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

Thu 16 April 2026, 09:30 - 11:40

Haylock House

Agenda

09:30 - 09:35
5 min

1. Welcome and Apologies

Advisory *Anu Singh*

09:35 - 09:35
0 min

2. Declarations of Interest relating to agenda items

Advisory *Anu Singh*

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 ICB and NHS Northamptonshire ICB

09:35 - 09:35
0 min

3. Draft minutes of the previous meeting held on 19 March 2026

Approval *Anu Singh*

Reference: ICBIC-26-17

ICBIC-26-17 Draft Minutes LLR ICB and NICB Board Public 19 March 2026 v3.pdf (13 pages)

09:35 - 09:35
0 min

4. Matters arising and action log

Advirsory *Anu Singh*

Reference: ICBIC-26-18

ICBIC-26-18 Action Log LLR ICB and NICB Boards meeting in common April 2026.pdf (1 pages)

09:35 - 09:40
5 min

5. Questions from member of the public

advisory *Anu Singh*

Reference: ICBIC-26-19

09:40 - 09:50
10 min

6. Chair and Chief Executive Updates

Advisory *Anu Singh*

Reference: ICBIC-26-20 (verbal update)

09:50 - 10:20
30 min

7. Neighbourhood Health Framework

Advisory *Peter Burnett*

Reference: ICBIC-26-21

ICBIC-26-21.pdf (42 pages)

10:20 - 10:40
20 min

8. Commissioning Outcomes Framework

Advisory *Nilesh Sanganee*

Reference: ICBIC-26-22

ICBIC-26-22 Outcomes Framework.pdf (9 pages)

10:40 - 10:55
15 min

9. SEND reforms

Advisory *Maria Laffan*

Reference: ICBIC-26-23

ICBIC-26-23 Board SEND Reforms v2.pdf (8 pages)

10:55 - 11:05
10 min

10. Quality and Performance reports (LLR & NICB)

Assurance *Maria Laffan*

Reference: ICBIC-26-24

ICBIC-26-24 QPO report.pdf (12 pages)

11:05 - 11:15
10 min

11. St Andrews Healthcare Quality Overview April 2026 update

Advisory *Maria Laffan*

Reference: ICBIC-26-25

ICBIC-26-25 StAH report April 26 V1.0 Board (002).pdf (7 pages)

11:15 - 11:25
10 min

12. Finance Assurance Report

Assurance *Matt Gaunt*

Reference: ICBIC-26-26

ICBIC-26-26 M11 Finance report April Board.pdf (5 pages)

11:25 - 11:30
5 min

13. Transition Assurance Report

Assurance *Toby Sanders*

Reference: ICBIC-26-27

ICBIC-26-27 Transition asssurance report.pdf (7 pages)

11:30 - 11:35
5 min

14. Chair's closing remarks

Advisory *Anu Singh*

Reference: ICBIC-26-28

11:35 - 11:35
0 min

15. Date of next meeting

Advisory *Anu Singh*

The next meeting will take place on Thursday 18 June.

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

Thursday 19 March 2026 at 09:30am
Suites 1 & 2, Melton Borough Council Offices,
Burton St, Melton Mowbray LE13 1GH

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

Apologies	
Afzal Ismail	Non-Executive Member

Present: Members - NHS Leicester, Leicestershire & Rutland ICB	
Richard Mitchell	Acute Sector Representative Group Chief Executive University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Trust
Dr James Ogle	Primary Medical Services Sector Representative
Mike Sandys	Local Authority Sector Representative Director of Public Health Leicestershire County Council and Rutland County Council

In Attendance	
Claire Middlebrook	Corporate Governance Officer (minutes)
Harsha Kotecha	LLNR Healthwatch representative
Julie Hogg	Chief Nurse, University Hospitals of Leicester NHS Trust
Ket Chudasama	Deputy Chief Officer, Strategy & Planning
Jenny Goodwin	Deputy Chief Officer, Communications and Engagement

Present: Members - NHS Northamptonshire ICB	
Angela Hillery	Community / Mental Health Sector Representative Chief Executive Officer, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust
Melanie Williams	Local Authority Sector Representative, Executive Director, People's Services West Northamptonshire Council

In Attendance	
Neil Boughton	Deputy Director of Corporate Affairs
Harsha Kotecha	LLNR Healthwatch representative

Apologies

Dr Jonathan Cox	Primary Medical Services Sector Representative and Chair, Local Medical Committee

Minute No:	Agenda Item
Verbal	**Welcome from the ICB Chair, Introductions and Apologies**

Anu Singh welcomed colleagues and members of the public to the NHS Leicester, Leicestershire & Rutland ICB (LLR ICB) and NHS Northamptonshire ICB (NICB) Boards meeting in common. She particularly welcomed newly appointed representatives on the Board in their new roles for the NHS or Local Authorities, as appropriate.

Apologies for absence were noted as above. There were 28 members of the public in attendance.

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

Verbal — **Declarations of Interest relating to agenda items**

Standing declarations of interest were noted.

Specific declarations were noted in relation to item ICB IC-26-013, St Mary's Birthing Centre (SMBC), by Peter Burnett as his is wife is Director of Midwifery at University Hospitals of Leicester NHS Trust (UHL) and acting Director at University Hospitals of Northamptonshire (UHN). It was noted that Peter Burnett had absented from the meeting at this time.

Richard Mitchell and Julie Hogg are also conflicted with this item, as UHL are the provider of this service, however as it is important to have the providers opinion on the paper, it was agreed they would remain in the meeting for the discussion.

ICBIC-26-10 — **Draft Minutes of previous Board Meetings**

The minutes of the NHS Leicester, Leicestershire & Rutland ICB and NHS Northamptonshire ICB Boards meeting in common, held in public on 19 February 2026 were received and **APPROVED** as a true and accurate record of the meeting.

ICBIC-26-11 — **Matters Arising and Action Logs**

The Boards received the Action Log and noted that there were no outstanding actions.

ICBIC-26-12 (Verbal) — **Questions from members of the public**

Anu Singh reported that nine questions had been received from members of the public, all in relation to SMBC and therefore these would be answered under the specific item.

ICBIC26-13 — **St Mary's Birthing Centre**

Anu Singh noted the item and asked Councillor Helen Cliff to speak to the item on behalf of the public in attendance today.

Cllr Helen Cliff thanked the Board for the opportunity to speak at the meeting on behalf of the local public. She noted that she has been campaigning for SMBC for over 20 years and had personally used the unit herself on five occasions, noting her personal poor experience at Leicester Royal Infirmary, followed by a very positive experience at SMBC.

Cllr Helen Cliff continued to speak about SMBC, noting that not all women are offered this as a choice. A number of personal quotes from patients were read out. Although it was acknowledged that members may have already made their decision, an appeal was made to consider the post-natal care offer, as this had been praised by the Care Quality Commission (CQC). The loss of trust in maternity services was highlighted, with the Board urged to try and repair this, by ensuring appropriate maternity services were in place for the future.

Anu Singh thanked Cllr Helen Cliff for her comments and insights into SMBC.

Maria Laffan spoke to the paper, highlighting the key points. Julie Hogg, Chief Nurse for University Hospitals of Leicester NHS Trust (UHL) was introduced and also provided insight into the current situation with maternity care within UHL.

The paper provides evidence and feedback from engagement that took place and noted that the original decision on maternity services, in 2021, was that SMBC should move to UHL. In July 2025 births at SMBC were paused as the number of births (1-2 per week) was not sustainable, and safety was compromised due to midwives not being able to maintain their clinical competency levels. Comments from staff, student midwives and patients were taken into account when the decision was made in July 2025.

It was hoped that maternity services would be changed as part of the Better Hospital Programme, however, in Leicester this has been paused. There are four key areas that are to be considered by the Board in order to make a decision today: safety, equity, workforce sustainability and low activity levels. Since the original decision in 2021 the situation has not improved, challenges and pressures on the service have increased.

The national position on maternity services has been made clear around stand-alone units and this position aligns to comments made by staff and students during the engagement process.

It was confirmed that UHL maternity services have been improving since 2023 and whilst progress has been made the risks at SMBC are still in evidence, in relation to staff resilience. It was confirmed that during 2024/25 there was 92 births at SMBC, which equates to 1-2 per week. Patients' feedback included comments on how quiet it was at SMBC. Staff have had limited exposure to births, thus reducing capacity to train new midwives.

Maternity workforce is a national issue, with approximately 30% of staff currently not at work, which is unsustainable. The cost of births at SMBC was noted to be £12k per birth, which is double to other midwife-led units. The decision to pause services at SMBC in July 2025 was made due to the service not being safe, due to the low activity levels and clinical exposure of staff.

Maria Laffan noted that due to all the reasons highlighted, it was no longer safe to have the midwife led, stand-alone unit at SMBC and therefore her recommendation was to move services to the Leicester General Hospital (LGH) as per the original decision made in 2021.

Engagement with staff and service users has taken place, along with focussed groups and 231 pieces of feedback had been received. This was a good level of response, and the legal team have confirmed that appropriate engagement had taken place. The Board have heard personal accounts of women who have used SMBC and valued the honest and emotional accounts provided. The decision should be based on the four items listed earlier.

SMBC was noted to have been a calm, personal, reassuring site; with the pause causing uncertainty with staff and patients. Concerns over parking at LGH were acknowledged. The planned future offer for maternity services at LGH and LRI will include enhanced breast-feeding support, better access and communications. The proposed plans have been shared with current UHL staff who are positive about the suggested changes.

Equality and Quality Impact Assessments (QIAs) have been carried out, noting the negative elements of the rurality of not having St Mary's for patients on low incomes etc and the lack of post-natal care. Overall, the impact on staff and patient experiences are neutral.

Julie Hogg confirmed that Melton was no longer a viable location to have a midwifery led unit, in order to sustain high quality stand-alone care.

The first recommendation, in relation to a possible deferring of the decision was noted, however it was confirmed that the request had been reviewed and due to no new information being available to change a decision made today, it was confirmed that this would not be considered.

The questions from the public were read out by Jenny Goodwin and answered as below.

Q1 - Following the request of the Joint Overview Health Scrutiny Committee that you delay your decision making related to the closure of St. Mary's Birth Centre pending proper scrutiny on behalf of Leicester, Leicestershire and Rutland residents. How can you justify bringing these proposals forward now for a final decision by the board before this has had a chance to take place. Disrespecting the Scrutiny process and full scrutiny of your findings and strategy. As well as ignoring the obvious strength of public feeling in opposition of what you are seeking to do?

Answer - Toby Sanders recognised the question asked and confirmed that the Joint Overview Health and Scrutiny Committee (JHOSC) was attended by several members around the table today and St Mary's was discussed in detail at the most recent committee. It was confirmed that if the decision was delayed further, there would be no additional benefit to the delay as no new information is likely to be received. As the service was paused in July 2025, this has allowed enough time for information to be received, and feedback sought. It was confirmed that the decision will be further reviewed by the JOHSC on 30 April.

Q2 - There doesn't appear to be any evidence of other options being considered to avoid withdrawing the postnatal ward as a casualty of withdrawing the birthing choice of a standalone midwife led unit. Can you explain why this cannot be protected for those who clearly place a high value on this type of postnatal environment and care, which currently cannot be replicated at the LGH, with different ways of staffing it explored, at least on the basis of the previously promised trial period – given the building of St. Mary's is being retained (e.g. staffed by those trained in offering breastfeeding support and wound care but not necessarily midwives)?
Answer - Maria Laffan confirmed that there had been strong engagement, and it is no longer sustainable to have a stand-alone post-natal unit based in St Mary's. whilst the building will remain, it would not be safe to only have a postnatal ward on site. The plan for the future will be to commission ante natal, post-natal, home births and breastfeeding support as part of the community offer in Melton. Feedback has been shared with UHL, who will provide a strong offer in these areas in the future, ensuring that the model is clinically safe.

Q3 - In light of the current suspension and downgrading of home birth services across Northamptonshire, are you confident the LLR home birth team is robust enough to continue offering low risk mothers an alternative to the hospital environment in the event of St. Mary's no longer being an option, and able to guarantee home births aren't also under threat across Leicester, Leicestershire and Rutland?
Answer - Julie Hogg confirmed that following two reported deaths in Manchester a review of the home birth team took place, including temporary services being offered in Kettering. Over the next three months, services will be scaled up, to ensure sustainability in the future. Within LLR the home birth service is continuing to operate as normal, with no consideration of stopping the service being discussed. This is a key part of the maternity services offer, and the team are receiving national support, via the national Home Birth Working Group.

Q4 - Research shows that, in low-risk pregnancies, outcomes are as good for babies and better for mothers (less intervention) in stand-alone midwife led units when compared with other types of birth unit. Why do the papers not make explicit the fact that 25% of pregnancies in LLR are 'low risk' pregnancies and that this means that from now on around 2,400 women every year will now not have the higher quality option provided for low-risk women by stand-alone midwife led units where outcomes for women are better than in other types of units?
Answer - Maria Laffan recognised evidence provided by national studies, that confirms that midwife led care in a stand-alone service is only safe and sustainable if the number of births is high, skills can be maintained, and appropriate escalation is available. At St Mary's the number of births is very low and maintaining appropriate staffing is problematic. Within LLR, only 25% of births are classed as low-risk and home births will still be offered from LGH or LRI.

Q5 - How many mothers in LLR expecting assistance for a home birth were left unattended in the past 12 months?
Answer - Julie Hogg confirmed that no women planning a home birth in LLR have been left unattended in the past 12 months. The homebirth teams work to clear and established processes that ensure a midwife is either present or en route, and women are always provided with safety netting advice and support while they await attendance. At no point are

women left without appropriate oversight or reassurance.

Q6 - How many mothers use the postnatal beds each year in St Mary's? Why have these data not historically been collated, thereby leading to an underestimate of the use of St Mary's birth centre, possibly misleading the public?
Answer – Julie Hogg confirmed that during the past six years the number had varied between 203 – 424 per year. This includes transfers into the service from other parts of the NHS. There was targeted promotion of St Mary's in 2024, and the average length of stay is 36-41 hours. Using these figures, utilisation of St Mary's stood at around between 4% - 37% per month.

Comment - Your own Equality Impact Assessment acknowledges the negative impact of these proposals on those living in our rural areas, including women with disabilities and other inclusion needs, those on low incomes, and those reliant on public transport, owing to the challenges of travelling further when in labour.
Q7 & Q8 - Do you consider worsening provision for these already vulnerable residents worth the sacrifice? How does this development align with the government's agenda for service provision to move from hospital to community?
Answer – Maria Laffan confirmed that the QIA has acknowledged the impact on travel and access for patients, which is a real concern, however, the site is not clinically safe. A community offer will be maintained in Melton, in order to give women choices. Impacts will be monitored in relation to Quality, via the appropriate committee. The current provision is not sustainable due to the low birth rate and safety concerns and therefore having a 6 bedded ward, massively under-utilised is no longer appropriate and safe. During the period 2019-2024 there was an average of 4 admissions per week, which is a very low level of activity. Midwife led care will still be part of the UHL offer, as well as home births.

Comment - St Mary's provides holistic, continuous care through pregnancy. The report does not appear to consider the large number of mothers who return to St Mary's after giving birth and stay for additional days at the centre for support.
Q9 - How many mothers have returned to the unit in the last year after giving birth in the last year and how many have been turned away when the unit has been at capacity as this additional use makes the unit more sustainable and cost effective whilst giving mothers much needed care and relieving the pressure on city hospitals.
Answer – Julie Hogg recognised positive comments made about the post-natal care provided by St Mary's, noting that for 2019-2025 there were only 4-8 admissions per week, including direct transfers. This level of activity is not viable due to reasons already stated.

Anu Singh thanked members of the public for the questions asked and the members for their answers.

Harsha Kotecha commented that Healthwatch have received feedback from families in relation to having services closer to home and asked for more assurance that post and ante-natal care will be maintained in Melton. In order to continue to support patients there need to be more options in relation to travel and parking and home births must continue across the cluster. A specific question was asked about supporting patients Right to Choose in Kettering. Maria Laffan confirmed that they have heard comments about this during the engagement process and clinical delivery of the model will be key. The team will continue to monitor feedback, to

ensure high quality clinical care is in place. Services in Kettering are not currently safe and therefore the ICB team are working closely with the acute trust. The ICB will continue to support Right to Choose for patients and has no plans to change this.

It was confirmed that within the cluster two separate home birth teams will be maintained and will adopt national working practices. A three-month plan is in place to move the situation forward in Kettering and this is being monitored by the Peri-natal Assurance Committee, with escalation to this Board. The team are engaged with Healthwatch in relation to home births in Kettering.

The safety concerns were acknowledged and assurance provided that SMBC was promoted, however, no change to birth rates was experienced. The post-natal offer will be maintained for the women of Melton, as this will help rebuild trust in the Board. The number of unattended births was questioned, with more assurance requested.

The reason for the continued low birth rates at SMBC was unknown. Midwives in UHL have been actively encouraging use of SMBC and social media was also used to highlight options available. Over 50% of births in LLR are now C-sections and only 25% of births are appropriate for midwife led care. The need for enhanced post-natal care at LGH and LRI were acknowledged. The team are planning to recreate services that were available at SMBC at the LGH site. Julie Hogg confirmed that she had verified with her team about unattended home births and the figure quoted was correct.

Liz Gaulton, as Chair of the Quality Performance and Outcomes Committee highlighted the importance of clinical safety and was reassured by the planned increased post-natal offer at LGH.

Co-production of services in the future was noted, along with working with NHS partners to ensure services are in place for all women in the cluster, as well as partners and families. The team will continue to listen to feedback and take this into consideration when designing services.

It was confirmed that the number of post-natal beds has been increased in UHL and they are also considering the number of overall maternity beds. The staffing model is also being considered to ensure services are clinically safe and appropriate, along with commissioning new services in Melton. There will not be a reduction in the number of midwives and the home birth offer remains strong. The team are committed to grow services if required, as part of the national model. Overall capacity is being reviewed as maternity services are busy at present. The team are also considering a dedicated area for post-natal care at LGH, which would be midwife led. This is an opportunity to work with colleagues and the Board to make improvements.

Nil Sanganee noted the emotion felt in the room and that the investigation taking place by Donna Ockenden into midwifery services has found that a number of midwifery services require improving at national, regional and local levels. Work has already taken place within LLR, and the recruitment and retention of midwives has improved, despite the changes taking place in maternity care.

Ensuring equity of care is important for the population of LLR, which has around

9500 births per year. The number of C-sections carried out used to be 1 in 6 and now sits at 50%. The choice and complexity of births and the change in demographics has changed the level of C-sections that are undertaken. The peri-natal mortality rate in LLR is higher than average and the challenge will be to maintain services, whilst learning from the comments in the engagement feedback. Strong governance arrangements are in place.

Concern was noted around the estates of LLR as historically this can be a problem, especially in light of the delay with the Better Hospital Programme.

Richard Mitchell confirmed that he was the accountable officer for SMBC and thanked everyone for attending to discuss this important item today. The decision to be made is difficult and important and he offered his apologies for the impact on patients. SMBC has been significant for patients and staff alike and they were thanked for feedback received during the pause in services. Feedback noted that women who had given birth in UHL and then transferred to SMBC enjoyed the calm and personal service provided by SMBC. Richard Mitchell noted his personal experience of using UHL and since that time there have been 100,000 births in LLR, with 99% taking place at LRI or LGH.

The recommendations suggested today are in line with other changes taking place to maternity services elsewhere in the country. There are concerns around clinical safety, staffing and sustainability. UHL will aim to ensure transparency of decisions made in order to try and rebuild trust and confidence in services provided in the future. Within UHL Dr Ruw Abeyratne, Director of Health Equality and Inclusion is already working on the co-production of the offer for maternity services in the future.

