Leicester, Leicestershire and Rutland Integrated Care Board

Northamptonshire Integrated Care Board

NHS Leicester, Leicestershire & Rutland ICB
NHS Northamptonshire ICB

Boards Meeting in Common in Public

Thursday 18 December 2025

Meeting Room 1 & 2, Haylock House, Kettering Parkway, NN15 6EY

NHS Leicester, Leicestershire & Rutland ICB and NHS Northamptonshire ICB Boards Meeting in Common in Public

Thu 18 December 2025, 09:30 - 11:30

Meeting Rooms 1 & 2 Haylock House, Kettering Parkway, NN15 6EY

Agenda

09:30 - 09:30
0 min

1. Welcome from the ICB Chair Introductions and Apologies

Advisory *Anu Singh*

Verbal

09:30 - 09:30
0 min

2. Declarations of Interest relating to agenda items

Advisory *Anu Singh*

Verbal

Members are reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of NHS Leicester, Leicestershire & Rutland Integrated Care Board and Northamptonshire Integrated Care Board

09:30 - 09:30
0 min

3. Draft Minutes of previous Board Meeting held on 16 October 2025

Approval *Anu Singh*

Reference: ICBiC-25-16

ICBiC-25-16 Draft Minutes of the meeting held on 16 October 2025.pdf (9 pages)

09:30 - 09:30
0 min

4. Matters Arising and Action Log

Advisory *Anu Singh*

Reference: ICBiC-25-17

ICBiC-25-17 Action Log December 2025.pdf (1 pages)

09:30 - 09:35
5 min

5. Questions from members of the public

Advisory *Anu Singh*

Verbal

Members of the public will be given the opportunity to ask questions which have been submitted in advance. These must relate to items that are on the agenda and responses will be provided under the next agenda item.

5.1. Response to questions raised by members of the Public

Advisory *Anu Singh*

Verbal

09:35 - 09:40
5 min

6. Chair and Chief Executive Updates

Advisory *Anu Singh and Toby Sanders*

Verbal

09:40 - 09:50
10 min

7. Joint Transition Assurance Report

Assurance *Toby Sanders*

Reference: ICBiC-25-18

ICBiC-25-18 Joint Transition Assurance Report.pdf (7 pages)

09:50 - 10:00
10 min

8. Board Partner Members

Approval *Toby Sanders*

Reference: ICBiC-25-19

ICBiC-25-19 Proposal for Board Partner Member and Participant Representation.pdf (5 pages)

10:00 - 10:10
10 min

9. Quality and Performance Assurance Reports - LLR ICB and N ICB

Assurance *Maria Laffan and Eileen Doyle*

Reference: ICBiC-25-20

ICBiC-25-20 Quality, Performance and Outcomes Assurance Reports – LLR ICB and N ICB.pdf (10 pages)

10:10 - 10:20
10 min

10. All-Age Continuing Healthcare

Assurance *Maria Laffan*

Reference: ICBiC-25-21

ICBiC-25-21 All-Age Continuing Healthcare (CHC) Report.pdf (10 pages)

10:20 - 10:30
10 min

11. Finance Assurance Reports - LLR ICB and N ICB

Assurance *Matt Gaunt*

Reference: ICBiC-25-22

ICBiC-25-22 Finance Assurance Reports – LLR ICB and N ICB.pdf (3 pages)

10:30 - 10:40
10 min

12. Emergency Preparedness Resilience and Response (EPRR) Annual Report

Assurance *Eileen Doyle*

Reference: ICBiC-25-23

ICBiC-25-23 Emergency Preparedness Resilience and Response.pdf (6 pages)

10:40 - 11:00
20 min

13. LNR ICBs Planning Submission and Response

Advisory *Peter Burnett and Matt Gaunt*

- **5 Years**
- **1 Year**

Reference: ICBiC-25-24

ICBiC-25-24 LNR ICBs Planning Submission and Response (5 years & 1 year).pdf (9 pages)

11:00 - 11:20
20 min

14. Implementation of Lung Cancer Screening in LNR

Approval *Eileen Doyle*

Reference: ICBiC-25-25

ICBiC-25-25 Implementation of Lung Cancer Screening in LNR.pdf (16 pages)

11:20 - 11:25
5 min

15. CHAIR'S CLOSING REMARKS

Advisory *Anu Singh*

Verbal

Date of Next Meeting - Thursday 19 February 2026

Minutes of the NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board Meeting in Common in Public

Thursday 16 October 2025 at 14:00
Board Room, Victoria Building, Leicester Royal Infirmary

Present: Members jointly appointed across NHS Leicester, Leicestershire & Rutland ICB and NHS Northamptonshire ICB	
Anu Singh	Chair
Pete Burnett	Chief Strategy Officer
Eileen Doyle	Chief Delivery Officer
Liz Gaulton	Non-Executive Member
Matt Gaunt	Interim Chief Finance Officer
Andrew Hammond	Non-Executive Member
Afzal Ismail	Non-Executive Member
Maria Laffan	Chief Nursing Officer
Prof Nil Sanganee	Chief Medical Officer
Toby Sanders	Chief Executive Officer
Apologies	
Simone Jordan	Non-Executive Member

Present: Members - NHS Leicester, Leicestershire & Rutland ICB	
Dave Maher	Partner Member NHS & Foundation Trusts Managing Director and Deputy Chief Executive, Northamptonshire Healthcare NHS Foundation Trust
Richard Mitchell	Partner Member NHS & Foundation Trusts Group Chief Executive, NHS University Hospitals Northamptonshire
Dr James Ogle	ICB Partner Member Primary Medical Services GP
Mike Sandys	Partner Member Local Authority Director of Public Health, Leicestershire County Council and Rutland County Council
In Attendance	
Daljit Bains	Head of Corporate Governance
Charlotte Gormley	Corporate Governance Officer
Apologies	
Mark Andrews	Partner Member Local Authority Chief Executive, Rutland County Council
Angela Hillery	Partner Member NHS & Foundation Trusts Group Chief Executive Officer, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust
Laurence Jones	Partner Member Local Authority Strategic Director, Social Care & Education, Leicester City Council

Present: Members - NHS Northamptonshire ICB	
Jane Bethea	Partner Member Local Authority Director of Public Health and Wellbeing, North Northamptonshire Council
Dr Jonathan Cox	Primary Medical Services Chair, Local Medical Committee and GP
David Johns	Partner Member Local Authority Director of Public Health, West Northamptonshire Council
Dave Maher	Partner Member NHS & Foundation Trusts Managing Director and Deputy Chief Executive, Northamptonshire Healthcare NHS Foundation Trust
Richard Mitchell	Partner Member NHS & Foundation Trusts Group Chief Executive, NHS University Hospitals Northamptonshire
In Attendance	
Neil Boughton	Deputy Director of Corporate Affairs
Apologies	
Anna Earnshaw	Partner Member Local Authority Chief Executive Officer, West Northamptonshire Council
Angela Hillery	Partner Member NHS & Foundation Trusts Group Chief Executive Officer, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust
Adele Wylie	Partner Member Local Authority Chief Executive, North Northamptonshire Council

Minute No:	Agenda Item
ICBiC25/26-01	**Welcome from the ICB Chair, Introductions and Apologies**

Anu Singh welcomed colleagues and members of the public to NHS Leicester, Leicestershire & Rutland ICB (LLR ICB) and NHS Northamptonshire ICB (NICB) Boards meeting in common.

Apologies for absence were noted as above.

Due notice had been given in line with the Constitutions, and the meeting was quorate.

ICBiC25/26-02 **Declarations of Interest relating to agenda items**

Standing declarations of interest were noted and it was confirmed that there were no declarations of interest relating to items on the agenda.

ICBiC25/26-03 **Draft Minutes of previous Board Meetings**

The minutes of NHS Leicester, Leicestershire & Rutland ICB Board meeting and Annual General Meeting held in public on 14 August 2025 were received and **APPROVED** as a true and accurate record of proceedings.

The minutes of NHS Northamptonshire ICB Board meeting held in public on 21 August 2025 were received and **APPROVED** as a true and accurate record of proceedings.

ICBiC25/26-04 Matters Arising and Action Logs

All actions were satisfactorily completed or in progress.

ICBiC25/26-05 Questions from members of the public

No questions had been submitted from members of the public in advance of the meeting.

ICBiC25/26-06 Chair and Chief Executive Updates

Toby Sanders reflected on the achievement of the LLR ICB and NICB Boards meeting in common for the first time. He encouraged colleagues to continue with the same energy and momentum moving forwards.

Toby Sanders outlined the key areas of focus over the second half of the year, beginning with delivery of the in-year agenda - priority areas included winter, urgent and emergency care (UEC), elective activity, equity of access and financial delivery. Secondly, he highlighted the importance of medium-term planning in the context of the 10-Year Health Plan. He noted the opportunity across the ICBs to develop bold ambitions for neighbourhood services, primary care, and the voluntary sector. Consideration would be given to how work in these crucial areas could be accelerated. Finally, Toby Sanders highlighted the role of governance in achieving a safe transition and shaping organisational change. He noted the opportunity to work collectively, taking the best from both systems to deliver services and transformation.

Anu Singh emphasised the importance of innovation, imagination, and bold thinking. She noted the opportunity to invent a new approach to strategic commissioning using a partnership approach. This approach would draw from a wealth of intelligence regarding what needed to be done differently, and the skills to translate this into a positive experience for future generations. Finally, Anu Singh highlighted the need to develop a new commissioning paradigm, noting the significant role of Boards and committees in working differently.

During discussion, it was agreed that strong links between ICBs and Public Health would be crucial to retaining primacy of place. There was a need to establish how this would be achieved at a local level without creating duplication. Additionally, the Boards considered the importance of achieving the three shifts to delivery in conjunction with partner organisations whilst ensuring the focus remained on strategic commissioning. It was noted that public expectations had altered, and it was important to take the public's input into account when shaping services and making difficult decisions going forward. Finally, it was noted that inefficiency and demand were two priority issues to be addressed in a way that managed risks appropriately between organisations.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the Chair and Chief Executive updates.

ICBiC25/26-07 Cluster LNR ICB Appointments

Toby Sanders reported that a single Executive Team had been appointed for the LLR ICB and NICB cluster. He noted that this step had been taken in line with the national requirement to reduce running costs.

Each of the Chief Officers introduced themselves and provided the Boards with a summary of their portfolios. Toby Sanders noted the progress represented by achievement of this milestone. He thanked all colleagues for their professionalism and dignity throughout the difficult process. Finally, he confirmed the commitment of the Executive Team to support staff and deliver against priorities.

Anu Singh reported that a process had also commenced to appoint a single Non-Executive Team for the cluster. She introduced each of the appointed Non-Executive Members and noted that one role remained to be appointed to. It was highlighted that Non-Executive Members had a responsibility to hold the Boards to account. Furthermore, consideration would be given as to how the Non-Executive Members and Executive Team portfolios could align to each of the five places across the clustered ICBs thus strengthening links with the respective Health and Wellbeing Boards.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the Cluster LNR ICB Appointments.

ICBiC25/26-08 Joint Transition Committee Assurance Report

Toby Sanders introduced the report, which provided an update on the safe transition for the ICB cost reduction programme aligned to the *Model ICB Blueprint*. The report included a summary of the 6 core programmes of work and key highlights of progress for the Boards to be aware of. Toby Sanders noted that the program of transition would have a longer timeline than originally announced, which presented opportunities as well as challenges. Due to the cost implications of change, particularly the need for a redundancy scheme, the transition process was likely to extend into the following financial year.

Furthermore, Toby Sanders highlighted that some functions currently undertaken by ICBs would be transferred elsewhere under the *Model ICB Blueprint*. Many of these functions were described within primary legislation, and ICBs were working with partners to consider the implications and timelines for any functional changes. It was noted that these functions would be right sized prior to transfer and would therefore be included within the Management of Change process. Finally, Toby Sanders advised that a Mutually Agreed Resignation Scheme (MARS) had been launched across both ICBs. The scheme would run for a period of four weeks.

During discussion it was noted that, as the Management of Change process would be delayed, there was a need to create capacity for innovation within retained functions, support the development of staff skill mix, and work with partner organisations to reflect the changed focus of the ICB as a strategic commissioner. Additionally, it was recognised that there was a need to scale-up areas that were working effectively and learn from examples of good practice.

Responding to queries raised, Toby Sanders confirmed that the required running cost reductions equated to one third at cluster level and were threaded throughout the core programmes. It was not yet known how NHS England would manage running cost allocations from the beginning of the next financial year. Additionally, Toby Sanders confirmed that some corporate and statutory functions were already being carried out at a 'supra' cluster level. Referencing Programme 5, he confirmed that the service changes scheduled for 2026 were to reshape existing functions. It was suggested that two or three key milestones be selected from the core programmes for the Boards to measure progress and ensure accountability.

It was requested that future reports would include detailed delivery measures and milestones against the programmes to enable greater visibility and assurance, and for the information to describe what the emerging new organisation would look and what skillsets would be required. Toby Sanders confirmed that he would inform Alice McGee of this request to action. **Action: Toby Sanders**

Finally, it was acknowledged that, due to the revised timescales, ICBs would be required to progress the transition, achieve cost reductions, and retain talent whilst managing in-year delivery areas under intense scrutiny. This was in addition to addressing local quality issues and elective activity. It was however noted that the original national timeline may not have adequately enabled ICBs to determine what strategic commissioning would look like for the cluster, what functions were needed or how partners would work together to deliver change.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board received **ASSURANCE** from the Joint Transition Committee Report.

ICBiC25/26-09 Cluster Governance Framework

Toby Sanders introduced the paper, which built on the informal and formal engagement previously undertaken on the development of an aligned Governance Framework between LLR ICB and NICB. The Boards were invited to approve the recommendations outlined within the paper. This included approval of the Executive and Non-Executive composition of the Boards, endorsement of the respective constitutions for submission to NHS England, and support to implement the proposed interim Committee Meetings in Common.

Neil Boughton outlined the proposal for interim committee governance. He noted that the LLR ICB and NICB Board development sessions had reached a consensus to align governance arrangements by establishing Committees in Common and Joint Committees. The proposed timeline had however been revisited, and it was recommended to defer approval of the wider Governance Framework to the December Boards Meeting in Common. There was therefore a need to seek approval for interim 'in common' arrangements to mitigate inefficiency and duplication.

Neil Boughton confirmed that the 'shadow' cluster committee structure would maintain oversight, assurance and delivery of statutory duties and functions. It would also provide an opportunity to test new ways of working and inform the proposals to be presented for the Boards' consideration in December.

