

**NHS Leicester, Leicestershire & Rutland ICB  
NHS Northamptonshire ICB**

**Board Meetings in Common in Public**

**19 February 2026**

**Conference Hall, NSPCC, National Training Centre,  
3 Gilmour Close, Beaumont Leys, Leicester, LE4 1EZ**

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

Thu 19 February 2026, 09:30 - 11:30

Conference Hall, NSPCC, National Training Centre, Leicester, LE4 1EZ

## Agenda

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### 09:30 - 09:30 1. Welcome from the ICB Chair Introductions and Apologies

0 min

Advisory Anu Singh

Verbal

### 09:30 - 09:30 2. Declarations of Interest relating to agenda items

0 min

Advisory Anu Singh

Verbal

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

### 09:30 - 09:30 3. Draft Minutes of previous Board Meeting held on 18 December 2025

0 min

Approval Anu Singh

Reference:

Reference: ICBiC-26-01

 ICBiC-26-01 - Draft Minutes LLR ICB and NICB Board Public 18 Dec 2025 v3.pdf (9 pages)


### 09:30 - 09:35 4. Matters Arising and Action Log

5 min

Advisory Anu Singh

Reference:

Reference: ICBiC-26-02

 ICBiC-26-02 - Matters Arising and Action Log.pdf (1 pages)

### 09:35 - 09:40 5. Questions from members of the public

5 min

Advisory Anu Singh

Verbal

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

#### 5.1. Response to questions raised by members of the Public

Advisory Anu Singh

Verbal

Gormley Charlotte  
13/02/2026 11:10:19

**09:40 - 09:50 6. Chair and Chief Executive Updates**

10 min

*Advisory Anu Singh and Toby Sanders*

Verbal

## COMMISSIONING STRATEGY

**09:50 - 10:15 7. Hinckley Day-Case Scheme Cancel**

25 min

*Approval Peter Burnett*

**Reference: ICBiC-26-03**

 ICBiC-26-03 - Hinckley Day-Case Scheme Cancel.pdf (35 pages)

**10:15 - 10:30 8. LNR ICBs Planning Submission and Response – 5 Year Plan**

15 min

*Assurance Peter Burnett / Matt Gaunt*

**Reference: ICBiC-26-04**

 ICBiC-26-04 - LNR ICBs Planning Submission and Response - 5 Year Plan.pdf (97 pages)

**10:30 - 10:40 9. LNR ICBs Planning Submission and Response - 2026/27 Operational Plan**

10 min

*Assurance Peter Burnett*

Verbal


## TRANSITION

**10:40 - 10:50 10. Transition Assurance Report**

10 min

*Assurance Toby Sanders*

**Reference: ICBiC-26-05**

 ICBiC-26-05 - Transition Assurance Report.pdf (7 pages)

**10:50 - 11:00 11. Establishing the Office of Pan ICB Commissioning proposed transition and governance arrangements**

10 min

*Approval Toby Sanders*

**Reference: ICBiC-26-06**

 ICBiC-26-06 - Establishing the Office of Pan ICB.pdf (100 pages)

## QUALITY, PERFORMANCE AND OUTCOMES

**11:00 - 11:10 12. Quality and Performance Assurance Reports - LLR ICB and N ICB**

10 min

*Assurance Maria Laffan / Eileen Doyle*

**Reference: ICBiC-26-07**

 ICBiC-26-07 - Quality and Performance Assurance Reports - LLR ICB and N ICB.pdf (11 pages)

**11:10 - 11:20 13. SEND Update – LNR ICB Cluster**

10 min

*Assurance Maria Laffan / Eileen Doyle*

**Reference: ICBiC-26-08**

Gormley Charlotte  
13/02/2026 11:19:19

## FINANCE

### 11:20 - 11:25 **14. Finance Assurance Reports - LLR ICB and N ICB**

5 min

*Assurance*                      *Matt Gaunt*

**Reference: ICBiC-26-09**

ICBiC-26-09 - Finance Assurance Reports - LLR ICB and N ICB.pdf (6 pages)

### 11:25 - 11:30 **15. CHAIR'S CLOSING REMARKS**

5 min

*Advisory*                      *Anu Singh*

Verbal

**Date of Next Meeting - Thursday 19 March 2026**

## ACTION LOG

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

Updated 7 January 2026

Minute No:	Agenda Item	Action	Lead	Status/Update	Timescale	RAG
<b>Meeting Date: 18 December 2025</b>						
No actions recorded						

Gormley Charlotte  
 13/02/2026 11:50 AM

- Completed
- On Track
- Overdue
- No further action

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

**Thursday 18 December 2025 at 09:30  
Haylock House, Kettering Parkway, NN15 6EY**

**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
Afzal Ismail	Non-Executive Member
Prof Nil Sanganeer	Chief Medical Officer
Matt Gaunt	Chief Finance Officer
Pete Burnett	Chief Strategy Officer
Maria Laffan	Chief Nursing Officer
Chris Pallot	Deputy Chief Operating Officer, deputising for Eileen Doyle, Chief Delivery Officer

**Apologies**

Eileen Doyle	Chief Delivery Officer
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**Present: Members - NHS Leicester, Leicestershire & Rutland ICB**

Mark Andrews	Local Authority Sector Representative Chief Executive, Rutland County Council
Angela Hillery	Community / Mental Health Sector Representative Chief Executive Officer, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust
Simon Barton	Acute Sector Representative Deputy Chief Executive Officer, University Hospitals of Leicester NHS Trust, deputising for Richard Mitchell
Dr James Ogle	Primary Medical Services Sector Representative

**In Attendance**

Adam Andrews	Associate Director of Planned Care (for item ICBiC25/26-31 only)
Becky Hartlett	Senior Cancer Screening Project Manager (for item ICBiC25/26-31 only)
Tamara Hazell	Corporate Governance Officer (minutes)

**Apologies**

Laurence Jones	Local Authority Sector Representative Strategic Director, Social Care and Education Leicester City Council
Richard Mitchell	Acute Sector Representative Group Chief Executive University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Trust

Mike Sandys	Local Authority Sector Representative Director of Public Health Leicestershire County Council and Rutland County Council
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**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
Dr Julia Railson	GP, ICB Partner Member - Primary Medical Services, deputising for Dr Jonathan Cox
Adele Wylie	Local Authority Sector Representative Chief Executive, North Northamptonshire Council

**In Attendance**

Neil Boughton	Deputy Director of Corporate Affairs
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**Apologies**

Dr Jonathan Cox	Primary Medical Services Sector Representative Chair, Local Medical Committee
Richard Mitchell	Acute Sector Representative Group Chief Executive University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Trust
Melanie Williams	Local Authority Sector Representative Executive Director, People's Services West Northamptonshire Council

**Minute No:      Agenda Item**

- |                      |  |
|----------------------|--|
| <b>ICBiC25/26-18</b> | <p><b>Welcome from the ICB Chair, Introductions and Apologies</b></p> <p>Anu Singh welcomed colleagues and members of the public to the NHS Leicester, Leicestershire &amp; Rutland ICB (LLR ICB) and NHS Northamptonshire ICB (NICB) Boards meeting in common.</p> <p>Apologies for absence were noted as above. There were five members of the public in attendance.</p> <p><b>Due notice had been given in line with the Constitutions, and the meeting was quorate.</b></p>  |
| <b>ICBiC25/26-19</b> | <p><b>Declarations of Interest relating to agenda items</b></p> <p>Standing declarations of interest were noted. It was confirmed that a conflict of interest applied to the item on the Implementation of Lung Cancer Screening in LNR, as Simon Barton (deputising as the Acute Sector Representative and employed by UHL and UHN) may be conflicted given that Trust and Primary Care providers could benefit from the commissioning of the service. Accordingly, he would be excluded from the decision-making element of this item.</p> |
| <b>ICBiC25/26-20</b> | <p><b>Draft Minutes of previous Board Meetings</b></p> <p>The minutes of the NHS Leicester, Leicestershire &amp; Rutland ICB and NHS Northamptonshire ICB Boards meeting in common held in public on 16 October 2025 were received and <b>APPROVED</b> as a true and accurate record of proceedings.</p>   |

**ICBiC25/26-21 Matters Arising and Action Logs**

The Boards received the Action Log and noted that all actions were either satisfactorily completed or remained in progress.

**ICBiC25/26-22 Questions from members of the public**

Anu Singh reported that two questions had been received from members of the public. One, which did not relate to a specific agenda item, would be responded to separately as a general enquiry. The second, concerning Healthwatch representation on behalf of the Healthwatch Rutland Advisory Board, would be addressed under item *ICBiC25/26-25 Board Partner Members*.

**ICBiC25/26-23 Chair and Chief Executive Updates**

Anu Singh reflected on the challenging operating environment, noting ongoing winter pressures, industrial action and wider system strain. She also highlighted the significant opportunity to progress commissioning reform, reduce health inequalities and strengthen neighbourhood-based care, emphasising the need for clarity on shared priorities while maintaining resilience through winter.

Toby Sanders updated the Boards on organisational priorities, including winter and industrial action planning, preparations for 2026/27 and transition work. He noted leadership changes, congratulating Matt Gaunt on his appointment as substantive CFO, and highlighted continued progress on neighbourhood development and NHFT's inclusion in the early wave of the Advanced Foundation Trust programme.

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

**ICBiC25/26-24 Joint Transition Assurance Report**

Toby Sanders presented the Joint Transition Assurance Report, updating the Boards on preparations for the 2025/26 organisational reset, the ICB cost-reduction programme and the move to a Model ICB through the establishment of cluster arrangements. He confirmed that the emerging design supported the future strategic commissioning role and remained deliverable within the reduced funding envelope. He acknowledged the pace of work and the understandable anxiety for staff, noting that the organisations were well positioned ahead of the formal consultation period beginning in January 2026.

He reported strong interest in the voluntary redundancy scheme and confirmed that wider transition activity, including the transfer of functions, was progressing as planned. Toby Sanders outlined the communications approach and noted that national redundancy funding guidance remained unchanged, with proposals now under regional oversight. He also highlighted ongoing work to strengthen organisational connectivity through agile working, with a refreshed policy in development.

Matt Gaunt confirmed continued engagement with regional finance colleagues to ensure assurance around the redundancy envelope and noted that discussions were ongoing regarding flexibility across clusters. He also confirmed engagement

with external audit, with further consideration to follow through the Audit Committees.

The Boards were asked to approve the updated Terms of Reference for the Joint Transition and Transformation Committee, including its proposed renaming to include transformation within its remit. It was confirmed that the quorum would require one non-executive member, consistent across the other committees.

Anu Singh emphasised the importance of future reports more clearly articulating the strategic commissioning ambition the organisations were moving towards. She noted that structural design alone would not define success and highlighted the need to strengthen population health management capability, work closely with providers and embed patient and citizen voice throughout the commissioning cycle. She also encouraged clearer articulation of organisational values, direction and future capability requirements.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the progress to date of the Transition to *Model ICB* in order to achieve its mandated reductions and **APPROVED** the updated Terms of Reference for the Transition Committee, to be renamed as *Transition and Transformation Committee*.

## ICBiC25/26-25 **Board Partner Members**

Toby Sanders presented the Board Partner Members report, outlining work to align partner and participant arrangements with the move to a single executive model and new cluster structure. He confirmed that discussions had taken place with local authority, Healthwatch and VCSE colleagues to understand their perspectives.

Toby Sanders emphasised that the proposed model aimed to ensure a balanced range of system perspectives rather than sectoral representation. While the Board would remain an important forum for collaboration, he noted that more partnership working would increasingly take place at place level.

The report proposed one NHS Trust, one Local Authority and one Primary Medical Services Partner member for each statutory body, creating six partner member seats in total and meeting national requirements. Toby Sanders also recommended reinstating Healthwatch and VCSE representatives as non-voting participants to retain important system voices.

Approval was sought to proceed with the proposed arrangements and refreshed nomination process. Toby Sanders confirmed that he and Anu Singh would support the assessment of nominations, and that further work would be undertaken with Healthwatch and VCSE partners to agree nomination routes.

In relation to the question received from Healthwatch Rutland:

*In the light of the ICB's proposal to create a single Healthwatch partner member to represent the entire LLNR population, how will the ICB ensure that the voices of 41,000 Rutland residents remain influential and acted upon during this time of major reform and financial pressure on the NHS?*

Toby Sanders acknowledged that similar concerns had been raised by other Healthwatch organisations and recognised the understandable anxiety about losing local connection. He clarified that the proposed single Healthwatch representative was intended to provide sector-wide insight rather than represent whole populations.

Toby Sanders noted that Rutland's specific population needs would continue to be addressed primarily through local health and wellbeing and neighbourhood-level arrangements, where close working with Healthwatch Rutland would remain central. He confirmed that these mechanisms would ensure Rutland's voice continued to influence system decisions despite the move to a single Healthwatch partner member.

From a local authority perspective, it was emphasised that representation should support collective work at place level, including alignment with Health and Wellbeing Boards and the emerging neighbourhood model. Directors of Public Health were highlighted as well aligned to the ICB's strategic commissioning role, and the Board noted that further work would take place with each local authority to agree the most appropriate nomination approach.

Anu Singh highlighted the scale of change underway and the importance of developing shared population health intelligence, including strengthening actuarial-style capabilities. She welcomed ongoing discussions about how these functions should evolve and reiterated the need to embed citizen voice throughout the commissioning cycle and ensure this was reflected in governance and programme design.

Mark Andrews stressed the importance of ensuring local authority contributions reflected the wider determinants of health, such as housing and economic development. Anu Singh agreed, emphasising that future arrangements must be rooted in a people-centred view of place and avoid duplicating existing local authority work.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **APPROVED** the proposed Partner Member and Participant sector representative structure.

## ICBiC25/26-26 **Quality, Performance and Outcomes Assurance Reports**

Maria Laffan presented the first joint assurance reports of the Committees in common for Quality, Performance and Outcomes, highlighting key quality and safety issues. She drew attention to the recent Care Quality Commission (CQC) inspection of St Andrew's Healthcare, which had placed the organisation into special measures, noting strong oversight arrangements and ongoing pressures on mental health bed capacity.

A decline in Initial Health Assessments for looked-after children was reported, driven by paediatrician capacity, with a system-wide approach required to improve performance.

Positive findings from the Joint Targeted Area Inspection on child sexual abuse

within families were noted, particularly in maternity and community services. Maintaining strong safeguarding arrangements remained essential, alongside continued work on maternity assurance and de-escalation of concerns within Community Mental Health Team (CMHT) services. An alert relating to Special Educational Needs and Disabilities (SEND) was highlighted, with future reports to incorporate wider education and SEND developments.

Operationally, Chris Pallot reported on the current doctors' strike, noting strong system coordination and early positive impact from winter schemes, despite continued pressure at acute sites. Cancer performance remained challenged, though recovery plans were in place, and joint schemes in Northamptonshire were beginning to improve flow for patients with no criteria to reside.

Nil Sanganee outlined work to strengthen the outcomes framework in light of the national 10-year plan, supporting the ICB's longer-term strategic commissioning role.

Further discussion covered the financial impact of industrial action, the continued closure of St Andrew's to admissions, and variation between Community Diagnostic Centres. Updates were also provided on mental health flow, including pressures across adult, Child and Adolescent Mental Health Services (CAMHS) and forensic beds.

Toby Sanders emphasised the need for urgent joint work to understand rising urgent and emergency care (UEC) demand and accelerate transformation in out-of-hospital and neighbourhood-based care. Simon Barton confirmed full implementation of winter plans and highlighted the need for longer-term service transformation.

The Boards welcomed Rainbows Hospice's Outstanding CQC rating across all domains.

In closing, Anu Singh reflected on the value of the discussion and confirmed that future reporting would focus on the metrics and longer-term indicators needed to support the Board's strategic commissioning role as the cluster matured.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** Quality, Performance and Outcomes Assurance Reports with assurance that ICB teams were prioritising appropriate actions under agreed plans to address the issues identified.

## **ICBiC25/26-27 All-Age Continuing Healthcare**

Maria Laffan presented the All Age Continuing Healthcare (CHC) report, confirming that services currently delivered by Arden and Greater East Midlands Commissioning Support Unit (AGEM CSU) and Midlands and Lancashire Commissioning Support Unit (ML CSU) would be brought in-house by July 2026. A programme board was in place and progressing well, though challenges were anticipated around workforce, estates and IT. Work with local authority partners was underway to shape the future in-house model, with partners to join the programme board.

In Leicestershire, CHC continued to face significant financial pressures, and an improvement board had been established to focus on priority areas. Early work had begun, with further exploration needed to inform future financial planning. Strong partnership working would be essential given variation across the system.

Mark Andrews highlighted the value of presenting CHC expenditure on a population basis to support clearer discussion. Maria Laffan confirmed this data was available, noting the need to interpret it in the context of population health profiles.

The Boards were assured that patient experience and quality remained central to the programme, with continued focus on achieving positive outcomes.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the All-Age Continuing Healthcare Report.

#### **ICBiC25/26-28 Finance Assurance Reports - LLR ICB and N ICB**

Matt Gaunt presented the Month 7 financial position for 2025/26, noting that reporting remained one month behind to align with committee and Board cycles. Across both ICBs, the year-to-date position was ahead of plan once deficit support funding was applied, although underlying pressures continued. He highlighted ongoing cost pressures in All Age CHC, prescribing and ADHD activity, alongside shifts in elective activity between NHS and independent sector providers.

For LLR ICB, the risk-adjusted forecast indicated a significant deficit against the breakeven plan, despite improvement work underway. Matt Gaunt confirmed discussions with NHS England (NHSE) regarding the likely year-end position, noting that Month 8 figures showed some improvement, though these had not yet been reviewed by the Committees in common for Finance and Contracting.

In response to questions, Matt Gaunt explained that the withdrawal of £1.3m deficit support funding reflected Quarter 2 performance falling behind plan, in line with NHS business rules, and that reinstatement assumptions would be tested with NHSE. He also clarified that corporate cost reduction slippage related to the timing of the restructure, with savings now expected to fall into the next financial year.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the Finance Assurance Reports for LLR ICB and N ICB.

#### **ICBiC25/26-29 Emergency Preparedness Resilience and Response Annual Report**

Chris Pallot presented the EPRR Annual Report for LLR ICB and N ICB, noting that the NHS Core Standards set out the requirements with which all NHS Category 1 responders must comply. The report detailed the level of compliance across organisations within the cluster and included provider updates on training and incident preparedness.

It was reported that UHL, LPT and NHFT were compliant with the standards. Progress had been made across University Hospitals of Northamptonshire (UHN) Group over the previous 12 months, with both KGH and NGH showing continued improvement.

Toby Sanders acknowledged the positive progress made in EPRR, noting that performance had improved incrementally across both LLR ICB and NICB, and from a partner perspective.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** assurance of the results of the 2025 EPRR Core Standards for LLR ICB and N ICB and the ongoing EPRR work being carried out across both ICBs.

### ICBiC25/26-30 LNR ICBs Planning Submission and Response

Pete Burnett presented the LNR ICBs' Planning Submission and Response, confirming that the first submission had been made in December 2025 and work was underway on the second submission due in February 2026. He outlined the two components of the planning process: the Strategic Five-Year Plan, setting out the system's long-term population health ambitions, and the Medium-Term Plan for 2026/27.

The Strategic Five-Year Plan aligned with the national 10-Year Plan and focused on three major shifts: moving care into the community, accelerating digital transformation and strengthening prevention. Emerging local priorities, frailty, premature mortality, and children and young people had been identified through population health analysis and alignment with Health and Wellbeing Board strategies. Further refinement would take place through upcoming workshops and committee discussions.

In discussion, members welcomed the direction but noted risks relating to tight timelines, contracting clarity and the need to maintain focus on longer-term priorities amid operational pressures. It was emphasised that the process required shared ownership across partners and clear communication to avoid perceptions that other areas were being deprioritised.

Pete Burnett also outlined next steps for the Medium-Term Planning Framework, noting that separate submissions were required from providers and ICBs covering finance, performance, activity, workforce and the Board Assurance Framework. Challenges remained in elective care and community waiting times, though balanced financial plans had been submitted. Assurance ratings were currently between 2 and 3, with further work to follow in the subsequent private Board session.

Anu Singh and Toby Sanders highlighted the importance of aligning the various planning components and strengthening provider dialogue. Triangulation of the planning elements would be considered at the LNR Health Partners' Executive meeting on 16 January 2026, with further development work to follow.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** assurance on the development of the 5-Year Strategic Commissioning Plan and Medium-Term Plan in order to deliver local priorities and national ambitions set out within the 10-Year Health Plan.

### ICBiC25/26-31 Implementation of Lung Cancer Screening in LNR

Becky Hartlett and Adam Andrews presented the implementation plan for Lung Cancer Screening in LNR and sought approval to proceed with procurement for a £27.8m contract. The programme was a mandated national screening requirement under Section 7 of the NHS Act, with rollout due to begin in April 2026 and full implementation by 2030.

The Boards received an overview of the proposed patient pathway, including targeted invitations for eligible 55-74 year old current or former smokers, risk assessment, lung health checks and same-day CT scanning in community settings. The programme aimed to improve early detection and reduce health inequalities.

In discussion, members raised concerns about incidental findings, workforce and diagnostic capacity, and the impact on primary and secondary care. Assurance was provided that modelling had been undertaken, national quality standards would apply, and further planning on capacity would follow. The programme design prioritised deprived areas and included aligned communications and smoking cessation support.

The robustness of the procurement process was confirmed, with the proposal progressing through an established framework. Members emphasised the importance of targeted engagement, maintaining focus on high-risk populations, and understanding wider system implications and long-term benefits.

It was noted that additional capacity would be required at Glenfield Hospital, and that governance and quality oversight would be provided through a mandated national framework and monthly steering group.

The NHS Leicester, Leicestershire and Rutland ICB Board and the NHS Northamptonshire ICB Board were **ASSURED** that the programme was a mandated requirement aligned with national and local priorities, and that appropriate due diligence and governance processes had been undertaken through the planning stages. The Boards **APPROVED** the procurement and contract award, via the MECSS Framework, with the recommended preferred provider (name redacted in the public papers in line with procurement requirements) for the Lung Cancer Screening Programme across LNR.

#### ICBiC25/26-32 **Chair's Closing Remarks**

Anu Singh reflected on the meeting, noting the continued shift in report style, focus and culture as the organisation strengthened its role as a strategic commissioner.

Afzal Ismail welcomed the progress, highlighting assurance on key items, clearer summaries and effective use of time.

Angela Hillery noted the strong sense of transition and the positive focus on population health, recognising both the progress made and the work still ahead.

The Chair brought the meeting to a close at 11:30am

# Board Meetings in Common in Public

**Report Title: Hinckley Day-Case  
Scheme Cancel**

**Date of Meeting: 19 February 2026**

Gormley Charlotte  
13/02/2026 11:50:19

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>Thursday 19 February 2026</b>		
<b>Report Title</b>	<b>Hinckley Day-Case Scheme Cancel</b>		
<b>Paper Reference No:</b>	<b>ICBIC-26-03</b>	<b>Agenda Item No:</b>	<b>7.</b>

<b>Presented by</b>	<b>Pete Burnett, Chief Strategy Officer</b>
<b>Report Author(s)</b>	<b>Joanna Clinton, Head of Strategy and Planning, LLR ICB</b>
<b>Executive Sponsor</b>	<b>Pete Burnett, Chief Strategy Officer</b>

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input checked="" type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.
<b>Recommendations</b>		
<p><b>The Boards are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>APPROVE the reports recommendation to cancel the scheme</b></li> <li>• <b>APPROVE the delivery of the stakeholder communication plan</b></li> <li>• <b>APPROVE the suggested next steps to develop an alternative solution for the site</b></li> </ul>		

<b>Executive Summary of the report</b>
<ol style="list-style-type: none"> <li>1. The STP Capital business case for the Hinckley Day Case Unit received national approval in March 2024. The scheme's proposal was to demolish the existing Hinckley District Hospital as it's no longer fit to deliver modern healthcare, replacing with a modular building (a theatre and an enhanced procedure suite) adjacent to the Hinckley Community Diagnostic Centre (CDC) scheme on Mount Road. Planning permission for the scheme was granted by Hinckley and Bosworth Borough Council in July 2025.</li> <li>2. The STP Capital (£7.035m) was awarded to West Leicestershire Clinical Commissioning Group (CCG) in December 2018. The development of the scheme has been delayed for several reasons including a pause during the outbreak of COVID-19.</li> <li>3. However, since business case approval there have been further key changes which have impacted the schemes development and driven the recommendation to cancel the scheme:</li> </ol>

- Changing financial context nationally and local financial challenges at both UNIVERSITY Hospitals Leicester (UHL) and the Leicester Leicestershire and Rutland (LLR) ICB; this includes no additional elective recovery funding (ERF) to pay for increased elective care.
  - Increased capital costs of the scheme circa £2m compared to that approved by the board.
  - Programme delays resulting in a significantly reduced capital resource without an agreement to carry forward the STP funding into 2026/27.
  - NHSE's confirmation that the STP Capital cannot be carried over into 2026/27 without a viable scheme.
  - East Midlands Planned Care Centre (EMPCC) capacity and underutilisation. The EMPCC opened in December 2024 and is a modern, purpose-built facility designed to help reduce waiting times for appointments and treatments, including day case surgery.
  - UHL's confirmation that due to the EMPCC and activity flows they cannot make the project affordable.
  - An activity review which demonstrates that there is sufficient day-case capacity within the system and therefore the Hinckley Day-Case scheme is no longer required.
4. Over the seven years since the funding was awarded, changes in the delivery of elective care have significantly reduced the need for day-case capacity in Hinckley. As a result, even if capital were now made available to complete the scheme, current and projected demand would be insufficient to make it viable
5. Since 2018, Hinckley has benefited from significant investment in health and care services from both the NHS and the local authority. A Community Diagnostics Centre was established in 2025 on the Hinckley Hospital site which also includes a Health Centre that provides a wide range of outpatient, primary care services and a pharmacy. Nearby, the Hinckley Hub offers additional community services, including Citizens Advice and Jobcentre provision, as well as a recently refurbished clinical area with ten treatment rooms and two large therapy gyms used by Leicestershire Partnership NHS Trust to deliver physiotherapy and occupational therapy for children and adults.

The recommendation therefore is that the scheme should be cancelled, and reconsideration should be given to the delivery of community services in Hinckley.

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

<input checked="" type="checkbox"/>	<b>Improve Outcomes</b> - Improve outcomes in population health and healthcare	<input checked="" type="checkbox"/>	<b>Health Inequalities</b> - Tackle inequalities in outcomes, experience, and access
<input checked="" type="checkbox"/>	<b>Value for money</b> - Enhance productivity and value for money	<input checked="" type="checkbox"/>	<b>NHS Constitution</b> - Deliver NHS Constitutional and legal requirements
<input checked="" type="checkbox"/>	<b>Social and economic development</b> - Help the NHS support broader social and economic development		

**Conflicts of interest – Please select**

<input type="checkbox"/>	No conflict identified
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input checked="" type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision
<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	Conflict noted, conflicted party to be excluded from the meeting

**If conflicted identified, please list conflicted party and nature of conflict:**  
 Richard Mitchell (Chief Executive, University Hospitals of Leicester NHS Trust), this matter directly impacts University Hospitals of Leicester NHS Trust as the current service provider.

**Board Assurance Framework Risk - Please insert BAF risk identified in report**

LLR ICB BAF No: BAF4 – Finance	NICB BAF No: Not applicable
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<b>Appendices</b>	<ul style="list-style-type: none"> <li>• <i>Appendix 1 – Equality and Health Inequalities Impact and Risk Assessment (EIA)</i></li> <li>• <i>Appendix 2 – Images of Hinckley District Hospital</i></li> </ul>
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**Who has been engaged and where else has this report been considered:**

*The report’s recommendations have been received by the Joint Executive Team meeting on the 19<sup>th</sup> of November 2025 and then again on the 14<sup>th</sup> of January 2026, the report recommendations were supported.*

*The report’s recommendations have been received by the Finance and Contracting Committee on the 3<sup>rd</sup> of February 2026.*

*Browne Jacobson LLP have considered the recommendations and provided advice regarding next steps and public engagement (point 24)*

**Implications: Select which of the following implications need to be considered**

<input type="checkbox"/>	Quality & Patient Safety	<input checked="" type="checkbox"/>	Legal	<input checked="" type="checkbox"/>	Equality, Diversity & Inclusion		
<input type="checkbox"/>	Environmental	<input type="checkbox"/>	Data & Digital	<input checked="" type="checkbox"/>	Financial	<input type="checkbox"/>	Workforce

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## Hinckley Day Case Unit (DCU) Scheme Cancel 19 February 2026

### Background

1. In December 2018 the Department of Health and Social Care awarded West Leicestershire CCG £7,035,000 STP capital funding for Hinckley and Bosworth Community Health Services.
  2. The preferred option for the funding included:
    - The refurbishment of the Hinckley Health Centre to accommodate X-ray/Ultrasound, Physiotherapy and increase the amount of consulting rooms.
    - The creation of a combined day case surgery and endoscopy unit at the Hinckley Community Hospital with day-case beds.
  3. In 2020 the NHS Leicester, Leicestershire, and Rutland (LLR) Integrated Care Board (formerly Clinical Commissioning Groups) found it necessary to pause the scheme due to the Covid-19 pandemic.
  4. In 2020/21 delays to the STP Capital scheme occurred due to the need to review the preferred option from the original Pre-Consultation Business Case (PCBC) pre-COVID19. The preferred option was quickly discounted as it included the removal of a ward at the community hospital which had been used successfully during COVID-19 to support the separation of patients. It was agreed that the scheme should focus on the 3 main services in need: Day case (DC), X-ray and endoscopy which were being delivered from the Hinckley District Hospital (HDH).
  5. Despite delays to the STP Capital scheme it should be noted that during this time there has been significant expansion in health and community services in Hinckley. This includes the re-location of physiotherapy and occupational therapy services for both adults and children into a newly refurbished floor at the Hinckley Hub and the opening of the Community Diagnostic Centre on Mount Road offering a range of diagnostics including endoscopy and X-ray.
  6. The HDH was built as a 'cottage hospital' 125 years ago for Queen Victorias Diamond Jubilee with extensions built between 1928 and 1978. Due to the design and specification of the building, it was no longer fit to provide modern healthcare services e.g. the theatre used bottled gas and often had to cancel day-case procedures due to anaesthetist availability (newly qualified anaesthetist are only trained to use piped gas not bottled so the service relied on older anaesthetists to provide the service) There was also privacy and dignity issues with shared changing room facilities resulting in same sex clinics being delivered at any one time. Please see appendix 2 for images of the Hinckley District Hospital as it stands now.
  7. Further delays to the Programme occurred due to several factors outlined below:
    - Cost pressures that exceeded the STP capital allocation (exacerbated by the rise in inflation).
    - The introduction of the Hinckley Community Diagnostic Centre (CDC), which absorbed X-ray and endoscopy services, leaving the STP Capital scheme to focus on day case only.
- Uncertainty from NHSE about the business case process i.e. short form or full business case. The final guidance confirmed short form due to the level of STP Capital.

- Confusion over whether the ICB could combine the CDC and STP capital schemes into a single business case to achieve efficiencies. The final NHSE guidance confirmed they must remain separate due to different funding streams.
8. Since the approval of the STP Capital Business case in 2024, delays can be attributed to:
- The planning application phasing (considering the contention surrounding the demolition of the HDH due to the history of the building it was agreed that the CDC planning application should be submitted ahead of the HDH planning application to avoid any delays with the CDC development),
  - Further cost pressures leading to a top-up from the system capital funds (£2.7m),
  - The NHSE change request process to carry-forward to March 2026 for the STP capital due to Programme delays,
  - The delay in submitting the planning application to allow the development of a robust design to address the Local Planning Authority’s concerns about the demolition.
  - The elongated RIBA stage 3 design due to changes requested by the service provider.
9. Despite the delays the scheme attained planning permission in July 2025 to demolish the existing building replacing it with a modular build linked to the CDC. The scheme’s aim was to provide a day case theatre and an enhanced procedure suite to the local population, providing over 2000 planned elective procedures a year, this would’ve more than doubled the previous activity that was delivered from Hinckley District Hospital through improved efficiency and productivity due to it being a new facility.
10. The HDH is no longer in use and stands derelict. Activity was temporarily ceased in November 2023 due to the commencement of work for the Community Diagnostic Centre (CDC) which opened in June 2025. Since then, the top 5 providers that have been used by patients for day-case services are (Apr 25-Nov 25 data):

Provider Name	2526	% 2526
UHL	8,652	55.2%
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	1,896	12.1%
GEORGE ELIOT HOSPITAL NHS TRUST	898	5.7%
LLR Alliance	887	5.7%
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	839	5.3%

11. The HDH is situated within an existing health campus which includes a CDC, a health Centre providing a range of outpatient and primary care services, a pharmacy and a leisure centre. Close by is the Hinckley Hub which offers a range of services including citizens advice, a job centre and a recently refurbished area providing ten treatment rooms and two large treatment gyms to treat children and adults with physiotherapy and occupational therapy needs delivered by Leicestershire Partnership NHS Trust.

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12. Since business case approval there have been key changes which have impacted the scheme and supports the recommendation which is outlined in the next sections.

### Finance (Capital)

13. This is a £10.5m scheme with funding being provided by £7.035m of STP Capital (previously carried over to March 2026), £800k from NHSPS Capital receipts and £2.7m of system capital. Initially NHSPS advised that £3.5m of STP Capital would not be spent before March 2026 but the figure now sits at £5.901m due to programme delays.
14. Darwin Group, the previously appointed main contractor significantly increased their cost estimate for building the Day Case by c.£4m between RIBA stage 2 and stage 3. Subsequently a value engineering exercise was undertaken by costs consultants who advised the scheme as designed, will cost £2.081m more than the original business case funding. This estimate is based on the adjoining CDC scheme, which was completed in 2025, so is anticipated to be an accurate assessment of the costs.
15. A change request form (CRF) was submitted to NHSE to request a carry forward to 26/27 for the remaining STP Capital including the additional funding required for the scheme. NHSE have confirmed that they are unable to support the CRF without a viable Programme. Should the recommendations be approved, and the Programme closes the STP capital will be withdrawn.
16. The total STP Capital spend to date is £942,664 (including VAT). £750,000 has been drawn down to date with the remainder of £192,664 to be reimbursed still. NHSPS have advised that they have requested a further draw down from the STP Capital to pay for the remaining outstanding development costs.
17. The development costs incurred include the schemes design development, the fee's associated with planning consent and the pre-contract service agreement with Darwin's Group.

### Finance (Revenue)

18. The business case has not been fully re-worked since approval; however, it is likely that:
- The revenue costs associated will increase related to the c19% increase in capital costs.
  - There is a risk that the total revenue cost to the ICB will increase further if activity cannot be re-patriated from University Hospitals Leicester (UHL), BMI, George Elliot Hospital etc. To note the UHL East Midlands Planned Care Centre business case was based on similar repatriation which has not yet been evidenced. There is equally a risk from a provider perspective that the service will not be efficient enough to be affordable if sufficient activity cannot be repatriated.
  - NHSE rules regarding the Elective Recovery Fund (ERF) have changed since the business case was approved in 2024. It was thought that any additional elective activity undertaken would be funded by NHSE through additional ERF funding, however ERF funding available is now largely fixed.
19. The level of revenue cost included within the original business case (and therefore a potential financial pressure to the LLR system) is £1.6m per annum (this could increase by circa £0.1m due

to additional capital charges related to the increased capital costs). Note the potential pressure for the ICB is expected to be larger than this based on tariff costs (as the original case suggested provider costs of £1.6m would be more than offset by income from the ICB of £2.5m).

## UHL Activity Modelling

20. In June 2025, UHL and the ICB were asked to re-visit the business case activity and any other potential activity that could be delivered from Hinckley Day Case due to concerns about demand and capacity.

21. UHL have confirmed following the activity review that for the reasons outlined below they can no longer support the scheme:

- **Additional day case and short stay capacity**

In the period the day case unit has not been built, NHSE funded UHL £50m to develop the East Midlands Planned Care Centre the capacity to treat an additional 18,094 additional patients annually. However, demand analysis would not currently support the creation of additional low complexity capacity, particularly at a remote site like Hinckley, which lacks the capacity for overnight stays. Current modelling, especially when considering independent sector providers, suggests there is sufficient capacity for High Volume Low Complexity (HVLC) based on current referral patterns to UHL.

The analysis further reveals that most patients waiting at UHL are now those with mid-to-high complexity cases, such as individuals with multiple co-morbidities or those requiring more complex procedures. This has necessitated a change in the case-mix for the activity planned through the EMPCC, thereby reducing the numbers treated at the EMPCC (due to the increased complexity of patients).

- **Productivity-** Getting It Right First Time (GIRFT) and Model Hospital (MH) guidance highlights the challenges associated with delivering highly productive Elective services from a unit with only one available Day Case theatre.
- **Financial Sustainability** - Analysis of the patients that travelled from the local area to Out of County NHS providers (in 2024/25) highlighted that to ensure Elective Services are not delivered at a loss (from this site), 100% of these patients would need to be repatriated to the Hinckley Day Case Unit. With the legal requirements of Patient Choice and no contractual leaver to prevent patient flow leaving Leicester, Leicestershire and Rutland (LLR), there is real risk to delivering a financially sustainable service with no current plan from commissioners to underwrite this loss if it occurred.

22. Over the seven years since the funding was awarded, changes in the delivery of elective care have significantly reduced the need for day case capacity in Hinckley. As a result, even if capital were now made available to complete the scheme, current and projected demand would be insufficient to make it viable

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## Risk Analysis

Risks: Scheme Closure			
Risk/Issue	Implications	Risk score	Mitigations
Daycase is an existing service (activity was temporarily moved due to adjacent CDC build) by not delivering the activity from the HDU could it be considered a significant service change, therefore a formal publication is required.	Formal public consultation required	3	Legal advice has been provided. No requirement for the ICB to consult but it must engage with the population in developing an alternative proposal for the site.
Incomplete Development and derelict site; Part of a wider health campus with CDC, health centre and GP practices.	The building is not fit to provide any services from due to asbestos removal and demolition of attached wings. The building risks standing derelict if we are unable to demolish becoming a community safety issue.	12	Would need to explore alternative schemes but this would be contingent upon the availability of national capital - potential 'neighbourhood' capital. See next steps.
Scheme Development costs already incurred	Current cost £830k (doesn't include Darwins costs still waiting for this) but £750k has been drawn down from the STP Capital towards this, leaving a liability cost of £80k + darwins costs	3	NHSPS has requested scheme closure draw down from STP Capital to pay remaining scheme development costs. NHSPS has advised that should funding not be released, they will explore alternative funding sources.
NHSE request payback of STP capital already drawn down	An additional cost pressure of £750k to ICB.	3	The ICB will need to consider utilising some of the £2.7m system capital funds ringfenced to make the site safe.
Political Impact	MP and HDC fully supportive of the scheme, likely to damage relationships.	9	Chief Strategy Officer attended recent MP briefing, the MP was updated on current status of the scheme. The MP and CEO of HDC will be notified of the recommendation ahead of Board with follow-up meetings offered as per the communication plan.
Reputational Damage	Scheme has been promised for several years, and the public have been continuously engaged. Faith with the ICB could be lost due to lack of delivery. Strategically aligns with neighbourhood health programme; hospital to community; Partners/public lose faith in ICB's ability to deliver on this agenda	9	As per the communication plan. Key messages: scheme is unaffordable, the ICB will need to re-consider plans for the site.
Patient Experience - No local day case facility	Patients will be unable to access day case services in Hinckley and will need to travel to alternative day case sites to access treatment	3	The current service has been temporarily suspended for 2 years, and in that time the ICB hasn't received any patient complaints regarding travel to alternative sites. The closest facility, George Elliot, is 6 miles from Hinckley. The impact of this has been assessed in the EIA.
The recommendations within the report are not approved and the scheme continues.	There is Insufficient capital to proceed with the current scheme. Using ICB strategic capital allocation will slow down the scheme over many years.  The activity in the DCU could impact/destabilise the revenue position of UHL if this was not repatriated activity from OOC.	16	Phase the scheme over multiple years to spread capital requirements. Explore alternative funding sources.
The alternative option cannot be delivered and isn't affordable	The ICB have been engaging with the population since 2014 on improving community services in Hinckley. Failure to deliver an alternative solution will impact upon the ICB's reputation.	6	The ICB will use the lessons learned (to be developed) from the current scheme combined with a strong project management approach including regular reports to the Strategic Commissioning Committee.

23. An Equality Impact Assessment (EIA) has been undertaken, see Appendix 1. It has highlighted potential negative impacts for several protected characteristics due to the population having to travel outside of Hinckley for day case procedures e.g. Age: Older population having to travel further for day case procedures incurring higher travel costs, carers and those with disabilities. As those services haven't been provided from Hinckley since November 2023 it is perceived that the impact is reduced, and mitigations are in place including the use of Non-Emergency Patient Transport Services (NEPTS). These cohorts will be identified in the communications plan. As

this is an iterative process, the EIA will need to be re-visited as the ICB re-considers an alternative solution for the site.

24. Legal advice was sought to explore whether the ICB would be required to consult upon the cancellation of the scheme, as this was an existing service and only temporarily moved to allow the CDC build. This has confirmed there is no express requirement in legislation for the ICB to undertake a public consultation, however the ICB has a duty to involve the public in developing an alternative plan and should engage with the population on the proposal to cancel the current scheme.

## Next Steps

25. A lesson learned document will be developed with regards to the cost's escalation and delays within the Programme. This will be presented to JET and the Strategic Commissioning Committee in due course.
26. The cancellation of the scheme, if approved, will result in significant public interest and therefore a robust stakeholder communication plan has been developed which sets out the ICB's plan for engaging local MP's, councilors and community groups.
27. Alongside this, a comprehensive communications and stakeholder-management approach has been established to ensure transparency, consistent messaging and coordinated engagement across partners. Identified spokespeople and defined sequencing of communications activity is set out. Internal communications arrangements have also been planned to ensure staff are briefed ahead of public messaging. The purpose of the approach is to ensure the ICB is prepared to manage the reputational, political and community impacts associated with the recommendation.
28. The key stakeholder message is that there is insufficient money to continue with the scheme and from a wider impact assessment, it is also no longer an efficient and sustainable use of resources.
29. The ICB acknowledges that the building cannot be left in the current condition. The ICB have every intention to develop a proposal for the building that meets the needs of the local population and supports the development of neighbourhood health in line with the government's 10-year health plan.
30. The £2.7m of System Capital funds allocated to the scheme continues to be ring-fenced and is included in next years approved system capital plan. The funds will be used to enable development of the site.
31. Should the recommendations be approved the ICB's Strategy and Planning directorate will lead the development of an alternative solution for the site with relevant stakeholders. Regular updates will be provided to the ICB's Joint Executive team and Strategic Commissioning Committee.
32. The next steps will be to develop a case for change for Hinckley Community Services in line with the NHS 10-year plan and the recently published neighbourhood health guidelines. A proposal will be ready by the end of quarter 2 in 2026/27. Please note this may be impacted by the management of change process, affecting ICB staff, commencing in January 2026.

