EAST OF ENGLAND
PROVIDER COLLABORATIVE
BETTER CARE CLOSER TO HOME

East of England Provider Collaborative

Commissioning Intentions

2026 - 2030

Adult Secure Services

Adult Eating Disorders

Children and Young People & Perinatal

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1. Introduction

The East of England Provider Collaborative is responsible for commissioning specialised mental health and Learning Disability and Autism (LDA) services across our region. We work in partnership with providers, service users, clinicians and system leaders to ensure services are safe, effective and responsive to need. Our approach is based on clinical leadership, co-production and operational accountability.

In this document, we set out the East of England Provider Collaborative's strategic commissioning intentions for the period 2026 to 2030. It defines the direction we will take across adult secure care, adult eating disorders, children and young people's services, and perinatal mental health. It builds on existing pathway strategies and reflects our role as a strategic commissioner. Our aim is to deliver transformation through collaborative commissioning, influence service design and shape the market.

Setting our strategic intentions for five years is a challenge. Therefore, our commissioning intentions will not be static. Whilst our areas of focus will remain consistent, we will work with our partners to define and design service-line specific plans for what we will do differently. We will listen to our clinical leaders, involvement partners and services and reflect on what works well to ensure these plans are responsive and support quality, productive and efficient delivery of service.

2. Principles

The Provider Collaborative is committed to delivering safe, sustainable, effective and efficient specialised mental health services across the East of England. Our commissioning intentions are shaped by four years of data trends, current demand and capacity insights, and the direction set by regional and national policy.

As strategic commissioners, we have the autonomy to lead transformation and redesign services to meet population needs. We are responsible for reinvestment decisions and for delivering against nationally specified care and treatment responsibilities.

The principles below apply across all service lines and underpin our ambitions. They reflect our strategic priorities and guide both service design and contract delivery:

Optimise length of stay: Reduce unnecessary time in inpatient settings by embedding discharge planning from the point of admission and commissioning community alternatives.

Deliver care closer to home: Reduce out-of-area placements and ensure that inpatient care is purposeful, short, and locally accessible.

Invest to improve: In 2025/26 the Provider Collaborative reinvested £22 million in inpatient quality improvement and community services. We will continue to shift resources to initiatives that enhance patient experience and improve efficiency of delivery, ensuring services are high-quality and cost-effective.

Improve patient experience, access and outcomes: Embed co-production, strengthen transitions, and ensure services are responsive to individual needs and preferences, delivered by a workforce with the right skills and capabilities to offer evidence-based care and treatment.

Reduce health inequalities: Use data to identify and address disparities in access, experience and outcomes across all service lines, with a focus on ethnicity, gender and geography.

To deliver against these principles we will:

- ✓ Use data to forecast demand and evaluate impact.
- ✓ Align commissioning decisions with ICB investment plans.
- ✓ Apply contract levers and incentives to support quality, sustainability and responsiveness.
- ✓ Work in partnership with providers, ICBs, system partners, patients and their families to co-design and implement service improvements through our embedded clinical leadership model.

3. Commissioning Intentions

3.1 Summary

We have worked with stakeholders, clinical leads and involvement partners to understand our areas of focus required to achieve our Commissioning Principles above. We have identified the following 16 key commissioning intentions.

PC1: We will improve our data and information to better support patient flows and our quality assurance framework, to support evidence-based decision making and improve our understanding of health inequalities

PC2: We will work in partnership with ICB Commissioners and NHSE to identify opportunities to add value through joint or delegated commissioning and closely align PC commissioned Alternative to Admission Services with ICB commissioned admission avoidance models to ensure there is no duplication or gaps

PC3: We will commission services that minimise the use of seclusion, restraint and long-term segregation, in line with national policy and trauma-informed care models

PC4: We will commission for quality, supporting services to meet established standards, safeguard patient safety, and drive continuous improvement

PC5: We will move from co-design to coproduction and ensure the voices of Service Users and Carers are embedded across the Collaborative

AS1: We will reduce time spent in hospital and optimise inpatient stays

AS2: We will invest in community alternatives to admission and implement an equitable community forensic service across the Region

AS3: We will ensure we have the right beds in the right places to meet the needs of our population

AED1: We will increase access to community-based alternatives to admission

AED2: We will ensure our Inpatient Services are providing high quality, effective care with capacity aligned to demand

CYP1: We will work with ICBs to embed the functions set out in the national specification: day services, intensive support, and high-intensity environments

CYP2: We will improve the pathway for Children and Young People with Eating Disorders

CYP3: We will improve transition for young people moving between CYP and adult services

CYP4: We will reduce Health Inequalities and improve services for CYP with LD&A

P1: We will invest in our regional Mother and Baby inpatient services to ensure a standardised high quality service that delivers good outcomes for mothers, babies and their families

P2: We will improve continuity of care and joint working between MBUs, maternity and community teams

3.2 Provider Collaborative Cross-Pathway Commissioning Intentions

PC1: We will improve our data and information to better support patient flows and our quality assurance framework, to support evidence-based decision making and improve our understanding of health inequalities

Our commissioning intentions reflect a radical shift in how we gather, analyse, present and use data. We are moving away from fragmented, manual reporting and towards an approach that brings together our strategic and operational data sources. This will enable cross-analysis, improve interpretation and maximise the value of the intelligence we already hold. Redesigning how we use data is essential to achieving the ambition set out in these commissioning intentions.

We will replace fragmented reporting with a data-driven approach that combines strategic and operational sources. This will enable real-time insight, improve interpretation, and support whole pathway planning. Our approach follows NHS Making Data Count principles:

- Focus on understanding, not just monitoring.
- Use visualisation to support interpretation.
- Enable action through insight.
- Avoid false assurance from averages.

We will develop a data framework to support our understanding of health inequalities in terms of both access and outcomes, identifying any gaps in data and further areas for analysis. We will reshape our approach to data to support our core functions. This includes:

- Performance improvement across all service lines.
- Identification of transformation opportunities.
- Measurement of impact from commissioning decisions.
- System flow management, including admission, discharge and transition.
- Risk stratification to inform oversight and escalation.
- Board and committee assurance, with clear, triangulated reporting.

To do this, we will:

Redesign what we collect
We will collect only what is essential, eliminate duplication, and align wherever possible with national datasets.

Standardise how data is collected
We will co-design new templates with providers, move to monthly submissions, and embed ward-level tagging to enable more granular analysis.

Transform how data is used
We will develop a new data warehouse and reporting suite, enabling automated dashboards, real-time tracking, and strategic insight.