During discussion, it was agreed that the proposed timescales would test potential governance arrangements whilst enabling further discussion and coproduction. It was noted that changes to the respective Constitutions would require approval from NHS England, however it was within the gift of the ICBs to amend the Governance Handbooks as required. The cluster committee structure would therefore be able to evolve and ensure the effective discharge of core business. Members noted the need to be clear on the role of each committee and the outcomes required by the Boards. This would be reflected in the committee terms of reference and membership. It was suggested that 3 or 4 key outcomes be identified for each of the committees against which the Boards would be able to measure effectiveness, as it was important for the Boards to maintain sufficient oversight of committees without duplicating work.

It was agreed for further discussion and shaping of governance arrangements to take place with progress fed into the upcoming Board development session. Further shaping of Board Partner Membership and Regular Participants proposals would be led by Anu Singh and Toby Sanders; and continued consideration of how the broader ICB operational structure may support the maintenance of engagement/ involvement of partners within the appropriate forum/"engine rooms" is recommended whilst reflecting the clearly defined role of the ICBs as strategic commissioners..

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the Cluster Governance Framework and **APPROVED** the recommendations outlined in the report.

ICBiC25/26-10 Board Assurance Framework - LLR ICB and N ICB

Neil Boughton introduced the report, which provided an update on alignment of the LLR ICB and NICB Board Assurance Frameworks (BAFs). He noted that some differences remained between the BAFs as the ICBs were two distinct statutory organisations. Neil Boughton outlined proposed updates to the individual BAFs and invited the respective Boards to approve the changes.

There was some discussion as to whether the BAFs had sufficiently captured the shift towards the role of a strategic commissioner, appropriately reflected what may be a shift in the focus/description of strategic priorities. A review of strategic priorities and subsequent risks to delivery was recommended to ensure the content of the BAF reflected/ responded to the future direction. It was agreed that the Executive Team would consider what the strategic objectives and the strategic risks are now and make a recommendation to the Boards via the Chief Executive's Report in December 2025. **Action: Toby Sanders**

It was suggested that a Board development session to consider strategic risk appetite would be considered and that this would enable risks to be reframed against the emerging priorities for the cluster.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board received **ASSURANCE** from the Board Assurance Framework.

ICBiC25/26-11 Quality Assurance Reports - LLR ICB and N ICB

Maria Laffan presented the report which provided a consolidated overview of key quality and safety issues across the system. She drew the Boards' attention to concerns regarding St Andrew's Healthcare, which remained under CQC-imposed restrictions following serious safeguarding and workforce failings. Maria Laffan outlined the oversight measures in place and noted improvements in leadership.

Secondly, Maria Laffan highlighted the positive progress across Maternity and Children & Young People's (CYP) services following CQC and peer reviews. It was noted that Kettering General Hospital was a part of the National Maternity Improvement Programme. Furthermore, UHL had been identified as one of 14 Trusts to be included in a national maternity and neo-natal investigation. The investigation was due to commence in November 2025 and would include a focus on family engagement.

Finally, it was noted that services from St Mary's Birthing Unit remained on pause.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board received **ASSURANCE** from the Quality Assurance Reports.

ICBiC25/26-12 Joint LLR ICB and N ICB Special Educational Needs and Disabilities (SEND) Assurance Report

Maria Laffan presented the report, which provided an overview of the current position and improvement activity across Northamptonshire and LLR. She outlined the oversight arrangements in place in Northamptonshire to address significant systemic weaknesses. Outcomes from a recent deep dive had been positive regarding leadership and engagement with partners, families, and the voluntary sector. Additionally, ongoing reductions in waiting times were reported for speech and language therapy (SALT), CAMHS, and ASD/ADHD pathways.

Regarding LLR, Maria Laffan reported a focus on strengthening Individual Health Care Plans (IHCPs) in schools, quality assurance of health information in Education, Health and Care Plans (EHCPs), and advancing the Change Partnership Programme to promote inclusion and reduce EHCP demand. The Board supported the need to triangulate the findings of Office for Standards in Education, Children's Services and Skills (Ofsted) reviews within the planning process.

Maria Laffan informed that the CYP Transformation Board had been re-established in Northamptonshire. Workshops had convened to discuss what the Board aimed to achieve, what families needed to know and how to assist families with navigating information. Jane Bethea highlighted the opportunity to strengthen work on early prevention and intervention and emphasised the importance of families receiving a better offer early in the process. The Board supported the continued collaboration between organisations.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board received **ASSURANCE** from the Joint Special Educational Needs and Disabilities Assurance Report.

ICBiC25/26-13 LNR ICBs 5-Year Strategic Commissioning Plan

Pete Burnett presented the report, which provided an update on the development of 5-Year Strategic Commissioning Plans in line with the recently published NHS Planning Framework. He noted the move from annual to medium-term planning to ensure integrated service delivery and financial sustainability. In response to the national ask, separate plans would be required from ICBs and providers in a move away from single system plans. It was noted that Planning Instructions were not yet available. Work had however commenced to collectively determine organisational governance arrangements for ICBs and providers, with agreement of key principles, planning assumptions and commissioning intentions. A system planning meeting would take place to review funding arrangements, operational flows, and finances.

During discussion, it was agreed that the Boards would identify local priorities to deliver change over the next 3-5 years. Suggested areas of focus included neighbourhoods, elective reform, and CYP mental and physical health. It was noted that Public Health and Local Authorities would support healthcare partners with a consistent approach to addressing health inequalities as part of the co-ordination of intelligence across health and care partners. There was also a need for ICBs to communicate with primary care regarding the anticipated needs of local contracts. It was noted that the move to community-based care carried a number of risks which increased the importance of coproduction, not least the need to manage the potential risk of overloading neighbourhoods and broader unintended consequences

Additionally, Maria Laffan highlighted the availability of local intelligence on the demand for SEND and CYP mental health services. Work around national drivers for epilepsy and diabetes were also in train and needed to be captured through the commissioning intentions. It was acknowledged that the changes discussed would require a radical shift in resource positioning and reimagining of where care was delivered across the system.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board received **ASSURANCE** from the LNR ICBs 5-Year Strategic Commissioning Plan.

ICBiC25/26-14 2025-26 Finance Reports - LLR ICB and N ICB

Matt Gaunt informed that the year-to-date system position at month 5 was a deficit of £41.5m. This was after non-recurrent deficit support funding of £66.4m and was a £6.1m adverse variance to plan. The year-to-date position at month 5 for NICB was £0.6m better than plan whilst LLR ICB had reported a £6.7m adverse variance to plan. Matt Gaunt noted that, despite the significant work underway across LNR to reduce the level of risk, there was no clear path to achieve delivery of the financial plans. It was confirmed that the Committee responsible for finance would continue to scrutinise the granularity of the forecasting on behalf of the Board.

Responding to queries raised, Matt Gaunt confirmed that Cost Improvement Plans were phased, meaning that the required efficiencies would increase month on month. The gradient was steeper for LLR ICB as the year progressed and so presented a greater challenge compared to NICB. He informed that productivity

and efficiency were thought to be greater drivers of the deficit than demand. NHSE had granted the ICBs one month to confirm the details.

There was some discussion regarding the appropriate management of risk across the system. Toby Sanders assured that decisions would be taken transparently. Explicit discussions would take place with a view to minimise impact on partner organisations.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the 2025/26 Finance Reports.

ICBiC25/26-15 Performance Assurance Reports LLR ICB and N ICB

Eileen Doyle presented the report, which provided a summary of performance against constitutional standards, NHS System Priorities and certain local measures within the local system. She highlighted some stylistic differences between the reports from the two ICBs and noted that a smaller, more coordinated pack had been developed for the Quarterly System Review Meeting.

Eileen Doyle identified CYP long waits and SALT as areas of focus across both reports. Specific to LLR, 62-Day Cancer performance remained a priority, with UHL in Tier 1 monitoring. Other key areas of performance included A&E 4 hour performance, category 2 ambulance response times, and reliance on impatient care for individuals with learning disabilities and autism. Key areas of performance for NICB included elective care and UEC.

Additionally, Eileen Doyle noted that some gaps in assurance remained in the Winter Plan. A multi-agency review of the plan would take place to identify further mitigations. It was recognised that pressures in elective, cancer and primary care would still be present during the winter period.

During discussion, it was noted that there was a need for the Boards to be sighted on the outcomes of plans, such as delivering neighbourhood health and improving life expectancy. It was suggested that 10-15 areas of focus be identified against which the Boards would evaluate progress through future reporting. Members acknowledged the importance of data in telling the full story.

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board received **ASSURANCE** from the Performance Assurance Reports.

ICBiC25/26-16 Chair's Closing Remarks

Anu Singh thanked members for their energy and appetite for change. She acknowledged that the transition period would be challenging however remained optimistic regarding opportunities for the Boards to make a real difference.

ICBiC25/26-17 Board Sub-Committee Reports

The LLR ICB Sub-Committee Reports, NICB Sub-Committee Reports, and Joint Sub-Committee Reports were **NOTED** for information.

The Chair brought the meeting to a close at 16:30

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

NHS
Northamptonshire
Integrated Care Board

ACTION LOG

NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB Board
Meeting in Common in Public

Updated 10 December 2025

Minute No:	Agenda Item	Action	Lead	Status/Update	Timescale	RAG
Meeting Date: 16 October 2025						
ICBiC25/26-07	Joint Transition Committee Assurance Report	Future reports to provide detailed delivery measures and milestones against the programmes.	Toby Sanders	Action complete and incorporated into December Transition Report	December 2025	
ICBiC25/26-10	Board Assurance Framework – LLR ICB and NICB	Strategic objectives and strategic risks to be considered and recommendation to be presented to the next Board Meeting.	Executive Team	Verbal update to be provided at December meeting.	December 2025	

Hazell, Tamara
16/12/2025 14:45:29

Completed
On Track
Overdue
No further action

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**Joint Transition Assurance Report**		
Paper Reference No:	**ICBiC-25-18**	**Agenda Item No:**	**7**

Presented by	**Eileen Doyle, Chief Delivery Officer**
Report Author(s)	**Alice McGee, Cluster Transition Director**
Executive Sponsor	**Toby Sanders, Chief Executive Officer**

Select the Primary Purpose for the Report		
☐ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☒ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☒ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- Note the progress of the Transition to Model ICB and achieve its mandated reductions
- Approve the updated Terms of Reference for the Transition Committee, to be renamed as Transition and Transformation Committee

Executive Summary of the report

The Joint Transition Committee has commenced meeting to consider the safe transition in 2025/26 for the ICB cost reduction programme and move to Model ICB. The Board will receive a regular assurance report on the committee and will have decisions escalated as appropriate. For this report, an updated Terms of Reference is included.

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?			
☒	**Improve Outcomes** - Improve outcomes in population health and healthcare	☒	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☒	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☒	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest	
☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
☐	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting
If conflict identified, please list conflicted party and nature of conflict: N/A	

Board Assurance Framework Risk	
LLR ICB BAF No: 10 and 11	**NICB BAF No: 9**

Appendices	***N/A***

Who has been engaged and where else has this report been considered:
August 2025 – Separate ICB Board, assurance report and approach to transition *October 2025 – Boards meeting in Common assurance report* *Bi-weekly Transition Committee meetings*

Implications:							
☒	**Quality & Patient Safety**	☒	**Legal**	☒	**Equality, Diversity & Inclusion**		
☒	**Environmental**	☒	**Data & Digital**	☒	**Financial**	☒	**Workforce**

Joint Transition Assurance Report

Thursday 18 December 2025

Introduction

1. The Transition Committee was set up in shadow form in May 2025 to oversee the transition and to provide assurances to the Board on progress, and escalate and concerns, risks or decisions required.

2. The committee oversees the assurance and mitigations for the Board Assurance Framework risks identified for Transition and specifically considers:

    a. Oversight of the transition across the complexity of all the ICB functions.

    b. Readiness assurance of any transferred functions, including resources, legal basis and receiver readiness.

    c. Impact of clustering on place and neighbourhood development including relationships with partners and development of improved outcomes for the population.

    d. Financial risks associated with transformation (cost of management of change).

    e. Workforce turnover, morale injury and risk of employee relations cases up to and including employment tribunals as a result of the management of change process.

3. The Transition Committee is not a decision making committee and seeks assurance through other formal governance structures in the ICB Cluster, namely the Joint Executive Team and Remuneration Committee.

4. The transition programme has been set up focussing on 6 strands of work and this report provides an update on progress as assured by the committee

Terms of Reference

5. The Transition Committee was stood up in May 2025 in response to the national directive and a mechanism to review progress against the work programme. As the committee has continued to meet it has reviewed its terms of reference

6. The terms of reference was reviewed and considered at the November 2025 meeting with the following proposed changes. The updated Terms of Reference will be received by Boad in February in line with all committee updates

    a. The title and function of the Committee to include transformation in addition to transition and strengthened reference in the terms of reference to ensure that the transition agenda includes a focus on transformation in line with Model ICB, Neighbourhood Health Guidelines and the newly published Strategic Commissioning Framework
    b. Membership section has been updated to reflect the new membership, including the Chief Strategy Officer.
    c. Chairing arrangements has been updated in line with the joint Non-Executive Director Appointments. The NED for Remuneration, Simone Jordan will now Chair the committee
    d. Quorum remains as four, with an amendment to state that this will be two executive and two non-executive members and the reference to "one from each organisation" has been removed.
    e. Meeting frequency has been changed to monthly

Progress Against Programmes of Work

7. Progress has been made in a significant number of programmes and table 1 below shows the key highlights of progress for the Board to be aware of.