## Summary

33. The scheme is no longer viable due to changes in the delivery of elective care since the money was awarded which have significantly reduced the need for day-case capacity in Hinckley. As a result, even if capital were now made available to complete the scheme, current and projected demand would be insufficient to make it viable.
34. Currently there are insufficient funds to develop the scheme and from a wider impact assessment, it is also no longer an efficient and sustainable use of resources.
35. Whilst there are risks associated with cancelling the scheme, to continue would place the ICB in an untenable financial position, using resources in an inefficient and unsustainable manner, potentially resulting in a vacant DCU due to lack of patient need.
36. Day case procedures have not been delivered from HDH for over 2 years with most patients accessing UHL for their day-case treatment. To date the LLR ICB has not received any patient complaints from the Hinckley population regarding travelling to access day-case treatment. This indicates that whilst patients do need to travel out of Hinkley for their care the population are still able to access day-case treatment when required.
37. An activity review undertaken by UHL demonstrates that there is sufficient Day-Case capacity across LLR and therefore the Hinckley Day-Case scheme is no longer required.
38. The ICB will need to consider an alternative plan for the site. Currently the building stands derelict and is part of a wider 'Health' campus. In the interim the £2.7m allocated to the scheme will be used to develop the site.

## Recommendations

### The Boards are asked to:

- ***APPROVE the reports recommendation to cancel the scheme***
- ***APPROVE the delivery of the stakeholder communication plan***
- ***APPROVE the suggested next steps to develop an alternative solution for the site***

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# Appendix 1

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Leicester, Leicestershire  
and Rutland

# Inclusive Decision-Making Framework (IDMF) Equality Analysis

## Part B Template

Title of Service / Policy / Business Plan:

**Hinckley Day Case Unit**

**Please complete all sections of this IDMF template and refer to the IDMF/EIA Toolkit for more information.**

**For further support, contact your Equality, Diversity and Inclusion team.**

# Inclusive Decision-Making Framework:

**Step 1:** Aims of the Proposal

**Step 2:** Develop the Evidence Base

**Step 3:** Design your Inclusive Engagement Plan

**Step 4:** Equality Impact Assessment

**Step 5:** Options Appraisal

**Step 6:** Monitoring, Re-Evaluation, and Publishing

**Name of organisation:** Leicester, Leicestershire and Rutland ICB

**Assessment Lead Contact:** Jo Clinton

**Responsible Director/Board Member for this assessment:**

Pete Burnett

**Other contacts involved in undertaking this assessment:**

Jenny Goodwin

**Start Date:** 27/11/2025 **Completed Date:** 17/12/2025

## 1. Aims

Who is impacted by this service / policy / decision?	Yes	No	Indirectly / Possibly
Staff	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients / Service Users	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carers or Family	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Public	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner Organisations	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Sections of this template which come from the Health Equity Assessment Tool (HEAT) are indicated with an \*. HEAT has been developed by Public Health England to embed action on health inequalities and equalities in policies, work programmes, and services. If you complete this Part B template, you do not also need to complete the HEAT tool separately.

## Summary information of the service / policy / business plan being assessed:

The Sustainability and Transformation Partnerships (STP) Capital Business case for the Hinckley Day Case Unit received national approval in March 2024. The scheme's proposal was to provide a day case theatre and an enhanced procedure suite to the local population more than doubling the previous activity that was delivered from Hinckley District Hospital.

The proposal was to demolish the existing Hinckley District Hospital as it is no longer fit to deliver modern healthcare and to replace with a modular building adjacent to the Hinckley Clinical Diagnostic Centre (CDC) scheme on Mount Road. Planning permission for the scheme was granted in July 2025.

However, since business case approval there have been key changes which have impacted the scheme and steered the recommendation to close the scheme.

1. Changing financial context nationally and local struggles to deliver plans at both UHL and ICB. (this includes no Elective Recovery Fund (ERF) to pay for increased elective care).
2. Increased costs of the scheme compared to that approved by the board.
3. Programme delays resulting in a significantly reduced resource without an agreement to roll-over the STP funding again.
4. NHSE's confirmation that the STP Capital cannot be rolled over again without a viable scheme.
5. East Midlands Planned Care Centre (EMPCC) capacity and underutilisation
6. UHL's confirmation that due to the EMPCC and activity flows they can't make the project affordable.

**What are the aims and objectives of the service / policy / business plan being assessed?\*** (The term 'proposal' covers activities such as, policy development, policy review, service redesign, commissioning and decommissioning, and internal reorganisation or restructuring processes)

The Hinckley Hospital on Mount Road previously provided outpatients, day case and diagnostic procedures. The conditions at the current hospital, which was built in 1899, did not meet modern requirements or needs of the local population. There were challenges for patients and staff at the site which could not be rectified or improved by internal refurbishment.

Two aligned projects commenced – the first to build the Clinical Diagnostic Centre (CDC) to provide MRI, CT, ultrasound and a plain film X-ray, and the second to build a Day Case Unit to provide a day case theatre and an enhanced procedure suite. These were two separate projects

due to the separate funding streams (the first funded by the CDC national programme, and the second using Sustainability and Transformation Plan (STP) funding).

The CDC required part demolition of the one of the wings of Hinckley Hospital to commence construction, requiring a temporary suspension of activity from the site, which included:

General Surgery  
Gynaecology  
Ophthalmology  
Orthopaedics  
Plastic Surgery  
Podiatric Surgery

Planning permission was granted by Hinckley and Bosworth Borough Council (HBBC). The CDC build was completed in July 2025, and is now operational.

The Day Case Unit required full demolition of the remaining Hinckley Hospital on Mount Road and the land would be used to locate the new unit. Planning permission was granted in July 2025 by HBBC. The ICB project team have been working continuously with NHS Property Services (NHSPS) and University Hospitals of Leicester (UHL) to develop the hospital design and activity plans for the site, however since approval several issues outlined above have resulted in an exploration of the scheme closure.

**This EIA seeks to review the impact of this recommendation and considers mitigations.**

**What are the main changes proposed and what are the reasons for the review? Which organisational priorities does this link to?** (State if the proposal is a review of a current service; involves relocating a service to another site; extended service hours; puts staff at risk or involves significant change)

The proposal is to permanently suspend the following services from Hinckley:  
The day case services that were provided from the site were: General Surgery, Gynaecology, Ophthalmology, Orthopaedics, Plastic Surgery, and Podiatric Surgery.

**How do you expect your work to impact on health inequalities?\***

Not reintroducing the Day Case specialties into Hinckley will have an impact on access to these services. As they are temporarily suspended, mitigations are in place resulting in patients in accessing these Day Case procedures at George Elliot Hospital (6 miles from the Hinckley Hospital on Mount Road) or at the East Midlands Planned Care Centre, EMPCC, at the Leicester General Hospital Site (17 miles from the Hinckley Hospital on Mount Road).

Local patients who have access needs may be impacted by not reintroducing these services to the local area.

## 2. Evidence Base

### What evidence have you considered to inform your decision-making within this assessment?\*

The more evidence you can provide in this section, the better informed your decision-making will be. Such evidence may include case studies and benchmarking from similar organisations, NICE guidance, clinical research, literature reviews, quality and performance data, RightCare data, workforce metrics, engagement findings, demographic data, community intelligence, health inequalities data (e.g. JSNA), Fingertips health profiles, Public Health Outcomes Framework, Hospital Outcomes statistics etc.

**NHS 10-year plan:** Since the business case was developed in 2023, new national guidance has been published in the form of the NHS 10-year plan. This sets out three major shifts for the NHS: hospital to community, analogue to digital, and sickness to prevention. The plan does not eliminate inpatient services but redefines their role for specialist and crisis care, while shifting routine and ongoing care into community settings through integrated neighbourhood models.

**Financial:** Since the STP capital allocation was awarded, building costs have increased, resulting in a reduced level of capital to carry out the project, resulting in a financially unviable project.

**Health Building Note (HBN) Standards:** The building is not fit to provide any service from in its current state due to the asbestos removal and demolition of attached wings that have already been carried out. The building risks standing derelict if we are unable to proceed with an alternative scheme – this is being explored as part of the neighbourhood health model which has a national capital allocation.

The above points mean that the way that we re-develop the site needs to be revisited and refreshed to reflect the change in circumstances. A steering group will be established to develop the plan in collaboration with our stakeholders.

### What are the key sources of data, indicators, and evidence that allow you to identify health inequalities in your area of focus?\*

Consider nationally available data such as health profiles and RightCare, and local data such as that available in JSNA, contract performance data, and qualitative data from local research. Performance data, qualitative data previous engagement and consultation.

2021 Census data has provided us with the split of protected characteristics within Hinckley and Bosworth as detailed below:

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**Sex**

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents	113,640	100.0
Female	57,607	50.7
Male	56,033	49.3

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS008)

**Age**

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents	113,640	100.0
Aged 4 years and under	5,686	5.0
Aged 5 to 9 years	6,350	5.6
Aged 10 to 15 years	7,686	6.8
Aged 16 to 19 years	4,349	3.8
Aged 20 to 24 years	5,037	4.4
Aged 25 to 34 years	13,808	12.2
Aged 35 to 49 years	21,225	18.7
Aged 50 to 64 years	24,089	21.2
Aged 65 to 74 years	13,776	12.1
Aged 75 to 84 years	8,577	7.5
Aged 85 years and over	3,057	2.7

[Show table notes...](#)

Source: ONS - 2021 Census (TS007B)

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### Ethnic group

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents	113,641	100.0
Asian, Asian British or Asian Welsh	3,147	2.8
Black, Black British, Black Welsh, Caribbean or African	692	0.6
Mixed or Multiple ethnic groups	1,990	1.8
White	107,180	94.3
Other ethnic group	632	0.6

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS021)

### Religion

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents	113,639	100.0
No religion	47,368	41.7
Christian	56,637	49.8
Buddhist	265	0.2
Hindu	1,251	1.1
Jewish	39	0.0
Muslim	796	0.7
Sikh	740	0.7
Other religion	556	0.5
Not answered	5,987	5.3

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS030)

### Sexual Orientation

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents aged 16 and over	93,917	100.0
Straight or Heterosexual	86,221	91.8
Gay or Lesbian	1,105	1.2
Bisexual	865	0.9
Pansexual	85	0.1
Asexual	47	0.1
Queer	7	0.0
All other sexual orientations	55	0.1
Not answered	5,532	5.9

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS079)

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### Gender Identity

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents aged 16 and over	93,919	100.0
Gender identity the same as sex registered at birth	89,409	95.2
Gender identity different from sex registered at birth but no specific identity given	130	0.1
Trans woman	54	0.1
Trans man	46	0.0
Non-binary	51	0.1
All other gender identities	18	0.0
Not answered	4,211	4.5

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected. Source: ONS - 2021 Census (TS070)

Gender identity estimates from Census 2021 are official statistics in development. This reflects their innovative nature and the evolving understanding of measuring gender identity, along with the uncertainty associated with these estimates. To support appropriate use, please refer to the Sexual Orientation and Gender Identity Quality Information page before using these estimates. <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/methodologies/sexualorientationandgenderidentityqualityinformationforcensus2021>

### Long term health problem or disability

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents	113,640	100.0
Disabled under the Equality Act: Day-to-day activities limited a lot	7,699	6.8
Disabled under the Equality Act: Day-to-day activities limited a little	12,227	10.8
Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited	9,154	8.1
Not disabled under the Equality Act: No long term physical or mental health conditions	84,560	74.4

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected. Source: ONS - 2021 Census (TS038)

### Provision of unpaid care

	Persons	
	Hinckley and Bosworth Local Authority	
	count	%
All usual residents aged 5 and over	107,954	100.0
Provides no unpaid care	97,712	90.5
Provides 19 hours or less unpaid care a week	5,514	5.1
Provides 20 to 49 hours unpaid care a week	1,760	1.6
Provides 50 or more hours unpaid care a week	2,968	2.7

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected. Source: ONS - 2021 Census (TS039)

The consultation report published in May 2023 can be found using the following link: [Improving-Community-Services-in-Hinckley -Final-May-2023.pdf](#).

The respondent profile showed us:

That most age groups were well represented, although only 10% (191 respondents) were aged under 35 so unrepresentative when compared to the 2021 census. A total of 41% (813 respondents) to the engagement were aged 65 or over so over representative of the local population.

In total, 61% (1,128 respondents) to the engagement are female, with 31% (622 respondents) to the engagement are male. Men were underrepresented in their feedback.

- 2) 1636 respondents identified as the gender they were assigned at birth, 3 did not, 209 preferred not to say, and 156 did not provide an answer.
- 3) The large majority of responses received were from respondents who consider their ethnic origin to be White (88% - 1,760 respondents). Only a small minority of responses (4% - 74 respondents) were from BAME respondents. This is comparable to the local population.
- 4) Overall, 49% (991 respondents) taking part in the engagement identify with, or follow, the Christian religion, with 25% (505 respondents) saying that they identify with no religion. This is comparable to the 2021 census data in that people of Christian faith or no religion were the top two categories. However, it should be noted that 15% (309 respondents) preferred not to say what their religion is, while 8% of all respondents taking part in the engagement provided no information about this issue.
- 5) Only a small minority (3%) of respondents had a sexual orientation that is not heterosexual. However, it should be noted that 11% preferred not to say what their sexual orientation was, while 12% of all respondents taking part in the engagement provided no information about this issue.
- 6)
- 7) In total, 22% (436 respondents) of those taking part in the engagement considered themselves to have a disability or suffer from poor health – although it should be noted that minorities either preferred not to say whether they have a disability or suffer from poor health (12% - 234 respondents) or did not answer this question (8% - 160 respondents). Of the 22% of respondents who indicated they had a disability or suffered from poor health, the most common condition is a physical one (11% - 225 respondents) or a long standing illness or condition (11% - 217 respondents). It should be noted that a minority of respondents would rather not say what their disability or poor health relates to (12% - 234 respondents) or did not provide information for this question (9% - 172 respondents).
- 8) Overall, only 1% (16 respondents) said that they were pregnant or have given birth in the last 26 weeks. It should be noted that small minorities preferred not to say whether they were pregnant or had given birth in the last 26 weeks (4% - 75 respondents) or did not answer this question (11% - 215 respondents)
- 9) Overall, 25% (496 respondents) which is more than representative of the 2021 census data said that they provided care for someone – the most common care provided was for an older person aged over 50 (16% - 325 respondents). However, the majority (62%) say they do not provide care for someone. It should be noted that small minorities preferred not to say whether they provide care for someone (3% - 68 respondents) or did not answer this question (10% - 195 respondents).
- 10) Overall, a small minority (4% - 79 respondents) said that they had served in the Armed Forces. It should be noted that small minorities preferred not to say whether they had served in the Armed Forces (5% - 101 respondents) or did not answer this question (11% - 215 respondents).

## Which populations face the biggest health inequalities for your topic, according to the data and evidence above?\*

Consider the diverse range of social economic factors which influence people's health and wellbeing. For example, income, education, employment, housing, community life, racism and discrimination, cultural, environmental, digital.

**Older people, disabled people, carers and those who are pregnant**

## What does the data and evidence tell you are the potential drivers for these inequalities?\*

Which wider determinants are influential, E.g. income, education, employment, housing, community life? Which health behaviours play a role? Does service quality, access and take up increase the chance of health inequalities in your work area? Which of these can you directly control? Which can you influence? Which are out of your control? Have you considered the interplay of multiple factors?

As demonstrated in the demographic data above, Hinckley and Bosworth has a large proportion of older adults and this has seen an increase over the years. and growth is expected to increase in the coming years which means that more people may be impacted by the loss of these services. There are also a high number of people in the district with a disability and number of people providing unpaid care.

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## 3. Inclusive Engagement Plan

Inclusive engagement is required with:

- Staff
- Patients/Service Users
- Carers or Families
- General Public
- Other Teams/Organisations

### How will you engage with staff and patients/service users?

We have already met with the H&B Borough Council CEO, and the Local MP. We have a comms plan in place which includes a recommended approach via the channels previously used as part of the earlier engagement exercise (including face to face meetings/events, local media and mailshots). This will also be how we identify groups of the public that we need to engage with.

### Where will you speak with them? Who will facilitate?

In local venues in Hinckley and the surrounding area. This will be facilitated by Head of Strategy and Planning and the ICB Comms and Engagement team.

### What questions will you ask them?

This is under development, and we are seeking legal advice on our duties.

### How will you ensure everyone's voice is heard?

Could you co-design the project with communities who face the biggest health inequalities to maximise the chance of it working for them? What will you need to enable this?\*

We will engage with our PPG representatives and work with local volunteers to ensure that all voices are represented.

### After the engagement sessions: What were your findings from your inclusive engagement work?

- We will update this section and include our findings once we have engaged with our communities.

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## 4. Equality Impact Assessment

### Identify the risks and benefits of the proposal for certain groups:

- protected characteristic groups
- groups experiencing health inequalities

### Protected Characteristics

<p><b>Age</b> Groups impacted may include young people, older people or working-age population.</p>	<p><b>Positive impact</b></p> <p><input type="checkbox"/></p>	<p><b>Negative impact</b></p> <p><input checked="" type="checkbox"/></p>	<p><b>Neutral impact</b></p> <p><input type="checkbox"/></p>
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*Consider access to services or employment based on need/merit not age, effective communication strategies etc.*

Day case services will no longer be available in Hinckley, however mitigations are in place with alternative care provided at George Elliot Hospital (6 miles from Hinckley) and at the EMPCC (17 miles from Hinckley). As the services have already been temporarily suspended, this model of care has already been tested. In Hinckley and Bosworth, older people may be adversely affected permanently with the need to travel further for future day case appointments, 22.3% of the population are over 65 years old. Those of working age, 56.5%, may also be impacted as day case services won't be closer to home. Younger people/students (10.6% aged 10-19 years) may be affected by the cost of travel. The alternative services meet accessibility standards and are accessible to disabled people. Public transport is a travel option, along with Non Emergency Patient Transport Services and voluntary drivers that are available locally.

<p><b>Disability</b> Groups impacted may include people with physical / learning disabilities, Sensory impairment (d/Deaf/hard of hearing, Blind/partially sighted), long term conditions, or poor mental health.</p>	<p><b>Positive impact</b></p> <p><input type="checkbox"/></p>	<p><b>Negative impact</b></p> <p><input checked="" type="checkbox"/></p>	<p><b>Neutral impact</b></p> <p><input type="checkbox"/></p>
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*Consider building access, wellbeing, communication needs, making reasonable adjustments etc.*

Travel to the closest day case facility will impact some patients with a disability, 17.6% of the population are classified as having a disability under the Equality Act 2010. Mitigations are in place via the Non-Emergency Patient Transport service to assist patients in these cases. Alternative services are accessible to disabled people. This section covers people with sensory and learning disabilities and the staff at these alternative services have training in place to ensure that they are disability aware.

Many patients with chronic and complex conditions may have reduced mobility or may not be able to access transport, making travel to hospital challenging. Those with particularly severe disability may be reliant on the availability of a carer, who is able to drive them to and from the hospital, and stay with them during their appointment. 9.5% of the population in Hinckley and Bosworth provide

at least 19 hours of unpaid care each week. With a national carer shortage for basic support packages, patients often have to rely on family / friends to take them to and from hospital appointments. This burden can impact wider family members' lives and their ability to work. If there is no-one able to take a patient to their appointment they could miss critical health treatment and guidance on how to manage their condition, leading to worsening outcomes, however alternative services are accessible to people with disabilities. Public transport is a travel option, Non Emergency Patient Transport Services and voluntary drivers are available locally to support people.. The increase in availability of home care (HomeFirst) which offers intensive nursing and therapy as part of an integrated team offer (NHS and social care staff) reablement, rehabilitation (within 2 days) and crisis response within 2 hours) will positively impact disabled patients as it will enable more patients to receive their care at home reducing the need to travel.

<p><b>Sexual Orientation</b> Groups impacted may include gay, lesbian, bisexual, asexual, pansexual, or heterosexual people.</p>	<p><b>Positive impact</b></p> <p><input type="checkbox"/></p>	<p><b>Negative impact</b></p> <p><input type="checkbox"/></p>	<p><b>Neutral impact</b></p> <p><input checked="" type="checkbox"/></p>
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*Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.*

We do not envisage any additional negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated. We would continue to ensure that there is LGBTQ+ awareness for workforce in the alternative sites. LGBTQ+ communities are less likely to access healthcare due to past negative experiences so it is important that they feel included and aware of the change, which will be incorporated in the engagement plan.

<p><b>Gender Reassignment</b> People proposing to undergo, undergoing or have undergone gender reassignment.</p>	<p><b>Positive impact</b></p> <p><input type="checkbox"/></p>	<p><b>Negative impact</b></p> <p><input type="checkbox"/></p>	<p><b>Neutral impact</b></p> <p><input checked="" type="checkbox"/></p>
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*Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.*

We do not envisage any additional negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated. We would continue to ensure that there is gender reassignment awareness for workforce in the alternative sites. These communities are less likely to access healthcare due to past negative experiences so it is important that they feel included and aware of the change, which will be incorporated in the engagement plan.

<p><b>Sex</b> Groups impacted may include males or females, boys or girls.</p>	<p><b>Positive impact</b></p> <p><input type="checkbox"/></p>	<p><b>Negative impact</b></p> <p><input type="checkbox"/></p>	<p><b>Neutral impact</b></p> <p><input checked="" type="checkbox"/></p>
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*Consider gender preference in key worker, single sex accommodation etc.*

We do not envisage any additional negative impacts on this protected characteristic, but we will monitor to ensure that any negative impact will be mitigated.

<p><b>Race</b> Groups impacted may include different ethnicities, nationalities, national identities, and skin colours.</p>	<p><b>Positive impact</b></p> <p><input type="checkbox"/></p>	<p><b>Negative impact</b></p> <p><input type="checkbox"/></p>	<p><b>Neutral impact</b></p> <p><input checked="" type="checkbox"/></p>
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Consider cultural traditions, food requirements, communication styles, language needs etc.

Within the Hinckley and Bosworth split of race is shown below:

Asian, Asian British or Asian Welsh 2.8% (3,147 people)

Black, Black British, Black Welsh, Caribbean or African 0.6% (692 people)

Mixed or Multiple ethnic groups 1.8% (1990 people)

Other ethnic group 0.6% (632 people)

We will ensure that translation and language services are available for people who need this in our model going forward. We will ensure that this is included in our communication plan and continue to ensure that staff at alternative sites are culturally aware.

<b>Religion &amp; Belief</b> Groups impacted can include all recognised faith groups and those who do not follow any religion or belief system	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.

Within Hinckley and Bosworth the religion and belief profile is shown below:

	count	%
All usual residents	113,639	100.0
No religion	47,368	41.7
Christian	56,637	49.8
Buddhist	265	0.2
Hindu	1,251	1.1
Jewish	39	0.0
Muslim	796	0.7
Sikh	740	0.7
Other religion	556	0.5
Not answered	5,987	5.3

We would ensure that at the alternative facility, staff are culturally aware to ensure that services such as chaperoning or male/female clinician is available, along with dietary considerations and prayer space.

<b>Pregnancy &amp; Maternity</b> Relates to women who are pregnant or within their allocated maternity period; up to 26 weeks after birth.	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Consider impact on working arrangements, part-time working, infant caring responsibilities etc. How will people on parental leave be engaged with and kept up to date?

Pregnant women may have reduced mobility or may not be able to access transport easily, making travel to hospital challenging. Non Emergency Patient Transport Services and voluntary drivers that are available locally would be able to support people in this group.

<b>Marriage &amp; Civil Partnership</b> This includes people within a formal legal partnership – same sex and opposite sex	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Consider whether civil partners are included in benefit and leave policies etc.

## Health Inequalities

The services we commission should be available to all and as inclusive as possible. Your proposal should also consider those experiencing deprivation and any other population groups that are (or are at risk of being) socially excluded. This can include carers, the armed services community, people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers and many other socially excluded groups.

Think about which other inclusion health groups may be impacted by your proposal. Select from the drop-down list below or manually state which other socially excluded groups you are considering. Select the table and click the blue '+' symbol in the bottom right of the table to add more sections if required.

**For more information about inclusion health groups, please refer to our Guidance Document.**

<b>People Experiencing Deprivation*</b> Including people experiencing poorer than average health access as defined by Core20PLUS5 ( <a href="https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/">https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/</a> ) and the Index of Multiple Deprivation ( <a href="https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019">https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019</a> )	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Consider the impact of the proposal for those on low incomes, as well as issues around rural and urban deprivation. Consider the impacts for people experiencing homelessness, people in prison, and young people leaving care. Consider ease of access, location of service, historic take-up etc. Could your work widen inequalities by:

- requiring self-directed action which is more likely to be done by affluent groups?
- not tackling the wider and full spectrum of causes?
- not being designed with communities?
- relying on professional-led interventions?
- not tackling the root causes of health inequalities?
- relying upon digital access?
- relying upon high level of literacy?

Whilst the overall Index of Multiple Deprivation (IMD) score is lower than the mean for England, areas of deprivation are present in some areas in and around Hinckley and Earl Shilton areas. Patients who require a Day Case procedure may be impacted by travelling further and the costs associated with this, however Non-Emergency Patient Transport (NEPT) is available to mitigate this where required.

<b>Looked After Children &amp; Young People</b>  Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Looked after children and young people may be reliant on the availability of a carer, who is able to drive them to and from the hospital, and stay with them during their appointment. With a national carer shortage for basic support packages, patients often have to rely on a responsible adult to take them to and from hospital appointments. Younger people may be affected by the cost of travel.

<b>Carers</b>  Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

People with particularly severe disability will be reliant on the availability of a carer, who is able to accompany them to hospital, and stay with them during their appointment. With a national carer shortage for basic support packages, patients often have to rely on responsible adults to take them to and from hospital appointments. This burden can impact wider family members' lives and their ability to work. If there is no-one able to take a patient to their appointment they could miss critical health treatment and guidance on how to manage their condition, leading to worsening outcomes.

<b>People living in rural/remote communities</b>  Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	Positive impact	Negative impact	Neutral impact
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

People living in rural and remote communities who require a Day Case procedure may be impacted by travelling further and the costs associated with this, however Non-Emergency Patient Transport (NEPT) is available to mitigate this where required.

We would also fulfil our duties to ensure that mitigations are in place for any other underserved group such as armed forces, asylum seekers and homeless people and ensure that they are

included in our communication plan to ensure that the alternative services are skilled to support these groups of people.

## Compliance with Legal Duties

Has the organisation given due regard and consideration to the following areas?

**Eliminating unlawful discrimination, harassment and victimisation** YES  / NO

Unlawful discrimination takes place when people are treated 'less favourably' due to having a protected characteristic.

**Advancing equality of opportunity between people who share a protected characteristic and those who do not.** YES  / NO

This means making sure that people are treated fairly and given equal access to opportunities and resources.

**Fostering good relations between people who share a protected characteristic and those who do not.** YES  / NO

This mean creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference.

**Are there any Human Rights concerns?** YES  / NO

If you have answered 'Yes' please seek advice from the Equality, Diversity and Inclusion Team.

**Compliance with the NHS Standard Contract, including the Accessible Information Standard?** YES  / NO

The Accessible Information Standard requires services to communicate with patients, service users, and their carers in an accessible way depending on their specific needs.

**Please provide a supporting narrative to support your responses to the above questions: This section must be completed**

The ICB and the Trusts have robust policies in place which they adhere to across all hospital sites. These can be found via their organisation websites. The activity that they carry out is contracted via the NHS Standard Contract and therefore the service conditions are applied. The ICB will continue to pay due regard and fulfil statutory duties to involve people in the development of the proposals.

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## 5. Options Appraisal

Use the space provided below to elaborate on your decision based on the findings of the IDMF equality analysis – Please complete one of the following options (1,2, 3 or 4) by adding appropriate comment.

Options	Tick one box
1. <b>Accept the proposal</b> – no equality impacts identified	<input type="checkbox"/>
2. <b>Adjust the proposal</b> - take steps to remove barriers to advance equality.	<input type="checkbox"/>
3. <b>Continue the proposal despite negative equality impacts</b> – this can ONLY be done if the negative impacts can be objectively justified. <b>Seek advice from your EDI team.</b>	<input type="checkbox"/>
4. <b>Stop the proposal</b> – the policy shows unlawful discrimination and adverse effects that cannot be mitigated.	<input type="checkbox"/>

Rationale for above decision

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## 6. Monitoring, Re-Evaluation, and Publishing

Please outline any actions or recommendations arising from this assessment of the proposal. A target completion date is required for all actions and recommendations.

What specific actions can your work programme or project take to maximise the potential for positive impacts and/or to mitigate the negative impacts on health inequalities?\*

- How can you act on the specific causes of inequalities identified above?
- Could you consider targeting action on populations who face the biggest inequalities?
- Could you design the work with communities who face the biggest health inequalities to maximise the chance of it working for them?
- Could you seek to increase people’s control over their health and lives (if appropriate)?
- Could you use civic, service and community-centred interventions to tackle the problem – to maximise the chance of reaching large populations at scale?
- Who else can help?

How will you quantitatively or qualitatively monitor and evaluate the effect of your work on different population groups at risk of health inequalities? What output or process measures could you consider?\*

Action Required	Lead Person and Resources Required	Target Date	Outcome
We will monitor the areas where we have identified a negative impact and ensure that the mitigations are in place including our comms plan and ensuring that the alternative service are trained to support our identified cohorts.	Pete Burnett	DD/MM/YYYY	This will take place if the decision to stop the scheme is approved
We will monitor the areas where we have identified a positive impact and ensure that these continue to be in place	Pete Burnett	DD/MM/YYYY	This will take place if the decision to stop the scheme is approved
We will monitor the areas where we have identified a neutral impact to ensure that their status has not changed or improved.	Pete Burnett	DD/MM/YYYY	This will take place if the decision to stop the scheme is approved
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

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## Approval

All IDMF Equality Analysis should have governance oversight via formal committee. Please provide details of the arrangements for formal approval below.

**Name of formal committee/Director approving this assessment:** Joint Executive Team Meeting 14/1/26

**Date of committee meeting (if applicable):** 08/01/2026

**Name of person completing this assessment:** Carrie Harris, Planning Manager & Shaun Cropper EDI Business Partner for assurance 08/01/2026

## What Next?

1. Regularly review the action plan and update the Equality Impact Assessment accordingly. How will the proposal be monitored and by whom? Make plans to revisit the proposal and re-evaluate if there are any addition equality impacts you hadn't previously considered.
2. Save a finalised copy for your records and share via your governance pathways. What are the arrangements for distributing this Equality Analysis where and by whom?
3. Follow any specialist advice or guidance from the EDI Team (if provided).

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# Appendix 2

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## Appendix 2

Hinckley District Hospital images.



Image 1: Hinckley DH Exterior – Main entrance



Image 2: Hinckley DH Exterior



Image 3: Hinckley DH Exterior



Image 4: Hinckley DH Exterior



Image 5: Hinckley DH Interior post asbestos removal



Image 6: Hinckley DH Interior post asbestos removal

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Image 7: Hinckley DH Interior post asbestos removal



Image 8: Hinckley DH Interior post asbestos removal

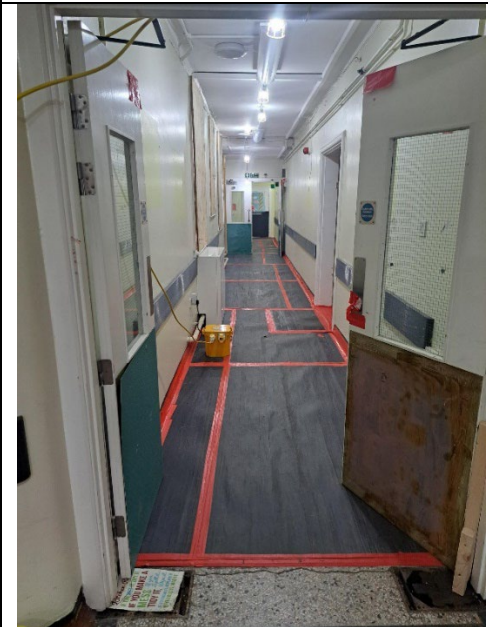


Image 9: Hinckley DH Interior post asbestos removal



Image 10: Hinckley DH Interior post asbestos removal

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# Board Meetings in Common in Public

Report Title: LNR ICBs Planning  
Submission and Response  
– 5 Year Commissioning Strategy

Date of Meeting: 19 February 2026

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13/02/2026 11:50:19

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>19 February 2026</b>		
<b>Report Title</b>	<b>LNR ICBs Planning Submission and Response – 5 Year Commissioning Strategy</b>		
<b>Paper Reference No:</b>	<b>ICBiC-26-04</b>	<b>Agenda Item No:</b>	<b>8.</b>

<b>Presented by</b>	Pete Burnett, Chief Strategy Officer, LNR ICB
<b>Report Author(s)</b>	Ket Chudasama, Deputy Chief Strategy Officer, LLR ICB
<b>Executive Sponsor</b>	Pete Burnett, Chief Strategy Officer, LNR ICB

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input checked="" type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.
<b>Recommendations</b>		
<p><b>The Boards are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>Note</b> the contents of this report</li> <li>• <b>Note</b> the submission of the 5 Year Strategic Commissioning Strategy</li> </ul>		

<b>Executive Summary of the report</b>
<p>The purpose of the 5 Year Strategic Commissioning Strategy is to set long-term priorities that improve population health and reduce inequalities by integrating services, aligning resources and workforce, and providing a sustainable framework shaped by national priorities and local input. The Commissioning Committee discussed the approach for the 5 Year Commissioning Strategy at its meeting on 2 December 2025 and commented upon the first iteration of the Commissioning Strategy (on a page) on 13 January 2026 and this was also presented to the LNR ICB Board for broad consensus on 15 January 2026. The Board confirmed three strategic transformation priorities and emphasised the need for a bold, iterative plan that clearly explains expected changes for patients and staff.</p> <p>The 5 Year Strategic Commissioning Strategy sets out how we, as the strategic commissioners of NHS services across Leicestershire, Northamptonshire and Rutland, will improve population health, reduce inequalities and improve access to high-quality, efficient healthcare for the people we serve over the next five years. The Strategy was submitted to NHSE on 12 February 2026.</p>

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

<input checked="" type="checkbox"/>	<b>Improve Outcomes</b> - Improve outcomes in population health and healthcare	<input checked="" type="checkbox"/>	<b>Health Inequalities</b> - Tackle inequalities in outcomes, experience, and access
<input checked="" type="checkbox"/>	<b>Value for money</b> - Enhance productivity and value for money	<input checked="" type="checkbox"/>	<b>NHS Constitution</b> - Deliver NHS Constitutional and legal requirements
<input checked="" type="checkbox"/>	<b>Social and economic development</b> - Help the NHS support broader social and economic development		

**Conflicts of interest – Please select**

<input checked="" type="checkbox"/>	No conflict identified
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision
<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	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: 2, 4, 5, 10, 11	NICB BAF No: 3, 6, 8, 10
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<b>Appendices</b>	<b>Appendix 1 – Cluster Integrated Needs Assessment</b> <b>Appendix 2 – 5 Year Commissioning Strategy</b>
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**Who has been engaged and where else has this report been considered:**

*Commissioning Strategy Committee members have been engaged, system partners across LNR, to include UHL, UNH, NHFT, LPT, Local Authority, Public Health Leads, Strategy Leads, Clinicians from UHL, General Practice leads.*

**Implications: Select which of the following implications need to be considered**

<input checked="" type="checkbox"/>	<b>Quality &amp; Patient Safety</b>	<input type="checkbox"/>	<b>Legal</b>	<input checked="" type="checkbox"/>	<b>Equality, Diversity &amp; Inclusion</b>		
<input type="checkbox"/>	<b>Environmental</b>	<input checked="" type="checkbox"/>	<b>Data &amp; Digital</b>	<input checked="" type="checkbox"/>	<b>Financial</b>	<input checked="" type="checkbox"/>	<b>Workforce</b>

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# LNR ICBs Planning Submission and Response – LNR 5 Year Commissioning Strategy

## Introduction

The purpose of the 5 Year Strategic Commissioning Strategy is to set long-term priorities that improve population health and reduce inequalities by integrating services, aligning resources and workforce, and providing a sustainable framework shaped by national priorities and local input.

The strategy sets out how we, as the strategic commissioners of NHS services across Leicestershire, Northamptonshire and Rutland, will improve population health, reduce inequalities and improve access to high-quality, efficient healthcare for the people we serve over the next five years.

We face significant and growing challenges:

- An ageing population with increasing frailty and multimorbidity
- Widening health inequalities driven by deprivation
- Rising demand for urgent, emergency and elective care
- Sustained pressure on general practice access
- Workforce constraints
- Ongoing financial pressure

These challenges are closely connected. Difficulty accessing timely GP care contributes to worsening health, avoidable emergency department attendances and long waits for planned treatment. Without a fundamental shift in how care is commissioned and delivered, demand will continue to outpace capacity, leading to poorer outcomes and poorer experience for local people.

The development of NHS commissioning across Leicestershire, Northamptonshire and Rutland reflects a shift towards a more strategic, population focused and partnership driven model. The evolution demonstrates how commissioning will move from transactional service oversight to a systemwide approach that integrates prevention, neighbourhood models, and long-term transformation priorities.

Our aim is to improve health outcomes and reduce inequalities by shifting from reactive, hospital-centred care to proactive, preventative and integrated support delivered as close to home as possible.

## Cluster-integrated needs assessment

The foundation of the 5 Year Strategic Commissioning Strategy is the Cluster Integrated Needs Assessment 2026/27 - 2030/31 (appendix one). This report is a system-wide needs assessment that brings together health, care and wider population data to understand current and future health needs across the population. This needs assessment has provided us with the evidence base to support our understanding of what the population needs now and over the next 10 years, and how services must change to meet these needs.

The Cluster Integrated Needs Assessment is supported by a wider evidence base – LLR and Northamptonshire have both developed health profiles for the ICBs and have published health inequalities annual reports. The five places across LLR and Northamptonshire have developed Joint

Strategic Needs Assessments and Joint Health and Wellbeing Strategies. The ICBs are also developing neighbourhood health intelligence data and resources to support the development of neighbourhood health approaches. The Cluster Integrated Needs Assessment has considered the breadth and depth of these reports to identify the key health and wellbeing challenges that we need to address through the 5 Year Strategic Commissioning Strategy.

The key health needs that were identified through the Cluster Integrated Needs Assessment are:

### **Demographic growth**

- The population is projected to increase by 2.3% by 2030. However, the growth in population is distributed towards older people. The ageing population will drive increases in people with frailty and people with complex multi-morbidity which will drive an increase in the need and demand for services
- The need for health and care services will grow faster than overall population growth rate for all health and care sectors, including primary, community, mental health and acute hospital services.

### **Health inequalities**

- The needs assessment sets out the inequalities in life expectancy and healthy life expectancy across LLR and Northamptonshire, particularly in Leicester City and North Northamptonshire, and illustrates that that the most significant causes of the gap in life expectancy for the cluster are attributable to cancer, cardiovascular disease and respiratory disease
- There is a need to focus on Core20+ groups, including people living in areas of deprivation and people living with conditions where there are known health inequalities, where there is clear evidence of lower life expectancy, people develop long term conditions earlier in life and spend more time living in poor health
- The strategic commissioning intentions must target and address poorer health outcomes in Leicester City and in areas of deprivation in LNR.

### **Children and young people**

- Giving every child the best start in life is the most important policy objective for reducing health inequalities
- The needs assessment identifies a need to strengthen support for CYP and families, with an initial focus on mental health and neurodiversity.

### **Three common conditions linked to preventable risk factors**

- Cardiovascular diseases, cancer, and respiratory diseases are the largest causes of inequalities, morbidity and mortality for the cluster.
- It is also noted that mental health and Musculo-skeletal conditions drive a significant burden of disability in LLR
- Obesity, blood glucose, hypertension, smoking and alcohol are identified as the biggest preventable risk factors driving the “big three”, and many other long-term conditions.

### **System sustainability**

- The drivers of current and future health needs for the cluster mean that we need to do things differently to manage the growing health needs in our population
- There is a need for a system focus on the three left shifts, supporting the shift from acute to

community, treatment to prevention and analogue to digital and the development of neighbourhoods to support this

- It is essential that the plans that the ICB develops as strategic commissioners are sensitive to the underlying growth across all health and care sectors and that this should be a core component as the system develops new models of care
- Transforming services for people with frailty will be essential for future sustainability.

## Development of the Commissioning Strategy

Engagement across Leicester, Leicestershire, Rutland and Northamptonshire has been broad, collaborative and iterative, supporting the development of a coherent cluster-wide Strategic Commissioning Strategy.

This work has helped build a shared understanding of the future strategic role of the ICB Cluster, the underlying health needs across both ICBs, current service challenges, and the interventions required over the next five years.

Pre-Christmas workshops brought together providers, local authorities, commissioning leaders and GPs to review the evidence base and identify the three strategic priorities:

- Preventable Mortality, with a focus on cancer, respiratory disease and cardiovascular disease
- Frailty
- Children and Young People's Mental Health and Neurodiversity (CYP MH & ND).

These sessions also generated initial interventions for each area.

Post-Christmas, further workshops were held to refine these interventions and begin shaping delivery roadmaps. These sessions involved colleagues from preventable mortality, frailty, CYP services, mental health, neighbourhood teams and strategic planning functions.

A collaborative, engagement-led approach to strategic commissioning has shaped how interventions should be designed and delivered, considering the financial, workforce, digital and estates implications. Partners also highlighted key delivery risks and the importance of aligning commissioning intentions with local authority, provider and neighbourhood plans. This collective effort ensures the emerging Five-Year Strategic Commissioning Strategy is grounded in clinical insight, operational reality and shared system ambition.

## Summary of the Commissioning Strategy

The Strategy sets a strategic ambition to move from reactive, hospital-centred care towards proactive, preventative and integrated support delivered closer to home. As strategic commissioners, the ICBs will focus on: centred care towards proactive, preventative and integrated support delivered closer to home:

- Targeting communities with the greatest need, including Core20PLUS5 groups
- Investing earlier to prevent avoidable illness, deterioration and crisis
- Strengthening neighbourhood based, multidisciplinary models of care based, multidisciplinary models of care
- Reducing unwarranted variation in access, quality and outcomes
- Using data, digital tools and workforce capacity more effectively

## What will change

Neighbourhoods will become the core delivery unit, with Integrated Neighbourhood Teams bringing together general practice, community services, mental health, social care and the VCSE sector to provide coordinated, person-centred support. This will improve access, reduce fragmentation, and help people receive the right support earlier, reducing pressure on emergency departments and enabling hospitals to focus on planned care recovery. Investment will gradually rebalance from hospital settings towards neighbourhood, primary and community services, while maintaining high quality acute care for those who need it.

