding that has not been attached to a specific service deliverable will be removed from 2027/28 onwards.

- ICB growth funding will not automatically be passed to providers, with demographic and activity growth expected to be met via the delivery of recurrent productivity improvements. Provider plans must first demonstrate how demographic, activity and cost pressures will be addressed through agreed recurrent productivity, pathway redesign and demand-management actions. Where additional funding is required, this will be considered against population need, system priorities, affordability, evidence of value and the impact on the wider pathway.
- Service developments and new investments will be assessed in the context of the overall system priorities in line with the 10-Year Health Plan.

Our approach will embed transparent decision-making, consistent prioritisation and clear accountability for resource allocation. This will support financial sustainability while enabling resources to move towards the services, pathways and populations where they can deliver the greatest improvement in outcomes, experience and value.

9.5. Contracting approach

Appendix D provides an overview of our contracting, activity and payment approach. The ICB intends, where appropriate, to adopt a two-year contracting approach for 2027/28 and 2028/29. This approach recognises meaningful transformation cannot be delivered within a single annual contracting cycle and that providers require a greater degree of funding and planning certainty to invest in service redesign, workforce development and new models of care. This will not apply universally and contract duration will reflect both service requirements and commissioning objectives.

The two-year approach will strengthen the link between activity, performance and funding, support a progressive move away from historic funding arrangements, and create a stronger foundation for outcome-based commissioning and collaborative delivery models as detailed in the diagram below.



The ICB will continue to strengthen the relationship between activity, performance and funding over the two-year period. Contract values will increasingly reflect evidenced activity requirements, agreed service models, healthcare utilisation trends and agreed performance trajectories. This will support a progressive move away from historic funding allocations that are not demonstrably linked to activity, outcomes or strategic priorities, whilst allowing an appropriate pace of change. Where there is national policy or direction, including development of Modern Service Frameworks and Prevalence Reviews, these will be considered as part of our overall commissioning and contracting approach.

The ICB will work with providers to use activity and coding data to understand the impact on services of demand management, developments, commissioning changes and wider transformation. This will

be essential to monitor changes in utilisation and to ensure the impact of commissioning changes are properly understood. Where the required availability and granularity of data does not exist, additional local non-identifiable datasets may be required. Providers will adopt an open book approach, and these local data requirements will be incorporated into the relevant contract schedules, with agreed formats and reporting frequencies.

What does this mean for system partners?

Providers will be held accountable for healthcare utilisation, productivity, clinical quality and outcomes, with an expectation that commissioned services consistently deliver agreed clinical standards, evidence-based best practice and quality thresholds.

Commissioning Intention	Expected impact and contribution
Clinical standards	Clinical standards will form a core component of commissioning and contracting arrangements and will be translated into Indicative Activity Plans (IAPs), quality requirements and performance trajectories. The ICB reserves the right not to fund activity that falls outside agreed clinical, coding, referral or pathway standards unless explicitly agreed through contractual governance arrangements. See Appendix C for further detail.
Indicative Activity Plans (IAPs)	Indicative Activity Plans (IAPs) will establish the agreed basis of commissioned activity, quality and utilisation assumptions. Overperformance, underperformance and material variance against agreed plans will be managed through Activity Query Notices, Activity Management Plans and contractual performance mechanisms.
Block contracts	Block contracts will not be rolled forward indefinitely and should not become the default contracting mechanism. The ICB will continue its programme of block deconstruction, applying a proportionate pace of change deconstruction adjustment in each year of the contract period, with funding progressively aligned to evidenced activity, outcomes, service requirements and demonstrable value.
Clinical coding	New coding and counting standards will be implemented across the Central East footprint to improve consistency, transparency and assurance in the recording and reporting of clinical activity, reducing unwarranted variation and strengthening confidence in performance, quality and financial information.

Over the life of the contracts, the ICB will continue to move towards value-based commissioning and contracting approaches. Whilst core services may continue to be funded through traditional mechanisms where appropriate, an increasing proportion of investment will be linked to the delivery of agreed outcomes, quality improvements and transformation objectives. This will ensure that additional investment is directed towards interventions that deliver measurable benefits for patients, communities and the wider health and care system. Specifically, the ICB will:

- Introduce a population and outcome based contractual model for dermatology services
- Incentivise delivery of agreed Neighbourhood health team objectives and outcomes, across sectors, to underpin collaboration and integration in pathway delivery.
- Fund activity on a national tariff, guide price or best practice tariff in all circumstances possible. Where no national unit price applies (tariff or guide price), local prices or alternative payment approaches must be explicitly agreed through the relevant contractual process.
- Review all local prices across CE ICB footprint for implementation from 27/28.
- Establish APAs with clinically validated conversion rates for activity (day case – elective, first appointment – follow up)

9.6. Year of care and pathway payments

The ICB will signal a move towards year-of-care or whole-pathway payment models where these can improve coordination and outcomes. Rather than applying a single model across all services, the ICB will work with willing providers to test approaches in pathways with a clearly defined cohort; reliable data; an agreed outcome set; a credible baseline; manageable financial risk; and governance capable of resolving attribution and shared accountability.