Table 1

Programme 2 – Designing functions for a new Cluster ICB	In October 2025 a process was undertaken to appoint Non-Executive Directors to the joint Board. The appointment process was internally ring fenced for current LLR ICB and Northamptonshire ICB Non-Executive Directors. The appointments have been confirmed as: • Simone Jordan – NED for Remuneration and Transition • Andrew Hammond – NED for Finance • Afzal Ismail – NED for Audit • Liz Guant – NED for Quality There remains a vacancy for the NED for Commissioning and this will be national advertised in the coming weeks. It was accepted by the ICBs that any further management of change or reductions in staff structures to meet the 31% target reduction could not be met within the 2025/26 financial allocation. On 11th November 2025 NHS England and Department of Health and Social Care published a national Voluntary Redundancy Scheme for ICBs to use, and announced a financial settlement to support ICBs to fund the cost of change

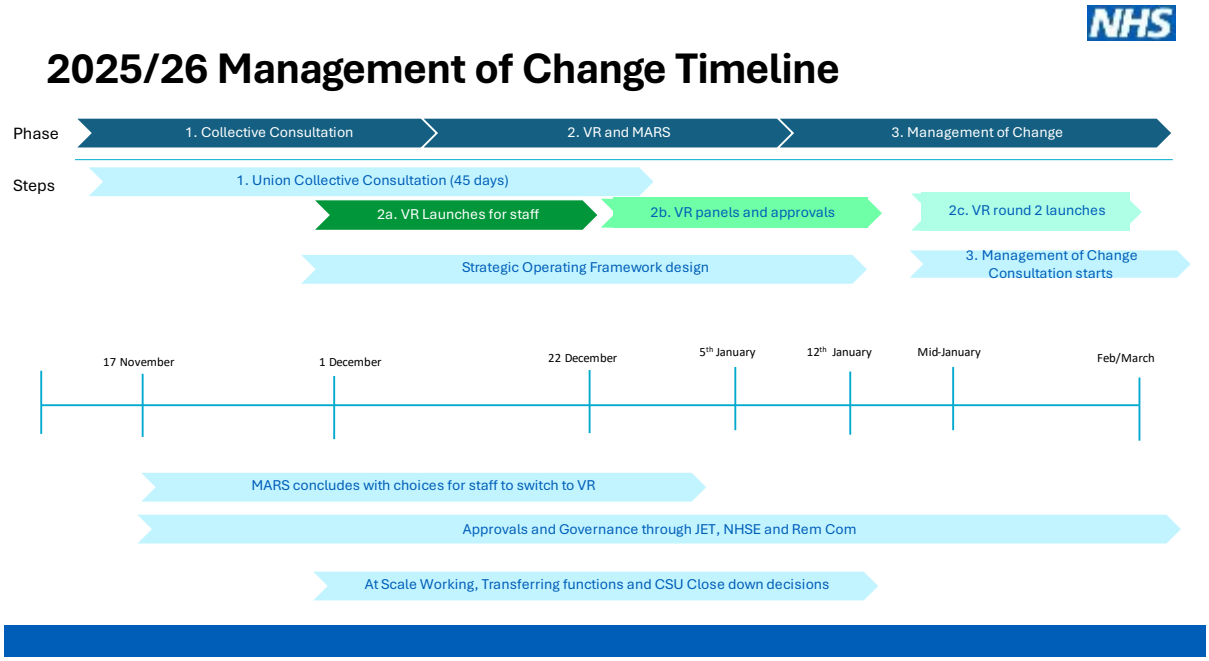
	(redundancy costs). This allocation for the Cluster is approximately 70% of the modelled maximum cost of redundancy payments and work is on going to identify the use of this allocation and ensuring patient funding is not used for the remainder of the maximum cost. On 19th November 2025, the Remuneration Committee approved the approach to Voluntary Redundancy and Compulsory Redundancy in 2025/26 to reduce the ICB cluster management costs by £17m. Work is on going to design the functions of a new cluster ICB management infrastructure with an anticipated timeline of consultation with staff in January 2026.
Programme 3 – Designing clustered governance	In November 2025 Board Development session, the Board were engaged in the proposal for the new clustered governance, including the critical path to implement the Board membership and sub-board governance In summary: • Revised Constitutions approved by NHS England. • Draft Terms of Reference and wider arrangements scoped in detail with lead Non-Executive and Executive. • Principles for reservation and delegation tested further and built upon in detail through Committee scoping meetings. • Collective ambition for streamlined reporting to Board to focus on summary positions, support escalation and align to core risks. • First meetings of all Committees in December; diarised to happened periodically thereafter. • Governance Framework components to be developed through Committees, the Executive and Non-Executive wholistically to test alignment and completeness. • Ambition for Board Partner Member and Participant proposal to be brought to December 2025 Board, and for joint nominations selection and appointment process to commence in January 2026 • Ambition for the wider Governance Framework proposal to be brought to the February 2026 Board Meetings in Common.

Programme 4 – reviewing functions that have another destination	There were 17 functions that were identified in the Model ICB framework that ICBs currently undertake that were going to be undertaken by another public body in the future, these functions are listed within the Model ICB and are broadly described as: - Going to a NHS Provider - Going to NHSE/DHSC regional offices - To be explored further Many of the functions are described within primary legislation, therefore the ICBs are working with partners to consider the implications and timelines for any functional changes.
Programme 5 – Functions that could be done at a 'supra' cluster level	As part of the review of functions it was identified that some of the corporate and statutory functions could be done on a footprint that is larger than the Cluster. The primary aims would be to increase the efficiency, attract expertise and improve quality. Initially 12 corporate functions were considered and were reviewed by experts through a options appraisal and 5 functions are considered to meet the criteria for further work to be explored (Business Intelligence, Cyber, HR Transactional Services, non-healthcare procurement, Medicines policy). These functions are being reviewed again in line with the national policy decision to close CSU's, where many of the at scale corporate functions for ICBs are already done. The East Midlands Joint Committee are receiving an options appraisal for consideration of the at scale functions and the ongoing work with CSUs to support close down. Decision will be made by January 2026, via the Joint Executive Team to inform structural design of the new Cluster.

Key Milestones and Outcomes

8. The programmes of work have a number of key milestones that have been updated to reflect the national timeline and funding. Table 2 sets out the key milestones for the remainder of 2025/26 financial year

Table 2



Recommendations:

The Board is asked to:

- **Note** the progress of the Transition to Model ICB and achieve its mandated reductions
- **Approve** the updated Terms of Reference for the Transition Committee, to be renamed as Transition and Transformation Committee

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**Proposal for Board Partner Member and Participant Representation**		
Paper Reference No:	**ICBiC-25-19**	**Agenda Item No:**	**8**

Presented by	**Toby Sanders, Chief Executive Officer**
Report Author(s)	**Neil Boughton, Deputy Director of Corporate Affairs**
Executive Sponsor	**Toby Sanders, Chief Executive Officer**

Select the Primary Purpose for the Report		
☒ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☐ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☒ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- **APPROVE** the proposed Partner Member and Participant sector representative structure.
- **NOTE** subject to the above approval the next steps signalled within the paper regarding submissions to the NHS England Midlands Regions Team and Joint Nomination, Selection and Appointment processes.

Executive Summary of the report

The October NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and NHS Northamptonshire Integrated Care Board (NICB) Boards Meeting in Common approved the revised Board Executive and Non-Executive Membership and noted the intention to reshape the sector Board Partner Members and Participant representative structure and present the proposal to the December Boards Meeting in Common.

The proposal contained within this paper fulfils that intention. The proposal builds upon all previous engagement undertaken with the Boards of LLR ICB and NICB, and the wider engagement with collaborative partners, stakeholders, and comparable organisations led by the LLR ICB and NICB Joint Chair and Chief Executive Officer.

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?			
☐	**Improve Outcomes** - Improve outcomes in population health and healthcare	☐	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☐	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☐	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest – Please select	
☐	No conflict identified
☒	Conflict noted, conflicted party can participate in discussion and decision
☐	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting
The conflict for existing partner members and participants is noted. These parties bring the knowledge, skills and experience for their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of the sector or an organisation. This combined with the proposal to undertake Joint Nomination, Selection and Appointment processes supports mitigation of personal / professional interest.	

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: Not applicable for specific risks, however Board composition maintains overall oversight and assurance of strategic risk.	**NICB BAF No:** Not applicable for specific risks, however Board composition maintains overall oversight and assurance of strategic risk.

Appendices	*N/A*

Who has been engaged and where else has this report been considered:
Previous engagement with Board and LNR Senior Leadership representatives. Proposal most recently presented to the Novembers Boards Development Session in Common; paragraph 3.2 describes the subsequent further engagement undertaken with sector representatives.

Implications: Select which of the following implications need to be considered							
☐	**Quality & Patient Safety**	☒	**Legal**	☐	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☐	**Data & Digital**	☐	**Financial**	☐	**Workforce**

Hazell, Tamara
16/12/2025 14:45:42

Proposal for Board Partner Member and Participant Representation

1. Purpose

1.1. This paper is presented to the Boards Meeting in Common of the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and Northamptonshire Integrated Care Board (NICB) to seek **APPROVAL** of the proposed Partner Member and Participant sector representative structure.

1.2. The LLR ICB and NICB Boards are asked to **NOTE** that subject to the above the Constitutions will be varied to reflect the new configuration and submitted to the NHS England Midlands Regions Team for approval.

2. Background

2.1. The October LLR ICB and NICB Boards Meeting in Common approved the revised Board Executive and Non-Executive Membership and noted the intention to reshape the sector Board Partner Members and Participant representative structure and present the proposal to the December Boards Meeting in Common.

2.2. The proposal contained within this paper fulfils that intention. The proposal builds upon all previous engagement undertaken with the Boards of LLR ICB and NICB, and the wider engagement with collaborative partners, stakeholders, and comparable organisations led by the LLR ICB and NICB Joint Chair and Chief Executive Officer.

2.3. The ICB Model Constitution and associated guidance set out that an ICB Board must include Partner Members as follows:

- At least one member jointly nominated by the eligible NHS Trusts and Foundation Trusts.
    - This Partner Member is normally expected to be the Chief Executive of one of those NHS T/ Foundation Trusts.
    - They should bring the perspective of the sector, and it will be of benefit for them to additionally engage with other significant providers, notably social enterprises.
- At least one member jointly nominated by the eligible providers of primary medical services.
    - This partner member should bring the perspective of general practice and an understanding of wider primary care, including PCNs and primary dental, community pharmacy and optometry providers.
- At least one member jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the area of the ICB.
    - This partner member will often be the Chief Executive of their organisation, or in a relevant executive local authority role; however, they may be a councillor where locally most appropriate.

And states that:

- While the Partner Members will bring knowledge and experience from their sector, and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

2.4. The ICB Model Constitution and associated guidance sets out that an ICB Board may:

- Invite specified individuals to be Participants or Observers at its meetings in order to inform its decision making and the discharge of its functions as it sees fit.

3. Proposal

3.1. Table 1 sets out the current and proposed configuration of Board Partner Member and Participant sector representatives for LLR ICB and NICB. This proposal is built through consideration of the NHS Reforms agenda and the engagement led by the Chair and Chief Executive Officer. The proposal seeks to respond to the evolution of ICBs whilst maintaining compliant, efficient and effective LLR ICB and NICB Boards / Boards Meeting in Common through not least:

- Supporting a balance of Non-Executive, Executive and Partner Members that compose the Membership and decision makers.
- Retaining compliance with nationally mandated ICB Board member roles, and the function of those roles.
- Enabling core sector representation at the Boards.
- Establishing the breadth of knowledge, skills and experience to support the Board to effectively discharge its duties.
- Minimising the numbers present to support the efficient and effective operation of the Board and Board governance.

Table 1; Board Partner Member and Participant Sector Representation

	Current		**Proposed**	
	LLR ICB	**NICB**	**LLR ICB**	**N ICB**
Partner Members	2 x NHS Trusts 3 x Local Authority 1 x Primary Medical Services	2 x NHS Trusts 2 x Local Authority 2 x Primary Medical Services	1 x NHS Trusts 1 x Local Authority 1 x Primary Medical Services	1 x NHS Trusts 1 x Local Authority 1 x Primary Medical Services
Participants	2 x Healthwatch 1 x NHS Trusts	1 x Healthwatch 1x VCFSE	1 x Healthwatch 1 x VCFSE	
Total Number for Cluster	17 sector representatives		8 sector representatives	

3.2. The proposal was open for discussion at and received broad support from the November Boards Meeting in Common development session. Further engagement led by the Chair and/ or Chief Executive Officer has been undertaken with partners within the Leicester, Northamptonshire and Rutland (LNR) Cluster. A summary of this engagement can be seen below:

- Local Authority,
  - Chief Executive Officer meeting with representatives of all 3 LLR Local Authorities – 11 December 2025.
  - Chief Executive Officer meeting with representative of North Northamptonshire Local Authority – 12 December 2025.

  - Chief Executive Officer meeting with representative of North Northamptonshire Local Authority – 12 December 2025.
- Voluntary, Community, and Social Enterprise (VCSE),
  - Chair and Chief Executive Officer meeting with representatives of LLR and Northamptonshire VCSE – 30 October 2025.
  - Chief Executive Officer follow up meeting with Russell Rolph of Voluntary Impact Northampton, representative nominated by the collective LLR and Northamptonshire VCSE – 14 November 2025.
- Healthwatch,
  - Chair and Chief Executive Officer meeting with representatives of North Northamptonshire, West Northamptonshire, Leicester and Leicestershire, and Rutland Healthwatch organisations – 4 November 2025.
  - Follow up letter sent from the collective Healthwatch organisations to the Chair and Chief Executive Officer thanking them for the engagement and stating that on balance it was felt the ICB's access to reliable, place-based insight would be significantly strengthened through two Healthwatch seats on the Board, one for LLR and one for Northamptonshire – 1 December 2025.
- NHS Organisations (NHS Trusts and Foundation Trusts, and Primary Medical Services),
  - Ongoing engagement between the Chair and / or the Chief Executive Officer and the current Partner Member representatives to ensure sight of and the opportunity to comment on emerging proposals.

4. Next Steps

4.1. Subject to the LLR ICB and NICB Boards approval the following sets out the key next steps:

- Corporate Team to reflect revised configuration in LLR ICB and NICB Constitutions and submit for approval to the NHS England Midlands Regional Team – December 2025.
- Remuneration and People Committees Meeting in Common to receive the Joint Nominations, Selection and Appointment process – Jan 2026.
- Joint Nominations, Selection and Appointment process to be undertaken with the ambition of appointments being made where possible prior to the February 2026 Boards Meeting in Common – commence Jan 2026.

5. Recommendation

5.1. The LLR ICB and NICB Boards are each asked to **APPROVE** the proposal for Board Partner Member and Participants set out in Table 1, and subject to these approvals **NOTE** the next steps.

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

NHS
Northamptonshire
Integrated Care Board

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**Quality, Performance and Outcomes Assurance Reports – LLR ICB and N ICB**		
Paper Reference No:	**ICBiC-25-20**	**Agenda Item No:**	**20**

Presented by	**Maria Laffan, Chief Nursing Officer LNR** **Eileen Doyle Chief Delivery Officer LNR**
Report Author(s)	**Maria Laffan, Chief Nursing Officer LNR** **Eileen Doyle Chief Delivery Officer LNR**
Executive Sponsor	**Maria Laffan, Chief Nursing Officer LNR** **Eileen Doyle Chief Delivery Officer LNR**

Select the Primary Purpose for the Report		
☐ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☒ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- The Boards are being asked to RECEIVE and NOTE the position, with assurance that ICB teams are prioritising appropriate actions under agreed plans to address the issues identified.

Executive Summary of the report

This report summarises key updates from the **Quality, Performance and Outcomes Committee (QPO)**. With recognition of current ICB operational change, the cluster continues to strengthen assurance activity across quality, outcomes, and performance.