Toby Sanders recognised and acknowledged the strength of feeling about this topic and the original decision made in 2021. Although SMBC was a local service, the decision today has to be based on safety and quality and reflect the direction of travel of services in the future. Melton has undergone a number of changes to local services recently, including changes to the GP practice and commercial decisions. The team at UHL will work hard to rebuild trust and there is a duty on the Board members to ensure they continue to engage with the public to help shape the maternity services offer.

Anu Singh thanked everyone for their comments, questions, answers and information, noting a co-produced service will be developed for the future, including the lessons learnt from feedback received. She noted that the team will work with the local population and UHL to ensure future services are appropriate.

Jane Hunt was invited to ask a specific question in relation to Q2 from the public. She noted that as the report into the review of maternity services is not due until Spring and asked if the decision could be delayed at this time to allow the report to be published. The comment was noted.

Anu Singh spoke about the recommendations listed in the paper, noting the first recommendation, in relation to delaying the decision. Maria Laffan confirmed that the report has not yet been published and however, the findings from the Independent Investigation into Maternity and Neonatal Services in England (the Amos Inquiry) do not appear to have any material impact on the decision to be made

today. Headlines appear to be consistent and similar to previous investigations and would have no material change. Julie Hogg concurred that one identified theme is how UHL works with post-natal women, and she does not anticipate any material changes to the plans.

Anu Singh thanked members for their comments, noting that the decision made today will be reviewed again by the JOHSC on 30 April 2026.

The NHS Leicester, Leicestershire and Rutland ICB Board.

- **CONSIDERED** the request from JHOSC to defer the decision on the future of St Mary's Birth Centre, following the recommendation proposed at the JHOSC meeting on 23 February 2026 and **agreed not to defer the decision.**
- **RECEIVED** the engagement findings.
- **APPROVED** LLR ICB has met its statutory duties and ensured that an effective and robust public engagement process has been undertaken.
- **APPROVED** the relocation of intrapartum services from St Mary's Birth Centre to the midwifery-led Unit at LGH, (in line with the original 2021 decision on maternity services, as far as possible, and in a safe, sustainable and fair way).
- **NOTED** the consequence of this decision will also cease the provision of postnatal inpatient services at St Mary's Birth Centre.
- **NOTED** the engagement findings to be shared with UHL as part of the ongoing improvement of UHL Maternity, Neonatal and Children and Young People services.
- **NOTED** the engagement findings to inform the commissioning of women's health and maternity services across LLR in line with the NHS 10-Year Health Plan.

The meeting paused for a short time, to allow members of the public to leave if they wished to.

Peter Burnett joined the meeting, Ket Chudasama, Julie Hogg, Jenny Goodwin and Maria Laffan left the meeting.

ICBIC-26-14 Planning Submission 2026/27

Pete Burnett took the paper as read, noting interim submissions made in December 2025 and February 2026. Since the initial submission in December work has taken place on performance and the ICBs are now compliant. Despite investment in elective care the ICBs are still not achieving their targets and waiting lists reman high with over 100,000 patients waiting in LLR and approximately 60,000 - 80,000 in Northampton.

Updates were provided on specific target areas, including Referral to Treatment, cancer, Urgent & Emergency Care (UEC) and Children and Young People (CYP) waiting lists.

Following comments received from NHS England, plans were resubmitted on 18 March 2026, with changes aligning to provider plans. LLR submitted a £5m deficit plan, as support funding was supplied by NHS England. The plan relies on £141m of efficiencies being identified across the cluster. At the present time both organisations have not yet identified enough savings.

A question was asked about point 23 in the paper, in relation to virtual wards, asking for clarity on which wards are being removed and the consultation in relation to removal of these wards.

It was noted that the direction of travel is to ensure that in three years' time, all targets can be met. There are still some challenging areas, such as CYP and ADHD long waits. The aim is to have high quality services, it was suggested that its important to be ambitious, however, not over-promise.

Ensuring patients get the right care, in the right place, in a suitable time frame, is key. The use of Advice and Guidance by GPs is being reviewed. Virtual wards are being reviewed in detail, feedback from patients has been received and despite some wards producing good results, this has not been the case for all virtual wards. Some virtual wards have not been achieving what they set out to do, which was to reduce hospital waiting times. If a virtual ward is closed, it can be reopened in future.

Choices have had to made to ensure a suitable plan was submitted. In the future ensuring services are commissioned appropriately will be closely scrutinised in order to ensure financial balance. Having appropriate contracts in place with acute trusts can affect how Primary Care colleagues work, as they also need to help the ICBs achieve financial balance.

Richard Mitchell noted the positive planning process this year and the fact that plans are in place much earlier than in previous years. He noted that University Hospitals of Northampton (UHN), consists of two separate organisations and the finances for UHN remain a concern at this time. He attended a Board session with UHL and UHN recently, at which it was agreed to continue the cost improvement work, look at using digital technology more, and ensuring the acute Trusts work together to review where services are available. There are 40-50 clinical services available, however, most are available at 4 or 5 different sites. This is an opportunity to review and possibly relocate some services, to make them more efficient.

Matt Gaunt noted the financial pressure, as identified in the reports provided and the nature of the financial challenge year on year. A paper is being presented to Health Partners Executive tomorrow, which highlights the work UHL are undertaking with regards to relocating services.

It was noted that there is scope to change plans mid-year if needed, to further reduce waiting lists etc. LLR ICB would be given a financial penalty if waiting list targets are not achieved.

The Finance and Contracting Committee has the remit to oversee the waiting lists targets and will report back to this Board. It was noted that the allocation formula is generally underfunded.

Anu Singh thanked everyone for their comments, noting the updated submission had been made.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the full submission made on 12 February 2026.

ICBIC-26-15 2026/2027 Budget Sign Off

Matt Gaunt confirmed that this paper is brought for approval today and covers approval to implementation. The Finance and Contracting Committee will ensure that the budget is monitored, and senior colleagues have been involved with agreeing their budgets.

Tables one and two provide additional information on how the ICBs will move forward with reporting and ensuring financial balance, based on the allocations. Table three highlights' resources. There is a section outlining the Accountable Officer responsibilities and responsibility of the Board members.

Harsha Kotecha asked how the Board would ensure that financial pressures do not result in services being reduced. It was confirmed that as the ICB does not have budgetary control this would be a local issue for budget holders to manage.

It was suggested that the tables could be made more useful, by including information from past years, as a comparison. It was highlighted that it is the Boards responsibility to ensure that the ICBs live within their means and to take difficult decisions, if required. Finding a balance between what communities need and what is within the financial envelope will be important. Teams will need to ensure services are equitable, are of high quality and value for money.

Maria Laffan rejoined the meeting.

It was agreed that financial reports need to clear, transparent and ensure they provide enough information for the Board to be informed about financial decisions that need to be made.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board.

- **NOTED** the approach to budget setting being taken across the cluster following the approval of the financial plan.
- **APPROVED** the financial budgets for 2026/27

ICBiC-26-16 LLR ICB and N ICB Clustered ICBs Governance Framework

Matt Gaunt confirmed that his paper is brought today to confirm new governance arrangements with regards to clustering the two ICBs. Revised Terms of Reference (ToR) are presented for approval, along with the LLR ICB and NICB Scheme of Reservation and Delegation (SoRD).

Neil Broughton stated that the paper had been developed over several weeks and includes updating statutory duties of the committees, as per the paper.

The disestablishment of the LLR ICB Health Equity Committee (HEC) was noted and questioned if it was appropriate to disestablish a committee that looked at health inequalities at this time. It was confirmed that health inequalities sit within commissioning, and engagement has taken place with Local Authorities etc. Mike Sandys stated that whilst health inequalities still need to be at the forefront, HEC was

not at the appropriate level for it to have a meaningful impact.

Health inequalities need to be embedded in all committees, as part of the Terms of Reference. This will ensure that there is clear evidence of improvement and engagement in this area. Healthwatch will also be assured that the ICBs are taking the necessary steps to improve health inequities.

It was noted that the Quality Performance and Outcomes committee also look at health inequalities in some detail, at placed based levels. A review of the committees ToR will be carried out in six months', in line with the Outcomes Framework. Andrew Hammond noted that the Audit Committee can question if committees have met their obligations with regards to reducing health inequalities.

Anu Singh noted the recommendations as set out the in the paper with the Board approving all the recommendations as listed.

a) **The LLR ICB Board APPROVED the disestablishment of the following LLR ICB Committees:**
   - The LLR ICB System Executive Committee
   - The LLR ICB Finance Committee
   - The LLR ICB Health Equity Committee
   - The LLR ICB Quality and Safety Committee

b) **The NICB Board APPROVED the disestablishment of the following NICB Committees:**
   - The NICB Integrated Planning and Resources Committee
   - The NICB Delivery and Performance Committee
   - The NICB Quality Committee

c) **The LLR ICB and NICB Boards meeting in common:**
   - **APPROVED the updated terms of reference for the following mandated Committees:**
     - Audit Committees in common (Appendix 1)
     - Remuneration and People Committees in common (Appendix 2)
   - **APPROVED the establishment and the terms of reference for the following locally determined Joint Committees:**
     - Joint Commissioning Strategy Committee (Appendix 3)
     - Joint Finance and Contracting Committee (Appendix 4)
     - Joint Quality, Performance and Outcomes Committee (Appendix 5)
     - Joint Transition and Transformation Committee (Appendix 6)
   - **APPROVED** the aligned LLR ICB and NICB Standing Financial Instructions (SFIs) (Appendix 7).
   - **APPROVED** the aligned LLR ICB and NICB Scheme of Reservation and Delegation (SoRD) (Appendix 8).
   - **NOTED** for information that the Chief Executive Officer will approve the aligned LLR ICB and NICB Operational Scheme of Delegation (OSoD).

Chair's Closing Remarks

Anu Singh thanked Julie Hogg and Maria Laffan for their input into the St Mary's discussions today.

The value of the discussion in relation to St Mary's was highlighted with a clear

decision being made, following a full discussion, with all contributors' comments valued. The need for further review highlights the commitment of listening to feedback received and acting on it for future services.

The decision made in relation to St Mary's today proves that UHL and the ICB can work together and have meaningful conversations about difficult decisions to be made. Both organisations are learning to shape and support future ways of working.

It was noted that the public gallery was engaged with the process and allowing Cllr Helen Cliff to speak was a popular decision. The full outcome of the Amos review will have to be considered, once available, with safety conversations continuing at present.

It was felt that the Board had made a clear decision, with future plans identified.

The Chair brought the meeting to a close at 11:47am

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

Minute No:	Agenda Item	Action	Lead	Status/Update	Timescale	RAG
Meeting Date: 16 April 2026						
		No action outstanding				

Completed
On Track
Overdue
No further action

Board Meetings in Common in Public

Report Title: Neighbourhood Health Framework

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland and
NHS Northamptonshire Integrated Care Boards

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Board Meetings in Common in Public

Name of Meeting	**Board Meetings in Common in Public**		
Date of Meeting	**Thursday 16 April 2026**		
Report Title	**Neighbourhood Health Framework**		
Paper Reference No:	**ICBIC-26-21**	**Agenda Item No:**	**7.**

Presented by	**Eileen Doyle, Chief Delivery Officer**
Report Author(s)	**Eileen Doyle, Chief Delivery Officer**
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 Committees that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Board is asked to consider and be advised by the report as this provides greater clarity on the future direction of travel and in particular the pivotal role of the ICB as strategic commissioners.

The Boards are asked to:

Note the report and approach implementing the framework.

Executive Summary of the report

Purpose

This paper sets out the role of the Integrated Care Board (ICB) in delivering the national Neighbourhood Health Framework published by the Department of Health and Social Care and NHS England in March 2026.

It outlines the statutory, strategic and operational responsibilities placed on ICBs, the expectations for partnership working with local authorities and wider system partners, and the implications for commissioning, performance, workforce and estates. The Board is asked to note the scale of the change required and the central role of the ICB in enabling successful implementation across the system.

Context

The Neighbourhood Health Framework establishes a national ambition to organise health and care services around defined neighbourhood populations, with a strong emphasis on prevention, proactive care, and integrated delivery. The document describes neighbourhood health as an approach that "puts the person at the centre of how we deliver their health and care by organising services so they can work together to serve a defined population" and positions this as a fundamental shift in how the NHS and local government collaborate.

The framework is explicit that the success of neighbourhood health depends on the ability of ICBs and local authorities to transform how they work together. It states that "the success of neighbourhood health hinges on the NHS, local authorities and partners transforming how they work together" and that ICBs must evolve into strategic commissioners capable of enabling this transformation. The ICB therefore sits at the heart of the national reform programme.

The framework represents a significant shift in how health and care services are expected to operate over the next decade, with a clear emphasis on integration, prevention, and the re-orientation of care into neighbourhoods.

The framework makes clear that ICBs are system leaders and strategic commissioners for neighbourhood health, working jointly with local government and Health and Wellbeing Boards (HWBs) and health providers.

Strategic Leadership and Commissioning

The ICB is responsible for embedding neighbourhood health within its five-year strategic commissioning plan and ensuring that neighbourhood-level delivery models are aligned with the national goals and local Joint Strategic Needs Assessments. The framework makes clear that ICBs must reflect neighbourhood health in their commissioning intentions as they refresh their plans for 2026–27 and beyond. This includes setting out how neighbourhood services will contribute to improvements in health outcomes, access to general practice, planned care performance, urgent and emergency care, and patient and staff experience.

The ICB must also ensure that neighbourhood health is integrated into wider system strategies, including primary care transformation, community services redesign, mental health pathways, children and young people's services, and the development of modern service frameworks. The framework highlights that these national programmes will evolve over time and that ICBs must adapt their commissioning approach accordingly.

ICBs are responsible for:

- Acting as strategic commissioners, using population health insight to plan, prioritise and allocate resources over the medium term.
- Ensuring neighbourhood health is embedded into medium-term planning, commissioning intentions and resource deployment.

Partnership and place leadership

- Working jointly with local authorities, HWBs and VCSE partners to create shared neighbourhood footprints and collaborative governance arrangements
- Supporting place-based leadership, enabling partners to organise services around people rather than organisational boundaries.

Delivery expectations

ICBs are expected to:

- Deliver the national minimum set of interventions set out in the framework over three years.
- Ensure progress against the five national goals, while allowing for additional locally defined outcomes.
- Develop neighbourhood health plans (from 2027/28), working through HWBs and place partnerships.

Enablers and system improvement

ICBs must also:

- Enable integration of data, digital tools and intelligence to support proactive care and risk stratification.
- Use mechanisms such as the Better Care Fund and pooled funding to support joint delivery.
- Balance consistency and assurance with local flexibility and innovation.

The Neighbourhood Health Framework sets a national direction of travel: integrated, preventative, community-first care delivered at neighbourhood level.

ICBs are pivotal: not as micromanagers, but as strategic commissioners, convenors and enablers, creating the conditions for local partners to succeed while assuring delivery of national priorities. Delivering the framework will require sustained partnership with local authorities, providers and communities, alongside a fundamental shift in commissioning, contracting and service delivery.

Recommendation

The Board is asked to note the responsibilities placed on the ICB

GOV•UK

Department of Health & Social Care

NHS England

Policy paper

Neighbourhood health framework

Published 17 March 2026

Applies to England

Contents

This publication is available at https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

Ministerial foreword

Most people and communities want to access health and care as close to home as possible, in a way that is most convenient for them and that gives them what they need when they need it.

Similarly, our staff want to support patients and service users without being constrained by organisational boundaries, and often echo the frustrations voiced in their communities when the design and delivery of local services fall short of what the NHS could - and should - be delivering.

Despite these 2 things being persistently true, for too long the NHS and wider health and care system has struggled to create the environment in which local services can work together, be co-ordinated, funded and delivered in a consistent way that enables what is often described as the ‘left shift’ to happen in an industrialised way while still meeting local needs and circumstances.

This government and ministerial team are determined to change that.

In the 10 Year Health Plan for England (https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future), we promised to give power to people. If we are to do this, we need to end people being passed from pillar to post in a fragmented and, at times, chaotic system, and make local health services meaningfully accountable to local residents and service users.

We will address this by creating a neighbourhood health service - building on the plethora of inspiring pilot programmes that have tested this in different parts of the NHS, local government and wider health and care system over recent years.

Neighbourhood health will only work as a joint endeavour between the NHS and local authorities, alongside wider partners. We expect this to be a truly collaborative effort between all partners, combining the NHS’s responsibility for our health services with local authorities’ responsibility for adult and children’s social care services and public health. This will foster a true partnership for the benefit of all citizens to ensure we achieve the left shift from hospital to community, and sickness to prevention.

The Medium Term Planning Framework (https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/) commits to creating the conditions for making that vision a reality by enabling 4 crucial changes:

- creating the archetypes so local systems have the governance structures to help neighbourhood health succeed

- delivering guidance to create both a common description of neighbourhood health and a common set of outcomes and metrics to help define success
- developing early financial incentives to support local systems to accelerate change
- establishing a new approach to joint working across NHS and local government leaders, including more collaborative strategic commissioning that will help to hard-wire the establishment of neighbourhood health now and into the future

The first 3 changes are set out in this document and the NHS England guidance for population health delivery models (https://www.england.nhs.uk/publication/fit-for-the-future-towards-population-health-delivery-models/). These changes will be supported by the development of integrated care boards (ICBs) into strategic commissioners and this new collaborative way of working with local authorities.

All of this is designed to create the conditions through which local leaders can succeed in delivering their ambitions for neighbourhood health, and wherever possible, remains light touch and flexible.

The aim is to support greater consistency by building on existing best practice. At the same time, where neighbourhood health is scarce, the guidance is designed to support local leaders to accelerate the creation of provision.

This framework has been co-produced with leaders from primary care, mental health, community and acute providers and leaders in local government and ICBs. This framework won't just help to create the conditions to accelerate the delivery of neighbourhood health, it will be central to the continuing effort to regain public confidence in the NHS. This is something that can only happen when the public see and feel a difference when they use NHS services, and have better access and continuity of care when they need it, as well as reduced waiting times.

It's therefore essential that the reforms in this framework accelerate improvements in delivery in the short term while creating new, sustainable ways of working for the future. Early improvements in transforming outpatients and frailty, for example, can have an immediate impact on the way patients experience the services they use now and can help create the headspace for further reform and improvement.

In terms of improving the experience of people and communities, as a core part of the delivery of neighbourhood health, the government is investing in the future of the neighbourhood estate by building and upgrading 250 new neighbourhood health centres up and down the country.

Neighbourhood health centres (NHCs) will be seen as the place to go for most health needs in every community. They will:

- bring together GP services with a mix of community, local authority and civil society sector services
- allow staff to join up care, which is better for people and communities
- make care easier to access and easier to deliver, while also reducing pressure on other parts of the system

In line with NHS England's strategic commissioning framework (https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/), ICBs are setting out their commissioning intentions over the next 5 years through 5-year strategic commissioning plans. As ICBs refresh these in the 2026 to 2027 financial year and beyond, this framework gives them the tools to properly reflect neighbourhood health in their commissioning approach. It's important to recognise this will be an incremental process - as local understanding develops and national reforms progress, plans for neighbourhood services will develop over time.

I am proud to be the Minister for Care and for neighbourhood health. I have seen that every day, across the sector, staff are working tirelessly to change the way the health and care system works to make it better for communities. However, I have also seen how frustrated they are at the rules, regulations and roadblocks put in their way. The government is fixing this, step by step.

This framework is designed to support ICBs and local authorities, including health and wellbeing boards (HWBs) and their local voluntary, community and social enterprise organisations (VCSEs) and wider system partners to deliver the vision that the 10 Year Health Plan offers, the truly modern service that people, communities and staff are crying out for.

As we work together to make neighbourhood health a reality across the country, we will regularly update this framework to reflect the learning from communities up and down the country.