Potential test sequence:

1) DEFINE Cohort, pathway, outcomes and inequalities	2) BASELINE Activity, cost, quality, workforce, and current variation	3) TEST Blended payment with risk limits and shadow reporting	4) EVALUATE Outcomes, experience
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Further contracting reform will follow evaluation of new models and demonstrated benefits.

9.7. Managing provider sustainability

Sector	Expected impact and contribution
Primary care and community care providers (physical and Mental health services)	- The independent partner model will remain an important part of a sustainable primary care market. The ICB will seek more consistent access and outcomes through effective PCNs offering the ability to deliver expanded commissioned services. - At place level, providers may develop collaborative arrangements. Any future integrator arrangements will be developed transparently and in accordance with appropriate procurement regulations - Community services specifications will be focused on scaled models of care that support neighbourhood health delivery, focusing on frailty outcomes initially. Increasingly, commissioned services will deliver more complex proactive care to prevent long term condition deterioration and/or crisis, deliver rehabilitation and recovery services that maximise independence, work at top of scope to avoid admission to hospital beds, and work with acute providers to proactively redesign pathways to shift care out of acute settings. Care at home should become the default. - This has the potential to change the landscape of primary and community services provision Future contracting models may operate at greater scale aligned around natural geographies following appropriate procurement processes.
Acute providers	- Greater focus on specialist and complex care provision – acute provider collaboratives that enable effective working across organisational boundaries. - Specialist generalist consultant provision capable of being deployed to neighbourhood pathways to reduce the avoidable use of acute hospital services.

Mental Health Providers	• Enable greater consistency of high-quality mental health provision including an effective provision of high intensity services and inpatient care delivered via a provider collaborative or lead provider model. • Support to neighborhood provision of low to moderate mental health in partnership with integrators. Proactive and Reactive advice and guidance and shared case loading.
VCFSE	• VCFSE networks will be commissioned via integrators to strengthen sector sustainability through shared infrastructure, governance and support arrangements. • This will provide greater market stability, facilitate longer-term investment, and enable resources to be targeted effectively towards delivering population health outcomes and addressing identified community needs.
Residents	• Improved access, earlier intervention, more personalised care and better outcomes across the life course.

10. System enablers

10.1. Quality and clinical standards

The ICB will place quality at the centre of commissioning decision-making. All commissioned services will be expected to demonstrate how they improve safety, effectiveness, patient experience, health outcomes and equity of access. Commissioning priorities will be informed by population health needs, evidence, innovation and patient insight, with providers expected to operate effective quality management systems, reduce unwarranted variation, deliver continuous improvement and contribute to the wider objectives of neighbourhood health, prevention, productivity and financial sustainability.

The ICB expects providers to actively support effective pathway development, neighbourhood working, interface working, referral governance and continuous service improvement, while meeting relevant national standards and requirements for their service user as detailed in Appendix C.

10.2. Digital and data

The ICB will support equitable digital access, interoperability, shared records and use of the NHS App as a digital front door. Digital will be first where it improves access and productivity, but never the only route. Priority developments include shared care information, emerging single-patient-record capability, AI-supported triage, prevention functions, patient-entered data and analytics for population health and commissioning. Digital tools will be tested and evaluated before scaling.

10.3. Estates and capital projects

The ICB will continue to work with providers, local authorities and NHS England to support the development of major capital and estates programmes across Central East, ensuring investments are aligned to population need, future demand and the ambitions of the NHS 10-Year Plan. Capital investment will be prioritised through a population health-led framework, with a particular focus on expanding primary care capacity, delivering Neighbourhood Health and Community Mental Health Centres, supporting strategic growth areas and ensuring that new infrastructure enables more integrated, digitally enabled and preventative models of care. The ICB will continue to assess and endorse major capital schemes through its established assurance processes, ensuring proposals are affordable, sustainable and aligned to long-term service transformation objectives.

NHS Trusts will be supported by the ICB to take on responsibility for specific NHS assets from NHS Property Services from 2027 where business cases demonstrate a robust strategic case, and appropriate asset management arrangements, including for other tenants of the buildings such as primary medical care service providers.