The report follows the **AAA governance approach**:

- **Alert** – Key risks/issues requiring escalation and action
- **Assure** – Areas where progress is being made but targets are not yet met
- **Advise** – Positive developments and achievements impacting outcomes

Key Issues for Board Attention

Leicester, Leicestershire and Rutland Integrated Care Board

Northamptonshire Integrated Care Board

Quality & Performance

- **Mental Health (MH):**
  - Complex patient provision challenges; quality concerns at St Andrew's Healthcare (admissions closed). NICB as host commissioner – future strategic role.
  - General MH bed availability impacting Urgent and Emergency Care (UEC) and Emergency Departments (ED).
- **Urgent and Emergency Care (UEC):**
  - University Hospitals of Leicester (UHL) experiencing high demand.
  - Northampton General Hospital (NGH) ambulance handover improvements noted.
- **Special Educational Needs and Disabilities (SEND):**
  - Good partnership progress, but significant challenges remain in neurodevelopmental (ND) pathways and long waiting times.
- **Initial Health Assessments (IHA):**
  - Statutory performance critically low; urgent recovery actions underway.

Safeguarding & Inspection

- **Joint Targeted Area Inspection (JTAI):**
  - Announced for Leicestershire (8–12 Dec), focusing on child sexual abuse in family settings.

Finance & Escalation

- **Continuing Healthcare (CHC)/Complex Care (CCC):**
  - NHSE Level 3 financial escalation due to £13m overspend.
  - New recovery board chaired by CNO established.

Overall Position
Contractual assurance structures are active and recovery plans are in place, but risks remain in:

- Statutory compliance (IHA)
- MH Bed provision including St Andrews
- Elective recovery
- Financial sustainability
- Provider quality

Board oversight is essential to ensure delivery against recovery trajectories, regulatory requirements, and future strategic commissioning responsibilities. Supplementary reports from the Committees in Common for Quality, Performance and Outcomes (QPO) meeting on 09 December 2025 are available for the Board to view via admin control to support the Board's understanding

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?			
☒	**Improve Outcomes** - Improve outcomes in population health and healthcare	☐	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access

☒	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☐	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest – Please select	
☒	No conflict identified
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☐	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting
If conflict identified, please list conflicted party and nature of conflict: N/A	

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: 5	**NICB BAF No: 1**

Appendices	***N/A***

Who has been engaged and where else has this report been considered:
Executive officer for Quality Performance & Outcomes committee. NED for QPO committee in common – wider deputy officers from quality & performance directorates

Implications: **Select which of the following implications need to be considered**							
☒	**Quality & Patient Safety**	☐	**Legal**	☒	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☐	**Data & Digital**	☒	**Financial**	☐	**Workforce**

Quality Performance & Outcomes Board report December 2025

Table of Contents

Making Meetings Matter use of 3 As – Good Governance

Adopting best practice from the Good Governance Institute
The 3 As – what is this and what does this mean?

- The 3As report format provides a simple way for groups and committees to report to their parent group/committee or indeed to the executive group or board of directors.
- It provides a succinct way in which to report and highlight particular areas of a programme of work that require action/escalation

What are the 3 A's

- **Alert** – what are the 3-4 key issues/risks that you need to alert the Board/meeting on? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage
- **Assurance** – what are the key areas that require and you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated
- **Advise** – what are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes

Not everything will be covered with the above and therefore the box on update, risks and learning should support leads to include into the report any sharing of learning, brief updates and review of any risk

Performance Report – LLR Executive Summary

Alert

October UHL ED attends activity volume increased 26,041 compared to 24/25 24,116 – 8% adverse variance – awaiting November data to understand if this is a sustained increase in overall volume. UHL is the single ED for LLR. Additional winter actions in place to manage demand.

Cancer 62-day performance is behind plan with a significant risk to the delivery of the planned target of 63.2% - improvement plan is place with improvements expected in Q4.

Cancer FDS standard is behind plan now – risk to recovery on this is Breast 1st Appointment time remains at 4 weeks with additional capacity in place.

Shift in LOS in in-patient MH – an increase in CRFD (Clinically Ready for Discharge) noted and escalated via the UEC Operational group to identify the operational actions required to reduce the number of patients delayed that impact on LOS.

Assure

CAT 2 EMAS Ambulance response (<30mins) remains red – Ambulance Handover delays remained challenged – Release to Respond (W45) has now been implemented from 10/12/25. This will improve the performance of Ambulance Handovers thus impact on the CAT 2 Mean Response.

LDA adult patients in MH inpatient settings – reduction in the number of MH inpatients seen.

LLR remain in tiering for Elective (52 weeks), Cancer (62 Day), ED (4 hours performance and Ambulance Handover).

Update, risk and learning on Plans

Upcoming further IA of resident doctors 17/12/25 to 22/12/25. This is likely to impact on the Elective and Cancer Performance – Plans are in place to mitigate against the risk.

Rollout of PAS has impacted on overall productivity in 25/26 in UHL impacting on total waiting list size.

Impact of court of protection delays due to MoJ impact on timelines adversely impacting on LOS

Advise

65 Week + waiters – delivery of reduction to plan with forecast plan to 0 by 21st December

Community waiting list for CYP Services – the position has been improving. However, the continuing level for referrals does place this continued improvement at risk

System delivery of the 4-hour performance in October and delivery against the standard during Q1. Delivery of plans continue to maintain this with continued increase in volume of activity demand on ED.

Performance Report – Northamptonshire Executive Summary

Alert

- Bed Occupancy: Remains high with extended ALoS reflecting increased acuity seen as result of early impact of flu and respiratory season
- Ambulance Handovers: Performance remains inconsistent with NGH being the most challenged, being in OPEL 4 as a system for 10 days towards the end of October. However significant improvements since winter schemes have commenced.
- Patients NC2R: Remains challenged at KGH & NGH. NGH OPEL 4 with 21% - 31% NC2R, KGH OPEL 3 & OPEL 4 18% - 32% NC2R.
- Cancer 62-days, FDS and % receiving diagnosis in 28-days are all behind plan
- Overall elective activity remains behind plan with a recovery plan in-place.

Assure

- Additional winter schemes implemented embedding including, New Rapid Assessment Unit at NGH, Primary Care Acute Respiratory Hubs, Spinneyfield beds and additional night home visiting capacity to support hospital discharges and community escalations
- Resulting performance at NGH has significantly improved since schemes commenced particularly the RAU.
- Implementation of no 45 min ambulance breaches between 8am and 8pm from 15th December
- 65-week position is being carefully managed but current maintaining 0 position.
- 52-week cohort also reducing in line with plans.
- Community and Mental Health delivery remains good.

Update, risk and learning on Plans

- Upcoming further IA of resident doctors 17/12/25 to 22/12/25. This is likely to impact on the Elective and Cancer Performance – Plans are in place to mitigate against the risk.
- Risks surrounding urgent care remain, particularly in-light of the flu situation but plans and schemes are much more developed than last winter

Advise

- Spinal services have ceased at KGH. Escalated to strategic contract meeting, with SBAR and options to be developed.
- Corby CDC now open with recovery actions in place to recover up to planned activity (Kings Heath delivering versus plan).
- Planning permission has been received for the Urgent Treatment Centre at NGH which is expected to open in the summer of 2026

Quality Report – LNR Executive Summary

Alert

CHC/CCC – NHSE Level 3 Escalation Forecast overspend of c.£13m. new CNO-led Improvement Board and recovery plan in place.

St Andrew's Healthcare (Northampton) Persisting serious quality and safeguarding concerns; organisation under enhanced scrutiny. CQC report pending publication.

Statutory Initial Health Assessments (IHA/RHA)Performance has deteriorated due to provider capacity, misaligned commissioning and paediatric workforce pressures. Compliance critically low, requiring urgent systemwide recovery.

JTAI – Leicestershire (Child Sexual Abuse in the Family Environment) Multi-agency inspection underway (8–12 Dec). System-wide coordination and response underway.

Willows Health – Further assurance required after RQRM and site visit identified in-hours signposting to 111 without clinical triage; actions due by 02/12/25.

Assure

LPT Section 29A (MH Waiting Times)Adequate assurances provided, including strengthened MCA/MHA compliance, transparency, and improved training; de-escalated at QIG pending CQC feedback

Greenacre Park – CQC Outcome Rated Good in all areas; no current quality concerns. Rainbows Hospice – CQC Outcome Rated Outstanding in all domains, a first children's hospice nationally to achieve this distinction.

CHC/CCC In-Housing Programme Board established with dedicated workstreams (workforce, digital, governance, finance). Regular reporting and escalation mechanisms functioning well.

Cardiac Surgery – UHL De-escalated to Level 2 following progress against QIP; awaiting final RCS and CQC reports.

EMED/UHL/LPT Incident Management Improved triage of incidents and clearer operational structure following joint review.

Update, risk and learning on Plans

System-wide pressures on Mental Health beds capacity continue, with limited community provision driving delays in Acute settings and prolonging length of stay.

BadgerNet Transition – Ongoing stabilisation required.

Embedding EQHIA within outcomes monitoring will improve the system's ability to assess quality, equity and health inequalities impacts consistently.

System Learning from RQRM and Inspections (JTAI/SEND) – Improvements in data transparency, incident governance and escalation are being embedded.

Persistent SEND assessment delays risk statutory compliance, requiring action

Advise

SEND Pathways Significant waits remain, especially for neurodiversity assessments, but improvement work progressing. Requires strategic commissioner decisions on prioritisation and funding.

Maternity (UHL & KGH)Continued monitoring of culture, consent and safety themes via MSSP, IOAG frameworks and the Amos Review.

UHN ongoing oversight of KGH paediatric services continues through the Quality Concerns Oversight Group and JIOAG, with priority on sustaining a safe and compliant service.

National Patient Safety Alert: Risk of harm from mis-recorded penicillin allergies; system-wide action required with CCIO-led oversight.

Acronyms Explanation

- LLR – Leicester, Leicestershire and Rutland
- NGH – Northampton General Hospital
- KGH – Kettering General Hospital
- UEC – Urgent and Emergency Care
- CYP – Children and Young People
- MH – Mental Health
- SEND – Special Educational Needs and Disabilities
- CQC – Care Quality Commission
- CHC – Continuing Healthcare
- CCC – Complex Care Cases
- IA – Industrial Action
- OPEL – Operational Pressures Escalation Level

Leicester, Leicestershire and Rutland Integrated Care Board

Northamptonshire Integrated Care Board

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**All-Age Continuing Healthcare (CHC) Report**		
Paper Reference No:	**ICBiC-25-21**	**Agenda Item No:**	**11**

Presented by	**Maria Laffan, Chief Nursing Officer** **Nilesh Sanganee Chief Medical Officer**
Report Author(s)	**Mandy Staples, Director of Nursing, NICB**
Executive Sponsor	**Maria Laffan, Chief Nursing Officer** **Nilesh Sanganee Chief Medical Officer**

Select the Primary Purpose for the Report		
☐ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☒ **ASSURANCE** To assure the Board that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- Be Alerted, Advised and Assured through the report.

Executive Summary of the report

NHS Continuing Healthcare (CHC) is a statutory framework providing fully funded packages of care for individuals with a primary health need as defined in the National Framework (2012, revised 2022). The report highlights that services cover adults and children with complex, long-term, or end-of-life care needs, spanning CHC, Children's Continuing Care (CCC), Funded Nursing Care (FNC), Personal Health Budgets (PHBs), and joint-funded arrangements.

In Northamptonshire, CHC and related services are currently delivered by Arden and GEM CSU under delegated arrangements, with Children's Continuing Care managed in-house (see Northamptonshire CHC Services). In LLR, the full AACC function is commissioned through Midlands and Lancashire CSU, encompassing CHC, CCC, FNC, and Section 117 aftercare services (see LLR ICB All Age Continuing Care Services).

2 key matters for Board attention is 1. The development of improvement and efficiency Board aligned to LLR top 10 priorities to aid financial recovery and service improvement.

2. The forthcoming national closure of all Commissioning Support Units (CSUs) as part of the government's 10-year Health Plan, requiring the safe transfer of AACC functions to ICBs. The board is now provided with and update of the in housing mobilisation board.

☒	**Improve Outcomes** - Improve outcomes in population health and healthcare	☒	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☒	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☒	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest	
☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
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If conflict identified, please list conflicted party and nature of conflict: N/A	

Board Assurance Framework Risk -	
LLR ICB BAF No:5	**NICB BAF No:1**

Appendices	***N/A***

Who has been engaged and where else has this report been considered:
The contents of this report have been taken from the Quality Committee, System Quality Group and system engagement activity for both LLR and NICB.

Implications:							
☒	**Quality & Patient Safety**	☒	**Legal**	☒	**Equality, Diversity & Inclusion**		
☒	**Environmental**	☒	**Data & Digital**	☒	**Financial**	☒	**Workforce**

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Continuing Healthcare Update

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NHS Continuing Healthcare

NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. To receive NHS CHC funding, individuals must be assessed by Integrated Care Boards (ICB's) according to a legally prescribed decision-making process to determine whether the individual has a *'primary health need'*. This process is set out in the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, published 2012 (Revised 2022).

To become eligible for NHS continuing healthcare, the person must be assessed as having a "primary health need" and have a complex medical condition and substantial and ongoing care needs. Not everyone with a disability or long-term condition will be eligible.

Citizens eligible for NHS continuing healthcare will receive a package of care for the commissioning and operational delivery support team. The package of care is specific to that individual and may range from a single episode of care through to the provision of a long-term complex care package for some of the most vulnerable individuals, frequently with the highest levels of need within the care system.

Care is provided to citizens across all demographics (from children to older people) and across the broadest spectrum of care needs covering physical and mental health, long term conditions, complex care, and end of life.

