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Strategic commissioning framework

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Content

Foreword

The Model ICB Blueprint establishes a shared vision for integrated care boards (ICBs) by setting out the direction of travel for their role and functions. Strategic commissioning will be the central purpose of the ICBs of the future.

The 10 Year Health Plan (https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future) promised a new commissioning framework for ICBs to turn this ambition into reality.

Strategic commissioning is a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare. ICBs, as strategic commissioners, are accountable for creating the best value for the public from their NHS budget. They do so by considering how this should be spent within their population to secure high quality accessible

healthcare, now and in the future, and ensure that the health services they plan and commission uphold the rights and values outlined in the NHS Constitution for patients, the public and staff. ICBs will work alongside government, including local government, to address the wider determinants of health, such as employment, in line with the government's health mission and the 4th purpose of ICBs to support wider socioeconomic development.

Our ambition for the future of strategic commissioning is that:

- ICBs will continue to work in partnership. They will use their ability to bring together providers, local government and other stakeholders to best improve healthcare and the health and wellbeing of their local population, prioritising the achievement of system goals within total available resource.
- ICBs will work with public health and local stakeholders to assess the needs of local populations. They will use healthcare intelligence, and a clear understanding from people with lived experience, to create a strong evidence base for commissioning decisions.
- ICBs will take a biological, psychological and social view of population health. This will include assessing the impact that poor health has on children and young people's life chances and population employment outcomes as well as using strategic commissioning to integrate work, health and skills where appropriate.
- ICBs will develop a clear, evidenced-based methodology for determining priorities and the commissioning and decommissioning of services to meet these priorities.
- ICBs will be transparent in making decisions and sharing the evidence on which they are based. They will use high quality data, analysis and dialogue and a sound understanding of what or who is driving cost in a system and of any variations in productivity between providers.
- ICBs will commission across pathways of care and increasingly focus on population-based care. They will be guided by population segmentation and risk stratification, to ensure commissioning models take a person centric approach to address the drivers of risk and have a sharp focus on equity in access, experience and outcomes.
- ICBs will strengthen their understanding of and ability to carry out their payor functions (Note 1). In particular, they will be capable of driving efficiency and performance through cost, market and contractual management; translating payment reform nationally; and driving change locally to ensure incentives align to local need.

- ICBs will continue to fulfil their quality duties as part of strategic commissioning. They will assess procurements from a quality perspective, monitoring quality as part of contracts, using contractual levers to drive quality improvement, and proactively managing risks in accordance with the National Quality Board guidance. Within this, ICBs are responsible for both the care they directly commission for their population and the services the NHS commissions within their catchment area.
- ICBs will strengthen their understanding of the role of technology and data in how and what they commission. This includes leveraging service user and staff apps and digital health technologies, including AI, to drive prevention, integrate care provision across pathways and ease management of workforce within and across organisations.
- ICBs will continue to use their role as social and economic anchor institutions within their local communities to influence the wider determinants of health and promote social value in line with Cabinet Office guidelines on procurement (https://www.gov.uk/government/publications/ppn-002-taking-account-of-social-value-in-the-award-of-contracts/ppn-002-guide-to-using-the-social-value-model-html).
- ICBs will continue to develop a clear set of skills and capabilities to carry out strategic commissioning. They will focus on identifying, developing and deploying their diverse workforce and growing the data, analytical and transformation capabilities required to drive change.
- ICBs will support providers to develop their commissioning and integrator capabilities as some look to take on new roles as multi-neighbourhood providers and integrated health organisations (IHOs).
- ICBs, NHS regions and their partners will share an understanding of the appropriate scale of commissioning for specific services and population groups (see section 5).

This strategic commissioning framework supports all ICBs to meet our ambition for the future of strategic commissioning. We expect all ICBs to begin to adopt the strategic commissioning approach outlined in the framework as part of the NHS planning process for the financial year 2026/27. A strategic commissioning development programme will be in place from April 2026 to support ICBs and others who commission NHS services to develop as strategic commissioners. As part of this we expect ICBs to carry out a baseline assessment against this framework in March 2026 to inform the development support they need. We plan to incorporate elements of the framework in the assessment of each ICB as a strategic commissioner that NHS England is required to undertake from 2026/27.

Glen Burley, Financial Reset Director and Accountability Director, NHS England

1. Introduction: the future of commissioning

The Model ICB Blueprint marked the first step in a programme of work to reshape the purpose, role and functions of integrated care boards (ICBs), laying the foundations for delivery of the 10 Year Health Plan and following the announcement of a significant reduction in the operating costs for ICBs from 2026/27. This has led to the significant changes underway that redesign their operating model and structures, including consolidation of their number from the current 42 to an expected 26.

This strategic commissioning framework supports ICBs in commissioning NHS services as well as others with this function – regional NHS teams currently and in future some providers, to understand what strategic commissioning means in practice. It updates the commissioning cycle and sets out the important enablers to support effective commissioning. We use the term 'strategic commissioning' to describe the updated approach to commissioning presented in this framework.

The framework covers all NHS commissioned services, including (but not limited to) the following for all ages: prevention (for example, vaccinations and secondary preventative interventions to address modifiable risk factors), primary care, health and justice, community care, chronic disease management, elective care, urgent and emergency care, specialised services, end of life care, mental health, learning disabilities and autism, and maternity and neonatal care. The framework also describes the crucial and growing role of providers in strategic commissioning; the importance of strong relationships with local government in carrying out strategic commissioning; and the importance of having a multidisciplinary clinical, professional and people and communities' voice at the centre of strategic commissioning.

In this framework, the term 'providers' means anyone commissioned to provide a service for the commissioner (such as voluntary, community and social enterprise (VCSE) organisations, primary care including general practice, community and neighbourhood health care, secondary care and independent sector providers). 'Local government' means all types of statutory local government organisations.

Under the NHS Act 2006 (as amended), the core statutory duty of each ICB is to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population. This framework

presents a strategic commissioning approach for ICBs and their partners, ensuring there is a common understanding of how shared system duties, strategies and plans contribute to the delivery of successful commissioning.

This framework has been developed through engagement with a variety of NHS leaders across ICBs, providers and national organisations, including the NHS Confederation, NHS Providers, Local Government Association and the County Council Network. Engagement will continue with partners to support the development of a strategic commissioning development programme, which will be launched in April 2026. This will offer ICBs the support tools they require to deliver strategic commissioning for their population.