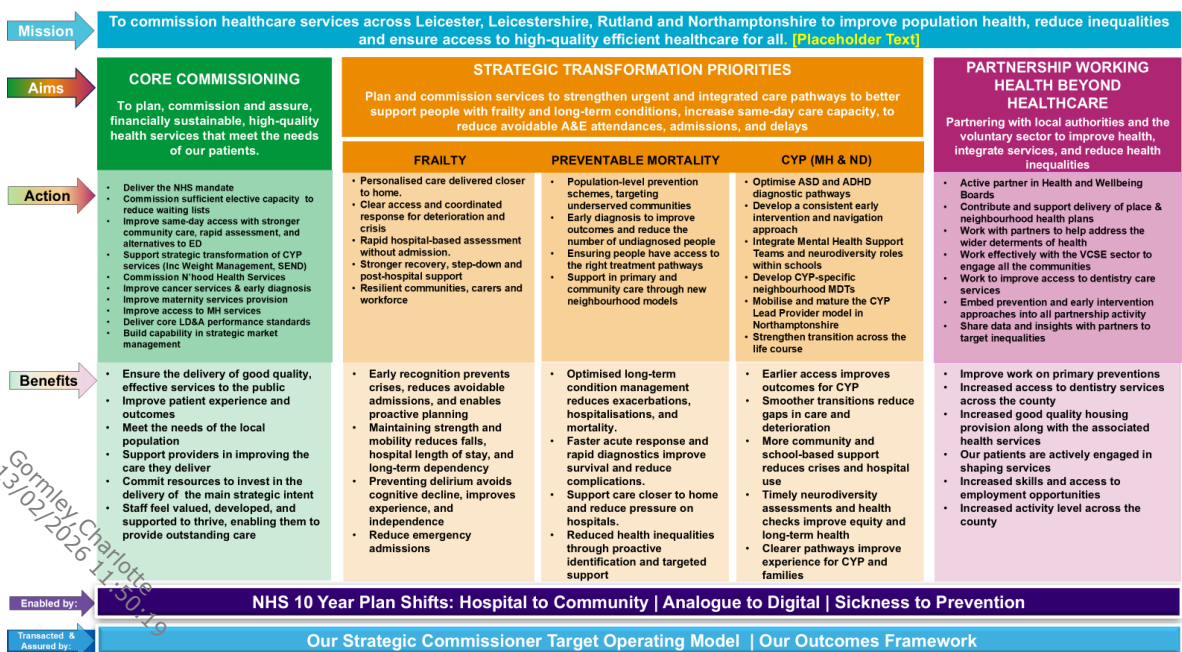
**Commissioning priorities:** The Plan focuses on a small number of areas where strategic commissioning can have the greatest impact:

- **Elective care:** improving access, reducing long waits and modernising pathways
- **Urgent and emergency care:** building a resilient, integrated system with stronger prevention and alternatives to admission
- **Neighbourhoods:** developing a Neighbourhood Health Service supported by digital connectivity and population health management

Alongside these system priorities, three strategic transformation priorities address the most significant population health challenges across LNR and are presented in figure 1:

- **Frailty:** enabling people to live independently for longer through early identification and proactive, personalised support
- **Preventable mortality:** reducing early deaths from cardiovascular disease, cancer and respiratory disease through prevention, early diagnosis and improved long term condition management term condition management-term condition management
- **CYP mental health and neurodiversity:** creating a joined up, needs led system with earlier, more equitable access, reduced waiting times and better transitions

Figure 1: Commissioning Strategy (on a page)



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

## Delivering the Strategy

Delivery will rely on strong partnership working across the NHS, local authorities and the VCSE sector. Much of the change will be driven locally through neighbourhoods and places, with the ICB Cluster setting strategic direction, aligning incentives, assuring quality and enabling improvement.

This strategy provides a clear, shared framework for action over the next five years. By working collectively with partners and communities, the system will reshape care to better meet the needs of the population now and in the future. Further work will be undertaken to develop delivery plans

We recognise that the five-year commissioning strategy needs to be edited to improve accessibility. We will produce a shorter, easier-to-read version, and undertake further work to ensure the full commissioning plan is accessible, clear, and user-friendly.

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# Appendix 1

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# Our Cluster Integrated Needs Assessment

2026/27 – 2030/31

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

# Contents

1. Purpose and Scope
2. Our Landscape
3. Our Integrated Needs Assessment
4. Alignment to existing system strategies

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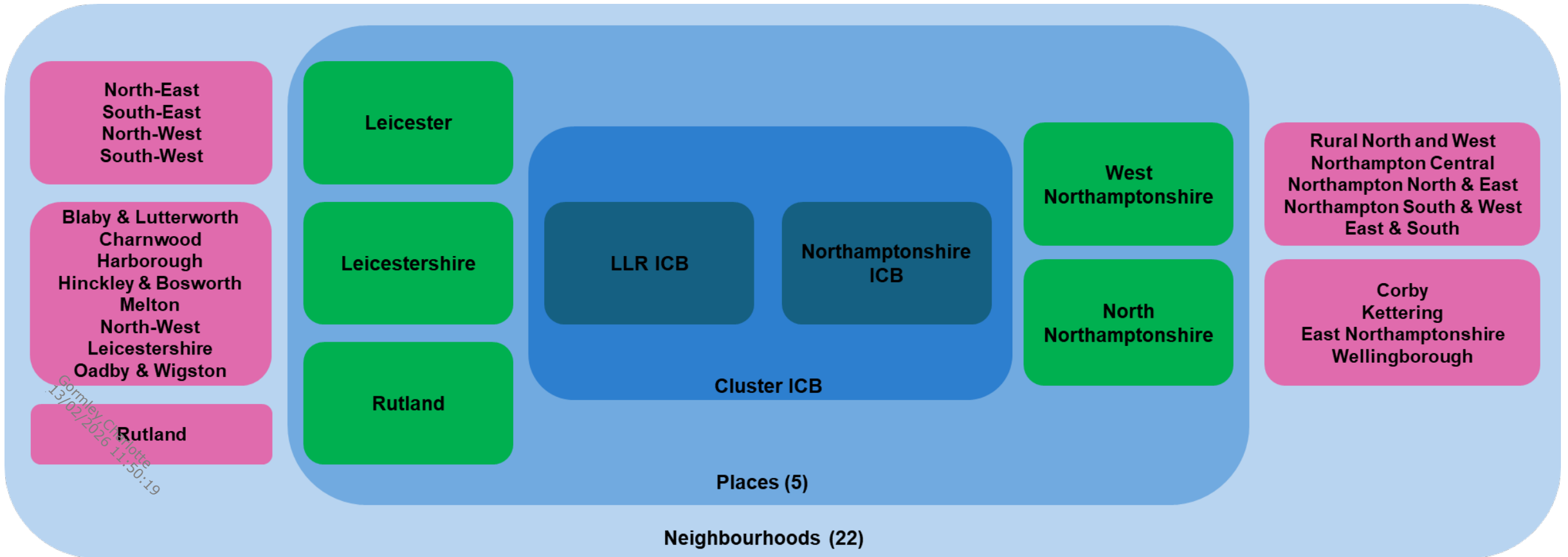
# 1. Purpose and Scope

- An Integrated Health Needs Assessment (IHNA) is a system-wide assessment that brings together health, care, and wider population data to understand current and future health needs across its population and to shape long-term commissioning decisions under the NHS 10 Year Health Plan
- It should provide an evidence base to better understand what our population needs now over the next 10 years, and how must services change to meet those needs
- An IHNA is the mechanism that enables the three major shifts in the 10YP (Hospital to Community, Analogue to Digital and Sickness to Prevention) by providing a single, integrated view of need across health, social care, and wider determinants
- This document acts as the precursor to our 5-Year Strategic Commissioning Plan which operationalises our IHNA into specific commissioning intentions, outcomes, metrics and delivery mechanisms.

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# 2. Our Landscape

Whilst operating as individual statutory organisations, in line with national directives, NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board and NHS Northamptonshire Integrated Care Board are working under a cluster arrangement. This means between our two organisations, we have single board, a unified leadership team and over time a shared staffing structure. Our cluster allows us to drive forward with delivering the mandate of the NHS 10-year plan within the communities and neighbourhoods we serve and continue to improve health outcomes while at the same time rise to the very real financial challenges we face. Importantly, with these new arrangements, primacy of place and neighbourhood remain integral to how we plan, commission and improve services, enabling locally led solutions within a shared strategic framework.



# 3. Our Integrated Needs Assessment: Key messages

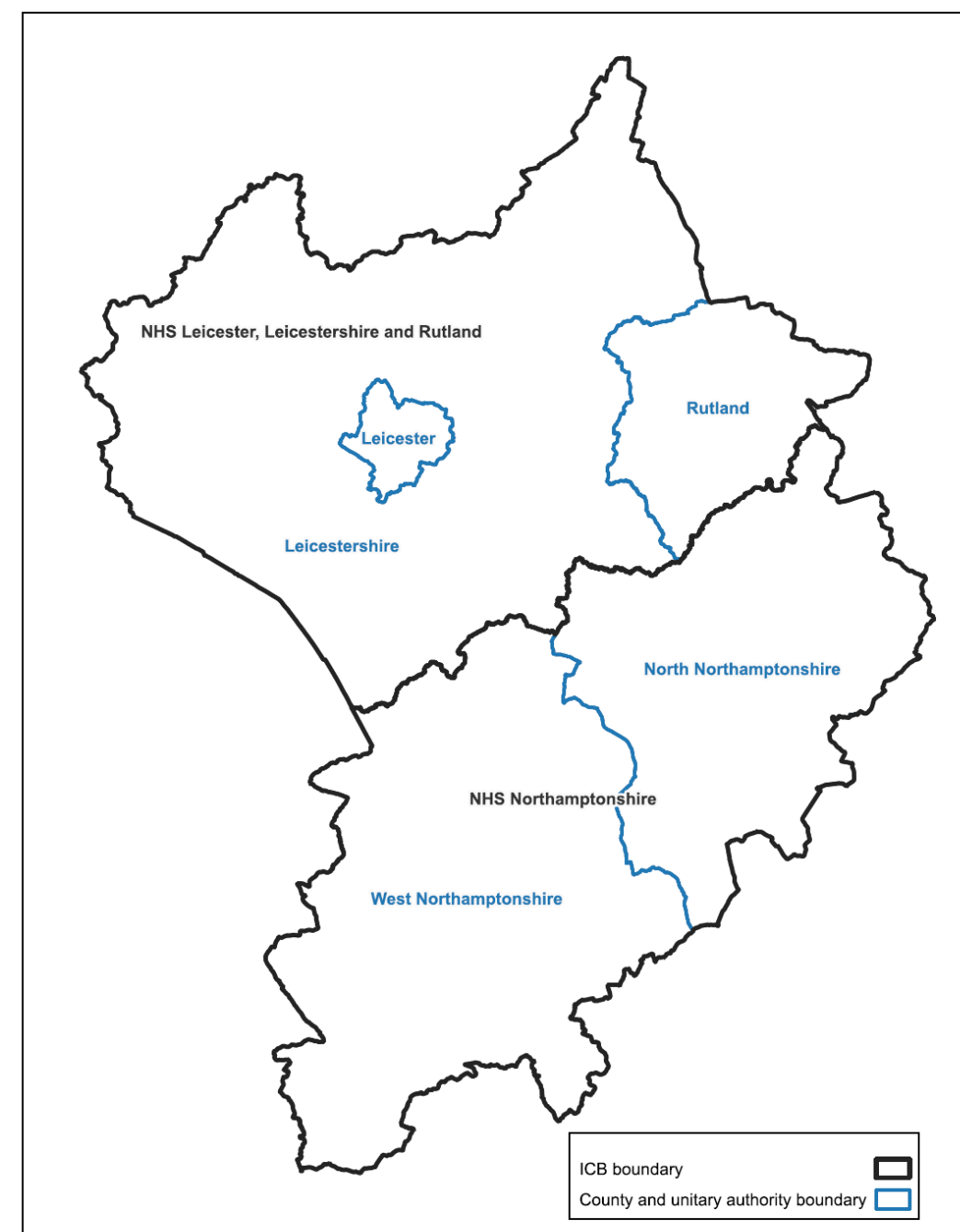


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# Northamptonshire, Leicester, Leicestershire and Rutland

- 2,086,090 patients registered with GP practices (September 2025)
  - 852,545 in Northants
  - 1,233,545 in LLR
- 191 GP practices
  - 65 in Northants
  - 126 in LLR
- 5 Local Authorities
- 21 Neighbourhoods
  - 9 In Northants
  - 12 in LLR

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# Population and Demographic Growth in LNR



- In 2024, for the ICB cluster
  - Resident population of 1.989 million
  - 19,205 live births
  - 17,082 deaths
- In the next 5 years (2026-2030), the population is projected to rise to 2.059 million, an increase of 2.3%
- The population aged 80 and older is expected to grow the fastest, increasing by 20.6% by 2030
- The population of children is expected to reduce across Northamptonshire and Leicester, Leicestershire and Rutland between 2026 and 2030
- The ageing population structure across the cluster, in particular the growth in older age groups, will drive an increase in patients with higher health and care needs

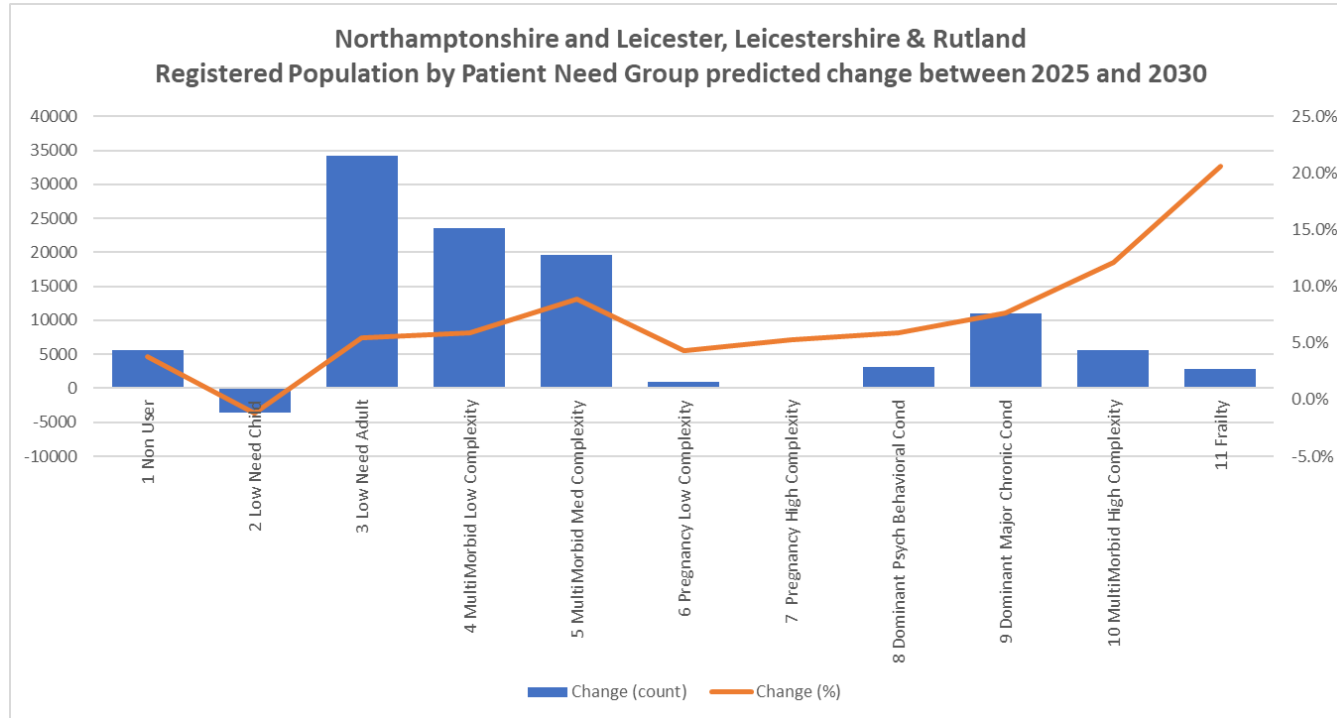
## Population Estimates and Projections

Source: 2024 Population Estimates, 2022 Based Sub National Projections, Office of National Statistics

	Estimate	Projection					Growth %
	2024	2026	2027	2028	2029	2030	2026-2030
<b>00-04</b>	104,511	101,020	99,873	99,761	99,621	99,318	-1.7%
<b>05-09</b>	118,244	113,054	112,299	110,322	108,920	107,583	-4.8%
<b>10-14</b>	125,683	123,022	121,657	120,976	120,270	119,462	-2.9%
<b>15-24</b>	246,737	258,516	261,651	264,425	265,896	267,417	3.4%
<b>25-39</b>	399,508	404,414	403,804	402,676	403,043	402,923	-0.4%
<b>40-64</b>	630,816	638,333	642,007	646,383	650,656	655,303	2.7%
<b>65-79</b>	265,917	272,557	273,352	275,791	279,444	284,210	4.3%
<b>80+</b>	96,112	102,204	109,336	115,064	119,606	123,236	20.6%
<b>All Ages</b>	1,987,528	2,013,120	2,023,979	2,035,397	2,047,456	2,059,451	2.3%

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# Population health – Drivers for commissioning intentions: Population growth and demographic change



- Population growth is highest in those in poor health
- Over the next five years we forecast:
  - 21% increase in frailty (3,000)
  - 6,000~ more patients with high complexity LTCs (12%)
  - 43,000~ more patients with low / medium complexity LTCs, particularly depression, hypertension and diabetes (7%)

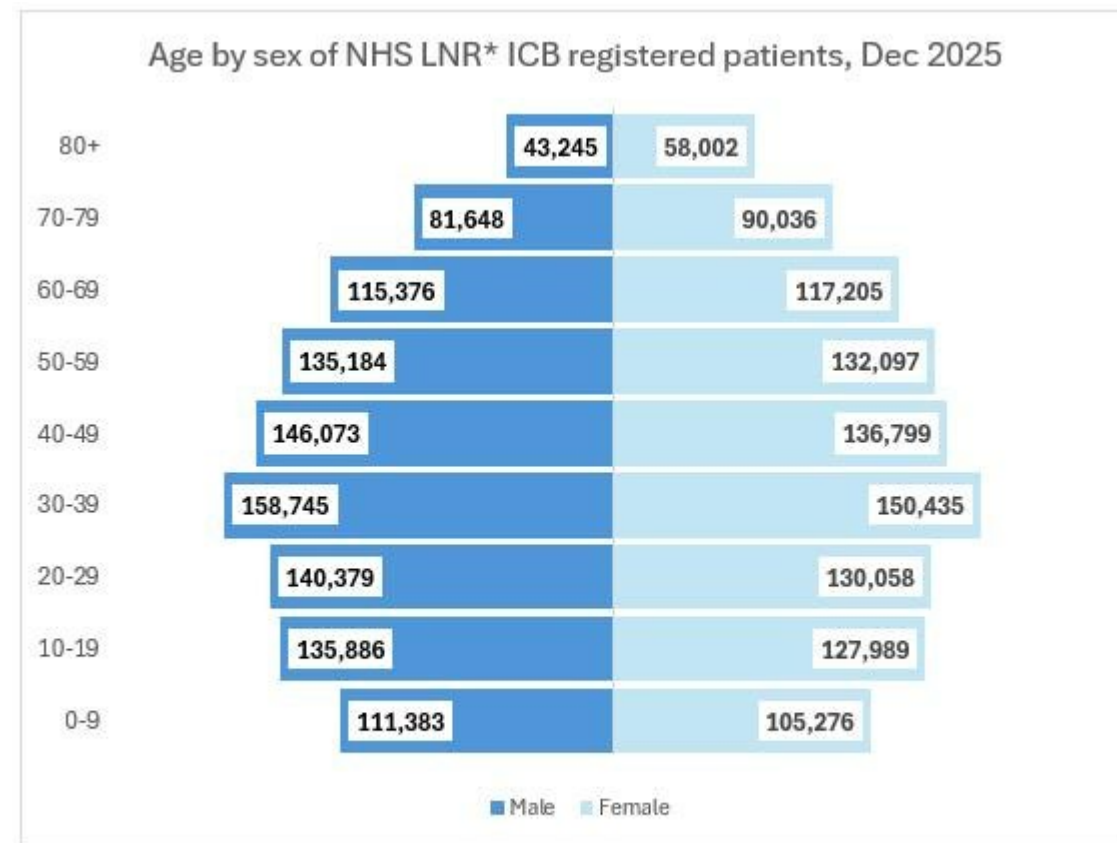
Data is sourced from LLRs PHM data in Aristotle and Northamptonshires NARP data

In the chart

- the blue bar represent the absolute growth in patients, which is highest in the low to medium health need groups.
- the orange line represents the % growth which is highest in PNGs reflecting highest health needs which is reflected in the forecast admissions and primary and community care growth

# LNR registered population

- Nearly half of the population consists of working-age adults between 30 and 59 years old (41%)
- Children and young people under the age of 20 make up nearly a quarter of the total population (23%)
- Young adults aged 20-29 years account for roughly one in eight people (13%)
- Adults aged 70 years and older make up over 1 in 10 of the total population (13%)
- The population is broadly balanced between males and females across most age groups
  - a slightly higher number of females is observed in the older age categories, particularly among patients aged 80+
  - a slightly lower number of females is seen in younger ages, in particular those aged 19 and under

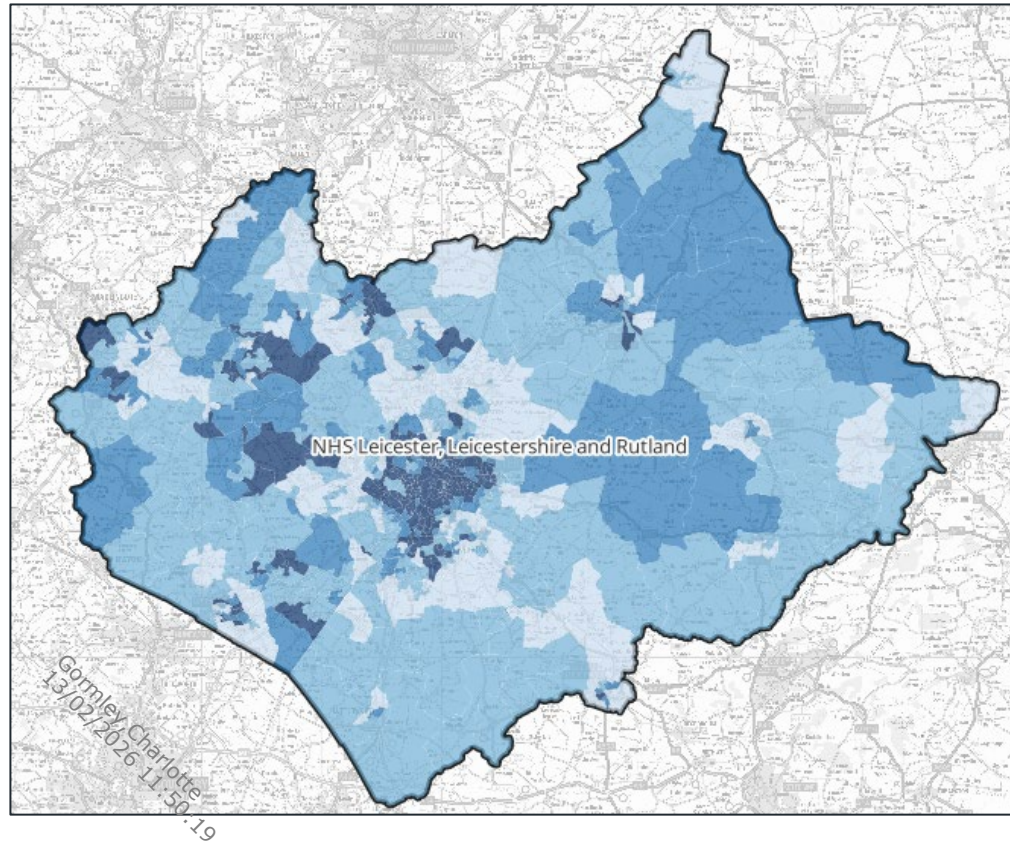


\* LNR: Leicester, Leicestershire, Rutland, and Northamptonshire  
Source: NHS Digital, 2025

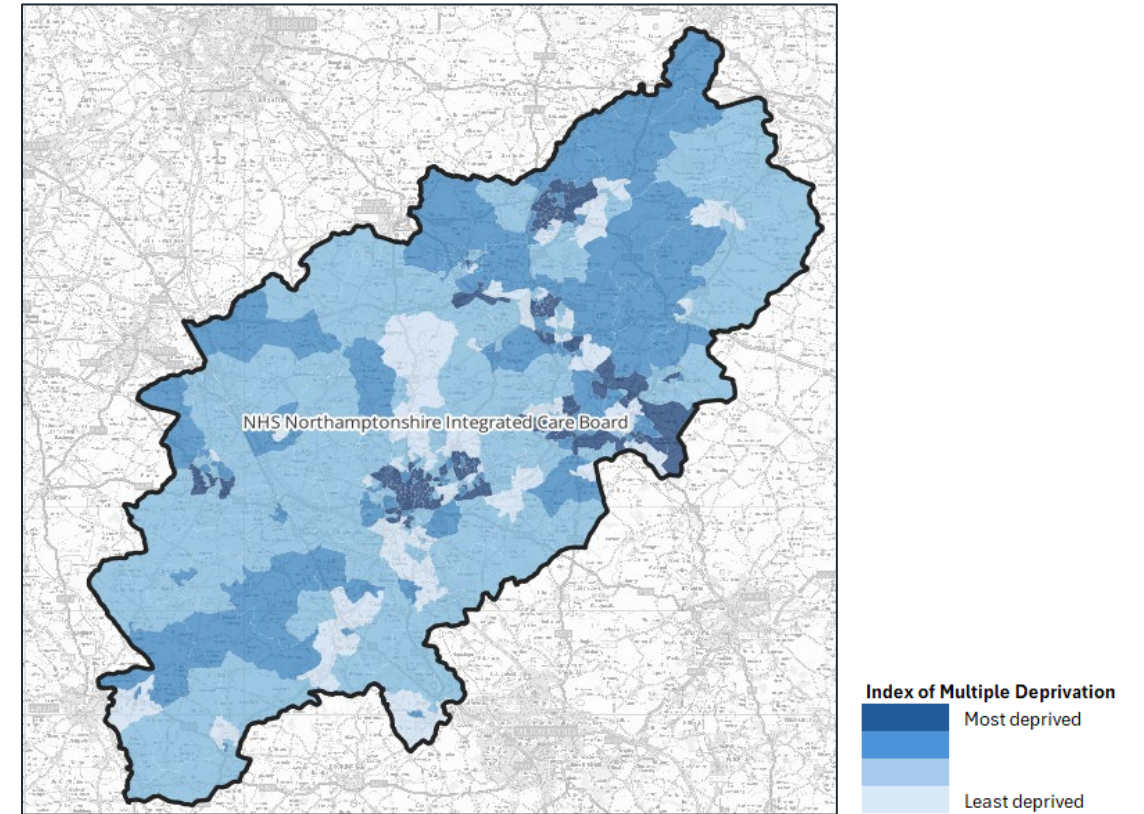
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# Deprivation

### Levels of deprivation in LLR at Lower Super Output Area level



### Levels of deprivation in Northamptonshire at Lower Super Output Area level



Source: Index of Multiple Deprivation, ONS, 2025

Contains OS data © Ordnance Survey 2025 Licence number: AC000859469. Created by Population Health, NHS Northamptonshire ICB.

# Deprivation

## For the LNR Cluster

- 17% of the population live in Core20 areas, or quintile 1
- Leicester City has the highest percentage of the population living in Core20 areas

## In Northamptonshire

- 12.4% of the population live in Core20 areas
- around one-third live in the most or more deprived areas (deprivation quintiles 1 and 2)
- almost half of the registered population lives in the less or least deprived areas (deprivation quintiles 4 and 5)
- North Northamptonshire has a higher proportion of residents living Core20 areas compared to West Northamptonshire

## Within Leicester, Leicestershire and Rutland (LLR)

- 20.3% of the population live in Core20 areas
- over one-third of the population lives in the most or more deprived areas (deprivation quintiles 1 and 2)
- nearly half live in the less or least deprived areas (deprivation quintiles 4 and 5)
- deprivation varies considerably across LLR, with more than half of Leicester's population living in Core20 areas (53.3%)

Overall 2025 Index of Multiple Deprivation - % of registered population

	Deprivation Quintile (1=most deprived)				
	1	2	3	4	5
LLNR Cluster ICB	17.0%	17.8%	18.6%	25.5%	21.1%
Northamptonshire ICB	12.4%	20.0%	19.9%	25.4%	22.3%
North Northamptonshire	13.1%	21.4%	23.1%	18.8%	23.6%
West Northamptonshire	11.9%	18.9%	16.7%	30.7%	21.8%
LLR ICB	20.3%	16.3%	17.6%	25.5%	20.3%
Leicester	53.5%	26.5%	14.1%	4.8%	1.1%
Leicestershire	2.4%	11.3%	19.5%	35.7%	31.1%
Rutland			15.4%	52.6%	32.0%

Source: English Indices of Deprivation 2025, DCLG

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# Ethnicity (2021 Census)

Ethnic group	Leicester	Leicestershire	North Northamptonshire	Rutland	West Northamptonshire	LNR
Total: All usual residents	368,571	712,366	359,523	41,050	425,723	1,907,233
Asian, Asian British or Asian Welsh	159977 (43%)	58066 (8%)	12726 (4%)	634 (2%)	22463 (5%)	253866 (13%)
Black, Black British, Black Welsh, Caribbean or African	28766 (8%)	7913 (1%)	11017 (3%)	552 (1%)	20661 (5%)	68909 (4%)
Mixed or Multiple ethnic groups	13899 (4%)	15543 (2%)	8175 (2%)	744 (2%)	12116 (3%)	50477 (3%)
White	150657 (41%)	623429 (88%)	324664 (90%)	38909 (95%)	365758 (86%)	1503417 (79%)
Other White	25177 (7%)	22856 (3%)	31699 (9%)	1168 (3%)	40628 (10%)	121528 (6%)
Other ethnic group	15272 (4%)	7415 (1%)	2941 (1%)	211 (1%)	4725 (1%)	30564 (2%)

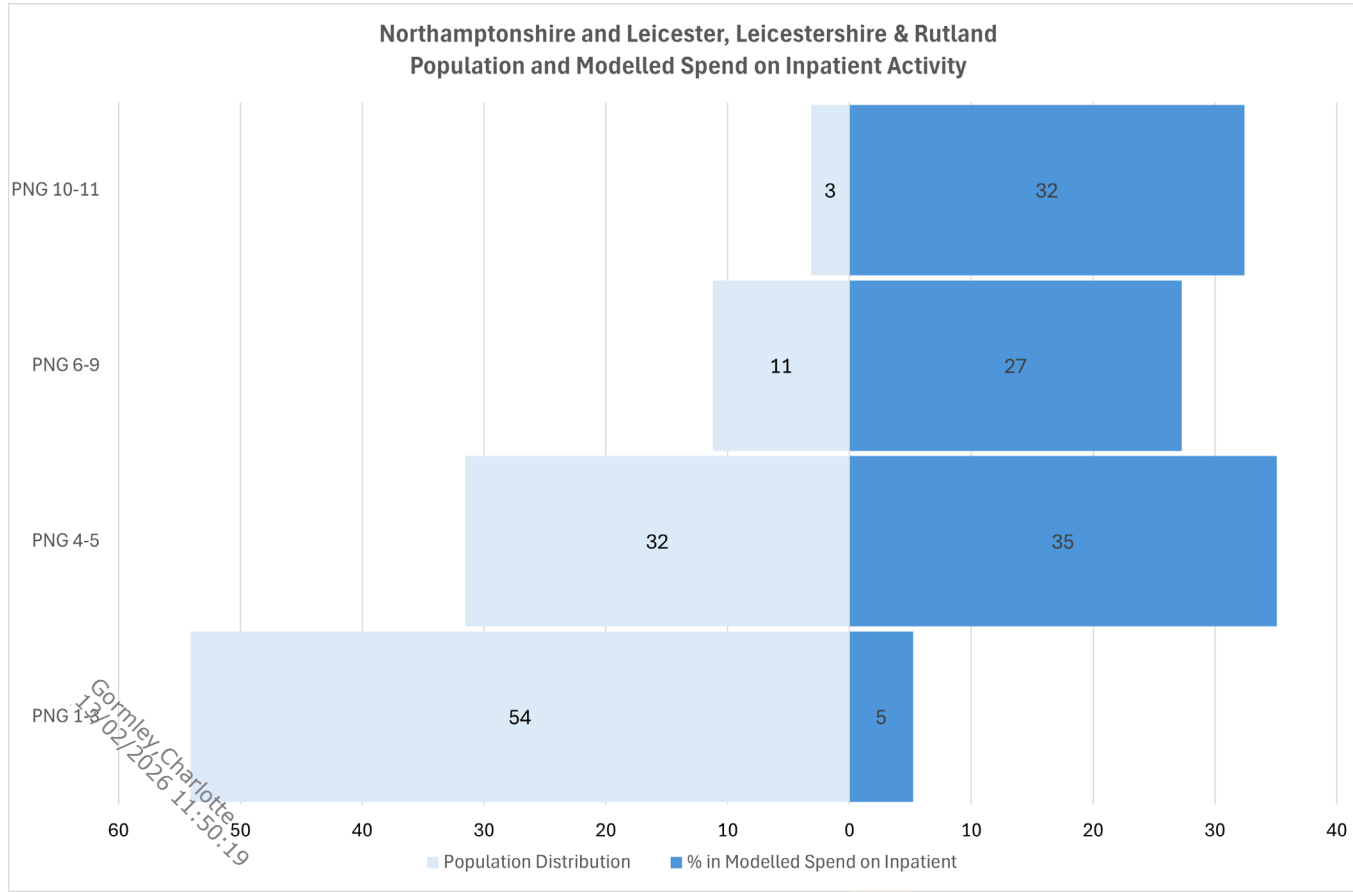
- LLR and Northants has a wide range of ethnic diversity in the population
  - 79% of the population are White
  - 13% are Asian
  - 4% are Black, Caribbean or African
- There is considerable diversity in different parts of LNR
  - 43% of Leicester residents are Asian
  - For Northamptonshire, the most significant ethnic minority group is White other, with individuals of East European origin making up the largest group within this category

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*Note: Other White is included in the White category*

*Source: 2021 Census, Office of National Statistics*

# Population Health: Population and spend on inpatient services by patient need group



- Patient Need Groups (PNGs) enable the grouping of patients into cohorts that have similar health and care needs
- PNGs 1-3: **Non-users, low need child and low need adults**
  - Population 54%, inpatient spend 5%
  - Average spend £42 per person.
- PNGs 4 & 5: **Patients with multi-morbidity and low and medium complexity**
  - Population 32%, acute spend 35%
  - Average spend £483 per person
- PNGs 6-9: **Specific cohorts with high health and care needs – pregnancy, psychiatric and behavioural conditions and patients with a dominant chronic condition**
  - Population 11%, acute spend 27%
  - Average spend £1,056 per person
- PNGs 10 & 11: **Multi-morbid high complexity and frail populations – the populations with highest health care needs**
  - Population 3%, acute spend 32%
  - Average spend £4,469 per person

# The population is living longer but not always in good health

Area	Life Expectancy at birth		Healthy life expectancy at birth		Number of years in poor health		Proportion of life in poor health	
	Male	Female	Male	Female	Male	Female	Male	Female
Leicester	76.5	80.6	56.7	56.3	19.8	24.3	25.9%	30.1%
Leicestershire	80.2	83.7	62.7	62.6	17.5	21.1	21.8%	25.2%
Rutland	81.6	85.1	69.1	69.6	12.5	15.5	15.3%	18.2%
North Northamptonshire	78.7	82.2	60.3	59.9	18.4	22.3	23.4%	27.1%
West Northamptonshire	79.4	83.4	62.4	62.7	17	20.7	21.4%	24.8%
England	79.1	83.1	61.5	61.9	17.6	21.2	22.3%	25.5%

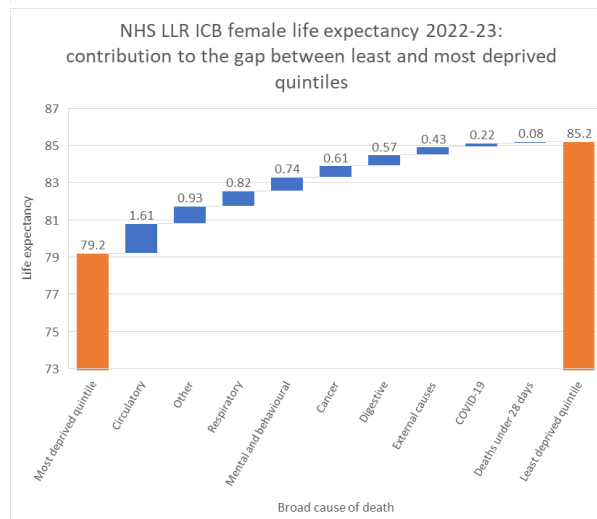
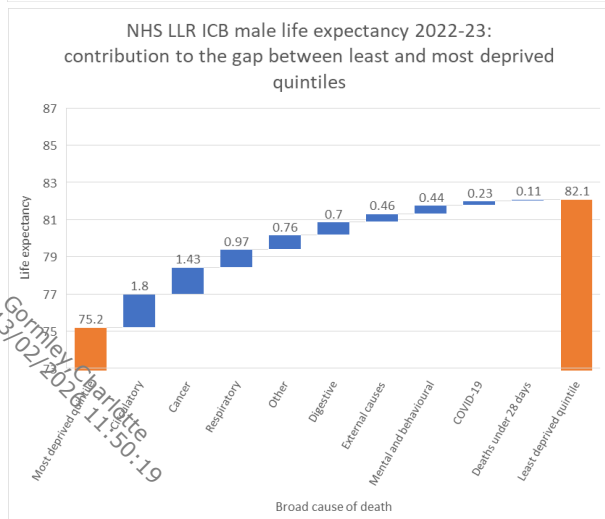
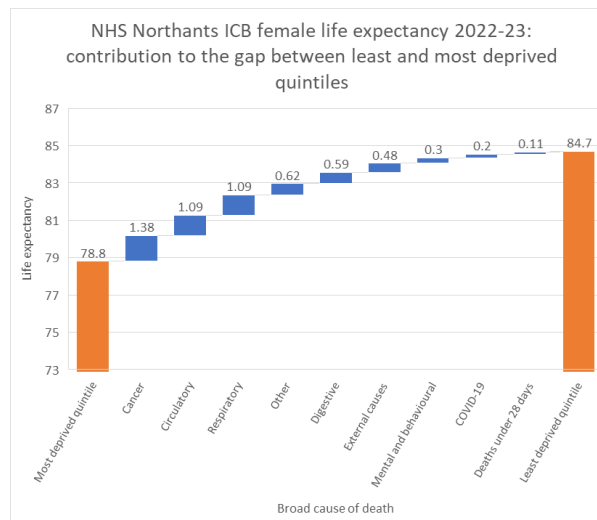
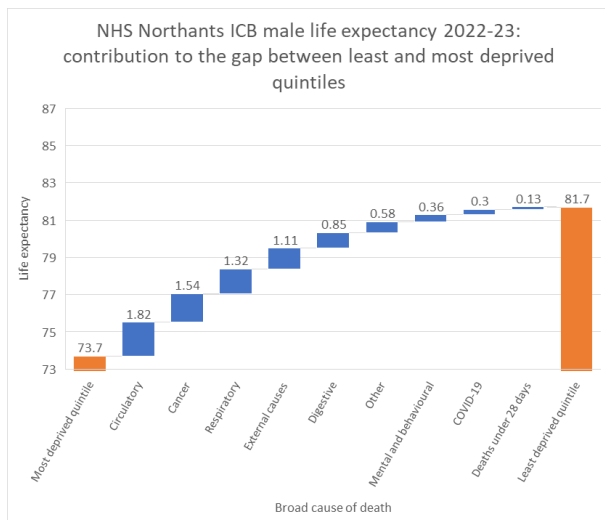
Source: OHID, Fingertips, Life expectancy 2021-2023

Significantly lower than England
Statistically similar to England
Significantly higher than England

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- Life expectancy is the average number of years a person is expected to live for, healthy life expectancy is the average number of years that a person can expect to live with good health
- On average, males born in LNR can expect to live for 79.3 years (17 years in poor health) and females 83 years, (20.8 years in poor health), similar to the England average.
- For all places in LNR, excluding Rutland, the healthy life expectancy is below retirement age – meaning that people will either continue to work with poor health or will be pushed out of the workforce due to poor health.
- There is considerable variation at place level with significantly lower than England life expectancy in Leicester and North Northamptonshire.
- Population of Leicester is expected to spend 26% of their lifespan for males and 30% of their lifespan for females living in poor health.
- Population of North Northamptonshire is expected to spend 23% of their lifespan for males and 27% of their lifespan for females living in poor health.