This is the beginning of an exciting new chapter in how we build an NHS, and wider health and care system, fit for the future.

Stephen Kinnock MP, Minister of State for Care

Introduction to neighbourhood health

Neighbourhood health puts the person at the centre of how we deliver their health and care by organising services so they can work together to serve a defined population. This includes the services that people rely on close to

home and on the high street, such as GPs and community services and, where appropriate, urgent care, diagnostics and outpatients. This also includes local authority-commissioned services, such as adult and children's social care and public health services.

The aims of this approach are set out below.

Improve people's health and care outcomes, reduce health inequalities and help them stay well at home

We aim to do this by:

- focusing on prevention and proactive care management, including using data to effectively manage risk and prevent escalation
- strengthening primary and community services
- working better with specialists traditionally based in hospitals, public health, adult and children's social care, VCSEs and other partners

Organise services around the person with more convenient, personalised and joined-up care

We aim to orientate services around a person's needs, rather than organisational convenience. A strong digital approach will be critical to this. This includes:

- improving access to care (by phone, online or in person)
- moving more outpatient care from hospitals into neighbourhoods
- improving continuity of care for those with longer-term needs
- more effectively co-ordinating services for those with the most complex needs, for example, those at end of life

Reduce pressure on more acute services - including hospitals and care homes

We aim to do this by:

- using effective neighbourhood working to decrease avoidable hospital admissions or attendances and facilitate timely discharge
- reducing the de-conditioning that happens to many people when they spend time in hospital
- reducing avoidable care home admissions
- ensuring acute services are focused on those who need them most

Cut waste and duplication

We aim to do this by:

- integrating services across health, local government and wider partners
- making full use of digital opportunities
- ensuring the NHS is more sustainable

Help the NHS deliver against core targets

This will ensure that patients get a better service overall and their rights under the NHS Constitution for England (https://www.gov.uk/government/publications/the-nhs-constitution-for-england) are honoured.

Conclusion

Similar proposals have been set out over the last 15 years and many other countries have moved to a similar way of working. Yet, over the last 10 years, the system has orientated more to hospitals, with significantly greater spend and investment in hospitals rather than in primary and community care. The challenge is the ability of the system to make the change.

Although the setup of neighbourhood health will be different for each community, the success of neighbourhood health hinges on the NHS, local authorities and partners transforming how they work together. They need to work collaboratively to agree a joint vision and re-design commissioning and delivery of services at neighbourhood level, including through integrated neighbourhood teams (INTs).

Local leaders should consider how they can plan neighbourhood health services. Services should complement and build upon local plans to transform the wider scope of public services, and support investment in local places and community regeneration. Health is an important contributor to that agenda, and our approach reflects the 3 principles that guide the government's approach to public sector reform. These principles are to:

- integrate services so that they are organised around people's lives
- improve long-term outcomes for people through a focus on prevention, relying less on expensive crisis management
- devolve power to local areas, which understand the needs of their communities best, with services that are designed with and for people, in partnership with civil society and the impact economy

Measuring the overall success of neighbourhood health

Neighbourhood health and care services will deliver clear benefits. Neighbourhood health will have clear national minimum goals and objectives, which will be complemented by locally developed aims and outcomes, specific to communities. These will be defined locally through the neighbourhood health plan, designed under the collective leadership of the HWB.

During the 2026 to 2027 financial year, as part of developing neighbourhood health plans for the 2027 to 2028 financial year, HWB members will need to work with communities, health and care organisations and wider partners on how to establish outcome measures that cover the whole life course of the individual and reflect both health and social care needs.

National NHS goals, objectives and metrics

For the NHS, there are minimum national goals, objectives and metrics - outlined below. These should be achieved over the course of the 10 Year Health Plan period, with initial progress expected over the Medium Term Planning Framework period of April 2026 to March 2029.

The national goals are based on the Medium Term Planning Framework. They are not the ceiling of what neighbourhood health can or should achieve. Where systems can set out credible and radical proposals to go

further, they should do so, and we will keep these metrics under review as system plans become clearer.

We recognise some of these metrics are still being developed and, as we confirm details, we will communicate them to the system as part of the usual planning round. This will include any changes that will take place as a consequence of the current development of modern service frameworks (covering cardiovascular disease (CVD), sepsis, frailty and dementia, severe mental illness, children and young people, and palliative and end of life care).

Goal 1: improve health outcomes

We aim to improve health outcomes with specific focus on high-priority cohorts:

- people with frailty
- care home residents
- housebound patients
- those receiving end of life care
- those with:
  - CVD
  - diabetes
  - chronic obstructive pulmonary disease (COPD)
  - dementia
  - mental health conditions
- children and young people
- any other cohort identified by local areas

Goal 1 objectives and metrics (compared with 2025 to 2026 baseline)

We have 4 core objectives and corresponding metrics for this goal. We will:

- help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer. We aim to reduce non-elective admissions and bed days of one day or over by 10% for this cohort by March 2029
- better identify people coming to the end of life and improve access to services so people can die in a place of their choosing. By March 2029, we aim to:
  - increase the number of people identified as approaching end of life by 10%
  - reduce non-elective admissions and bed days of one day or over for people in the end of life cohort by 10%

- have better diagnosis and treatment for people with long-term conditions, particularly people with CVD, diabetes, COPD, mental health conditions and dementia. ICBs should agree targets to reduce variation in access to elective care for each of these areas, in line with goal 3 below. Modern service frameworks will specify further metrics for CVD and mental health in due course. By March 2029, we aim to:
  - see an improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia, where warranted
  - increase the percentage of patients with diabetes who receive all 8 elements of the diabetes care process bundle in the preceding 12 months by 10%

- improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care. By March 2029, we aim to:
  - reduce acute outpatient appointments for children under the age of 16 by 10%
  - make substantial progress towards reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures

Goal 2: improve access to general practice
We aim to improve access to general practice so people can see their GP in a timely, high-quality way.

Goal 2 objectives and metrics (compared with 2025 to 2026 baseline)
We have 3 core objectives and corresponding metrics for this goal. We will:

- ensure that clinically urgent patients are seen on the same day by their GP practice team. We aim to see 90% of clinically urgent patients on the same day by March 2027
- make sure there is faster access for routine GP care. During the 2026 to 2027 financial year, we will collect data to baseline and set future trajectories. In the interim, ICBs may set local goals in agreement with contractors
- improve patient satisfaction with GP access. During the 2026 to 2027 financial year, we will collect data to baseline and set future trajectories. In the interim, ICBs may set local goals in agreement with contractors

Goal 3: improve experience of planned care
We will improve experiences of planned care and cancer care, and support delivery of the referral to treatment (RTT) standard.

Goal 3 objectives and metrics (compared with 2025 to 2026 baseline)
We have 2 core objectives and corresponding metrics for this goal. We will:

- reduce variation in referrals to outpatient services across the system through a single point of access (SpoA) and multidisciplinary team model. We aim to contribute to a diversion rate of at least 25% by March 2027 for at least 10 high volume specialties, supporting overall RTT trajectories of 70% by March 2027 and 92% by March 2029
- make sure there is better co-ordination of outpatient activity across multiple specialties for patients in high-priority cohorts. We aim to deliver more follow-up outpatient care in neighbourhoods, and contribute to an overall reduction in secondary care follow-up appointments by at least 10% by March 2027. For cancer, these should be delivered in line with the metrics in the National Cancer Plan for England (https://www.gov.uk/government/publications/national-cancer-plan-for-england)

Goal 4: better urgent and emergency care performance
We aim to improve urgent and emergency care (UEC) performance in line with agreed standards, including improving ambulance response times.

Goal 4 objectives and metrics (compared with 2025 to 2026 baseline)
We have 3 core objectives and corresponding metrics for this goal. We will:

- make sure there is better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making use of a single point of access, urgent community response, hospital at home, and virtual wards. By March 2029, we aim to:
  - keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts
  - contribute to an increase in type 1 emergency department (ED or A&E) admitted and non-admitted performance, supporting overall 4-hour trajectories of 85%. We aim for an interim trajectory of 82% by March 2027
  - contribute to an overall reduction in type 1 ED attendances for high priority cohorts
- have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community. We aim to reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029
- ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. We aim to contribute to an improvement in the average length of discharge delay for all acute adult patients, derived from:
  - the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)

- for those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge

Goal 5: improve patient and staff satisfaction
We want to improve patient and staff satisfaction with NHS services.

Goal 5 objectives and metrics (compared with 2025 to 2026 baseline)
We have 2 core objectives and corresponding metrics for this goal. We will:

- take a proactive approach, where the patient feels in control of their care. We will introduce a reformed set of patient-reported experience measures and patient-reported outcome measures in the 2026 to 2027 financial year, with trajectories for improvement each year. These will be collected consistently across places and details will be confirmed in due course. In the interim, ICBs may set local goals. In addition, by 2027, 95% of people with complex needs will have an agreed care plan
- ensure that teams working within neighbourhoods feel more motivated in their work. We will introduce a set of neighbourhood staff experience measures in the 2026 to 2027 financial year, with trajectories for improvement each year. These will be collected consistently across places and details will be confirmed in due course. In the interim, ICBs may set local goals

Local goals, objectives and metrics

Through HWBs, ICBs and local authorities will:

- agree how neighbourhood health can deliver further measurable benefits and how these will develop over time
- address local priorities and health inequalities set out in the local joint strategic needs assessment (JSNA)

Firstly, the government recommends that HWBs consider the Local Outcomes Framework (https://www.gov.uk/government/publications/local-outcomes-framework/) metrics and outcomes across health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration.

Secondly, as part of this process, alongside their shared focus on improving local health outcomes, we recommend that ICBs and local authorities work with other HWB partners to identify how neighbourhood health can help improve relevant outcomes for adult social care (as set out in Adult social care priorities for local authorities: 2026 to 2027 (https://www.gov.uk/government/publications/adult-social-care-priorities-for-local-authorities) and detailed below):

- the proportion of people who receive long-term support who are enabled to live in their home or with family
- the number of adults whose long-term support needs are met by admission to residential and nursing care homes, split by age (18 to 64, 65 and over) per 100,000 population
- overall satisfaction of people who use services with their care and support
- overall satisfaction of carers with social services (for them and the person they care for)

Thirdly, neighbourhood health is part of the government's wider agenda of local public service reform. HWBs and their partners should build strong links between neighbourhood health and these wider reforms where possible. The government encourages HWBs, as part of setting their neighbourhood health plans, to consider how neighbourhood health plans can complement and build upon plans for opportunities for wider public service reform and further integration of services, refocusing services towards prevention and early intervention. Local authority leaders will play a critical part here in terms of ensuring that plans for wider public services integration are complementary and best serve the needs of their population.

As such, there are several other local initiatives and reform programmes that HWBs will wish to consider as part of the neighbourhood health strategy, where relevant, such as existing community initiatives and governance structures in place (for example, area committees, ward partnerships, parish councils or their equivalent and Pride in Place neighbourhood boards) and how they can constructively work with neighbourhood health services.

Examples of local initiatives and reform programmes
The Test, Learn and Grow programme (https://www.gov.uk/government/news/communities-across-the-country-to-benefit-from-innovation-squads-to-re-build-public-services) supports initiatives that start small to test reforms and innovations, iterating and growing what works. There are currently 2 such accelerator sites on neighbourhood health. Test, Learn and Grow can act as a channel for sharing lessons and evidence about iterative, patient-centred approaches in a neighbourhood health context. This evidence should be used when developing further plans for neighbourhood health.

As part of Best Start in Life reform, local authorities have been asked to develop local plans to improve early child development and health outcomes by 2028. Together, Best Start in Life (https://beststartinlife.gov.uk/) and neighbourhood health are a whole-government commitment to integrated, locally tailored approaches, focused on prevention, that support the healthy development of all

children. HWBs are therefore encouraged to ensure alignment between neighbourhood health and Best Start local plans.

Best Start Family Hubs (https://www.gov.uk/government/publications/best-start-family-hubs-and-healthy-babies-guidance-for-local-authorities) will provide health services, with a particular focus on 0 to 5 year olds, including Healthy Babies services. They improve child health and development outcomes by streamlining access to early, co-ordinated support and strengthening the integration of local services around families. Local authorities, ICBs and other health and wellbeing partners should consider, in their neighbourhood health plans, how they will:

- use Best Start Family Hubs, as part of their neighbourhood health infrastructure, to provide health services in community settings
- ensure services are organised around the needs of babies, children and families to proactively identify risks and early signs of developmental delay and target early interventions
- make sure that existing plans for Best Family Hubs complement and do not duplicate any new NHCs

Reform to the system of support for children with special educational needs and disabilities (https://www.gov.uk/government/consultations/send-reform-putting-children-and-young-people-first) (SEND) is designed to deliver high-quality support to children as soon as a need is identified. ICBs are already working with local authorities as they set out plans for delivery of SEND reforms in their areas and will be required to jointly establish an integrated local 'Experts at Hand' offer to provide early support to children with SEND.

Young Futures Hubs (http://www.gov.uk/guidance/young-futures-hubs) will offer open access provision and targeted, evidence-based support for young people who need additional help with early mental health advice, prevention from involvement in crime, and access to opportunities.

Reform of children's social care and safeguarding will place more emphasis on earlier intervention and embedding support in communities for children and families, delivered through the Families First Partnership programme (https://www.gov.uk/government/publications/families-first-partnership-programme). Local authorities should consider, as part of planning with ICBs through HWBs, how the recruitment and deployment of family help and multi-agency child protection teams will complement and work jointly with new INTs.

The Pride in Place programme (https://www.gov.uk/government/publications/pride-in-place-programme-prospectus) will deliver £5.8 billion of funding over the next decade to 284 communities that have been overlooked and left behind. Pride in

Place neighbourhood boards, made up of local people and led by an independent chair, will come together to come up with a plan for the future of their place. Boards may choose to invest in interventions to improve health outcomes locally and will bring local residents together to shape and influence local health services. Where relevant, ICBs and local authorities should consider the priorities of Pride in Place neighbourhood boards to ensure that health services meet the needs of communities.

Local Get Britain Working plans (https://www.gov.uk/government/publications/guidance-for-developing-local-get-britain-working-plans-england) set out a holistic approach to understanding and tackling challenges within local labour markets, including those related to health. Plans have been developed by local government in collaboration with ICBs, Jobcentre Plus and wider partners.

The Pathways to Work Green Paper (https://www.gov.uk/government/consultations/pathways-to-work-reforming-benefits-and-support-to-get-britain-working-green-paper) set out plans to offer personalised work, health and skills support for all disabled people and people with health conditions on out-of-work benefits. The goal is to combine new investment with existing capacity under the banner of 'Pathways to Work'. This will bring together and build on existing support to offer a range of different options tailored to individual needs from a diversity of providers, such as:

- WorkWell, which is an early intervention health and employment support service to help people with health conditions stay in or return to work that will be rolled out across all of England, backed by up to £259 million investment over the next 3 years
- Individual Placement and Support (IPS) for those with severe mental illness or substance dependency
- Connect to Work
- the new Get Britain Working trailblazers and the new national jobs and careers service

The government's national plan to end homelessness (https://www.gov.uk/government/publications/a-national-plan-to-end-homelessness) aims to end all forms of homelessness and improve local support for people with complex, co-occurring needs.

Housing policy reforms to improve housing in England, including the Decent Homes Standard (https://www.gov.uk/government/consultations/consultation-on-a-reformed-decent-homes-standard-for-social-and-privately-rented-homes), which will include new minimum energy efficiency standards. These will set a minimum standard for all rented homes to be safe, decent and warm.

Awaab's Law (https://www.gov.uk/government/publications/awaabs-law-guidance-for-social-landlords) also requires social landlords to investigate and remedy dangerous hazards within fixed timescales.

The Changing Futures programme (https://www.gov.uk/government/collections/changing-futures) improves outcomes for people experiencing multiple disadvantage (combinations of homelessness and rough sleeping, poor mental health, substance use, domestic abuse and contact with the criminal justice system) by transforming the way local public service systems respond to deliver holistic, tailored support that meets their full range of needs.

The Tackling Loneliness Hub (https://tacklinglonelinesshub.org/) is a government-funded platform for professionals across the country to share best practice and research with the aim of working together to tackle loneliness and build more social connections within our society.

Making more effective use of established networks and community resources, such as library services and sport facilities, is important. As established spaces in local communities that may already provide or host a range of important preventative work, there is scope to consider how such services can be used to contribute to neighbourhood health.

The government's cross-sector and place-based approach to increasing physical activity levels will be set out in the forthcoming national plan for physical activity.

The place-based budget pilots in 5 mayoral strategic authority areas were outlined in the 2025 Budget (https://www.gov.uk/government/publications/budget-2025-document). These pilots will explore how public services can refocus onto prevention and early intervention through pooled budgets, building on the legacy of Total Place.

The new Office for the Impact Economy (https://www.gov.uk/government/news/local-communities-set-to-benefit-as-new-office-for-the-impact-economy-to-partner-with-philanthropists-social-investors-and-businesses) (OfIE) was launched by the Prime Minister to:

- facilitate government partnerships with investors, philanthropists and businesses
- unlock impact capital
- make public funding work harder
- drive national renewal

Support for neighbourhood health (co-designed with the Department of Health and Social Care (DHSC) and NHS England) is likely to include:

- developing the capacity and capability of National Neighbourhood Health Implementation Programme places towards ‘investment readiness’ - see more on this programme in the ‘Delivering neighbourhood health’ section
- developing communities of practice to showcase impact partnerships across neighbourhood health
- facilitating or convening activity to support investment pipelines

Delivering neighbourhood health

To deliver the aims of neighbourhood health, the NHS and local authorities must transform how they work together - and with wider partners, including civil society (such as the VCSE sector) - to improve planning and, in turn, health and care outcomes. This will need to include increasing alignment across multiple services, contracts and pathways at a neighbourhood level, through to increasing alignment between ICBs and local authorities, and mayoral strategic authorities where relevant. This joint planning and working should build upon existing best practice.

ICBs and local authorities, working with other local partners, will make the changes to services to:

- improve services for people who need routine healthcare, so neighbourhood health benefits everyone
- improve proactive care for people with complex needs
- deliver better alternatives to hospital care

Many of the best ideas will come from people in our communities. These reforms will need to be led locally. ICBs need to reform services based on what’s right for their local population, and what the frontline tells them needs to change.

Importantly, in line with the strategic commissioning framework, as part of developing the neighbourhood health plan, listening to and working with patients, people and communities will be central to delivery.

However, from listening to health and care partners, we have learned that there are many common-sense actions that work well everywhere. These are the building blocks of neighbourhood health that need to be in place in every community. Without them, it’s difficult to make the changes we need.

That's why we are asking ICBs to implement a series of minimum interventions in every community over the next 3 years.

These are not the ceiling of neighbourhood health, but the foundation upon which local priorities will be built.

Reform agenda 1: improve services for people who need routine healthcare, so neighbourhood health benefits everyone

General practice is the bedrock of neighbourhood health. Without good access to GPs and their teams, we cannot shift the dial on outcomes, patient experience or sustainability.

As part of building a neighbourhood health service, the NHS will support GP access recovery.

The NHS will deliver better GP access, with increased digital tools
We will improve access, as measured by new GP access targets. We will continue to tackle the outliers, ensuring all practices are open during core hours (all modes), improve the online experience, and ensure faster, more organised access.

The NHS will empower GPs to deliver better care
GPs will be empowered to better manage the health of their population by incentivising proactive population health management. This will take place through risk stratification, long-term condition management, secondary prevention and better continuity of care, backed up by improved access to specialist opinion. This will specifically benefit patients with frailty, in line with the Medium Term Planning Framework.