We will also ensure that data supports population-level commissioning. This means using linked datasets, forecasting tools and segmentation models to understand need, plan capacity and evaluate outcomes. We will work with ICBs to align data flows and ensure that our commissioning decisions are evidence-based, locally responsive and strategically coordinated.

This is a significant change. It will take time, collaboration and testing. But it is essential if we are to deliver the transformation set out in this document.

PC2: We will work in partnership with ICB Commissioners and NHSE to identify opportunities to add value through joint or delegated commissioning and closely align PC commissioned

Alternative to Admission Services with ICB commissioned admission avoidance models to ensure there is no duplication or gaps.

We will work with Integrated Care Boards and Local Authorities to take a whole pathway approach to commissioning. This reflects the national direction set out in the NHS specialised commissioning roadmap, the delegation framework , and provider collaborative guidance. These documents emphasise the need to reconnect specialised services with community, acute and primary care, enabling joined-up planning and reducing fragmentation.

Our commissioning intentions already reflect this approach:

Adult Secure: We are developing community forensic services that align with locally commissioned forensic mental health provision. This includes further join up with ICB plans to strengthen Intensive and Assertive Outreach and enable continuity across secure and community settings.

Children and Young People: We plan to use the national developmental specification to design a new model in partnership with ICBs that connects inpatient care with local physical and mental health services. This includes education, social care and acute hospital interfaces.

Adult Eating Disorders: We are shifting investment into community-based care through the A-EDIT model, reducing reliance on inpatient beds and embedding shared care with community eating disorder teams.

Perinatal Mental Health: We are strengthening outreach and liaison functions to ensure MBUs are integrated with community perinatal pathways, maternity services and early intervention teams.

In extending our approach to partnership commissioning we will work with ICBs to explore where the Provider Collaborative is best placed to lead development, implementation and assurance of whole pathway models. This includes:

- Defining shared outcomes across specialised and non-specialised services.
- Aligning investment to support upstream intervention and prevention.
- Embedding joint planning forums and shared governance structures.
- Using population health data to forecast demand and plan capacity
- Working with ICBs to pilot ‘whole pathway’ commissioning for pathways where there are potential benefits from having specialist expertise

This will support better outcomes, more efficient use of resources and a more coherent experience for people using our services and explore with ICBs other potential areas for regional commissioning that would reduce inequalities, maximise economies of scale and efficiency in the NHS or add other value to local systems.

PC3: We will commission services that minimise the use of seclusion, restraint and long-term segregation, in line with national policy and trauma-informed care models.

We are committed to providing care in the least restrictive setting, this commitment includes: providing robust step down pathways between inpatient provision of different levels of security, developing community alternatives to admission, implementing trauma-informed practice across the Collaborative and ensuring a reduction in delayed discharges through embedding recent guidance around Clinical Readiness for Discharge (CRFD). In our inpatient settings we will reduce the use of restraint, long term segregation and seclusion as well as increasing our oversight and approach to enhanced observations. In our Mother and Baby Units we will minimise restrictive interventions and prevent unnecessary separation of mothers and babies.

We will incorporate strategies for reducing restrictive practice building on national guidance and standards, and seeking to learn from and share with other Provider Collaboratives to identify and implement good practice.

We will support providers in the following key areas:

Delivering Person-Centred Care: Understanding individual needs, triggers, and communication methods to prevent crisis situations.
Culture Shift: Moving from a "compliance" culture to one focused on therapeutic engagement and positive risk-taking and embedding changes into daily practice.
Training and Education: Equipping staff with skills in de-escalation, trauma-informed care, and proper, ethical intervention techniques.
Review and Oversight: Using data to review incidents, identifying themes, and strengthening accountability, such as through Reducing Restrictive Practice Oversight Groups (RPOGs).
Evidence-Based Approaches: The Reducing Restrictive Practice Collaborative (RRP) demonstrated that such initiatives can significantly decrease the use of restraint, seclusion, and rapid tranquilisation.

PC4: We will commission for quality, supporting services to meet established standards, safeguard patient safety, and drive continuous improvement

In 2025/26 we completed our first Quality and Performance Assurance Framework for inpatient services. We introduced a structured assurance framework that scores provider performance across four domains: safety, effectiveness, experience, and contractual delivery. The framework allows us to:

- Identify where support or escalation is needed.
- Align our contract and case management response to the level of risk.
- Ensure consistency and transparency in how we assess and respond to provider performance.

In 2026/27 we will implement a tailored quality and performance assurance framework to support community and alternative to admission services ensuring robust oversight of effectiveness, safety and outcomes.

We will invest in commissioned services using resources from transformation to improve the delivery models within care pathways to reflect coproduced priorities for service improvement. We will develop appropriate monitoring for the outcomes of this investment, considering the effectiveness, patient experience and value of investment. We will work with providers to support their QI initiatives bringing all services up to a consistent standard of high quality care.

We will ensure our workforce has the skills and training to deliver the new models of care through continuing to offer workforce initiatives that support delivery of our transformational ambitions through:

- Regularly reviewing workforce establishment and skills mix within providers
- Standardising and improving availability of evidence-based treatment options through providing training opportunities
- Supporting providers with recruitment and retention
- Using the expertise within the Provider Collaborative to provide cross-support in terms of training or capacity.
- Supporting providers to consider and resolve shared issues, developing cross-working posts where this adds value.

Underpinning high quality services and our ability to drive improvements is communication. We will develop a dedicated Provider Collaborative webpage and support shared access to resources and information between the Provider Collaborative and ICBs, service users and carers and members of the Collaborative.

PC5: We will move from co-design to coproduction and ensure the voices of Service Users and Carers are embedded across the Collaborative

Co-production is an equal relationship between people who use services and the people responsible for services. They work together, from design to delivery, sharing decision-making about designing services as well as decisions about the best way to deliver them.

Since the establishment of the Provider Collaborative we have moved from engagement to co-design, working towards coproduction. We have developed service user advisory groups, recruited involvement partners, embedded experts by experience within our Transformation and Commissioning Team and established family ambassadors within our CYP and ED units to support family members. We are able to get timely information and intelligence on service user and carer feedback on processes, facilities, environments and care and treatment within our inpatient services. The next stage of development will involve broadening representation, seeking to engage hard to reach groups and moving from codesign to an embedded culture of true coproduction across all Provider Collaborative activities.