10.4. Research, innovation and evaluation

The ICB will commission services that embed research, innovation and continuous improvement, ensuring care is evidence-based, outcomes-focused and informed by proven innovations that improve safety, effectiveness, patient experience, equity and value. Providers will be expected to demonstrate how research, quality improvement, innovation and evaluation are integrated into service delivery, supported by collaboration with academic, clinical and community partners to improve population health outcomes and reduce inequalities.

The ICB will provide a coordinated route for identifying, assessing, adopting and spreading proven innovations and transformation across Central East working with internal and external partners.

11. Planning, delivery and assurance

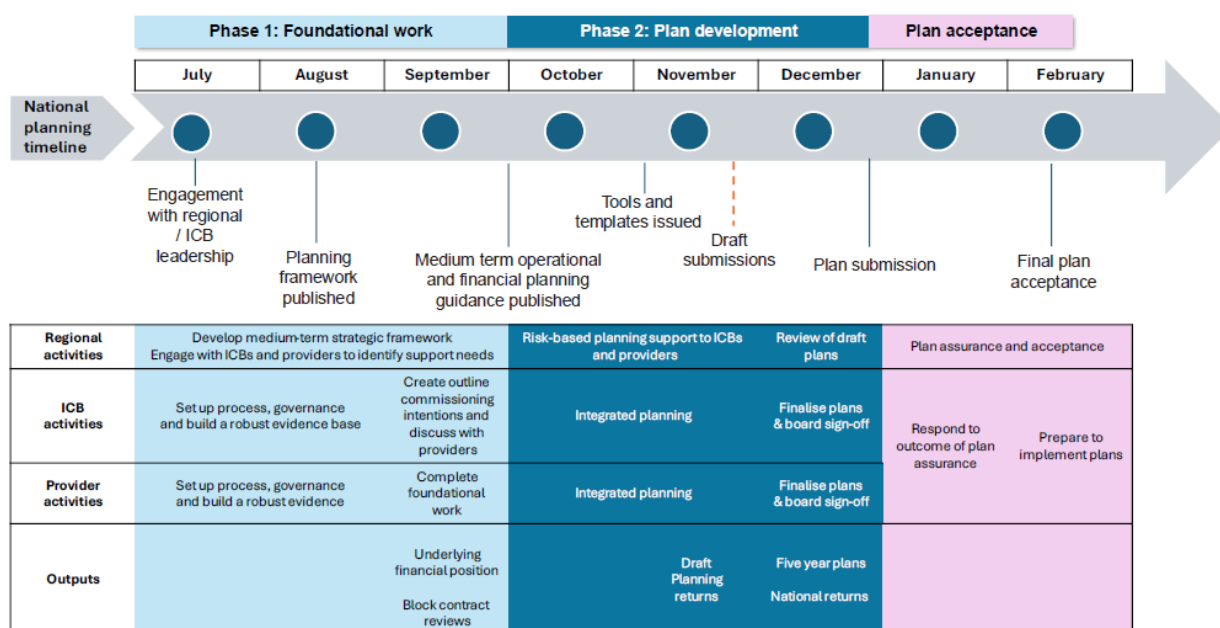
Strategic Aim: Translate strategic intent into credible, integrated and measurable delivery plans with clear accountability and early action where delivery is off track.

Our planning approach will be evidence-led, using refreshed population health intelligence, inequalities analysis, healthcare utilisation data, future demand forecasts and resident insight to identify the areas where commissioning can have the greatest impact on outcomes, experience and value.

Pending national guidance, we will work with providers and partners on the assumption that the planning process will be similar to last year as shown in the NHSE diagram below.

Planning Framework for the NHS in England

Indicative timetable for 2026/27 – across two phases



We will continue to strengthen collaboration with providers, local authorities, VCSE partners, Place partnerships and neighbourhood teams throughout the planning process to support the momentum required to deliver on our neighbourhood health ambitions, increase productivity while ensuring financial sustainability.

The ICB will coordinate its strategy development and technical planning submissions through agreed planning groups, reporting via the Management Executive Team Committee. Priority programmes will use a single quality, performance and finance view with clear tolerances, benefit ownership and escalation.