2. What is strategic commissioning?

Strategic commissioning is a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare. ICBs, as strategic commissioners, are accountable for creating the best value for the public from their NHS budget. They do so by considering how this should be spent within their population to secure high quality accessible healthcare now and in the future and ensure that the health services they plan and commission uphold the rights and values outlined in the NHS Constitution for patients, the public and staff. ICBs will work alongside government, including local government, to address the wider determinants of health, such as employment, in line with the government's health mission and the 4th purpose of ICBs to support wider socioeconomic development.

Strategic commissioning is key to enabling the NHS to secure improvements in access, care, quality and greater value for money (Note 2) by delivering the 10 Year Health Plan's 3 strategic shifts for the NHS – from sickness to prevention, hospital to community and analogue to digital – and thereby improve both allocative efficiency (identifying and directing the money to the most clinically appropriate and cost-effective mix of activities, including flow between them) and technical efficiency (enabling providers to undertake the activities more efficiently).

2.1 The 4 stages of strategic commissioning

Strategic commissioning comprises 4 stages:

1. **Understanding the context** – ICBs will use joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.
2. **Developing long-term population health strategy** – ICBs will focus on long-term population health strategy and planning and care pathway redesign. They will use national modern service frameworks and guidance to create the evidence base for new integrated models of neighbourhood care that maximise value, guiding the development of population health improvement plans.
3. **Delivering through payor function and resource allocation** – ICBs will understand and allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services to deliver the outcomes set out in the ICB strategy and population health improvement plan.
4. **Evaluating impact** – ICBs will rigorously evaluate the outcomes from commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence.

Section 3 describes each of these stages in more detail.

ICBs, to varying degrees of success, have been carrying out the 4 stages of strategic commissioning but now is the time for a more comprehensive and consistent approach across all ICBs. This requires commissioners to be bold and rearrange and, potentially, decommission services to secure the best possible health outcomes, quality of services and value for the taxpayer, while ensuring they continue to reduce healthcare inequalities.

2.2 Enablers for successful strategic commissioning

To be successful in their role as strategic commissioners, ICBs will need:

- capability in strategic leadership and partnership working with other commissioners, providers, local government and service users to co-design services and improve population outcomes

- effective and broad multidisciplinary clinical and professional leadership embedded in how they work to drive cross-organisation improvements
- access to high quality data analysis, sustained and meaningful engagement with people and expertise to inform decision-making and target interventions. This will include having a greater understanding of how to identify geographical and demographic inequalities and what is working well locally and elsewhere, and greater use of technology in the solutions commissioned
- an ability to involve people and diverse communities and understand their experiences through asset-based approaches that facilitate co-production and empower community-driven solutions
- strong relationships with their local government partners (including adult social care, children's services, housing and public health) within their footprint; to build a shared understanding of their population and work together to improve outcomes, tackle inequalities and develop neighbourhood health
- an ability to use market management, contract management and procurement mechanisms to support a focus on quality, value for money and delivery of improved outcomes
- to develop a shared understanding with providers of current and future delivery costs, ensuring each investment improves access, care quality, efficiency and outcomes
- to develop the skills and capability of the workforce and effectively deploy it across the whole health and care system, to deliver effective strategic commissioning

Each of these enablers is explored in more detail in section 4.

3. Reimagining our strategic commissioning approach

The strategic commissioning approach described below sets out the 4 stages ICBs are required to work through to deliver effective strategic commissioning of NHS services wherever and from whomever they are commissioned.

Engagement and co-design with local government is critical for ICBs in strategic commissioning of appropriate, effective (evidence-based) and equitable health services; particularly with local government directors of adult social care, directors of children's services and directors of public health and their teams who have a statutory role in supporting ICBs and their strategic commissioning through public health advice.

Ongoing partnership between ICBs and providers of services is also vital in making strategic commissioning a reality. This is expanded on in section 5.3.

3.1 Understanding the context

ICBs will use joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.

An integrated needs assessment sets out a detailed understanding of the population served (current and future) and should be produced by March 2026, shared with providers and other partners and updated annually across the ICB geography (Note 3). This should be informed by:

- a fully linked and costed person-level data set across ICB partners that pools insight into local need and risk factors and allows for modelling of demand and cost at a person and population group level for now and predicted. This should be underpinned by the necessary data sharing agreements across partners and information governance to allow for re-identification of at-risk cohorts within clinical settings. This also includes establishing the data sharing agreements to support integration into the local NHS Federated Data Platform (NHS FDP)
- in-depth understanding of the population's drivers of risk and demand across biological, psychological and social factors and including health deterioration and inequalities in access to health and care
- leveraging real-time data and predictive modelling to understand projected use and the real cost of health and care services, identify unwarranted variation (including across different communities) and risk in different parts of the system and potential mitigations, and support resource allocation to where it will have the greatest impact (allocative efficiency)
- a segmentation of the population and stratification of health risks, including by disaggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity, as well as focusing resources on the most efficient interventions
- an understanding of the comparative demand for, cost and performance of the services commissioned for the population served against the national position and peers using a range of the tools on offer (see section 3.3 for details)

- an opportunity analysis to identify the care models, interventions and innovations likely to have the biggest impact on health outcomes, experience and mitigatable demand

We would expect an integrated needs assessment to be in place in each ICB by March 2026 and updated annually thereafter.

It should be possible to break down the integrated needs assessment by the agreed local places (typically at a health and wellbeing board level) and neighbourhoods that make up the ICB geography. In addition, ICBs should seek to gain an understanding of population projections, future local housing and local government-led growth plans and their potential impact on demand for healthcare services.

In line with the Core20PLUS5 approach and considering health inequalities more broadly, strategic commissioners should also ensure they understand how different population groups (such as ethnic minority communities and inclusion health groups) access services and experience care and how their outcomes vary, and consequently how any gaps will be narrowed through the ICB strategy and population health improvement plan.

Each ICB should be actively developing an intelligence function and have this in place by March 2027. This function should bring together the skills and expertise to support strategic planning (activity, finance, workforce, quality) and population health management. It will support the actions set out above and develop actionable insight, including for place and neighbourhood teams, to set priorities, co-ordinate care and support case finding across multidisciplinary clinical and professional teams. There are a variety of ways in which such a function could be provided, such as integrating with local public health teams to develop an integrated health and local government function. Examples of ICB intelligence functions can be found in the Population Health Academy (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fpopulationhealth%3Fsm%5Fnewemail%3D) (on the FutureNHS collaboration platform; login required).