3.2.1 Priorities for Delivery

PC1: We will improve our data and information to better support patient flows and our quality assurance framework, to support evidence-based decision making and improve our understanding of health inequalities	
2026/27 Priorities	Milestone Date
Development of a data warehouse and suite of reporting tools to provide robust quality and performance data, reducing the reporting burden on providers whilst delivering improved monitoring and validated intelligence. Initial Phase- Establish data warehouse and initial dashboards Second Phase- Refine dashboards and implement further reporting functions	 Q1 2026/27 End of Q3 2026/27
Establish a data framework to understand variations in access and outcomes for different patient demographic groups, so that we can understand and address health inequalities in line with the Core20Plus5 approach and the Patient and Carer Race Equality Framework	End of Q4 2026/27
Benchmark referral and access data by locality using rates per 100,000 across all pathways to understand local variation	End of Q2 2026/27
Increase use of clinical outcome measures and establish robust reporting mechanisms	End of Q4 2026/27
For MBUs we will improve data quality and reporting, including enhanced demographic recording, preparation for new infant outcome measures, monitoring of ante and postnatal admission numbers and more accurate monitoring contributing to a reduction in out-of-region MBU admissions.	End of Q1 2026/27
Longer Term Priorities	
Work with NHS Benchmarking and comparator Provider Collaboratives to develop tools which allow us to benchmark our services and service user profile with other Provider Collaboratives	2027/28
Deploy real-time dashboards for outcomes	End of Q3 2028/29

PC2: We will work in partnership with ICB Commissioners and NHSE to identify opportunities to add value through joint or delegated commissioning and closely align PC commissioned Alternative to Admission Services with ICB commissioned admission avoidance models to ensure there is no duplication or gaps.	
2026/27 Priorities	**Milestone Date**
Work with NHSE to agree arrangements for the transfer of commissioning for under 13 year olds and strengthen interim gatekeeping and assessment arrangements.	Q1 2026/27
Benchmark referral rates and length of stay for CYP accessing inpatient treatment and work with ICBs to understand variations per 100,000 in order to support understanding of potential commissioning gaps or pathway issues that are leading to over-representation of CYP from some local areas.	Q1 2026/27
Complete scoping and planning for transformation of Under 13s pathway developing pathways that support under 13s in line with the Provider Collaborative principles	Q4 2026/27
Longer Term Priorities	

Work with an ICB to pilot a joined up approach to commissioning that provides an end to end pathways from primary care to inpatient provision in a seamless and integrated model with a shared outcomes framework and structured treatment pathway.	2027/2028
Implementation of Under 13s pathway	2027/28
Work with local authorities and ICBs to share best practice across the Region, looking at the potential for co-commissioning models for complex children and young people who require a joint social care, health and education response	2028
Target resources at key identified variations in referral and access patterns to further reduce admission rates.	2030

PC3: We will commission services that minimise the use of restrictive practice, seclusion, restraint and long-term segregation, in line with national policy and trauma-informed care models.	
2026/27 Priorities	**Milestone Date**
Launch programme of British Institute of Human Rights Least Restrictive Practice training.	End of Q1 2026/27
Implement consistent restrictive practice data collection across all units	End of Q2 2026/27
Establish targets for reducing restrictive practice across all settings	End of Q3 2026/27
Begin discharge planning from admission using the 12-Point Discharge Plan Framework	End of Q3 2026/27
Benchmark our services against national standards and guidance	End of Q4 2026/27
Work with providers of women's inpatient services to ensure national statistics around proportionally higher incidence of restrictive practice for women is addressed	End of Q4 2026/27
Establish robust RC led peer reviews for service users in long term segregation	End of Q4 2026/27
Support providers to map blanket restrictions across inpatient units and facilitate peer review to reflect on future use.	End of Q4 2026/27
Longer Term Priorities	
Implement trauma-informed care that includes appropriate environments to meet sensory needs	2027/28
Ensure appropriate seclusion facilities to allow for proportional restraint and to enable step down from prison for service users who have enhanced violence risk, allowing for care and treatment to be provided	2027/28

PC4: We will commission for quality, supporting services to meet established standards, safeguard patient safety, and drive continuous improvement	
2026/27 Priorities	**Milestone Date**
Develop a Quality Assurance Framework for community services	End of Q2 2026/27
We will scope the potential for Family Ambassador roles in secure and perinatal services	End of Q3 2026/27
We will implement and recruit Family Ambassadors based on the outcome of the scoping work	End of Q4 2026/27
Develop a clear operational framework for transgender and nonbinary service users	End of Q4 2026/27
We will consider potential digital and technological solutions to improve patient experience, improve access and make best use of staff resources.	End of Q4 2026/27
Longer Term Priorities	
Create a data-informed health inequalities action plan to deliver equitable access and outcomes for all service users	End Q2 2027/28
Implementation of digital and technological solutions to support therapeutic aims and increase efficiency.	2027/28
Workforce sustainability: Recruitment, retention, and upskilling strategies, particularly in trauma-informed and neurodiversity-specialist roles.	2027/28
Develop a dedicated Provider Collaborative webpage to support communication with partners and stakeholders	2027/28
We will invest in research where there is a lack of a national evidence base, to understand the efficacy of interventions, and we will work with other Provider Collaboratives to prioritise and co-develop opportunities for research.	2027/28

PC5: We will move from co-design to coproduction and ensure the voices of Service Users and Carers are embedded across the Collaborative	
2026/27 Priorities	Milestone Date
Expand our Patient Advisory Groups into Expert by Experience Panels with broader representation.	End of Q2 2026/27
Develop carer engagement tools to ensure we have greater representation and engagement with carers in our decision making	End of Q2 2026/27
We will create a range of opportunities for our inpatient service users to engage in coproduction	End of Q3 2026/27
Increase our number of involvement partners for perinatal services and seek feedback from existing and previous involvement partners on how we can recruit and keep people engaged	End of Q4 2026/27
We will establish annual involvement events to inform Collaborative planning cycles	End of Q4 2026/27
Longer Term Priorities	
Double the number of Involvement Partners working with the Provider Collaborative	2030
Ensure our experts by experience and involvement partners are broadly representative through monitoring diversity and targeting under-represented groups as we grow our network.	2030

3.3 Adult Secure Commissioning Intentions

AS1: We will reduce time spent in hospital and optimise inpatient stays

AS2: We will invest in community alternatives to admission and implement an equitable community forensic service across the Region

AS3: We will ensure we have the right beds in the right places to meet the needs of our population

Our commissioning model supports the principle that, with the right set of services in place in the community, the need for secure inpatient care will significantly be reduced. Over the next five years, our commissioning model for adult secure services will shift decisively towards prevention, least restrictive care, and whole pathway delivery. We will reshape the market by embedding trauma-informed, gender-responsive models, strengthening support for autistic adults, and aligning secure care with broader system priorities including ageing, justice, and data-driven commissioning.