Appendix A: Population Health Insights

Insight	What the analysis shows	Implications for commissioning
Ageing population	The ageing population is expected to be the principal driver of future demand, with increasing frailty, multimorbidity and increasing utilisation of healthcare services.	Need to prioritise healthy ageing, frailty, advanced illness and proactive management of long-term conditions. Shift towards more preventative and anticipatory care.
Variation in access, experience and outcomes	Significant variation exists in health outcomes, healthcare service utilisation, deprivation and wider determinants of health across Central East.	Commission single evidence-based models of care, whilst tailoring delivery, resource allocation and intensity of the intervention to best meet the needs of the local population.
Health inequalities	Pockets of poor outcomes and disadvantage are often hidden within system-wide averages.	Target investment towards communities experiencing the poorest outcomes, applying a proportionate universalism approach.
Perinatal & Women's Health	Variation in utilisation of healthcare services with a need to improve outcomes through prevention and earlier intervention.	Strengthen women's health pathways, perinatal support and targeted interventions aimed at reducing inequalities in outcomes.
Cardiovascular, renal and metabolic diseases (CVRM)	Cardiovascular disease and its associated risk factors remain one of the largest drivers of emergency admissions.	Expand cardiovascular risk management, diabetes prevention and long-term condition management through future neighbourhood-based models of care.
Respiratory	Respiratory disease is the largest driver of emergency hospital admission bed days, with the majority being in older adults.	Integrated respiratory pathways that reduce risk of hospital admissions, and optimise evidenced-based care for those with advanced disease and frailty.
Cancer outcomes	Variation in cancer screening uptake, referral pathways, and conversion rate of urgent referrals to diagnoses across the ICB footprint.	Strengthen screening uptake and ensure more equitable access to diagnostic and treatment pathways.
Frailty	Falls and hip fractures are a major driver of emergency admissions with increasing complexity and frailty driving substantial growth in service demand over the next decade.	Develop integrated frailty pathways, advanced care planning, proactive care models and coordinated end-of-life services.
MSK	Lower back pain affects a large proportion of the population with variation across the ICB.	Consistently commissioned services to effectively manage low back pain, reducing burden of disease and mitigating escalating care needs.
Mental health	Mental health need remains a significant contributor to health inequalities and demand across the life course.	Commission earlier intervention, improved access and integrated neighbourhood-based mental health support.
End of life	The increasing numbers of people are living longer with frailty is expected to increase demand for end-of-life care services across all settings.	Systematically commission the identification and accurate coding of people in their last year of life alongside robust community palliative services and advanced care planning.

Appendix B: Neighbourhood Health Design Principles

Central East ICB's principles to design and deliver on our neighbourhood health ambitions.

1	People before organisations	We will organise care around the needs of residents and neighbourhood populations, not organisational structures, contracts or institutional boundaries. Neighbourhoods will become the primary unit through which care is planned, coordinated and delivered.
2	Prevention before crisis	We will prioritise prevention, early intervention and proactive care management, investing upstream to reduce avoidable deterioration, hospital use and dependency. Success will be measured by improved outcomes, not increased activity.
3	Start with need, not services	We will use population segmentation, risk stratification and population health intelligence to identify those who will benefit most and target interventions where they add greatest value. Frailty is our first priority cohort, but the same neighbourhood infrastructure will support future cohorts including CYP, SEND, mental health, multiple long-term conditions, end-of-life care and future priorities.
4	One person, one plan, one clinical accountability model	We will reduce duplication by creating shared care plans, trusting clinical decisions once made, and moving towards a single accountable clinical model across organisations wherever possible. Clinical leadership should simplify care, reduce repetitive assessment and decision-making, and improve continuity for residents.
5	Health and social care act as one system	We will design neighbourhood services jointly with Adult Social Care and wider partners, recognising that improved outcomes require shared ownership across health, social care, housing, employment, education, VCSE and community services. Integration with Adult Social Care is a fundamental design requirement, not an optional enhancement.
6	Neighbourhoods by default; hospitals by exception	Care should be delivered as locally as possible, digitally when appropriate, at home whenever feasible, and in hospital only when necessary. Neighbourhoods should become the default setting for most proactive, planned and coordinated care.
7	Accountability follows population	We will progressively align decision-making, responsibility and resources around defined populations, creating clear accountability for outcomes, experience, quality and value across neighbourhoods and wider systems.
8	Outcomes over activity	We will reward improvements in health, independence and experience rather than organisational activity, throughput or institutional performance. We will focus on whether people are healthier, more independent and receiving better care, not simply whether more services have been delivered.
9	One budget mindset	We will act as stewards of the total public resource available to support residents, progressively aligning clinical, operational and financial accountability around populations. Our long-term ambition is to move towards population-based funding, whole-population budgets and year-of-cost accountability that support better outcomes and prevention.
10	Earn greater freedom through delivery	Neighbourhoods and Integrators that demonstrate capability, maturity and delivery will be trusted with greater autonomy, responsibility and financial accountability. As confidence and capability grow, accountability can evolve from service delivery to population outcomes and ultimately population-resource stewardship.

Appendix C: Clinical Standards: provider interface, pathway development and referral governance

Purpose: To establish clear and consistent provider expectations that support safe, integrated and person-centred pathways, strengthen neighbourhood working and prevention, reduce avoidable variation and administrative burden, and ensure high-quality, sustainable care is delivered in the most appropriate setting across Central East.