# Inequalities in Life Expectancy



- In 2023, for LNR residents
  - aged under 75 years - the leading cause of death is neoplasms (36%), followed by cardiovascular diseases (22%) and respiratory disease (9%)
  - all ages - the leading cause of death is neoplasms (27%), followed by cardiovascular diseases (23%) and respiratory diseases (12%)
- Inequalities in life expectancy between the most and least deprived areas are associated with several health conditions. CVD, Cancer and Respiratory disease contribute more than half the gap
  - In Northamptonshire, 4.7 years of the total life expectancy gap is due to circulatory disease, cancer and respiratory disease
  - In LLR, 4.2 years of the total life expectancy gap is due to circulatory disease, cancer and respiratory disease

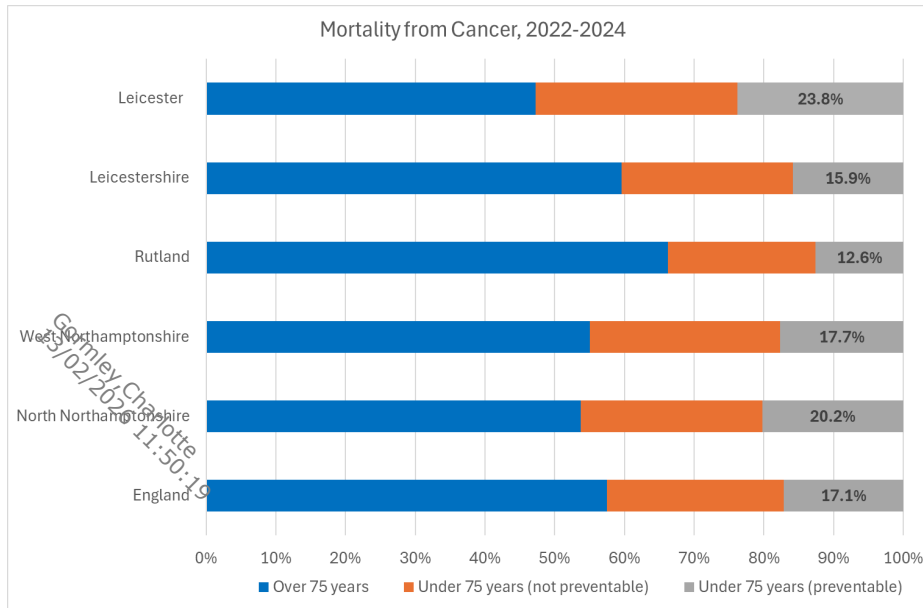
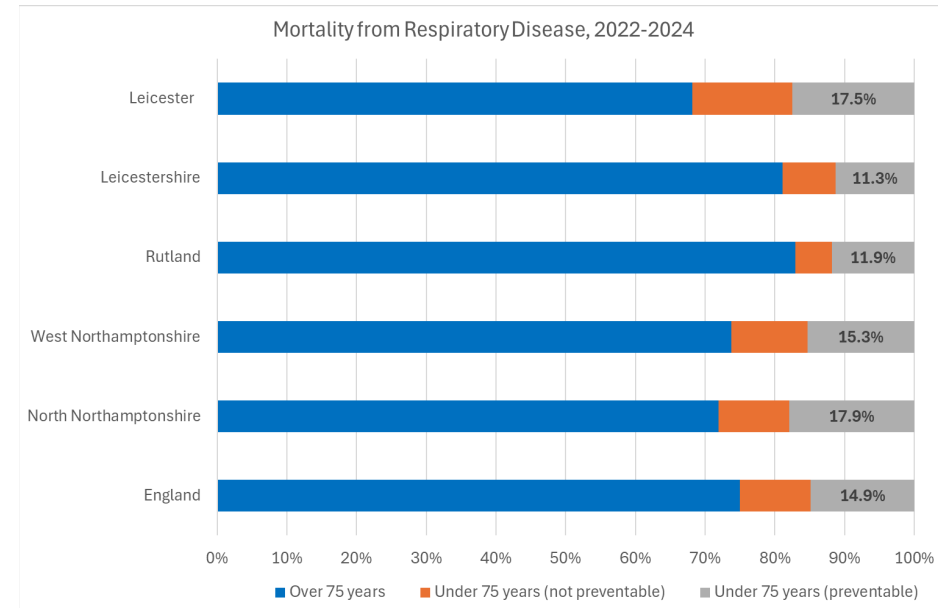
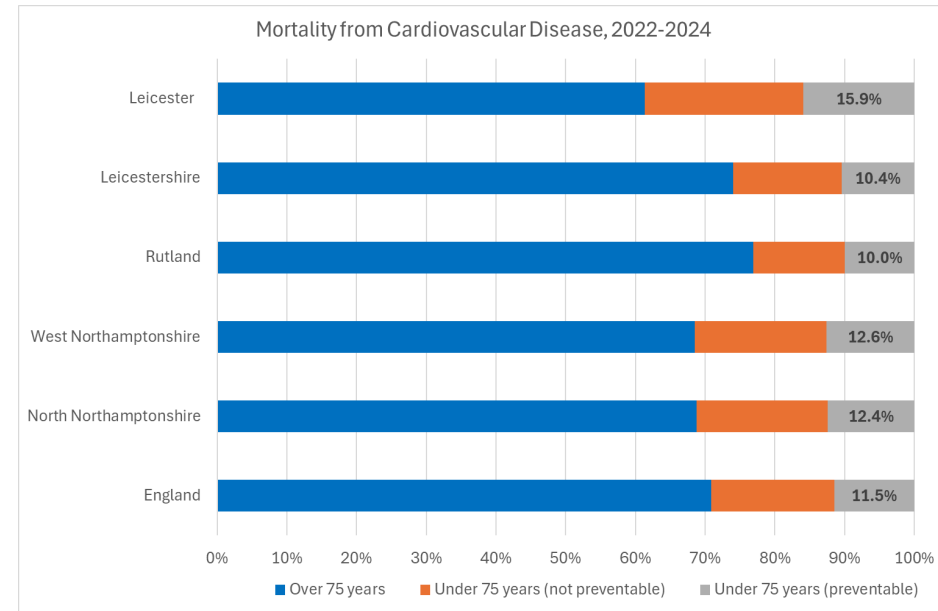
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# Mortality in LNR 2022-24

14% of mortality LNR is estimated to be preventable through healthcare treatment or public health interventions

These graphs demonstrate a significant proportion of preventable deaths across the cluster for the three leading causes of death:

- CVD (12%; 1,503 deaths)
- Respiratory Disease (15%; 896 deaths)
- Cancer (18%; 2,500 deaths)



Source: Fingertips, OHID

# Risk factors and causes that drive ill-health and death in LNR

- Years of life lived with disability will drive the health and care needs of the LNR population
- The Global Burden of Disease enables us to explore the risk factors that drive ill-health and death locally
- The primary risk factors highlighted for LNR are
  - Obesity
  - Tobacco
  - Blood glucose
  - Alcohol
  - High Blood Pressure
- The causes of ill-health that are hidden in the mortality data but drive a significant proportion of the health and care needs in LNR – particularly
  - Musculoskeletal conditions
  - Mental health
  - Diabetes

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# Children and Young People

- **Giving every child the best start in life** is the most important objective for reducing health inequalities. Initial focus identified for mental health and neurodiversity
- Within all place areas in LNR there are significant increasing rates of **children with social, emotional and mental health needs** over the last 5 years. Current rates range from 3.8% identified in Leicester and 4% in West Northamptonshire to 4.2% in North Northamptonshire and 4.5% in Rutland (DfE 24/25)
- Data also shows demand for **SEND** services rising both locally and nationally. Local JSNAs identifying priority areas around early intervention, reducing wait times, partnership commissioning and integrated support
- **Hospital admissions for mental health conditions** highest in West and North Northamptonshire (73.9 and 89.5 per 100,000 population) and hospital admissions as a result of self-harm (10 to 24 years) significantly higher than England for West Northamptonshire (437.2 per 100,000) and Leicestershire (296.8 per 100,000 population)
- Focus on reducing inequalities alongside addressing physical health needs, as identified in the **Core20PLUS** framework including asthma, epilepsy, oral health and diabetes

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# Health outcomes for children and young people

## LLR

- Leicester City has significantly worse health outcomes than England for infant mortality, MMR vaccines, school readiness, 16-17 year olds not in education, employment or training, children in low income families, homelessness, low birth weight, under 18 conceptions, year 6 obesity, 5 year olds with dental decay, babys first breastmilk
- Leicestershire has significantly worse health outcomes than England for immunisations for children in care, babys first breastmilk, hospital admission for self harm
- Rutland does not have any CYP indicators with worse health outcomes than England

## Northamptonshire

- West Northamptonshire has significantly worse health outcomes than England for MMR vaccination rates, 5 year olds with dental decay, Hospital admission for substance misuse, Smoking status at time of delivery and hospital admissions as a result of self-harm
- North Northamptonshire has significantly worse health outcomes than England for 5 year olds with dental decay and smoking status at time of delivery

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# Health Inequalities

- LNR has five diverse places with inequalities in health outcomes at a place level. People living in more deprived areas in LNR get ill much younger and die earlier than people in more affluent areas
- As well as dying younger, the population of Leicester City and North Northamptonshire, for example, are estimated to spend more of their lifespan living with poor health (between 23% and 30%)
- Equitable outcomes and access to services must be a core principle for all our commissioning intentions. Both ICB health inequalities reports show significant health inequalities in all 5 clinical Core20PLUS priorities
- Core20 populations are
  - less likely to access preventative care, less likely to receive LTC management and be diagnosed early when they have Cancer
  - more likely to smoke and be overweight and more likely to attend A&E or be admitted as an emergency
- Closing diagnosis gaps for targeted conditions shifts focus from illness to prevention. Closing the Core20+ inequality gap is the largest efficiency opportunity for the ICBs but requires close partnership working with councils, providers and communities. This is a focus of neighbourhood health

Our evidence base sets out the areas that need to be targeted to reduce health inequalities across LNR

- 14% of deaths across the cluster are considered preventable, from 10% in Rutland, 12% in Leicestershire, 15% in West Northamptonshire, 16% in North Northamptonshire and 19% in Leicester City
- Disease focus should target **cancer, CVD and respiratory**
- Disability focus should include **mental health and MSK**
- Risk factor focus should be **obesity, blood glucose, smoking, hypertension and alcohol**
- **Giving every child the best start in life** is the most important policy objective for reducing health inequalities

# Health Inequalities



Domain	Indicator	Reporting Period	National	Midland	Northamptonshire ICB	LLRICB
Maternity	Deprivation gap in preterm birth rate (% difference)	Oct 24 to Sept 25	2.66%	2.24%	1.69%	1.80%
Maternity	Preterm birth rate of both Black and Asian women compared to White women (ratio)	Oct 24 to Sept 25	1.08	1.01	1.02	1.12
CVD	Deprivation gap in emergency admissions in Myocardial Infarction (% difference)	Apr 24 to Mar 25	35.9%	38.7%	36.0%	32.30%
CVD	Deprivation gap in emergency admissions in Stroke (% difference)	Apr 24 to Mar 25	29.3%	38.5%	28.40%	42.7%
CVD	Patients with GP recorded hypertension, whose last BP reading is to the appropriate threshold, in the preceeding 12 mths (%)	Jul 24 to Jun 25	68.3%	67.9%	66.7%	68.4%
CVD	Patients with GP recorded CVD, whose most recent blood cholesterol is to the appropriate threshold, in the preceeding 12 mths (%)	Jul 24 to Jun 25	47.6%	49.6%	49.1%	55.0%
Cancer	Deprivation gap in cancer early diagnosis (%point difference)	Jan 2024-Dec2024	-6.9	NA	-8.43	-6.06
Respiratory/Vaccines	Deprivation gap in pulmonary rehab completion rate (%point difference)	Mar-25	-8.5	-6.0	-13.4	-13.8
Respiratory/Vaccines*	Deprivation gap in flu vaccination uptake (aged 65+)(%point difference)	31st, Mar, 25	12.8	14.9	12.8	15.8
Mental Health	People with severe mental illness (SMI) receiving a full annual physical health check and health action plan (%)	Oct 24 to Sept 25	58.0%	58.6%	68.0%	68.9%
Learning Disability & Autism	Patients aged 14+ on GP learning disability registers who have had an annual health check (%)	Apr to May 25	8.0%	7.1%	6.8%	6.5%

These measures align with the national health inequality measurement framework and reported in the NHS Performance Overview Dashboard.

Each metric displays the inequality gap (deprivation or by ethnicity)

Northamptonshire outlier for

- MI admissions
- hypertension treated to threshold
- early diagnosis for cancer
- LDA health checks\*

LLR outlier for

- pre-term births
- stroke admissions
- flu vaccinations
- LDA health checks\*

\*local data has highlighted this position is ahead of last year with Q1 data showing 12.5% in LLR and 10.8% in Northants (data as of August 2025)

Worse (Higher/Lower) compared to National (not statistically tested)

Source: Performance Overview Dashboard, NHS England

# Sustainable services – the do nothing scenario – growth rates for our health services

How much will our activity change in 15 years

Today 2040

- LLR is projecting 9% population growth by 2040, in Northants this is 11%
- Activity is projected to rise above the rate of population growth across core areas
  - Primary care 17% in LLR and 14% in Northants
  - Community contacts 27% in LLR and 18% in Northants
  - Inpatient admissions 17% in LLR; inpatient bed days 25% in Northants
  - Outpatients 16% in LLR & Northants

	LLR Projection			Northants Projection		
	2024/25 Activity	2040 Projection	% Growth	2022/23 Activity	2040 Projection	% Growth
1. Primary Care Contacts	8,044,736	9,451,695	17%	4,596,029	5,220,832	14%
2. Community Contacts	1,334,119	1,697,244	27%	806,725	955,786	18%
3. Community Bed Days	80,049	116,692	46%	77,672	92,024	18%
4. Mental Health Contacts	287,799	315,151	10%	716,595	772,933	8%
5. Mental Health Bed Days	97,058	109,784	13%	128,385	139,531	9%
6. LD Bed Days	2,655	2,792	5%	9,630	9,993	4%
7. Acute Emergency Attendances	475,417	522,095	10%	326,250	354,549	9%
8. Outpatients Attendances	1,042,918	1,211,868	16%	1,078,795	1,247,143	16%
9. Inpatients Admissions	263,885	307,821	17%			
10. Inpatients Bed Days				549,708	688,213	25%
Population growth (2022 for Northants; 2024 for LLR)	1,174,900	1,281,576	9%	792,755	878,394	11%

Notes:

- LLR and Northants data drawn from different sources and time points but provide an illustration of potential growth between now and 2040

# Benchmarking opportunities - how does spend in LNR compare with peers (Model Hospital Q1 25/26)

	Non Elective		Elective		Outpatients		A&E		Prescribing	Total Spend		
	Spend (Millions)	Adm	Spend (Millions)	Adm	Spend (Millions)	Att	Spend (Millions)	Att	Spend (Millions)	Totals (Millions)	LNR Total (Millions)	Northants Total (Millions)
<b>Total</b>	<b>£43.90</b>	<b>10765</b>	<b>£25.49</b>	<b>25431</b>	<b>£15.63</b>	<b>125967</b>	<b>£12.30</b>	<b>82319</b>	<b>£21.74</b>	<b>£119.06</b>	<b>£52.26</b>	<b>£66.80</b>
PBC 11 Problems of the respiratory system	£14.57	3139	£1.38	1000	£1.41	8583	£4.10	27590	£0.91	£22.37	£9.39	£12.98
PBC 10 Problems of circulation	£6.33	1080	£4.94	1976	£3.18	52449	£0.60	3802	£4.31	£19.36	£10.44	£8.92
PBC 04 Endocrine, nutritional and metabolic disorders	£1.72	395	£1.43	2901	£0.36	4238	£0.10	470	£12.37	£15.98	£11.93	£4.05
PBC 15 Problems of the musculoskeletal system			£9.69	3389	£3.99	32768	£0.90	6404	£0.18	£14.76	£1.37	£13.39
PBC 13 Problems of the gastro intestinal system	£4.01	1814	£2.54	2927			£2.40	16225	£2.46	£11.41	£6.87	£4.54
PBC 18 Maternity and reproductive health	£8.36	1191	£0.07	98	£0.37					£8.80	£2.79	£6.01
PBC 17 Problems of the genito urinary system	£3.09	1119	£0.75	93	£0.22		£1.60	10908	£0.26	£5.92	£1.20	£4.72
PBC 02 Cancers & tumours	£1.36	183	£2.80	7864		9113			£0.12	£4.28	£1.99	£2.29
PBC 08 Problems of vision		19		664	£1.47	1696	£1.90	13166		£3.37	£1.60	£1.77
PBC 07 Neurological conditions	£0.41	517	£0.30	1035	£0.71	2771	£0.30	2478	£1.13	£2.85	£1.37	£1.48
PBC 03 Disorders of Blood	£0.40	77	£1.08	2454	£0.84	5426				£2.32	£0.06	£2.26
PBC 09 Problems of Hearing	£0.06	22		99	£2.07	4685				£2.13	£0.06	£2.07
PBC 14 Problems of the skin	£1.52	363								£1.52	£1.13	£0.39
PBC 20 Adverse effects of poisoning	£1.36	619								£1.36	£0.92	£0.44

- The table shows all Programme Budgeting Categories (PBCs) where an opportunity of over £1m is identified for the two ICBs combined on Model Hospital. Using regional peers
- Model hospital identifies a total financial opportunity of £119 million (£52 million LLR, £66 million Northants)
- Respiratory is the largest opportunity for the system and LLR, MSK offers the largest opportunity for Northants
- The areas identified within programme budgeting correspond with
  - The disease focus of cardiovascular disease, cancer and respiratory disease
  - The disability focus of MSK
  - The risk factor focus of blood glucose, obesity, hypertension and obesity

*Notes:*

- No costing for A&E so cost of £150 applied
- Benchmark is regional peers

- The population in PNGs 10 & 11- multi-morbid high complexity and frail populations – the populations with highest health care needs are projected to increase by 14% by 2030
- This population currently utilises 32% of Hospital inpatient spend with an average spend £4,469 per person
- We project an additional 8,400 patients in PNGs 10 & 11 by 2023 – this could generate £37 million extra inpatient activity at today's prices if we continue to access healthcare at the same rate
- There are a number of evidence based strategies that the system can use to redevelop pathways to mitigate for potentially avoidable hospital activity

## Potentially mitigable activity

### Redirection 792k bed days

- No overnight stay
- Frailty
- Ambulatory Care Sensitive Conditions
- Readmissions
- End of Life
- Medicines related admissions

### Prevention 242k bed days

- Alcohol
- Smoking
- Obesity
- Mental health
- Self harm

### Relocation 142k bed days

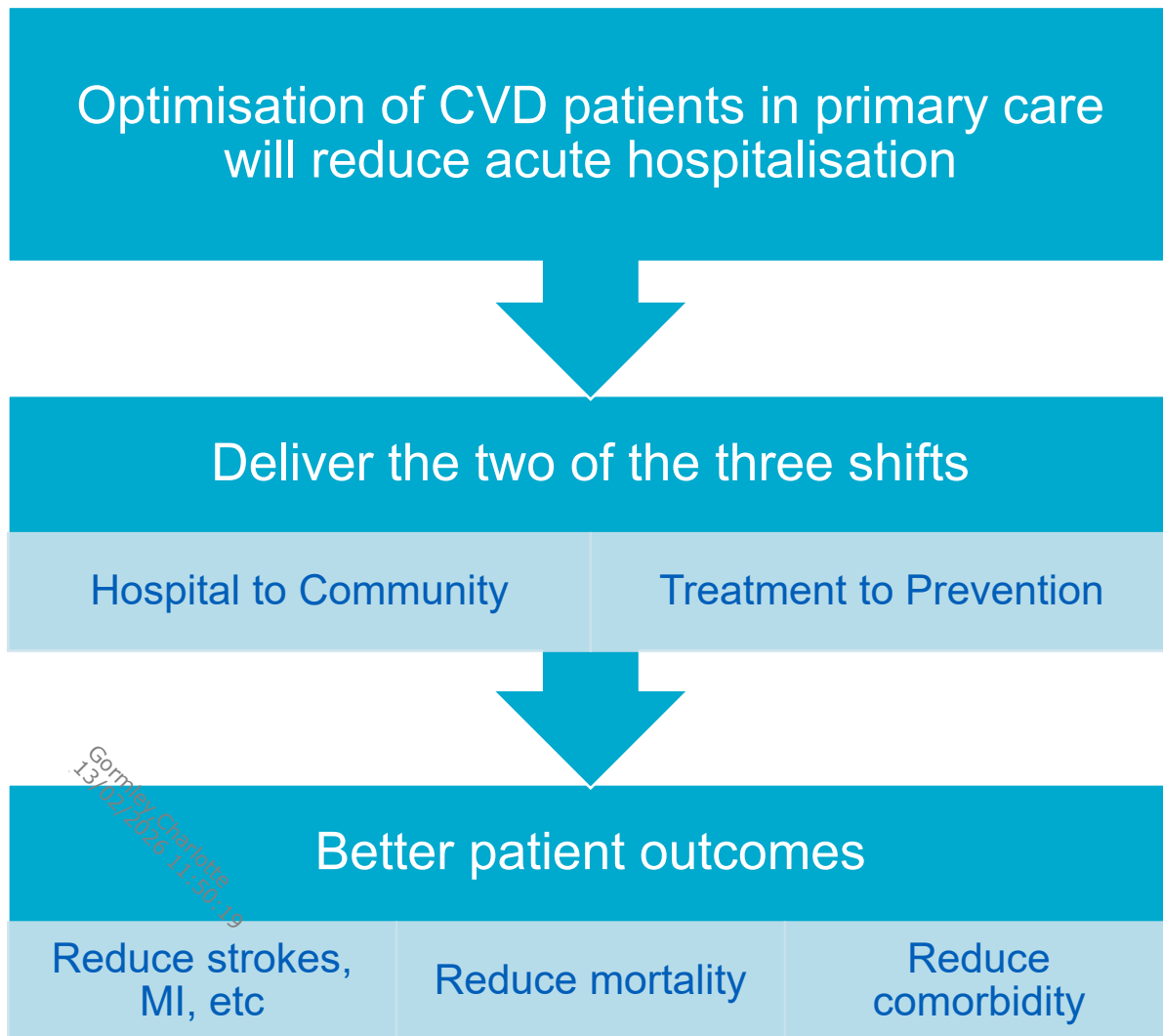
- Virtual Wards

### Efficiencies – LoS Reductions 800k bed days

- Stroke
- MH comorbidity
- Older people

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# Cardiovascular Disease



- If LLR and Northamptonshire were to meet NICE ambitions for **hypertension, lipids, CKD and diabetes optimisation**
- In 3 years
  - Prevent 2,145 health events
  - Cost of £21 million
  - System benefits of £87 million
- In 5 years
  - Prevent 3,442 health events
  - Cost of £33 million
  - System benefits of £174 million
- Closing the diagnosis gap by identifying and adding patients to GP QOF registers will significantly increase potential opportunities for better health outcomes for patients with CVD

- Earlier diagnosis
- Management in primary care
- Care planning - advanced care planning for complex multi-morbidity and care planning for self-care
- Immunisation to prevent acute exacerbation
- Pulmonary rehabilitation for COPD patients
- Strategies for out of hospital care
  - Virtual wards for step up and step down
  - Reducing length of stay
  - Reducing readmissions
  - Ambulatory care sensitive conditions for vaccine preventable and chronic conditions

## Early diagnosis

- 15,000 COPD patients not on QOF registers
- Up to 85,000 asthma patients not on QOF registers

## ED

- Model Hospital 27,590 attendances above benchmark

## Non Elective Admissions

- Model Hospital – over benchmark by 42,300 bed days, potential £14.6 million
- Immunisations\* – 8,780 admissions, potential £22 million
- Virtual wards\* - 20,027 admissions, potential £50 million
- Smoking attributable\* - 12,107 admissions, potential £30 million
- Pulmonary rehabilitation – estimated 8.2% reduction in 12 month hospitalisation following completion
- Patients with COPD should have a co-developed personalised self-management plan

\* indicative cost estimate of £2,500 per admission

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## Early diagnosis

- In 2022, for cancers that were staged across LLR and Northants, 51% were diagnosed at stage 1 or 2
  - 86% breast, 31% lung, 42% bowel, 73% cervix

## Improved survival

- 5 year survival rates for cancers diagnosed in 2016 were 55% in LLR, 54.8% in Northants. Both areas are below the 55.7% for England
- 12 month survival has shown a steady improvement across LLR and Northants between 2005 and 2020

## Performance standards

- Faster Diagnostic Standard - LLR is 67.6%, Northants is 70.1%, 25/26 ambition is 80%
- 62 day combined standard – LLR is 58.5%, Northants is 60%, 25/26 ambition is 75%

## Inequalities

- Deprivation gap in early cancer diagnosis is -6% for LLR and -8% for Northants – both systems have lower percentages of patients diagnosed at stage 1 & 2 for patients living in Core 20 areas

- **Earlier Diagnosis** - By 2028, 75% of people with cancer will be diagnosed at stage 1 or 2 (currently around 51% in LNR)
  - Expanding screening programmes (cervical, breast, bowel)
  - Increasing uptake of lung cancer screening for high-risk groups
  - Lowering GP referral thresholds and accelerating diagnostic pathways
- **Improved Survival** - By 2028, 55,000 more people each year in England will survive their cancer for five years or more
- **Performance Standards**
  - Compliance with Faster Diagnosis Standard (FDS): definitive diagnosis or ruling out within 28 days of referral
  - Meeting modernised cancer waiting time standards (31-day and 62-day targets)
- **Personalised Care** - Every person diagnosed with cancer will have access to personalised care and support throughout treatment and beyond
- **Reducing Inequalities** - Targeted interventions for deprived and vulnerable groups
- Investment in **Research and Innovation**

## Prioritise local and accessible services

- Invest in community hospitals and local hubs
- Improve transport links and digital access
- Tailor services to meet needs of rural, ageing, and diverse populations

## Build trust through communication

- Develop culturally competent, jargon-free messaging
- Ensure consistent, compassionate interactions across all services
- Improve interpreter access and staff training in empathy and communication

## Deliver integrated, person-centred care

- Implement shared IT systems and integrated patient records
- Strengthen collaboration across NHS, social care, and voluntary sectors
- Support smooth transitions between services, especially for mental health and end-of-life care

## Support prevention and self-care

- Promote health literacy and community resilience
- Expand access to mental health support and self-referral options
- Empower carers and patients with tools, information, and choices

## Strengthen support for CYP and families

- Co-design services with young people to ensure relevance and accessibility
- Improve transitions between children's and adult services, especially in mental health
- Prioritise emotional wellbeing and prevention (e.g. sleep, obesity, school-based education)
- Ensure families are recognised as partners in care, with tailored communication and support

# Population Health priorities on a page

## Demographic growth

- Population growth of 2.3% to 2030
- Ageing population = increases in frail population and people with complex multi-morbidity = increase in the need and demand
- Need for health and care services will grow faster than overall population growth rate for all health and care sectors, including primary, community, mental health and acute hospital services

## Health inequalities

- Gap in healthy life expectancy across LNR driven by socio-economic deprivation
- Strategic commissioning intentions must target and address poorer health outcomes in Leicester City and in areas of deprivation in LNR
- Focus on Core20+ groups - lower life expectancy, more time in poor health, develop LTCs earlier in life
- Giving every child the best start in life is the most important policy objective for reducing health inequalities

## Three common conditions linked to preventable risk factors

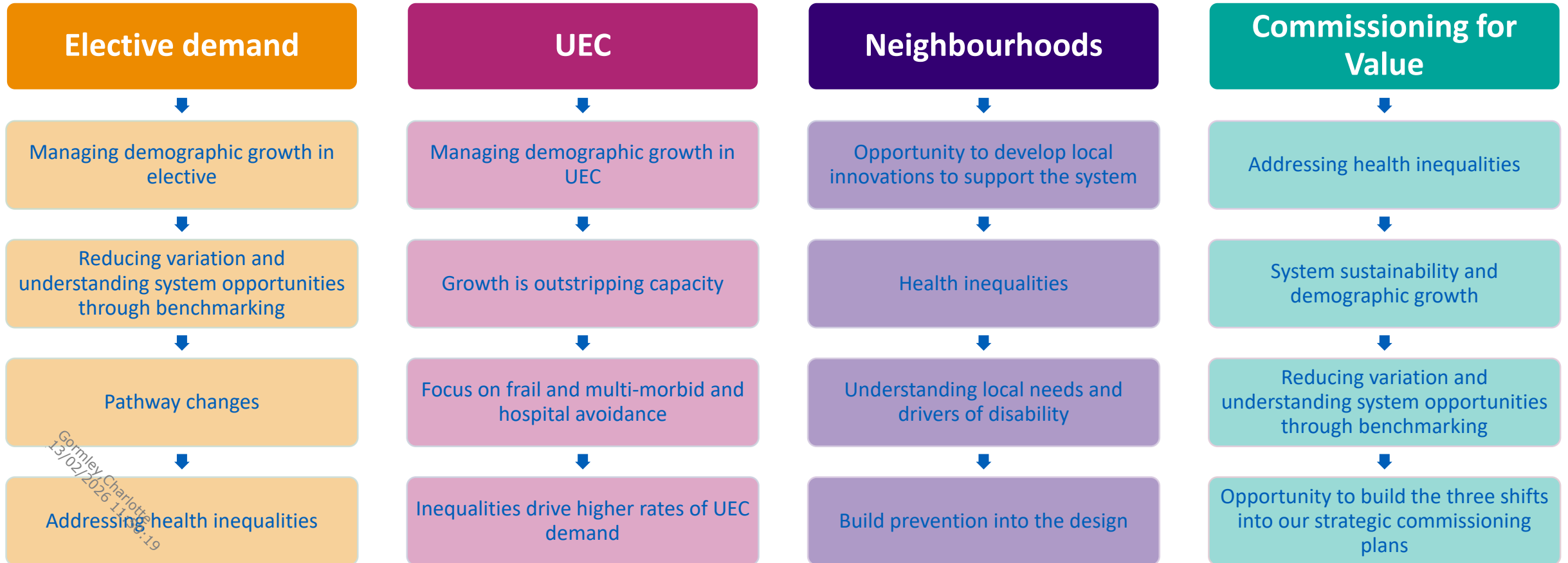
- Cardiovascular diseases, cancer, and respiratory diseases largest causes of inequalities, morbidity and mortality
- Mental health and Musculo-skeletal conditions also drive a significant burden of disability in LLR
- Obesity, blood glucose, hypertension, smoking and alcohol biggest preventable risk factors driving the “big three”, and many other long term conditions

## System sustainability

- System focus on the three left shifts and supporting the shift from acute to community, treatment to prevention and analogue to digital and the development of neighbourhoods to support this
- It is essential that the plans that the ICB develops as strategic commissioners are sensitive to the underlying growth across all health and care sectors and that underlying growth should be a core component as the system develops new models of care
- Transforming services for people with frailty will be essential for future sustainability

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# Translating health priorities to commissioning intentions



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## 4. Alignment to System Strategies

- Based on our analysis we have determined that our Strategic Transformational Priorities will centre on Frailty, Premature Mortality (Cardiovascular, Respiratory and Cancer) and CYP (Mental Health and Neurodiversity).
- The following section demonstrates synergy and alignment to synch with existing system-wide strategies.

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# Integrated Care Strategies

Improving health and wellbeing in **Leicester, Leicestershire and Rutland**  
Our Integrated Care Strategy 2023-2028

## Key Areas of Focus:

### Focus 1

Improving health equity

### Focus 2

Preventing illness and helping people to stay well

### Focus 3

Championing integration

### Focus 4

Fulfilling our role as 'Anchor' organisations

## Our Priorities:

- **Best start in life**
- **Staying healthy and well**
- **Living and supported well**
- **Dying Well**

# Integrated Care Strategies

## Integrated Care Strategy **Northamptonshire**

### Live your best life, a ten-year strategy 2023-2033

#### Our Ten Ambition Areas:

- The best start in life
- Access to the best available education and learning
- Opportunity to be fit, well and independent
- Employment that keeps them and their families out of poverty
- Good housing in places which are green and clean
- To feel safe in their homes and when out and about
- Connected to their families and friends
- The chance for a fresh start, when things go wrong
- Access to health and social care when they need it
- To be accepted and valued simply for who they are

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# Health and Wellbeing Board Strategies



## Leicester's Health, Care and Wellbeing Strategy 2022-2027

### Themes for Action

Healthy Places

Healthy Minds

Healthy Start

Healthy Lives

Healthy Ageing

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## Leicestershire Joint Health and Wellbeing Strategy 2022-2032

### Life Course Approach

Best start for life

Staying healthy, safe and well

Living and supported well

Dying well

## Rutland Health and Wellbeing Strategy 2022-2027

### Priority Themes

The best start for life

Staying healthy and independent: Prevention

Healthy ageing and living well with long term conditions

Ensuring equitable access to services for all Rutland residents

Preparing for significant population growth and change

Ensuring people are well supported in the last phase of their lives

Cross-cutting themes (Mental health and reducing health inequalities)

## West Northamptonshire Joint Health and Wellbeing Strategy 2023-2028

### Ambition

(Placeholder as being updated/reviewed)

The best start in life

Access to the best available education & learning

Opportunities to be fit well and independent

Employment that keeps you and your family out of poverty

Good housing in places which are clean and green

Safe in your homes and when out and about

Connected to friends and family

The chance for a fresh start when things go wrong

Access to health and social care

Accepted and valued for who you are

## North Northamptonshire Health and Wellbeing Strategy 2024-2029

### Five Key Priorities

Smoking and Vaping

Keeping Active

Mental Health and Wellbeing

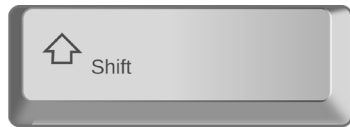
Children and Young People

Financial Resilience

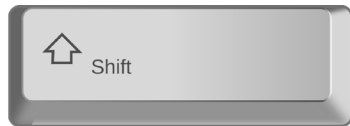
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# The 10-Year Health Plan for England

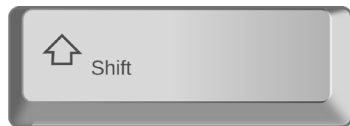
## The Three Fundamental Shifts



**Hospital to Community**



**Analogue to Digital**



**Sickness to Prevention**

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<b>Population Impact</b>	Frailty is a major driver of UEC activity, longer lengths of stay, and social care demand. Modelling across the cluster shows a significant increase in an older and frailer cohort with greater pressure on services.
<b>Commissioning Framework Alignment</b>	Guidance commands the use of population segmentation and risk stratification; frailty is a high-risk cohort where proactive, integrated care can reduce demand and improve outcomes.
<b>LLR ICS Strategy</b>	<p><b>Aligns with priorities and key focus areas:</b></p> <ul style="list-style-type: none"> <li>Staying healthy and well</li> <li>Living and supported well</li> <li>Preventing illness and helping people to stay well</li> </ul>
<b>Northamptonshire ICS Strategy</b>	<p><b>Aligns with ambitions:</b></p> <ul style="list-style-type: none"> <li>Opportunity to be fit, well and independent</li> <li>To feel safe in their homes and when out and about</li> <li>Access to health and social care when they need it</li> </ul>
<b>Leicester JHWS</b>	<p><b>Aligns with themes:</b></p> <ul style="list-style-type: none"> <li>Healthy Lives</li> <li>Healthy Ageing</li> </ul>
<b>Leicestershire JHWS</b>	<p><b>Aligns with life course approach:</b></p> <ul style="list-style-type: none"> <li>Staying healthy, safe and well</li> <li>Living and supported well</li> </ul>
<b>Rutland JHWS</b>	<p><b>Aligns with priority themes:</b></p> <ul style="list-style-type: none"> <li>Staying healthy and independent</li> <li>Healthy ageing and living well with long term conditions</li> </ul>
<b>West Northamptonshire JHWS</b>	<p><b>Aligns with ambitions:</b></p> <ul style="list-style-type: none"> <li>Opportunity to be fit, well and independent</li> <li>To feel safe in their homes and when out and about</li> <li>Access to health and social care when they need it</li> </ul>
<b>North Northamptonshire JHWS</b>	<p><b>Aligns with key priority:</b></p> <ul style="list-style-type: none"> <li>Keeping Active</li> </ul>
<b>10-Year Plan Shifts</b>	Investing in frailty pathways supports the shift from <b>hospital to community</b> care, harnesses neighbourhood models of care and can reduce avoidable admissions, improving independence and quality of life.

# Premature Mortality (Respiratory, CVD, Cancer)

<b>Population Impact</b>	These three disease areas are leading cause of early death across the cluster. They drive inequalities, demand and mortality.
<b>Commissioning Framework Alignment</b>	The guidance explicitly highlights the need to assess the impact of poor health on children and young people's life chances
<b>LLR ICS Strategy</b>	<p><b>Aligns with priorities and key focus area:</b></p> <ul style="list-style-type: none"> <li>Preventing illness and helping people to stay well</li> <li>Staying healthy and well</li> <li>Living and supported well</li> </ul>
<b>Northamptonshire ICS Strategy</b>	<p><b>Aligns with ambition:</b></p> <ul style="list-style-type: none"> <li>Opportunities to be fit, well and independent</li> </ul>
<b>Leicester JHWS</b>	<p><b>Aligns with theme:</b></p> <ul style="list-style-type: none"> <li>Healthy Lives</li> </ul>
<b>Leicestershire JHWS</b>	<p><b>Aligns with life course approach:</b></p> <ul style="list-style-type: none"> <li>Staying healthy, safe and well</li> </ul>
<b>Rutland JHWS</b>	<p><b>Aligns with priority theme:</b></p> <ul style="list-style-type: none"> <li>Staying healthy and independent: Prevention</li> </ul>
<b>West Northamptonshire JHWS</b>	<p><b>Aligns with ambition:</b></p> <ul style="list-style-type: none"> <li>Opportunities to be fit, well and independent</li> </ul>
<b>North Northamptonshire JHWS</b>	<p><b>Aligns with key priorities:</b></p> <ul style="list-style-type: none"> <li>Smoking and Vaping</li> <li>Keeping Active</li> </ul>
<b>10-Year Plan Shifts</b>	Clear alignment with one of the three shifts within the 10YP – <b>Sickness to Prevention.</b>

# Children and Young People

<b>Population Impact</b>	Giving every child the best start in life is the most important long-term objective for reducing health inequalities.
<b>Commissioning Framework Alignment</b>	Guidance emphasises tackling drivers of risk and demand and reducing unwarranted variation. Respiratory disease, cardiovascular disease, and cancer all show significant inequalities in incidence, access, and outcomes.
<b>LLR ICS Strategy</b>	<p><b>Aligns with priorities and key focus areas:</b></p> <ul style="list-style-type: none"> <li>Best start in life</li> <li>Preventing illness and helping people to stay well</li> </ul>
<b>Northamptonshire ICS Strategy</b>	<p><b>Aligns with ambition:</b></p> <ul style="list-style-type: none"> <li>The best start in life</li> </ul>
<b>Leicester JHWS</b>	<p><b>Aligns with theme:</b></p> <ul style="list-style-type: none"> <li>Healthy Start</li> </ul>
<b>Leicestershire JHWS</b>	<p><b>Aligns with life course approach:</b></p> <ul style="list-style-type: none"> <li>Best start for life</li> </ul>
<b>Rutland JHWS</b>	<p><b>Aligns with priority theme:</b></p> <ul style="list-style-type: none"> <li>The best start for life</li> </ul>
<b>West Northamptonshire JHWS</b>	<p><b>Aligns with ambition:</b></p> <ul style="list-style-type: none"> <li>The best start in life</li> </ul>
<b>North Northamptonshire JHWS</b>	<p><b>Aligns with key priorities:</b></p> <ul style="list-style-type: none"> <li>Children and Young People</li> </ul>
<b>10-Year Plan Shifts</b>	Care closer to home, greater opportunities for joint commissioning with partners and preventing escalation to hospital care. CYP cohort ideal beneficiaries of digital by default approach. Today's CYP are tomorrow's adults - childhood is the most critical stage for prevention — tackling obesity, smoking, poor diet, and mental health early has lifelong benefits.

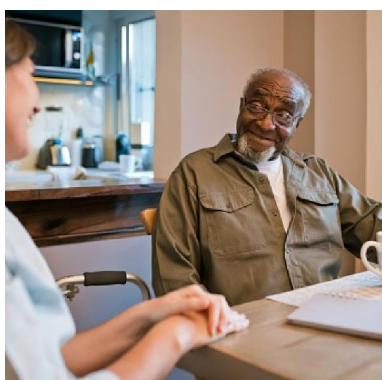
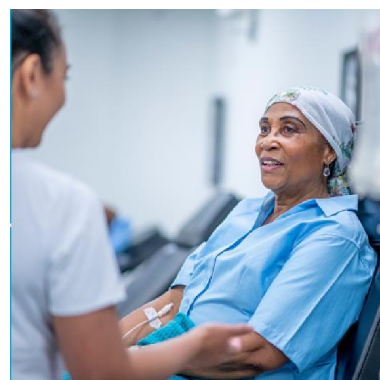
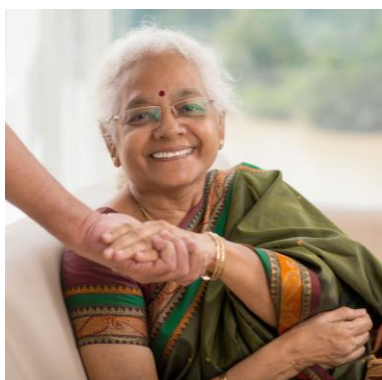
# Appendix 2

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# FIVE-YEAR STRATEGIC COMMISSIONING PLAN

2026-27 to 2030-31

Version 1.0



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

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## EXECUTIVE SUMMARY

This Plan sets out how we, the strategic commissioners of NHS services across Leicestershire, Northamptonshire and Rutland, will improve population health, reduce inequalities and improve access to high-quality, efficient healthcare for the 2 million people we serve, over the next five years.

We face significant and growing challenges: an ageing population with increasing frailty and multimorbidity; widening health inequalities driven by deprivation; rising demand for urgent, emergency and elective care; sustained pressure on general practice access; workforce constraints; and ongoing financial pressure. These challenges are closely connected. Difficulty accessing timely GP care contributes to worsening health, avoidable emergency department attendances and long waits for planned treatment. Without a fundamental shift in how care is commissioned and delivered, demand will continue to outpace capacity, leading to poorer outcomes and experience for local people.

Our aim is to improve health outcomes and reduce inequalities by shifting from reactive, hospital-centred care to proactive, preventative and integrated support delivered as close to home as possible.

We will use our role as a strategic commissioner to create the conditions for high-quality, equitable and sustainable care by:

- Focusing on communities with the greatest need, including Core20PLUS5 populations
- Investing earlier to prevent avoidable illness, deterioration and crisis
- Strengthening Neighbourhood-based, multidisciplinary models of care
- Reducing unwarranted variation in access, quality and outcomes
- Making better use of data, digital tools and workforce capacity

### What will change

Over the next five years, healthcare commissioning will move from short-term recovery and activity-driven approaches towards longer-term transformation, with a clearer focus on outcomes, value and population health impact.

Neighbourhoods will become the cornerstone of delivery. Integrated Neighbourhood Teams will bring together general practice, community services, mental health, social care and the voluntary, community and social enterprise sector to provide coordinated, person-centred support. This will improve access to care – particularly for those with frailty, multimorbidity and complex physical and mental health needs – reduce fragmentation and help people receive the right support earlier, in the most appropriate setting.

Strengthening neighbourhood care is central to addressing the issues local people raise most often. By expanding the range of professionals available in primary care settings and improving coordination across services, we will improve access to general practice, reduce pressure on emergency departments and create more capacity for hospitals to tackle waiting times for planned procedures.

We will rebalance investment from hospital settings towards Neighbourhoods, primary care and community services, while ensuring hospital-based care remains high quality and accessible for those who need it. Commissioning decisions will be increasingly evidence-led, informed by population health management, quality and performance insight, and the lived experience of local people.

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## Our commissioning ambitions and priorities

To deliver this shift, we have deliberately focused on a small number of priorities where we can make the greatest difference.

Our core commissioning ambitions focus on improving access, flow and experience through:

- **Elective care** – improving access and reducing long waits, modernising pathways, reducing unwarranted variation and delivering more care closer to home.
- **Urgent and emergency care** – creating a resilient, integrated and community-focused system that delivers the right care, in the right place, first time, with stronger prevention, same-day care and alternatives to admission.
- **Neighbourhoods** – developing a Neighbourhood Health Service, delivered through Integrated Neighbourhood Teams, supported by digital connectivity, shared care records and population health management.

Alongside these system priorities, we have identified three strategic transformation ambitions that reflect the most significant population health challenges across LNR:

- **Frailty** – enabling people to live a healthy older age with independence and dignity through early identification, proactive and personalised support, and reduced reliance on hospital care.
- **Preventable mortality** – preventing early deaths from cardiovascular disease, cancer and respiratory disease through prevention, early diagnosis and improved long-term condition management.
- **Children and young people’s mental health and neurodiversity** – creating a joined-up, needs-led system that enables earlier, more equitable access to support, reduced waiting times and better transitions across the life course.

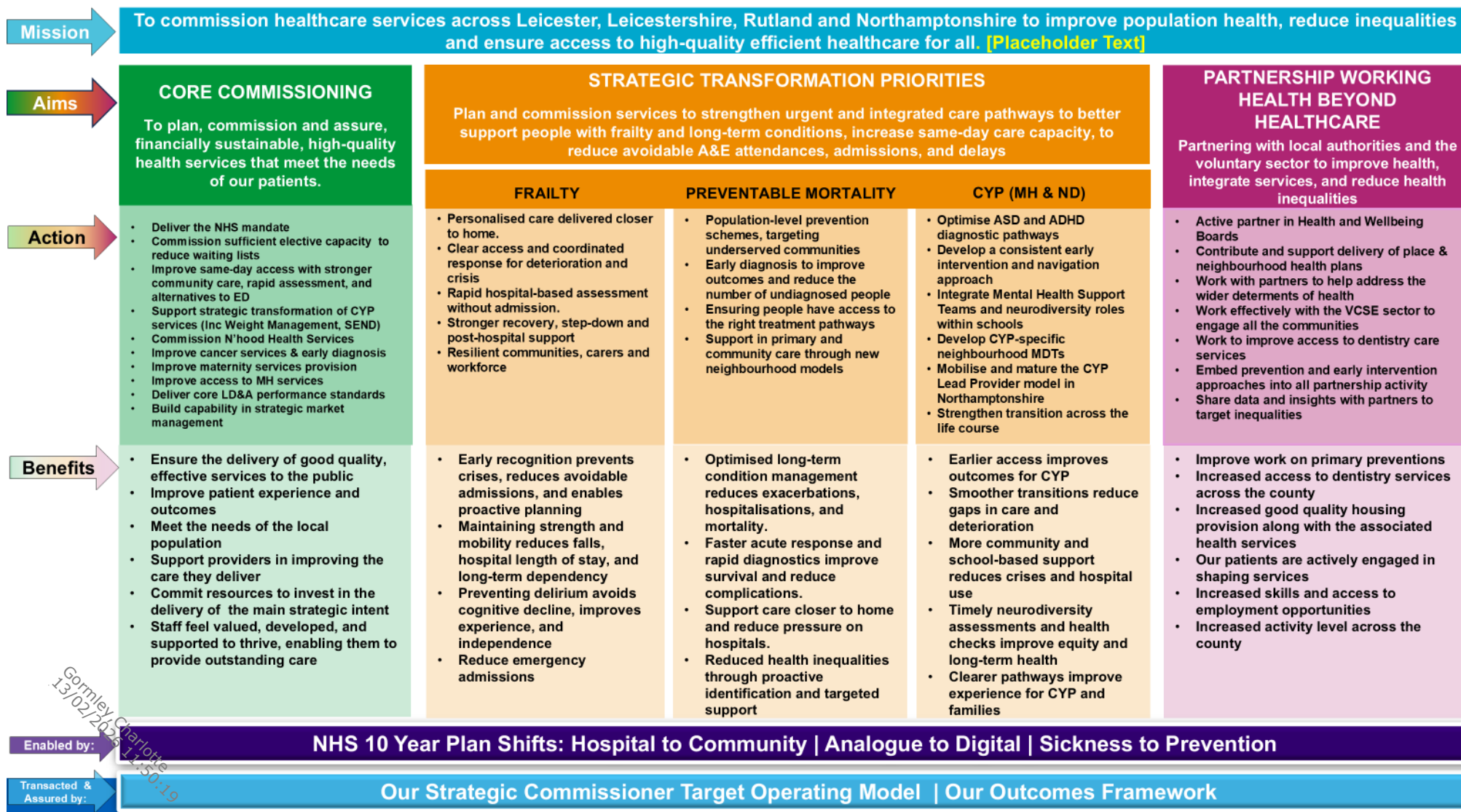
## Delivering this plan

Delivery of this Plan will require strong partnership working across the NHS, local authorities and the voluntary, community and social enterprise sector. Much of the change will be delivered locally, through Neighbourhoods and places; our strategic commissioning role being to set direction, align incentives, assure quality and enable improvement.