We will work with Health and Justice commissioners and providers to seek early advice for prisoners and prevent unnecessary transfers. We will meet the 28-day target for transfers to secure inpatient care when clinically appropriate and support timely return to prison after treatment.

We are completing a full bed base review and will implement actions to right-size the secure bed base and identify pathways that need to be brought into the region to reduce out-of-area reliance such as frailty and neurodevelopmental services through embedding trauma-informed and neurodiversity responsive care and remaining responsive to physical health needs and aligned with local provision.

Demand for **women's services** has reduced, particularly in low secure care. We have reconfigured our bed model and will continue to align with the National Women's Transformation Programme. The lack of national provision for autistic women remains a gap and will be escalated with NHS England. We will work with providers to ensure that we embed a trauma informed approach and that women are only admitted to secure care settings when clinically appropriate and necessary.

Men's services remain stable. We will maintain current provision, ensure placements are clinically appropriate, and embed discharge planning from admission. In doing so we will be improving access across services.

Learning Disability and Autism demand is changing. LD inpatient use is falling, while autism-related admissions are rising. Our commissioning response will:

- Set inpatient reduction targets and ensure we have the right beds that meet the population needs, regularly reviewing data and trends to ensure we maintain a responsive bed base.

- Embed positive risk-taking.
- Improve transitions and discharge planning through embedding planning from admission. We will strengthen advocacy and compliance with Care and Treatment Reviews and Dynamic Support Registers
- Align with national recommendations and standards.

We have invested in community services that provide an alternative to admission. We will now ensure that there is a consistent, **enhanced community forensic offer** in place across the region that provides high quality care and achieves positive patient outcomes, reducing length of stay and preventing admission, this will build on existing ICB commissioned provision where available, ensuring join up and eliminating the risk of duplication.

We understand that in order to ensure patient flow and reduce delays in supporting service users back into the community that we need to work with local authorities and housing providers to ensure the correct support is available. We will therefore act as a system leader and work closely across health, social care and housing to articulate what that need is and helping to identify gaps in currently commissioned and delivered provision, supporting housing and community support providers and commissioners to understand the needs of our service users. We will do this through bringing people together to plan, improving housing needs assessments for our service users, embedding housing expertise throughout our services and ensuring that by 2030 there is a clear plan for each locality to meet the housing needs of our population.

3.3.1 Priorities for Delivery

AS1: We will reduce time spent in hospital and optimise inpatient stays	
2026/27 Priorities	**Milestone Date**
Embed the Clinically Ready for Discharge (CRFD) definition into practice to ensure discharge planning begins within one month of admission	End of Q1 2026/27
Embed the refreshed Transfer & Remissions Good Practice Guidance across all secure units	End of Q2 2026/27
Deliver first round of length of stay reviews and individual solution-focused work for service users requiring additional support to step down to a less restrictive environment/community.	End of Q2 2026/27
Implement and evaluate use of sensory-integrated and therapeutic environmental equipment across women's secure services	End of Q2 2026/27
Implement the national improvement framework for prison transfers and remissions, including agreed structures, actions, and enabling conditions.	End of Q3 2026/27
Develop a strategic coordinated approach across health, social care and housing providers to identify and address the housing needs of our service users	End of Q4 2026/27
Longer Term Priorities	
Implement real-time bed tracking and discharge dashboards to improve flow, monitor readiness, and support data-led commissioning decisions.	Data flow from April 2027
Review arrangements for physical care including access to screening, dentistry and primary care	End of Q1 2027/28
Embed housing expertise into the pathway across inpatient and community forensic provision	End of Q4 2027/28
Introduce a robust housing needs assessment framework consistently across providers that feeds into assessment, CPA and discharge planning processes.	End of Q4 2027/28
Establish a housing pipeline with each local system to inform local authority housing strategies and ensure there are the right resources available for our service users to ensure patient flow and reduce delays in discharge planning	2028/29

AS2: We will invest in community alternatives to admission and implement an equitable community forensic service across the Region	
2026/27 Priorities	**Milestone Date**
Complete scoping of demand and market assessment of Alternative to Admission beds	End of Q1 2026/27

Implement a minimum service offer across all parts of the Region by investing in community forensic teams in Hertfordshire, Beds and Luton	End of Q2 2026/27
Enhance existing community forensic services in Essex, Norfolk and Suffolk to include extended hours and broader remit	End of Q3 2026/27
Interim solution for Alternative to Admission Beds	End of Q3 2026/27
Longer Term Priorities	
Deliver a fully mobilised and operational standardised community forensic service across the East of England	Q1 2027/28
Commission final Alternative to Admission bed model, as for use by community forensic teams to avert longer admissions using learning from interim solution.	End of Q4 2027/28

AS3: We will ensure we have the right beds in the right places to meet the needs of our population	
2026/27 Priorities	**Milestone Date**
Complete bed reconfiguration to right-size our LD bed base in line with demand and implement new delivery model including co-located low and medium inpatient care at sites in Herts and Norfolk.	End of Q1 2026/27
Complete demand and capacity work to assess feasibility of commissioning local ASD beds and offering shared resources to all forensic units to ensure neurodiversity informed care planning.	End of Q1 2026/27
Complete scoping for potential pre-admission ward for brief admissions to support a robust assessment and meet requirements around 28 day transfers	End of Q1 2026/27
Implementation of Women's Pathway Delivery Plan and scoping to identify areas for investment that will improve patient experience	End of Q1 2026/27
Increasing low secure male bed capacity to meet demand within our NHS units	End of Q4 2026/27
Longer Term Priorities	
Review commissioning arrangements for frailty to ensure adequate capacity and capability within region.	End of Q2 2027/28

3.4 Adult Eating Disorders

AED1: We will increase access to community-based alternatives to admission

AED2: We will ensure our inpatient services are providing high quality, effective care with capacity aligned to demand

Our commissioning intentions for adult eating disorder services reflect a change in how we plan to use inpatient care. Demand for inpatient care is reducing because of investment into community alternatives. We plan to continue this shift, with a focus on reshaping the pathway to support treatment closer to home.

Whilst supporting people outside of the inpatient setting is our aspiration, we will also ensure that when admission is needed, the offer is appropriate, responsive and able to meet complex clinical need.

We will:

- Reduce the use of inpatient services by commissioning community alternatives that support earlier intervention and discharge.
- Ensure a sufficiency of commissioned beds that can support Nasogastric (NG) feeding and accept patients detained under the Mental Health Act.
- Launch A-EDIT as a regional alternative to admission, offering intensive support in the community and virtually.
- Expand the Family Ambassador role and embed carer engagement tools developed by the advisory group.
- Establish a regional multidisciplinary oversight team to lead joint assessments, support bespoke treatment planning and improve transitions. This will include consultancy support for acute hospitals managing disordered eating presentations.
- Explore options to enable autism diagnosis within inpatient settings and adapt environments to meet sensory and communication needs.