1. Status and relationship to the NHS Standard Contract

This Schedule forms part of Schedule 2, The Services, and sets out additional provider requirements relating to pathway development, neighbourhood working, interface working, advice and guidance, referral management and assurance. It supplements, and does not replace, the obligations in the NHS Standard Contract, including co-operation, service delivery and standards, financial consequences, dispute resolution and continuing obligations.

2. ICB core expectation

- Providers shall work collaboratively with the ICB, primary care, community services, secondary care, mental health, ambulance, local government, social care, public health, VCSE partners and other relevant partners to develop, implement and continuously improve clinical and operational pathways.
- Pathways shall be clinically led, patient-centred and designed to support safe, high-quality, timely and streamlined care across organisational boundaries, including primary, community, neighbourhood, secondary, urgent and emergency care services.
- Providers shall actively support neighbourhood working and the left shift by enabling more care to be delivered at home, closer to home or in neighbourhood settings where clinically appropriate, while maintaining clear clinical accountability, safety and quality governance.
- Providers shall not introduce additional referral steps, administrative requirements, thresholds, documentation or workarounds unless these are proportionate, transparent and agreed through the relevant governance route.
- Providers shall ensure pathway changes remain within the agreed commissioned service scope, activity assumptions and financial envelope, unless prior written ICB approval has been obtained.
- Providers shall be able to evidence compliance with relevant national standards, guidance, safety alerts, regulatory expectations and professional guidance that apply to their service user cohort.

3. National context and standards providers must align to

Providers are expected to deliver services within the national policy, quality, safety, operational and reform context relevant to their commissioned services. The following requirements should be read as the minimum expected alignment, not an exhaustive list.

National requirement or source	ICB expectation of providers
NHS England 2025/26 priorities and operational planning guidance	Meet the requirements set out in the national operating planning guidance.

NHS England 2026/27 planning guidance	Meet the requirements set out once available.
NHS England: Reforming elective care for patients	Meet the requirements set out in the national elective reform plan.
NHS National UK Framework for Quality Standards	Ensure that principles and practice align with the national quality standards framework.
NHS England Urgent and emergency care plan 2025/26	Meet the requirements set out in the national Urgent and Emergency Care plan.
Getting It Right First Time	Meet GIRFT requirements pertinent to the provider service user cohort.
Relevant national bodies and professional guidance	Meet applicable requirements set by national bodies pertinent to the service user cohort, including NICE, MHRA, CQC, Royal College guidance, GPICS, GPACS, HSSIB and NPSA. Alignment should be linked to Central East ICB clinical policies and formulary.
National Patient Safety Alerts	Implement necessary changes as standard when relevant National Patient Safety Alerts are identified.
NHS England Fit for the Future: 10 Year Health Plan for England	Deliver services within the context of the national 10 Year Health Plan.
DHSC and NHS England Neighbourhood Health Framework, published 17 March 2026	Meet the latest national neighbourhood health requirements, including the expectation that health and care partners work together to create and deliver neighbourhood health services.
NHS England Neighbourhood health guidelines 2025/26	Continue to progress neighbourhood health in line with the 2025/26 guidelines, including better care at home or closer to home, integrated working and tailored local implementation.
Left shift: hospital to community and sickness to prevention	Enable clinically appropriate shifts of activity, support and resource into neighbourhood, community and preventative models of care, ensuring this is safe, governed and aligned to commissioned pathways.
NHS England interface working expectations, including the Red Tape Challenge and Primary Care Access Recovery Plan	Apply interface working expectations and bureaucracy reduction principles, including onward referrals, complete care, call and recall, and clear points of contact. Ensure alignment and progress with the primary care access recovery plan and submission of the self-assessment report at the requisite time points
Maternity 10-point plan	Rapid alignment to the plan and submission of the Standardised National template at the requisite time points.

Primary Care Access Recovery Plan reference: [NHS England Delivery plan for recovering access to primary care](#)

Latest neighbourhood health framework reference: [DHSC and NHS England Neighbourhood health framework](#)

Neighbourhood health 2025/26 guideline reference: [NHS England Neighbourhood health guidelines 2025/26](#)

4. Neighbourhood working and left shift requirements

Providers shall support delivery of neighbourhood health as a core component of pathway development and interface governance. For the purpose of this Schedule, neighbourhood working means organising services around defined local populations and enabling services to work together around the person, rather than around organisational convenience.