Each ICB will need to have a comprehensive understanding of the lived experience of those receiving health and care support and achieve this by using an ICB-agreed and adequately resourced co-production methodology that actively involves people and communities (see Care Quality Commission's Framework for engaging with people and communities to address health inequalities (2025) (https://www.cqc.org.uk/local-systems/integrated-care-systems/framework-engaging-people-and-communities)). It is for each ICB to determine the way this is undertaken, including whether it will be done within the ICB or via a third party. Each

ICB should have its methodology in place by March 2027. Engagement of staff from across the ICB and commissioned services should also be prioritised to drive effective planning. Each ICB will need to combine quantitative and qualitative insights to inform its integrated needs assessment.

Each ICB will carry out an annual baseline mapping exercise to risk assess the healthcare services it commissions. The baseline map should include activity, costs, demand, capacity and access (including waiting times and waiting lists), pulling on existing data flows and taking account of any recent inspections or other reviews. ICBs should then use the map to prioritise those healthcare services that should be reviewed to assess the quality, performance and productivity of existing provision. Reviews will include assessing current performance (quality, workforce, operational and productivity), feedback received from people using services and staff relevant to the service in question, and the degree of service integration where appropriate. Further information is provided in section 3.4.

The reviews will be conducted in partnership with commissioned providers and their staff, local government, the VCSE sector (where appropriate) and those with lived experience alongside regional NHS teams as appropriate. ICBs will use them to understand how services perform on patient experience, outcomes, productivity and national standards and priorities. Taken with the integrated needs assessment, ICBs will be able to analyse the gap between current provision and desired future provision.

3.2 Developing long-term population health strategy

ICBs will focus on long-term population health strategy and planning and care pathway redesign. They will use national modern service frameworks and guidance to create the evidence base for new integrated models of neighbourhood care that maximise value, guiding the development of population health improvement plans.

The NHS Planning Framework (https://www.england.nhs.uk/long-read/planning-framework-for-the-nhs-in-england/) sets out a shared view of what effective medium-term planning looks like – the core principles and key planning activities that organisations should undertake. Planning should be a shared endeavour that crosses organisational boundaries to ensure a coherent and co-ordinated approach that delivers on jointly agreed priorities.

ICBs, acting as strategic commissioners, will set an overall 5-year strategy by January 2026. This will be reviewed and updated annually and as such will ensure they have a strong strategy function, including staff with good problem-solving and

analytical skills. The overall strategy should describe the ICB's vision for improving health and healthcare, including access to high quality care, and addressing health inequalities by improving experience, safety and outcomes across the life course.

To set the strategy, each ICB will use a clear structure that should start by setting out the case for change using the integrated needs assessment, the baseline mapping exercise of current performance and quality of care and the service reviews, as set out in section 3.1. The strategy should build on the existing integrated care system (ICS) strategy led by the integrated care partnership (ICP) and health and wellbeing board strategies within the ICB geography and be anchored to the 3 strategic shifts in the 10 Year Health Plan. The strategy should clearly define a manageable number of outcomes and any supporting sub-outcomes, outputs and the actions, alongside the key performance indicators (KPIs).

Each ICB will then set out and use a clear and transparent approach to prioritise current and potential commissioning intentions. This should create an evidence-led, manageable number of priorities for inclusion in its 5-year population health improvement plan for its footprint, to support the delivery of the strategy and the requirement of each ICB to have a joint forward plan. Each ICB should involve local stakeholders to determine the approach it uses to develop its plan and further consider the integrated needs assessment, for the baseline mapping exercise of current performance and quality of care and for the service reviews set out in section 3.1.

To clearly set out the commissioning intentions for the ICB over the next 5 years, the population health improvement plan should take account of the neighbourhood health plans produced by health and wellbeing boards within the ICB geography, the 3 strategic shifts in the 10 Year Health Plan and the national planning commitments, including national access and quality standards.

ICBs will determine the number of commissioning intentions to include, ensuring each is achievable within the 5-year lifespan of the plan. For each agreed commissioning intention, the plan will include:

- defined outcomes and metrics
- clear milestones and delivery timescales
- delivery scale (for example, neighbourhood, place, ICB, pan-ICB – potentially one or more levels)
- governance arrangements

The plan should also set out, as appropriate, where the ICB intends to commission jointly with local government or delegate commissioning to another provider(s) and identify where system or service reconfiguration may be required to deliver the agreed priorities (including potential decommissioning options). Where system or service reconfiguration or service changes are proposed, ICBs will need to follow relevant consultation requirements and conduct quality impact assessments or equality and health inequalities impact assessments.

Population health improvement plans should be in place by January 2026 and will be reviewed and updated annually, taking account of the Medium Term Planning Framework and changes to local priorities as appropriate. Plans should be approved by the ICB board and shared with NHS England regional teams. In determining how to take plans forward, ICBs should consider their wider engagement plan and capability to deliver the plan.

Building on the population health improvement plan, ICBs will develop and commission best practice care models and care pathways with partners, people and communities, and in this include consideration of where innovation has the greatest potential to support impact. ICBs will use modern service frameworks and guidance, working closely with local clinical and professional leaders as well as regional and national clinical networks to develop these with consideration of best practice and evidence from a range of sources. Building on the Model Health System and RightCare, ICBs will be provided with national benchmarking information – how much they are spending and the clinical outcomes they are achieving compared to their peers; this can signal potential productivity improvements. See section 4.3 for details.

Throughout the development of their strategy, population health improvement plan and care models and pathways, ICBs should continue to involve residents, communities, staff and stakeholders in a meaningful and sustained way.

3.3 Delivering through payor function and resource allocation

ICBs will allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services to deliver the outcomes set out in the ICB strategy and population health improvement plan.

Delivery of each ICB’s strategic outcomes will be supported through allocating resources, informed by local data and intelligence and the priorities agreed in its population health strategy and set out in its population health improvement plan.

This will involve changes to services currently commissioned by the ICB, including potentially ceasing certain services or provision, changing existing services significantly or adding new services. ICBs will prioritise aligning funding to needs using data-driven models and defining outcome-linked service specifications. In allocating funding, ICBs will be expected to balance achieving national priorities with locally agreed outcomes and priorities. ICBs should also consider how to eliminate waste (such as by adopting preventative approaches and minimising the risk of duplication) and deliver economies of scale through maximising value for money to achieve improvements in outcomes.