The NHS will improve GP access to diagnostics
The NHS will review direct access to diagnostics by GPs, aiming to make it easier for patients to receive a diagnosis and understand the need for secondary care intervention much more quickly. NHS England will begin by undertaking a review of diagnostic services, so we can map out existing community diagnostic centres (CDC) capacity and planned increases over the next 3 years.

The NHS will reduce bureaucracy so GPs can focus on delivering better care
ICBs will implement a 'red tape challenge', improving the connection between primary and secondary care through a range of common-sense interventions, including:

- full national implementation of the Getting It Right First Time (GIRFT) programme's bridging the interface (or gap) checklist
- new electronic patient records (EPRs), increasing access to shared care records
- direct prescribing to community pharmacies
- structured medication information
- prescriptions issued for 28 days in outpatients unless clinically inappropriate

NHS trusts will play a full role in maximising the interface for the benefit of patients and staff alike.

The NHS will improve the productivity of GP practices by increasing the use of technology to free up clinical time and assist flow
We will roll out artificial intelligence (AI) and ambient voice technology, expand AI-assisted triage pilots, embed access to online consultation tools through the NHS App and make the NHS App the default for messaging and push notifications from practices.

NHS England will work with ICBs to reform out-of-hours services, so the public can better access care when GP practices are closed
We will begin reforming out-of-hours services, which are currently fragmented and inefficient, setting a common minimum expectation across all systems, including the relationship to NHS 111. This will be addressed in the upcoming urgent and emergency care strategy.

ICBs will build on the progress we have made to strengthen pharmacists' role in delivering care, recognising that pharmacies are one of the most accessible parts of primary care
Pharmacies' convenience for patients means they are optimally placed to offer services such as contraception, blood pressure checking and support on smoking cessation, as well as the Pharmacy First service. As pharmacies become increasingly established in supporting prevention and treating minor illness our ambition is for pharmacies to become a first point of contact for more patients to support demand on general practice. In September 2026, all newly qualified pharmacists will for the first time be qualified to independently prescribe. This provides an enormous opportunity for the NHS and over time, as the number of prescribing-trained pharmacists grows, the ability to manage demand in primary care will rely on pharmacy teams including prescribers managing a greater volume of patient need.

The Medium Term Planning Framework asked ICBs to start to roll out local prescribing-based services and we will support this through national digital infrastructure. Not only will these developments support a greater range of patients within existing currently patient group direction (PGD) led services, but they will unlock opportunities to improve management of everyday

prescriptions, support medicines value and overprescribing opportunities and reduce pressure on general practice. Our ambition is for pharmacies to be a first port of call.

Reform agenda 2: improve proactive care for people

We will redesign services to prevent deterioration, avoid unnecessary hospital use and provide seamless care across settings.

Integrated neighbourhood teams (INTs) will help people stay healthier, for longer

INTs will bring together different professions and partners to work side by side to support people. These teams know their neighbourhoods inside out and can tailor care to what matters most for local people. In line with the 10 Year Health Plan's commitment to support people to be active participants in their own care by ensuring 95% of people with complex needs will have an agreed care plan by 2027, these teams will deliver assessment, care planning, co-ordination and follow-on support.

The NHS will not define nationally what should constitute an INT. This will vary based on different conditions and populations and will be decided locally. The NHS will amend national contracts and funding flows so ICBs can ensure the provision of INTs is commissioned effectively at an appropriate scale to serve patient cohorts. ICBs will work closely with local authorities and partners on how these can be set up, considering the interdependencies with adult and children's social care and VCSE services. For example, some INTs may benefit from the inclusion of care workers.

When ICBs, or partners, are setting up INTs, they need to ensure effective follow-on provision of care and treatment of people with mental illnesses, taking advantage of the opportunity to align the delivery of physical and mental healthcare, as most treatment for such patients happens in primary care settings.

Nationally, NHS England will ask ICBs to ensure INTs are set up with an initial focus on:

- people with frailty, and those who need end of life care: this cohort is the priority because those over 75 living with frailty, those at end of life and care home residents account for 3 to 5% of the population yet represent over 25% of non-elective admissions and 50% of bed days
- multiple long-term conditions: better management of multiple long-term conditions can result in slow onset of frailty and reduced incidences of acute presentation. INT development should focus on the conditions that have the highest impact (CVD, diabetes, COPD, dementia). In some

medical disciplines, such as diabetes, these will align with outpatient reform, and ICBs should consider how these areas will align

- children and young people (CYP): GPs will use children and young people INTs to provide timely access to paediatric expertise in the community, alongside wider health and care professionals, including mental health and community services. INTs will also help families to manage some conditions at home if clinically appropriate. The evidence base shows that many ED attendances and outpatient appointments are a result of children receiving care in the wrong place. The NHS will address this through the INTs, and we will build this service over time, with every child who needs one having access to an INT by the 2028 to 2029 financial year. In practice, we expect systems will see a shift in outcomes through the reduction of outpatient appointments, with wider benefits including a reduction in ED attendances and hospital appointments. As part of setting up INTs, ICBs and local authorities should work together to consider how these services join up with other children's services - for example, safeguarding, family help and multi-agency child protection teams, Best Start Family hubs, and the 'Experts at Hand' service for children with SEND
- cancer: in line with the National Cancer Plan, over the course of the next 3 years, INTs will be set up to improve the quality of life for those living with cancer

Where ICBs can go further and faster, they will do so, setting up INTs for other conditions, population groups and communities as they and their partners see fit, based on the priorities identified by HWBs.

NHS England will produce a best practice guide for NHS frailty pathways

This will set out essential actions for ICBs and providers to improve the entire frailty provision, from identification and assessment to proactive and urgent care. This will be based on what systems have told us works across the health and care service, and ICBs will be able to use this as a baseline on which to improve pathways in line with the upcoming modern service frameworks.

ICBs will maintain and develop access to women's health services as part of neighbourhood care, and women's health hubs will be aligned to new neighbourhood health pathways and structures

Women face disproportionate challenges in access and quality of healthcare over the course of their lives. Women's health hubs are designed to improve care for women, including avoiding them having to have multiple appointments in different settings. ICBs will ensure that any changes to wider neighbourhood provision are aligned with women's health hubs.

ICBs will grow core community services and work with providers to reduce waiting times

We recognise that community waits are having an impact on many high-priority population groups - those with frailty, those needing palliative and end of life care, children and young people, and those with multiple long-term conditions. We'll deliver better access to core community services by increasing capacity to meet demand growth (around 3% per year nationally), and actively managing long waits for community health services, with at least 78% of community health service activity occurring within 18 weeks by the 2026 to 2027 financial year and at least 80% by the 2028 to 2029 financial year, and backed up by new ICB plans to eliminate all 52-week waits.

The NHS will introduce a new model for planned care that meets the 10 Year Health Plan commitment of "ending outpatient care as we know it", starting with closer working between GPs and specialists

The NHS will put GPs in control when it's unclear whether a patient needs specialist care, so people do not make unnecessary trips to hospital and instead focus on providing care closer to home. GPs and secondary care consultants will work closer together, first by expanding advice through single points of access (starting with at least 10 specialties in all providers in the 2026 to 2027 financial year).

We will move more follow ups, for those who need specialist input, into neighbourhood settings, delivered by professionals in the community, starting with conditions such as diabetes, all backed up by new digital pathways and single points of access. In line with the Medium Term Planning Framework, systems should start planning for the introduction of a radical new neighbourhood approach to elective pathways, establishing a single point of access with better access to specialist opinion and diagnostics.

This should focus on the core specialties identified in the elective reform plan (https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/): gastroenterology, ENT, cardiology, respiratory, diabetes, gynaecology and urology. We will work closely with GPs to ensure these arrangements work effectively within their competency and that they are supported. Where systems are ready to go further and faster, devolution of budgets and reforms to funding flows will be available in exchange for credible plans.

The NHS will standardise the expectations of data sharing between neighbourhood health services and hospitals

Systems will make the NHS work around the needs of the individual, not the other way round, by improving data sharing between hospitals and neighbourhood health services, including social care. This will mean neighbourhoods can put in place more effective proactive care for those who might otherwise default to secondary care, rather than leaving patients to co-ordinate their own care.

Reform agenda 3: deliver better alternatives to hospital care

Patients are going to hospital as the default too often and are stuck in ward beds when they should be cared for safely in the community. This is bad both for those who don't need to be there and for those who need specialist hospital care. Working closely with our partners, including social care, the NHS will take the following actions.

Expand urgent community response services, so the NHS is there for people when they need it most
We will prevent avoidable attendances, particularly for frailty and falls, by expanding urgent community response capacity, delivered through the new community INTs.

The NHS will increase the capacity of virtual wards, so people don't have to attend hospital unnecessarily
Rather than make patients come to hospital, the NHS will come to them by radically increasing the capacity and efficiency of virtual wards.

The NHS will work with local authorities and other partners to increase intermediate care capacity
Increasing and optimising the capacity of step-up and step-down intermediate care will help avoid admissions and attendances, improve discharge and support better recovery. This includes making best use of community beds and expanding home-based care. We will reduce the length of stay in NHS-commissioned community beds, maintain that improvement and build intermediate care capacity (step-up and step-down).

We will explore better alternatives to mental health hospitals
Some local areas have been piloting a neighbourhood approach for mental health through 24/7 neighbourhood mental health centres. These centres for people with severe mental illnesses are intended to improve care continuity, reduce crisis and provide an alternative to hospital for people experiencing a mental health crisis, and are distinct from INTs.

Rather than having care passed to a separate team, pilots are testing having patients being supported by the same team, whether they need planned care, crisis care or an overnight stay in an alternative to hospital. The aim is to reduce how often people reach the point of needing hospital care and make it easier for those who do to access hospital care quickly and close to home. Pilots are also aiming to reduce the number of people who end up presenting to A&E in a mental health crisis. For systems that wish to use this approach, further guidance on the model will be made

available in autumn 2026, following the results of an independent evaluation.

National Neighbourhood Health Implementation Programme

Local systems will be supported by the National Neighbourhood Health Implementation Programme (https://neighbourhood-health.co.uk/), which will build capability, develop infrastructure and identify success criteria for the scaling of these new models. The programme will mobilise change and build relationships to transform care delivery for the priority national cohorts, as well as supporting the development of local partnership working across health, social care and other relevant agencies. It will help local systems generate the necessary changes in culture and integrated working across neighbourhoods, and we will share learning with the wider NHS, local government, social care, public health and VCSE communities as part of that ongoing work.

Going further in other services

We know there are areas where we need to go further. This framework describes the minimum expectation. Neighbourhood health will be built over time.

Over the next few years, we will look at how we can support other important services to effectively contribute to neighbourhoods, such as community pharmacy, dental services, optometry, learning disabilities and neurodiversity services and others. In the meantime, important reform agendas will continue to improve services in these areas.

If they choose to, ICBs can - and will - go further and earlier in such services as part of their neighbourhood plans.

Importantly, ICBs will work with local authorities to agree how to design and deliver those aspects of neighbourhood health that require joint working across the NHS, social care and other local services. They will also agree, through HWBs, how neighbourhood health will support wider local priorities for improving overall health outcomes and reducing health inequalities, having due regard to both local JSNAs and the Local Outcomes Framework published by the Ministry of Housing, Communities and Local Government (MHCLG) and the Civil Society Covenant

(https://www.gov.uk/government/publications/civil-society-covenant) principles of partnership working.

Representatives of mayoral strategic authorities sitting on ICB boards can support ongoing work to integrate and co-ordinate neighbourhood health at the sub-regional level, including with skills provision and spatial planning, providing further democratic accountability and strategic alignment.

Providers of neighbourhood health

Care will continue to be delivered by those who know their communities best, such as, among others:

- GPs
- nurses
- therapists
- pharmacists
- community health service providers
- hospitals
- social care providers
- public health services

What will change is how services are commissioned and contracted, removing barriers that prevent the integration the NHS and councils have long known is needed and enabling improvements in the core services themselves.

The focus will be on outcomes, not organisational form. ICBs will be responsible for ensuring neighbourhood health is the default for NHS care provision in their population.

ICBs will work closely with both local authorities as commissioners of social care and public health services, and the providers of those services across civil society and the public, private and VCSE sectors.

Neighbourhoods are not currently single organisations. In many cases, they won't need to be. It may make sense in some areas for a single organisation to begin delivering the different parts of neighbourhood health. It is for local providers, ICBs and local authorities to work through what is right for them and their communities.

Neighbourhoods need to be organised around populations, with the ability to develop management models that can join up resources and form partnerships that enable them to hold contracts. As part of developing the neighbourhood health plan, HWBs will need to set the geography ('a neighbourhood') around which services should be delivered. Many of these already exist and are working well.

DHSC and NHS England will take an enabling, non-prescriptive approach, allowing local systems to determine optimum models. Over time, we will assess whether these can or should be standardised, depending on what we learn from local systems.

Local areas will want to consider the footprint of INTs in terms of local authority boundaries - including new local government boundaries through the Local Government Reorganisation programme (https://www.gov.uk/government/collections/local-government-reorganisation-policy-and-programme-updates) where possible. Local areas should choose geographies that work best for them, taking into account a broad range of requirements such as:

- the local health economy
- access requirements
- local governance structures (for example, area committees, ward partnerships and parish councils or their equivalent)
- Pride in Place neighbourhood boards

This will help enable people and communities to have input into the shift to neighbourhood health in their area. Over time, we will assess whether these can or should be standardised, depending on what we learn from local systems.

For the NHS, ICBs will set clear expectations and contract accordingly - DHSC and NHS England are not going to dictate how all of this should be delivered and by whom. We do have some red lines - hospital standard contracts and general medical service contracts will remain the primary vehicles of delivery for the 2 biggest groups of NHS providers.

Therefore, at least in the initial stages, neighbourhood health will be delivered through commissioning reform. In its simplest form, this means changes to existing ways of working and contracts.

In some areas of the country, parts of neighbourhood health are being run effectively, and we don't want to disrupt good work.

In addition, we will develop options for population health contracting if systems believe better outcomes can be achieved through different provider models. Single neighbourhood provider contracts and multi-neighbourhood

provider contracts aim to strengthen the infrastructure and capability to design and deliver integrated services within and across neighbourhoods, with the potential for more incentive and outcomes-based contracts at greater scale.

Single neighbourhood providers

Single neighbourhood providers (SNPs) will deliver new services through INTs within a defined single neighbourhood.

SNPs enable primary care to take on new neighbourhood services that are not contracted for through today's general practice contracts (General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS), which will continue to be determined nationally and commissioned locally).

The SNP contract holder will need to work closely with practices that cover the neighbourhood population to ensure they can deliver care to the registered patient lists of the neighbourhood population. NHS England will consult on how this collaboration might work in the coming months.

Multi-neighbourhood providers

Multi-neighbourhood providers (MNPs) will co-ordinate the consistent delivery of services across multiple neighbourhoods.

MNPs will have a clear relationship with SNPs and practices, so they too can deliver care to the registered population list across the neighbourhoods they serve. This will allow commissioners to set consistent outcomes for aligned populations. As with SNPs, NHS England will consult on how this collaboration might work in the coming months.

MNPs will use their scale to design and co-ordinate the neighbourhood health services in their footprint, which may include delivering services directly at a larger scale than a neighbourhood, or 'filling in' services where it is locally agreed to be more appropriate for an MNP to deliver.

New risk-sharing approaches will incentivise neighbourhood providers to deliver effective preventative care that reduces avoidable non-elective admissions, focusing on high-priority cohorts.

It is our working assumption that an MNP contract would work well for a population of around 250,000 or more, and an SNP contract would work for

a population of around 50,000. However, we will not mandate nationally the size of neighbourhood health geographies under these arrangements. Contracts will be commissioned at the scales ICBs consider appropriate for their population. The size and shape of neighbourhoods will be agreed with local authorities and HWBs as part of the planning process, given the interdependence with public health and social care services.

Integrated health organisations

Integrated health organisation (IHO) contracts give providers a whole population health budget for a geographically defined population, underpinned by a contract.

IHO contract holders will take on responsibility for resource allocation and planning of services across the whole care pathway, holding responsibility for effectively meeting the needs of that population using available resources. Models where providers do not take on the whole population risk for a geography, for example, by taking on funding for a set of services, pathways or cohorts, are lead provider arrangements rather than an IHO.

The model will empower highly capable providers to lead change through their understanding of local population need, knowledge of activity and costs, and ability to engage frontline clinicians in service redesign. IHOs will undo needless NHS fragmentation and create incentives to invest in community-based preventative care.

IHO contract holders will allocate resources and design services to support implementation of new models of person-centred care - including the shift to neighbourhoods - that will improve health outcomes, patient and staff experience and efficacy of care. This will require the designated host provider to work with and contract other providers to deliver services, including multi-neighbourhood providers.

The IHO contract holder will develop decision-making infrastructure to shift the balance of care, and the balance of existing spend, out of the acute sector and into the community, demonstrating a strong understanding of cost effectiveness, healthcare value and the relationship between cost and outcomes.

The defined population covered by an IHO contract should share borders with one or more MNP footprints to create an aligned delivery chain for the local population and to enable commissioners to set consistent outcomes.

NHS trusts will be designated as eligible to hold IHO contracts by DHSC and NHS England. Designation will provide assurance that these trusts have the capability to work in partnership across systems and to manage

the additional risk and subcontracting requirements of holding an IHO contract. Initially, these will be high-performing and highly capable advanced foundation trusts. Designated trusts will be commissioned by ICBs using a newly developed IHO contract. We anticipate that community, mental health and acute trusts could all be eligible to be designated as IHO contract holders.

NHS England will work alongside the first wave of IHO contract holders to test the model and develop a pipeline for wider rollout, including to areas where there is compelling evidence that an IHO approach can solve entrenched problems in a health system.

We expect all IHO contract holders to think carefully about how they build and sustain mature partnerships with their local communities, including local authorities and third sector organisations, both as they develop their proposals and in their future governance. In particular, primary care clinical leadership in IHOs will bring local insight and patient-centred design right to the heart of decision-making. This will enable communities to design care that works for them, integrating primary, community and specialist services into one seamless system.

IHO contracts will only ever be held by NHS organisations. However, we will develop routes to enable mature neighbourhood providers to lead an IHO through forming, working within or developing alliances or joint ventures with statutory NHS organisations - blending the agility of general practice with the scale and accountability of the NHS.

In all primary care contract types, General Medical Services (or PMS or APMS), General Dental Services (or Personal Dental Services), community pharmaceutical services and General Ophthalmic Services contracts will continue to be commissioned in accordance with national contracts, with the ICB delegating commissioning responsibilities to the IHO, if an IHO is agreed and constituted.

We will consult on how MNPs, SNPs, GMS and the Primary Care Network Directed Enhanced Service (PCN DES) will work together, including how primary care networks might evolve into SNPs.

We will consult on how the 3 new contractual options will work. Between MNPs and SNPs, it will be up to ICBs to decide in their commissioning how to organise these arrangements based on what's right for their local population, although we would expect an appropriate level of coterminous arrangement.