- Support the left shift from hospital to community by enabling clinically appropriate care closer to home, including outpatient, follow-up, proactive, reactive, urgent community and preventative models where these form part of agreed pathways.
- Support the shift from sickness to prevention by contributing to proactive care, early intervention, risk stratification, population health management and care planning for agreed priority cohorts.
- Work with ICB, local authority, social care, public health, primary care, community, mental health, acute, ambulance and VCSE partners to design and operate integrated neighbourhood pathways.
- Contribute to integrated neighbourhood team arrangements where relevant to the service user cohort, including clear roles, timely communication, shared care planning and agreed escalation routes.
- Ensure that activity shifted from hospital to community, neighbourhood or primary care settings is clinically appropriate, safely governed and supported by agreed resource, workforce, digital, data and information governance arrangements.
- Avoid transferring workload, clinical risk or administrative burden to another part of the system without explicit pathway agreement, governance approval and clarity of accountability.
- Use pathway redesign to reduce waste, duplication, avoidable hospital attendance, avoidable admission, unnecessary outpatient follow-up and fragmented patient experience, while maintaining patient choice and quality of care.
- Provide assurance to the ICB on delivery against agreed neighbourhood health objectives, pathway outcomes, quality standards, safety requirements and financial assumptions.

5. Pathway development and interface working

Providers shall support pathway development and interface working in a way that improves patient flow, reduces duplication and supports the most appropriate setting of care. This includes, where relevant:

- clear referral criteria and access thresholds;
- advice and guidance arrangements that support appropriate referral decision-making rather than referral ownership;
- triage, referral management and onward referral processes that operate on behalf of the ICB-commissioned system of care;
- discharge, step-down and transfer processes that support safe continuity of care;
- proportionate and transparent administrative requirements for referrers.
- Providers shall maintain up-to-date, clinically approved and accessible referral information on their websites and agreed referral systems. Information must enable primary care and other referrers to identify the appropriate service and make safe, clinically appropriate referrals first time. Providers must update information promptly where there is a material change to service scope, eligibility criteria, referral thresholds, pathway, capacity, access arrangements or contact details.

The ICB will work with pathology providers, primary care and cardiology services to implement a standardised laboratory-based NT-pro BNP testing pathway across Central East, replacing historic local arrangements where appropriate. The overall objective is to provide the following benefits:

- improve equitable access to heart failure diagnostics and support improved pathways including related to earlier diagnosis and treatment
- reduce unwarranted variation, enhance the patient experience
- secure improved value for money through a lower-cost diagnostic model

The pathway will incorporate standardised reporting and referral guidance to support timely access to echocardiography and specialist assessment where clinically indicated.

6. Interface principles: reducing avoidable burden

In line with national primary-secondary care interface expectations, providers shall apply the following principles:

- Onward referrals: providers should make clinically appropriate onward referrals within agreed pathways rather than requiring avoidable re-referral by primary care.
- Complete care: providers should complete the episode of care they have initiated, including necessary investigations, communication and follow-up within agreed pathways.
- Call and recall: providers should take responsibility for call and recall arrangements where these form part of the provider-led episode or commissioned pathway.
- Clear points of contact: providers should maintain clear and accessible contact routes for pathway queries, clinical advice, operational issue resolution and escalation.

7. Professional Standards

In line with NHS England, providers shall;

- Maintain effective clinical, professional, workforce and patient-safety governance arrangements appropriate to the Services and service-user cohort. The Provider shall comply with applicable legislation, regulatory requirements, national standards, NHS guidance, professional standards and safety alerts, and shall provide assurance to the ICB on request.
- Ensure that all registered professionals hold current and appropriate registration, licensing and indemnity, comply with the standards of their relevant professional regulator, and are subject to appropriate arrangements for appraisal, revalidation, supervision and continuing professional development. Staff must work within their competence and scope of practice, complete mandatory training and maintain the skills required to deliver safe, effective and person-centered care.
- Maintain systems to identify, manage and escalate clinical and organisational risks; learn from incidents, complaints, feedback and audit; and implement resulting quality-improvement actions. Assurance shall include, but not be limited to, infection prevention and control, safeguarding, medicines management, workforce competence, professional registration, appraisal and revalidation, patient safety and quality improvement. The Provider shall promptly notify the ICB of any material concern affecting the safety, quality or delivery of the Services.

8. Assurance, evidence and governance

Providers shall maintain evidence that demonstrates delivery against applicable national guidance, quality standards, safety alerts, professional guidance and agreed pathway requirements. The ICB may request assurance through appropriate contract, quality, performance, neighbourhood, place-based or pathway governance routes.

Where a relevant National Patient Safety Alert, regulatory requirement, professional standard or national guidance update applies to a provider service user cohort, the provider shall implement the necessary change as standard and provide assurance where requested.

Providers shall have a Board and Commissioner-approved Patient Safety Incident Response Policy and Plan, aligned with national requirements and proportionate to the size and complexity of the organisation, which is published on the organisation's website. Providers shall report patient safety incidents and risks through the Learning from Patient Safety Events (LFPSE) system and to the ICB as required, and share relevant patient safety intelligence, learning response outputs, emerging risks and learning with the ICB to support oversight and system-wide improvement. Providers shall demonstrate how learning from patient safety incidents and risks is translated into improvement activity, with evidence of how the impact and effectiveness of those improvements are monitored and evaluated.