In contracting and procurement, each ICB should consider the best approaches to achieve its priorities, including consideration of the following:

- the appropriate scale at which a service is commissioned – for example, multi-ICB, system, place and neighbourhood (including joint commissioning with local government)
- focusing on commissioning for improved quality, defined as improved experience, safety and outcomes as well as equity of access based on population groups and agreed priorities, as opposed to prescriptive operational design, which providers should lead on. This should include horizon scanning to understand new developments and innovations that may help deliver agreed priorities
- understanding and using the options and flexibilities set out through the Provider Selection Regime (PSR) alongside exploration of joint procurements with local government, where appropriate, to determine who is best placed to provide services
- ensuring that the overall configuration of services commissioned allows access, quality and financial sustainability standards to be met across the whole system, addressing local constraints including estates/capital and workforce. The ICB should be clear where providers are ready to lead this change and where it must still provide the leadership – in either case senior clinicians are expected to work with people and communities to shape and explain to the public those changes necessary to meet standards
- exploring different contractual forms including lead provider or commissioning potentially delegated to providers to further develop and deliver agreed priorities (see section 5.3 for details)
- understanding the levels of service set out in national contracts and taking steps to ensure these are consistently in place and are performing effectively across the ICB area, such as for primary care

- understanding current and future costs of commissioned services and considering different financial and risk share models to incentivise partnership working across VCSE, primary, community, secondary and social care to deliver the agreed priorities (see the NHS social value playbook (https://www.england.nhs.uk/publication/nhs-social-value-playbook/))
- understanding of optimal workforce deployment in the commissioning of services, including exploration of innovative ways of working to maximise value and efficiency across the system
- committing to market shaping and management working, including with local government where appropriate such as through the Care Act 2014 responsibilities. This includes understanding organisational stability and sustainability, particularly for fragile or vulnerable services, and the different costs and outcomes for a range of providers and introducing and encouraging new providers where gaps exist in the market. This includes online market entrants where appropriate

Strategic commissioners must increasingly look beyond traditional healthcare providers, recognising the value community assets can bring to improving health and wellbeing and reducing healthcare inequalities in line with the move towards a neighbourhood health service. To sustain this shift, investment should follow prevention opportunities to focus resources on interventions that deliver long-term health benefits, reduce cost and alleviate pressure on the wider health and care system; with accompanying longer-term outcome measures detailed in the ICB strategy and population health improvement plan.

Where a movement of resource is required, a clear prioritisation methodology should be developed and used. All partners should be given full transparency on resource movement and for what purpose and a provider impact analysis should be undertaken. Transition of funding may need to be over several years. Systems should consider where medium-term financial planning can support the investment decision-making process.

Strategic commissioners should explore a range of payment and risk share mechanisms, including designing incentives to improve quality, equity, efficiency and productivity; implementing risk mitigation strategies; using financial stewardship tools; and deploying payment models to improve equity.

For oversight and assurance, each ICB should undertake an ongoing, risk-based assessment of the contract(s) it holds, taking account of safety, quality, finance and operational performance, and tailor contractual monitoring and intervention accordingly (in partnership with stakeholders where appropriate). This includes risk-

based approaches to national primary care contracts to ensure effective delivery of high-quality services. The stratification should result in clear points of escalation to ensure issues are actively managed.

Section 4.4 provides further detail on how ICBs should continue to develop as an intelligent healthcare payor.

3.4 Evaluating impact

ICBs will rigorously evaluate the outcomes from commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence.

To do so, ICBs will need to monitor and evaluate the performance (quality, operational or financial) of the services they commission, including by:

- understanding gaps or challenges in the achievement of agreed priorities or within individual commissioned services (such as those in the national planning priorities: for example, urgent and emergency care and elective care)
- learning from and adapting services (including decommissioning and scaling successful innovations where appropriate)
- ensuring quantitative metrics are triangulated with qualitative data, professional insight and regulatory intelligence to fulfil this function effectively (such as complaints, 'You and Your General Practice', Freedom to Speak Up, Patient Safety Incident Response Framework and safety incident data)

To support evaluation, each ICB will set an evaluation approach by March 2027, supported by its intelligence function and working with other partners as appropriate. The approach must encompass both quantitative and qualitative data, including feedback from staff (ICB, provider and other partners), communities and people using services. Findings will contribute not only to the ICB's understanding of the effectiveness of interventions within a local setting but also, through peer learning, the evidence base available to all ICBs. From this ICBs will learn, adapt and grow as confident commissioning organisations.

As not all initiatives and KPIs will improve over the same time period, ICBs should consider monitoring and evaluating over 3 timeframes – KPIs and leading indicators monitored weekly or monthly; KPIs and outputs monitored quarterly; and longer-term outcomes assessed annually even though they may take longer to deliver in line with the ICB strategy and population health improvement plan.

ICBs will ensure they have processes in place to monitor priority metrics in their population health improvement plans, identifying unwarranted variation including inequalities and developing feedback mechanisms to inform commissioning adjustments and understand the expected return on investment as a result.

ICBs will establish clear ways to capture feedback and experience from people, diverse communities, staff and partners and their teams, including by making use of existing partners' forums and groups. They will use evaluation and co-design deliberative and inclusive dialogue with people and communities, to ensure user feedback mechanisms are embedded in how commissioning decisions are made. NHS England will support this by rolling out the integration index to collect statistically robust data on experience, outcomes and health and care use within priority population groups. Local teams will be able to use this data to guide neighbourhood-based care interventions and monitor impact over time. ICBs should also have the ability to benchmark performance and productivity metrics across other systems to understand where they may need to support improvements.

ICBs will need to work closely with regional NHS teams in line with the emerging changes to their role. Regional NHS teams will take a lead on overall provider trust performance from April 2026 as set out in the Model Region Blueprint. This will include where a trust is unable to manage a risk themselves as it crosses organisational boundaries, for instance. ICBs are expected to continue to be accountable for the performance of primary care providers and national contract requirements such as for primary care. Further detail is in the NHS performance framework (https://future.nhs.uk/integratedcare/view?objectId=259585349) (on the FutureNHS collaboration platform; login required).

ICBs will continue to have an agreed governance and monitoring framework in place for quality oversight, covering core statutory duties and aligned to the NQB's risk response and escalation guidance and the provider patient safety incident response plans (as part of the NHS Patient Safety Strategy). This may change over time as the role of regional NHS teams evolves from April 2026. Rapid quality reviews and quality improvement groups should be used: for example, where action is needed to improve a service or on a performance standard as well as to decommission services or terminate contracts on the grounds of poor quality.

4. Enablers for effective strategic commissioning

For strategic commissioners to be effective, several features and characteristics will need to be in place. System partners will need to work together to deliver a number of these arrangements and, for some areas, it may be that one system partner delivers on behalf of all or one ICB on behalf of multiple ICBs.

Where an ICB does not host the arrangement, it will want to secure assurance from those that do.