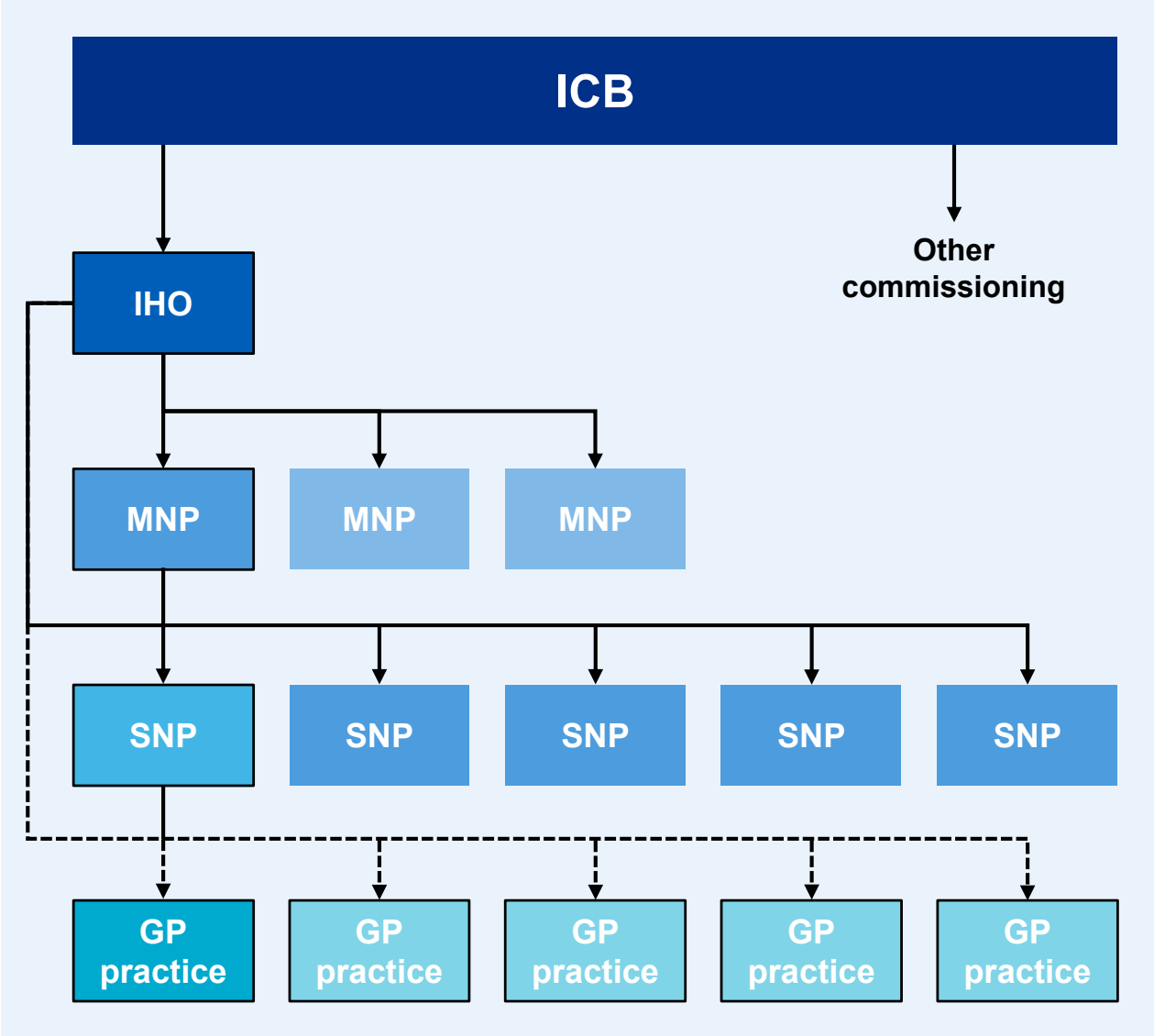
Figure 1 below demonstrates how these population-based contracts could fit together in a system where all 3 contractual mechanisms are in use - though many systems will have different arrangements where IHOs are not constituted.

The IHO, MNP and SNP (and GMS, PMS and APMS) are all population-based contracts. The populations should be nested where possible to ensure commissioners can set aligned outcome objectives.

The ICB contracts a single IHO for an area. The IHO then contracts a number of multi-neighbourhood providers. Each MNP works with multiple SNPs. Each SNP works with all local GP practices in the neighbourhood.

The dotted line shows how GP contracts will remain nationally determined.

Figure 1: population-based contract arrangements



NHS England will insist on strong clinical leadership, particularly from general practitioners. Any provider will need to provide clinical leadership, with accountability, professional oversight, and responsibility for the quality of care and evidence-based practice delivered locally. NHS England will also set clear expectations that providers must be data-led, with a strong analytical approach to informing proactive care management.

ICBs, local authorities and providers will need to transform how they work together, including through HWBs, to design and deliver a neighbourhood health service. Local communities need to work together to determine what

is right for them through strong partnership working - this will be a necessity. This is particularly important if ICBs and local authorities decide they wish to integrate aspects of local authority-commissioned services (for example, social care or sexual health services) into their neighbourhood health architecture. It is for local communities to decide how that is done.

See further details on these arrangements in the NHS England guidance for population health delivery models (https://www.england.nhs.uk/publication/fit-for-the-future-towards-population-health-delivery-models/). We will also set out the minimum requirements the NHS will expect of the governance, leadership and financial discipline of any provider.

Neighbourhood health estates and locations

In many cases, services will be delivered in the same locations as now. Some services may move online, or from a hospital to the GP practice, pharmacy or health centre.

The 10 Year Health Plan promised services would happen:

- as locally as it can
- digitally by default
- in a patient's home if possible
- in an NHC when needed
- in a hospital if necessary

NHCs are a crucial part of the neighbourhood health model, and work has been rapidly progressing to identify essential criteria of an NHC, develop guidance for systems and ensure we are able to deliver on our ambitious pipeline goals.

However, across the country, the quality of buildings in many GP practices is poor and not suitable for modern-day care. There is often a plethora of buildings used for different services - community care, mental healthcare, primary care, acute care and so on. This is confusing and inefficient, resulting in considerable amounts of money being spent on buildings rather than on care.

In addition, we have an opportunity to bring together healthcare and wider support for individuals, families and communities - for example, by co-locating healthcare services with Best Start Family Hubs, food banks, housing services and employment support.

NHCs will be seen as the place to go for most health and wider needs in every community. They will bring together GP services with a mix of community, local authority, civil society and VCSE sector services, allowing staff to join up care, which is better for patients.

Our pipeline is ambitious: we are aiming to deliver 250 NHCs by 2035, 120 of those by 2030. They will be a mixture of repurposed underused estate and new builds, with 20% of new builds funded from public capital and the rest through public-private partnerships. Our wave 1 pipeline for 2026 to 2027 will largely focus on repurposing existing NHS buildings - mostly NHS Property Services and LIFT (NHS Local Improvement Finance Trust) estates - in areas with the highest deprivation. Future waves are under development and will include further repurposed estate alongside new builds, funded through public capital and public-private partnerships.

We are developing guidance for systems to inform estates planning around neighbourhood health. Nationally, we are aligning this work with neighbourhood mental health centres and community diagnostic centres. ICBs and HWBs should consider if plans can complement and build upon existing programmes, including, for example, Best Start Family Hubs, or in community centres and spaces funded and developed as part of the Pride in Place programme. Locally, planning will need to be led by ICBs and undertaken alongside local partners to maximise opportunities from One Public Estate (https://www.local.gov.uk/our-support/one-public-estate) and from the broader growth and housing agendas and investments in local areas).

Beyond that, it is for ICBs, as the commissioners, and providers to work together to decide the best location.

The neighbourhood health workforce

In most cases, this is about existing staff working differently. For example, consultants in hospitals will work more closely with GPs and community health services, and GPs will work with INTs alongside district nurses and others.

In some cases, we will be setting up new services, and this will require new staff roles at local level.

The shift to neighbourhood health will entail a fundamental reimagining of the roles, skills and ways of working across health and social care over the next decade. We are developing proposals for the 10 Year Workforce Plan that will deliver our aim to make neighbourhoods great places to work, with strong leaders and teams skilled at delivering proactive, preventative and personalised care that improves health outcomes and stops need

escalating. Staff will work together seamlessly across boundaries as part of multidisciplinary integrated teams, and their careers will develop fluidly through different parts of the system. People will experience better care that is easier for staff to deliver.

The shift to neighbourhood health should be felt by staff working in all parts of the health and care system, not just those based in community settings. Systems will need to ensure they have shared planning assumptions about the scale of the shift from and to different places and professions, to ensure patients feel the benefit. These will necessarily vary depending on the configuration of local services, and the 10 Year Workforce Plan will set out some aggregate assumptions and scenarios to help inform local plans. We will need to ensure we have the right modelling assumptions about the scale of the shift across all parts of the workforce, and this is currently being tested.

System leaders will need to focus on collaboration across boundaries, innovation and transformation, with the 10 Year Health Plan setting out more detail on this.

Neighbourhood health finances

As strategic commissioners, ICBs will identify funding for NHS-delivered neighbourhood health through active prioritisation. This must be led locally as one size does not fit all - it will be up to ICBs to decide the optimal way to configure local services to meet population needs.

Where HWBs agree any changes to public health, adult and children's social care or other local government services to reflect agreed local priorities for neighbourhood health, this does not alter the accountability or funding responsibilities of local authorities.

Nationally, the NHS will support this by:

- progressing vital interventions described here by constructing allocations and expectations in the Medium Term Planning Framework on the basis that, over the Spending Review period, ICBs will move funding from the acute sector into neighbourhood services
- amending the financial framework from the 2026 to 2027 financial year, including changes to block contracts and payment flows, to help systems invest in the left shift and deliver better outcomes within constrained financial resources
- supporting neighbourhoods with credible and agreed plans to reduce UEC attendances and non-elective admissions by testing payment approaches that incentivise prevention and community-based care

In parallel, we will develop financial mechanisms that support the establishment and scaling of neighbourhood health. Over the coming months, we will work with finance, commissioning and operational colleagues to shape these mechanisms so they are simple, flexible and support service redesign. We will take a permissive approach when neighbourhoods propose changes to money flows, new payment mechanisms or alternative contractual approaches, provided these are backed by credible plans and deliver improved outcomes and value for money.

This may include proposals to test more population, risk or outcome-based contracting approaches, as signalled in the 10 Year Health Plan, where systems believe these models could strengthen incentives for prevention, improve value for money, and support the shift towards neighbourhood-based care. These plans should, however, demonstrate that neighbourhood health will be funded by rebalancing existing resources rather than relying on new funding, while recognising that the scale and pace of the shift will be determined locally.

This permissive approach sits alongside existing arrangements such as outpatient and frailty budget devolution and other potential left-shift funding reforms.

Next steps

DHSC and NHS England will set the baselines ICBs need to proceed with new arrangements. Over the coming months, we will:

- publish the model NHCs definition, which will describe different archetypes of provision of neighbourhood health services that can be used to inform the better use and enhancement of existing estates, together with new-build solutions, where appropriate
- support the goals of neighbourhood health in national reform agendas, including introducing new GP access targets, developing new payment approaches that support the left shift and the development of neighbourhood health, and publishing a series of modern service frameworks on core conditions to give ICBs the baseline they need to inform future commissioning

Our plans will be delivered in 2 stages, which can run in parallel.

Stage 1: immediate changes in the 2026 to 2027 financial year

The Medium Term Planning Framework asks ICBs to prioritise the fundamentals at pace and to work with their local partners to make the changes required to deliver neighbourhood health.

ICBs will need to ensure the NHS delivers the minimum basic requirements in 2026 to 2027, as well as laying the groundwork for more fundamental reform. As part of this, ICBs and HWBs should start developing and embedding new ways of working with local government and wider partners in 2026 to 2027 to start jointly developing their approach to neighbourhood services in their area. These minimum basic requirements are:

- agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis
- agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements
- agree neighbourhood footprints around natural communities for the future development of INTs
- agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area
- start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population
- confirm plans to meet 18-week community waits and eliminate 52-week waits.
- confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance (https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027) (noting that any funding decisions must also be consistent with the national conditions for the fund, including the required increases in ICBs' minimum contributions to adult social care over the next 3 years)
- continue to improve the primary and secondary care interface in line with the red tape challenge
- confirm organisational ownership of planned deliverables

- confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation

Regional teams will work with ICBs on progress against the essential actions. ICBs are requested to ensure these are completed as soon as possible.

Stage 2: longer-term reform (April 2027 to March 2029)

In parallel to stage 1 and over the longer term, the NHS and local authorities must work together with partners to deliver the fundamental changes we want to see. For implementation from at least the 2027 to 2028 financial years, ICBs should work with HWBs and their partners to develop a locally owned neighbourhood health plan.

Once agreed with HWB partners, the plan will need to:

- provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas outlined above
- set out how neighbourhood health will support wider local goals to improve health outcomes and reduce health inequalities, and deliver on any locally agreed wider public service reform agendas
- set out how local objectives are informed by the JSNA, and any other assessments by ICBs or local authorities, as deemed necessary by them and the HWB
- confirm final geographies that partners will then work within
- confirm which organisations are responsible for different elements of delivery
- confirm the arrangements that will be in place to deliver this, including governance and operational partnership arrangements
- confirm how any other relevant initiatives align with the strategy (such as Best Start Family Hubs, housing, mental health hubs, Pride in Place and employment support)

Once this is agreed, the ICB will incorporate this locally owned plan into their refreshed 5-year strategic commissioning plan, in line with the strategic commissioning framework, which will be the formal NHS commissioning strategy for neighbourhood health. Systems are expected to go beyond the measures outlined in this framework (for example to develop the role of neighbourhood health in prevention) if they choose to do so.

The success of neighbourhood health hinges on the NHS, local authorities and partners transforming how they work together by working

collaboratively to agree a joint vision, and redesign commissioning and delivery of services at the neighbourhood level. We expect ICBs and local authorities to work constructively together during this process, with local authorities involved in the strategic development of the approach for all reform agendas outlined above (and particularly 2 and 3), which critically rely on common approaches to cohorts such as people with frailty and people nearing end of life.

Conclusion

Creating the conditions for neighbourhood health to be universally established - and to flourish in the future - is central to the leadership challenge the NHS and local communities face over the next period.

A thriving health service in every community has always been in reach, but the conditions needed to make this a truly universal offer haven't aligned until now.

Those conditions now exist. We have the very real opportunity to make the kind of change that will impact communities today and long into the future. But success depends on local leaders working together beyond the boundaries of their own organisations.

The motivation is simple: creating accessible services as close to home as possible will be pivotal to regaining the confidence of our local communities and our staff across the NHS and care services.

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

Board Assurance Framework Risk	
LLR ICB BAF No:	**NICB BAF No:**

Appendices	

Who has been engaged and where else has this report been considered:
This report has been published nationally by the NHS England and the DHSC.

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

Board Meeting in Common

Report Title: Development of an ICB Outcomes Framework

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland and
NHS Northamptonshire Integrated Care Boards

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Board Meetings in Common in Public

Name of Meeting	**Board Meetings in Common in Public**		
Date of Meeting	**Thursday 16 April 2026**		
Report Title	**Development of an ICB Outcomes Framework**		
Paper Reference No:	**ICBIC-26-22**	**Agenda Item No:**	**8.**

Presented by	**Paul Birch, AD Population Health and Intelligence**
Report Author(s)	**Paul Birch, AD Population Health and Intelligence**
Executive Sponsor	**Nil Sanganee, CMO**

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 paper presents work to date on the development of an Outcomes Framework for the ICB and its application to the 3 Transformational Priorities identified in the LNR 5 Year Commissioning Strategy. This work aims to present a developed Outcomes Framework proposal to the May Board development workshop.

The Boards are requested to:

- **Note** the content of the work to date.
- **Approve** the Outcomes Framework approach and its application to the Transformation Priorities

Executive Summary of the report

Outcome based commissioning has been a key part of NHS Policy and Strategic Direction for a number of years and is a central concept in Strategic Commissioning. Often, however, its application has been challenging with performance and financial imperatives diverting from a focus on outcomes. Work on outcomes has been progressed in both ICBs but this has tended to follow a service and pathway specific rather than a consistent strategic approach leading to variation.

Following a JET discussion it was agreed to develop an outcomes framework that would support the development of a consistent approach to outcomes-based working. This would initially be focused on the three Transformation Priorities identified in the 5 Year Plan in a way that would allow it to be applied to all areas of the ICB remit and portfolio. The outcomes framework was seen as part of a "balanced scorecard" approach alongside quality, performance and financial measures and this is reflected in its design. Initial focus should be on our Transformation Priorities: Frailty, Children and Young People's Neuro Diversity and Mental Health access, and Preventable Mortality

(CVD-RM*, Respiratory, Cancer.) *(*Cardiovascular–Renal–Metabolic (CVD-RM) is used to describe a group of conditions that frequently co-exist with cardiovascular disease and share common risk factors, symptoms, and physical impacts. This grouping is increasingly used in clinical and policy contexts.)*

A working group has been established to progress this work and a number of workshops and focus sessions held to build on the progress made during the commissioning round and development of the Strategic Commissioning Strategy. A workshop with attendance from across the ICB and Local Authorities was held on 24th March, and this work has identified a logic model approach using short, medium and long term outcomes as well as three key "Outcome Priorities" for the ICB: Prevention, Identification and Management to structure outcomes to reflect the ICBs core purpose.

Inequalities are a key element of the outcomes based approach, and it is intended that wherever possible metrics are developed which allow them to be reported at Place and Core20PLUS (Deprivation Quintile & Ethnic Categories) in addition to ICB. Consideration will also be given in the selection of metrics to those linked to health inequalities and this will form a key part of the logic modelling process.

Where possible metrics will be aligned to National policy and outcomes frameworks. An example may be the target within the new Neighbourhood framework to reduce non-elective bed days by 10% for the cohort of people with mild to severe frailty or the Diabetes care processes in relation to CVD-RM.

Focused sessions will be held to apply the framework in each of the thematic priorities, for Preventable Mortality individual sessions will be held for each of CVD-RM, Respiratory and Cancer to reflect the specifics of each as an integrated approach was felt to be provide insufficient detail. While this work is in progress an indicative view of how the approach could be applied to Cardiovascular Renal – Metabolic (CVD-RM) is provided.

The committee is asked to consider the proposed outcomes framework and provide commentary and guidance on:

- The proposed structure of the outcomes framework
- The proposed approach to develop the outcomes framework
- The role of the Committee in relation to the oversight of the delivery of the Outcomes Framework

It is also proposed that the framework is considered by the Committee following the Board Development workshop to allow consideration of the complete framework and metrics for each of the thematic priorities.

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 to be excluded from the meeting
If conflict identified, please list conflicted party and nature of conflict:	

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: BAF 1 – Collaborative working BAF 2 – Health Inequalities BAF 11 – Deliver strategic objectives	**NICB BAF No:** BAF 4 – Data to support decision making BAF 9 – Deliver NHS Reforms BAF 10 – Deliver strategic objectives

Appendices	None

Who has been engaged and where else has this report been considered:
The report is a development of a previous report presented to the Joint Executive Team and has been considered by the Quality Performance and Outcomes Committee. Wide engagement across the ICB and with all Local Authority Public Health teams has been undertaken. This will be extended to providers, the VCSE and representative groups in the next stage of this work.

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

Board Meeting in Common
Development of an ICB Outcomes Framework

Introduction

1. Outcome based commissioning is a strategic approach that focuses on achieving specific, measurable outcomes for individuals and communities rather than merely delivering services. It has been a key part of NHS Policy and Strategic Direction for a number of years and is a central concept in Strategic Commissioning. Often, however, its application has been challenging with performance and financial imperatives often diverting from a focus on outcomes. Work on outcomes has been progressed in both ICBs, but this has tended to follow a service and pathway specific rather than a consistent strategic approach leading to variation.

2. Following a JET discussion it was agreed to develop an outcomes framework that would support the development of a consistent approach to outcomes-based working as part of a balanced scorecard approach to managing delivery. This would initially be focused on the three Transformation Priorities identified in the LNR 5 Year Commissioning Strategy in a way that would allow it to be applied to all areas of the ICB remit and portfolio.

Outcomes as a Strategic tool

3. Outcomes describe population change, not organisational activity. They are described in terms of wellbeing, equity, independence, avoidable harm, healthy life expectancy, community resilience. They are not waiting times, throughput, cost improvement, or service volumes but look to capture the patient benefits related to these metrics.