This Plan provides a clear framework for action over the next five years. By working together with partners and communities, we will reshape care to better meet the needs of our population now and in the future.

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# 1. OUR PLAN ON A PAGE



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## 2. WHAT WILL BE DIFFERENT WHEN THIS PLAN IS DELIVERED

Over the next five years, our population will see real improvements in access to care and how services are redesigned to meet the local needs.

1. People with frailty, multimorbidity, complexity and severe mental illness will have their needs identified earlier, will have a co-developed personalised care plan and will receive proactive, integrated support that focusses on prevention, self-care and maximising independence.
2. We will tackle health inequalities and life expectancy gaps in our populations, in particular, by addressing the three most common contributing conditions: Cardiovascular disease (CVD), cancer and respiratory disease.
3. People will experience a resilient, integrated and community-focused urgent and emergency care (UEC), providing the right care, in the right place, first time.
4. Delivery of 1), 2) and 3) above, will release hospital-based urgent and emergency care capacity that can better be used to provide timely care to those with the most acute needs.
5. Access to general practice will improve. Neighbourhood models of care will bring together wider multidisciplinary teams, aligned to the needs of local populations and providing wrap-around care to those with complex needs (see 1 above). This will free up general practice capacity, making easier for all registered patients to get timely GP appointments, which will improve continuity of care and reduce variation in access across different areas.
6. Children and young people will receive earlier and more equitable support for mental health and neurodiversity needs. Waiting times for neurodiversity assessments will reduce, with better support provided while families wait pre, during and post-diagnosis.
7. Across LNR, we will develop sustainable, coordinated services, reducing duplication and delays by working across the system to provide seamless care.
8. We will change how services are commissioned and delivered by developing outcome-based contracts; ensuring care is more focused on local population needs, and delivering the most appropriate treatment in the right setting.
9. Ensure better value for money by, for example, redirecting resources from reactive care to proactive management of conditions, as well as commissioning in a way that maximises productivity and reduces unwarranted variation in how care is delivered and outcomes are achieved.

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### 3. OUR NEW ROLE AS A STRATEGIC COMMISSIONER

Our Integrated Care Boards (ICBs) were established with a core purpose of bringing partner organisations together to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access to health and care, as well as enhance productivity and value for money.

However, the Darzi review<sup>1</sup> concluded that, nationally, the roles and responsibilities of ICBs needed to be clarified to provide more consistency and better enable the strategic objectives of redistributing resource out of hospital and integrating care. Crucial to this, the review concluded, was the need to rebuild strategic commissioning capabilities and skills.

The subsequent publication of the 10 Year Health Plan for England reinforced the importance of this role and the need for our ICBs to focus on delivering three strategic *shifts*:

- **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and reducing inequalities in health.
- **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **analogue to digital:** Harnessing technology and data to transform care delivery and decision-making.

To focus on our core purpose, and deliver these *shifts*, we are realigning Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB to operate in a ‘Cluster’ arrangement – **to be known as Leicestershire, Northamptonshire & Rutland (LNR)**. This will strengthen us as a commissioner to better understand the health and care needs of our populations, strengthen our work with partners and wider communities to develop strategies to improve health and tackle inequalities and contract more effectively with providers to ensure consistently high-quality and efficient care, in line with best practice.

As LNR develops as a strategic commissioner, our Board will define a Target Operating Model describing how we will organise ourselves to deliver our functions and commissioning intentions. This operating model will include elements such as our desired culture, values, systems, processes, capabilities, frameworks; and will be underpinned by effective organisational development.

Our functions going forward, therefore, can be summarised as per Figure 1.

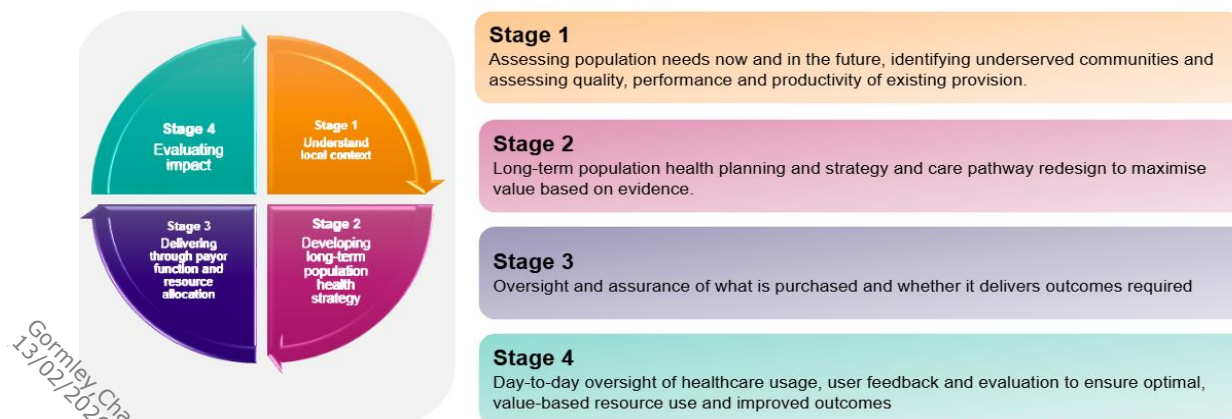


Figure 1 – Our core functions as a strategic commissioner

<sup>1</sup> Independent Investigation of the National Health Service in England NHS England. 2024

## 4. ABOUT US

### 4.1 OUR HEALTH AND CARE LANDSCAPE

Our geographical area covers the ceremonial counties of Northamptonshire, Leicestershire and Rutland, and includes five upper-tier local authorities (see Figure 2). Northamptonshire is a predominantly rural county of 852k people, however, nearly 70% live in towns and urban areas. Leicestershire and Rutland has a population of 1,234k, living across rural, market towns and urban areas.<sup>2</sup>

#### Health and care provision

##### – A summary<sup>3</sup>

- 191 GP Practices
- 347 Community Pharmacies
- 198 Dentists
- 239 Optometrists
- 4 Acute Hospitals (of which 3 have an A&E Department)
- 1 Specialist Hospital
- 1 Ambulance service partner

#### Operating at different levels

##### Neighbourhoods

21 Neighbourhoods are developing as the cornerstone for the delivery of accessible, proactive, digitally enabled care close to home. They bring together primary care, community services, social care, voluntary partners and acute providers into Integrated Neighbourhood Teams as a single, coordinated system focused on prevention, continuity, and equity.

##### Places

We have 5 'Places', which mirror the boundaries of our upper-tier local authorities (see Figure 2). At Place level, care alliances, including hospitals, local authorities ([Health and Wellbeing Boards](#)), urgent care, mental health and community services, transport providers and Neighbourhoods initiate and encourage the integrated delivery of health, social care and other services with health and wellbeing related responsibilities such as housing, policing, education, skills, employment, leisure, planning and community activities to meet local need.



<sup>2</sup> Population source: Registered patient with GP Practices – September 2025

<sup>3</sup> Data accurate as at January 2026

<sup>4</sup> Source: ONS. 2026. Created by Population Health, NHS Northamptonshire

## Systems

We have 2 [Systems](#); one covering the 3 upper-tier local authority areas of [Leicester](#), [Leicestershire](#) and [Rutland](#), and one covering the 2 upper-tier local authority areas of [West](#) and [North](#) Northamptonshire. Each System has a statutory ICB that have started working together in a 'cluster' arrangement and we expect that the ICBs will discharge their strategic commissioning functions (see [Chapter 3](#)) as a single entity, from 2026-27.

Health and care provision takes place at the appropriate level for a specific service, which may be at one or a combination of Neighbourhood, Place, System, Cluster, supra-Cluster, regional or national level.

## 4.2 ABOUT OUR POPULATION

We serve a population of just under 2 million people. In order to ensure that the right services are in place over the coming years, we have developed a comprehensive understanding of our populations' health and care needs<sup>5</sup>. These needs can be described in terms of population health priorities (see Figure 3).

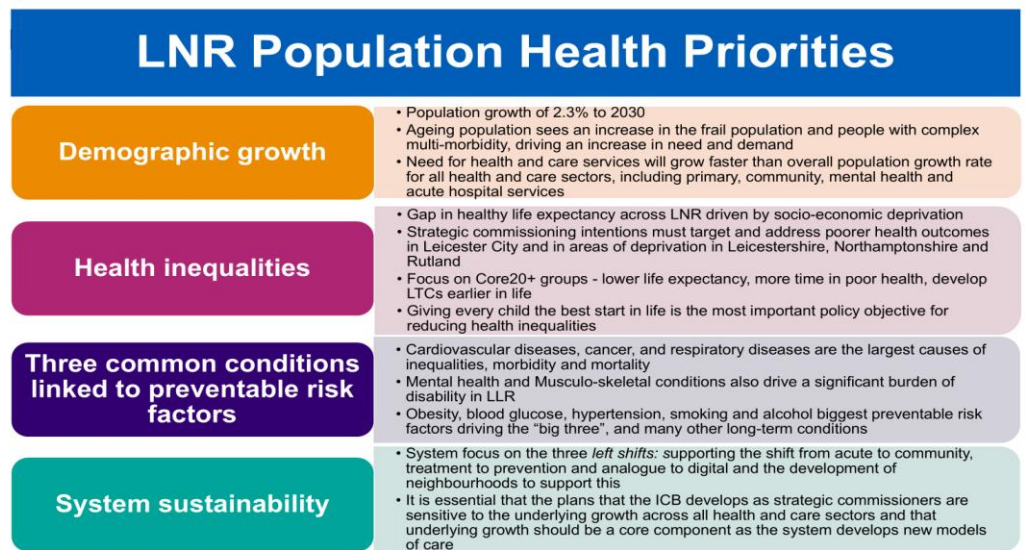


Figure 3 – Our population health priorities.

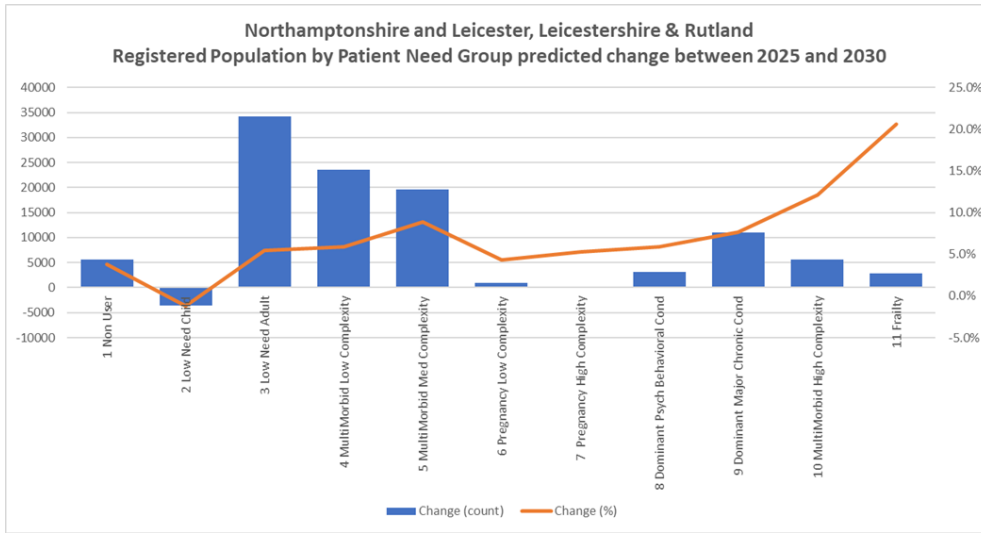
### Demographic growth and increasing frailty needs

We expect our population to grow by 2.3% (approx. 70,000 people) in the next five years. Although the majority of this growth is expected to be people with a low to medium health need, the highest percentage of growth will be in those groups of people with the greatest multimorbidity and frailty need (see Figure 4).

The population aged 80 and older is expected to grow the fastest, increasing by 20.6% by 2030, whereas the population of children is expected to reduce. The ageing population structure across LNR, in particular the growth in older age groups, will drive an increase in patients with higher health and care needs.

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<sup>5</sup> LNR. Cluster Integrated Needs Assessment. 2026



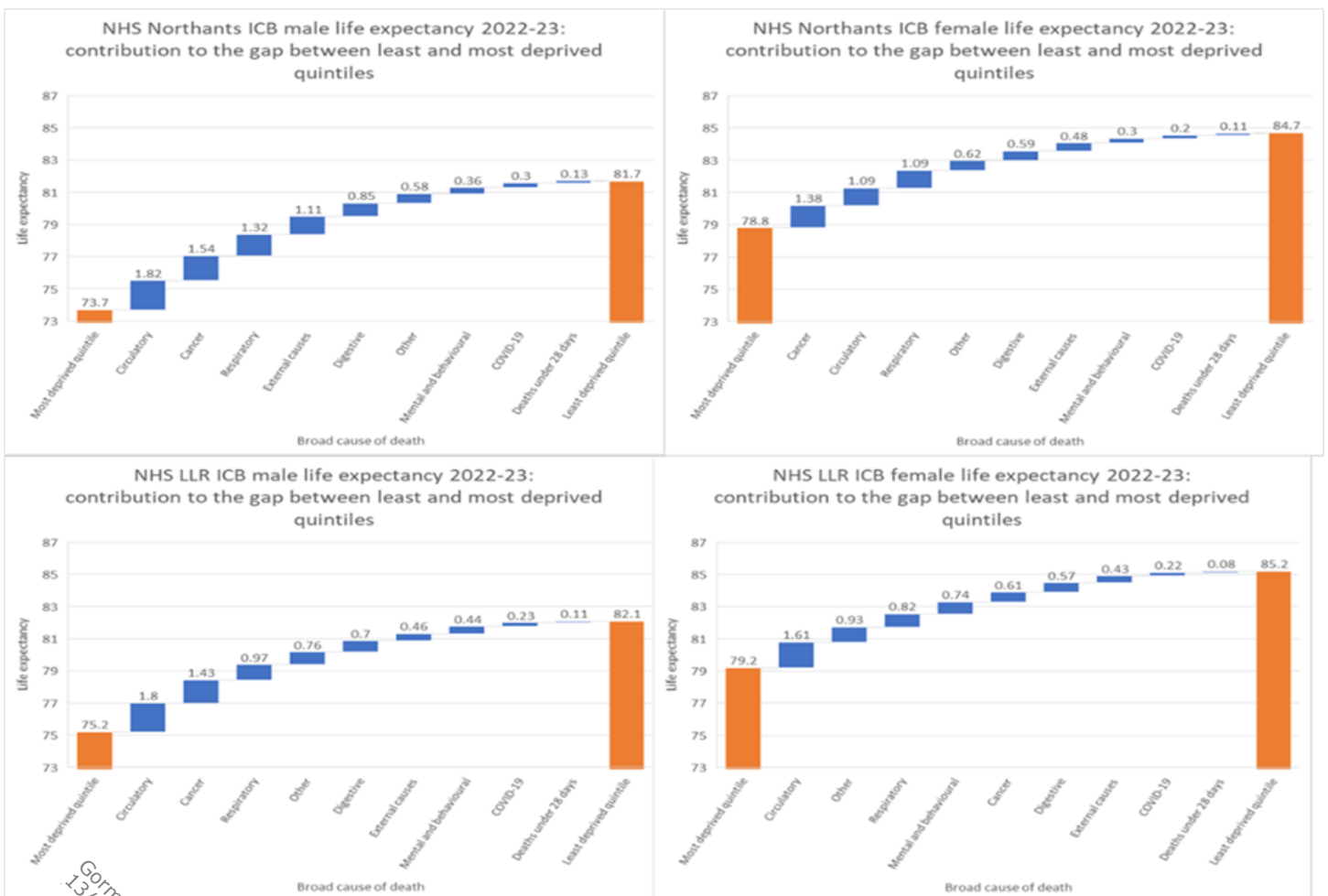
**Figure 4 – Our predicted population growth grouped by health need**

The blue bar represent the absolute growth in patients, which is highest in the low to medium health need groups.

The orange line represents the percentage growth which is highest in groups reflecting greatest health need

## Health Inequalities

Health inequalities are avoidable and unfair differences in health between different groups of people. This concerns not only people’s health but the differences in care they receive and the opportunities they have to lead healthy lives.



**Figure 5 – Inequalities in life expectancy<sup>6</sup>**

<sup>6</sup> Source: OHID Segment Tool. 2022-23

There are stark health inequality gaps across LNR, demonstrated by the difference in life expectancy between those that are most and least deprived (see Figure 5). For example, there is a 5.9-year difference in female life expectancy between the most deprived and least deprived in Northamptonshire. As well as dying younger, the population of Leicester City and North Northamptonshire, for example, are estimated to spend more of their lifespan living with poor health (between 23% and 30%)

Gaps in healthy life expectancy are driven by socio-economic deprivation (see Table 1):

- 17% of our population live in the most deprived areas in England (Quintile 1). Of these, Leicester City has the highest percentage (53.3%) in Quintile 1.
- Over one-third (34.8%) live in the most or more deprived areas (Quintiles 1 and 2)
- Almost half (46.6%) of our population live in the less or least deprived areas (Quintiles 4 and 5).

**Overall 2025 Index of Multiple Deprivation - % of registered population**

	Deprivation Quintile (1=most deprived)				
	1	2	3	4	5
<b>LLNR Cluster ICB</b>	<b>17.0%</b>	<b>17.8%</b>	<b>18.6%</b>	<b>25.5%</b>	<b>21.1%</b>
<b>Northamptonshire ICB</b>	<b>12.4%</b>	<b>20.0%</b>	<b>19.9%</b>	<b>25.4%</b>	<b>22.3%</b>
North Northamptonshire	13.1%	21.4%	23.1%	18.8%	23.6%
West Northamptonshire	11.9%	18.9%	16.7%	30.7%	21.8%
<b>LLR ICB</b>	<b>20.3%</b>	<b>16.3%</b>	<b>17.6%</b>	<b>25.5%</b>	<b>20.3%</b>
Leicester	53.5%	26.5%	14.1%	4.8%	1.1%
Leicestershire	2.4%	11.3%	19.5%	35.7%	31.1%
Rutland			15.4%	52.6%	32.0%

**Table 1 – Our population by quintiles of deprivation<sup>7</sup>**

Our strategic commissioning intentions must target and address poorer health outcomes in Leicester City and in areas of deprivation in Leicestershire, Northamptonshire and Rutland.

### Three common conditions linked to preventable risk factors

Analysis of gaps in life expectancy (see Figure 5) demonstrates that three conditions – circulatory disease, cancer and respiratory disease – accounts for:

- 4.7 years of the total life expectancy gap for males, and 3.6 years of the total life expectancy gap for females in Northamptonshire.
- 4.2 years of the total life expectancy gap for males and 3 years of the total life expectancy gap for females in LLR.

### Children and Young People’s mental health

Children and young people’s mental health and neurodiversity needs continue to rise in both volume and complexity across LNR<sup>8</sup>. Increasing numbers of children are presenting with anxiety, low mood, behavioural challenges, trauma-related difficulties and unmet neurodevelopmental needs, mirroring national trends<sup>9</sup> where demand is outpacing the capacity of traditional clinical models.

Targeting these conditions, therefore, is our focus in order to reduce health inequalities across LNR and we set out our plans to do this in Chapter 5.

<sup>7</sup> Source: English Indices of Deprivation. 2025. DCLG

<sup>8</sup> Source: LLR and Northants. Council’s JSNA

<sup>9</sup> [National Study of Health and Wellbeing: Children and Young People. NHS England. 2025](#)

## 4.3 SERVICE QUALITY

### What is working well

Our quality teams utilise a framework of statutory duties and NHSE [National Quality Board](#) (NQB) principles to oversee and support quality and safety across LNR. All our commissioned providers deliver against a quality schedule or agreed work programme within the [NHS Standard Contract](#), with regular reporting, review and follow up. Most providers remain in routine monitoring, with a small number moving into more focused Quality Improvement or [Rapid Quality Review](#) processes when additional support or assurance is needed.

### A shared commitment to quality

We are building a strong foundation of partnership working across LNR. Quality is not seen as a technical exercise but as a shared responsibility rooted in safety, effectiveness and experience, aligned to NQB principles, enabling us to triangulate intelligence. Each place has matured governance arrangements, and there is a growing alignment in how we define, measure and talk about quality, safety and outcomes across the cluster.

### Patient Safety

The [Patient Safety Incident Response Framework](#) (PSIRF) has been adopted by all our NHS Standard Contract providers; each having PSIRF policies and annual Plans. The quality teams provide supportive, improvement-focused oversight rather than monitoring the number of cases.

### Better use of insight and population health data

Our ability to understand need is improving. We now have richer data on people's experience of health and care services, outcomes and variation, which allows us to identify underserved communities (see 4.2 above), with [Core20PLUS5](#) helping us make more informed commissioning decisions. The shift towards using a [population health management](#) approach is enabling us to identify equity blind spots, deprivation and PLUS cohorts earlier, and design support that is more personalised and prevention focussed.

## The major quality challenges

### Pressures on access and flow

Urgent and emergency care remains under significant strain, with a consequent impact on the quality of care that people receive. Waiting times for elective care and diagnostics continue to impact people's experience and outcomes. Delayed discharges and long lengths of stay affect both safety and flow, and they place additional pressure on patients, families/carers and staff.

### Variation in quality and outcomes

While many services deliver excellent care, there is variation across providers and pathways. The data shows inconsistent adherence to best practice. This is noted currently with some conditions, such as cardiovascular disease, respiratory illness, frailty and serious mental illness. In addition, transitions between services can be fragmented, particularly at points of vulnerability. Children and Young People continue to have challenges navigating into care provision in Adulthood.

## Workforce pressures

Workforce challenges are felt across LNR. High vacancy rates and vacancy freezes, reliance on temporary staffing and the emotional impact of sustained pressure affect both quality and staff wellbeing. There is also variation in improvement capability and the capacity to embed change.

## Workforce culture and safety

Related to workforce challenges and emotional pressures, there are embedded cultural practices that require redress to ensure the delivery of safe and effective care across services.

## The impact of financial and productivity challenges on quality

The financial pressures across the system are real, and they are shaping the choices we make. Our task is to work differently and more efficiently, whilst keeping the patient central to our decision making. By understanding where variation exists and focusing our efforts where they matter most, we can make better use of our resources while continuing to protect the quality and safety of care.

## Opportunities to improve quality across LNR

### Tackling inequalities with focus and intention

- Service specifications that explicitly target equity gaps
- Stronger partnerships with communities, local authorities and the VCSE sector
- Culturally competent models of care that build trust and improve access
- Clear quality schedules with regular review and shared accountability
- Standardised dashboards that include quality, safety and patient outcome
- Align risk appetite and thresholds

### Improving access, timeliness and flow

- Continue to improve and grow a wider UEC model that will offer earlier care closer to home and build on the prevention agenda
- Stratify the current waiting times and prioritise elective recovery where waits are longest and variation or patient clinical need is greatest
- Strengthening navigation and care coordination for people with complex needs which is consistent across LNR

### Reducing unwarranted variation and strengthening pathways

- Work with new neighbourhoods and federations to understand priority needs
- Standardising pathways for priority conditions across LNR
- Using benchmarking to identify opportunities for redesign and better value
- Improving transitions of care through multi agency working to develop shared plans and have clearer accountability

### Supporting our workforce and building improvement capability.

- Investing in quality improvement skills and collaborative learning
- Strengthening multidisciplinary neighbourhood teams
- Enhance digital and data literacy across all staff groups to support a digital by default approach to commissioning
- Embedding staff experience and wellbeing into commissioning frameworks

## Delivering quality, productivity and value together

- Identifying low value activity and reinvesting in prevention and care closer to home, including increased use of home monitoring and virtual wards
- Developing a shared outcomes framework that links quality, performance and value
- Using digital tools and real-time insight to support proactive, safer care

## Quality in strategic commissioning

We have strong foundations to build on, but as a new Cluster, we will need to shape this together so that our approach works for all our populations and feels sustainable across our wider footprint. Much of the delivery will sit with providers at Neighbourhood level, and our role as strategic commissioners is to create the conditions that help this thrive. That means:

- Focusing on the communities who need us most
- Shifting investment towards prevention and earlier support/intervention
- Standardising, safe, effective, high quality care pathways while still respecting local context
- Strengthening quality assurance, qualitative intelligence, escalation thresholds and improvement capability across the system
- Bringing quality, equality, performance and productivity together to support sustainable, person-centred care
- Supporting our workforce to thrive, learn and lead change

## 4.4 SERVICE PERFORMANCE

We monitor performance against both national and local standards, targets and pledges. Whilst our performance is good in some areas, there are areas where performance is not at the levels expected. Both across and within services such as cancer care and mental health, there are performance successes and shortfalls. Here, across key service areas, we summarise what is working well and where performance challenges exist.

### Urgent and Emergency Care (UEC)

Population health factors (growth; levels of deprivation; increases in multimorbidity & frailty; unhealthy lifestyle choices<sup>10</sup>) are driving increased demand for UEC services, with increased pressure on capacity including urgent GP appointments, NHS 111, ambulances, emergency departments (ED), hospital beds and step-down facilities. Our UEC systems are, therefore, routinely failing to deliver on key performance targets and best practice, including ambulance response times, ambulance handover times, ED waiting times, hospital length of stay and delays to discharge.

### Elective Care (including cancer treatment)

Waiting times for treatment are a key area of underperformance across LNR. We are not achieving planned levels of performance to deliver the target of 18 weeks from referral to the beginning of treatment. The number of people waiting over 52 weeks for treatment, although reducing, is still a significant challenge.

We are providing faster diagnosis for people suspected of having cancer, however, we are not meeting the [NHS Constitution](#) standards for how quickly treatment should commence.

<sup>10</sup> Source: LLR UEC Strategy/Northamptonshire UEC Strategy. 2025

## Mental Health

National standards focus on mild mental health issues, however, serious mental health is the significant challenge across LNR. We perform well in areas such as eliminating inappropriate [Out of Area placements](#), ensuring access to mental health community teams and expansion of mental health teams in schools. We fare less well in minimising inpatient length of stay and dementia diagnosis rates against expected prevalence. A significant challenge is [Attention Deficit Hyperactivity Disorder \(ADHD\)](#) waiting times and diagnosis, followed by onward treatment and support especially for children and young people.

## General Practice

People's experience of access to general practice remains a challenge; both for people who contact their practice urgently seeking assessment the same or next day, as well as for people who need an appointment with their GP practice within 2 weeks.

## Opportunities to improve performance across LNR

In 2025, we developed Strategies for both our UEC systems that, once implemented, will transform care through a greater focus on prevention and proactive care, same day urgent care and bespoke pathways for specific groups of people, including children and young people, people with frailty and complexity, and people needing a mental health response.

Benchmarking data suggests that there is significant scope to improve productivity towards national best practice, through maximising existing resources and embedding efficiency improvements. There are also significant opportunities to better manage demand, for example, through equitable service provision, Neighbourhood based triage and strengthened pathways to tackle wider determinants. Service Transformation offers the opportunity to redesign care pathways, reduce unwarranted follow-up activity and embed better patient ownership.

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## 5. OUR COMMISSIONING INTENTIONS FOR THE NEXT FIVE YEARS

### 5.1 KEY DRIVERS OF OUR COMMISSIONING INTENTIONS

#### Our strategic commissioning role

One of our key roles, as the strategic commissioner of NHS funded services for LNR, is to signal to our providers, partners and communities what our priorities are – and how we intend to commission services to deliver these priorities – over the next five years. By so doing, we provide an open and transparent framework that will inform how we allocate resources and influence service re-design in order to improve population health, reduce inequalities, and deliver sustainable, high-quality care.

#### Alignment to national policy and direction

Local delivery of key national policies and frameworks, including commitments within the [NHS Constitution for England](#), the fundamental shifts set out in [10 Year Health Plan for England](#), continuously improving patient safety [The NHS Patient Safety Strategy](#), as well as the new operating model and performance ambitions in the [Medium Term Planning Framework](#).

#### Alignment to wider system partner's ambitions

[Integrated Care Strategies](#) and the [Health and Wellbeing Strategies](#) of our local [Health and Wellbeing Boards](#). This ensures our commissioning intentions are responsive to local needs, maximise system-wide impact and support joined-up planning and delivery between partners, across organisational boundaries.

#### Financial sustainability

Our ongoing financial pressures and the imperative to move LNR to financial sustainability. This recognises the need to balance shorter-term recovery efforts with longer-term transformation aspirations.

### 5.2 HOW WE DEVELOPED OUR COMMISSIONING INTENTIONS

#### Evidence-led

In chapter 4, we set out the case underpinning our choice of commissioning intentions. A distillation of our Cluster Integrated Needs Assessment highlights the biggest population health challenges. A summary of the key quality and performance challenges provides clarity on the improvements needed to have a real impact on the care people receive. Collectively, this analysis ensures that our commissioning intentions are firmly grounded in a robust evidence base, reflect current and projected population health needs, inequalities, service pressures and challenges.

#### Targeted and Manageable

We have deliberately focussed on a limited and deliverable set of commissioning intentions, that will concentrate collective effort and resources to achieve the greatest impact on outcomes and inequalities.

## Clinical co-production

Our commissioning intentions have been co-produced with clinicians from across LNR, alongside input from commissioning and delivery leads, ensuring priorities are clinically credible, patient-centred and deliverable.

## Iterative and Collaborative

The commissioning intentions were iteratively developed, through system engagement, including Board development sessions and partner discussions to build shared ownership, alignment and commitment to delivery across the system.

## Local people's insights

We undertake large-scale involvement projects, with local people and the insights and data from this work is evidenced and has informed this Plan.

## OUR COMMISSIONING INTENTIONS

Our commissioning intentions are split into two domains (see Figure 6). The first – Core Commissioning Aims – focuses on addressing key performance challenges, the improvement of which will have an every-day positive impact on the quality and timeliness of care people receive. The second – Strategic Transformational Priorities – focuses on addressing the key population health challenges across LNR.



Figure 6 Our Commissioning Intentions

The remainder of this chapter describes, in detail, our ambitions for each of the above six commissioning intentions, including the interventions we intend to make, as well as the outcomes we expect to deliver for local people.

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## 5.3 OUR CORE COMMISSIONING AIMS

### 5.3.1 ELECTIVE CARE

#### Our ambition for Elective Care

##### *We will:*

- **Improve access:** reduce waiting times and ensuring timely access to treatment leading to improved clinical outcomes
- **Improve quality:** reduce unwarranted variation, achieve equity and address inequalities in access to and quality of care
- **Improve choice, personalisation and experience of care**
- **Transform pathways of care, improve productivity and workforce resilience**

#### Background and Strategic Context

People are still waiting too long to receive elective care, which impacts on their quality of life and outcomes. Despite progress in reducing the longest waits, elective care recovery is constrained by several challenges, including:

- Sustained growth in demand,
- Persistently long waiting times in some specialties and pathways
- Variable productivity
- High outpatient follow-up volumes delivered in acute settings
- Fragmented pathways with avoidable outpatient attendances
- Diagnostic bottlenecks and variation in access to [Community Diagnostic Centres](#) (CDCs) capacity
- Pressure on acute theatres limiting elective reliability
- Inequalities in elective access, waiting times and outcomes across LNR
- Workforce constraints
- Ongoing impact of UEC pressures on planned activity.

Nationally, the [NHS Reforming Elective Care for Patients](#) sets clear expectations to reduce long waits, return to [NHS Constitutional standards](#), and improve cancer and diagnostic waiting times. This includes:

- Eliminating the longest waits
- Increasing elective activity beyond pre-pandemic levels
- Expanding protected capacity through surgical hubs and CDCs
- Transforming outpatient care through new models such as [Patient-Initiated Follow-Up](#) (PIFU), virtual care and advice and guidance.

There is also a strong emphasis on improving productivity, strengthening patient choice, and tackling inequalities in access and outcomes.

We plan to move beyond short term recovery towards sustained elective transformation. This will be underpinned by realistic activity planning, productivity improvement and effective demand management, with commissioning priorities aligned to national elective standards to ensure recovery trajectories are affordable, deliverable and resilient.

#### The Key Interventions we will focus on

##### **Intervention 1 – Reduce elective waiting times and protect planned activity**

We will prioritise the reduction of long waits while maintaining national elective access standards by increasing protected elective capacity, improving pathway efficiency and strengthening system grip on

performance. This includes aligning elective and urgent care planning to minimise disruption to planned care during periods of pressure.

### **Intervention 2 - Transform Outpatient care**

Outpatient services are a cornerstone of elective care, yet many local pathways remain fragmented and overly reliant on face-to-face appointments in acute hospital settings. Over the period of this plan, we will commission redesigned outpatient models delivered within neighbourhoods and community settings, closer to where people live.

We will align national best practice outpatient guidance with our Neighbourhoods and New Models programmes, focusing on developing the capacity and infrastructure required for sustainable delivery. A key ambition is to significantly reduce the number of follow-up appointments undertaken in acute settings over the next three years through pathway redesign, virtual models and PIFU. Alongside this, there will be a strong focus on reducing [Did Not Attend](#) (DNA) rates and narrowing inequalities in DNA rates across population groups, supported by improved booking processes, digital communications and targeted interventions for high-risk cohorts.

### **Intervention 3 – Strengthen cancer and diagnostic pathways**

Nationally, 20% of diagnostics are test only, i.e. there is no further appointment, and 13% are diagnostics following an outpatient appointment. CDCs are central to early diagnosis and elective recovery. Building on national evidence that a growing proportion of diagnostics can be delivered as test only activity, we will strengthen straight to test pathways for breathlessness, gastrointestinal symptoms and suspected cancer, enabling people to access diagnostics without first attending an outpatient appointment.

These pathways will be delivered in close integration with primary care, neighbourhood teams and acute outpatient services to ensure clear referral criteria, rapid reporting and timely clinical decision-making. By embedding CDCs within end-to-end pathways, we will reduce unnecessary outpatient attendances, shorten time to diagnosis and improve patient experience.

Aligned to outpatient redesign, we will also develop capacity in primary care and community settings for amendable high-volume diagnostics, including phlebotomy, spirometry and [Fractional Exhaled Nitric Oxide](#) (FeNO) testing.

### **Intervention 4 – Develop community surgery models**

We will commission community surgery models to shift appropriate elective activity out of acute hospitals, reduce pressure on theatre capacity and improve access and productivity. These models will focus on high-volume, low-complexity procedures that can be safely delivered closer to home, using accredited community settings and standardised pathways. This will release acute theatre capacity for more complex cases while improving elective reliability and patient experience.

### **Intervention 5 – Address inequalities and improve outcomes**

Across all elective pathways, we will focus on reducing unwarranted variation and addressing inequalities in access, waiting times and outcomes. This includes reducing follow-up intensity in acute settings, improving screening uptake and outcomes for cancer, and targeting interventions towards underserved communities across LNR.

### **How we will get there**

Elective care recovery will be delivered through a combination of protected elective capacity, pathway reform and care closer to home. The development of the Northamptonshire capital elective hub will provide dedicated, reliable capacity for high-volume planned procedures, reducing cancellations and

long waits caused by emergency pressures. This will be supported by delivery of the system elective care plan, agreed last summer, refreshed to reflect current demand and translated into clear specialty-level actions.

Straight to test pathways and expanded diagnostic capacity will reduce unnecessary outpatient appointments and accelerate diagnosis and treatment. At the same time, multidisciplinary teams in the community, supported by advice and guidance and digital models, will manage appropriate care outside acute settings. Together, these interventions will reduce outpatient waits, improve productivity and deliver sustained elective recovery across LNR.

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## 5.3.2 URGENT & EMERGENCY CARE

### Our ambition for Urgent and Emergency Care

*We will create a resilient, integrated and community-focused urgent and emergency care (UEC) system, where people receive the right care, in the right place, first time, and which is delivered, wherever possible, outside of traditional hospital settings.*

To achieve this, we will commission UEC services focussed on strengthening – for key cohorts of people, including those with frailty, multimorbidity, complex needs and severe mental illness – prevention, early intervention, general practice access and urgent community response while ensuring that hospital-based services remain available for those with the most acute needs.

We will commission more consistent models across LNR, that improve flow through Same Day Emergency Care and discharge pathways, expand alternatives to hospital admission, and embed digital connectivity and shared records to support seamless care. Through coordinated system leadership, neighbourhood level delivery and a shift towards proactive, place-based models, we will improve outcomes, reduce variation and ensure a sustainable UEC system that can meet rising demand.

### Background and Strategic Context

UEC services across LNR are experiencing sustained and increasing pressure, driven by population growth, demographic change, rising prevalence of long-term conditions and increasing public expectations for rapid access to care. Demand continues to rise across all access points, including general practice, NHS 111, Urgent Treatment Centres, ambulance services and emergency departments.

Both of our UEC systems share a similar challenge: over reliance on acute hospital-based responses, with high bed occupancy, constrained flow and growing workforce pressures. Without a shift in models of care, demand growth will continue to outpace the capacity of general practice, community, acute and mental health services to respond safely and sustainably.

We need to rebalance care towards prevention, early intervention and community-based support, while ensuring emergency services are protected for those who need them most. We have made progress and can demonstrate sustained improvement in a number of areas, for example, through our [Ageing Well](#) programme. We have proven that rates of emergency admission for the over 65s can be reduced through effective neighbourhood-based services.<sup>11</sup>

Other initiatives, such as neighbourhood working, urgent community response, Same Day Emergency Care (SDEC), community diagnostics and strengthened discharge and recovery pathways will be crucial to our success. Further system-wide alignment is needed to reduce unwarranted variation, improve flow and deliver consistent outcomes across LNR. National policy direction, including the [NHS UEC Recovery Plan](#) and the [Fuller Stocktake](#), reinforces the need for primary care-led, integrated and place-based approaches to urgent care, supported by digital connectivity, shared records and coordinated governance.

<sup>11</sup> Source: NHS Data Dashboard. 2025

## Key Interventions we plan to make

We will focus on a small number of system-wide interventions (see Table 2) that, collectively, support a consistent “right care, right time, right place” approach, while allowing flexibility for local delivery models across LNR.

<b>Intervention 1 - Empowered self-care and active prevention</b>	<b>How we will get there</b>
<ul style="list-style-type: none"> <li>• Support people at risk of escalation due to their Long-term condition</li> <li>• Holistic Care Plans for people, to include crisis planning</li> <li>• Keyworker support in the person’s community</li> <li>• Remote monitoring to support those at risk</li> <li>• Long-term condition groups to improve outcomes</li> <li>• Advanced Care Planning for those at the end of life</li> <li>• Enhanced healthcare in care homes</li> </ul>	<p>We will embed prevention and proactive care at neighbourhood level by aligning UEC delivery with Local Area Partnerships, neighbourhood models and place-based governance across LNR. This will support early identification, proactive care planning and coordinated support for people most at risk of deterioration.</p>
<b>Intervention 2 - Same day urgent care and rapid access to primary and community services</b>	<b>How we will get there</b>
<p>Delivering same day access at scale through:</p> <ul style="list-style-type: none"> <li>• A consolidated Urgent Treatment Centre model</li> <li>• Neighbourhood-based same day urgent care hubs</li> <li>• A trusted single point of contact (SPOC) for triage and navigation</li> <li>• Expanded community pharmacy and primary care same day access</li> <li>• Increased use of Same Day Emergency Care across acute sites</li> </ul>	<p>We will ensure people can access the right same-day care by scaling effective neighbourhood and place-based care, reducing reliance on emergency departments and minimising unwarranted variation between areas.</p>
<b>Intervention 3 - Coordinated urgent care and crisis response</b>	<b>How we will get there</b>
<p>Strengthened integrated responses across physical and mental health through:</p> <ul style="list-style-type: none"> <li>• Urgent Community Response (UCR) and integrated triage models</li> <li>• Mental health crisis assessment and response pathways</li> <li>• Trusted assessor models to reduce duplication and delays</li> <li>• Integrated pathways for CYP, frailty, LDA and end of life care</li> <li>• Improved data flows between teams to support joined up care</li> </ul>	<p>We will strengthen and align Urgent Community Response across both systems, enabling rapid assessment and treatment in people’s usual place of residence, avoiding unnecessary conveyance and admission, and ensuring consistent access regardless of location.</p>

<b>Intervention 4 - Expanded sub-acute and same day diagnostic provision</b>	<b>How we will get there</b>
Providing timely assessment and treatment outside acute settings, reducing avoidable ED attendances and admissions.	We will expand and standardise sub-acute and Same Day Emergency Care pathways, including integrated frailty and children and young people pathways, supporting timely assessment, diagnostics and treatment without defaulting to inpatient admission.
<b>Intervention 5 - Improved acute emergency care pathways</b>	<b>How we will get there</b>
Ensuring that people with time critical needs receive rapid, high quality care through: <ul style="list-style-type: none"> <li>• Improved Emergency Department flow</li> <li>• Enhanced Same Day Emergency Care and acute frailty services</li> <li>• Integrated mental health support within the Emergency Department</li> <li>• Expanded Urgent Treatment Centre service</li> <li>• Reduced length of stay in the acute sector</li> </ul>	We will protect acute and emergency services for those with time-critical or complex needs by ensuring effective front-door models, consistent triage and clear pathways into community, sub-acute and recovery services.
<b>Intervention 6 - Recovering independence and improving discharge pathways</b>	<b>How we will get there</b>
Enabling timely discharge and recovery through: <ul style="list-style-type: none"> <li>• A fully embedded Intermediate Care model</li> <li>• Rehabilitation and reablement pathways improvement to support reablement</li> <li>• Stronger links to Voluntary and Community Sector and community support</li> <li>• Reduced length of stay and improved patient experience</li> </ul>	We will prioritise timely discharge and recovery by strengthening integrated reablement, rehabilitation and discharge pathways across Leicestershire and Northamptonshire, enabling people to return home or move to the most appropriate setting without delay.

Table 2 – Key UEC interventions and how these will be achieved

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### 5.3.3 NEIGHBOURHOOD MODEL OF CARE

#### Our ambition for Neighbourhoods

*We will create a Neighbourhood Health Service across LNR that delivers accessible, proactive, digitally enabled care close to home. Care will be provided by Integrated Neighbourhood Teams, progressively co-located in Neighbourhood Health Centres (NHCs) as part of multidisciplinary teams. Digital capability will be optimised and prevention will be scaled through population health management and Core20PLUS5 partnerships.*

#### Background and Strategic Context

The challenges identified in [Chapter 4](#) are placing severe pressures on services. Of particular concern are UEC services (as described in [Section 5.3.2](#)), as well as general practice. Although general practice remains the foundation of the health and care system and the first point of contact for most people, access to care remains variable across neighbourhoods, with high levels of unmet need driving avoidable use of urgent and emergency services. General practice workforce capacity is stretched, the administrative burden is high, and the current model of care, largely organised around individual practices, limits the ability to deliver proactive, preventative and coordinated support for people with complex needs. These pressures risk undermining continuity of care, staff wellbeing and the sustainability of general practice services.