4.1 System leadership for population health

Effective system leadership will be essential to tackle healthcare inequalities and drive improvements in population health and deliver good quality healthcare. ICB leaders and staff need to be adept at system thinking, leadership, analytics and collaboration. They will need to work diplomatically and be comfortable driving change and influencing without direct authority, including navigating any tension between fostering partnership working and rigorously seeking to maximise quality and value for money and reduce health inequalities.

Strategic commissioning should facilitate ongoing collaboration across the health and care system, including the VCSE sector and partners with lived experience, while also using competition for certain commissioned services where this adds value. Joint mechanisms must continue to replace organisational silos, enabling integrated working and fostering a culture of shared responsibility for outcomes.

4.2 Clinical and care professional leadership and governance

ICBs will need to embed effective and broad multidisciplinary clinical and professional leadership in how they work and draw on available local expertise including appropriate clinical networks.

The term ‘clinical and care professional leadership’ is intended to be fully inclusive, reflecting the broad range of practitioners who need to work together at the different levels of the ICS, from multi-system to neighbourhood. This includes allied health professionals, pharmacists, doctors, nurses, social workers or practitioners, psychologists, healthcare scientists, physician associates, midwives, dentists, optometrists, orthoptists and public health professionals, among others.

ICBs should ensure appropriate clinical and care professional leadership and input at all stages of the strategic commissioning approach.

ICBs will ensure they have a solid understanding of biological, psychological and social risk and of the best practice care pathways to meet population needs and improve quality and outcomes. Governance and oversight will be crucial in ensuring that ICBs make robust decisions, particularly regarding the prioritisation of resources. Contract management of commissioned services will need to include effective planning, improvement and quality assurance processes. The new NQB Quality impact assessment framework and tool (2025) (https://www.england.nhs.uk/publication/quality-impact-assessment-framework-tool/) is an important resource for this.

NHS England has developed guidance for ICSs on implementation of effective clinical and care professional leadership (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-13). This describes 'what good looks like' in this regard, based on an extensive engagement exercise involving over 2,000 clinical and care professional leaders from across the country, led by a multiprofessional steering group.

The clinical decisions that clinicians, in particular GPs, make for individual patients drive the allocation of resources (for example, referrals and prescribing) on an almost continuous basis. ICBs have an important role in ensuring that these decisions are based on best evidence and support the system to maximise value for money.

4.3 Healthcare data, analytics and technology

Strategic commissioning decisions should be guided by a data and insight-led population health management (PHM) approach that uses outcome indicators, insight from linked data sets and feedback from people using services, communities and staff. ICBs should use their intelligence function to drive continuous improvement and transformation across all commissioned services. Guidance on building an intelligence function is available (https://www.england.nhs.uk/publication/building-an-ics-intelligence-function/) and e-learning resources (https://www.e-lfh.org.uk/programmes/population-health-management/) and the Population Health Academy (https://future.nhs.uk/connect.ti/populationhealth?sm_newemail=) (on the FutureNHS collaboration platform; login required) provide guidance on PHM.

ICBs should apply a single, consistent system-wide PHM approach to segment and risk stratify populations based on complexity and forecasted resource, using the tools provided by NHS England. These tools will be underpinned by a person-level, longitudinal, linked data set that integrates local and national data sources alongside public and patient feedback, with appropriate data sharing and governance agreements. ICBs should use the capabilities that will be provided through the NHS FDP to support segmentation, risk stratification and predictive modelling and work with the NHS FDP team to develop this offer further.

Appropriate data sharing and governance agreements will be needed to track individuals' journeys across health and care (to understand needs and outcomes holistically) and deploy predictive modelling to foresee future demand, cost and impact of interventions. ICBs will need to cultivate teams that can analyse and interpret complex data (for example, health economists and data scientists) and deploy data-driven techniques (such as modelling the return on investment for interventions). Reliable integration of data between services provides real-time, accurate data that enables better decision-making and interoperability – the NHS FDP will be crucial for this and ICBs should use it as the default tool, supplemented with local tools that improve data integration and impact.

To support strategic commissioning across the country, ICBs can source data insights locally and from national tools such as the NHS FDP strategic commissioning tool and wider data insights. The Model Health System strategic commissioning insights compartment (https://model.nhs.uk/compartments/fa1e0016-6dea-4527-b054-8d333353ce57) contains metrics designed to support ICBs in identifying potential opportunities: a mix of both spend or cost and activity volumes based on data to the end of March 2025. These metrics are intended to provide an initial short-term set of information while NHS England undertakes further work to develop a longer-term solution to support strategic commissioning. Additional iterations of the Model Health System compartment will further support value-based healthcare (ensuring only clinical interventions that add the most value are undertaken) and improved healthcare outcomes for the population. They will provide ICB and sub-ICB mapping and visualise commissioner metrics on a service-by-service basis, initially focusing on cardiovascular, stroke and diabetes with metrics spanning the patient pathway. These will also be available on the NHS FDP alongside segmentation and risk stratification capabilities by March 2027 and we expect all ICBs to adopt them.

ICBs have a duty to promote innovation in the NHS and should use their role as strategic commissioners to develop and commission new innovations in their local system that support the achievement of their strategy and population health improvement plan. ICBs should explore how they work closely with health innovation networks (HINs) as a crucial link between the NHS, academia, industry and the VCSE sector.

ICBs should build the role digital technology can play in how and what they commission into their ICB strategy and population health improvement plan. This includes the 5 key technologies – genomics, AI, wearable technologies, robotics and joined-up data – to drive innovation and transformation, as outlined in the 10 Year Health Plan. Strategic commissioners should consider these when commissioning healthcare services, to improve patient care, increase productivity and position the UK as a leader in healthcare innovation. ICBs should refer to the Model Digital Blueprint once published in 2026/27 for guidance on digital first approaches and how to connect with nationally provided digital tools and services such as the NHS App, NHS FDP and, from 2028, the single patient record.

4.4 Intelligent healthcare payor

For ICBs to become sophisticated and intelligent healthcare payors, they must build capacity and capability across all areas of the strategic commissioning framework. This includes assessing need, applying healthcare economics (for example, cost per patient per year) to manage markets, and developing expertise in strategic purchasing, contracting, payment design and oversight, utilisation management, resource allocation and evaluation. They will also require commercial skills to support innovative contracting and the management of new provider relationships.

Section 3.1 outlines the role of the intelligence function. Wherever that function sits in an ICS, ICBs will need strong analytical skills to interrogate multiple quantitative and qualitative sources and combine them into an integrated needs assessment that can directly inform priorities. Commissioners must then be able to develop models and specifications aligned with modern clinical standards, while also securing the implementation of national contract requirements in primary care and recognising the diversity of providers across their systems.