Within LNR there are 2 key priorities aligned to the CHC services

1. LLR efficiencies and improvement – refocus current service delivery and stabilise financial position. Working closely with NICB to provide consistent approach to cluster population

2. CSU transition – AGEM and MLCSU, mobilisation and in-housing by 1st July 2026

1. LLR CHC Refocus Efficiencies and Improvement

- New Cluster ICB Executives in post, aware of immediate steps required to improve LLR CHC financial position.
- LLR CHC Improvement Board established. This will bring together top expertise and skills across LLR/NICB to drive forward change.
- CHC deep dive carried out with new CNO and CFO
- Current CHC efficiency schemes reviewed
- Priority areas identified (including additional opportunities for efficiencies)
- Revised recovery plan developed and approved by ICB execs
- Refocus on Top 10 priorities – with key deliverables

Top 10 Priorities

Priority Area	Issue Identified	Efficiency Type
High-Cost Packages > £10k per week.	LLR has the highest cost per case in the East Midlands.	a) Financial Efficiency (Cash releasing)
CHC eligibility	The number of cases assessed as eligible in LLR is higher than the East Midlands average which suggests that LLR has a higher CHC conversion rate.	a) Quality Improvement b) Financial efficiency (Cost avoidance)
CSU delegation < £1k	MLCSU currently have delegated authority to approve packages up to £52k per annum (£1k p/w). Anything above this amount comes through panel for ICB approval.	a) Quality Improvement b) Financial efficiency (Cost avoidance)
1:1 Packages	1:1 Policy required to ensure robust processes are in place to allocate and review 1:1 hours for all cohorts. FNC 1:1 has been identified as an area requiring immediate review.	a) Financial Efficiency (cash releasing) b) Quality Improvement
Shared Care (locally agreed process)	Local process to provide support to individuals with delegated healthcare tasks is not in line with CHC Framework. Alternative solutions to be sought.	a) Financial Efficiency (cash releasing) b) Quality Improvement

Top 10 Priorities Continued

Priority	Summary	Efficiency Type
Joint Funding	Review the current funding split process to ensure the ICB contribution is paying for unmet health needs only.	a) Quality Improvement b) Financial efficiency (Cash releasing subject to LA agreement)"
Equity & Choice Policy	Review of current policy to support fairer decision making, better management of expectations and reduced overprescribing of care.	a) Quality Improvement b) Financial efficiency (Cost avoidance)
AQP Framework	**The existing AQP framework has been in place for over 10 years and is not open to new providers. Over 40% of providers are not accepting framework rates leading to more expensive spot purchase packages.**	a) Quality and Productivity Improvement
Brokerage with local authorities	**Brokerage contracts with local authorities do not reflect current practice. Not assured current offer is value for money under existing contracts.**	a) Quality and Productivity Improvement
Removal of S117, THC/D2A and ABI from CHC portfolio	**S117 clinical service sits with MLCSU, and financial approval sits within the CHC team. The budget sits within the Integration and Transformation Directorate.** **THC/D2A clinical service sits with MLCSU and is performance managed by the CHC Team. The budget sits within the Discharge Grant.** **ABI clinical service sits with LPT and is performance managed by the CHC Team. The budget sits within the CHC HoS Portfolio.**	a) Productivity Improvement

Medium Term planning (next 6 months)

1. Desktop review of High-Cost Cases costing over £10k per week and F2F reviews of all LDA high-cost cases
2. Work with LDA Collaborative to understand access to community health services for the high-cost individuals.
3. Liaison completing backlog of CHC/Joint Funded reviews.
4. Audit to review CHC eligibility decisions (Liaison reviews may identify changes in eligibility for backlog cases)
5. Review current CSU financial delegation threshold/put new ICB approval process in place
6. Publication of a new 1:1 policy and review of FNC 1:1 cases
7. Review of Equity and Choice policy, consideration of financial threshold/opt out clause
8. Review of remaining Shared Care cohort (c.75 cases) to move people to alternative provision and cease funding
9. Audit of 20 Joint Funded cases by NICB to establish if only unmet health needs are being funded.
10. Removal of S117, THC/D2A and ABI from the CHC portfolio
11. Safe transfer of AACC services from MLCSU to the ICB, this will improve grip and control.
12. Partnership development with LA's/ADASS/collaboratives

Longer Term Priorities (12-18 months)

1. Following on from AACC in-housing, explore opportunities for integrated working with NICB and remodelling to improve quality and efficiency of AACC services and processes.
2. To re-open/reprocure AQP framework to onboard more providers and ensure packages are in line with market rates.
3. To review current brokerage contracts with local authorities to ensure these are value for money and explore. opportunities for improved integrated working.
4. Identify a long-term solution for individuals with delegated healthcare tasks (Shared Care)
5. Joint development of a CHC Patient Transport policy with NICB to prevent unwarranted transport costs
6. Development of CYP challenging behaviour and respite position statements to ensure all CCC funding is in line with the CCC national framework.
7. Explore opportunity to develop a regional LDA provider Framework.

2. ALL Age Continuing Healthcare in- Housing Transition

Key areas of progress

- CHC programme board meetings commenced November 25 – CNO SRO
- IT digital workstream established – workplan drafted
- Workforce workstream established – workplan drafted
- Monthly operational group meetings established
- Meeting with IT digitals leads took place to discuss next steps and membership
- Mobilisation plan drafted and shared with colleagues across LLR, NH ML and AGEM
- PMO SharePoint and file structure fully established and accessible to colleagues
- Clinical Safety Officer appointed to ensure compliance with DB160 &NHS Digital clinical a safety requirement
- Procurement advice in respect of CMS confirmed that the Provider Selection Regime regulations would allow for novation of the digital licences/agreements so these could be transferred to ICBs when the services move across, without any procurement exercise

Current Identified Risks

- Pressures on workforce as a consequence of ICB cost reductions, CHC improvement & CIP activity, and uncertainty associated with the in-housing transaction
- Data migration plans for ADAM and Broadcare to be implemented asap – 34 weeks is recommended timescale for safe data migration.
- The decision to procure a Broadcare licence and ADAM licence for the ICB with a wider procurement of a single CMS post 1 July 2026 will have financial implications for the ICB

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Integrated Care Board

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**Finance Assurance Reports – LLR ICB and N ICB**		
Paper Reference No:	**ICBiC-25-22**	**Agenda Item No:**	**11**

Presented by	**Matt Gaunt, Chief Finance Officer, LLR ICB and NICB**
Report Author(s)	**Spencer Gay, LLR ICB Deputy Director of Finance (System)** **Jonathan Shuter, NICB Deputy Chief Finance Officer**
Executive Sponsor	**Matt Gaunt, Chief Finance Officer, LLR ICB and NICB**

Select the Primary Purpose for the Report		
☒ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☐ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- **RECEIVE and NOTE** the update provided on the 2025/26 financial positions at month 7 and forecast outturns, and the items noted at the December Finance and Contracting Committee.

Executive Summary of the report

This report confirms that the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and NHS Northamptonshire Integrated Care Board (NICB), collectively termed the Leicester, Leicestershire and Rutland (LNR) Cluster reported a collective deficit financial position at month 7 of £4.3m, after non-recurrent deficit support funding (DSF) of £7.6m which is better than plan by £1.0m. The position reflects:

- LLR surplus of £0.8m, (after DSF £7.6m), which is £1.0m better than plan
- Northamptonshire surplus of £3.5m, which is in line with plan

The full year reported forecast is achievement of plan across LNR Cluster, after £15.2m non-recurrent support. At M7 £1.3m of DSF has been withheld due to failure to meet NHSE business rules at the end of Q2.

A total risk after current mitigations to delivery of financial plans has been identified at month 7 of £19.6m all arising in LLR ICB.

The following items were noted at the December Finance and Contracting Committee of the LNR Cluster ICBs:

- Following the national launch of the new ledger system the ICBs are maintaining a watching brief on the ICBs and providers Better Payment Practice Compliance and cash positions to enable early identification of risk.
- Whilst recognising the challenged financial landscapes the Committee promotes the need to plan for transformation and drive innovation moving forward, and the need to establish the organisation risk appetite to inform the parameters within which this can be done.

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?			
☐	**Improve Outcomes** - Improve outcomes in population health and healthcare	☐	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☒	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☐	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest –	
☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
☒	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting
If conflict identified, please list conflicted party and nature of conflict: N/A	

Board Assurance Framework Risk -	
LLR ICB BAF No: 4	**NICB BAF No: 7 & 8**

Appendices	N/A

Who has been engaged and where else has this report been considered:
The detail that informs this report has been heard on behalf of the Boards through the Finance and Contracting Committee.

Implications: **Select which of the following implications need to be considered**							
☐	**Quality & Patient Safety**	☐	**Legal**	☐	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☐	**Data & Digital**	☒	**Financial**	☐	**Workforce**

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NHS
Northamptonshire
Integrated Care Board

LNR Cluster Finance Report Month 7 (October) 2025/26

Thursday 18 December 2025

Headlines

Table 1 – M7 LLR/NICB Financial Position

Net		Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FOT £m	Actual FOT £m	Variance FOT £m
LLR ICB	Position before support	(9.0)	(6.8)	2.2	(15.5)	(15.5)	(0.0)
	Deficit Support	8.8	7.6	(1.3)	15.2	15.2	0.0
	Net Position after support	**(0.2)**	**0.8**	**1.0**	**(0.3)**	**(0.3)**	(0.0)
Northants ICB	Position before support	3.5	3.5	0.0	10.0	10.0	0.0
	Deficit Support	-	-	-	-	-	-
	Net Position after support	**3.5**	**3.5**	**0.0**	**10.0**	**10.0**	**0.0**
LNR Cluster Total	Position before support	(5.5)	(3.3)	2.2	(5.5)	(5.5)	(0.0)
	Deficit Support	8.8	7.6	(1.3)	15.2	15.2	0.0
	Net Position after support	**3.3**	**4.3**	**1.0**	**9.7**	**9.7**	**(0.0)**

1. Table 1 above details the position before and after deficit support funding. At month 07, LNR Cluster is reporting a year-to-date surplus of £4.3m (after deficit support funding of £7.6m), which is £1.0m better than plan. Before deficit support funding the LNR Cluster has reported a £3.3m deficit.

2. The year-to-date variance to plan is driven by the following key areas:
   - Non receipt of Q3 deficit support funding the ICB (£1.3m)
   - Prescribing, CHC and ADHD growth in excess of planned levels
   - Elective underperformance at the ICB within NHS partners, partially offset by Independent Sector overperformance

3. The full year reported forecast continues to be a breakeven position across the LNR Cluster, after £15.2m non-recurrent support, which is in line with the approved ICS plans.

4. At month 7, LLR ICB has reported a forecast £4.4m under delivery against the efficiency plan of £70.2m

5. The LNR Cluster ICBs have reported an unmitigated risk position of £19.3m, resulting from a continuation of year to date performance across prescribing and CHC and failure to deliver planned CIP related to corporate cost reductions. The corporate cost reduction was assumed to follow from the ICB restructures which has been delayed.

6. Significant work is underway across LNR and with support from NHSE and will continue to reduce the level of risk in order to be able to achieve LNR Cluster required financial delivery.

Recommendations:
The Boards are asked to:

- **RECEIVE and NOTE** the update provided on the 2025/26 financial positions at month 7 and forecast outturns, and the items noted at the December Finance and Contracting Committee.

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Northamptonshire
Integrated Care Board

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**Emergency Preparedness Resilience and Response (EPRR) Annual Report**		
Paper Reference No:	**ICBiC-25-23**	**Agenda Item No:**	**12**

Presented by	**Eileen Doyle, Chief Delivery Officer/Accountable Emergency Officer, LLR ICB and NICB**
Report Author(s)	**Amita Chudasama, Head of EPRR, LLR** **Richard Jarvis, Head of EPRR and System Resilience, NICB**
Executive Sponsor	**Eileen Doyle, Chief Delivery Officer/Accountable Emergency Officer, LLR ICB and NICB**

Select the Primary Purpose for the Report		
☐ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☒ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- **RECEIVE** assurance of the results of the 2025 EPRR Core Standards for Leicester, Leicestershire and Rutland ICB and for Northamptonshire ICB, and the ongoing EPRR work being carried out across both ICBs.

Executive Summary of the report

The annual assurance process under NHSE EPRR Core Standards was completed during November 2025:

- Leicester, Leicestershire and Rutland ICB achieved Substantial compliance status.
- Northamptonshire ICB achieved Full compliance status.

Following the recent ICB cluster arrangements between Leicester, Leicestershire and Rutland (LLR) ICB and Northamptonshire ICB, work has begun to align EPRR ways of working, a joint governance process and to develop resilience as a wider team.

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?

☒	**Improve Outcomes** - Improve outcomes in population health and healthcare	☐	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☐	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☐	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest – Please select	
☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
☐	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting

If conflict identified, please list conflicted party and nature of conflict:
N/A

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: Risk 6	**NICB BAF No:** Risk 10

Appendices	***None***

Who has been engaged and where else has this report been considered:
The results of the EPRR Core Standards have been considered as a summary report by NHSE Midlands and system partner AEOs at Northamptonshire and LLR Local Health Resilience Partnership (LHRP) groups.

Implications: **Select which of the following implications need to be considered**							
☒	**Quality & Patient Safety**	☐	**Legal**	☐	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☐	**Data & Digital**	☐	**Financial**	☐	**Workforce**

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Emergency Preparedness Resilience and Response (EPRR)

Thursday 18 December 2025

Introduction

1. EPRR continues to be a high-profile deliverable of the NHS, particularly against a revised National Security Risk Assessment (NSRA) and increased Urgent and Emergency Care activity. These, and other issues, have increased the requirement for planning and assurance around the ability to respond to emergencies and maintain services.
2. The annual assurance process of NHSE EPRR Core Standards continues to form the structure of the ICB EPRR workplan and focusing resources on achieving the standards required for compliance.
3. Following the recent ICB cluster arrangements between Leicester, Leicestershire and Rutland (LLR) ICB and Northamptonshire ICB, work has begun to align EPRR ways of working, a joint governance process and to develop resilience as a wider team.

Compliance with the EPRR Core Standards Assurance Process

4. Under the NHS Act 2006, NHS England has a statutory duty to ensure that the NHS in England is properly prepared for dealing with an emergency. This includes monitoring the compliance of each ICB and service provider with EPRR requirements via the NHS EPRR annual assurance process.

5. The assurance process uses organisational self-assessments of compliance with the NHS Core Standards for EPRR. The outcome of this process is used by organisations to identify areas of good practice and issues that require further development. Organisations use their self-assessment to guide their annual work plan and prioritise the development of local arrangements.

6. LLR and Northamptonshire ICBs submitted their self-assessments against the EPRR Core Standards to NHSE Midlands at the end of August 2025, as did the relevant local NHS providers.

7. ICBs took the lead across their Local Health Resilience Partnership area to ensure that providers of NHS funded services remained accountable for their arrangements. Throughout September and October, the ICB EPRR teams and NHSE Midlands undertook a programme of Confirm and Challenge meetings, covering both the ICBs themselves and their in-county NHS providers.

8. Results of this assurance process were presented and agreed by system Accountable Emergency Officers and NHSE Midlands at the Local Health Resilience Partnership (LHRP) meetings held in Leicestershire and Northamptonshire during November 2025.

9. **Leicester, Leicestershire and Rutland ICB achieved Substantial compliance** status, with 44 of the 47 standards assessed as fully compliant and three as partially compliant.

LLR ICB were asked to downgrade their compliance level against Core Standards 2 (EPRR Policy) and 44 (Business Continuity Management Policy) due to governance sign off processes and the policies not being signed off by the ICB Board. This will be addressed as part of the new cluster governance arrangements. CS53 the ICB declared

as partial compliance as further work is required on the process for reviewing provider business continuity assurance. A plan is in place to address this by implementing the process used by Northants ICB.

10. **Northamptonshire ICB achieved Full compliance status**, with 47 of the 47 standards assessed as fully compliant.