4. Strategic outcomes are long-term and system-wide. They should reflect:
   - What matters to the population
   - What partners can influence together
   - What will take years, not months, to shift

5. There are three elements of an outcomes-based approach:
   - Strategic outcomes – Set by the board as the “compass” guiding long term work
   - Outcomes-based working - ICBs teams empowered and enabled to work together as the “engine” for transformational change guided by our strategic outcomes
   - Outcomes framework – The structure that supports and reports the work setting out the key principles, pulling together measures and indicators to show progress and aligning quality, performance and finance with the strategic outcomes allowing progress to be reported to the ICB board and our partners

Outcomes within a balanced scorecard

6. The approach proposed follows a balanced scorecard approach distinguishing between:

   - Outcome measures – population-level change
     - Is life getting better for the population of LNR?
   - Performance measures – operational delivery
     - Are services doing what they’re supposed to do, reliably and on time?
   - Financial measures – stewardship & sustainability
     - Are we using public money responsibly & sustainably?
   - Quality measures – safety, effectiveness, experience
     - Is the care we commission safe, effective, equitable & person-centered?

7. In this approach Outcomes set the direction for the system, but quality, finance and performance each need to be defined in their own terms. They have different priorities and keeping them distinct ensures they support outcomes rather than distort them.

8. Together, outcomes, quality, performance and finance form the core domains of system oversight and improvement — each offering a different lens on how well the system is functioning and what impact it is having. Domains should be aligned so they reinforce each other but distinct so each do their job properly. Overlap should be minimised and the governance of each managed distinctly.

Approach to Developing the Outcomes Framework

9. A working group has been established with clinical and Public Health involvement to progress this work and a number of workshops and focus sessions held to build on the progress made during the commissioning round and development of the 5 Year Plan. A workshop with attendance from across the ICB and Local Authorities was held on 24th March, and this work has identified a logic model approach using short, medium and long term outcomes as well as three key "Transformation Priorities" for the ICB: Prevention, Identification and Management to structure outcomes to reflect the ICBs core purpose.

10. Focused sessions will be held to apply the framework in each of the thematic priorities, for Preventable Mortality individual sessions will be held for each of CVD, Respiratory and Cancer to reflect the specifics of each as an integrated approach was felt to be provide insufficient detail. Wide engagement, particularly with clinicians, system partners and representative groups, will be a priority in ensuring the outcomes developed are valid and accepted. While this work is in progress an indicative view of how the approach could be applied to Cardiovascular Renal – Metabolic (CVD-RM) is provided.

Outcomes Framework Development

11. As part of the medium term planning process, which developed the 5 Year Commissioning Strategy (SCS), outcomes were developed for each of the three Thematic Priorities, however these were only included in the SCS document at high level. This used seven categories to structure outcomes for each priority with the draft metrics developed for CVD shown in Figure 1 below.

Outcome	How Measure	Frequency of Reporting	Good is
Reducing premature mortality	Under 75 mortality from cardiovascular disease considered preventable (Persons 1 year range)	Annual: Fingertips Public Health Profile	Reduction – target is 25% reduction from NHSE. Currently both ICBs amber, aim for Green.
Admission / Occupied Bed Days measure	ALOS for CVD ALOS for Stroke Number of >7 day LoS for CVD Number of >21 day LoS for Stroke	Monthly : SUS	Reduction from previous year
Readmission measure	SUS – 28 day Readmissions for a patient admitted with CVD	Monthly : SUS	Reduction from previous year
Inequalities measure	Gap between age standardised diagnosis rate between Core20+ groups	Monthly: CVD Prevent / PHM Systems	Reduction in prevalence gap from previous year Increase in hypertension optimisation
Prevention measure			
Early diagnosis measure	Increasing diagnosis of AF in community to reduce stroke risk	Monthly: PHM Systems	
Pathway management measure	BP managed to target Diabetes care processes	Monthly: PHM Systems	

Figure 1: Example Outcomes metrics for CVD developed in 5 Year planning

12. The outcomes approach described by JET was a more sophisticated approach to outcomes which:
    a. Viewed outcomes as part of a "balanced scorecard" with quality, performance and finance measures
    b. Had a hierarchy from ICB level strategic outcomes through our thematic priorities, delivery programmes and pathways which ensure a structured and consistent outcomes based approach
    c. Developed an overarching Outcomes Framework which encompassed ICB strategic outcomes and sets the principles for the development on outcomes specific to projects and pathways which also deliver against those specific outcomes

d. Supports strategic commissioning and integrated working within the ICB and across the ICS

13. The outcome framework developed follows a logic model approach to link inputs, resources invested and the activities following from them to their outputs and the outcomes they are intended to deliver. This is illustrated in Figure 2. Those outcomes are broadly divided into short (0-6 months), medium (6-18 months) and long term (>18 months). This distinction ensures progress can be demonstrated immediately while also addressing more entrenched challenges. Reflecting this while short, and to a lesser extent medium term outcomes, may be amended as issues are successfully addressed and workstreams progress, long term outcomes are expected to be consistent providing stability and consistency in approach.

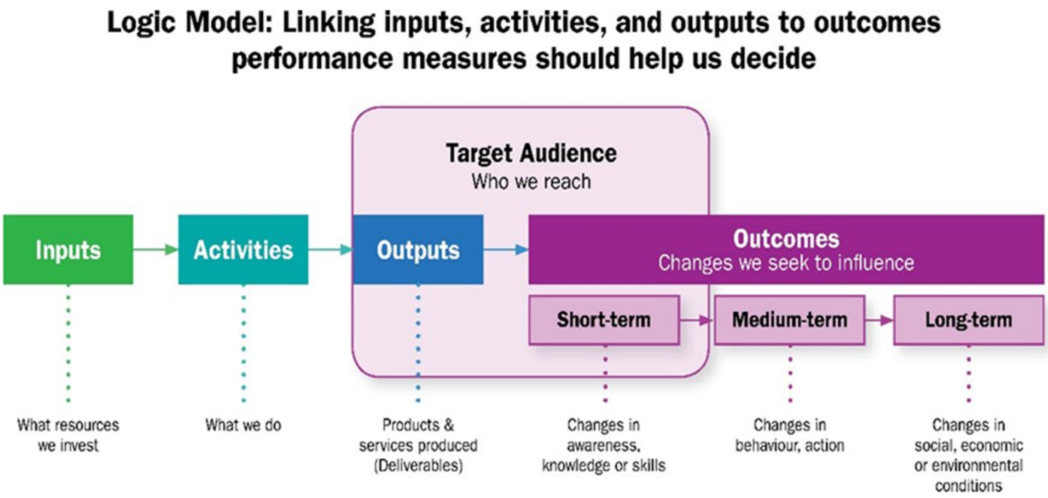

Figure 2: Logic model approach to outcomes

14. The outcomes developed for the 5 Year Plan (e.g. Figure 1) had seven categories, however they did not fully reflect a logic model approach, lacked time periods, and overlapped with performance, finance and quality metrics against a balanced scorecard approach. While it is recognised that a degree of overlap is unavoidable it should be minimised and the 7-category approach was not felt to be sufficient. Based upon the key priorities of the ICB a three-category approach has been developed:

    1. **Prevention** of avoidable ill health encompassing primary, secondary and tertiary prevention and encompassing the promotion of health behaviours
    2. **Identification** of health conditions at an earlier stage and equitably across population groups
    3. **Management** of conditions effectively according to local policy and National guidance

15. Inequalities are a key element of the outcomes approach, and it is intended that wherever possible metrics are developed which allow them to be reported at Place and Core20PLUS (Deprivation Quintile & Ethnic Categories) in addition to ICB. Consideration will also be given in the selection of metrics to those linked to health inequalities and this will form a key part of the logic modelling process. Consideration was given to a specific category of inequalities however this was seen as risking increasing complexity and drawing emphasis away from inequalities as a "golden thread" through all areas. It was recognised this a complex and difficult consideration that should remain under constant review and scrutiny.

16. An initial EQHIA (Equality Quality Health Inequality Assessment) has been carried out on the framework. While this is positive overall with the proposal viewed as acting to improve Quality and Equity it noted three key risks to be managed. Firstly, the lack of infrastructure to measure true outcomes, including Patient reporting outcomes, may limit our ability to develop effective measures. Secondly inequitable improvements, with more affluent and majority groups seeing greater improvements in outcomes that more deprived and diverse groups could increase, not decrease inequalities. Finaly under-representation of groups through data gaps lower engagement with services may cause "blind spots". Mitigations for these risks will be built into the design of the framework.

17. Where possible metrics will be aligned to National policy and outcomes frameworks. An example may be the target within the new Neighbourhood framework to reduce non-elective bed days by 10% for the cohort of people with mild to severe frailty or the Diabetes care processes in relation to CVD-RM. It was viewed however that it is important that the outcomes approach reflects the ICBs strategic vision while responding to National policy. The outcomes measures selected may need to be reviewed as new policy, for instance the expected Modern Service Frameworks, are released.

18. It was identified that while patient outcomes are key in an effective outcomes framework they are currently difficult to systematically capture in line with the metric principles outlined. This is recognised as a key limitation to be addressed and through the next phase VCSE and representative groups, including our 5 Healthwatch's will be involved to explore how this may be addressed and to test the outcomes approach, and outcomes matrix themselves, address the views and needs of our diverse populations. As approaches to capture patient reported outcomes measures are developed Nationally and locally they can be incorporated into the developed outcomes framework.

Proposed Outcomes Framework Development

18. Based on these principles an approach was developed combining logic model principles with ICB priorities to develop a 3x3 "Outcomes Matrix." This was discussed, enhanced and supported by the workshop session on 24th March and is illustrated in Figure 3.

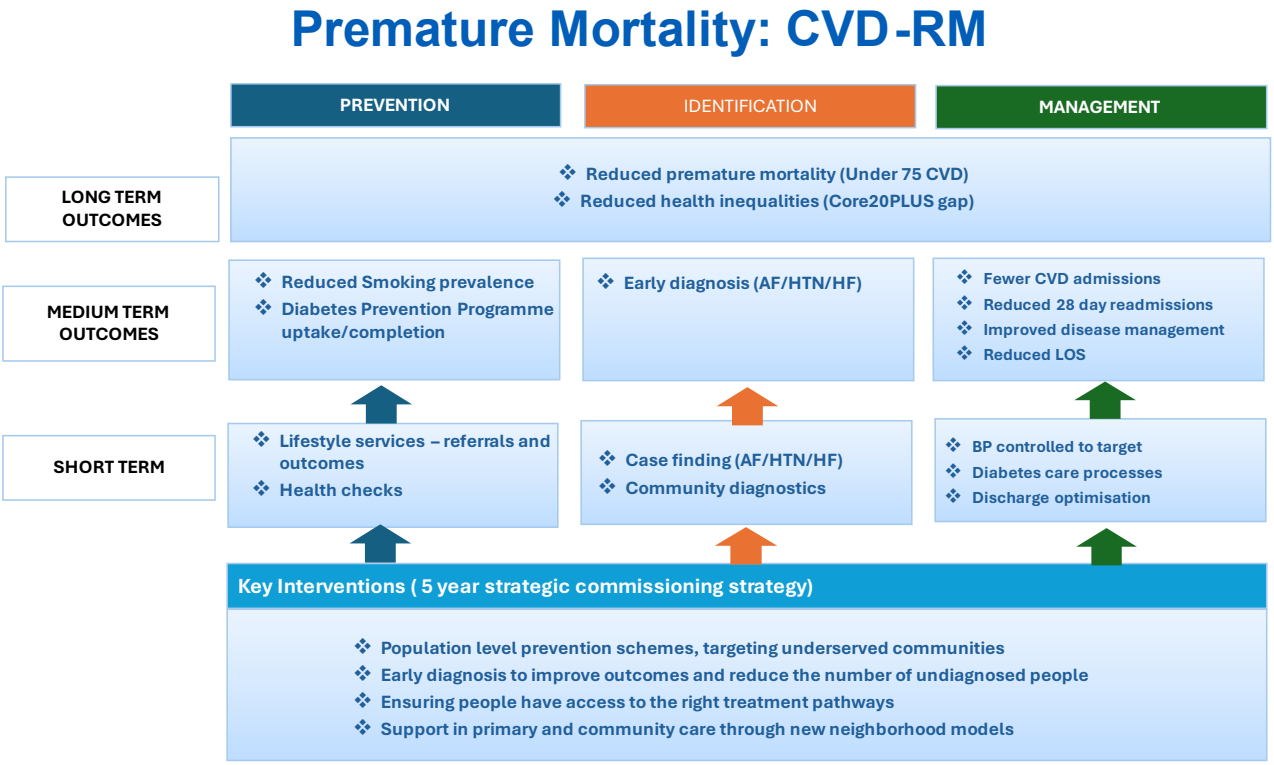

Figure 3: Proposed "Outcomes Matrix" applied to CVD-RM

19. This approach is for development and consultation so will now be tested on the three thematic priorities in detail to explore its effectiveness against the principles established by JET and reviewed as part of the approach developed for the Board workshop.

Next Steps

1. Outcomes Framework working group will oversee the development process updating to JET as required

2. Sessions to develop outcomes matrix for
    a. Frailty
    b. Children and Young People, Mental Health and Neurodiversity
    c. Premature Mortality
        i. Cardiovascular Renal Metabolic Disorders
        ii. Respiratory
        iii. Cancer
3. Discussion at Strategic Commissioning Committee (5th May, TBC)
4. Board workshop discussion (21st May)
5. Consideration of final proposal at Quality, Performance and Outcomes Committee (TBC)

Recommendations:

The committee is asked to:

- **RECEIVE** the report.

- **SUPPORT** the proposed approach to the development of an ICB Outcomes Framework

Board Meetings in Common in Public

Report Title: Board SEND (Special Educational Needs and Disabilities) Reforms Update

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland and
NHS Northamptonshire Integrated Care Boards

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
QPO

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 16 April 2026**		
Report Title	**SEND Reforms -Health Update**		
Paper Reference No:	**ICBIC-26-23**	**Agenda Item No:**	**9.**

Presented by	**Maria Laffan, Chief Nursing Officer**
Report Author(s)	**Miranda Tapfumanei, Director of Nursing**
Executive Sponsor	**Maria Laffan, Chief Nursing 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 Committees that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Committee are asked to:

- To be Assured

Executive Summary of the report

This briefing sets out the national SEND reform landscape following publication of the Schools White Paper (February 2026), the implications for the ICB and its partners, and the immediate actions required to meet the Local Area SEND Plan submission deadlines in May and June 2026.

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
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If conflicted 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:
NICB SEND Assurance Group Extra Ordinary Meeting WNC SEND & Alternative Provision (AP) Partnership Improvement Board NNC SEND & AP Partnership Improvement Board LLR SEND & AP Partnership Improvement Board

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

SEND Reform

1. National Context: SEND Reform

The Schools White Paper Every Child Achieving and Thriving (23 February 2026) introduces significant reform of the Special Educational Needs and Disabilities (SEND) system in England. The reforms are the most substantial change to the SEND framework since the Children and Families Act 2014.

Key drivers of reform

- Rising demand: the number of children with Education, Health and Care Plans (EHCPs) has increased significantly in recent years, placing growing pressure on local authority's high needs budgets.
- Unacceptable waits: families face long waiting times for neurodevelopmental assessments, speech and language therapy, and children's mental health services.
- Inconsistency: there is significant variation in access to support across local areas, leading to inequitable outcomes.
- Financial pressure: high needs deficits in local authorities are unsustainable without system redesign.

Core reform priorities.

- Earlier identification of need and intervention, with a focus on strengthening support in mainstream education.
- Greater consistency of provision across local areas through national standards and clearer accountability.
- Stronger integration across education, health and care services.
- A shift from statutory EHCP processes toward early, proactive, whole-system support.
- Introduction of Individual Support Plans (ISPs) new digital plans replacing some EHCP equivalent documentation for certain groups.
- A 'Experts at Hand' specialist workforce program, deploying multi-disciplinary professionals into mainstream schools.

2. Implications for the ICB

The White Paper places explicit statutory and strategic responsibilities on Integrated Care Boards (ICBs). The ICB and health system engagement, leadership, and resource commitment are required.

ICB Statutory Responsibilities

- Joint commissioning: the ICB must align NHS commissioning strategies and funding with local authority SEND plans and the new DfE early intervention funding streams.
- Pathway redesign: neurodevelopmental assessment, speech, language and communication (SLC), and children's mental health pathways must be redesigned to enable earlier access.
- Workforce deployment: NHS staff will be expected to work within schools as part of the 'Experts at Hand' specialist workforce program.
- Data and performance: strengthened reporting requirements on access, waiting times, and outcomes for children and young people with SEND.
- Digital readiness: the ICB must support improved information sharing across education, health and care, including contribution to digital ISPs.
- EHCP timeliness: increased scrutiny of health advice timeliness within EHCP processes; delays will be subject to national performance monitoring.

Role of the Designated Clinical Officer (DCO)

The DCO role is significantly enhanced under the reforms, they will:

- Lead alignment of health services with early intervention and inclusion priorities.
- Drive timely, high quality health advice for EHCPs to support statutory compliance.
- Ensure health input is integrated into emerging digital Individual Support Plans.
- Coordinate the multi-agency 'Experts at Hand' specialist workforce alongside local authority and provider partners.
- Work with partners to reshape local pathways and reduce waiting times; and
- Review NHS capacity data and lead mapping to support effective reform delivery.

Risks and Mitigation for the ICB & Commissioned Services

RISK	Workforce shortages in therapies, neurodevelopmental services and CAMHS may limit the ICB's ability to deliver reform commitments and could increase waiting times during the transition period. Mitigation: Workforce strategy; new roles; retention focus
RISK	Misaligned commissioning between ICBs and local authorities risks duplication, gaps in provision, and failure to meet national requirements. Mitigation: Joint commissioning strategy, aligned outcomes and expand pooled budgets
RISK	Rising demand from earlier identification may outpace current NHS capacity without proactive planning and pathway investment. Mitigation: Demand modelling; invest in early pathways; pathway redesign

3. Implications for NHS Provider Partners

NHS providers: community trusts, mental health trusts, and acute paediatric services – will face significant operational impacts from the reforms.

- Increased referral volumes: earlier identification of need in schools is expected to drive higher referrals to therapies, neurodevelopmental assessment pathways, and CAMHS.
- School-based delivery: NHS staff are expected to be deployed directly into schools to provide training and targeted interventions as part of the specialist workforce programme.
- MAT and SEND team collaboration: providers must strengthen relationships with Multi Academy Trusts (MATs), SEND teams and family services to reduce fragmentation.
- Enhanced reporting: providers must meet strengthened requirements for data on access, waiting times, and outcomes for vulnerable groups.
- Proactive capacity planning: workforce and pathway redesign will be required to manage anticipated demand increases.

4. The Local Area SEND Reform Plan

All local areas must produce a Local Area SEND Plan. This is a national requirement directing local authorities, ICBs, education providers, and partners to jointly redesign and improve the 0–25 SEND system. The local authority acts as system convener, but the ICB is a required co-author.

Mandatory plan components

- A joint vision and outcomes framework across education, health and care.
- A local needs assessment (SEND profile, waiting times, inclusion data, specialist placement pressures).
- A full Health Plan section covering early intervention, therapy access, neurodevelopmental pathway improvements, and mental health in education.
- Workforce planning – Experts at Hand, therapy staffing and SEND training.
- Digital and data plans for information sharing and interoperability.
- Joint commissioning intentions; and
- Alignment with the local authority's DSG High Needs Deficit Recovery Plan.

Maturity Matrix self-assessment

Local area partners are required to complete the national Maturity Matrix self-assessment tool. This enables partners to evaluate the maturity of the local SEND system, identify improvement priorities, and ensure the Local SEND Reform Plan is accurate, evidence-based and reflects system-wide perspectives. The ICB is expected to contribute directly to this assessment.