#### The Neighbourhood model

Our response to the above is to create a Neighbourhood model of care that will provide proactive, integrated, prevention-first care, at scale, to cohorts of people with frailty, multimorbidity and complex needs, thereby shifting the focus of care away from reactive, hospital-led interventions, as well as 'plugging' general practice into the capacity that supports their complex and frail patients.

In this model, multidisciplinary capacity, including general practice, wider primary care, community services, mental health, social care, the voluntary and community sector, and wider partners deliver a population health management approach, that enables better prevention, earlier intervention, better management of long-term conditions, multimorbidity and frailty, improved access to urgent care, and reduced reliance on acute services. Neighbourhoods place people, families and communities at the centre of how services are designed and delivered, ensuring support is accessible, coordinated and tailored to local need.

Elements of Neighbourhoods are already in place, across parts of LNR, and provide a strong foundation of support to general practice, including, [Integrated Neighbourhood Teams](#) (INTs), urgent community response, community diagnostics, [Same Day Emergency Care](#) (SDEC), intermediate care and redesigned discharge pathways. The next phase is to scale, align and embed these models consistently across LNR to reduce variation, improve flow and deliver equitable outcomes.

#### Key interventions we plan to make

##### **Intervention 1 - Design services around population need and inequality**

Neighbourhoods will use data and insights to:

- Segment populations and target Core20PLUS5 communities
- Reduce unwarranted variation in access, outcomes and experience
- Focus resources on those with the highest and rising risk
- Address persistent health inequalities across Leicester and Northamptonshire

##### **Intervention 2 - Shift care to proactive neighbourhood delivery**

Neighbourhood teams will move from reactive treatment to proactive, personalised care by:

- Using [Patient Need Groups](#) (PNGs) and [population health management](#) to identify risk early
- Delivering proactive care planning with clear escalation plans

- Supporting people with frailty, multimorbidity and long-term conditions to remain independent
- Reducing avoidable deterioration and urgent care escalation
- Increasing access to digital tools that support people

### **Intervention 3 - strengthen general practice, wider primary care and community as the default**

Neighbourhoods will become the first point of response for urgent, planned and long-term care. Using the [Fuller Stocktake](#) as our reference framework, we will continue to integrate care through:

- Maximising the [Additional Roles Reimbursement Scheme](#) (ARRS)
- Standardised neighbourhood access models
- Same day urgent care hubs and integrated triage
- Community diagnostics and virtual wards
- Urgent Community Response (UCR)
- Redesigned outpatient and long-term condition pathways
- Expanded SDEC and sub-acute pathways

### **Intervention 4 - Enable integration through infrastructure and enablers**

Neighbourhoods will be supported by:

- Shared digital records and interoperable systems
- NHCs and community infrastructure
- Workforce transformation and multidisciplinary team development
- Aligned contracting, joint commissioning and shared outcomes
- A single point of access for navigation and triage

### **Intervention 5 - Build sustainable neighbourhood systems**

Neighbourhoods will embed:

- Local governance and outcomes-based accountability
- Strong partnerships with the VCSE sector and Local authority Local Area Partnerships
- Continuous improvement and learning
- Scalable models that can be adopted across Leicester and Northamptonshire

## **How we will get there**

### **Transform general practice and wider primary care as the front door of the system**

General practice recovery will be underpinned by stabilising and expanding the workforce, maximising the ARRS, and enabling care to be delivered by the most appropriate professional. People with the greatest need will receive coordinated care from a named health or care professional, supported by expanded Neighbourhood-based multidisciplinary teams and integrated pathways. This wider Neighbourhood-led support for people with the most complex needs will free up general practice capacity, thereby improving access for all registered patients.

Recovery of general practice will be measured through a balanced set of metrics aligned to national priorities, including:

- Improved access to appointments and reduced variation between Neighbourhoods
- Improved patient experience, including ease of contacting practices
- Stabilisation and growth of the primary care workforce, including ARRS roles
- Increased total appointment capacity and improved productivity
- Improved continuity of care and outcomes for people with long-term conditions and complex needs
- Reduced inappropriate use of urgent and emergency care
- Targeted improvements in access and outcomes for Core20PLUS5 populations

Through delegated commissioning, community pharmacy, optometry and dentistry will be embedded within local care pathways to improve access, prevention and productivity. Community pharmacy will be the preferred first point of contact for minor illness and medicines optimisation; optometry will be integrated into redesigned eye care pathways to reduce unnecessary hospital referrals; and dentistry

recovery will focus on access, prevention and workforce sustainability, particularly in underserved communities.

Digital enablement will support consistent access across neighbourhoods, with cloud-based telephony, standardised triage and booking models, expanded same-day access, integrated urgent care pathways (including virtual wards) and improved access to specialist advice.

### **Scale Integrated Neighbourhood Teams**

We will expand INTs as the operational foundation of neighbourhood delivery. These teams will bring together general practice, community services, mental health, social care, VCSE partners and acute outreach to deliver proactive, personalised support. Learning from Northamptonshire's Ageing Well vanguard and West Leicestershire's implementer work, will be embedded across all Neighbourhoods to standardise proactive care planning, MDT huddles, continuity roles and early intervention models.

### **Establish NHCs**

We will phase the development of NHCs to co-locate INT staff, diagnostics, rehabilitation, mental health and social support. Where possible, NHCs will be aligned with Family Hubs to create a single, accessible front door for health, care and family support. These centres will operate extended hours and provide a consistent, community-based alternative to hospital care.

### **Redesign Community and Elective Pathways Around Neighbourhoods**

We will shift diagnostics, triage, treatment and follow up into neighbourhood settings, wherever clinically appropriate. Advice and Guidance, community diagnostics, virtual wards and enhanced rehabilitation will reduce unnecessary outpatient activity and support earlier intervention. Pathways for frailty, respiratory disease, CVD, cancer follow up and MSK will be redesigned to operate through neighbourhood teams.

### **Strengthen Urgent Community Pathways**

Urgent care will be delivered closer to home through a single point of contact, expanded Urgent Community Response (UCR), integrated mental health crisis pathways and neighbourhood based same day access hubs. This will reduce avoidable ED attendances and admissions, aligning with our UEC ambitions (see [Section 5.3.2](#)).

### **Embed Mental Health, CYP and Women's Health into Neighbourhood Delivery**

New models will integrate mental health practitioners, CYP pathways, neurodiversity support, perinatal care and women's health expertise directly into neighbourhood teams. This ensures earlier intervention, smoother transitions and reduced escalation to specialist services.

### **Enable Integration Through Digital and Data**

Shared care records, modern telephony, remote monitoring and PHM tools will underpin proactive care. Linked data across primary, community, mental health and social care will support risk stratification, neighbourhood profiles and targeted interventions for Core20PLUS5 groups.

### **Align Governance, Contracting and Workforce to Neighbourhood Delivery**

We will strengthen neighbourhood level accountability through shared outcomes, alliance based contracting and integrated workforce planning. Rotational roles, MDT development, digital skills and VCSE partnerships will support sustainable, community-based delivery.

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## 5.4 OUR STRATEGIC TRANSFORMATION PRIORITIES

### 5.4.1 FRAILITY

#### Our ambition for frailty care

*We want to enable people to live a healthy older age, with independence and dignity.*

To achieve this, we will commission services that focus on enabling older people to live independently at home for longer through proactive, personalised, and integrated support. We will shift from reactive, crisis-driven care to identifying frailty early, using multidisciplinary teams to manage health in the community, and reducing unnecessary hospital admissions.

#### Background and strategic context

We know that the highest percentage of growth in LNR over the coming years will be in those groups of people with the greatest need – those with multimorbidity and frailty (see Figure 3). People living with frailty are high users of health and care services and experience disproportionate risk of crisis, hospital admission, long lengths of stay, functional decline, and poor outcomes when care is fragmented or poorly coordinated.

We recognise that current models of care do not consistently meet the needs of people living with frailty. While there are areas of strong practice and innovation, provision remains fragmented, reactive, and often focused on the most severely frail who have limited scope for improvement. Approaches to identifying frailty, planning care, responding to deterioration, and supporting carers differ across places, organisations, and professional groups. This variation contributes to inequity in access, avoidable crises, and reliance on hospital-based care.

Across LNR, we are developing neighbourhood and place-based models of care. This means a “one-size-fits-all” approach to frailty is neither realistic nor desirable. Our aim is to provide a clear framework and direction, while allowing flexibility to ensure we meet the needs of our local populations by adapting and building on existing strengths and innovator sites.

#### Key interventions we plan to make

We will focus on a small number of system-wide interventions that, collectively, shift care from reactive, hospital-based responses to proactive, coordinated and person-centred support for people living with frailty. These interventions provide a clear strategic direction while allowing flexibility for local delivery and different stages of Neighbourhood maturity.

#### Intervention 1 - Personalised care delivered closer to home:

Strengthen neighbourhood-based models to identify people living with frailty earlier and provide personalised, proactive support through shared, comprehensive care plans. Care will focus on what matters to individuals, maintaining independence, preventing deterioration, and reducing avoidable escalation or crisis.

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### **Intervention 2 - Clear access and coordinated response for deterioration and crisis:**

Establish simple, consistent and clearly understood routes of access for people, carers and professionals, as needs change. This will include coordinated single points of access, clear pre-crisis and crisis pathways, and defined escalation routes aligned to local Neighbourhood and system models.

### **Intervention 3 - Rapid hospital-based assessment without admission**

Expand frailty-focused same-day assessment and decision-making within acute settings, ensuring timely access to senior clinical review and diagnostics. This will support safe alternatives to admission, reduce length of stay where admission is required, and maintain patient safety and experience.

### **Intervention 4 - Stronger recovery, step-down and post-hospital support**

Improve continuity after-hospital-care through seamless integration between acute, community, social care and voluntary sector services. This will strengthen step-down pathways, reduce readmissions, and support recovery, reablement and longer-term independence at home.

### **Intervention 5 - Resilient communities, carers and workforce**

Build system resilience by supporting unpaid carers, strengthening community capacity and self-care, and developing a confident, skilled, multidisciplinary workforce with a shared understanding of frailty. This includes consistent language, capability building and neighbourhood-based ways of working.

### **How we will know we've succeeded**

We are currently developing an LNR Outcomes Framework, within which we will identify specific outcomes we want to deliver for people with frailty. Progress in achieving these outcomes will then be tracked and reported, both through our frailty commissioning governance arrangements, as well as through wider LNR system monitoring. We expect to include outcomes that demonstrate the following:

- Earlier identification of frailty through increased use of structured frailty reviews will enable timely intervention before crisis points are reached, supporting proactive rather than reactive care.
- The expanded use of [Comprehensive Geriatric Assessment](#) (CGA) will ensure more people with frailty have personalised, holistic care plans that reflect their medical, functional and social needs. This will improve care coordination, reduce avoidable hospital use and support better quality of life
- Prevention and independence will be promoted by increasing participation in strength and balance programmes, helping people with frailty maintain mobility, reduce falls risk and delay functional decline.
- Supporting people living with frailty to live longer, healthier lives by preventing avoidable deterioration, reducing crisis admissions and improving care coordination across settings. Success will be measured through reductions in deaths occurring in hospital and in the period immediately following emergency admissions.
- Shifting care from hospital into community settings will reduce the time people with frailty spend in hospital, including a reduction in extended lengths of stay (over 21 days). This will help people maintain independence, avoid hospital-associated deconditioning and recover closer to home.
- Improving care following discharge, including timely follow-up and coordinated community support, reducing the number of people with frailty who are readmitted within 28 days, supporting safer transitions of care and better long-term outcomes.

- Working proactively with our highest-need Core20PLUS5 populations, we will increase rates of frailty identification and diagnosis, closing the gap with our least deprived communities and ensuring earlier access to appropriate support and interventions.

### How we will get there

Figure 7 describes, at high level and illustratively, the sequence of key strategic commissioning activities we will undertake to deliver transformed frailty care. This will be an iterative – rather than linear – process whereby, for example, piloted models will be evaluated before wider implementation. A detailed implementation plan will be developed and delivery elements may be added, brought forward for earlier action or pushed back to a later timeframe.

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# Frailty Delivery Roadmap

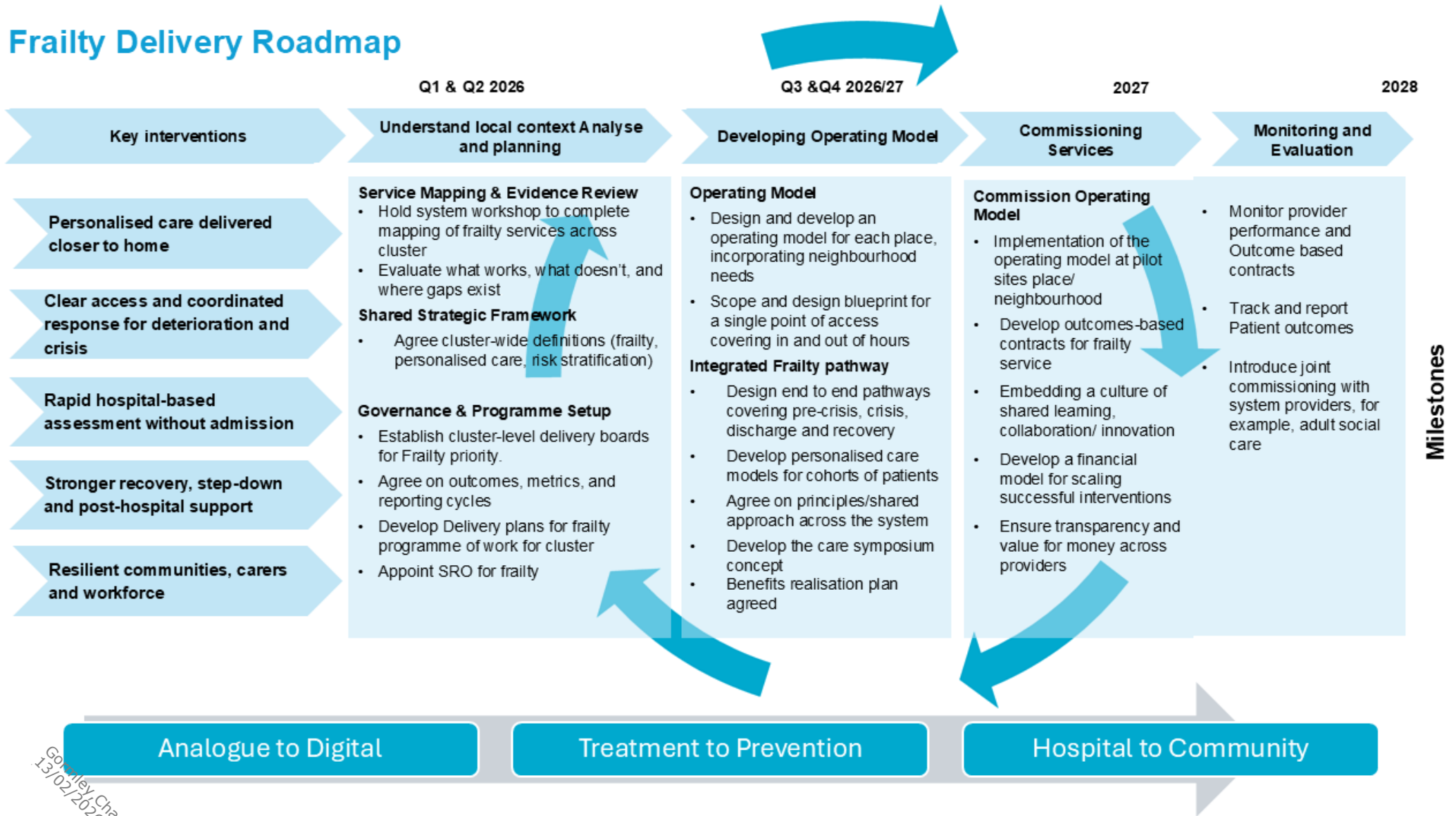


Figure 7 – Delivery road map for frailty care commissioning

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## 5.4.2 PREVENTABLE MORTALITY

### Our ambition for preventable mortality

*We want to prevent as many people as possible from developing cardiovascular disease (CVD), cancer and respiratory disease. Where people are at risk, we will improve the early identification of their condition. For those with a diagnosed condition, we will support them to understand and manage their condition as independently as possible in order to achieve the best possible outcomes that they can.*

To achieve this, we will commission services that prevent the development and progression of cardiovascular disease (CVD), cancer and respiratory disease. For people with a diagnosed condition, we will commission person-centred, integrated services that enable individuals to live well and independently for longer.

### Background and strategic context

We know that too many people in LNR die early due to cardiovascular disease (CVD), cancer and respiratory disease (See Figure 4, Section 4.2) and we know that we can prevent a substantial proportion of these early deaths from happening. We also know that these early deaths are higher in areas that are most affected by socio-economic deprivation but, despite this, many people in those communities are not diagnosed until their condition has progressed. These three conditions are also the most significant drivers of urgent and emergency care use and there is robust evidence that supporting people earlier in their pathway, to better manage their conditions, will lead to better outcomes and reduced need for urgent care services. By targeting effective care that meets the needs of disadvantaged communities, we will start to address the inequalities gaps in life expectancy between our most and least affluent populations.

Understanding what is driving preventable deaths is an essential component of understanding the health needs of our communities at a Neighbourhood level. To improve health outcomes, we need redesign the entire pathway, from population level prevention activities, through primary and community care and onto elective and urgent care services. These conditions are complex with many people having a range of diagnosis. Factors such as smoking, weight and general wellbeing can play a key role in both the risk of developing the condition as well as managing and treating it.

### Key interventions we plan to make

We will focus on a small number of system-wide interventions that, collectively, shift the focus of care from treatment to prevention. These interventions provide a clear strategic direction while allowing flexibility for local delivery and different stages of Neighbourhood maturity.

#### **Intervention 1 – Population-level prevention schemes, targeting underserved communities**

Working with partners to develop a whole system / whole population approach to prevention that includes obesity, smoking, alcohol and immunisations. Enhancing the whole population offer with targeted work with our partners in the voluntary and community sector to support under-served communities and people with higher health and care needs.

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## **Intervention 2 – Early diagnosis to improve outcomes and reduce the number of undiagnosed people**

Earlier diagnosis leads to better patient outcomes. We will improve case finding in primary care for patients with CVD and respiratory disease and screening and symptom recognition for onward referral for cancer. Maximising uptake of the [NHS Health Checks Programme](#), cancer screening programmes and other screening opportunities are essential to improving early diagnosis of patients. This will need implementation of [Making Every Contact Count](#) (MECC) through all our services and interventions. Patients will have rapid access to in-hospital diagnostic services, including rapid access for cancer diagnosis, with a commitment to the implementation of [Jess's Rule](#).

## **Intervention 3 – Ensuring people have access to the right treatment pathways**

We will ensure that people have equitable access to high quality treatment services and interventions appropriate to their needs. This will include meeting our waiting list commitments for rapid diagnosis for cancer patients.

## **Intervention 4 – Support in primary and community care through new neighbourhood models**

Once diagnosed, people will be supported through primary care, community services and Neighbourhoods to understand their condition, enabling them to manage their condition as independently as possible. Putting primary, secondary and tertiary prevention at the heart of our Neighbourhood strategies, we will ensure that conditions are optimised in primary care and that people are receiving all recommended care processes to ensure that their health conditions are managed effectively in the community to prevent further deterioration / exacerbations. People with CVD, respiratory disease and cancer will still experience exacerbations that will result in a need for urgent care services. Neighbourhood hubs will be essential in supporting people to understand when they will need urgent care services, how to access them and to provide people with support post-discharge.

## **How we will know we've succeeded**

We are currently developing an LNR Outcomes Framework, within which we will identify specific outcomes we want to deliver for preventable mortality. Progress in achieving these outcomes will then be tracked and reported, both through our preventable mortality commissioning governance arrangements, as well as through wider LNR system monitoring. We expect to include outcomes that demonstrate the following:

- Working in partnership with our Core20PLUS5 communities, we will identify people earlier and increase the number of people recorded on GP registers for hypertension, [coronary heart disease](#) (CHD), [atrial fibrillation](#), [chronic obstructive pulmonary disease](#) (COPD) and asthma, ensuring they receive proactive, evidence-based care to prevent disease progression and avoidable complications.
- Increasing uptake of flu, COVID-19, and other vaccinations will protect vulnerable populations from avoidable infections, reduce hospital admissions and excess mortality.
- Reducing preventable mortality from cardiovascular disease, cancer and respiratory disease by earlier diagnosis, timely treatment and targeted interventions. Earlier diagnosis and faster access to treatment will improve survival rates and help people remain in the best possible health for longer.
- Improving uptake of cancer screening programmes, particularly within Core20PLUS5 populations, alongside delivery of cancer waiting time standards, enabling faster diagnosis, earlier treatment and better outcomes, helping to narrow health inequalities.

- Ensuring accurate diagnosis and high-quality management of long-term conditions, for example, confirming COPD through spirometry and delivering diabetes care processes to support effective disease control, such as improved blood pressure management, and reduce the risk of preventable death.
- Supporting people to address modifiable risk factors, including obesity, smoking and alcohol use, to improve overall health, enable better self-management of long-term conditions and reduce reliance on acute care.
- Effective discharge planning and reduced readmissions will support recovery following acute illness, helping people remain independent at home, improving quality of life and contributing to sustained reductions in preventable mortality.

## How we will get there

Figure 8 describes, at high level and illustratively, the sequence of key strategic commissioning activities we will undertake to deliver transformed preventable mortality care. This will be an iterative – rather than linear – process whereby, for example, piloted models will be evaluated before wider implementation. A detailed implementation plan will be developed and delivery elements may be added, brought forward for earlier action or pushed back to a later timeframe.

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# Preventable Mortality Delivery Roadmap

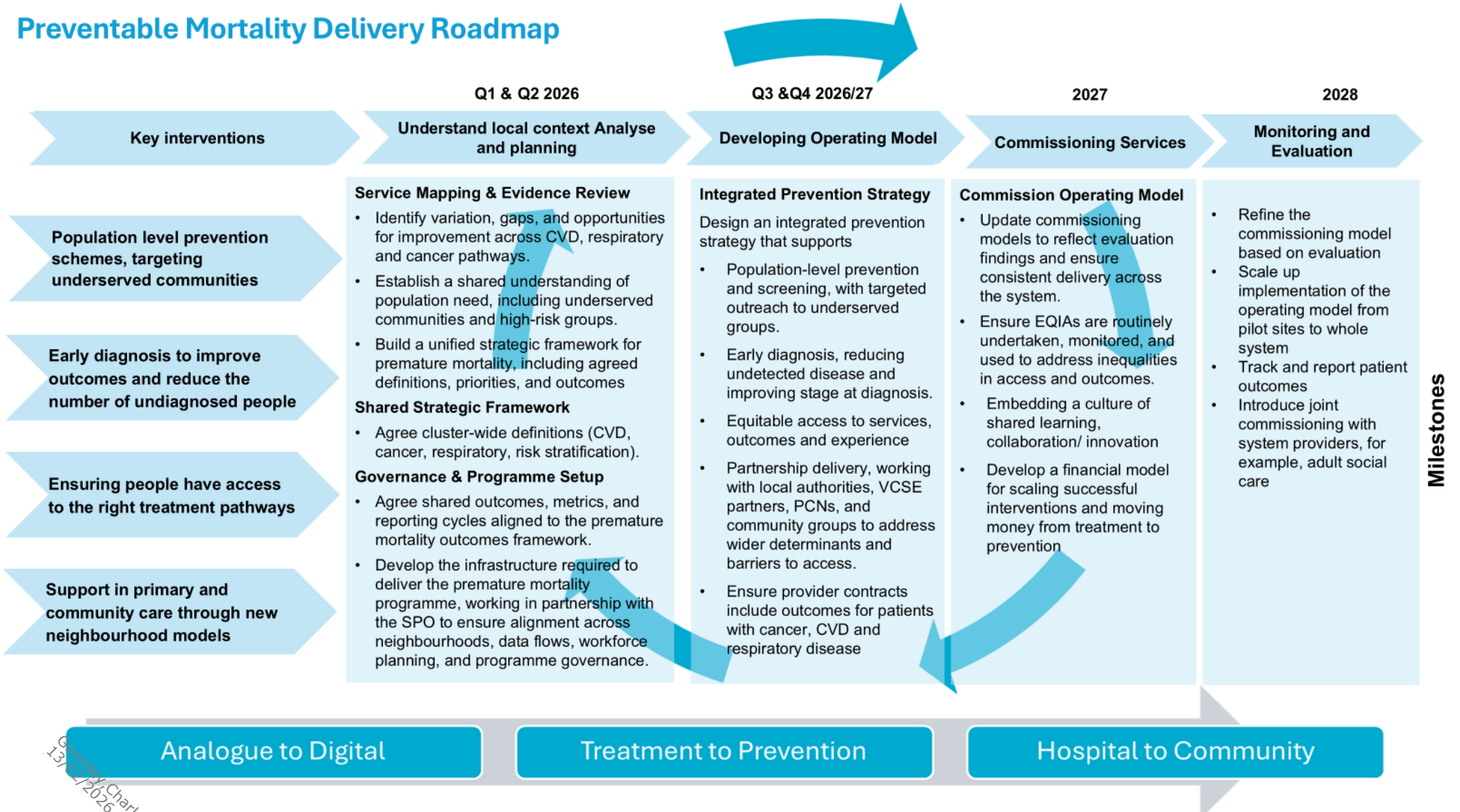


Figure 8 – Delivery roadmap for commissioning preventable mortality interventions

### 5.4.3 CHILDREN & YOUNG PEOPLE – Mental Health and Neurodiversity

Our ambition for children and young people’s mental health and neurodiversity care

*We will make it easier for children and young people to receive early and equitable mental health and neurodiversity care.*

To achieve this, we will create a joined up, needs-led system where mental health, physical health and neurodiversity support is available at the earliest opportunity, delivered in the right place, and shaped around lived experience. This includes strengthening prevention, improving assessment pathways, supporting families while they wait, and ensuring timely access to specialist care when required.

#### Background and Strategic Context

As highlighted at [Section 4.2](#), children and young people’s mental health and neurodiversity needs continue to rise in LNR, mirroring national trends. We acknowledge the need to transform the way assessments and support are delivered. Rising demand, combined with a national shortage of suitably qualified clinicians, will require us to adopt more innovative, efficient and family-centred approaches. This includes ensuring that CYP needs are not overshadowed by all-age priorities, and that pathways explicitly reflect the needs of children, young people, families and carers.

Alongside this, we recognise the significant physical health needs of CYP which must be explicitly integrated to avoid being overshadowed by adult-focused long-term condition priorities. Our approach is grounded in partnership with [SEND](#) alliances, local authorities, education, VCSE partners and neighbourhood teams, ensuring alignment with wider system strategies – for example, the delivery of CYP weight management approaches – and reducing fragmentation.

A core part of our inequalities focus is ensuring that Core20PLUS5 groups, including looked-after children, young carers, children with SEND, those experiencing socio-economic disadvantage, and other vulnerable cohorts are explicitly embedded across all interventions. These groups experience disproportionately poorer outcomes, higher levels of unmet need, and greater barriers to accessing timely support. Our commissioning approach therefore places them at the centre of system design, prioritisation and delivery.

#### Key interventions we plan to make

##### **Intervention 1 – Optimise ASD and ADHD diagnostic pathways**

Develop clear commissioning policies, referral thresholds, consistent governance and equitable access. Reduce variation, improve governance and address waiting list risk. Strengthen support for children, young people and families pre, during and post-diagnosis.

##### **Intervention 2 – Develop a consistent early intervention and navigation approach**

Aligned with SEND Alliances, local authority partners and wider system leadership.

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### **Intervention 3 – Integrate Mental Health Support Teams and neurodiversity roles within schools**

Supporting earlier identification, timely intervention and wrap-around support for children, young people and families.

### **Intervention 4 - Develop CYP specific neighbourhood MDTs**

Building on learning from ageing well programmes, but tailored to the needs of children, young people and their families.

### **Intervention 5 – Mobilise and mature the CYP Lead Provider model in Northamptonshire**

Commissioning towards outcome-based contracts, strengthened accountability and meaningful VCSE involvement.

### **Intervention 6 - Strengthen transition across the life course**

Ensuring planned, supported and seamless transitions between early years, school, adolescence and adult services, with a specific focus on vulnerable groups and reducing drop-out at points of transition.

### **How we will know we've succeeded**

We are currently developing an LNR Outcomes Framework, within which we will identify specific outcomes we want to deliver for children and young people's mental health and neurodiversity. Progress in achieving these outcomes will then be tracked and reported, both through our CYP mental health and neurodiversity commissioning governance arrangements, as well as through wider LNR system monitoring. We expect to include outcomes that demonstrate the following:

- Reduced waiting times for neurodiversity assessment with better support while children are waiting. Faster and more comprehensive support on diagnosis.
- Giving children and young people the healthiest possible start in life, supporting better health, wellbeing and life chances into adulthood. We will reduce avoidable child mortality by strengthening prevention, early intervention and timely access to high-quality care working with partners.
- Improved management of long-term conditions will reduce avoidable health crises and emergency hospital admissions for children and young people. Progress will be measured through reductions in hospital admissions for asthma, supporting better day-to-day disease control and improved quality of life.
- Increasing uptake of vaccinations and immunisations will protect children and young people from preventable illness, reduce the risk of serious infection and lay the foundations for better health across the life course.

### **How we will get there**

Figure 9 describes, at high level and illustratively, the sequence of key strategic commissioning activities we will undertake to deliver transformed mental health and neurodiversity care for children and young people. This will be an iterative – rather than linear – process whereby, for example, piloted models will be evaluated before wider implementation. A detailed implementation plan will be developed and delivery elements may be added, brought forward for earlier action or pushed back to a later timeframe.

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# Children and Young People Mental Health and Neurodiversity Delivery Roadmap

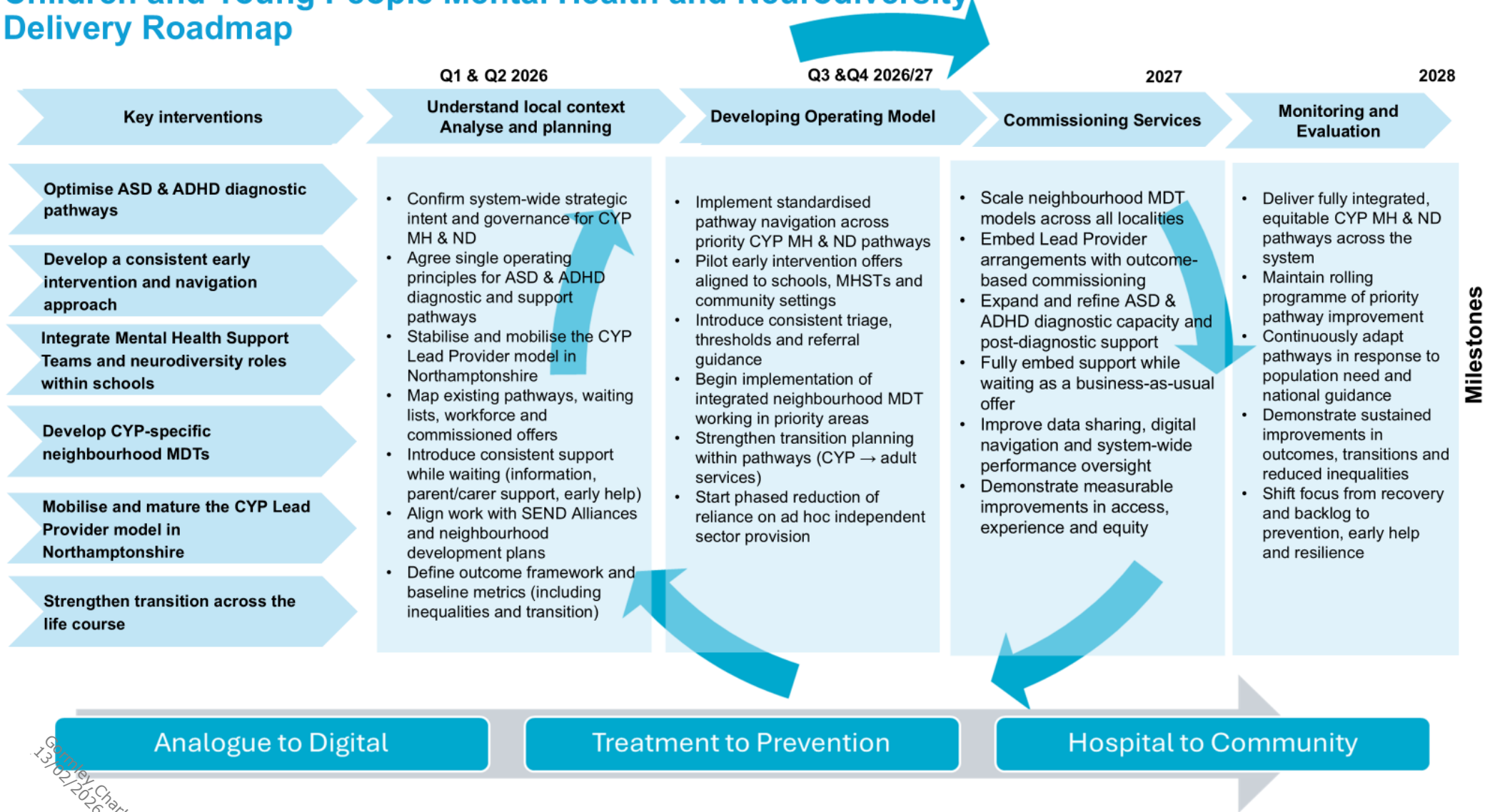


Figure 9 – Delivery roadmap for CYP mental health and neurodiversity care commissioning

## 6. TRANSFORMATION AND NEW CARE MODELS

### Our approach to transformation

Our new role as the strategic commissioner (see [Chapter 3](#)) frames our approach to transformation. This role provides both the mandate and the opportunity to accelerate transformation, to reshape care models and pathways, to maximise benefits of digital technology, to make investment decisions that drive and deliver better outcomes and value for taxpayer's money. We recognise that transformation can only be achieved through a genuine joined-up approach. We are committed to working collaboratively with NHS providers, local authorities and the VCSE sector to deliver sustained improvements in population health, reduced health inequalities and securing the long-term financial sustainability of our system.

Through this Plan, we signal our intent to shift the focus from treatment to prevention, investing upstream and supporting the creation of health, not solely the provision of health services. This is a commitment to a shared endeavour to place prevention, Neighbourhood capacity and digital innovation at the heart of the transformation agenda.

We will work with partners and act as the convenor and coordinator of major transformation programmes, underpinned by:

- Annually refreshed LNR Integrated Needs Assessment to ensure transformation priorities and linked outcomes are grounded and steered by a robust evidence base.
- Providing strategic leadership and governance for large-scale transformation programmes, ensuring alignment across places, providers and programmes.
- Supporting autonomy for Neighbourhood models of care whilst ensuring consistency and synergy with system-wide priorities.
- Thoroughly evaluate outcomes from commissioned services to ensure delivery and value.

### Community capacity transformation

Neighbourhoods are the foundational building block of LNR's new care model (see [Section 5.3.3](#)) and the primary vehicle for shifting resources from acute settings into community-based, preventative and proactive care. Our approach will:

- Scale Neighbourhood health models that deliver integrated, multidisciplinary care aligned to defined neighbourhood populations.
- Build on learning from West Leicestershire and Northamptonshire neighbourhood pilots to inform consistent, system-wide rollout.
- Strengthen community capacity through closer partnership with VCSE organisations, local authorities and primary care.
- Embed neighbourhood-level commissioning, outcomes frameworks and workforce planning within the system architecture to support sustainability and impact.

Through this approach, neighbourhoods will be empowered to address the wider determinants of health, reduce inequalities and support people to live well for longer.

## Embracing new system architecture

Delivering the scale and pace of transformation required means we need to actively explore, embrace and harness the evolving local system landscape, including new provider forms as detailed in the NHS 10 Year Health Plan for England. We also have a key role in shaping system architecture through our responsibilities for strategic market management. This includes developing a provider landscape that is aligned to population health needs and is able to deliver our commissioning intentions and priorities. In practice this means:

- Supporting the evolution and commissioning of Neighbourhood health services through single neighbourhood providers (SNP) or multi-neighbourhood providers (MNP) contractual arrangements and building on the learning and outputs of the West Leicestershire implementer pilot.
- Exploring the opportunities and benefits of [Integrated Health Organisations](#) (IHOs), including readiness for implementation; noting that Northamptonshire Healthcare NHS Foundation Trust (NHFT) has been selected as part of the first wave of Trusts being assessed for [Advanced Foundation Trust](#) status and additional designation to be eligible to hold an IHO contract.

## Ensure Value for our Population

Our transformation agenda is designed to maximise value for patients and taxpayers particularly in the context of significant and sustained financial challenges, by:

- Reaffirming our role as a strategic commissioner focused on population health need, outcomes and the delivery of financial sustainability, including the development and delivery of robust [Cost Improvement Programmes](#) (CIP).
- Embedding primary and community care as the foundation of integrated delivery.
- Aligning our commissioning priorities with those of Partner, to reduce duplication, maximise collective impact and support system-wide efficiency.
- Developing the provider market to support innovation, responsiveness and equity, including new delivery and contractual models that incentivise prevention, integration and value.
- Accelerating transformation through targeted investment, outcomes-based commissioning, robust evaluation and the strategic use of data, ensuring that resources are directed to interventions that deliver measurable improvements in outcomes, productivity and value for money.

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## 7. FINANCE

### Background and Strategic Context

The LNR Cluster is operating within a complex and pressured environment, shaped by rising demand, persistent inequalities, and significant variation in financial performance across Leicester, Leicestershire and Rutland (LLR) and Northamptonshire. To overcome these issues the ICBs will require relentless focus on understanding population health needs and devise a strategy to meet them. The role of the finance function will be to deliver its elements of that strategy, while remaining focused on overall service sustainability.

While Northamptonshire has maintained a stable financial position in recent years, LLR continues to face a substantial underlying deficit of £46m (1.6% of resources). This divergence reflects historic patterns of demand, service configuration, and productivity, and it underscores the need for a strategic, system-wide approach to commissioning and care model transformation. The financial priority for a system with an underlying deficit, is to create financial headroom to return to a balanced financial position and fund the return of accumulated deficit.

The ICB Cluster Board understands the need to make sustained change to existing models of care and develop successful primary and secondary prevention strategies in order to achieve financial sustainability. So the challenge ahead of the ICB Cluster will be to create the platform, climate and financial controls that meet and deliver a sustained focus on the delivery of value and population health outcomes.

Across both ICBs, the system is experiencing:

- **Increasing demand and acuity**, particularly in urgent and emergency care, mental health, and long-term conditions.
- **Pressure on elective recovery**, with backlogs continuing to drive activity and cost.
- **Variation in access, outcomes and experience**, particularly for communities experiencing deprivation, exclusion or unmet need.
- **Limited financial headroom to scale up new models of care**, limiting the pace at which services can shift into community and prevention-focused models.
- **Fragmented pathways and inconsistent models of care**, which reduce efficiency and limit the ability to deliver care in the most appropriate setting.

Despite these challenges, the LNR Cluster has strong foundations: a shared commitment to population health improvement, a maturing approach to strategic commissioning, and a clear financial strategy that prioritises value, prevention, and sustainability.

### How we are getting there

The start point for building a long-term population health strategy, and the engine of strategic commissioning, is comprehensive population-health insight. This insight will combine a deep understanding of how our population currently uses our services, the nature of health vulnerability within the population and predictive modelling to assess future health need. The ICB Cluster Board will facilitate innovation in new and improved clinically led care models and will assess how their

introduction changes the nature of service delivery. With a clear vision of how service provision will need to change, and mindful of the constraints of the resources available to us, we will set out on a journey to develop and implement a long-term population health strategy

The finance directorate will use insights predictive modelling and take a lead in developing strategic purchasing and market shaping functions, providing clear incentives to providers to change their service delivery models and evolve market capacity and capability from where it is today to where it needs to be to provide long term financial sustainability. This will require progressive change over a multi-year timeframe, driven by testing innovative approaches and assessing benefit in a rapid and controlled cycle.

Our commissioning approach over the next five years is designed to bring coherence, discipline and ambition to the way we plan, prioritise and invest across LNR. We will move from reactive, activity-driven commissioning to a strategic, outcomes-focused model that uses health economics, evidence and population insight to guide decisions.

## A Shared Financial and Strategic Framework

We will deliver a breakeven position across the planning period by:

- Embedding a single value assessment framework to prioritise investment, assess impact and ensure resources are deployed where they deliver the greatest benefit.
- Applying consistent financial stewardship across both ICBs, with transparent reporting and joint decision-making.
- Through the ICB Commissioning for Value Framework (CfV) the total £5bn resource envelope across LNR will be assessed for value delivery , not just new growth funding, to maximise system value. These reviews will be done in collaboration a broad range of partners,
- This approach will be critical to delivering the efficiency improvements required to return the NHS to a sustainable and productive footing.

## Transforming Key Patient Pathways

Commissioning intentions will focus on the pathways with the greatest opportunity to improve outcomes and reduce cost:

- **Frailty** – shifting care upstream, reducing avoidable admissions, and improving flow.
- **Preventable Mortality** – targeted prevention and earlier intervention for cardiovascular, respiratory and metabolic conditions.
- **Children and Young People** – improving access, experience and outcomes, with a focus on emotional wellbeing and complex needs.
- **ADHD and Neurodiversity** – redesigning pathways to reduce waits, improve equity and support families earlier.

These changes will ensure care is delivered in the **right place, at the right time**, supported by neighbourhood-level models and strengthened community capacity.

## Redesigning Financial Flows to Support Transformation

We will ensure that funding follows patients and rewards outcomes by:

- Applying innovative incentive models that support outcomes that are measurable, supported by partners and mean something to our population.

- Applying the Provider Selection Regime to commission at the right scale — neighbourhood, place, system or multi-ICB.
- Exploring risk-share models that encourage collaboration across VCSE, primary, community, acute and social care partners.
- Aligning financial flows with pathway redesign to support the “left shift” into community settings.

## Enabling Conditions for Delivery

To support the pace and scale of change required, we will:

- Strengthen estates, digital infrastructure and workforce planning to ensure services can operate efficiently and sustainably.
- Use horizon scanning and innovation adoption to bring new technologies and models of care into the system.
- Maintain strong governance through the Joint Executive Team and ICB Boards to ensure disciplined, evidence-based decision-making.

## Our Trajectory

By aligning commissioning, finance and transformation, the LNR Cluster will move from a position of variation and financial pressure to one of coherence, sustainability and improved outcomes. The roadmap will set out the year-by-year milestones, including pathway redesign, productivity gains, investment decisions and the expected financial impact.

## Our Route to Sustainability

Our route to sustainability is built on a disciplined, system-wide approach that aligns commissioning, transformation and financial stewardship across LNR. We will stabilise the current position by strengthening financial control, improving productivity and reducing unwarranted variation, while simultaneously investing in the pathways and enablers that deliver long-term value. Over the lifetime of the plan, we will shift activity into community settings, redesign high-impact pathways, and ensure that funding follows patients into the most appropriate and efficient models of care. This will be supported by the Commissioning for Value Framework, consistent prioritisation processes, and targeted transformation funding to accelerate change. By combining these elements, the LNR Cluster will move from a position of variation and underlying deficit to one of coherence, sustainability and improved outcomes for our populations.