ICBs will require the skills and capacity to deliver fair and effective resource allocation within constrained budgets. This means developing strong analytical and quantitative capabilities, including health economics methods, statistical analysis and modelling, to underpin evidence-based decisions. Equally important is a solid

understanding of healthcare systems and policy, including financing, equity and the wider regulatory environment. ICBs must also build robust decision-making and priority-setting skills to balance risks, costs and benefits, supported by clear communication and stakeholder engagement to explain trade-offs and secure consensus. Leadership and ethical judgement are essential to ensure transparency and fairness, while adaptability and resilience will be needed to manage uncertainty and emerging pressures. Together, these capabilities will enable ICBs to make balanced choices that improve healthcare and health outcomes while maintaining trust and accountability.

The 10 Year Health Plan sets out the ambition for a new model of care. To support this, strategic commissioners should take an active role in designing, shaping and managing healthy and resilient local provider markets, including strengthening GP leadership in primary care. This requires investment in understanding both the true cost of current provision and the efficient cost of best practice care models. ICBs can build on existing patient-level information and costing systems (PLICS), which capture the cost of each interaction with NHS trusts, allowing analysis by service line, cost type or patient cohort. Where PLICS is unavailable (for example, in general practice and non-NHS providers), ICBs should estimate average interaction costs from available data. This enables comparison of costs across providers and within patient groups.

When developing best practice models, ICBs and providers should work together to assess the economic and financial case, projecting demand and efficient costs over time. This process should begin by estimating the required activity for the population cohort served and set out the desired outcomes. Providers should use this information to develop a more detailed model, including the workforce, estate, training, equipment and digital tools they will need. Minimum efficient scale must also be considered to determine which models are best delivered at neighbourhood level and which require a larger footprint. These costs can then be compared with the true cost of current provision to assess potential returns, including resource freed up through change.

Moving from current models to best practice cannot rely on growth in funding; it requires reallocation of existing resources. Addressing double running and stranded costs is essential, supported by contracting methods and payment incentives that encourage providers to reallocate resources. Tailored commissioning models may be needed for specific pressures and population needs, alongside effective oversight of service quality. Commissioners should also recognise provider diversity – for example, VCSE organisations reliant on grants may need longer-term

investment and certainty to modernise. Active management and improvement approaches are required to maximise national primary care contracts (dental, optometry, pharmacy and general practice) for local benefit.

The 10 Year Health Plan signalled that NHS England–DHSC would progress the further development of best practice tariffs (driving improvements by making payment dependent on implementation of the best practice care model) and year of care tariffs (whereby a provider receives a payment for the annual care of a patient with a long-term condition), aligning financial incentives with keeping the patient as well as possible. These tariff innovations, alongside local payment agreements to align incentives and deliver financial sustainability, will further position providers to take greater responsibility for improvements across the system for patients.

Commissioners must understand contractual and legal frameworks and be able to use the PSR to secure system goals. This may involve contracts that bind providers together, share risk and distribute leadership responsibilities. ICBs also need the skills to actively manage and oversee contracts, applying levers to address quality and performance issues and intervening where necessary to support services to turnaround. ICBs will need to use active management and improvement approaches to maximise the nationally agreed primary care contracts (dental, optometry, community pharmacy and general practice) for best outcomes for the local population. Local procurement strategies should consider how supply chains and small and medium enterprise providers can promote social and economic development, drive inclusive growth and reduce inequalities.

ICBs must build capacity to rigorously model and measure impact. This requires clarity on the types of value strategic commissioning can deliver; application of a theory of change to track how resources translate into outputs and outcomes; the development of metrics to capture short, medium and long-term outcomes; and evaluation frameworks that both inform design and enable comparison of initiatives to identify those that are most effective.

Underpinning all these skills is a strong grounding in health economics, including its application to resource allocation, cost and value, incentives, efficiency, equity and economic evaluation. The forthcoming strategic commissioning development programme will support ICBs to strengthen these skills, alongside the support for IHOs set out in the 10 Year Health Plan.

4.5 User involvement and co-design

For services to truly meet the needs of communities, people must be involved from the start of planning through to implementation and review. Each ICB should have a systematic approach to co-production – meaningfully involving patients, service users, unpaid carers and community groups in co-designing solutions. This goes beyond formal consultation and means working with people as partners. ICBs will need to ensure that focused effort and resources are deployed to reach seldom heard and underserved people and communities, working with trusted community partners to achieve this. ICBs need to make best use of the skills, capability, capacity and expertise across the health and care system in carrying out these duties alongside their own.

NHS England's guidance on working with people and communities (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-12) sets out 10 principles to support ICBs to develop their approaches and put the voices of staff, people and communities at the heart of decision-making. ICBs can also use the experience of care improvement framework (https://www.england.nhs.uk/publication/experience-of-care-improvement-framework/) to better understand how organisations across the system are listening, valuing, understanding and improving experiences of care in partnership with other stakeholders, for example VCSE. NHS England's framework for involving patients in patient safety (https://www.england.nhs.uk/patient-safety/patient-safety-involvement/framework-for-involving-patients-in-patient-safety/) is another important resource. Other good practice guides for user involvement and co-design in strategic commissioning are the patient safety healthcare inequalities reduction framework (https://www.england.nhs.uk/long-read/patient-safety-healthcare-inequalities-reduction-framework/) and improvement framework: community language translation and interpreting services (https://www.england.nhs.uk/publication/improvement-framework-community-language-translation-interpreting-services/).

Involving people from the start and throughout the commissioning process helps ensure that decisions meet the needs of local communities, building on people's experiences of existing services and the range of health assets in communities. Being able to demonstrate how people have been involved in decisions can help avoid legal challenges to proposed changes to services and is essential where the duty to involve and consult applies.

4.6 Working with local government

Engagement and co-design with local government is critical. ICBs must continue to foster strong relationships with local government partners within their footprint, including adult social care, children's services, housing and public health, to build a shared understanding of their population and work together to improve outcomes, tackle inequalities and develop neighbourhood health.

As ICBs evolve and local government reform is progressed, health and wellbeing boards in all systems will be the key forums for joint planning with each of the upper tier local authorities, complemented at system level by working in partnership with strategic authorities discharging their new health duties.