5. Key Dates and Timelines

Date	Milestone	ICB Action Required
Now – April 2026	Co-production and drafting of Local Area SEND Plan, including Maturity Matrix self-assessment	Contribute health data, workforce mapping, and commissioning intentions to Local Authority-led drafting process
May 2026	Draft Local Area SEND Plan to be ready for review	Ensure Health Plan section is drafted and signed off internally; share with Local Authority for integration
19 June 2026	Formal submission of Local Area SEND Reform Delivery Plan and supporting documents to DfE and NHS England	Final ICB sign-off required; ensure governance approval is obtained before submission deadline
2026–2027	SEND Reform consultation and detailed national policy development	Monitor and respond to consultation; align local planning accordingly

6. Immediate Strategic Priorities for Health Partners

The following actions are required in the immediate term to meet national reform requirements and the June 2026 submission deadline:

Priority	Required Action

Local Plan Contribution	Contribute actively to the local authority-led SEND Reform Plan, including completion of the Maturity Matrix self-assessment. Finalise the ICB Health Plan section for May draft and June submission.
Joint Commissioning	Align NHS commissioning with new DfE early intervention funding streams and local authority SEND plans. Strengthen joint commissioning governance with the local authority.
Strategic Commissioning- Workforce Planning	Map workforce requirements across therapies, neurodevelopmental services and CAMHS. Develop a plan for Experts at Hand deployment and specialist SEND workforce capacity.
Transformation- Pathway Redesign	Develop proposals to improve access and reduce waiting times for neurodevelopmental assessment, SLC therapy and children's mental health pathways, aligned to reform requirements.
Digital Readiness	Review ICB digital readiness for improved information sharing across education, health and care, and identify steps needed to support digital ISP implementation.
DCO Governance	Formally recognise the enhanced DCO role ensure appropriate resources and leadership support is in place.
High Needs Deficit Alignment	Align health actions with the local authority's DSG High Needs Deficit Recovery Plan to ensure coherent system-wide financial planning.
Stakeholder Engagement	Strengthen governance arrangements with local authorities, schools, MATs, and parent-carer forums. Ensure family voice is embedded in local planning.

7. Recommendations for Board

ICB Executives are asked to:

- NOTE the national SEND reform requirements arising from the Schools White Paper (February 2026) and the statutory responsibilities placed on the ICB and Health Providers.
- NOTE ICB participation in the local authority-led Local Area SEND Reform Plan and authorise the development of the ICB Health Plan section for submission by 19 June 2026.
- NOTE the key risks to delivery, including workforce capacity, commissioning alignment, and EHCP timeliness, and request that a risk register entry is developed for oversight.
- REQUEST a further update to the ICB Board following the May draft submission and ahead of the June 2026 final deadline.

Appendix: Glossary of Key Terms

Term	Definition
CAMHS	Child and Adolescent Mental Health Services
DCO	Designated Clinical Officer – the ICB lead for SEND health functions
DfE	Department for Education
DSG	Dedicated Schools Grant – the main funding stream for education, including high needs
EHCP	Education, Health and Care Plan – the statutory document specifying support for children and young people with SEND
Experts at Hand	A national specialist workforce programme deploying multi-disciplinary SEND professionals into mainstream schools
ICB	Integrated Care Board – the NHS body responsible for commissioning health services for a local population
ISP	Individual Support Plan – a new digital plan proposed to replace some EHCPs under the reform model
MAT	Multi Academy Trust
Maturity Matrix	A national self-assessment tool for local areas to evaluate the maturity of their SEND system
SEND	Special Educational Needs and Disabilities
SLC	Speech, Language and Communication

Boards Meeting in Common in Public

Report Title: Quality Assurance – LNR ICB Cluster

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland and
NHS Northamptonshire Integrated Care Boards

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 16 April 2026**		
Report Title	**Quality, Performance Outcomes Assurance Reports – LLR ICB and N ICB**		
Paper Reference No:	**ICBIC-26-24**	**Agenda Item No:**	**10.**

Presented by	**Maria Laffan, Chief Nursing Officer, LNR ICB** **Eileen Doyle, Chief Delivery Officer, LNR ICB**
Report Author(s)	**Miranda Tapfumanei, Director of Nursing, N ICB** **Mandy Staples, Director of Nursing, N ICB** **Chris West, Deputy Chief Nursing Officer, LLR ICB** **Chris Pallot, Director of Operations and Deputy COO, NICB**
Executive Sponsor	**Maria Laffan, Chief Nursing Officer, LNR ICB**

Select the Primary Purpose for the Report

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

Recommendations

The Boards are asked to:

- **REVIEW** and **NOTE ASSURANCE** from the Committees in Common for Quality, Performance and Outcomes which met on 14 April 2026.

Executive Summary of the report

This report presents an overview of the cluster quality and performance system. Ther 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.

The Boards are asked to note that that the Committees in Common for Quality, Performance and Outcomes continue to evolve so that the future role and delivery is aligned to the model ICB blueprint, as Strategic Commissioners and the anticipated publication of the revised National Quality Board Quality Strategy.

The Terms of Reference have been amended to reflect these processes so far and future reporting will continue

to evolve to ensure reporting and oversight is efficient and focused.

The main alerts this month are as follows:

- St Andrew's Healthcare: NHSE intention to repatriate all patients from the Northamptonshire site, with significant quality, safety and system implications.
- UHN Maternity: KGH homebirth service paused for three months following identified safety, training and governance concerns.
- PODS: Delegated oversight arrangements end March 2026; transition planning required to maintain assurance and continuity.
- Ongoing UEC pressures across the system, including continued concern regarding mental health presentations in ED.
- Lack of commissioned community swabbing and antiviral logistics service presents ongoing outbreak and IPC risk.
- SEND pressures remain high across LNR, with long waits and workforce constraints continuing to affect delivery.
- **Bed occupancy** – LLR Acute and Community Hospital bed occupancy remains maximised at above 90% occupancy
- **Referral To Treatment (RTT)** – LLR Referral To Treatment (RTT) 65+ and 52+ weeks improved but remain above plan. Northants - Four patients at risk of 65-week breaches at the end of March. UHN are exploring all possible options to mitigate these patients.
- **Cancer** - LLR - Cancer 62-day performance is behind plan with a risk to the delivery of the planned target of 63.2%.
- **UEC** - Northants - 4hr performance: NGH impacted by poor flow although 12 hrs remains ahead of plan. UHN No Criteria to Reside remains challenged W/C 23rd Feb 44 x P1 patients waiting against a system target of 15.
- **Mental Health Patients in Acute Care** - Northants - Mental Health demand continues across UHN impacting ED capacity due to increased LoS >24hrs in dept. LLR - Shift in LOS in in-patient MH – Ongoing discharge delays due to social care capacity. Court of Protection, Prison repatriation and MoJ decisions causing extended delays.
- **LDA -** LLR - Number of LDA and Autistic Adults inpatients remains above plan. This is linked to the number of LDA inpatients that are under MoJ restrictions. Northants - At the end of February 2026, there were 36 LDA adult inpatients against an end of year target of 22.

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 14 April 2026 are available for the Boards to view via admin control to support the Boards' 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
☒	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

Peter Burnett, Chief Strategy Officer, declaration that spouse is Director of Midwifery and Deputy Chief Nurse University Hospitals Leicester.

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

Appendices	

Who has been engaged and where else has this report been considered:

The report has been a collaboration between teams in Leicestershire and Northamptonshire. Northamptonshire System Quality Group (SQG) will have been advised of the challenges. LLR's System Quality Group (SQG) stood down in January.

The contents have been discussed at the Committees in Common meeting for Quality, Performance & Outcomes on the 14 April 2026.

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

Performance Report – LLR Executive Summary April 25

Alert

- Acute and Community Hospital bed occupancy remains maximised at above 90% occupancy. This is despite the additional bed capacity opened.
- Referral To Treatment (RTT) 65+ and 52+ weeks improved but remain above plan. Trauma and orthopaedics, Gynaecology and ENT continue to be pressured with high volume of referrals.
- Cancer 62-day performance is behind plan with a risk to the delivery of the planned target of 63.2% - improvement plan is place with improvements expected in Q4.
- Shift in LOS in in-patient MH – Ongoing discharge delays due to social care capacity. Court of Protection, Prison repatriation and MoJ decisions causing extended delays.
- Number of LDA and Autistic Adults inpatients remains above plan. This is linked to the number of LDA inpatients that are under MoJ restrictions that risks meeting the end of year target.

Risks

- Operational pressures due to the emergency demand impacting upon elective activity
- 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
- Planned industrial action post Easter BH weekend – TCGs planned with regional oversight.

Assure

- CAT 2 EMAS Ambulance response (<30mins) Release to Respond (W45) has now been implemented. This has overall improved the performance of Ambulance Handovers thus impact on the CAT 2 Mean Response.
- MH Talking Therapies Reliable recovery improved and now Amber in Jan – Service working to deliver the target for Q4.
- Long waits for CYP services rate of increase continues to be slowed for December 25.
- LLR remain in tiering for Elective (52 weeks), Cancer (62 Day), ED (4 hours performance and Ambulance Handover).
- GP Appointments delivered in month for January were slightly below plan – the impact of the implementation of Online Consultation and new additional contractual obligations will have impacted on delivery. It is expected November will return to expected levels.
- Note the significant increase in the use of Pharmacy First with LLR seeing the most improved position in the region this will also impact on the GP Appointments

Advise

- Continue to deliver to the system 4-hour performance to target. Delivery of plans continue to maintain this with continued pressure on ED. Forecast to achieve delivery of the 4hour target
- 18 WW remains static and below plan.
- MH – TT reliable improvement performance continues to be strong
- MH – CYP access to MH services – more CYP continue to be able to access MH services in LLR.

Performance Report – Northamptonshire Executive Summary April 25

Alert

- 4hr performance: NGH impacted by poor flow although 12 hrs remains ahead of plan.
- UHN No Criteria to Reside remains challenged W/C 23rd Feb 44 x P1 patients waiting against a system target of 15.
- Longest Time in ED: Mental Health demand continues across UHN impacting ED capacity due to increased LoS >24hrs in dept. MH DTA pathway being reviewed to understand impact on delivery and we continue to escalate patients daily on our system calls.
- Four patients at risk of 65-week breaches at the end of March. UHN are exploring all possible options to mitigate these patients.
- At the end of February 2026, there were 36 LDA adult inpatients against an end of year target of 22.

Assure

- Bed Occupancy: Although this remains high, both Trusts below plan.
- 26/27 UEC Programme has been supported, and the focus now is on preparation for mobilisation.
- NGH FDS: Currently the unvalidated February position is 72.1%, which represents a 7.4% increase from January.
- Waiting list size continues to reduce at both UHN Sites, following a positive focus on validation, we have seen a UHN reduction of more than 3,217 in Quarter 4.
- UHN are focused on delivering additional activity via the Q4 funding routes and improvement actions identified through the Days Matter campaign
- 52-week cohort also reducing in line with plans.

Risks

- Challenges non-elective in demand, high levels of attendances & admissions with numbers of MFFD patients.
- See and Convey numbers remain higher than plan for EMAS with a reduction in See and Treat. This is being explored.
- Emerging risk regarding Supply of Bone Cement Products for joint replacements. Mitigations in development nationally via NHSE.
- Sourcing appropriate providers to manage ongoing risks in the community causes delays in discharging LDA inpatients.
- For cancer, risks remain largely unchanged from those reported in previous months.

Advise

- NHSE's focus in March is 4-hour performance and 12 hour waits. Key UHN staff have joined Regional Calls to respond to NHSE questions/lines of enquiry. The arrangement has worked well.
- 52ww and Validation "Sprints" funded by NHSE are underway. .
- NGH have developed a business casefor7-day radiology working, which will be part of planning discussion for next year.
- UHL continue to support with MRI, however there has been limited patient uptake due to travel.

Quality Report – LNR Executive Summary

NOF Scores	UHL	NGH	KGH	LPT	NHFT
Q4 25/26	3	4	4 (UP FROM 3)	2	2

Quality Risk	Trajectory & Impact	Key Issues	Actions & Grip
Regulatory Oversight & CQC	Amber/Red – active oversight	StAH repatriation and inadequate rating; KGH homebirth paused; PODS oversight transfer due March 2026	Enhanced oversight, transition planning and a standardised UHN maternity model
Patient Safety & Harm Signals	Amber – persistent themes	Eight PFDs across mental health, emergency care, severe infection, records, nutrition and hydration; UHN GP letter incident under review	Trust and system governance, clinical review and reissue, strengthened controls
Urgent & Emergency Care Quality	Red – sustained pressure	EMAS response and handover delays, rising violence to crews, and complex mental health discharges from ED	System escalation, high-intensity user task group, clearer multi-agency coordination
Mental Health Inpatient Quality	Amber/Red – ongoing concern	StAH remains inadequate, with repatriation of 287 patients and major system impact	National and local oversight, placement scrutiny and discharge planning
SEND Quality & Inequalities	Amber – persistent	High SEND pressures, long waits, workforce constraints, and weak outcomes and experience	Improvement activity, partnership oversight and Spring 2026 LNR SEND Summit

Quality Report – LNR Executive Summary

NOF Scores	UHL	NGH	KGH	LPT	NHFT
Q4 25/26	3	4	4 (UP FROM 3)	2	2

Provider	NOF Level	Quality Oversight Arrangements	Key NQB quality concerns
Leicestershire Partnership NHS Trust	NOF 2	• Provider Review Meetings (quarterly) • System Quality Group (ICB led Oversight NHSE attend)	• Section 29A Warning Notice (July 2025) – community-based services • PFD (Sept 2025) under routine ICB oversight
Kettering General Hospital FT	NOF 4	• Provider Review Meetings (monthly) • NHSE-IOAG • IPC Enhanced monitoring • Maternity MSSP	• Maternity: MSSP designation (June 2024) • PFD (media case)
Northampton General Hospital Trust	NOF 4	• Provider Review Meetings (monthly) • NHSE-IOAG • IPC Enhanced monitoring	• UEC / Medicine: Section 29A Warning Notice (March 2025) • Ongoing quality risks in 2025/26 • PFDs Feb 2026
Northamptonshire Healthcare FT	NOF 2	• Provider Review Meetings (quarterly) • System Quality Group (ICB led Oversight NHSE attend)	• IPC reporting (outbreaks V category) -requires validating • Immediate actions required in community services (CYP dietetics) • PFD x 5 (x3 suicide)
University Hospitals Leicester Trust	NOF 3	• Provider Review Meetings (bi- monthly) • Maternity UHL Enhanced oversight through 6 monthly touch point meetings, Chaired by Trust, Regional Chief Nursing Officer / Regional Chief Midwifery Officer attends.	• Independent Maternity – X3 MOSS alerts (since March 26 – 1 requiring external review (L2) • PFD (Sept 2025) under routine ICB oversight
St Andrew's Healthcare	Not formally NOF-rated	• NHSE- TEP/ Intensive oversight	• Intensive scrutiny arrangements in place • Significant patient safety concerns IPC under enhanced oversight

Quality Report – LNR Executive Summary

Alert

- **St Andrew's Healthcare (StAH):** NHSE has notified StAH of its intention to repatriate all 287 patients from the Northamptonshire site, attracting significant media interest and with major implications for patients, families, staff and the local system. Enhanced national and local oversight remains in place amid ongoing quality and safety concerns, with the provider continuing to be rated inadequate across all domains.

- **Pharmacy, Optometry and Dentistry (PODS):** Oversight arrangements for PODS, currently delegated to Nottinghamshire ICB, are due to end in March 2026. NICB is working with partners to manage the implications and secure continuity of oversight. The priority is a sustainable transition that maintains quality, statutory clarity and system assurance, while minimising disruption to providers and patients.

- **UHN Maternity** Following national and local assurance concerns, significant safety, training and governance risks were identified within the KGH homebirth model. The KGH Homebirth Service has been paused for three months to develop a safe, standardised UHN-wide model. Individual care plans and clear triage arrangements are in place to protect women and maintain public confidence.

Advise

- **Meningitis B:** A coordinated, system-wide response to the recent Meningitis B incident ensured consistent UKHSA messaging, supported practices to manage demand, and strengthened communication with students. Review of vaccine uptake across LNR will inform targeted improvement. The incident also exposed commissioning and escalation gaps; work is underway to strengthen compliance, governance and outbreak readiness.

- **Community Swabbing and Antiviral Logistics:** The absence of a commissioned swabbing and antiviral logistics service creates a material risk to timely outbreak identification and consistent IPC response, particularly in care homes and other vulnerable settings. A proposal has been submitted to ICB JET to commission a 24/7 ICB-led, externally delivered service, supported by a recurrent budget to provide a sustainable solution.

- **Short Breaks:** The Squirrels remains high risk, with ongoing quality, safety and governance concerns. Joint oversight continues, with limited assurance and persistent clinical and safeguarding risks. A Project Board is being established to drive coordinated decisions, contingency planning and sustainable improvement.

- **SEND Performance (LNR System):** SEND pressures remain high across LNR, with inspections highlighting significant weaknesses in outcomes and experience. Long waits and workforce pressures persist. Improvement is underway, with the Spring 2026 LNR SEND Summit intended to accelerate collective action.

- **Mental health presentations in ED:** Ongoing system pressures remain around mental health presentations in (LLR) ED, particularly for young people, those transitioning to adulthood, and out-of-area placements. Delays at discharge continue to expose fragmented responsibilities and increase risk. Further learning from recent complex cases will inform clearer coordination and earlier multi-agency action.

Quality Report – LNR Executive Summary

Assure

- **UHN KGH Maternity Safety Support Programme:** Maternity oversight remains strengthened, with a stable safety profile and continued recovery focused on workforce, governance and regulatory improvement. The CQC Section 29A Warning Notice has been responded to and revoked, with potential re-inspection anticipated.
- **LFPSE Usage in Primary Care:** LFPSE registration across LLR primary care remains below the required standard, despite this being a contractual requirement. Targeted ICB support since November 2025 has improved uptake, with 70 of 126 practices now registered; further engagement is underway to secure full compliance.
- **UHL Cardiac Surgery**: Sustained progress on governance, assurance and patient safety has supported de-escalation of cardiac surgery to routine oversight. Key actions, including the harm review and wider improvement requirements, are progressing, and the risk is now closed.
- **Northamptonshire Children in Care Health Assessments:** Initial Health Assessment (IHA) performance has improved from previous lows, but both Initial and Review Health Assessments (RHA) remain below standard amid rising demand and workforce pressures. An 8-month RHA backlog is reducing (333 → 153). Recovery action remains in place, with strengthened oversight, prioritisation and backlog reduction underway.
- **Prevention of Future Deaths (Regulation 28):** Eight PFD reports highlight recurring risks across mental health, emergency care, record access, deterioration from severe infection, and nutrition and hydration in frail patients. These are being reviewed through Trust and system governance, with coordinated action and Board oversight.

Assure

- **St Mary's Birth Centre** (Melton) has been paused since July 2025 due to low birth numbers and related safety concerns. Following the LNR ICB Board meeting in March 2026, plans are being developed to transfer the service to Leicester Royal Infirmary. Public and media interest remains high.
- **University Hospitals of Leicester maternity** services are one of 12 trusts included in the national maternity and neonatal review led by Baroness Amos. Interim findings were published in February 2026, with no immediate recommendations. The final report is expected in summer 2026.
- **The Maternity Outcomes Signal System (MOSS)** provides real-time maternity safety alerts at trust level. Alerts are rated Amber (Level 1), indicating a 95% probability of increased risk, and Red (Level 2), indicating a 99% probability. The Trust receives these alerts and responds in line with the MOSS standard operating procedure.

Emerging Risks.