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## 8. DIGITAL

### Background and strategic context

Digital and data are essential enablers of this Plan and will underpin delivery of improved population health outcomes, reduced inequalities, and more sustainable services across LNR. Over the five-year period, digital will be commissioned in direct support of pathway transformation, Neighbourhood delivery and new models of care, rather than as a standalone programme. This will ensure that investment is tied to measurable service impact, population need and the shift towards proactive, integrated Neighbourhood care.

We recognise that digital maturity, capability and readiness vary across our providers and Neighbourhoods. Our commissioning approach will, therefore, focus on building strong, shared digital foundations while enabling progressive delivery of digitally enabled care models that support INTs, urgent care transformation, elective redesign and prevention.

### Digital as part of strategic commissioning

Digital considerations will be embedded within all commissioning intentions and business cases. This includes:

- Ensuring that digital requirements are identified at the earliest stage of pathway design, with active involvement of digital and data leads.
- Avoiding isolated or duplicative digital solutions by taking a coordinated, system-wide approach aligned to our priorities.
- Ensuring commissioned services are interoperable, scalable, and aligned to agreed architectural and information standards.
- Working closely with providers to ensure digital commissioning intentions align with provider strategies and operational realities.

### Population health management and use of data

We will strengthen the use of data and analytics to support population health management, commissioning decisions, and system assurance. This includes:

- Proactive identification and management of priority cohorts of people, through improved segmentation and risk stratification, with a focus on frailty, children and young people, and reducing preventable mortality.
- Better use of linked data across health and care to inform commissioning and evaluate impact.
- Reducing variation in data quality and sharing intelligence to improve consistency across commissioned services.
- A new Digital and Data Strategy will be developed by September 2026, followed by a Data Quality Strategy by March 2027, ensuring alignment with the five-year commissioning plan and 10 Year Health Plan for England ambitions.

### Digital inclusion and equity

We recognise the risks associated with a “digital by default” approach. Commissioning decisions will therefore:

- Require explicit consideration of digital inclusion and accessibility within service specifications.
- Ensure non-digital routes remain available for individuals who cannot or choose not to access digital services.
- Support services to improve digital confidence and literacy among both the population and the workforce.
- Monitor the impact of digital services on health inequalities to ensure they do not exacerbate existing gaps.
- Require service specifications to include digital access variance, and equity impact evidence in business cases

## Workforce enablement and capacity

Digital transformation is dependent on a capable and confident workforce. Over the planning period, we will:

- Prioritise the retention of critical digital and data roles, recognising their importance to both commissioning and delivery.
- Ensure commissioned services support workforce digital capability, including training and change management.
- Recognise system capacity constraints when setting expectations for digital delivery and timescales.
- Strengthen workforce digital skills through targeted upskilling and ongoing learning support, enabling efficient use of digital tools and sustainable adoption for maximum productivity.

## Investment and funding approach

Given ongoing financial pressures, we will adopt a pragmatic and integrated approach to digital investment:

- Digital funding will be embedded within pathway redesign and service transformation to ensure funding aligns with service outcomes. This will complement existing dedicated digital funding streams, aligned with priority programmes to maintain core system-wide digital infrastructure.
- Business cases will clearly articulate digital dependencies, benefits realisation (management and monitoring after implementation), and risks.
- Investment decisions will prioritise solutions that deliver tangible commissioning and population health benefits.

## Governance, leadership and alignment

To address the risk of fragmentation and misalignment, we will:

- Strengthen central digital leadership to provide strategic oversight, coordination, and assurance.
- Ensure alignment between local, regional, and national digital strategies.
- Establish clear governance routes for digital decision-making within commissioning.
- Maintain strong engagement with provider digital leads to ensure coherence across the system.

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## 9. WORKFORCE

### Our revised workforce role

In readiness to take on our new strategic commissioning roles, remits and responsibilities, and as set out in the [Model ICB Blueprint](#), our workforce role is fundamentally changing, with many functions transferring elsewhere:

- High level strategic workforce planning, development, education and training will transfer, over time, to regional or national level; and
- Local workforce development and training, including recruitment and retention, will transfer, over time, to providers.

Our future workforce role will be more limited and focussed on providing workforce input to strategic commissioning functions:

- Subject matter expertise and insights to enable outcomes-based commissioning of new care and service models, and contract management.
- Commissioning multi-partner workforce strategies and plans (NHS, primary care, social care and VCSE employers), to support the development of Neighbourhood health models, and associated strategic risk management.
- Socio-economic and anchor impact: commissioning for reductions in health inequalities through work and workforce including local skills supply, apprenticeships, and routes into employment, health and care careers.

### Our workforce: Strategic commissioning capacity, capability and development

We are currently clarifying accountabilities, streamlining functions and refocusing capacity towards population health management, outcomes-based commissioning and system leadership. This realignment marks an important milestone in our evolution, however, we will need to build and develop our strategic commissioning workforce through:

- Investing in our staff, ensuring that they are equipped with the skills, tools and development opportunities to operate as effective strategic commissioners.
- Expanding specialist expertise in areas such as population health analytics, health economics, outcome-based commissioning and digital enablement.
- Developing leadership and system working to ensure collaboration and facilitate the required service transformation.
- Instilling and living positive values and principles that guide our work.
- Embedding learning and continuous improvement as default objectives to ensure insight, evaluation and feedback is used to refine and inform our commissioning approach.

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## 10. ESTATE & FACILITIES

### Background and strategic context

Estates and facilities are a key enabler for delivering our core commissioning and strategic transformation priorities. Our infrastructure underpins the shift toward Neighbourhood-based care, digital transformation, prevention, and integrated clinical pathways across LNR.

Our provider's estate is large and varied, spanning hospitals, mental health and learning disability facilities, primary care, and support buildings across both city and rural areas. It supports a wide range of needs, from emergency and inpatient care to prevention, mental health support, and recovery.

Upgrades and sustainability improvements have enhanced some estate, however, much of the estate remains outdated, inflexible, and designed for single-purpose use. Many buildings struggle to support evolving service models or patient needs, and the limited availability of flexible, multi-use, digitally enabled space constrains multidisciplinary working, care closer to home, and integrated physical and mental health services. Limited capital hinders backlog maintenance, modernisation, and investment in new capacity.

### Where we want to be

NHS national capital monies come from various sources to various organisations for specific purposes. We have a critical role in coordinating with the regional NHS team, our providers, local authorities and others to achieve a difficult outcome – to maximise the added value of the limited capital monies we collectively receive to provide estate and facilities that are modern, sustainable, flexible, digitally enabled, that achieve national net zero targets, and support integrated Neighbourhood care, prevention, and emerging clinical models across both urban and rural communities.

We have been allocated £26m [Strategic Capital](#) over four years which will be used to support demand management via neighbourhood models, primary care estates and digital innovation.

Capital funding to support achieving [NHS Constitution standards](#), as well as and the three strategic shifts ([see Chapter 3](#)) has also been allocated across LNR, as well as our providers, over four years, to support diagnostics, UEC, mental health, learning disabilities & autism, community services, elective and primary care. The largest schemes include:

- New CDCs at University Hospitals of Leicester (£23.5m) and University Hospitals of Northamptonshire (UHN) (£23.0m)
- Co-location of the Urgent Treatment Centre with the ED at UHN (£14.725m)
- A new Diagnostic and Elective Hub at UHN (£25.0m).

Capital funding is also being held, nationally, to support a number of areas including NHCs, [Frontline Productivity Programme](#), technology transformation and the [New Hospital Programme](#) (NHP).

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## 11. RISKS TO DELIVERY

This risk analysis provides a balanced, system-wide view of the key risks associated with delivering the LNR Commissioning Plan.

Risk is	Likelihood	Patient/Operational Impact	Financial Impact	Internal Mitigations (No External Funding Required)
<b>Inequalities not narrowing at the expected pace to deliver outcomes Framework</b>	Medium	Quality of care, poorer outcomes and patient experience, increased variation	Higher long-term demand for primary and urgent & acute care	Population Health Management, segmentation, neighbourhood profiles, targeted prevention, VCSE partnerships to reach the underserved group
<b>Organisational restructuring, management of the change process, and cultural resistance to new ways of working</b>	Medium	Workforce morale, Loss of organisational knowledge Reduced productivity during transition	Delays in developing delivery plans and slower realisation of efficiencies	Strong clinical & senior managerial leadership; clear communication; protected development time
<b>System Financial Sustainability and efficiency</b>	High	Reduced quality and consistency of care, with greater variation in patient experience and outcomes	Increased financial risk to system, threatening system stability and long-term affordability	Outcome-based commissioning: Aligning incentives to value, quality and population health outcomes rather than activity alone system CIP plans
<b>Insufficient digital and data capacity, Fragmented digital solutions and lack of interoperability and widening equalities due to digital exclusion</b>	Medium	Fragmented care; slower proactive interventions; reduced staff confidence	Duplication of assessments; manual workarounds; inefficiencies	Early engagement Prioritise shared care record adoption; standardised digital processes; digital champions; mandatory onboarding
<b>Cost Improvement Plans and cost-avoidance not realised at expected pace</b>	Medium	Slower shift to community-based care; reduced system confidence	Pressure on existing pathways reduced reinvestment in prevention	Phased implementation; strengthened demand & capacity modelling; internal resource reallocation; outcomes-based contracting
<b>Failure to reduce avoidable urgent care demand</b>	Medium	Poorer outcomes; increased inequalities; staff pressure	Continued pressure on ED, ambulance & acute beds	Strengthen UCR & same-day access; embed proactive care planning; expand pharmacy-first & neighbourhood urgent pathways
<b>Inconsistent quality &amp; safety across neighbourhoods</b>	Medium	Patient harm; reputational risk; regulatory scrutiny	Increased cost of reactive care; safeguarding interventions	Standardised governance; shared quality dashboards; case-based learning; strengthened clinical leadership
<b>Insufficient alignment across NHS, Local Authorities &amp; VCSE</b>	Medium	Fragmented care; reduced impact on inequalities	Inefficient commissioning; duplication of services	Joint planning via HWBs & BCF; shared outcomes; VCSE embedded in INTs; co-production with communities

## Glossary of terms used

Acronym	Explanation
ADHD	Attention Deficit Hyperactivity Disorder
A&E	Accident & Emergency
ARRS	Additional Roles Reimbursement Scheme
ASD	Autism Spectrum Disorder
BCF	Better Care Fund
CDC	Community Diagnostic Centre
CGA	Comprehensive Geriatric Assessment
CHD	Coronary Heart Disease
CIP	Cost Improvement Programmes
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
CYP	Children and Young People
DNA	Did Not Attend
ED	Emergency Department
FeNO	Fractional Exhaled Nitric Oxide
GP	General Practitioner
HWBs	Health and Wellbeing Boards
ICBs	Integrated Care Boards
IHO	Integrated Health Organisation
INT	Integrated Neighbourhood Teams
JSNA	Joint Strategic Needs Assessment
LD&A	Learning, Disability and Autism
LLR	Leicester, Leicestershire & Rutland
LNR	Leicestershire, Northamptonshire & Rutland
LTC	Long Term Condition
MDT	Multidisciplinary Team
MECC	Making Every Contact Count
NHFT	Northamptonshire Healthcare NHS Foundation Trust
MNP	Multi-Neighbourhood Providers
MH	Mental Health
MSK	Musculoskeletal
NHC	Neighbourhood Health Centre
NHS	National Health Service
NHSE	NHS England
NQB	National Quality Board
PIFU	Patient Initiated Follow-Up
PHM	Population Health Management
PNGs	Patient Need Groups
PSIRF	Patient Safety Incident Framework
SDEC	Same Day Emergency Care
SEND	Special Education Needs and Disability
SNP	Single Neighbourhood Providers
SPOC	Single Point of Contact
VCSE	Voluntary, Community, and Social Enterprise
UCR	Urgent Community Response
UEC	Urgent and Emergency Care
UHN	University Hospitals of Northamptonshire

# Board Meetings in Common in Public

## Report Title: Transition Assurance Report

Date of Meeting: 19 February 2026

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>Thursday 19 February 2026</b>		
<b>Report Title</b>	<b>Transition Assurance Report</b>		
<b>Paper Reference No:</b>	<b>ICBIC-26-05</b>	<b>Agenda Item No:</b>	<b>10.</b>

<b>Presented by</b>	<b>Pete Burnett, Chief Strategy Officer</b>
<b>Report Author(s)</b>	<b>Alice McGee, Transition Director</b>
<b>Executive Sponsor</b>	<b>Toby Sanders, Chief Executive Officer</b>

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input checked="" type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.
<b>Recommendations</b>		
<p><b>The Boards are asked to:</b></p> <ul style="list-style-type: none"> <li>Note the progress of the Transition to Model ICB and achieve its mandated reductions</li> </ul>		

**Executive Summary of the report**

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

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

<b>Conflicts of interest – Please select</b>	
<input checked="" type="checkbox"/>	No conflict identified
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision

<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	Conflict noted, conflicted party to be excluded from the meeting
<b>If conflicted identified, please list conflicted party and nature of conflict:</b> N/A	

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: 10 and 11	NICB BAF No: 9

Appendices	N/A
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Who has been engaged and where else has this report been considered:
<p>August 2025 – Separate ICB Board, assurance report and approach to transition</p> <p>October 2025 – Board in Common assurance report</p> <p>December 2025 – Board in Common assurance report</p> <p>Monthly Transition Committee meetings</p> <p>Monthly Transition updates to Joint Executive Team</p>

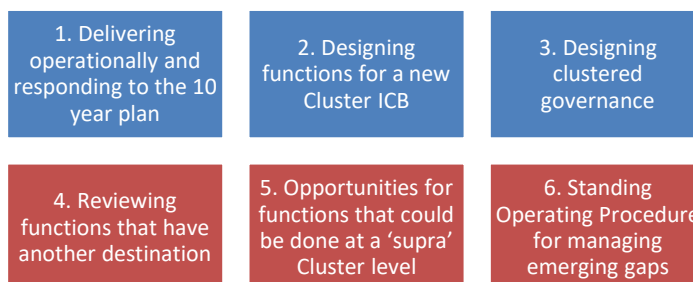
Implications: Select which of the following implications need to be considered							
<input checked="" type="checkbox"/>	Quality & Patient Safety	<input checked="" type="checkbox"/>	Legal	<input checked="" type="checkbox"/>	Equality, Diversity & Inclusion		
<input checked="" type="checkbox"/>	Environmental	<input checked="" type="checkbox"/>	Data & Digital	<input checked="" type="checkbox"/>	Financial	<input checked="" type="checkbox"/>	Workforce

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Joint Transition Assurance Report  
19 February 2026

Introduction

1. The Transition Committee was set up in shadow form in May 2025 to oversee the transition and to provide assurances to the Board on progress, and escalate and concerns, risks or decisions required.
2. The committee oversees the assurance and mitigations for the Board Assurance Framework risks identified for Transition and specifically considers:
  - a. Oversight of the transition across the complexity of all the ICB functions.
  - b. Readiness assurance of any transferred functions, including resources, legal basis and receiver readiness.
  - c. Impact of clustering on place and neighbourhood development including relationships with partners and development of improved outcomes for the population.
  - d. Financial risks associated with transformation (cost of management of change).
  - e. Workforce turnover, morale injury and risk of employee relations cases up to and including employment tribunals as a result of the management of change process.
3. The Transition Committee is not a decision making committee and seeks assurance through other formal governance structures in the ICB Cluster, namely the Joint Executive Team and Remuneration Committee.
4. The transition programme has been set up focussing on 6 strands of work and this report provides an update on progress as assured by the committee



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**Progress Against Programmes of Work**

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

**Table 1**

<p>Programme 2 – Designing functions for a new Cluster ICB</p>	<p>Since the last Board assurance report, the ICB has formally launched a Voluntary Redundancy scheme for all staff, completed consultation with unions under the Trade Unions and Labour Act and has commenced an all-staff consultation with 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.</p> <p>The proposed structure design enables the Cluster to move into Strategic Commissioners and align with a new national Model ICB Blueprint which outlines core roles and functions while also significantly reducing the running cost budgets – a 33 percent for LLR and 29 per cent for Northamptonshire.</p> <p>This Management of Change (MOC) for staff follows the recruitment and appointments to the Joint Executive Team carried out last year and involves all staff across both organisations with teams and functions being brought together to serve across the LLR and Northamptonshire areas and fulfil the organisations’ refreshed role.</p> <p>The consultation will run until March 5 during which there will be full engagement with staff to get views on proposed functions, structures and how they will fulfil the purpose of the organisation. A second round of Voluntary Redundancy is also live during this consultation period.</p> <p>A full support package has been developed to assist staff during this process including face to face drop in sessions, access to health and wellbeing support, support in CV development and financial support and advice.</p> <p>The Voluntary Redundancy Scheme (round 1) has been approved by Remuneration Committee, with 92 applications being recommended to NHS England for final approval and acceptance onto the scheme. The submission to NHS England was made on 13<sup>th</sup> January 2026 and at the time of writing the report, final approval is waiting to be received.</p>
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<p>Programme 3 – Designing clustered governance</p>	<p>A new clustered governance was approved in December 2025 and is being implemented, with support from the Non-Executive Directors to finalise terms of reference and schemes of delegations</p>
<p>Programme 4 – reviewing functions that have another destination</p>	<p>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:</p> <ul style="list-style-type: none"> <li>- Going to a NHS Provider</li> <li>- Going to NHSE/DHSC regional offices</li> <li>- To be explored further</li> </ul> <p>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 future 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.</p> <p><i>Transfer to provider or partner organisation</i> Active bystander and diverse leadership programmes, the Green Agenda, Strategic Digital, Personalisation Section 117s, GP IT, infection prevention and control, and System Control Centres.</p> <p><i>Functions transitioning to region</i> Provider oversight Operational workforce planning</p>
<p>Programme 5 – Functions that could be done at a 'supra' cluster level</p>	<p>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.</p> <p>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.</p>

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	The East Midlands Joint Committee are receiving the details of this decision in February 2026
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**Recommendations:**

The Boards are asked to:

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

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## **Board Meetings in Common in Public**

**Report Title: Establishing the Office of  
Pan ICB Commissioning proposed  
transition and governance  
arrangements**

**Date of Meeting: Thursday 19 February 2026**

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>Thursday 19 February 2026</b>		
<b>Report Title</b>	<b>Establishing the Office of Pan ICB Commissioning proposed transition and governance arrangements</b>		
<b>Paper Reference No:</b>	<b>ICBIC-26-06</b>	<b>Agenda Item No:</b>	<b>11.</b>

<b>Presented by</b>	<b>Toby Sanders, Chief Executive</b>
<b>Report Author(s)</b>	<b>Jo Melling, Deputy Director Integrated Commissioning, NHSE Midlands</b>
<b>Executive Sponsor</b>	<b>Toby Sanders, Chief Executive</b>

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input checked="" type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.

<b>Recommendations</b>
<b>The Boards are asked to:</b> <ul style="list-style-type: none"> <li>• RECEIVE and APPROVE the proposed transition and governance arrangements establishing the office of Pan ICB Commissioning.</li> </ul>

<b>Executive Summary of the report</b>
<p>This paper provides a summary of the move from an East Midlands and a West Midlands Joint Committee to a Midlands Joint and Collaborative Committee and the development of the Office of Pan ICB Commissioning (OPIC) as part of the transition prior to transfer/delegation of NHS England's regional commissioning functions.</p> <p>This paper will be presented to the East Midlands Joint Committee (EMJC) on 17 February 2026, where the Committee will be requested to endorse the proposal for approval by the ICB Boards. An update will be provided to the Boards on the outcome of the EMJC meeting to support the approval of the proposal.</p>

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Please select which of the LLR ICB Strategic Objectives/NICB Core Aims relate to the report?	
<input checked="" type="checkbox"/>	<b>Improve Outcomes</b> - Improve outcomes in population health and healthcare
<input checked="" type="checkbox"/>	<b>Health Inequalities</b> - Tackle inequalities in outcomes, experience, and access
<input checked="" type="checkbox"/>	<b>Value for money</b> - Enhance productivity and value for money
<input checked="" type="checkbox"/>	<b>NHS Constitution</b> - Deliver NHS Constitutional and legal requirements
<input checked="" type="checkbox"/>	<b>Social and economic development</b> - Help the NHS support broader social and economic development
Conflicts of interest – Please select	
<input checked="" type="checkbox"/>	No conflict identified
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision
<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	Conflict noted, conflicted party to be excluded from the meeting
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: All	NICB BAF No: All

<b>Appendices</b>	<b>Appendix 1:</b> Briefing Paper for ICBs: Establishing the Office of Pan ICB Commissioning proposed transition and governance arrangements. <b>Appendix 2:</b> Collaboration Agreement (including embedded Midlands Joint and Collaborative Committee Terms of Reference)
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Who has been engaged and where else has this report been considered:
Continued engagement with ICB Cluster Transition Leads and Governance Leads.

Implications: Select which of the following implications need to be considered					
<input type="checkbox"/>	<b>Quality &amp; Patient Safety</b>	<input type="checkbox"/>	<b>Legal</b>	<input type="checkbox"/>	<b>Equality, Diversity &amp; Inclusion</b>
<input type="checkbox"/>	<b>Environmental</b>	<input type="checkbox"/>	<b>Data &amp; Digital</b>	<input type="checkbox"/>	<b>Financial</b>
				<input type="checkbox"/>	<b>Workforce</b>

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# Appendix 1

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## Briefing Paper for ICB Boards

**Date:** 13 February 2026

**Paper Title:** Establishing the Office of Pan ICB Commissioning proposed transition and governance arrangements.

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**Executive summary: This paper provides a summary of the move from an East Midlands and a West Midlands Joint Committee to a Midlands Joint and Collaborative Committee and the development of the Office of Pan ICB Commissioning (OPIC) as part of the transition prior to transfer/delegation of NHS England's regional commissioning functions**

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### 1. Introduction

- 1.1 Following the announcement of the dissolution of NHSE (subject to approval by Parliament to necessary legislative changes) and the publication of the model ICB Blueprint, from April 27, Integrated Care Boards (ICBs) will take over statutory responsibility from NHS England for commissioning suitable specialised services; health and justice services; and screening and vaccination services. Collectively, these services account for £20bn of commissioning spend in 25/26; circa £5bn within the Midlands.
- 1.2 The National Planning Framework confirmed the agreed Direct Commissioning Policy requiring ICBs to establish, in each of the seven regions, an 'Office of Pan ICB Commissioning (OPIC)' with one host ICB per region to support all ICBs across a region in discharging these additional specialist statutory functions. For the Midlands, Birmingham and Solihull & the Black Country Cluster ICBs will be the host ICB for the Midlands
- 1.3 The OPIC model is designed to facilitate ICB collaboration and, where appropriate, 'at scale' commissioning as well as ensuring economies of scale and the critical mass of expert commissioning capability is maintained for these complex and high-profile services.

### 2. Responsibilities and Accountabilities

- 2.1 The delegation of services does not change the accountability of the services, as under delegation NHSE retains accountability. When a functions transfers both the responsibility and accountability pass to the receiving organisation. Transfers of commissioning functions are subject to the passage of legislation.

Services transferring under new legislation include

Mental Health learning Disability and Autism Services

- Specialised Acute
- Health and Justice

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2.2 For NHS public health functions (section 7A functions) this will be achieved through delegation of the Secretary of State's relevant public health functions directly to ICBs (currently delegated to NHSE).

Services that will be delegated from DHSC to ICBs:

- Vaccination Services (including within the secure and detained estate)
- Screening Service (including within the secure and detained estate)
- Child Health Information Services (CHIS)

2.3 Under transfer and delegation, the intent is the same, that ICBs have full responsibility for the commissioning functions.

2.4 Whilst it is intended that ICBs will be individually responsible, most of their new commissioning functions will require – due to the nature of the services and populations involved – the larger planning and commissioning footprint that OPIC provides.

2.5 Other direct commissioning functions of NHS England, including highly specialised services; high secure mental health services; the management of high-cost drugs and devices; and services for the armed forces community will transfer to DHSC (whilst continuing to work with each OPIC) and become the responsibility of the Secretary of State for Health and Social Care.

2.6 Staff currently delivering these commissioning functions within NHSE's seven regional teams will transfer to the host ICBs in April 2027 (or, at the point legislative provisions transferring these functions to ICBs is commenced), forming the seven OPICs. Until transfer NHS England will continue to host staff on behalf of ICBs for specialised services functions already delegated to ICBs.

2.7 NHS England's continued hosting and the OPIC transition will be governed through a Collaboration agreement, overseen by the Midlands Joint and Collaborative Committee.

### 3.0 Current Position

3.1 Specified Specialised Acute and MHLDA services were delegated to ICBs in April 2024 and April 2025 with the expected transfer of the specialist team to the host ICB (Birmingham & Solihull ICB) in July 2025. This transfer of staff was subsequently delayed due new policy (as described above).

3.2 Since April 2024 Midlands ICBs have successfully undertaken joint decision making for delegated specialised services through two formal Joint Committees, with the East Midlands and West Midlands Joint Committees operating autonomously. Given the intent to align priorities and decision making around care pathways, both Committees have NHSE around the table to support joint decision making on the specialised services currently still retained by NHSE.

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## 4.0 Working towards the future

- 4.1 The vision for OPIC is to create a new model of specialist commissioning, one that succeeds not through structural redesign alone, but through a fundamental shift in how we operate and work together.
- 4.2 OPIC will be built on the foundations of improving population health, reducing health inequalities and improving equitable access to consistently high-quality healthcare. Through shared leadership and collaboration OPIC will operate on behalf of all Midlands ICBs equally.

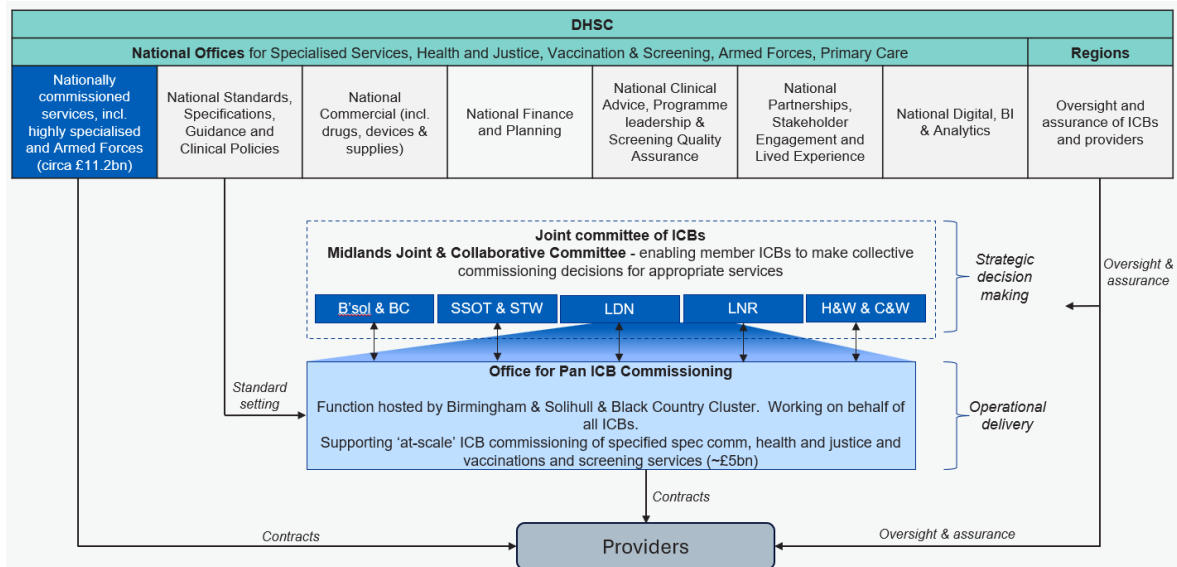


Figure 1: The Model for the Office of Pan-ICB Strategic Commissioning

- 4.2 This model requires a robust governance structure that drives pace and realises the benefits of integration. The running cost allowance (RCA) allocations for the OPIC will be confirmed shortly; this will be **in addition to the core ICB £19 per head RCA allocation**.
- 4.3 Provider Collaboration will be central to the development of new ways of working and will be built on proven principles of governance, shared financial risk, clinical integration and equity. This will enable a move from looking at service fragility and delivery to population health, access and equity promoting specialist innovation.

## 5.0 Governance

- 5.1 New governance arrangements will build on what works well currently, being capable of effectively overseeing and managing the 2026/27 transition. Transition arrangements will be as close as possible to the April 2027 end state, whilst ensuring each statutory body meets their obligations.
- 5.2 Recognising the move the 5 Clusters, the East Midlands and West Midlands Joint Committees have agreed that a Midlands Joint and Collaborative Committee is the most effective way of ensuring robust joint and collaborative strategic commissioning at scale. This single Midlands Committee will also operate as a Collaborative Committee with NHSE until the point that statutory duties change, so that decisions can be made

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collaboratively and with ICBs taking a greater leadership role for all relevant services, whilst recognising current NHSE responsibilities and accountabilities.

- 5.3 Moving to the end state governance model in April 2026 will provide ICBs with robust oversight of the transition and transfer of functions alongside managing business as usual, enabling a balance between the two whilst optimising ICB executive involvement. ICBs may also wish to add additional functions to the responsibilities of the Office of Pan ICB Commissioning.
- 5.4 During 2026/27 all staff will remain hosted by NHS England; therefore, as such they will continue to fulfil NHS England's statutory obligations whilst working for and behalf of ICBs.
- 5.5 Moving towards our end state governance and transforming functions prior to April 2027 is pivotal to enable us to maximise opportunities for designing services and pathways of care that better meet local priorities. Therefore, the NHSE employed team will transform to meet the agreed running cost allowance envelope, prior to transfer to the host ICB.
- 5.6 To move into the Midlands Joint and Collaborative Committee, cluster ICB Boards will need to provide their representative with the authority, to enable their executive representative to make decisions, at the Joint and Collaborative Committee, on behalf of their cluster ICB.
- 5.7 As part of the updated governance arrangements, ICB Boards will receive formal output from the Midlands Joint and Collaborative Committee to provide Boards with assurance that their statutory functions are being carried out robustly.

## **6.0 Next steps**

- 6.1 The OPIC will start to operate in shadow form, undergoing transformation change during 2026/27 in readiness for the transfer of functions and staff to BSol and Black Country ICB as the Midlands host ICB.
- 6.2 Further detailed operating model and workforce model will be developed during 2026
- 6.3 The updated Collaboration Agreement, outlines the 2026/27 joint working arrangements and terms of reference for the Joint and Collaborative Committee, and are subject to ICB board approval prior to April 2026.

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# Appendix 2

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# **Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27**

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Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration  
Agreement 2026/27

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**THIS AGREEMENT** is made on the first day of April 2026

**BETWEEN** the following clusters of ICBs & NHS England:

**Cluster 1**

- (1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and
- (2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and
- (3) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). and

**Cluster 2**

- (4) **NHS Leicester, Leicestershire & Rutland Integrated Care Board** Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and
- (5) **NHS Northamptonshire Integrated Care Board** of Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("Northamptonshire ICB"); and

**Cluster 3**

- (6) **NHS Birmingham & Solihull Integrated Care Board** of Eighth Floor, Alpha Tower, Birmingham
- (7) ("Birmingham & Solihull ICB"); and
- (8) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

**Cluster 4**

- (9) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and
- (10) **NHS Coventry & Warwickshire Integrated Care Board** of Shire Hall, Market Place, Warwick CV34,4RL ("Coventry & Warwickshire ICB"); and

**Cluster 5**

- (11) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and
- (12) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB");

and

- (13) **NHS England** of Wellington House, 133-155 Waterloo Road, London, SE1 8UG (acting under the name NHS England) ("NHS England").

each a "Partner" and together the "Partners".

**Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the “ICBs”, and “ICB” shall mean any of them.**

## **BACKGROUND**

- (A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- (B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- (C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.
- (D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.
- (E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.
- (F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs’ Populations.

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**NOW IT IS HEREBY AGREED** as follows:

**1. COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default*) below.

**2. PRINCIPLES AND AIMS**

**2.1 BACKGROUND**

- A. NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- B. The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.
- C. Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.
- D. Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.
- E. It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.
- F. This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.
- G. This Agreement sets out the arrangement that will apply between ICBs and NHS England in relation to the collaborative commissioning of NHSE retained commissioning functions

2.2 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

- 2.2.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of Services, including by working with local communities, under-represented groups, and those with protected characteristics for the purposes of meeting the obligation of the Equality Act 2010;
- 2.2.2 consider how, in performing its obligations, it can address health inequalities;
- 2.2.3 at all times exercise functions effectively, efficiently, and economically; and

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2.2.4 act always in good faith towards each other.

2.3 The Partners agree:

2.3.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.3.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.3.3 to act in a timely manner;

2.3.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks, and reduce cost;

2.3.5 to act at all times, ensuring the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

2.3.6 to act at all times in accordance with the scope of their statutory powers; and

2.3.7 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

2.4 The Partners' aims are:

2.4.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

2.4.2 to maximise the benefits to patients of integrating NHSE retained commissioning functions with the ICB Commissioning Functions through designing and commissioning services as part of the wider pathways of care of which they are a part

3. **SCOPE OF THE ARRANGEMENTS**

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

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- 3.1.6 the establishment of one or more Pooled Funds;
- 3.1.7 the use of one or more Non-Pooled Fund.
- 3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:
- 3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.
- 3.2.2 Establishment of the following Joint Working Arrangements for delegated and retained services:
- Maintenance of the established Commissioning Team, hosted by NHS England in accordance with Clause 5.1 through which agreed Delegated and Retained Services may be commissioned in line with the Commissioning Team Agreement in Schedule 6;
  - Delegation of responsibilities by the ICBs to a Joint Committee and other associated sub-groups established in accordance with Schedule 2;
  - Approval of the two schemes for the commissioning of delegated and retained services for the Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
  - Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

#### 4. FUNCTIONS

- 4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.
- 4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.
- 4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.
- 4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).
- 4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.
- 4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:
- 4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

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- 4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;
- 4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;
- 4.6.4 perform all commissioning obligations with all due skill, care and attention;
- 4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;
- 4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and
- 4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

## 5. COMMISSIONING TEAM

- 5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (Commissioning Team Arrangements)

## 6. STAFFING

- 6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and Joint Working Arrangements.

## 7. JOINT COMMITTEE

- 7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.
- 7.2 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions, outside of services defined in Schedule 3.
- 7.3 NHSE may table for discussion at any Joint Committee meeting an item relating to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions or any such other of NHSE's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working.

## 8. GOVERNANCE

- 8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

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8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.

8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

## 9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING

9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

## 10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

## 11. COMPLAINTS

11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

11.2 A report summarising complaints, actions and lessons learnt will be provided to the Joint and Collaborative Committee annually.

## 12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

## 13. VARIATION

13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.

13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 Where the Partners agree that there will be:

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- 13.4.1 a new Pooled Fund;
- 13.4.2 a new Individual Scheme; or
- 13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

- 13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.
- 13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:
  - 13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;
  - 13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:
    - 13.5.2.1 governance and decision-making arrangements;
    - 13.5.2.2 oversight and assurance arrangements;
    - 13.5.2.3 contracting arrangements; and/or
    - 13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;
  - 13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and
  - 13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

#### 14. DATA PROTECTION

- 14.1 The Partners must ensure that all Personal Data processed by or on behalf of them while carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection

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Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

- 14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:
  - 14.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or
  - 14.2.2 becomes aware of any security breach,in respect of the Relevant Information, it shall promptly notify the relevant Partners and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.
- 14.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.
- 14.4 Any information governance breach must be responded to in accordance with the Information Governance Guidance for Serious Incidents. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.
- 14.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.
- 14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of Law, including the Data Protection Legislation in respect of any Personal Data.
- 14.7 Other than in compliance with judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.
- 14.8 Schedule 5 (*Further Information Governance and Sharing Provisions*) makes further provision about information sharing, information governance and includes the data controller agreement (Schedule 5 Appendix 1) .

## 15. IT INTER-OPERABILITY

- 15.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Working Arrangements are inter-operable and that data may be transferred between systems securely, easily and efficiently.

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15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

**16. FURTHER ARRANGEMENTS**

16.1 The Partners must give due consideration to whether any of the Commissioning Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

**17. FREEDOM OF INFORMATION**

17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

17.2 Each Partner may be statutorily required to disclose further information about the Agreement and the FOIA or EIA Information in response to a specific request under FOIA or EIR, in which case:

17.2.1 each Partner shall provide the other Partners with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and

17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

**18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY**

18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

**19. CONFIDENTIALITY**

19.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

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- 19.2 Subject to Clause 19.3, the receiving Partner agrees:
- 19.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;
  - 19.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and
  - 19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.
- 19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:
- 19.3.1 in connection with any Dispute Resolution Procedure;
  - 19.3.2 to comply with the Law;
  - 19.3.3 to any appropriate Regulatory or Supervisory Body;
  - 19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;
  - 19.3.5 to NHS bodies for the purposes of carrying out their functions; and
  - 19.3.6 as permitted under any other express arrangement or other provision of this Agreement.
- 19.4 The obligations in Clause 19 will not apply to any Confidential Information which:
- 19.4.1 is in or comes into the public domain other than by breach of this Agreement;
  - 19.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Partner; or
  - 19.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.
- 19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.
- 19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.
- 19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

## 20. LIABILITIES

- 20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising

under an Individual Scheme) as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

- 20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.
- 20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:
- 20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;
  - 20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and
  - 20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.
- 20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.
- 20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:
- 20.5.1 the liability of NHS England to any person in respect of NHS England’s Commissioning Functions; or
  - 20.5.2 the liability of any of the ICBs to any person in respect of that ICB’s Commissioning Functions.
- 20.6 Each ICB must:
- 20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;
  - 20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

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- 20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

## 21. DISPUTE RESOLUTION

- 21.1 Where any dispute arises between the Partners in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.
- 21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.
- 21.3 Where any dispute is not resolved under Clause 21.1 or 21.2 the Partners can appoint an independent mediator to attempt to resolve the dispute. The cost of mediation will be borne in equal shares between parties involved in the dispute.
- 21.4 Where any dispute remains unresolved after mediation, the Partners will commission an independent review. The Partners will abide by the independent review findings. The cost will be borne in equal shares between parties involved in the dispute.

## 22. BREACHES OF THE AGREEMENT

- 22.1 If any Partner (“Relevant Partner”) fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).
- 22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:
  - 22.2.1 waive their rights in relation to such non-compliance;
  - 22.2.2 ratify any decision;
  - 22.2.3 terminate this Agreement in accordance with Clause 23 (*Termination and Default*) below; or
  - 22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 (*Dispute Resolution*).

## 23. TERMINATION AND DEFAULT

- 23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months’ notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective

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exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

#### 24. CONSEQUENCES OF TERMINATION

24.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

24.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may

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request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

24.1.7 termination of this Agreement shall have no effect on the liability, rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

24.2 The provisions of Clauses 14 (*Data Protection*), 17 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

## 25. PUBLICITY

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

## 26. EXCLUSION OF PARTNERSHIP OR AGENCY

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

26.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

## 27. THIRD PARTY RIGHTS

27.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

## 28. NOTICES

28.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

28.2 Notices by email will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

## 29. ASSIGNMENT AND SUBCONTRACTING

29.1 This Agreement, and any rights and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant Commissioning Function.

## 30. SEVERABILITY

30.1 If any term, condition, or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

## 31. WAIVER

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31.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by Law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

**32. STATUS**

32.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

**33. ENTIRE AGREEMENT**

33.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

**34. GOVERNING LAW AND JURISDICTION**

34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

**35. FAIR DEALINGS**

35.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any Partner and that, if in the course of the performance of this Agreement, unfairness to any Partner does or may result, then the Relevant Partner(s) shall use reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

**36. COUNTERPARTS**

36.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the Commencement Date

SIGNED by Amanda Sullivan ..... (Signature)

for and on behalf of NHS Nottingham &  
Nottinghamshire Integrated Care Board, Derby &  
Derbyshire Integrated Care Board and  
Lincolnshire Integrated Care Board ..... (Date)

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SIGNED by Toby Sanders ..... (Signature)

for and on behalf of NHS Northamptonshire  
Integrated Care Board and NHS Leicester,  
Leicestershire & Rutland Integrated Care Board ..... (Date)

SIGNED by Simon Trickett ..... (Signature)

for and on behalf of NHS Herefordshire &  
Worcestershire Integrated Care Board and  
Coventry and Warwickshire Integrated Care  
Board ..... (Date)

SIGNED by David Melbourne ..... (Signature)

for and on behalf of NHS Birmingham & Solihull  
Integrated Care Board and the Black Country  
Integrated Care Board ..... (Date)

SIGNED by Simon Whitehouse ..... (Signature)

for and on behalf of NHS Shropshire, Telford &  
Wrekin Integrated Care Board and Staffordshire &  
Stoke on Trent Integrated Care Board ..... (Date)

SIGNED by Roz Lindridge ..... (Signature)

For and on behalf of NHS England  
..... (Date)

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## SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

- “Agreement”** means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
- “Aligned Commissioning Arrangements”** means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
- “Annual Review”** means the annual review of the arrangements under this Agreement by the Partners;
- “Area”** means the geographical area covered by the ICBs;
- “Authorised Officer”** the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
- “Claim”** means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
- “Clinical Commissioning Policies”** a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
- “Clinical Reference Groups”** means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
- “Collaborative Commissioning Agreement”** means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
- “Commencement Date”** [means 1 April 2024];
- “Commissioning Functions”** the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
- “Commissioning Team”** means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using:
- i. Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or
  - ii. Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

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arrangement such as a Joint Committee or whether each Partner is required to take decisions;

**"Confidential Information"**

means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and:

- i. which comprises Personal Data or which relates to any patient or his treatment or medical history;
- ii. the release of which is likely to prejudice the commercial interests of a Partner; or
- iii. which is a trade secret;

**"Contracting Standard Operating Procedure"**

means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;

**"Data Controller"**

shall have the same meaning as set out in the Data Protection Legislation;

**"Data Processor"**

shall have the same meaning as set out in the Data Protection Legislation;

**"Data Sharing Agreement"**

means any data sharing agreement entered in accordance with Schedule 5 (*Further Information Governance and Sharing Provisions*);

**"Data Guidance"**

means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;

**"Data Protection Legislation"**

means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;

**"Data Protection Officer"**

shall have the same meaning as set out in the Data Protection Legislation;

**"Data Security and Protection Toolkit"**

means the toolkit at: <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit> or as amended or replaced from time to time

**Delegated Commissioning Group "DCG"**

means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

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<b>“Delegation Agreement(s)”</b>	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
<b>“Delegated Functions”</b>	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
<b>“Delegated Services”</b>	means those Specialised Services commissioned in exercise of the Delegated Functions;
<b>“Dispute Resolution Procedure”</b>	the procedure set out in Clause 21 ( <i>Dispute Resolution</i> );
<b>“EIR”</b>	means the Environmental Information Regulations 2004;
<b>“Finance Guidance”</b>	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: <ul style="list-style-type: none"> <li>• Commissioning Change Management Business Rules;</li> <li>• Contracting Standard Operating Procedure;</li> <li>• Cashflow Standard Operating Procedure;</li> <li>• Finance and Accounting Standard Operating Procedure;</li> <li>• Service Level Framework Guidance;</li> </ul>
<b>“Flexibilities”</b>	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 ( <i>Scope of the Arrangements</i> );
<b>“Financial Contribution”</b>	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
<b>“Financial Year”</b>	means each financial year running from 1 April in any year to 31 March in the following calendar year;
<b>“FOIA”</b>	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
<b>“FOIA or EIR Information”</b>	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
<b>“Good Practice”</b>	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
<b>“Governance Arrangements”</b>	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 ( <i>Governance Arrangements</i> );
<b>“Guidance”</b>	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
<b>“High-Cost Drugs”</b>	means medicines not reimbursed though national prices/ identified on the NHS England high-cost drugs list;
<b>“ICB Reserved Functions”</b>	Where there is any delegation of an ICB’s Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;

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<b>“Indemnity Arrangement”</b>	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
<b>“Individual Scheme”</b>	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
<b>“Joint Committee”</b>	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
<b>“Joint Functions”</b>	any Functions that are delegated to a Joint Committee;
<b>“Joint Commissioning”</b>	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
<b>“Joint Working Arrangements”</b>	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
<b>“Law”</b>	means: <ul style="list-style-type: none"> <li>i. any statute or proclamation or any delegated or subordinate legislation;</li> <li>i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and</li> <li>i. any judgment of a relevant court of law which is a binding precedent in England;</li> </ul>
<b>“Lead Commissioning Arrangements”</b>	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
<b>“Lead Partner”</b>	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
<b>“Loss”</b>	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
<b>“Managing Conflicts of Interest in the NHS”</b>	means the NHS publication by that name available at: <a href="https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/">https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/</a> or such publication that amends or replaces that publication;
<b>“Mandated Guidance”</b>	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;

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<b>“National Standards”</b>	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
<b>“National Specifications”</b>	the service specifications published by NHS England in respect of Specialised Services;
<b>“Need to Know”</b>	has the meaning set out in Schedule 5 ( <i>Further Information Governance and Sharing Provisions</i> );
<b>“NHS Act”</b>	the National Health Service Act 2006;
<b>“NHS England Functions”</b>	NHS England’s Commissioning Functions exercisable under or by virtue of the NHS Act;
<b>“NHS England Reserved Functions”</b>	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
<b>“Non-Personal Data”</b>	means data which is not Personal Data;
<b>“Non-Pooled Funds”</b>	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
<b>“Operational Days”</b>	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
<b>“Partners”</b>	means the parties to this Agreement;
<b>“Personal Data”</b>	has the meaning set out in the Data Protection Legislation;
<b>“Pooled Funds”</b>	means any pooled fund established and maintained by the Partners as a pooled fund;
<b>“Population”</b>	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
<b>“Provider Collaborative”</b>	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
<b>“Provider Collaborative Arrangements”</b>	means the arrangements entered in respect of a Provider Collaborative;
<b>“Provider Collaborative Guidance”</b>	means any guidance published by NHS England in respect of Provider Collaboratives;
<b>“Regional Quality Group”</b>	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
<b>“Regulatory or Supervisory Body”</b>	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: <ul style="list-style-type: none"> <li>i. CQC;</li> <li>ii. NHS England;</li> <li>iii. the Department of Health and Social Care;</li> </ul>

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- iv. NICE;
- v. Healthwatch England and Local Healthwatch;
- vi. the General Medical Council;
- vii. the General Dental Council;
- viii. the General Optical Council;
- ix. the General Pharmaceutical Council;
- x. the Healthcare Safety Investigation Branch; and
- xi. the Information Commissioner;

<b>“Relevant Information”</b>	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “ <i>To Share or Not to Share?</i> ”;
<b>“Reserved Functions”</b>	means NHS England Reserved Functions or ICB Reserved Functions;
<b>“Relevant Networks”</b>	<b>Clinical</b> means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
<b>“Retained Services”</b>	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
<b>“Risk Sharing”</b>	means an agreed arrangement for risk and benefit sharing between the Partners;
<b>“Scheme Specification”</b>	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
<b>“Services”</b>	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
<b>“Service Contract”</b>	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
<b>“Single Point of Contact”</b>	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 ( <i>Further Information Governance and Sharing Provisions</i> )
<b>“Special Category Personal Data”</b>	has the meaning set out in the Data Protection Legislation;
<b>“Specialised Commissioning Budget”</b>	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;
<b>“Specialised Commissioning Functions”</b>	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning

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Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);

- “Specified Purpose”** means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 (*Further Information Governance and Sharing Provisions*) to this Agreement;
- “Specialised Services”** means the services commissioned in exercise of the Specialised Commissioning Functions;
- “Specialised Services Contract”** means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
- “Specialised Services Provider”** means a provider party to a Specialised Services Contract;
- “Staff”** means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
- “Standard Operating Framework”** means the agreement(s) that sets out the arrangements for a Commissioning Team;
- “Terms of Reference”** means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
- “Triple Aim”** means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to:
- i. the health and well-being of the people of England;
  - ii. the quality of services provided to individuals by the NHS;
  - iii. efficiency and sustainability in relation to the use of resources by the NHS;
- “Underspend”** means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
- “UK GDPR”** means [Regulation \(EU\) 2016/679 of the European Parliament and of the Council of 27th April 2016](#) on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of [section 3](#) of the [European Union \(Withdrawal\) Act 2018](#).