- Standardise training, mentoring and supervision to build capability across inpatient and community teams.

3.4.1 Priorities for Delivery

AED1: We will increase access to community-based alternatives to admission	
2026/27 Priorities	**Milestone Date**
Full implementation of A-EDIT (Adult Eating Disorder Intensive Team) across the Region as a community alternative to admission model	End of Q1 2026/27
Establish regional complex and multiple needs case panels to support improved outcomes and greater collaboration.	End of Q3 2026/27
Strengthen Avoidant Restrictive Food Intake Disorder (ARFID) pathway with ICB commissioners and scope potential co-commissioning opportunities	End of Q4 2026/27
Work with providers of ICB commissioned community teams to regionally benchmark delivery models, workforce and variations in referral rates to specialised provision to inform ICB planning and co-commissioning potential	End of Q1 2026/27
Implement oversight team to provide advice and guidance and improve link between inpatient services and A-EDIT	End of Q2 2026/27
Introduce standardised assessments across inpatient and A-EDIT services	End of Q2 2026/27
Longer Term Priorities	
Implementation of ARFID pathway jointly with ICBs based on scoping work completed in 26/27 and reliant on co-commissioning arrangements being agreed.	Q1 27/28

AED2: We will ensure our Inpatient Services are providing high quality, effective care with capacity aligned to demand	
2026/27 Priorities	**Milestone Date**
Implement real-time dashboards to improve patient flow data	End of Q1 26/27
Embed discharge planning from admission within 14 days of admission	End of Q1 26/27
Scoping of workforce training requirements to ensure sufficient access to trauma-informed treatment modalities	End of Q1 26/27
Meet the national NHS staffing model for CPFT S3 ward	End of Q2 26/27
Adapt inpatient environments to ensure the needs of neurodivergent service users with sensory needs are met	End Q2 26/27
Pilot autism assessor post over 12 month period to improve formulation and treatment outcomes for those with suspected ASD within Adult Eating Disorder inpatient settings	End Q3 26/27
Review length of stay trends and establish clear expectations to optimise length of stay.	End of Q4 26/27
Develop and implement brief admission model (2-6 weeks) available via Oversight Team to support stabilisation for patients appropriate for A-EDIT	End of Q4 26/27
Finalise bed base review and needs assessment of detention and NG requirements to ensure commissioned levels align to demand	End of Q4 26/27
Extend therapeutic offer to include DBT and/or other trauma informed evidence-based treatment options to support service users with emotional dysregulation.	End of Q4 26/27
Longer Term Priorities	
Implement weekend therapy sessions and introduce weekend ward rounds on S3 Unit	End of Q1 27/28
Work with commissioned Independent Sector Providers (ISPs) to develop their workforce and skills mix to align more closely to the national NHS staffing model.	2027/28
Work closely with ICBs to develop a 'whole pathway' approach that improves skills within the whole pathway including physical health services and that supports service users to get appropriate physical health care for associated physical	

3.5 Children Young People Commissioning Intentions

CYP1: We will work with ICBs to embed the functions set out in the national Developmental Service Specification for an Intensive Mental Health Service: day services, intensive support, local mental health centres and high-intensity environments

CYP2: We will improve the pathway for Children and Young People with Eating Disorders

CYP3: We will improve transition for young people moving between CYP and adult services

CYP4: We will reduce Health Inequalities and improve services for CYP with LD&A

Our commissioning intentions for children and young people's mental health services reflect a shift towards integrated, least restrictive care. We aim to reduce out of area placements and ensure that inpatient care is purposeful, short, and close to home. We will have a strategic focus on improving transitions for those approaching adulthood.

Our approach builds on our 2023 CYP Commissioning Strategy commitments to adjust GAUs to include eating disorder pathways, progress alternatives to admission, reopen closed capacity, and embed QNIC standards.

The new national service specification sets out a model that combines inpatient, day services, and intensive community support within a single pathway. Our ambition is to deliver this model regionally, ensuring that children and young people can access the right care at the right time, in the least restrictive setting, and with strong family involvement. We will prioritise equity, neurodiversity responsiveness, and co-production throughout the pathway.

To deliver this ambition, we are initiating a bed reconfiguration review. This will ensure our future bed base is aligned with population health needs, supports the development of high-intensity environments, and enables reinvestment into community-based alternatives. This review will prepare us for the transition to the national model and ensure that our regional offer remains safe, sustainable, and responsive.

To achieve this we will:

- Ensure care is delivered as close to home as possible, with inpatient admission only when clinically necessary.
- Commission alternatives to admission as the first treatment option where appropriate.
- Ensure that when admission is required, it is purposeful, short, and delivered in the least restrictive environment.
- Embed the functions set out in the national specification: day services, intensive support, and high-intensity environments.
- Maintain QNIC standards across all commissioned inpatient provision.
- Reduce health inequalities by ensuring equity of access and outcomes for all children and young people, including those with neurodevelopmental needs, disabilities, and from diverse backgrounds.
- Improve the experience of transition for young people approaching adulthood through joint planning with adult services.
- Strengthen co-production with children, young people, and families in all aspects of service design and delivery.
- Use data and population health intelligence to shape capacity, monitor outcomes, and inform future commissioning decisions.

3.5.1 Priorities for Delivery

CYP1: We will work with ICBs to embed the functions set out in the national Developmental Service Specification for an Intensive Mental Health Service: day services, intensive support, local mental health centres and high-intensity environments	
2026/27 Priorities	**Milestone Date**
We will complete our review of current CYP inpatient capacity and develop plans to reconfigure our bed base as required, looking at requirements for integrating PICU and use of current High Dependency Areas	End of Q2 2026/27
Implementation of High Dependency Area on Norfolk's Dragonfly Unit to support complex children within a General Adolescent Ward.	End of Q2 2026/27
Out of hours detentions – Simulation Hub training to upskill professionals completing MHA assessments of CYP. To improve the experience and flow for CYP requiring assessment and to ensure that inappropriate admissions are avoided.	End of Q3 2026/27
Complete model review of Home Treatment Teams focussing on two key areas a) improving effectiveness and identifying a unified therapeutic model b) facilitating U13 intervention, considering appropriate interventions and requirements to deliver this.	End of Q4 2026/27
Work with providers to develop services in-line with national specification and with ICBs to agree commissioning arrangements for integrated service elements	End of Q4 2026/27
Longer Term Priorities	
Extend therapeutic offer to include broader range of evidence-based psychological interventions including RODBT	2027/28
Implementation of the new national service specification	2027-2030
Development of new Cambridgeshire and Peterborough Unit at Cambridge Children's Hospital which will be an integrated physical and mental health site.	End of 2030/31