All clinical risks identified related to their service user cohort should be entered into their departmental and/or organizational risk register and when escalated to the region should also be escalated to the ICB.

Lessons learnt from regional or national specialist clinical networks or incidents to be embedded into practice with assurance oversight by the ICB.

9. Financial envelope and commissioning control

Providers shall ensure pathway development, neighbourhood working and implementation of the left shift remain within the agreed financial envelope, commissioned service scope and activity assumptions. Providers shall not implement material pathway changes that may reasonably affect activity volumes, service scope, referral thresholds, capacity, workforce, clinical risk or financial risk without prior written ICB approval.

Nothing in this Schedule transfers commissioning authority to the provider.

10. Resolving operational issues and escalation

Providers shall work with other providers and system partners to resolve operational challenges, pathway disagreements, neighbourhood delivery issues and interface issues in the first instance through agreed clinical and operational governance arrangements.

Escalation to the ICB shall occur where a commissioning gap is identified, there is a material financial, contractual, quality, safety or capacity impact, or resolution requires an ICB commissioning or policy decision.

11. Non-exclusivity and continuing obligations

- Nothing in this Schedule guarantees referral volumes or creates exclusivity of patient cohorts.
- Nothing in this Schedule limits the ICB's right to commission alternative or additional providers.
- The obligations in this Schedule continue to apply for as long as necessary to give effect to commissioned pathways and neighbourhood working arrangements, notwithstanding expiry or termination of the Agreement.

12. Medicines Utilisation

Central East ICB expects all commissioned providers to demonstrate safe, evidence-based and best-value use of medicines.

During 2027/28, the ICB's intention is to prioritise

- High-risk medicine monitoring
- Medication review for high-risk and frail patients
- Reduction of harmful oversupply and waste
- Reliable implementation of medicines-safety alerts
- Coordinated management of shortages
- Effective use of the NHS Discharge Medicines Service
- Clinically appropriate adoption of best-value biological medicines
- Achievement of national antimicrobial resistance objectives
- Environmentally sustainable prescribing
- Evidence-based prescribing and formulary adherence
- Maximise the use of the NHS electronic prescription service to support safe, efficient and patient centered transfers of care, reducing delayed access to medicines.

Where these requirements are already included in legislation, professional standards or existing contracts, the ICB will use assurance, improvement support and contractual performance management.

Additional investment will be reserved for clearly evidenced service gaps, additional capacity or outcomes beyond the existing baseline.

13. Infection Prevention, Antimicrobial Stewardship and Health Protection Priorities

Central East ICB expects all commissioned providers to adopt a population health and prevention-focused approach to reducing avoidable infection, antimicrobial resistance and healthcare-associated harm while supporting effective use of healthcare resources.

During 2027/28, the ICB intention will prioritise:

- Winter (seasonal) virus screening, swabbing and results-to-treatment pathways for eligible patient cohorts.
- Safe management of uncomplicated urinary tract infections and reduction of unnecessary antibiotic use.
- Reduction of *Clostridioides difficile* infection risk through antimicrobial stewardship and appropriate prescribing.
- MRSA screening and decolonisation pathways for eligible high-risk patient groups.
- Continence promotion, catheter avoidance and reduction of catheter-associated harm.
- Early recognition, investigation and referral of suspected tuberculosis.
- Delivery of infection prevention, antimicrobial stewardship and health protection interventions that support prevention, early intervention and reduction of health inequalities.

This approach will support improved patient outcomes, reduction in avoidable infections, enhanced antimicrobial stewardship, reduced healthcare-associated harm and more effective utilisation of healthcare resources across Central East.

Where these priorities are already included within legislation, professional standards, national guidance or existing contractual requirements, the ICB will utilise assurance, improvement support and contractual performance management arrangements to monitor delivery.

Appendix D: Contracting, activity and payment approach

The ICB intends to implement several payment and activity planning changes as outlined below. These are in addition to any national expectations set out in planning guidance yet to be received.

1.1 Local Price Review

The ICB will review all local prices to confirm that they are evidence-based, transparent and aligned with the agreed service model, pathway, activity definition and payment approach. Providers will be expected to supply sufficient cost, activity and outcome evidence to support each locally agreed price. Where a local variation cannot be evidenced or is no longer justified, the ICB will seek to amend or remove it.

1.2 Block Deconstruction

The ICB will continue the work on deconstruction of community and mental health blocks and will recast the acute block deconstruction following the 2026/27 contracting round. The ICB will remove the maximum 2.5% of the total contract value from the block for all acute providers overfunded.