- Industrial action remains a risk to elective and cancer recovery, with potential knock-on quality impacts from service and flow pressures; mitigations are in place.

Glossary of abbreviations

Abbrev.	Meaning
CAT 2	Category 2
CRFD	Clinically Ready for Discharge
CQC	Care Quality Commission
CYP	Children and Young People
ED	Emergency Department
EMAS	East Midlands Ambulance Service
FDS	Faster Diagnosis Standard
GP	General Practitioner
IA	Industrial Action
ICB	Integrated Care Board
ICE	Integrated Clinical Environment
IHA	Initial Health Assessment
IPC	Infection Prevention and Control
JET	Joint Executive Team

Abbrev.	Meaning
KGH	Kettering General Hospital
LDA	Learning Disability and Autism
LFPSE	Learn from Patient Safety Events
LLR	Leicester, Leicestershire and Rutland
LNR	Leicester, Leicestershire and Northamptonshire
LOS	Length of Stay
MH	Mental Health
MFFD	Medically Fit for Discharge
MoJ	Ministry of Justice
MOSS	Maternity Outcomes Signal System
NC2R	No Criteria to Reside
NGH	Northampton General Hospital
NHSE	NHS England
NICB	Nottingham and Nottinghamshire Integrated Care Board

Abbrev.	Meaning
OPEL	Operational Pressures Escalation Level
PAS	Patient Administration System
PFD	Prevention of Future Deaths
PODS	Pharmacy, Optometry and Dentistry
RHA	Review Health Assessment
RTT	Referral to Treatment
SEND	Special Educational Needs and Disabilities
SOP	Standard Operating Procedure
StAH	St Andrew's Healthcare
UEC	Urgent and Emergency Care
UHL	University Hospitals of Leicester
UHN	University Hospitals of Northamptonshire
UKHSA	UK Health Security Agency

Derived from abbreviations used within the April 2026 QPO Board Report slides.

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

Board Meetings in Common in Public

Report Title: St Andrews Healthcare Quality Overview April 2026 Update

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB) NHS Northamptonshire ICB (NICB)
Committees Meeting in Common for Quality, Performance and Outcomes

Name of Meeting	**Board Meeting in Common in Public**		
Date of Meeting	**Thursday, 16th April 2026**		
Report Title	**St Andrews Update**		
Paper Reference No:	**ICBIC-26-25**	**Agenda Item No:**	**11.**

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

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 Committees that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to:

- **RECEIVE** the update related to quality oversight and assurance
- **NOTE** the emerging risks associated with repatriation of patients across the country and potential workforce implications to local impact.

Executive Summary of the report

On 9 March 2026, NHS England (NHSE) notified St Andrew's Healthcare (StAH) of its intention to repatriate all 287 patients from the Northampton site. This decision has attracted significant media attention. Northamptonshire ICB (NICB) continues to work closely with NHSE to ensure clear communication with patients, carers, and families.

The NICB Chief Nursing Officer (CNO) is engaging with system partners to assess the wider implications of the repatriation, including potential impacts on the workforce, local economy, and

demand on health and care services. There are currently 2,600 members of staff employed across the Northamptonshire site.

Patient safety remains the overriding priority. Assurance is overseen through the Intense Oversight and Assurance Group (IOAG), co-chaired by the NICB CNO and the NHSE Regional Medical Director.

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 conflicted identified, please list conflicted party and nature of conflict:

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

Who has been engaged and where else has this report been considered:
Extracts of this report have been taken from a report received at Quality Performance and Outcomes Committee (14th April)

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

Board Meetings in Common in Public
16th April 2026

St Andrew's Healthcare (Northampton) – Situation Update

Overview

On 9 March 2026, NHS England (NHSE) notified St Andrew's Healthcare (StAH) of its intention to repatriate all 287 patients from the Northampton site. This decision has attracted significant media attention. Northamptonshire ICB (NICB) continues to work closely with NHSE to ensure clear communication with patients, carers, and families.

The NICB Chief Nursing Officer (CNO) is engaging with system partners to assess the wider implications of the repatriation, including potential impacts on the workforce, local economy, and demand on health and care services. There are currently 2,600 members of staff employed across the Northamptonshire site. Local response is exploring Incident Response (EPRR) protocols.

Patient safety remains the overriding priority. Assurance is overseen through the Intense Oversight and Assurance Group (IOAG), co-chaired by the NICB CNO and the NHSE Regional Medical Director. Following the meeting on 11 March 2026, it was agreed that the Group's remit and Terms of Reference will be updated in line with the new National Incident Response arrangements and the establishment of a National Quality, Safety and Oversight Group.

The newly formed Partnership Engagement and Information Sharing Forum (PEISG)—replacing the Regional Tactical Silver Meeting—met on 12 March 2026 as part of national EPRR arrangements responding to the ongoing quality and safety concerns.

On 13 March 2026, the CQC published its latest report following unannounced inspections in October and November 2025. The Northampton site remains rated 'Inadequate' across all domains.

NICB continues to support NHSE-led commissioner meetings to validate commissioner and keyworker information, maintain oversight of placements, and support repatriation and discharge planning, with a continued emphasis on safe care for remaining inpatients.

National-level oversight remains in place with a 24/7 on-site presence from NHS England Recovery Support Programme Team (RSP team).

There have been significant leadership changes within StAH, including the retirement of the CEO and ongoing interim arrangements for the vacant Chief Nurse role. The

newly appointed Interim Chief Executive Trevor Torrington takes up the position on 7th April.

Summary

This paper provides an update on St Andrew's Healthcare (StAH), Northampton, a large independent mental health provider currently subject to extensive regulatory and system oversight.

Key recent events:

- **9 March 2026:** StAH CEO announced retirement.
- **9 March 2026:** NHSE announced plans to repatriate nearly 300 patients from the Northampton site.
- **13 March 2026:** CQC published reports confirming the provider remains rated **'Inadequate'**.
- Admissions remain suspended.
- **7 April 2026:** Interim Chief Executive commenced role.

NICB, as Host Commissioner, continues to work with NHSE and commissioners nationally to coordinate the repatriation of 287 inpatients.

A Large-Scale Enquiry undertaken by West Northamptonshire Council has concluded. Actions have been issued to the provider to ensure sustained improvement.

Situation

Throughout 2024 and 2025, CQC conducted multiple inspections of the Northampton site. Key enforcement actions include:

- July 2024: Section 29A Warning Notice issued for breaches of Regulation 18 (Staffing).
- December 2024: Additional concerns raised requiring immediate improvement.
- A further Warning Notice remains in place for breaches of Regulation 10 (Dignity and Respect).

Inspections across a range of ward types throughout 2025 have continued to identify significant issues. Reports published in March 2026 confirmed the site remains **Inadequate**.

Background

St Andrew's is one of the largest independent providers to the NHS and was placed in special measures in December 2025. Admissions to the Northampton site were suspended in July 2025 after serious concerns regarding care quality.

Key governance and regulatory issues include:

- Significant leadership turnover, including the Chair in November 2025 and CEO in March 2026.
- Ongoing police investigations, including 15 staff arrests relating to allegations of abuse and neglect.
- NHSE enforcement action in December 2025, with the provider required to accept a defined set of improvement undertakings.
- Despite intensive support from NHSE, insufficient progress led to the decision to relocate all patients away from the Northampton site.

The decision does **not** affect:

- StAH Birmingham
- StAH Essex
- Adult Care Services and Supported Transition Services (Northampton)
- Outpatient services

Current patient numbers:

- NICB: 46 patients
- Leicester**:** 26 patients

Inpatient beds are predominately commissioned by NHS England (Impact). LNR ICB is working closely with a newly formed placement cell led by NHS England to ensure that time frames for discharge and transfer remain realistic and safe.

Next Steps

NICB and NHSE will continue to support StAH throughout the repatriation process, ensuring the safe transition of all patients. Clinicians from NHSE (mental health, learning disability, and autism specialities) will maintain enhanced on-site safety oversight.

NHSE will continue to work with leadership at StAH, provider collaboratives, and Integrated Care Boards to identify appropriate placements for all patients requiring

transfer. Patients' and carers' views will be considered before final decisions are made.

A number of patients are clinically ready for discharge—**six across LLR**, 10 NICB—although some may face barriers such as community placement availability or criminal justice processes. Discussions are underway to expedite progress wherever possible.

Following the Changes to National Oversight, the IOAG will review its remit and update its Terms of Reference, considering alignment with the National Quality, Safety and Oversight Group.

The PEISG continues to meet weekly under national EPRR arrangements.

NICB quality oversight visits continue, with further visits scheduled to monitor progress and provide assurance.

Recommendations:

- **RECEIVE** the update related to quality oversight and assurance
- **NOTE** the emerging risks associated with repatriation of patients across the country and potential workforce implications to local impact.

Boards Meeting in Common in Public

Report Title: Finance Assurance

Reports - LLR ICB and N ICB

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland and
NHS Northamptonshire Integrated Care Boards

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 16 April 2026**		
Report Title	**Finance Report M11 2025/26**		
Paper Reference No:	**ICBIC-26-26**	**Agenda Item No:**	**12.**

Presented by	Matt Gaunt, Chief Finance Officer
Report Author(s)	Spencer Gay, LLR ICB Deputy Director of Finance (System) Nigel Mander, NICB Interim Deputy Chief Finance Officer
Executive Sponsor	Matt Gaunt, Chief Finance 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 Committees that controls and assurances are in place.	☐ **APPROVAL** Recommendation or particular course of action.

Recommendations

The Boards are asked to be advised by the report to:

RECEIVE and NOTE the 2025/26 financial position at Month 11 and the forecast outturn.

Executive Summary of the report

This report confirms that the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and Northamptonshire Integrated Care Board (NICB), collectively termed the LNR ICB Cluster, reported a year-to-date deficit financial position at month 11 of £12.9m (after non-recurrent deficit support funding of £7.6m), which is worse than plan by £21.4m. The position reflects:

- LLR deficit of £21.6m, which is £21.4m worse than plan
- Northamptonshire surplus of £8.7m, which is breakeven against plan

At month 11, LLR has formally reported a change to their annual forecast position following agreement to do so by the Board and agreement with NHSE. The full year reported forecast is a deficit position of £13.3m across LNR, (after £7.6m non-recurrent support) which is worse than plan by £23m. The position reflects:

- LLR deficit of £23.3m, which is £23.0m worse than plan
- Northamptonshire surplus of £10.0m, which is breakeven against plan

Given the official change in forecast, there is no longer any net risk after mitigations to delivery of financial plans identified.

At month 11, £6.3m of deficit support funding has been withheld due to failure to meet NHSE business rules at the end of Q2. The full amount forecasted to be withheld by the end of the year is £7.6m, which represents the total planned in Q3 and Q4 that will not be received.

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

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: 4	**NICB BAF No:** 7 & 8

Appendices	

Who has been engaged and where else has this report been considered:
This report has been received at the month 11 Health Executive Partners Meeting.

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

Finance Report Month 11 (February) 2025/26

Headlines Table 1 LNR – M11 ICB Financial Position

Net Position		Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FOT £m	Actual FOT £m	Variance FOT £m
LLR ICB	Position before support	(14.2)	(29.2)	(15.0)	(15.5)	(30.9)	(15.4)
	Deficit Support	13.9	7.6	(6.3)	15.2	7.6	(7.6)
	Net Position after support	**(0.3)**	**(21.6)**	**(21.4)**	**(0.3)**	**(23.3)**	(23.0)
Northants ICB	Position before support	8.7	8.7	0.0	10.0	10.0	(0.0)
	Deficit Support	-	-	-	-	-	-
	Net Position after support	**8.7**	**8.7**	**0.0**	**10.0**	**10.0**	**(0.0)**
LNR ICB Cluster Total	Position before support	(5.5)	(20.5)	(15.0)	(5.5)	(20.9)	(15.4)
	Deficit Support	13.9	7.6	(6.3)	15.2	7.6	(7.6)
	Net Position after support	**8.4**	**(12.9)**	**(21.4)**	**9.7**	**(13.3)**	**(23.0)**

1. Table 1 above details the position before and after deficit support funding. At month 11, LNR is reporting a year-to-date deficit of £12.9m (after deficit support funding of £7.6m), which is £21.4m worse than plan.

2. The year-to-date variance to plan is driven by the following key areas:
   - Non receipt of Q3 & Q4 deficit support funding at LLR (£6.3m)
   - Prescribing, CHC and ADHD growth in excess of planned levels at LLR

3. The full year reported forecast is a deficit position across LNR ICBs of £13.3m(LLR £23.3m Deficit, Northamptonshire £10 Surplus), after £7.6m non-recurrent support (£7.6m LLR and £0m Northamptonshire), which is £23.0m adverse to plans.

4. LLR ICB has reported a forecast £5.0m under delivery against the annual efficiency plan of £70.2m and Northants ICB has reported a breakeven forecast against an efficiency plan of £66.2m.

5. There is currently no net risk after mitigations across the LNR ICB cluster.

Recommendations:

Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB (Public) Board is asked to:

- **RECEIVE and NOTE** the financial position as at month 11

Board Meetings in Common in Public

Report Title: Transition Assurance Report

Date of Meeting: Thursday 16 April 2026

NHS Leicester, Leicestershire and Rutland and
NHS Northamptonshire Integrated Care Boards

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB)
NHS Northamptonshire ICB (NICB)
Board Meetings in Common in Public

Name of Meeting	**Board Meetings in Common in Public**		
Date of Meeting	**Thursday 16 April 2026**		
Report Title	**Transition Assurance Report**		
Paper Reference No:	**ICBIC-26-27**	**Agenda Item No:**	**13.**

Presented by	**Pete Burnett, Chief Strategy Officer**
Report Author(s)	**Alice McGee, 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 Committees 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

Executive Summary of the report

The Joint Transition Committee has responsibility to ensure the safe transition in 2025/26 for the ICB cost reduction programme and move to Model ICB. The Board receives a regular assurance report on the committee and will have decisions escalated as appropriate.

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		

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☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
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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 – Board in Common assurance report* *December 2025 – Board in Common assurance report* *February 2026 – Board in Common assurance report* *Remuneration Committee – October, December, January, February for decisions in relation to Redundancy and Management of Change* *Monthly Transition Committee meetings* *Monthly Transition updates to Joint Executive Team*

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

Joint Transition Assurance Report

16th April 2026

Introduction

1. The Transition Committee was set up formally through the governance framework in 2025 to oversee the transition and to provide assurances to the Board on progress, and escalate any concerns, risks or decisions required. This is likely to be a time limited committee for the period of Transition and Transformation.

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.

Progress Against Programmes of Work

4. 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.

5. In April 2026 the focus of the Transition programme will shift from implementing changes to structures and functions to operating as a Strategic Commissioner and considering future changes to the organisational form, including whether a Merger of the organisations is likely.

6. The Transition and Transformation Committee will retain oversight of the programme and will escalate any decisions as required to the Board. A Programme Director has been appointed for 2026/27 to oversee this change and support the Executive Team in its duties to deliver a new type of organisation.

Table 1

Designing functions for a new Cluster ICB	Since the last Board assurance report, the ICB has concluded two rounds of the Voluntary Redundancy Scheme, completed consultation with all-staff across both ICBs and the CSUs it contracts with (Midlands and Lancashire CSU and Arden and Greater East Midlands CSU). This affects approximately 650 staff across the four employing organisations. On 26th March 2026 a final Cluster structure was published, alongside a consultation outcome report which identified the themes of feedback and the changes made to the proposal as a result of the feedback. The changes incorporated included details regarding descriptions of functions and job descriptions, naming norms, alignment of resources (reducing some and increasing others), clarity of reporting lines and understanding of the reduction of staffing on the impact of workload. The allocation for ICBs is now £19.60 per head of population following a number of inflationary increases determined nationally which gives the ICB Cluster an allocation of £38m to delivery ICB duties. The design of the new structure is £35m for staffing and £2.5m for non-pay. This represents a reduction of approximately 170 staff compared with June 2025 staffing levels. The Voluntary Redundancy Schemes (round 1 and round 2) has been approved by Remuneration Committee and NHS England. 138 applications are now being progressed through to exit with the first exits on Voluntary Redundancy commencing in March 2026 and will complete in June 2026. On 1st March 2026 and 1st April 2026 all staff eligible for TUPE (Transfer of undertakings and protection of employment) from the two CSU's were transferred into Northamptonshire ICB and they will now be considered as employees for the purposes of implementing the management of change structures. The next phase of Management of Change is filling of the posts in the new structure. The ICB and unions have an agreed process of Slot In, Ring Fence and Suitable Alternative Employment to fill the structures and Remuneration Committee will be responsible for being assured of this process, including approvals of any Compulsory Redundancy at the end of the process. It is expected this stage of the change will conclude by the end of Quarter 1.
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 In December 2025, further guidance was received by NHS England regarding these functions and it was confirmed that as many of the functions are described within primary legislation. The design of the structures have incorporated this updated guidance and assurances have been provided to NHS England that the ICB will continue to be able to discharge its functions in full, whilst reducing its annual costs in line with the new financial allocations. *Transfer to provider or partner organisation* People Leadership, the Green Agenda, Strategic Digital leadership, System Control Centres. *Functions transitioning to region* Provider oversight Operational workforce planning This transfers of functions will be completed by June 2026, with some (provider oversight) already commencing for transfer
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 an options appraisal and 5 functions are considered to meet the criteria for further work to be explored. These functions were reviewed in December 2025 and a decision was made to work at scale across the Midlands for 111/999 commissioning, Pharmacy, Ophthalmic and Dental. Further opportunities around procurement for goods and services will continue to be explored in 2026.

Staff Survey results 2025

7. The NHS National Staff Survey has been, and will continue to be, a key enabler for NHS organisations to listen to and act on the views of their staff. For the 13th year, ICBs were given the option to participate in the survey and were encouraged to 'opt in' if it was appropriate for them. Both LLR and Northamptonshire ICBs took part in the survey in 2025 recognising that during periods of change, understanding our staff is integral to our success in the future. However, our of the 42 ICBs, only 23 decided to opt in so the comparisons we can make across the country are limited

8. The national staff survey took place between 6th October 2025 and 28th November 2025, the results were published in March 2026 across the country

9. It is important to note that at the time of the survey, the Executive Leadership Management of Change process had concluded and had been implemented. The movements between directorates to align to the new Executive Leadership structure had only just commenced and therefore when the ICB reviews directorate results it is important to note that this transition was occurring at the time of the survey i.e. directorate results won't be comparable now.

10. Whilst comparisons to historical data are difficult due to the organisational change, this data does allow the cluster to establish a new baseline and will be able to use this data to understand the impact of the 2026/27 plans and ensure improvements year on year as we establish a new type of organisation.

11. The average response rate for ICBs was 66%. For LLR ICB the response rate was 67% (73% in 2024) and Northamptonshire response rate was 60% (78% in 2024)

12. The executive team have received detailed reports on the staff survey results by theme, considering most improved areas, most declining areas and comparisons with national ICB reports. This information has informed an Organisational Development plan for 2026/27, particularly noting the context of the change process that staff and the organisation will be going through to become a Strategic Commissioning organisation.

13. Nationally there has been a drop in staff engagement and satisfaction across all sectors of the NHS. A comparative staff engagement score is given to each organisation and locally our engagement and satisfaction has decreased since 2024

    a. LLR ICB 2025 score was 6.39 compared to 7.10 in 2024
    b. Northamptonshire ICB score was 6.24 compared to 6.4 in 2024

14. The Transition and Transformation Committee, the Remuneration Committee and the Joint Executive Team will all have responsibility for considering the results and the actions to improve staff satisfaction through the next financial year. This will be supported by OD experts (within the new structure), staff forums and the senior leadership team.

Recommendations:

The Board is asked to:

- **Note** the progress of the Transition to Model ICB and achieve its mandated reductions
- **Note** the Staff Survey results