Organisational Compliance Summary

Organisation	Services provided or organisational type (X those which apply)											Compliance achieved:		
	Acute providers	Specialist providers	NHS Ambulance services	Patient Transport Providers	NHS 111	Community services providers	Mental health providers	ICB	Primary care (GP, community pharmacy)	Commissioning Support Unit	Other NHS funded organisations	Full / Substantial / Partial / Non		Change ↔ ↑ ↓
												2024/ 2025	2025/ 2026	
Leicester, Leicestershire and Rutland Integrated Care Board								X				Subs	Subs	↔
Leicester Partnership Trust						X	X					Full	Full	↔
University Hospitals of Leicester NHS Trust	X											Subs	Subs	↔

Organisation	Services provided or organisational type (X those which apply)											Compliance achieved:		
	Acute providers	Specialist providers	NHS Ambulance services	Patient Transport Providers	NHS 111	Community services providers	Mental health providers	ICB	Primary care (GP, community pharmacy)	Commissioning Support Unit	Other NHS funded organisations	Full / Substantial / Partial / Non		Change ↔ ↑ ↓
												2024/ 2025	2025/ 2026	
Northamptonshire Integrated Care Board								X				Subs	Full	↑
Kettering General Hospital NHS Foundation Trust	X											Non	Non	↔
Northampton General Hospital NHS Trust	X											Non	Non	↔
Northamptonshire Healthcare NHS Foundation Trust						X	X					Subs	Subs	↔
St Andrews Healthcare											X	Subs	Subs	↔

11. Progress has been made across University Hospitals of Northamptonshire (UHN) Group over the previous 12 months, with both KGH and NGH showing improvement in governance and sharing strategic oversight where appropriate, whilst also maintaining operational planning as individual sites. The ICB continues to support the development of EPRR at UHN and a comprehensive work plan is in place.

Training and Exercising

12. Both ICB EPRR teams ensure that all staff in an EPRR role receive relevant training so that they can fulfil their role, with a focus on the On-Call roles (Strategic and Tactical), EPRR team roles as well as general awareness training made available to all ICB staff. This training is provided through internally led sessions and external courses through partners such as the Local Resilience Forums including JESIP training, immersive TCG/SCG exercises, Loggist training and workshop sessions around subjects including the Manchester Arena Inquiry and Martyn's Law. All ICB staff are asked to maintain a Personal Development Portfolio (PDP) which aligns training to the National Occupation Standards (NOS).

13. Northamptonshire exercises during 2025 have included:
    a. Exercise Silver Siren – a live RAF-led mass casualty exercise with a multi-agency involvement and NHS utilising the scenario to test mass casualty planning and command and control.
    b. Exercise Tangra – an NHSE Midlands led tabletop pandemic exercise with an NHS coordination and response focus. (A precursor to Ex Pegasus)
    c. Exercise Pegasus – a tabletop exercise led by UKHSA, took place through September, October and November 2025 focusing on the national level pandemic

response. Whilst all LRFs took part, Northamptonshire LRF played as one of four Focus LRFs nationally and system engagement has provided extensive information for evaluation.

d. Exercise Echo 1 – a pan ICS cyber exercise testing how the LLR and Northants ICS' would respond to a major cyber security incident at a strategic level.

14. Leicester, Leicestershire and Rutland exercises during 2025 have included:
    a. Exercise Mercury – a live LRF led RTC on M1 exercise with multi-agency involvement with NHS organisations utilising the scenario to test their Incident Response plans, command and control and ICB setting up an Incident Coordination Centre.
    b. Exercise Tangra – an NHSE Midlands led tabletop pandemic exercise with an NHS coordination and response focus. (A precursor to Ex Pegasus)
    c. Exercise Pegasus – a tabletop exercise led by UKHSA, took place through September, October and November 2025 focusing on the national level pandemic response.
    d. Exercise Echo 1 – a pan ICS cyber exercise testing how the LLR and Northants ICS' would respond to a major cyber security incident at a strategic level.

Incidents Experienced

15. LLR and Northamptonshire ICBs have experienced a number of incidents over the past year, some of these have been Fire/Police focused incidents, with minimal impact to Health. The ICBs have represented Health as invited at all Local Resilience Forum led Strategic Coordinating Groups (SCGs) and Tactical Coordinating Groups (TCGs) and provided feedback to health partners on actions and updates that may have an impact on their service users and service delivery. In all incidents, but especially flooding, vulnerable residents were prioritised and the ICBs ensured medical needs were being considered, with support from Community Trust colleagues. The ICBs continue to contribute to LRF debriefs and support improvements to our collaborative planning. The ICBs are also actively engaged in any subsequent incident recovery groups.

16. The ICBs continue to coordinate and support the system planning and response to the instances of BMA members industrial action, and provide assurance to NHSE regional teams for national reporting, escalating any capacity issues and system pressures during industrial action. It should be noted that there was an increased focus on UEC performance and pressures during the recent periods of industrial action, particularly around ambulance delays.

Lessons Identified and Continuous Improvement

17. The ICBs and wider systems continue to take learning from all events, with debriefs taking place following all incidents. Whilst there is currently nothing of significance for escalation, the ICBs continue to support system partners in their management and response to incidents and coordinating the system response to continued industrial action.

18. Recent debriefs from NHS industrial action have produced no significant new learning as the ICBs and their providers are familiar with the processes and escalations regarding these periods of action. However, this is not viewed as 'business as usual' and the systems work closely together in order to maintain patient safety and continuity of service.

19. In addition to lessons identified, the ICBs take the opportunity to issue their policy documents and plans for consultation at the time of review (annually or 3-yearly as standard). These documents are sent to relevant partners such as NHSE Midlands, Local Authorities, NHS providers, and LRF partners as well as internal ICB colleagues across different directorates. Following feedback received through this consultation process, improvements have been made to Policies and Plans to make them more user friendly and include any recent guidance changes.

Recommendations:

- **RECEIVE** assurance of the results of the 2025 EPRR Core Standards for Leicester, Leicestershire and Rutland ICB and for Northamptonshire ICB, and the ongoing EPRR work being carried out across both ICBs.

NHS Leicester, Leicestershire and Rutland Integrated Care Board

NHS Northamptonshire Integrated Care Board

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**LNR ICBs Planning Submission and Response (5 years, 1 year)**		
Paper Reference No:	**ICBiC-25-24**	**Agenda Item No:**	**13**

Presented by	**Pete Burnett, Chief Strategy Officer, LLR ICB & NICB**
Report Author(s)	**Ket Chudasama, Deputy Chief Strategy Officer, LLR ICB**
Executive Sponsor	**Pete Burnett, Chief Strategy Officer, LLR ICB & NICB**

Select the Primary Purpose for the Report		
☒ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☐ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- ***NOTE the contents of the report***

Executive Summary of the report

This paper provides an update on the development of the 5-Year Strategic Commissioning Plan and Medium-Term Plan, which will deliver local priorities and national ambitions set out in the 10-Year Health Plan. The plans focus on improving population health, reducing inequalities, and integrating services, with priority areas including frailty, premature mortality, and children and young people.

The Medium-Term Planning Framework (MTPF) requires credible, deliverable, and affordable plans that triangulate finance, workforce, and activity. The first submission is due 17 December 2025, with full submission by 12 February 2026. Key risks include financial balance, staff capacity, and the changed approach to planning requiring individual organisational plans. Ongoing discussions with partners and NHS England assurance will focus on ensuring alignment with quality, safety, and national requirements.

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?			
☒	**Improve Outcomes** - Improve outcomes in population health and healthcare	☒	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☒	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☒	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest – Please select	
☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
☐	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting

If conflict identified, please list conflicted party and nature of conflict:
N/A

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: 2, 4, 5, 10, 11	**NICB BAF No: 3, 6, 8, 10**

Appendices	

Who has been engaged and where else has this report been considered:
The initial assessment against the MTPF performance targets and requirements has been considered and discussed by the Joint Executive Team on 19 November 2025 and with the Board at the Board Development Session on 20 November 2025. The contents of this report have been discussed with the Commissioning Strategy Committee.

Implications: Select which of the following implications need to be considered							
☒	**Quality & Patient Safety**	☐	**Legal**	☒	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☒	**Data & Digital**	☒	**Financial**	☒	**Workforce**

Hazell, Tamara
16/12/2025 14:45:42

LNR ICBs Planning Submission and Response (5 Years, 1 Year)

18 December 2025

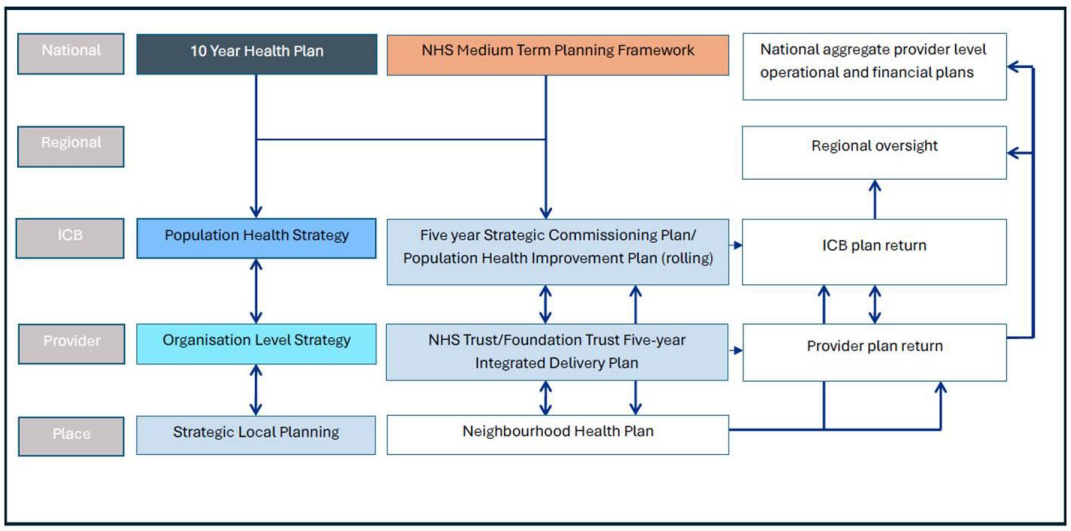
Introduction

1. The purpose of this paper is to provide an update on the development of the 5-Year Strategic Commissioning Plan and Medium-Term Plan. The paper outlines the key aspects of the respective plans, and the progress made to date.

2. As set out in the 10-Year Health Plan and the Medium-Term Planning Framework, ICBs are expected to produce a 5-Year Strategic Commissioning Plan. These plans are intended to support the delivery of both local priorities alongside the shared national ambitions outlined within the 10-Year Plan, such as the three shifts. The Strategic Commissioning Plan will set out how the ICB intends to deliver its strategy for the five-year period, 2026-27 to 2030-31.

3. Figure 1 below illustrates the wider relationship between the key elements of the national planning architecture.

Figure 1: Relationship between the key elements of the national planning architecture



4. The Strategic Commissioning Framework was published by NHSE in November 2025 to support ICBs in developing their plans. This key document is central to the new role of ICBs as Strategic Commissioners, repositioned as a leaner, high-impact bodies whose primary purpose is to improve population health outcomes, reduce health inequalities, and ensure the best possible value from public resources.

Population Health Strategy

5. The Population Health Strategy is a more concise document that sets out the ICB vision for improving the health and healthcare provision for the population it serves. It should be built upon a case for change led by an integrated needs assessment. It should be closely

aligned to previous Integrated Care System (ICS) Strategies and local Health and Wellbeing Board Strategies and anchored to the three shifts detailed in the 10-Year Plan. ICBs, acting as strategic commissioners, will set an overall 5-year strategy by January 2026.

ICB Five-Year Strategic Commissioning Plan

6. The ICB 5-Year Strategic Commissioning Plan is a more developed detailed document that provides the next logical step to support delivery of the strategy. The plan should be annually refreshed with the purpose of:

- Define long-term priorities, improving population health & reduce inequalities
- Set out how services across health, social care and partners will be integrated
- Align resources, workforce and investment to meet future population needs
- Provide a framework for transforming and commissioning services
- Show how national priorities and local stakeholder input shape system goals

7. Plans are expected to adhere to the following principles:

- Outcome focussed (SMART)
- Credible and deliverable
- Transparent and integrated
- Evidence-based

8. A proposed outlined of the plan is detailed below in Figure 2. The submission date of the plan has been confirmed as 12th February 2026.

Figure 2: Outline for ICB 5-year Strategic Commissioning Plan

1. Executive summary	• Overview of the ICB's Commissioning Strategy including vision and desired outcomes • How the Strategic Commissioning plan will seek to deliver the outcomes and key points of the plan
2. Health economy / Population health context	• Summary of integrated needs assessment and baseline mapping of current performance and quality of commissioned services • High level analysis of population health need now and in the future, the health and care economy and the implications of 10YHP and objectives in MTPF-delivering change together for the development and commissioning of provision. • Assessment of the quality, performance and productivity of existing provision and improvement opportunities including relevant benchmarking and clear identification of underserved communities
3. Commissioning intentions for 2026/26 – 2030/31	• A methodology/framework to set out priority commissioning intentions over the five-year period • Each priority/commissioning intention as a minimum should include: • defined outcomes and metrics • clear milestones and delivery timescales • delivery scale (e.g., neighbourhood, place, ICB, pan-ICB — potentially one or more levels) • governance arrangements
4. Finance	• An overview of the financial ambitions over the 5 years • Evidence of the financial rigour applied in decision making and the maintaining of long-term financial sustainability
5. Workforce	• Identify how their strategic commissioning plan will be impacted and supported by the workforce, including consideration of the workforce impact and implications of the 10YHP, the Medium-Term Planning Framework, and the Strategic Commissioning Framework • Set out the organisations strategic vision for its workforce across 5 years, including how the workforce will support the three shifts and the required productivity improvements
6. Transformation and new care models	• A description of the organisations approach to transformation • Summary of how the organisation will co-ordinate and work with all partners to deliver major transformation programmes including embedding digital transformation and enabling the 'left shift' by supporting the shift of resources from acute to community services and increasing community and neighbourhood health capacity • Description of new care models to maximise value for patients and taxpayers aligned to 10YHP and how the ICB will embed these models
7. Enablers	• Key enablers for the plan, how they will be resourced, any dependencies that have been considered in the development of the plan and how they will be aligned to support the plan. The key enablers could be: digital, data and technology; estates and facilities; workforce
8. Risk and mitigations	• Risk model • High-level risk analysis including: • assessment of likelihood • financial and non-financial impact • mitigating actions which should be implementable internally without the need for external resource i.e. additional funding from the centre

Progress to Date

9. Discussions to support progress have taken part at the following recent forums:

- Joint Executive Team (19th November 2025)
- Board Development Session (20th November 2025)
- Commissioning Strategy Committee (2nd December 2025)

10. There is a clear understanding that plan needs to be framed by our population health needs, targeted interventions and resource allocation. There is a consensus on our challenges and areas of focus. There is also a desire to ensure greater emphasis is placed upon prevention and the will to be bold and take on the challenges that have not been previously addressed.