1.3 Activity

Indicative activity plans will form the basis for activity planning and variance management.

- IAPs will be developed for all providers (fixed and variable services)
- IAPs will be expected to be delivered to planned levels
- Growth assumptions will be calculated based on trend analysis of activity and likely population growth demand and adjusted for changes in case mix, tariffs and material commissioning changes which may impact on demand and patient flows (see section 2 for the expected commissioning changes)
- Activity and cost growth should not be assumed by any provider
- Overperformance or underperformance will be managed through Activity Query Notices and Activity Management Plans and quarterly reconciliation
- The ICB will apply a robust monthly claims and challenge process
- The ICB will not pay for activity not reported through mandated datasets
- The ICB will apply Evidence Based interventions (EBI) and will not pay for activity outside of this
- The ICB will enhance Prior Approval policies and audit compliance
- The ICB will audit and apply Individual Funding Request (IFR) processes
- The ICB will implement referral management models to manage demand and support shift of care provision into the most appropriate setting

1.4 Information, Coding & Counting Requirements

The ICB will implement CE-wide coding and counting standards. This will also be issued directly to providers via appropriate contracting routes.

1.5 Payments

- Local price reviews will take place through Q3 26/27, with implementation thereafter by Q2 27/28 at latest
- The ICB will apply the NHS Payment Scheme hierarchy to all activity, with national tariff and guide prices, with local prices only applied in instances where these do not exist
- The ICB will pay only the national guide price for SDEC activity
- The ICB will pay only the national guide price for ADHD and ASD activity
- The ICB will apply maternity tariff changes
- Advice and guidance and Patient not Present will be paid on a variable elective basis from 27/28
- The ICB will apply all other NHS Payment Scheme rules as published in national planning guidance
- The ICB will test year-of-care models in selected cohorts during 2027/28, with shadow reporting and implementation from 2028/29. Providers should expect early modelling discussions in December.

1.6 Utilisation Management

The ICB will put in place Activity Planning Assumptions (APA) for the following areas. To enable improvement in productivity at an individual provider level and quality by increasingly managing patients in the best possible location there will be a series of trust-level APAs. Targets in year one is set as a minimum of national median performance, with year two expectations that top quartile is achieved. Finalised activity assumptions will be incorporated into provider indicative activity plans issued in November.

Indicators	27/28	28/29
Day case and outpatient procedure as % of total	83.5%	85.0%
Planned day case conversion into inpatients	<7.0%	<6.5%
Patient initiated follow up utilisation (total)	>5%	>7%
Ambulatory sensitive conditions potentially avoidable admissions as % of total admissions	<23%	<20%
Percentage of all specialist advice requests responded to within 0-2 days	70%	85%
Utilisation rate Advice and guidance 'pre referral' specialist advice	11	15
Advice and guidance diversion rate	45%	50%

The areas below will also be subject to APAs, following further work with providers to validate appropriate baselines for improvement.

Clinically appropriate SDEC utilisation – direct admission
Clinically appropriate NEL conversion rate
Discharge ready date reporting adherence
Percentage of patients discharged within <24 hours of DRD on Pathway zero

1.7 Alignment with GIRFT & best practice

GIRFT - The ICB will only fund activity in line with the GIRFT outpatient follow up protocols. Specifically, this includes the following specialties: **ENT, Gastroenterology, Gynaecology, Ophthalmology, Spinal Surgery and Trauma and Orthopaedics**

Best Practice Timed Diagnostic Cancer Pathways - The ICB will only fund activity in line with the GIRFT Pathways, specifically: Breast, Colorectal, Gynaecology, Lung, Head and Neck, Prostate, Skin, Oesophago-gastric.

The ICB expects to commission best practice pathways and will work with providers on an ongoing basis to improve quality of care provision for our residents. The ICB will apply adjustments in line with national best practice guidance in developing indicative activity plans at provider level.

1.8 Quality, safety and performance

Alongside the ICBs total quality management approach, providers need to ensure that plans reflect national commitments for quality, safety, and performance, specifically:

- Deliver within the context of the national 10 Year Health Plan: NHS England Fit for the Future: 10 Year Health Plan for England
- Meet the requirements set out in the national operating planning guidance
- Meet the requirements set out in NHS England Reforming elective care for patients
- Meet the requirements set out in NHS England Urgent and emergency care plan and NHSE The Model Emergency Department: high performing urgent & emergency care pathways
- Deliver within the context of the national neighbourhood health plan: NHS England Neighbourhood health guidelines.
- Implement any actions required in accordance with National Patient Safety Alerts, or other medication related safety monitoring aligned to the services which the provider undertakes.
- Align to the requirements in the National Quality Board Quality Strategy.