CYP2: We will improve the pathway for Children and Young People with Eating Disorders	
2026/27 Priorities	**Milestone Date**
Substantive implementation of the CYP Eating Disorder Intensive Day and Virtual Service pilot delivering from 4 hubs and providing full regional coverage	End of Q1 2026/27
Completion of NG Training roll-out to all GAU ward to support units to appropriately manage CYP with eating disorders.	End of Q1 2026/27
Development of the ED pathway, and implementation of protocols and guidance to increase use of beds in GAUs for CYP with Eating Disorders.	End of Q2 2026/27
Longer Term Priorities	
Scope potential to develop ARFID pathway with ICB	2027/28

CYP3: We will improve transition for young people moving between CYP and adult services	
2026/27 Priorities	**Milestone Date**
Review effectiveness of transitions pathway for 16-19 year olds, working with ICBs to describe patterns and trends and identify how we can improve the pathway to ensure seamless care.	Q2 2026/27
Improve transitions into adult services through development of a protocol that supports integrated care planning from 17.5yrs and follow up from adult mental health teams within 7 days of discharge.	Q3 2026/27
Longer Term Priorities	
Pilot recovery pathway for complex young people which extends beyond 18th birthday	2027/28
Deliver improved seamless transition models that bridge CYP and adult services, particularly for young people with complex needs or those stepping down from inpatient care.	2028/29

CYP4: We will reduce Health Inequalities and improve services for CYP with Learning Disabilities those with autism (LD&A)	
2026/27 Priorities	**Milestone Date**
Develop recommendations for pathway improvements for CYP with LD&A including scoping the potential to deliver assertive outreach model.	End of Q1 2026/27
Improve experience for children with LD&A including implementation of changes to GAU environments to meet sensory needs	End of Q1 2026/27
Implement workforce up-skilling to enable key clinicians to complete autism assessments within inpatient settings and additional neurodiversity informed training.	End of Q2 2026/27
Complete health inequalities scoping for CYP based on improved data	End of Q4 2026/27
Implement recommendations for pathway improvements for CYP with LD&A following scoping	End of Q4 2026/27
Longer Term Priorities	
Use information from health inequalities review to develop an action plan for reducing health inequalities in terms of access and outcomes	End of Q2 2027/28
Consider potential for establishing a Complex Cases Assessment Team – to complete assessment where there are significant complexities within a referral. Working to ensure that CYP receive the most appropriate care and avoid admissions to units without agreed treatment plan and expectations.	2027/28
Scope potential for regional autism and cognitive assessment service to provide in-reach.	2027/28

3.6 Perinatal Commissioning Intentions

Our commissioning intentions for specialised perinatal mental health services reflect the national ambition to provide safe, timely, and family-centred care for women during pregnancy and up to 12 months after birth. We are seeing under-utilisation of MBU capacity in some areas, alongside variation in referral rates and access across the region.

Our priorities include improving the referral process, increasing antenatal referrals, and strengthening ties with maternity and obstetric services. We will work with ICBs to better integrate community and inpatient pathways and ensure that outreach functions are consistently delivered across all units.

Our ambition is to improve access, reduce variation, and strengthen integration across the perinatal pathway. We will use these principles to guide transformation and improve outcomes for mothers, babies and families.

We will address inequalities in access, including barriers faced by young mothers, vulnerable and minority groups and those living further from inpatient units. We will improve data quality and use demographic insights to inform commissioning decisions. We will also ensure that MBUs are equipped to support parent–infant bonding and record early experiences to inform future care.

- Ensure timely access to inpatient Mother and Baby Units for women who require admission, avoiding separation of mother and infant wherever clinically appropriate.
- Commission services that deliver trauma-informed, family-inclusive care, supporting partners and significant others as part of the therapeutic approach.
- Embed linked outreach and specialist advice functions to maintain continuity of care and support safe discharge.
- Align all services with NICE guidance and the NHS service specification for specialised perinatal mental health, including compliance with core standards and progression toward developmental standards.
- Reduce health inequalities by ensuring equitable access and outcomes for women from diverse backgrounds, including those with additional vulnerabilities.
- Strengthening integration between MBUs, community perinatal mental health teams, maternity services, and primary care to deliver seamless pathways.
- Use data and outcome measures from the Mental Health Services Data Set (MHSDS) to monitor quality, experience, and impact on maternal and infant outcomes.

3.6.1 Priorities for Delivery

P1: We will invest in our regional Mother and Baby inpatient services to ensure a standardised high quality service that delivers good outcomes for mothers, babies and their families	
2026/27 Priorities	**Milestone Date**
Implement sensory environment improvements across MBUs to better support neurodiversity	End of Q1 2026/27
Delivery of commissioned training to upskill MBU staff in parent-infant bonding interventions	End of Q1 2026/27
Increase staff confidence in working with complexity and trauma through implementation of Circle of Security training to improve trauma informed practice across all MBUs.	End of Q1 2026/27
Complete scoping paper and business case for a consistent outreach offer across all MBUs that meets the requirements of the national service specification	End of Q1 2026/27
Scope and agree a consistent parent–infant mental health and attachment offer across the Provider Collaborative, with clear alignment to the Children and Young People (CYP) pathway.	End of Q2 2026/27
Implement the outcomes of the business case for consistent outreach offer across all MBUs that meets the requirements of the national service specification	End of Q3 2026/27
Prepare for the new national service specification for MBUs	End of Q4 2026/27
Improve access to MBUs by identifying and where possible addressing barriers such as transport and visiting times.	End of Q4 2026/27
Longer Term Priorities	
Focus on physical health, including smoking reduction and wider physical health monitoring.	2027/28
Identify key health inequalities and agree a collaborative approach to addressing them, working jointly with ICBs and VCSE partners.	End Q1 2027/28
Develop additional support for partners and opportunities to ensure secure bonding between baby and the non-admitted parent while the infant is in hospital. Increase the number of MH assessments and onward referrals for non-admitted parents	End of Q4 2027/28
Embed trauma-informed practice across MBUs, building on the Circle of Security training and outcomes from the trauma informed practice working group.	2027/28

P2: We will improve continuity of care and joint working between MBUs, maternity and community teams	
2026/27 Priorities	**Milestone Date**
Improve awareness of MBU referral pathways and opportunity for antenatal admissions	End of Q3 2026/27
Development of joint working protocols between MBUs and Maternity Services and Community Teams	End of Q4 2026/27
Prepare for the new national service specification by • Establishing link midwife and link health visitor roles for each MBU and strengthened midwifery relationships through closer working with ICBs to expand maternity mental health integration.	End of Q4 2026/27
Expand reflective practice networks that support discussion around complex cases and peer support for professionals within the perinatal network.	End of Q4 2026/27

4. Accountability and reporting

4.2 Performance Oversight

To ensure delivery, we will implement a structured reporting and assurance framework that combines high-level oversight with detailed service line accountability for meeting the milestones outlined in this document. We will report progress to the Board through a bespoke dashboard that tracks performance. In addition to meeting our milestones we want to measure the impact of work on patients, carers and systems.