Strategic commissioning and joint procurement involve joint planning, shared accountability and a collective role with local authorities in shaping population health strategies and plans. However, successful co-commissioning is not without challenges. Barriers include navigating complex governance structures, securing sustainable funding models and addressing workforce capacity issues. Overcoming these challenges will be essential to unlocking the full potential of integrated commissioning and ensuring that health and care systems are equipped to respond effectively to local health needs.

4.7 Supporting ICB competency and capability development

Excellent leadership and management are vital for delivering strategic commissioning. The NHS management and leadership programme (https://www.england.nhs.uk/leaders/nhs-leadership-and-management-development-programme/) is supporting the development of all leaders and managers, whether clinical or operational.

The evolving healthcare landscape demands leaders capable of making and implementing challenging decisions with the diplomacy needed to build and maintain effective partnerships across complex systems. Strategic commissioners will need to be more relational, strategic and collaborative in the way they work with all their local providers, the VCSE sector and local government partners, including strategic authorities (including those that are mayoral led) given their responsibilities in tackling the wider determinants of health. They will need to be expert facilitators to bring community insights into the design of new models of proactive care to achieve

better healthcare and better outcomes through early intervention and prevention. Strategic commissioners must also have access to sophisticated analytical and financial skills and capabilities to drive evidence-based change.

Contract management expertise should evolve to encompass both traditional approaches and new models of pathway commissioning. These technical skills need to be underpinned by a deep understanding of how to commission across entire pathways rather than individual services. Skills and capabilities in managing quality are also key, from planning quality improvements and delivering statutory quality functions, to identifying and mitigating quality risks and issues.

ICBs should develop robust change management and improvement capabilities while evolving their operating models to support new ways of working. This includes building mechanisms for cultural development and establishing effective peer review processes that support continuous improvement and learning across the system. ICBs can seek support from NHS IMPACT (https://www.england.nhs.uk/nhsimpact/) to support their staff in the skills and techniques around continuous improvement.

ICBs should consider how best to ensure they are equipped with the key skills and experience to carry out their role as strategic commissioners. This may include sharing certain skills and functions across more than one ICB, particularly in areas where working together represents better value for money.

A strategic commissioning development programme will be in place from April 2026 to support ICBs and others who commission NHS services to develop as strategic commissioners. This will have 3 core strands – ongoing Model ICB implementation support, organisational development and individual development. It will include a strategic commissioning capability toolkit based on the strategic commissioning framework that sets out a number of levels (starting out through to mastering) for each stage of the commissioning approach and the enablers at both an organisational and individual commissioner level. This will in turn anchor the organisational support and individual training offer and support individual career planning across commissioning roles.

5. Understanding and using the different scales of commissioning

Strategic commissioning involves bringing together all those with a legitimate interest in and relevant expertise to design the full range of services for the relevant population. Services therefore need to be commissioned at many different population and geographical scales, from national and multi-ICB all the way down to neighbourhoods. NHS England is devolving as many of its direct commissioning

responsibilities as possible to ICBs to allow them to plan services from end to end, enabling a shift from tertiary towards preventative services. As part of this, within each NHS region an Office of Pan ICB Commissioning is being established as a vehicle through which these direct commissioning responsibilities can be carried out.

Commissioning footprints should be aligned with service type, taking account of economies of scale and integration needs or put another way, devolving where possible and aggregating where necessary.

Typically, the ongoing co-ordination of long-term care for named individuals living with complex conditions is most effectively undertaken at neighbourhood level; tailoring service planning and co-ordination to meet local community needs at place level; planning and improvement of acute care (physical and mental health) at system level; and planning and improvement of specialised (and ambulance) care at multi-system level. However, individuals' needs will often span one or more of these levels at any one time, so ICBs need to ensure they are commissioning holistically across these levels to meet the needs of their residents.

ICBs need to ensure appropriate arrangements are in place to enable effective decision-making, involving relevant stakeholders and based on clear accountabilities, at each of these scales.

ICBs will in future be strategic commissioners for NHS England's current direct commissioning functions, with significant work required to support safe delegation, and ensure required pan-ICB commissioning arrangements are in place and collaboration across ICBs continues.

5.1 The role of primary care

Primary care includes general practice, community pharmacy, dental and optometry services and is the foundation of the NHS.

General practice cares for individuals and families in the round and is at the heart of successful neighbourhood working. It brings practitioners together with people using services and their unpaid carers with the aim of ensuring they receive ongoing high-quality co-ordinated care and support to stay as well as possible and enjoy the best quality of life. Through primary care networks and at-scale working we have seen greater collaboration in primary care (including through federations and collaboratives) and better outcomes for patients and primary care staff.

Community pharmacy is expanding its role by moving from dispensing to a clinical service.

There is a greater focus on improving dentistry including with access to urgent care and through contract reform.

We are encouraging optometry services to play a key role in the care pathway to improve eye health.

ICBs play a critical role in creating the right conditions for a resilient and sustainable primary care sector that can support neighbourhood working and underpin the move to greater care in the community described in the Darzi Review (https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england), the Fuller Stocktake Report (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) and the 10 Year Health Plan (https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future).

ICBs, as primary care commissioners, must both ensure contractual requirements are met and promote a culture of collaboration in delivering pathways of care, transformation and improvement in primary care, focusing on reducing unwarranted variation and working with wider system partners.

As part of a forthcoming strategic commissioning development programme, NHS England will support ICB commissioners of GP services to create the right conditions for improving general practice, including with nationally delivered tools and programmes that can enable ICBs to develop their capabilities. This support may be extended to commissioning of pharmacy, optometry and dentistry.

Primary care leaders are working with their ICBs to explore how best to organise their work, including through horizontal and vertical integration with other parts of the NHS, so that patients receive the appropriate care, whether episodic or ongoing co-ordinated care or part of a wider pathway of care. They are also playing a leading role in the development of neighbourhood health.

5.2 The role of neighbourhood

The national neighbourhood health guidelines (https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/) build on initiatives underway across the country to establish the best models for

such integrated ongoing care for individuals, prioritising those with complex needs before exploring how the model might be extended and adapted for the larger cohort of patients who have long-term conditions. The national neighbourhood health implementation programme is an important next step in the development of neighbourhood working nationwide. 43 areas identified as trailblazers for neighbourhood health will test and demonstrate the impact of more integrated team-based working for specific population groups.

The 10 Year Health Plan sets out a new provider system architecture for neighbourhood health. This – for the first time since the creation of the purchaser–provider split in 1991 – has the potential to shift the majority of NHS provision from a 'receive and treat' model to a population-based model. Individual GP practices, single neighbourhood providers (SNPs) and multi-neighbourhood providers (MNPs) are all population-based entities.