Areas of Focus

11. The Strategic Commissioning Framework makes it clear that plans should concentrate on a manageable number of evidence-led priorities. Based on our health summary analysis the follow areas have been identified as being central to our plan: Frailty, Premature Mortality and Children and Young People (CYP).

Frailty	**Population Impact**	Frailty is a major driver of UEC activity, longer lengths of stay, and social care demand. Modelling across the cluster shows a projected significant increase in an older and frailer cohort with greater pressure on services.
	Framework Alignment	Guidance commands the use of population segmentation and risk stratification; frailty is a high-risk cohort where proactive, integrated care can reduce demand and improve outcomes.
	Three Shifts	Investing in frailty pathways supports the shift from hospital to community care, harnesses neighbourhood models of care and can reduces avoidable admissions, improving independence and quality of life.

Premature Mortality (Respiratory, CVD, Cancer)	**Population Impact**	These three disease areas are leading cause of early death across the cluster. They drive inequalities, demand and mortality.
	Framework Alignment	Guidance emphasises tackling drivers of risk and demand and reducing unwarranted variation. Respiratory disease, cardiovascular disease, and cancer all show significant inequalities in incidence, access, and outcomes.
	Three Shifts	Clear alignment with one of the three shifts within the 10YP – Sickness to Prevention

	Population Impact	Giving every child the best start in life is the most important long-term objective for reducing health inequalities.

Children and Young People	**Framework Alignment**	The guidance explicitly highlights the need to assess the impact of poor health on children and young people's life chances.
	Three Shifts	Care closer to home, greater opportunities for joint commissioning with partners and preventing escalation to hospital care. CYP cohort ideal beneficiaries of digital by default approach. Today's CYP are tomorrows adults - childhood is the most critical stage for prevention — tackling obesity, smoking, poor diet, and mental health early has lifelong benefits.

Next Steps

12. Colleagues from the across the cluster will continue to develop and refine the priority areas, with relevant leads across the system, ensuring alignment with local needs and national ambitions. We shall begin to develop clearer programmes of work to understating what commissioning changes are needed, how they will be designed and transacted and the measures of success.

Medium-Term Planning Framework

13. The Medium-Term Planning Framework **(**MTPF) sets out the approach for developing credible, sustainable plans over a multi-year horizon. It focuses on achieving financial stability, embedding productivity improvements, managing risks effectively, and ensuring compliance with NHS contracting and commissioning processes. The framework also addresses workforce planning aligned to the 10-Year Health Plan, integration of urgent and emergency care pathway, including ambulance services, and maintaining quality and safety standards.

14. The MTPF sets out detailed requirements for the first medium-term plan submission (due 17 December 2025). It aims to support Integrated Care Boards (ICBs) and providers in developing robust, triangulated plans covering operations, workforce, and finance. These plans must be signed off by boards and align with national priorities and local needs.

Plan Development and Triangulation

15. ICBs and providers must create plans that:

- Show an integrated approach to activity, finance, and workforce planning.
- Demonstrate how national and local priorities will be delivered.

16. Plans should meet three key tests:

- Credibility – Assumptions and targets must be evidence-based and convincing to stakeholders (including regulators and the public).
- Deliverability – Plans must be realistic and executable within available resources and the operating environment.
- Affordability – Financial assumptions must be sustainable and align with available funding and budgetary limits.

17. Triangulation is critical to ensure:

- Each element of the plan reinforces the others, making it internally consistent and realistic.
- Goes beyond numerical alignment to include a rounded assessment of impacts across activity, workforce, and finance.

Governance Roles and Responsibilities

18. Boards of ICBs and providers are accountable for plan development and delivery. They must:
    - Engage actively throughout plan development, not just at sign-off.
    - Ensure plans are evidence-based, realistic, and aligned with organisational purpose and system strategy.
    - Provide constructive challenge to assumptions and ensure triangulation across activity, workforce, and finance.

19. Board Assurance Statements have been developed to help ICBs and providers confirm the robustness of processes used to create medium-term plans. These statements reflect the key expectations, and the role of the Board as set out in the NHS planning framework, alongside specific areas of assurance. These include productivity opportunities, financial risk management, NHS contract and commissioning processes, workforce implications of the 10-Year Health Plan, and alignment with ambulance trusts.

20. Each statement is scored against a four-level scale—Embedded, Maturing, Developing, or Not Embedded—to provide transparency, highlight varying organisational maturity, and support continuous improvement. Submissions also show evolving progress, with wording moving from “plans are being developed” to “plans have been developed,” demonstrating increasing confidence and maturity

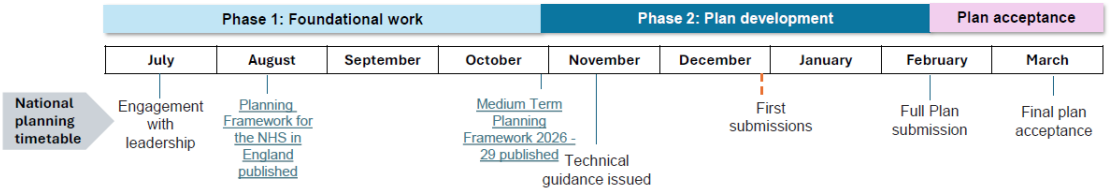
Planning Timeline and Submission

21. Revenue finance and contracting guidance was published on 17 November 2025, confirming allocations for the first two years. Year 3 allocations will be confirmed ahead of the full submission, which will require three-year plans and five-year strategic plans.

22. Figure 3 below illustrates the planning timetable and specific plans required for the first submission on 17 December 2025 and the full submission on 12 February 2025.

Figure 3: Planning Timetable

Planning timetable



Key process steps and dates:

- Planning framework for the NHS shared with NHS in August, published 8 September (setting out *how* planning will work, including roles and key tasks)
- MTP Planning framework (setting out targets and guidance) published 24 October 25, technical guidance and 2-year allocations on 17 November (year 3 allocations will follow)
- First plan submission – 17 December
- Full plan submission – 12 February
- Plan acceptance – 12 March

Event	Date	Content
First submission	17 December 25 (12 noon deadline)	• 2 year finance plans (4 year for capital) • 2 year workforce plans • 2 year activity and performance plans • Integrated medium term plan template giving commentary of areas of non-compliance and board assurance statements • 2 year ambulance operational plans
Full submission	12 February 26 (12 noon deadline)	• 3 year finance plans (4 year for capital) • 3 year workforce plans • 3 year activity and performance plans • Integrated medium-term plan template giving commentary of areas of non-compliance and board assurance statements • 5 year plans (Trust delivery plan or ICB Strategic commissioning plan / PHIP) • 3 year ambulance operational plans
Plan acceptance	12 March 26 onwards	Final plans will be accepted from 12 March. This should be completed by the end of March, and all plans ready for implementation by 1st April.

Progress to Date

23. Discussions to support progress have taken part at the following recent forums:

- Joint Executive Team (19 November 2025)
- Board Development Session (20 November 2025)
- Commissioning Strategy Committee (2 December 2025)
- Health Partnership Executive Meeting (9 December 2025)

24. An initial assessment has been undertaken against the ambitious delivery targets across cancer, urgent care, waiting times, access to primary and community care, mental health, learning disabilities and autism, and dentistry.

25. A further assessment has been undertaken across all the MTPF requirements covering financial sustainability, productivity improvements, risk management, NHS contracting and commissioning compliance and workforce planning aligned to the 10-Year Health Plan.

26. We are working closely with system partners to refine and develop medium-term plans, ensuring alignment with the requirements of the MTPF and national priorities. The ongoing discussions focus on shared financial sustainability, productivity improvements, and integrated service delivery with emerging Neighbourhood Health Models. Regular engagement and joint assurance processes will help maintain transparency, strengthen governance, and support the delivery of high-quality, sustainable care across the system

27. There are several key planning risks for the MTFP, which are in line with this current phase of planning and with the transitional phase of the ICB:

    - The ICBs underlying financial position impact on developing a balanced financial plan
    - The changed approach to planning for 2025/26 requiring each statutory organisation to produce separate plans for the first time since the 2019/20 plans. This presents reduced opportunity to triangulate plan based upon timing of receipt of information from partners which require their own organisations approval.
    - Impact of cluster transition (people and processes)
    - Ability to ensure alignment with longer-term strategic focus in the 2026/27 plan
    - Staff capacity due to multiple and competing priorities (2026/27 planning, 5 Year Strategic Plan, managing a safe winter and impending wider management of change process).

Recommendations:

- **NOTE** the contents of the report

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

NHS
Northamptonshire
Integrated Care Board

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Boards Meeting in Common in Public

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 18 December 2025**		
Report Title	**Implementation of Lung Cancer Screening in LNR**		
Paper Reference No:	**ICBiC-25-25**	**Agenda Item No:**	**14**

Presented by	**Adam Andrews - Associate Director, Planned Care**
Report Author(s)	**Becky Hartlett - Senior Project Manager, Cancer team**
Executive Sponsor	**Eileen Doyle - Chief Delivery Officer**

Select the Primary Purpose for the Report		
☐ **ADVISORY** To receive and note implications, may require discussion to help to shape/develop item.	☒ **ASSURANCE** To assure the Boards that controls and assurances are in place.	☒ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- Be **ASSURED** by information provided within this report that this is a 'must do' for the ICBs which aligns with national and local priorities/ strategies and that relevant due diligence and governance approval has been undertaken/ sought throughout the planning process.
- **APPROVE** procurement and contract award via the MECSS Framework with the recommended preferred provider (provider name redacted on public board paper in line with procurement process requirements) for the lung cancer screening programme across LNR

Executive Summary of the report

The Lung Cancer Screening Programme (LCS) is nationally mandated and included in the Section 7A agreement between DHSC and NHSE England. It seeks to transform lung cancer outcomes through proactive, targeted screening. 100% of eligible patients (ever smokers aged 55–74, registered with a GP) should be invited to participate by March 2030.

The full business case (which is available upon request) outlines the joint plan for screening across Leicester, Leicestershire, Rutland and Northamptonshire (LNR) under new cluster arrangements. An outsourced provider will need to be procured and contracted. Procurement is progressing via PSR. LLR will be the lead commissioner for the service for both ICB areas. The business case details the rationale, operational model, benefits, risks, and the recommended delivery approach for with an aim to commence procurement in December 2025 and start scanning in April 2026.

The paper also details financial commitments for both LLR and Northamptonshire for the screening service. Lung Cancer Treatment and diagnostic financial implications (downstream costs) have been presented in detail for LLR/ UHL but are still in development for Northamptonshire. Aligned cases relating to trust capacity, staffing and theatre space will be considered by internal trust governance processes as part of their strategy for 2026/27.

The full financial position presented in the executive summary of the business case is for LLR ICS only. A full financial position is in development for Northamptonshire ICS and once complete will be considered at Northamptonshire Spend Review Panel and Commissioning for Value Group (if appropriate) and added to the business case detail in due course.

The programme recognises the funding risk to the ICBs in approving the 4-year model, particularly in relation to specialised commissioning budgets. To mitigate this, expected activity levels will be built into annual planning to help secure appropriate funding. National allocations through the Cancer Plan and EMCA (2026–2029) may also offer financial support and ease pressure. Additionally, the ICB retains flexibility to revise or pause the roll-out if funding settlements worsen, with regional or national support likely in such circumstances.

Please refer to the full business case executive summary for high level financial modelling and more detailed content on finances in appendix 1 of the business case.

Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?			
☒	**Improve Outcomes** - Improve outcomes in population health and healthcare	☒	**Health Inequalities** - Tackle inequalities in outcomes, experience, and access
☒	**Value for money** - Enhance productivity and value for money	☒	**NHS Constitution** - Deliver NHS Constitutional and legal requirements
☒	**Social and economic development** - Help the NHS support broader social and economic development		

Conflicts of interest –	
☐	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
☒	Conflict noted, conflicted party can participate in discussion but not in decision
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
☐	Conflict noted, conflicted party to be excluded from the meeting

Trust and primary care providers who may benefit from the commissioning of this service.

Board Assurance Framework Risk -	
LLR ICB BAF No: 3, 6 and 8	**NICB BAF No: 3, 6 & 8**

Appendices	Full Lung Cancer Screening business case and appendices are available upon request

Who has been engaged and where else has this report been considered:
• UHL TLT – (screening feasibility assessment)

- ODG – (briefing paper) 25th Feb 2025 – PRINCIPLE SUPPORTED
- Clinical Executive – (briefing paper) – 11th March 2025 – PRINCIPLE SUPPORTED
- System Executive – (briefing paper) – PRINCIPLE SUPPORTED
- LCS Stakeholder Steering Group – (draft BC & recommendations ratification) – 17th July 2025
- Cancer Design Group – (final draft business case) -22nd July 2025 - SUPPORTED
- LLR Digital Strategy Board (IT, Data and IG focus) – 24th July 2025
- LLR PSAG (Procurement recommendation only) – 15th August 2025 - SUPPORTED
- Planned Care Partnership – draft business case 26th August 2025 - SUPPORTED
- Finance deep dive T&F mtgs – (Finance detail) – 8th & 14th August and 8th September 2025
- LLR Spend Review Panel –22nd September 2025 - SUPPORTED
- LLR Strategic Commissioning Group – 23rd September 2025 - SUPPORTED
- UHL OMG – by Email in October 2025 - SUPPORTED
- UHL TLT – 14th October 2025 - SUPPORTED
- Northamptonshire Procurement Delivery Group – 15th August 2025 - SUPPORTED
- Northamptonshire Cancer Improvement Group – 2nd October 2025 - SUPPORTED
- Joint Executive Team (JET) – 5th November 2025 - APPROVED

Implications: Select which of the following implications need to be considered							
☒	**Quality & Patient Safety**	☐	**Legal**	☒	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☒	**Data & Digital**	☒	**Financial**	☒	**Workforce**

Summary business case for the LNR lung cancer screening programme

Thursday 18 December 2025

1. Introduction & Purpose

The Lung Cancer Screening Programme (LCS), mandated nationally for England, seeks to transform lung cancer outcomes through proactive, targeted screening. The aim is to ensure that 100% of eligible patients (ever smokers aged 55–74, registered with a GP) are invited to participate by March 2030, with an interim target of 50% by March 2026. The business case outlines the joint programme for Leicester, Leicestershire, Rutland (LLR), and Northamptonshire (NH), detailing the rationale, operational model, financial implications, benefits, risks, and the recommended delivery approach and asks for support to rollout the programme and finalise the procurement and contract award to a provider to begin delivering screening activity in April 2026

2. Strategic Alignment & Rationale

The programme supports the 'Fit for the Future' 10-year health plan for England, aligning with ambitions to improve early cancer diagnosis, reduce mortality, and address health inequalities. It integrates with Cancer Alliance strategies and local operational plans to increase the proportion of lung cancers diagnosed at early stages (1 & 2) and prioritise diagnostic and treatment capacity aligned to the findings.