Each service line will report against the milestones set out in its section of this document. This will include:

- A delivery plan for each pathway, setting out agreed actions, milestones, and owners.
- A clear line of accountability for each action, with named leads and escalation routes.
- Evidence of progress against both quantitative metrics and qualitative improvements.

4.2 Measuring Success

The core metrics are attached as Appendix One, these will be developed as we implement our reporting suite and grow our reporting capabilities. Targets will be applied where they provide a meaningful measure of progress. Indicators will be applied across our commissioned inpatient and community services where appropriate.

4.3 Governance

Reports will be produced bimonthly in collaboration with the CDDGs and presented to the Provider Collaborative Board. Each report will include:

- Performance dashboard
- Service line delivery status
- Risks, mitigations and dependencies

Exceptions and risks will be escalated through the governance structure, with corrective actions agreed and tracked

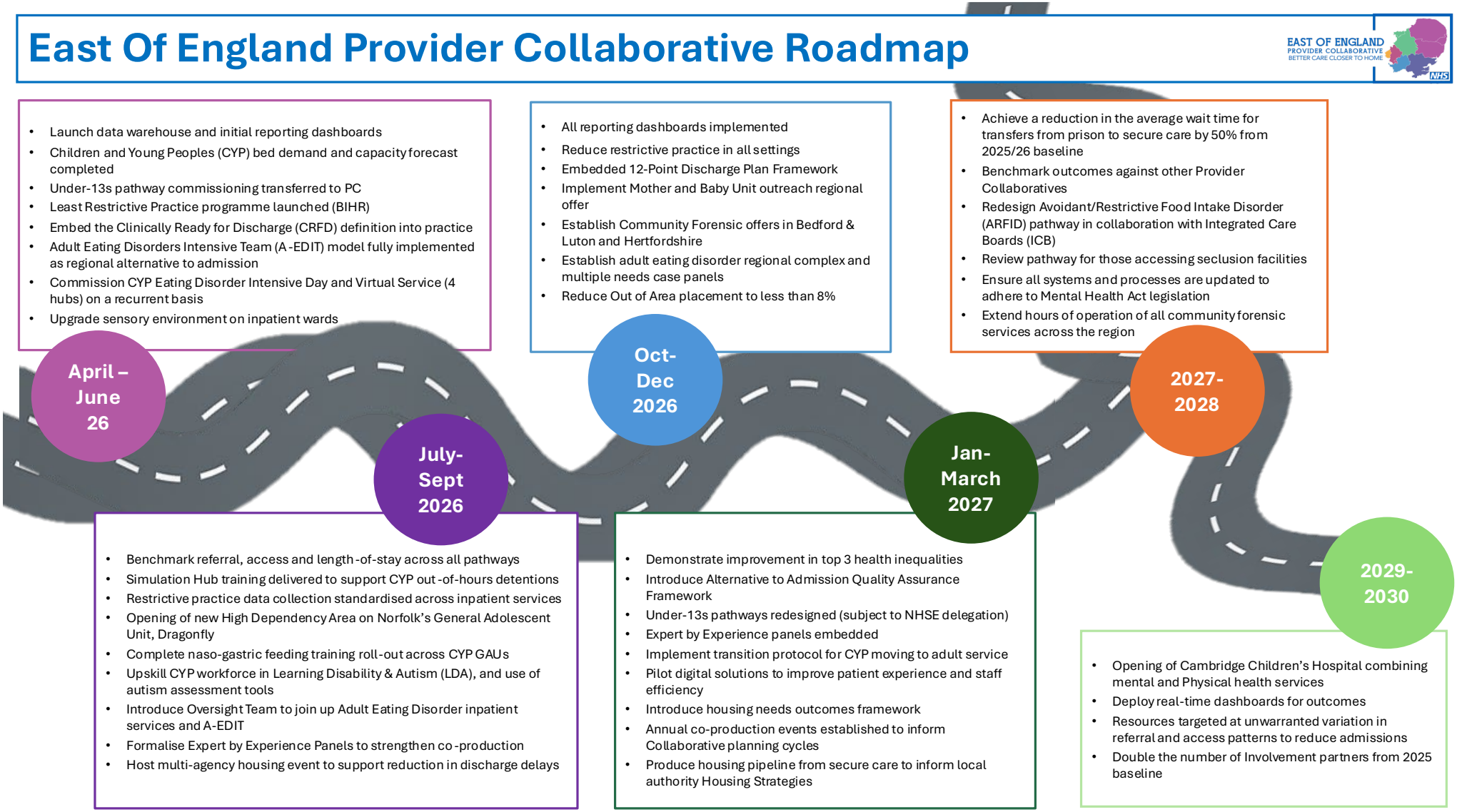
Underpinning delivery we shall ensure that the Provider Collaborative:

- Develops a master delivery plan.
- Tracks milestones and dependencies across all service lines.
- Coordinates data flows for the dashboard and measures.
- Implements risk management and escalation processes.

This approach ensures that accountability is clear, progress is visible, and delivery risks are managed. It also embeds a culture of continuous improvement, using data and feedback to inform decision-making.