This creates opportunities for ICBs working in partnership with local government and other partners, including a market shaping role for ICBs: first to determine the populations of neighbourhoods and places in their local systems and to identify the needs of different population cohorts within these; second to then shape the development of providers and use of novel contract models to create the right provider landscape to deliver population health improvement.

The strategic commissioning of neighbourhood health offers a genuine opportunity to begin addressing the differential needs of different communities and with this start to reduce the health inequalities between those communities. Further information about the new contract models (IHO and MNP) and how they will work with ICBs will follow in late 2025.

5.3 The role of place and providers within it

Place-based partnerships – collaborations of primary, community, mental health, secondary and social care providers, the ICB, local government, the VCSE sector and wider partners – play a pivotal role in planning and improving health and care services within every ICS. Place-based partnerships proactively identify and respond to local needs through the adoption of PHM and co-ordinated multidisciplinary care.

Many systems have already established clear leadership and governance arrangements at place level to support integrated commissioning and delivery, but to thrive these partnerships need to be supported through greater delegation over time and clearer leadership and operating models, including how they interact with local government.

The 10 Year Health Plan strengthens the role of place partners through 2 main mechanisms:

- Planning at place level: local government, the NHS and its partners at single or upper tier authority level will draw up a neighbourhood health plan under the leadership of the health and wellbeing board, incorporating public health, social care and the Better Care Fund. This will set out shared objectives across place partners, how the model of care will change based on local need and how commissioners and providers will reorganise themselves to deliver services in a more integrated way.
- New delivery models: place partners will work together to define the optimal delivery model for their population and configuration, including the development of single and multi-neighbourhood provision and, in some parts of the country, IHOs. ICBs will commission these models and will play a key role in shaping and supporting providers to work collaboratively and develop the necessary capabilities to implement them.

ICBs can use contracting arrangements to give providers greater freedom in determining how to achieve agreed objectives: for example, through awarding outcomes-based contracts that may include explicit conferral of discretion (Note 4) on the provider. Such arrangements allow providers greater flexibility to drive transformation by determining what services are needed; over how a service is redesigned; over the allocation of resources between services; and the best ways to align incentives between providers.

ICBs may wish to commission a lead provider, where that provider has the required capability and relationships with other providers, to drive greater integration and oversee the delivery of better outcomes. ICBs may also go further and choose to give providers a formal role in commissioning decision-making. This could involve establishing a committee or sub-committee of the ICB that includes provider representatives, or a joint committee between the ICB and providers. NHS England has published guidance on arrangements for delegation and joint exercise of statutory functions (https://www.england.nhs.uk/publication/arrangements-for-delegation-and-joint-exercise-of-statutory-functions/).

The success of all these approaches is highly contingent on system maturity, provider skills and capability in commissioning, clear accountabilities, strong relationships and a robust case that changes will deliver benefits to people using services. ICBs will need to support the development of skills and capability within

providers so they can understand the needs and drivers of risk within their defined population, and where cost can be mitigated and outcomes and experience enhanced through proactive care management and co-ordination.

This capability supports:

- demand projections, capacity planning and resource management through PHM
- targeted population health initiatives to address modifiable risk factors
- streamlining access and transitions of care
- people and community engagement and activation
- facilitating and guiding multidisciplinary teams
- contract and supply chain management across partners

ICBs will need to consider how they can balance economies of scale to support access to scarce skills (without stripping capacity and capability at place) and to develop the conditions for these new contractual and delivery models to operate. In particular, teams will be needed who can support population health analytics, primary care engagement, service redesign and change management.

The 10 Year Health Plan envisages some new foundation trusts – those that have shown an ability to meet core standards, improve population health, form partnerships with others and remain financially sustainable over time – will have a new opportunity to hold the whole health budget for a local population as an IHO. An IHO is a new capitated contractual form that gives the contract holder responsibility for planning services and allocating resources to improve the health of a defined population. IHO contract holders will play a key role in managing the shift towards neighbourhood health. They will work closely with neighbourhood providers, including multi-neighbourhood provider contract holders, to transform models of care.

Over time we anticipate some of the new capabilities outlined in sections 3 and 4 will transfer to, or be delivered jointly with, providers that hold IHO contracts. In these instances, the ICB strategic commissioning function will need to refocus on robust oversight of these new arrangements, ensuring that IHO contract holders are using their budget optimally to meet population health need. As IHO contracts will be commissioned and overseen by ICBs, we expect the IHO assessment process will consider commissioner capability to manage these novel contracts.

Along with the system architecture of MNPs and SNPs, the establishment of IHOs creates a further mechanism to place provider responsibilities on a population footing and so create the opportunities for ICBs to further enhance the incentives for implementing population-based outcome measures and the shifts towards primary and community and prevention. Further details on the IHO model will be published in late 2025. NHS England will work with providers and commissioners to develop the model as contracts are awarded and prior to go live.

6. Summary and next steps

ICBs are critical to the delivery of the NHS's priorities. This framework sets out our expectations of commissioners, particularly ICBs, to adjust to the new legislative landscape and financial context and to ensure we are making the most of new opportunities – such as those from collaborative working with providers, system partners and other ICBs, and using modern data and analytics to support more proactive care.

We expect all ICBs to begin to adopt the strategic commissioning approach outlined in the framework as part of the NHS planning process for 2026/27. Table 1 below sets out key milestones.

A strategic commissioning development programme will be launched from April 2026 to support ICBs to develop as strategic commissioners as well as all those carrying out commissioning. As part of this we expect ICBs to carry out a baseline assessment against the strategic commissioning framework in March 2026. We plan to incorporate elements of the framework in the assessment of each ICB as a strategic commissioner that NHS England is required to undertake from the financial year 2026/27.

Table 1: Key milestones for the strategic commissioning approach

Strategic commissioning framework released	November 2025
Strategic commissioning capability toolkit issued	January 2026

ICB's development and approval of integrated needs assessment, ICB strategy and population health improvement plan	January 2026
ICB baseline assessment against the framework carried out	March 2026
Launch of strategic commissioning development programme	April 2026

Notes

Note 1: Payor functions are defined as allocating resources, contracting and procuring for services, shaping the provider market and ongoing contractual management of commissioned services.

Note 2: Defined as improving outcomes that matter to patients relative to the costs of delivering those outcomes.

Note 3: The integrated needs assessment must build on and complement the joint strategic needs assessments led by local government public health teams and overseen by health and wellbeing boards within each ICS.

Note 4: Conferral of discretion is where an ICB can give a provider discretion in relation to the services provided under the contract, permitting the provider greater latitude in service design and delivery.

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