Key National and Local Drivers

- Lung cancer is England's leading cause of cancer death; in 2020, it accounted for 20% of all cancer deaths.
- Only 4% of late-stage (stage 4) patients survive five years, compared to 63% for those diagnosed at stage 1.
- Currently, 45% (LLR) and 51% (NH) of patients are diagnosed at stage 4; the programme aims to shift diagnosis earlier, improving survival and treatment outcomes.

3. Programme Model & Eligibility

Target Population

Screening focuses on ever smokers aged 55–74, identified via GP registries and will use both an opt in and opt out approach to ensure those with no smoking code recorded are not missed. Evidence shows that smoking and age are the strongest predictors of lung cancer risk; research found no cost-effective benefit in screening never-smokers.

Screening Pathway

The national protocol mandates a sequence:

- Invitation and triage (virtual or phone)
- Face-to-face Lung Health Check (LHC)
- Low Dose CT (LDCT) scan (on mobile units in community locations)
- Review and management of findings, including referrals for cancer or incidental findings as per national protocol

A multi-phased, community-based approach is proposed, including equitable access for deprived and underserved groups. Smoking cessation support is integrated, with dedicated advisors at screening units where possible.

4. Business Options Considered

Four primary options have been considered:

- Option 1: Do nothing – discounted due to lack of early diagnosis and increased health inequalities.
- Option 2: Mobilise screening only, without downstream clinical support – discounted as unethical and likely to overload existing care pathways.
- Option 3a: Screening with an outsourced provider contract for end-to-end screening delivery plus limited supporting investments (clinical capacity and robotic bronchoscopy) – discounted due to anticipated treatment capacity deficits in the areas that matter most such as surgery.
- Option 3b: Recommended: Full-scale screening with an outsourced provider contract for end-to-end screening delivery with investments in clinical capacity, robotic bronchoscopy and a new theatre build and staffing at Glenfield Hospital.

Option 3b was recommended and supported by JET on 5th November 2025 for its alignment with strategic targets, equitable coverage, and sustainable financial and operational planning.

5. Implementation Plan & Volumes

The plan requires an initial 4-year rollout (2025–2029) to achieve 100% coverage, staggering invitations and scan appointments to match capacity. Key projected screening volumes for LLR and Northamptonshire are:

- In LLR: 139,600 eligible patients (initial invites), 60,000 Lung Health checks, and 25,000 LDCT scans.
- In Northamptonshire: 90,700 invites, 40,000 Lung Health checks and 16,700 scans.
- Initial scans, aging in cohorts and repeat scanning at 24 and 48 months will build and create activity spikes which Trusts and primary care will need to manage. Careful resource planning is required.

Lung Cancers

Screening is expected to diagnose 1,219 lung cancers in LLR and 872 in Northamptonshire over a 7-year period, with 75% of those detected at stages 1 & 2 equating to a 45% change in staging. In the first 5 years this is expected to be in addition to lung cancers presenting via 2ww and emergency presentation routes, with a shift to proactive identification expected in the long term.

Incidental Findings

Around 11% of LDCTs will reveal clinically significant incidental findings, such as coronary artery calcification and emphysema. A proportion (exact % unclear) of individuals will already have been identified and be under a management plan for their condition, some will not require any management, and others will need new clinical management. A national IF protocol will apply. Clinical management, where required, will take place in primary or

secondary care as appropriate and will add extra workload into the system in the initial 4 years but is expected to reduce significantly from year 5 onwards.

6. Financial Overview

The contractual value for an outsourced screening provider to deliver the lung cancer screening programme in LLR and Northamptonshire could be

A total combined value for the jointly procured contract is circa £27.8m over 4 years*

Financial year	LLR (£'000)	Northamptonshire(£'000)	Total (£'000)
2026/27	£3,020	3,033	6,053
2027/28	3,603	3,164	6,767
2028/29	5,558	2,715	8,273
2029/30	4,056	2,666	6,722
Total	**16,237**	**11,578**	**27,815**

*If delivered according to planned activity trajectory

The full financial overview in the business case includes the screening programme income and cost (outsourced provider, governance and operational requirements) and trust tariffs and activity increases (for lung cancer and incidental findings diagnostics and treatments). To illustrate using LLR as the example, Option 3b has a total expenditure in **LLR** over seven years of **£62m**, offset by **£30m** in new screening activity income and **£22m** in specialised commissioning tariffs/ API tariffs. The net 7-year LLR ICS revenue position is a **£9.8m** deficit.

In addition, capital investment is required of **£7.4m** for a new theatre and pathology equipment at Glenfield Hospital, of which **£2m** is planned from philanthropic charitable fundraising for the surgical robot.

LLR Key cost components:

- Capital investment of £7.4m for a new theatre and pathology equipment at Glenfield Hospital, with £2m expected from charitable funds for the surgical robot.
- Programme operating costs including delivery of screening pathway, programme oversight, data, communications, and clinical governance including recurrent and one-off costs will be covered by national tariffs: £50 per LHC, £255 per LDCT scan. The financial case assumes a specific pace of activity that drives funding into the system to cover operational costs from year 2 onwards.
- A mixed funding model for Trust based activity will be required. This includes API income and specialised commissioning income into UHL, which will need to be paid by the ICB under the new devolved funding arrangement. There is no uplift for activity related income from specialised commissioning in relation to LCS additional activity in 2025/26.

The financial case assumes activity-driven funding will cover operational costs from year 2 onwards, but downstream care (treatments, management of incidental findings) presents additional system pressure.

A similar finance summary is being prepared for Northamptonshire.

7. Key Benefits

- Clinical: Early diagnosis, improved survival and quality of life, reduced late-stage presentations, and reduced cancer mortality—from 14% to 7% of all cancer deaths in LLR within 10 years.
- Workforce: Enhanced recruitment and retention in respiratory services.
- Equity: Focus on delivering screening in deprived communities first, aiming to narrow lung cancer incidence and mortality gaps.
- System-wide: Earlier, less costly treatments; reduced demand on palliative and emergency care.
- Economic/environmental: Mobile CT scanning reduces travel and carbon emissions; earlier diagnosis lowers sick pay and recovery costs.

8. Risks & Mitigations

- Capacity constraints in thoracic surgery and diagnostics could lead to delays in treatment, impacting performance against national cancer targets.
- No dedicated national capital for LCS; reliance on system prioritisation and funding, charitable fundraising, or reallocation of resources.
- Workforce shortages, especially in specialist roles.
- Variation in General Practice engagement could affect data sharing and patient identification.
- Additional demand from incidental findings may strain primary and secondary care.
- Financial gap between cost and income due to commissioning arrangements.
- Public engagement: If uptake is lower than anticipated, effectiveness and cost-efficiency could suffer.

Mitigations include robust planning, phased rollout, engagement strategies, cross-sector collaboration, and ongoing monitoring.

9. Provider Selection & Procurement

Following a review of procurement options, a call-off from the NHS Supply Chain 'Managed Equipment and Clinical Service Solutions' (MECSS) framework was recommended and supported by PSAG, PAA, SCG and JET. Using the framework allows a direct award to a provider experienced in end-to-end LCS pathways. This approach ensures compliance, value for money, and mobilisation within required timescales.

10. Equality, Health Inequality & Patient Involvement

An Equality and Health Inequality Impact Assessment confirms the recommended programme design is inclusive and addressed deprivation and access barriers. Dedicated communications, targeted engagement, accessible venues, and tailored support (e.g. for disabled, underserved, and ethnic minority groups) are central to the implementation plan. Community representatives and local leaders will be involved throughout to maximise uptake and equity.

11. Milestones & Governance

Key milestones span team recruitment, data modelling, procurement, provider mobilisation, and delivery commencement (target: March 2026). Governance is provided by a joint

Steering Group, with oversight from Cancer Alliances, Acute Trusts, and ICBs. Progress will be monitored against national and local targets, with iterative review and adaptation.

12. Conclusion

The LLNR LCS Programme represents a significant, evidence-based step towards reducing lung cancer mortality and addressing longstanding health inequalities in Leicester, Leicestershire, Rutland, and Northamptonshire. The recommended model (Option 3b) balances clinical, operational, financial, and equity considerations, with a clear roadmap for phased, sustainable rollout. Success will depend on system-wide collaboration, adequate resourcing, and a relentless focus on patient outcomes and accessibility.

Recommendations:

- Be **ASSURED** by information provided within this report that this is a 'must do' for the ICBs which aligns with national and local priorities/ strategies and that relevant due diligence and governance approval has been undertaken/ sought throughout the planning process.

- **APPROVE** procurement and contract award via the MECSS Framework with the recommended preferred provider (provider name redacted on public board paper in line with procurement process requirements) for the lung cancer screening programme across LNR

Lung Cancer Screening Programme

Prepared by: Becky Hartlett – LCS Senior Project Manager LNR

Presented by: Adam Andrews – Associate Director of Planned Care

Business Case

- The project has been in progress for 2 years.
- The business case was prioritised in 2025/26 and is aligned to a national must do under section 7a of the national screening programme
- Due consideration has been given to all aspects of planning & scoping for future year impact (of the non-screening element, ie. incidental findings and lung cancer treatments and diagnostics)
- The business case has been developed to comply with the national ambition for 100% cohort invites by March 2030
- Approaches and recommendations are informed by pilot programmes and national IPSOS MORI evaluation and with a consideration of health inequalities, risks and mitigations locally

Business case history

- ✓ UHL TLT – (screening feasibility assessment)
- ✓ ODG – (briefing paper) 25th Feb 2025
- ✓ Clinical Executive – (briefing paper) – 11th March 2025
- ✓ System Executive – (briefing paper)
- ✓ LCS Stakeholder Steering Group – (draft BC & recommendations ratification) – 17th July 2025
- ✓ Cancer Design Group – (final draft business case) -22nd July 2025
- ✓ LLR Digital Strategy Board (IT, Data and IG focus) – 24th July 2025
- ✓ LLR PSAG (Procurement recommendation only) – 15th August 2025
- ✓ Planned Care Partnership – draft business case 26th August 2025
- ✓ Finance deep dive T&F mtgs – (Finance detail) – 8th & 14th August and 8th September 2025
- ✓ LLR Spend Review Panel –22nd September 2025
- ✓ LLR Strategic Commissioning Group – 23rd September 2025
- ✓ UHL OMG – by Email in October 2025
- ✓ UHL TLT – 14th October 2025
- ✓ Northamptonshire Procurement Delivery Group – 15th August 2025
- ✓ Northamptonshire Cancer Improvement Group – 2nd October 2025
- ✓ LNR ICB Joint Executive Team (JET) – 5th November 2025

Service Summary

New mandated national screening programme for lung cancer under section 7A agreement between DHSC and NHSE.

Purpose: Invite high risk individuals with smoking history between age 55-74 for routine screening risk assessment. Followed by an initial CT scan and 24 and 48-month interval screening if appropriate based on risk score.

Aim: Improve early cancer diagnosis in line with NHS 10-year plan and local operational plans, reduce mortality from lung cancer, and address health inequalities by increasing the proportion of lung cancers diagnosed at early stages (1 & 2)

This is a transformational BAU routine screening programme which requires recurrent funding and due consideration of both the screening income/ costs and the treatment and diagnostic income/costs and capacity to treat patients diagnosed with lung cancer and other incidental findings.

Finance Summary

Screening funding: Patient pathway is defined in the national protocol document. **Screening activity attracts new tariff funding via EMCA of £50 per lung health check and £255 per LDCT scan performed. This funding will cover cost of delivering screening as per national protocol and local operating requirements.**

No financial commitment for screening is expected from ICB funds in 2025/26, activity will commence in April 2026.

Increased lung cancer treatment and diagnostic activity funding: **From April 26/27 ICB budgets (Tariff -API/ delegated specialised commissioning and block or unbundled activity uplifts) are required to support local trusts to manage the significant demand LCS will generate**. Trust income calculation/ costs to ICB are aligned with the planned activity trajectory for screening, they adopt national modelling assumptions (including % of cancers found on CT scans)

Trusts will be expected to operate within activity-based income and align resources appropriately to manage impact.

Finance summary

Capital Requirements:

UHL undertake all thoracic surgery LLR and Northamptonshire lung cancer patients.
Existing theatres have inadequate capacity to cope with additional demand created by LCS.
Investment in a new theatre at Glenfield hospital is being requested, 30% of the capacity would be reserved for the LCS programme. System capital support is required.
The theatre build is crucial to the programmes ability to achieve national targets but moe importantly to ensure individuals diagnosed with lung cancer get timely treatment

Procurement & Contract Summary

An outsourced provider delivering the full screening end to end patient pathway will be called off and direct awarded via the NHS Supply chain MECSS Framework. The contract will run for 2 years + a 2-year extension to deliver the initial bulk of screening. The MECSS Framework is PSR compliant and suitable for our purposes and providers have been pre-assessed for suitability.

The contract value will:

- Be directly linked to activity delivered so will vary month on month and year on year
- Be capped each year in accordance with our planned activity trajectories (in place to meet the national target 100% of eligible patients invited to participate by March 2030)
- Have flex applied to help manage demands for lung cancer and other clinically significant findings within trust and primary care providers
- Have a minimum contract value to ensure we cover local programme fixed costs

Outsourced Contract Value

Outsourced screening provider contract value

A total combined value for the jointly procured contract is circa £27.8m over 4 years*

Financial year	LLR (£'000)	Northamptonshire(£'000)	Total (£'000)
2026/27	£3,020	3,033	6,053
2027/28	3,603	3,164	6,767
2028/29	5,558	2,715	8,273
2029/30	4,056	2,666	6,722
Total	**16,237**	**11,578**	**27,815**

*If delivered according to planned activity trajectory

Linked Opportunities Summary

This is a targeted ***lung cancer*** screening programme but has other benefits that LNR can capitalise on

1. Incidental findings – High risk cohort opportunity to impact on long-term condition management. Screening *will* find IFs that *need* to be managed and *will* require resourcing and funding appropriately. There is no dedicated national funding pot for IF's. ICBs will need to manage IFs within annual long term conditions strategies planning.
2. Smoking cessation – Current smokers will be offered smoking cessation support as part of the programme. This will lead to increased quit rates and better long-term health for our population.
3. Signposting opportunities for healthy lifestyle advice – in future we can look to incorporate the MECC approach for this high-risk cohort.