5. Provider Collaborative Roadmap

East Of England Provider Collaborative Roadmap



April – June 26

- Launch data warehouse and initial reporting dashboards
- Children and Young Peoples (CYP) bed demand and capacity forecast completed
- Under-13s pathway commissioning transferred to PC
- Least Restrictive Practice programme launched (BIHR)
- Embed the Clinically Ready for Discharge (CRFD) definition into practice
- Adult Eating Disorders Intensive Team (A-EDIT) model fully implemented as regional alternative to admission
- Commission CYP Eating Disorder Intensive Day and Virtual Service (4 hubs) on a recurrent basis
- Upgrade sensory environment on inpatient wards

July-Sept 2026

- Benchmark referral, access and length-of-stay across all pathways
- Simulation Hub training delivered to support CYP out-of-hours detentions
- Restrictive practice data collection standardised across inpatient services
- Opening of new High Dependency Area on Norfolk's General Adolescent Unit, Dragonfly
- Complete naso-gastric feeding training roll-out across CYP GAUs
- Upskill CYP workforce in Learning Disability & Autism (LDA), and use of autism assessment tools
- Introduce Oversight Team to join up Adult Eating Disorder inpatient services and A-EDIT
- Formalise Expert by Experience Panels to strengthen co-production
- Host multi-agency housing event to support reduction in discharge delays

Oct-Dec 2026

- All reporting dashboards implemented
- Reduce restrictive practice in all settings
- Embedded 12-Point Discharge Plan Framework
- Implement Mother and Baby Unit outreach regional offer
- Establish Community Forensic offers in Bedford & Luton and Hertfordshire
- Establish adult eating disorder regional complex and multiple needs case panels
- Reduce Out of Area placement to less than 8%

Jan-March 2027

- Demonstrate improvement in top 3 health inequalities
- Introduce Alternative to Admission Quality Assurance Framework
- Under-13s pathways redesigned (subject to NHSE delegation)
- Expert by Experience panels embedded
- Implement transition protocol for CYP moving to adult service
- Pilot digital solutions to improve patient experience and staff efficiency
- Introduce housing needs outcomes framework
- Annual co-production events established to inform Collaborative planning cycles
- Produce housing pipeline from secure care to inform local authority Housing Strategies

2027-2028

- Achieve a reduction in the average wait time for transfers from prison to secure care by 50% from 2025/26 baseline
- Benchmark outcomes against other Provider Collaboratives
- Redesign Avoidant/Restrictive Food Intake Disorder (ARFID) pathway in collaboration with Integrated Care Boards (ICB)
- Review pathway for those accessing seclusion facilities
- Ensure all systems and processes are updated to adhere to Mental Health Act legislation
- Extend hours of operation of all community forensic services across the region

2029-2030

- Opening of Cambridge Children's Hospital combining mental and Physical health services
- Deploy real-time dashboards for outcomes
- Resources targeted at unwarranted variation in referral and access patterns to reduce admissions
- Double the number of Involvement partners from 2025 baseline

Appendix One- Measuring Success

Key Principle	What we want to achieve	What we want to measure	How we will measure this	Proposed Targets/ Standards
Optimise Length of Stay 	Ensure treatment durations are clinically appropriate to the service and pathway, and support least restrictive care.	How long service users are receiving treatment within inpatient settings and community teams and whether it is appropriate to the service and treatment model they are receiving.	Average length of stay on discharge and for current caseloads, benchmarked against comparable services and agreed pathway expectations across inpatient and community settings.	Reduction targets agreed with services where performance falls outside expected statistical ranges, supported through quality improvement plans.
	A reduction in time from patients being Clinically Ready for Discharge (CRfD) and discharge.	Delays in discharge and transfers from our services	No of bed days meeting criteria for delay (30 days post CRFD) by ICB No of inpatients who meet the criteria for delay by ICB Reasons for delayed discharges and transfers	Baseline to be established in 2026/27
	Earlier discharge planning to reduce the risk of extended inpatient admissions	Discharge planning from the point of admission	Percentage of new admissions with an estimated discharge date in place within one month Percentage of caseload with an estimated discharge date in place	90% of new admissions to have an estimated discharge date in place within one month by Q4 2026/27
	Improved transitions for CYP approaching adulthood	Increased proportion of 17 years olds with a transition plan 6 months before their 18th birthday.	Numbers of CYP who are 17.5 years Numbers of CYP who are 17.5 years with a transition plan in place	Baseline to be established in 2026/27
Care Closer to Home 	A reduction in avoidable out-of-area admissions and a clear understanding of the reasons for any out-of-area admissions to inform our commissioning	How many people are being avoidably placed out of region and how far away from home our service users are being placed.	No of OBDs out of Region No of OBDs outside of natural clinical flows Reasons for out of area admission (patient choice/natural clinical flow/insufficient capacity in-region) Distance from home by admission	
	Maximisation of our in-region inpatient services	How many people are using our inpatient and	Numbers accessing A2A services and utilisation percentage calculated	Targets will be set by service, considering

	and community alternative to admission models	alternative to admission pathways against commissioned capacity	from overall caseload capacity and numbers on caseload. Percentage bed occupancy against commissioned capacity. Bed closures, lost OBDs and reasons	mobilisation phase and baseline.
Invest to improve 	Improved pathways and service quality through investment that provide value and positive outcomes	Reinvestment levels in inpatient and community services	Service-line financial reporting demonstrating reinvestment into inpatient service quality and community pathways.	
		Outcomes of investment	This will be measured and reported through robust KPIs attached to all new investment	
Improve patient experience, access and outcomes 	An increase in clinical outcome monitoring so that we can understand the effectiveness of the services we commission	Improvement in clinical outcome monitoring	Percentage of service users with paired clinical outcome scores	70% of all patients to have a paired clinical outcome score on at least one measure by Q4 2026/27
	Services that provide clinically effective care that delivers positive outcomes for our service users	Clinical Effectiveness of the Services we deliver	Service level and compiled clinical outcome scores Friends and Family Test Scores Additional Patient Reported Experience Measures (PREMs) Data on post-discharge outcomes for our service users Readmission Rates	
	A reduction in restrictive practices to support our service users' recovery and reduce incidents of harm	How we are using restraint and to what degree	Service level and compiled data on incidences of seclusion, restraint, and long-term segregation.	Baseline in 2026/27
	Ensure we have a broad range of service user and carer voices to inform our commissioning and service development and delivery	Increase in the number of involvement partners	Numbers of involvement partners using numbers in 2025/26 as a baseline	100% increase by 2030

	An increase in access for women who require MBU admission based on national data which indicates unmet need	Increase in the number of antenatal referrals	Referral reporting split between antenatal and postnatal	
	Meet the 28 day prison to secure hospital transfer standard	How many new admissions are transferred within 28 days and how long it is taking on average	Average times for transfer Numbers and percentages of those exceeding the 28 day transfer standard	50% Reduction on 2025 baseline by 2028 0% by 2030
Reduce health inequalities 	Reduction in variation in access, length of stay and outcomes by ethnicity, gender, deprivation and geography	Variations in access, outcomes and length of stay across our population	Service user data mapped against key population data	
	Improved support and care planning for our LDA service users to reduce length of stay and avoid admission where possible through close inter-agency working	Whether we are ensuring appropriate care planning and admission avoidance	Inpatient C(E)TR Compliance Numbers of service users admitted with LDA by locality Length of stay for patients with LDA by locality benchmarked against non-LDA patients*	