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.
5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation, or organisation.
6. Words importing the singular number only shall include the plural.
7. Use of the masculine includes the feminine and all other genders.
8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.
9. Any reference to the Partners shall include their respective statutory successors, employees and agents.
10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

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## SCHEDULE 2: GOVERNANCE ARRANGEMENTS

### 1. Joint & Collaborative Committee

- 1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through a Joint Committee established by the ICBs.
- 1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committee are appended to this Schedule. They set out that the Joint Committee will have delegated authority on behalf of the ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.
- 1.3. The NHS England regional commissioning team will continue to work jointly with the Joint Committee on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committee.
- 1.4. The subsidiary arrangements established by the Joint Committee will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committee and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

### 2. Subgroups

- 2.1.1 There will be joint subgroups established by the partners to support these arrangements, these being:
  - **Midlands Acute Specialised Commissioning Group (MASCg)**
  - **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**
  - **Specialised Commissioning Quality Group**
  - **Finance and Contracting Group**
- 2.1.2 The following NHS England Subgroups for NHSE decision making with ICB colleagues in attendance
  - **Vaccination Governance Group**
  - **Screening Governance Group**
  - **Health and Justice Assurance and Improvement Group (HJAIG)**
- 2.1. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCg)** and **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**, Joint Sub-Groups established by all the partners to make decisions on both the delegated and retained services.
- 2.2. The role of MASCg and the MHLDACG will be to support the partners and the Joint Committee in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities. The role of these subgroups will be to
  - **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
  - **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
  - **Prepare** annual plans and monitor performance maintaining oversight and remediation

- **Review** detailed monthly financial information on actual, planned, forecast outturn
  - **Deliver** strategic and operational plans
- 2.3. MASCG and MHLDACG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1-7 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.
- 2.4. Each of the partners will appoint a member of MASCG and MHLDACG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.
- 2.5. **Specialised Commissioning Quality Group** – This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.
- 2.6. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.
- 2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.
- 2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.
- **Review** annual plan including investment plan
  - **Review** monthly update on financial position against plan and forecast outturn by service type
  - **Receive** a quarterly summary of clinical business cases, Contract variations or extensions approved by Joint Committee
  - **Review** STAs, losses and special payments and consultancy spend
- 2.11 **Vaccination Governance Group (VGG)** – will make decisions on the commissioning, quality and value of Vaccination Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Vaccination services. The role of this subgroup will be to
- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
  - **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
  - **Prepare** annual plans and monitor performance maintaining oversight and remediation
  - **Review** detailed monthly financial information on actual, planned, forecast outturn
  - **Deliver** strategic and operational plans
- 2.12 The Vaccination Governance Group will ensure ICB collaboration in all decisions in relation to the portfolio it holds

2.13 **Screening Governance Group (SGG)** – will make decisions on the commissioning, quality and value of Screening Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Screening services. The role of this subgroup will be to

- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
- **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
- **Prepare** annual plans and monitor performance maintaining oversight and remediation
- **Review** detailed monthly financial information on actual, planned, forecast outturn
- **Deliver** strategic and operational plans

2.12 The Screening Governance Group will ensure ICB collaboration in all decisions in relation to the portfolio it holds

2.13 **Health and Justice Assurance and Improvement Group (HJAIG)** - will make decisions on the commissioning, quality and value of Health and Justice (Including SARC) Services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and NHS England schemes of reservation and delegation and standing financial instructions for Health and Justice and SARC Services. The role of this subgroup will be to

- **Review** all business cases including for Contract Variations and extensions, investments, single tender actions, consultancy spend and CSU spend
- **Approve** business cases within functional limits unless specifically escalated to the Joint Committee for approval
- **Prepare** annual plans and monitor performance maintaining oversight and remediation
- **Review** detailed monthly financial information on actual, planned, forecast outturn
- **Assure** performance and quality of commissioned service provider delivery against national and local requirements and standards
- **Deliver** strategic and operational plans

### 3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team (employed by NHS England) via the Joint Working arrangements.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision-making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

- 3.5. The Commissioning Team will include Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.
- 3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups. The pharmacy team for High Costs Drugs will work across ICBs and NHS England drawing on the expertise of the specialised commissioning pharmacy team and collaborating with senior pharmacists from across the region, including High-Cost Drugs pharmacists, specialist pharmacists, and regional cancer pharmacists.
- 3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

#### **4. Quality Governance**

- 4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group, Vaccination Governance Group, Screening Governance Group and Health and Justice Assurance and Improvement Group. Furthermore, key quality concerns for all services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.
- 4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASC) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making on quality matters.
- 4.3. Key quality concerns involving all other functions will also be reported to the Joint Committee as appropriate
- 4.4. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASC.
- 4.5. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

#### **5. Financial Governance**

- 5.1. The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.
- 5.7. **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a

monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

- 5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

## **6. Assurance arrangements**

- 6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:
- (a) the Oversight and Assurance Framework published by NHS England;
  - (b) any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements; and
  - (c) any other relevant NHS oversight and assurance guidance;
- collectively known as the “Assurance Processes”.

And that the ICBs must:

- (a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.
- (b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.
- (c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.
- (d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

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## Terms of Reference

# Midlands Joint and Collaborative Committee

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<p><b>Introduction and purpose</b></p>	<p>The Joint &amp; Collaborative Committee has been established by the ICBs &amp; NHSE as listed:</p> <p><b>Cluster 1</b></p> <p>(1) <b>NHS Lincolnshire Integrated Care Board of</b> Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and</p> <p>(2) <b>NHS Nottingham &amp; Nottinghamshire Integrated Care Board of</b> Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham &amp; Nottinghamshire ICB"); and</p> <p>(3) <b>NHS Derby &amp; Derbyshire Integrated Care Board of</b> Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby &amp; Derbyshire ICB"). and</p> <p><b>Cluster 2</b></p> <p>(4) <b>NHS Leicester, Leicestershire &amp; Rutland Integrated Care Board of</b> Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire &amp; Rutland ICB"); and</p> <p>(5) <b>NHS Northamptonshire Integrated Care Board of</b> Haylock House, Kettering Parkway, Venture Park, Kettering NN15 6EY ("<b>Northamptonshire ICB</b>"); and</p> <p><b>Cluster 3</b></p> <p>(6) <b>NHS Birmingham &amp; Solihull Integrated Care Board of</b> Eighth Floor, Alpha Tower, Birmingham ("<b>Birmingham &amp; Solihull ICB</b>"); and</p> <p>(7) <b>NHS Black Country Integrated Care Board of</b> Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and</p> <p><b>Cluster 4</b></p> <p>(8) <b>NHS Herefordshire &amp; Worcestershire Integrated Care Board of</b> Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire &amp; Worcestershire ICB"); and</p> <p>(9) <b>NHS Coventry &amp; Warwickshire Integrated Care Board of</b> Shire Hall, Market Place, Warwick CV34,4RL ("Coventry &amp; Warwickshire ICB"); and</p> <p><b>Cluster 5</b></p> <p>(10) <b>(NHS Shropshire, Telford &amp; Wrekin Integrated Care Board of</b> Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford &amp; Wrekin ICB"); and</p> <p>(11) <b>NHS Staffordshire &amp; Stoke-on-Trent Integrated Care Board of</b> Stafford Education &amp; Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire &amp; Stoke-on-Trent ICB") and</p> <p>(12) <b>NHS England – Midlands Region,</b> Cardinal Square, 10 Nottingham Road, Derby DE1 3QT</p> <p>The Committee has been established by the partners to fulfil the following core functions:</p>
<p><b>Introduction and purpose</b></p>	<p>The Committee has been established by the partners to fulfil the following core functions:</p>

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	<ul style="list-style-type: none"> <li>• For the ICBs to jointly discharge commissioning responsibilities for Specialised Services that have been delegated to them by NHS England which NHS England requires them to exercise collaboratively</li> <li>• To act as a Collaborative forum for NHS England to discharge its retained Direct Commissioning responsibilities (including for retained Specialised Services, Health and Justice Services and Screening and Immunisation Services) in consultation with the ICBs.</li> </ul> <p>The Joint &amp; Collaborative Committee will make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities for services within its purview.</p> <p>The Joint &amp; Collaborative Committee will establish sub-groups or sub-committees with such Terms of Reference and delegated responsibilities as it agrees.</p>
<b>The Terms of Reference</b>	<p>These Terms of Reference support effective partnership working between all Partners acting through this Joint &amp; Collaborative Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint &amp; Collaborative Committee.</p>
<b>Statutory Framework</b>	<p>The Joint &amp; Collaborative Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint &amp; Collaborative Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.</p>
<b>Role of the Joint Committee</b>	<p>The Joint &amp; Collaborative Committee and aligned subsidiary arrangements will be responsible for the safe, effective, efficient and economic discharge of the Joint Functions by the ICBs. It will also serve as a collaborative forum for NHS England to make decisions on retained Direct Commissioning services (Retained Specialised Services, Health and Justice Services and Immunisation and Screening services). This will involve the discharge of the following key responsibilities:</p> <p><b>Strategic Leadership:</b></p> <ul style="list-style-type: none"> <li>• Supporting setting the strategic direction for commissioning across the Midlands, ensuring clarity of purpose, outcomes and value for all services outlined in Schedule 3 of the Collaboration Agreement.</li> <li>• Oversight of the development and integration of Strategic Commissioning Frameworks for agreed Pan ICB commissioning across the Midlands.</li> <li>• Oversight of the development of system plans and strategies to enable the three shifts, with clear outcome metrics, financial sustainability, and public accountability for the defined population that are evidence based and responsive to population health needs.</li> </ul> <p><b>Population Health and Insight:</b></p> <ul style="list-style-type: none"> <li>• Oversight of work to ensure members have a deep understanding of population health needs through advance analytics, predictive modelling, and citizen insight.</li> <li>• Ensuring that there is effective use of robust, high-quality data and insight in the development of evidence-based prioritization frameworks aligned to value and equity.</li> <li>• Ensuring that there is alignment with other relevant plans and strategies including Integrated Care Strategies, Joint Strategic Needs Assessments and Health and Wellbeing Strategies.</li> </ul> <p><b>Value, Prioritisation and Investment:</b></p> <ul style="list-style-type: none"> <li>• Approving system-wide commissioning priorities based on value, equity, and outcomes to support investment and disinvestment decision making.</li> <li>• Developing subsidiary arrangements to enable effective and efficient operational decision making arrangements that will support the exercise of the Joint Functions by sub-groups and/or staff working on behalf of the partners</li> </ul>

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	<p><b>Innovation and Delivery:</b></p> <ul style="list-style-type: none"> <li>• Supporting the development of strategies including setting expectations for outcome-based commissioning.</li> <li>• Oversight of collaborative commissioning across the Midlands for all services within its scope with other ICBs and NHS England.</li> <li>• Acting as a forum for discussion and making recommendations on issues where further joint action or working between ICBs and NHSE commissioners would be of benefit outside the arrangements delegated to it</li> </ul>
<p><b>Accountability and reporting</b></p>	<p>The Joint &amp; Collaborative Committee will be formally accountable to the Boards of the ICBs for the functions delegated by them to the Joint &amp; Collaborative Committee through their Schemes of Reservation and Delegation (SORDs).</p> <p>The Joint &amp; Collaborative Committee operates as the collaborative body for NHS England to make decisions on direct and retained services in consultation with the ICBs through its accountable officers to NHS England’s Regional Director and National Directors in line with NHSE the Scheme of Reservation and Delegation (SORDs).</p> <p>The Joint &amp; Collaborative Committee may also report to NHS England’s Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions relating to Specialised Services. The Chair (or, at their discretion, another member) may also attend the DCG to present reports on behalf of the committee.</p> <p>Where an ICB Board or National or Regional Directors requests that the Joint &amp; Collaborative Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.</p>
<p><b>Membership</b></p>	<p><u>ICB Membership</u></p> <p>The core voting membership of the Committee will be made up of one Authorised Officer (who must be the CEO or their nominated representative) from each of the ICB Clusters.</p> <p>Each of the ICB Clusters must ensure that the members nominated on their behalf are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint &amp; Collaborative Committee.</p> <p>The Authorised Officers may nominate a named substitute who may attend meetings on their behalf with the same decision-making authority.</p> <p><u>NHSE Membership</u></p> <p>The NHSE Regional Director of Commissioning (or their nominated representative) will attend meetings of the Committee to take decisions in relation to the retained services in consultation with the wider committee.</p> <p><u>Other Participants</u></p> <p>Each of the Partners may be represented at meetings by representatives who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote.</p> <p>The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint &amp; Collaborative Committee’s deliberations as required. These representatives will not have the right to vote.</p> <p><u>Term of Membership</u></p>

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	<p>Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner.</p> <p><u>Membership Lists</u> The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and named substitutes and that this list is made available to the Partners.</p> <p><u>Other Attendees</u> The Joint &amp; Collaborative Committee will be supported by a Secretariat, who will be provided by the Office of Pan ICB Commissioning.</p>
<b>Chair</b>	<p>The Joint &amp; Collaborative Committee will appoint two of the Authorised Officers as Co-Chairs of the Joint &amp; Collaborative Committee. The Co-Chairs will serve as Strategic leads for Specialised Services and Health &amp; Justice/Screenings &amp; Immunisation respectively.</p> <p>The Joint &amp; Collaborative Committee will confirm or appoint new Co-Chairs at the first meeting of each financial year.</p>
<b>Meetings</b>	<p>The Joint Committee shall meet at least quarterly.</p> <p>At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint &amp; Collaborative Committee shall prepare a schedule of meetings for the forthcoming year (“the Schedule”). The Co-Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members.</p> <p>Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Co-Chairs. The Co-Chairs may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks’ notice of the special meeting.</p>
<b>Quorum</b>	<p>A Joint &amp; Collaborative Committee meeting will be quorate if at least one authorised representative member (or substitute) from each ICB Cluster is in attendance.</p> <p>Attendance at meetings by telephone/video conferencing will count towards the quorum.</p>
<b>Decisions and veto.</b>	<p>The Joint &amp; Collaborative Committee must seek to make decisions relating to the exercise of the ICB Cluster Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint &amp; Collaborative Committee meetings for discussions and negotiations between Partners to take place.</p> <p>Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter relating to ICB Cluster Joint Functions put before the Joint &amp; Collaborative Committee, the Chair of Part may require the decision to be put to a vote. Where such a vote is required, each Authorised Officer will have one vote, per cluster ICB, with decisions being made by a simple majority of those voting. Any disputes will be resolved using the dispute resolution process outline in section 21 of the Collaboration agreement.</p>
<b>Conduct and conflicts of interest</b>	<p>Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: <a href="https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/">https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/</a></p> <p>Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): <a href="https://www.gov.uk/government/publications/the-7-principles-of-public-life">https://www.gov.uk/government/publications/the-7-principles-of-public-life</a></p>

	Members should refer to and act consistently with the NHSE guidance: <i>Managing Conflicts of Interest in the NHS: Guidance for staff and organisations</i> . See: <a href="https://www.england.nhs.uk/ourwork/coi/">https://www.england.nhs.uk/ourwork/coi/</a>
<b>Confidentiality of proceedings</b>	<p>The Joint &amp; Collaborative Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners.</p> <p>All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.</p>
<b>Publication of notices, minutes and papers</b>	<p>The Office of Pan ICB Commissioning shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint &amp; Collaborative Committee.</p> <p>The Chair(s), with the support of the Secretariat Lead, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting).</p> <p>The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Joint &amp; Collaborative Committee shall confirm those minutes at its next meeting.</p>
<b>Review of the Terms of Reference</b>	<p>These terms of reference will be reviewed in six &amp; twelve months of the Joint &amp; Collaborative Committee establishment and then at least annually thereafter.</p> <p>Any changes to the Joint &amp; Collaborative Committee decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the Joint &amp; Collaborative Committee and reported to the Partners for assurance.</p>
<b>Date of Approval of Terms of Reference</b>	TBC

The secretariat can be contacted on [jomelling@nhs.net](mailto:jomelling@nhs.net)

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## SCHEDULE 3: INDIVIDUAL SCHEMES

### PART 1 MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2026/2027

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services delegated to the Midlands Integrated Care Boards (ICBs) by NHS England.

1.2 The Partners' aims are:

- (a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

## 2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the specified specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

- (a) decisions in relation to the commissioning and management of the delegated services;
- (b) planning delegated services for the population, including carrying out needs assessments;
- (c) undertaking reviews of delegated services in respect of the population;
- (d) supporting the management of the specialised commissioning budget for delegated services;
- (e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and
- (f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

### **3 PARTNERS**

3.1 The partners of this scheme are Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

### **4 THE ARRANGEMENTS**

4.1 The Scheme will be overseen by the Midlands Joint Committee whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of this Collaboration Agreement.

4.2 Administrative and management functions will be provided to the Partners by the Commissioning Team, which is hosted by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

### **5 GOVERNANCE ARRANGEMENTS**

5.1 The scheme shall be governed by the Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Midlands Joint Committee are set out in the in schedule 2 of the ICB Collaboration Agreement

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## **6 COMMISSIONING, CONTRACTING, ACCESS**

### **6.1 Commissioning Arrangements**

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team hosted by NHS England in line with legislative requirements, NHS planning guidance and the Delegation Agreement between the ICBs and NHS England.

### **6.2 Contracting Arrangements**

The list of contracts which are in place across the Midlands for delegated specialised services are contained in Appendix 1. This includes details of Lead Commissioning arrangements where this has been determined.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP, the Delegation agreement and the ICB Collaboration Agreement.
- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.
- The contracts will be managed on behalf of the ICBs, by the Commissioning Team.

### **6.3 Access**

The scheme will apply to all delegated specialised services provided via contracts with providers.

## **7. HIGH-COST DRUGS**

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

## **8. FINANCIAL GOVERNANCE ARRANGEMENTS**

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

## **9. NON FINANCIAL RESOURCES**

9.1. The non-financial resources required to deliver the scheme will be provided by NHS England in accordance with Schedule 6 of the Collaboration Agreement.

## 10. STAFF

- 10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be employed by NHS England covering both retained and delegated services.
- 10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out in agreed Joint Working Arrangements.

## 11. ASSURANCE AND MONITORING

- 11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 2 of this agreement.

## 12. AUTHORISED OFFICERS

- 12.1. The authorised officers for this scheme are as follows:

<b>Partner</b>	<b>Name of Authorised Officer – Tier 1</b>
<b>Cluster 1</b> Nottingham & Nottinghamshire ICB Derby & Derbyshire ICB Lincolnshire ICB	Amanda Sullivan
<b>Cluster 2</b> Northamptonshire ICB Leicester, Leicestershire & Rutland ICB	Toby Sanders
<b>Cluster 3</b> Birmingham and Solihull ICB Black Country ICB	David Melbourne
<b>Cluster 4</b> Herefordshire & Worcestershire ICB Coventry and Warwickshire ICB	Simon Trickett
<b>Cluster 5</b> Shropshire Telford and Wrekin ICB Staffordshire & Stoke on Trent ICB	Simon Whitehouse

## 13. INTERNAL APPROVALS

- 13.1. The levels of authority relating to this scheme are described within Schedule 4 of the Collaboration Agreement.

## 14. REGULATORY REQUIREMENTS

- 14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

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**15. COMPLAINTS**

15.1 Complaints for delegated services will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2 A report summarising complaints, actions and lessons learnt will be provided to the Joint Committee annually.

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## **PART 2 – RETAINED SERVICES SCHEME**

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

### **1 OVERVIEW OF THE SCHEME FOR NHS ENGLAND RETAINED SPECIALISED SERVICES IN 2026/27**

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England.

1.2 The Partners' aims are:

- (a) to maximise the benefits to patients by working collaboratively on the Retained Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

### **2 SERVICES AND FUNCTIONS**

2.1 NHS England will retain the statutory function for the commissioning of a number of specialised services. Whilst this responsibility is being retained by NHS England the staff involved will be also be working on the commissioning of delegated specialised services and it will involve the ICBs in the of delivery of these functions being, in summary:

- (a) decisions in relation to the commissioning and management of the services;
- (b) planning for the services for the population, including carrying out needs assessments;
- (c) undertaking reviews of services in respect of the population;
- (d) supporting the management of the specialised commissioning budget for the services;
- (e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and

2.2 A list of the services included within the scheme are detailed within the Appendix of this Schedule.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

### **3 PARTNERS**

3.1 The partners for joint working within this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

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## 4 THE ARRANGEMENTS

- 4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the Midlands Joint Committee.
- 4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted by NHS England. Details of which are set out in a commissioning team agreement between all parties.
- 4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

## 5 GOVERNANCE ARRANGEMENTS

- 5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.
- 5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committee where appropriate.
- 5.3 The exercise of NHS England functions in consultation with the Joint Committee will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the Midlands Joint Committee when exercising that authority.
- 5.4 NHS England will report on the delivery of the functions under this scheme to the Midlands Joint Committees.

## 6 COMMISSIONING, CONTRACTING, ACCESS

### 6.1 Commissioning Arrangements

- 6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance.

### 6.2 Contracting Arrangements

- 6.2.1 The scheme will be administered by the Commissioning Team.
- 6.2.2 The contracting arrangement for the scheme will be as follows:
  - The scheme will encompass all existing contracts.
  - The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
  - The contracts will be funded by NHS England.
  - The contracts will be managed by the Commissioning Team.

### 6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

## 7 HIGH-COST DRUGS

- 7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and

networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

## **8 FINANCIAL GOVERNANCE ARRANGEMENTS**

8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

## **9 NON-FINANCIAL RESOURCES**

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB & NHSE Collaboration Agreement.

## **10 STAFF**

10.1 The commissioning team responsible for the operational delivery of all specialised commissioning (delegated and retained) services will be employed by NHS England.

## **11 ASSURANCE AND MONITORING**

11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

## **12 INTERNAL APPROVALS**

12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

## **13 REGULATORY REQUIREMENTS**

13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

## **14 COMPLAINTS**

14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

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## **PART 3 – HEALTH AND JUSTICE & SCREENING AND VACCINATION SERVICES SCHEME**

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

### **1 OVERVIEW OF THE SCHEME FOR NHS ENGLAND RETAINED SPECIALISED SERVICES IN 2026/27**

1.1 This scheme sets out the arrangements through which the Partners will work together to commission Health and Justice and Screening and Vaccination Services for which responsibility is being retained by NHS England in 2026/27 but will be delegated to the ICBs in the future.

1.2 The Partners' aims are:

- (a) to maximise the benefits to patients by working collaboratively on the Retained Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

### **2 SERVICES AND FUNCTIONS**

2.1 NHS England has determined that the statutory function for the commissioning of the Health and Justice and Screening and Vaccination services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2025/26 it will involve the ICBs in the of delivery of these functions being, in summary:

- (a) decisions in relation to the commissioning and management of the services;
- (b) planning for the services for the population, including carrying out needs assessments;
- (c) undertaking reviews of services in respect of the population;
- (d) supporting the management of the specialised commissioning budget for the services;
- (e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and

2.2 A list of the services included within the scheme are detailed within the Appendix of this Schedule.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

### **3 PARTNERS**

3.1 The partners for joint working within this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB (Cluster 1), Leicester, Leicestershire & Rutland ICB and Northamptonshire ICB (Cluster 2), Birmingham and Solihull ICB and Black Country ICB (Cluster 3), Coventry & Warwickshire ICB and Herefordshire & Worcestershire ICB (Cluster 4) and Shropshire, Telford & Wrekin ICB and Staffordshire ICB & Stoke on Trent ICB (Cluster 5).

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## 4 THE ARRANGEMENTS

- 4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the Midlands Joint Committee.
- 4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted by NHS England. Details of which are set out in a commissioning team agreement between all parties.
- 4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

## 5 GOVERNANCE ARRANGEMENTS

- 5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.
- 5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committee where appropriate.
- 5.3 The exercise of NHS England functions in consultation with the Joint Committee will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the Midlands Joint Committee when exercising that authority.
- 5.4 NHS England will report on the delivery of the functions under this scheme to the Midlands Joint Committees.

## 6 COMMISSIONING, CONTRACTING, ACCESS

### 6.1 Commissioning Arrangements

- 6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance.

### 6.2 Contracting Arrangements

- 6.2.1 The scheme will be administered by the Commissioning Team.
- 6.2.2 The contracting arrangement for the scheme will be as follows:
  - The scheme will encompass all existing contracts.
  - The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
  - The contracts will be funded by NHS England.
  - The contracts will be managed by the Commissioning Team.

### 6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

## 7 FINANCIAL GOVERNANCE ARRANGEMENTS

7.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

## **8 NON-FINANCIAL RESOURCES**

8.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB & NHSE Collaboration Agreement.

## **9 STAFF**

9.1 The commissioning team responsible for the operational delivery of these services will be employed by NHS England.

## **10 ASSURANCE AND MONITORING**

10.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

## **11 INTERNAL APPROVALS**

11.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

## **12 REGULATORY REQUIREMENTS**

12.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

## **13 COMPLAINTS**

Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

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PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
33C	Transanal endoscopic microsurgery (adults)		
33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)		
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
			Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

### Acute Services Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES
GEORGE ELIOT HOSPITAL NHS TRUST
HCRG
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

**Section 75 Contract**

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
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**Specialised Mental Health, Learning Disability and Autism Lead Provider Contracts**

Lead Provider	Coordinating Commissioner
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM ADULT SECURE)	LLR ICB
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM CYPMH)	LLR ICB
LEICESTERSHIRE PARTNERSHIP NHS TRUST (EM ADULT EATING DISORDER SERVICES)	LLR ICB
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM PERINATAL SERVICES)	LLR ICB
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST (WM ADULT SECURE)	BSOL ICB
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (WM CYPMH)	BSOL ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM ADULT EATING DISORDER SERVICES)	SSOT ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM PERINATAL SERVICES)	SSOT ICB

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**SCHEDULE 3: APPENDIX 2 – NHS ENGLAND COMMISSIONING RESPONSIBILITY AND ACCOUNTABILITY (RETAINED) SPECIALISED SERVICES**

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	42E	Gender dysphoria: other surgical services
		04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
65	Specialist services for adults with infectious diseases	04L	Reconstructive surgery and congenital anomalies of the female genital tract
		18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients with complex physical disabilities	05C	Specialist augmentative and alternative communication aids

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	(excluding wheelchair services) (adults and children)	05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) – ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

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**SCHEDULE 3: Appendix 3 – NHS ENGLAND COMMISSIONING RESPONSIBILITY AND ACCOUNTABILITY (RETAINED) Health and Justice and Screening and Vaccinations Services**  
**Screening Programmes**

**NHS England commissions 11 national population screening programmes:**

**Antenatal & Newborn Screening**

- Infectious diseases in pregnancy (HIV, hepatitis B, syphilis)
- Fetal anomaly screening
- Sickle cell and thalassaemia screening
- Newborn blood spot screening
- Newborn hearing screening
- Newborn and infant physical examination (NIPE)

**Adult Screening**

- Abdominal Aortic Aneurysm (AAA) screening
- Bowel cancer screening
- Breast cancer screening
- Cervical screening
- Diabetic eye screening

**Vaccinations**

**NHS England commissions the national immunisation programmes, which include:**

- Routine Childhood Vaccinations
  - 6-in-1 vaccine
  - MMR (Measles, Mumps, Rubella)
  - Hib/MenC
  - MenB
  - MenACWY
  - HPV
  - Pre-school boosters
- Adult Vaccinations
  - Seasonal influenza (flu)
  - Pneumococcal
  - Shingles
- Targeted Vaccinations
  - Hepatitis B (including neonatal)

- BCG (Tuberculosis)
- Mpox (for at-risk groups)
- MenB for gonorrhoea (specific risk groups)
- COVID-19 Vaccination Programme
- School-age Immunisation Programmes (HPV, flu, MenACWY)

## **Child Health Information Services**

### **Health and Justice Services**

**NHS England commissions healthcare for people in secure and detained environments, including:**

- Prison Healthcare
  - Primary care (GP, nursing, optometry, therapies)
  - Mental health services
  - Substance misuse services
  - Dental services
  - Public health services (including screening and immunisation)
- Children and Young People's Secure Estate
  - Physical health
  - Mental health
  - Neurodevelopmental support
  - Substance misuse services
- National CYP Vanguard pilots
- Immigration Removal Centres (IRCs)
  - Adult healthcare
  - Mental health services
  - Primary care and dental care
- Short-Term Holding Facilities
  - Basic healthcare provision

### **Non-Custodial Settings**

- Liaison and Diversion Services
  - Early identification and support for vulnerable individuals in police custody or courts
  - Referral into community services (eg mental health and social care referrals)
  - Recommendations to the court regarding sentencing options

- RECONNECT (not a treatment service)
  - Continuity of care support following release from prison
- Mental Health Treatment Requirements
  - Mental health interventions under a court order
- Court healthcare (Midlands and North of England) – co-commissioned with MoJ
  - Peripatetic paramedic based service

**As well as commissioning services for survivors of sexual assault and abuse**

- Sexual Assault Referral Centres (SARCs) – co-commissioned with Police and OPCCs
  - Section 7a services
  - Access to psychotherapies
  - Forensic medical services
- National Pathfinders (complex mental health)

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## SCHEDULE 4: FINANCIAL ARRANGEMENTS

### PART A: FINANCIAL RISK MANAGEMENT

#### 1 ESTABLISHMENT OF A RISK SHARE

- 1.1 The ICBs have agreed to establish and maintain a risk share arrangement for in-year financial management, based on the defined reserves held for elective activity under ERF and variable services within the specialised commissioning contracts.
- 1.2 The principles of the risk management agreement are that in year financial risk will be managed collectively across the ICBs in the Midlands. All allocations received for ERF and reserves specifically held for non-ERF variable services will be considered collectively as part of a notional pooled fund, managed by the specialised commissioning finance team on behalf of the ICBs. In year variation in contract performance will be monitored collectively and funds will be transferred between ICBs proportionately to fund the financial impact of in year variable activity to opening allocations.
- 1.3 The monies held in the notional Pooled Fund may only be expended on the following:
- Performance payments associated with the Elective Recovery Scheme (ERF),
  - Activity above opening contract levels for defined variable services within the specialised commissioning contracts,
  - Approved expenditure agreed by all parties in the Pooled Fund.
- (collectively known as "Permitted Expenditure")
- 1.4 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes contractual commitments for the population of Midlands ICBs including any out of region contractual arrangements.
- 1.5 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.
- 1.6 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.
- 1.7 The Specialised Commissioning Finance Team, on behalf of the Midlands ICBs, shall be responsible for providing the financial administrative systems for the Pooled Fund and the Pooled

Fund Manager will be the Director of Commissioning of Finance. The Specialised Services Finance and Contracting subgroup will be responsible for oversight of the management of the pooled fund and ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

## **2. RISK EXPOSURE**

### **2.1. Elective Services**

2.1.1. Elective activity is managed through the Elective Recovery Fund. Baseline activity is outlined within the Indicative Activity Plan (IAP) and is included within the fixed element of ERF payments which are included in opening provider contracts.

2.1.2. Any financial impact of agreement of final IAPs will need to be managed from the performance reserve and are subject to the terms of this Pooled Fund Agreement.

2.1.3. The 2026/27 ERF process allows for additional activity payments under the Activity Management Process. These will be managed through the terms of this Pooled Fund Agreement.

### **2.2. Variable Activity**

2.2.1. There are a small number of variable services within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.2.2. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2025/26 outturn.

2.2.3. For 2026/27 radiotherapy services have a blended payment approach with activity above planned levels being reimbursed at 50% of tariff. Performance payments are included within variable activity and therefore included within the risk share agreements.

2.2.4. All ICBs have created a reserve to manage 2026/27 activity growth in variable services. Payments above opening contract values for variable services will be subject to the terms of this Pooled Fund Agreement.

### 3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the notional Pooled Fund and risk management arrangements,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

### 5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Specialised Commissioning Team Pooled Fund manager shall manage expenditure within the notional pooled fund and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Pooled Fund Manager shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.

5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

5.7. Illustrative examples of the application of the risk share

5.7.1. Variable Activity using Chemotherapy variable activity performance.

ICB	Contract	Forecast	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	9,000	10,000	1,000	11.11%	653	9,653	7.25%	347
ICB 2	8,500	9,000	500	5.88%	617	9,117	7.25%	-117
ICB 3	7,500	9,000	1,500	20.00%	544	8,044	7.25%	956
ICB 4	8,500	10,000	1,500	17.65%	617	9,117	7.25%	883
ICB 5	11,000	11,000	0	0.00%	798	11,798	7.25%	-798
ICB 6	9,500	10,500	1,000	10.53%	689	10,189	7.25%	311
ICB 7	10,000	9,000	-1,000	-10.00%	725	10,725	7.25%	-1,725
ICB 8	9,000	9,500	500	5.56%	653	9,653	7.25%	-153
ICB 9	7,500	8,500	1,000	13.33%	544	8,044	7.25%	456
ICB 10	5,000	5,500	500	10.00%	363	5,363	7.25%	137
ICB 11	11,000	11,500	500	4.55%	798	11,798	7.25%	-298
Total	96,500	103,500	7,000	7.25%	7,000	103,500	7.25%	0

5.7.2. Elective Activity

ICB	Opening Contract	Finalisation of IAP	Performance Payments	Outturn	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	90,000		2,000	92,000	2,000	2.22%	2,798	92,798	3.11%	-798
ICB 2	85,000	2,000	3,000	90,000	5,000	5.88%	2,642	87,642	3.11%	2,358
ICB 3	75,000		4,000	79,000	4,000	5.33%	2,332	77,332	3.11%	1,668
ICB 4	85,000		0	85,000	0	0.00%	2,642	87,642	3.11%	-2,642
ICB 5	110,000		3,000	113,000	3,000	2.73%	3,420	113,420	3.11%	-420
ICB 6	95,000		2,000	97,000	2,000	2.11%	2,953	97,953	3.11%	-953
ICB 7	100,000	4,000	4,000	108,000	8,000	8.00%	3,109	103,109	3.11%	4,891
ICB 8	90,000		1,000	91,000	1,000	1.11%	2,798	92,798	3.11%	-1,798
ICB 9	75,000		2,000	77,000	2,000	2.67%	2,332	77,332	3.11%	-332
ICB 10	50,000		0	50,000	0	0.00%	1,554	51,554	3.11%	-1,554
ICB 11	110,000		3,000	113,000	3,000	2.73%	3,420	113,420	3.11%	-420
Total	965,000	6,000	24,000	995,000	30,000	3.11%	30,000	995,000	3.11%	0

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## **PART B: OTHER FINANCIAL ARRANGEMENTS**

### **6. BUDGETARY DELEGATION**

- 6.1. Commissioning decisions will be made in line with the Arrangements agreed by the Midlands Joint and Collaborative Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.
- 6.2. ICBs have agreed to delegate budgetary responsibility via the joint committees to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement.

### **7. AUDIT ARRANGEMENTS**

- 7.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the audit plan.
- 7.2. The Specialised Commissioning Team responsible for the management of specialised commissioning resources will be employed by NHS Birmingham and Solihull ICB but will access all ICB ledgers to process transactions for specialised services.

### **8. FINANCIAL MANAGEMENT**

- 8.1. Financial transactions for delegated specialised services will be processed through the ISFE2 ledger system of the eleven Midlands ICBs. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.
- 8.2. Financial monitoring reports will be produced by the hosted Specialised Commissioning Team on behalf of the ICBs.
- 8.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.
- 8.4. Monthly budget reporting with variance analysis and forecasting will be provided to Joint Committee Finance Subgroup, Host ICB, and Partner ICBs including:
  - ICB reporting based on risk management arrangements,
  - Overall financial performance report to be shared with all ICBs,
  - Management and review of reserves and investments.

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Schedule 4 - Appendix 1

**Budgetary Delegation Schedule for Specialised Services Only**

<b>Contract award, signature and variation</b>			
<b>Description of delegation:</b> Approval of contract award reports, providing requirements for competitive tendering have been met. Approval of contract signature and variation* Signature of contracts and contract variations must be made by the host commissioners			
<b>Delegated Limit</b>	Up to £50m	Up to £250m	
Limits are annual values			
<b>Approvers and/or restrictions</b> No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Director of Specialised Commissioning  Director of Commissioning Finance (specialised) – for contract variations	Regional Director of Commissioning  Director of Commissioning Finance (specialised) – for contract award	

<b>Purchase Requisitions, invoices and non POs</b>			
<b>Description of delegation:</b> Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
<b>Delegated Limit</b>	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £1m or 1/12 of contract value for NHS Providers
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning  Director of Commissioning Finance (specialised)  For delegated and retained functions

<b>Budget Virements</b>			
<b>Description of delegation:</b> Approval of budget virements/movements within approved revenue and capital budgets.			
<b>Delegated Limit</b>	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning  Director of Commissioning Finance (specialised)	MASCG

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## Budgetary Delegation Schedule for Retained Services Only

Delegated Limit	Up to £50m	Up to £250m	£250m to £750m
Limits are annual values			
<b>Approvers and/or restrictions</b> No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Director of Specialised Commissioning  Director of Commissioning Finance (specialised) – for contract variations For delegated and retained functions	Regional Director of Commissioning for NHSE functions  Director of Commissioning Finance (specialised) – for contract award for NHSE functions  Joint & Collaborative Committee for delegated functions	Regional Director of Commissioning for NHSE functions  Joint & Collaborative Committee for delegated functions

<b>Purchase Requisitions, invoices and non POs</b>			
<b>Description of delegation:</b> Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £1m or 1/12 of contract value for NHS Providers
<b>Approvers and/or restrictions</b> Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning  Director of Commissioning Finance (specialised)  For delegated and retained functions

<b>Budget Virements</b>				
<b>Description of delegation:</b> Approval of budget virements/movements within approved revenue and capital budgets.				
Delegated Limit	Up to £50k (Bands 8A-D)	Up to 100k (Band 9)	Up to £2m	Over £2m
<b>Approvers and/or restrictions</b> Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services	Commissioning Assistant Directors Contract Managers or Budget Holders For delegated and retained functions	Deputy Directors For delegated and retained functions	Director of Specialised Commissioning  Director of Commissioning Finance (specialised) For delegated and retained functions	Regional Director of Commissioning for NHSE functions  Joint & Collaborative Committee for delegated functions

## SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

### PART 1

#### 1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:
  - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;
  - 1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;
  - 1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;
  - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;
  - 1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;
  - 1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
  - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
  - 1.3.8. apply to the activities of the Partners' Staff; and
  - 1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

#### 2. Purpose

The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

- 2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

### **3. Benefits of information sharing**

- 3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Services.

### **4. Lawful basis for sharing**

- 4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The Partners shall ensure that there is a Data Protection Impact Assessment (“DPIA”) that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

### **5. Restrictions on use of the Shared Information**

- 5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be always handled on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners’ Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.
- 5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.
- 5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement.

## 6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. To achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:
  - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;
  - 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;
  - 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
  - 6.1.4. considering carrying out activities to promote public understanding of how data is processed where appropriate.
- 6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The Partners shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement between the Partners.

## 7. Governance: Staff

- 7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.
- 7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

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- 7.4. Each Partner shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.
- 7.5. The Partners shall ensure that:
  - 7.5.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information;
  - 7.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and
  - 7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered in accordance with this Schedule.

## 8. Governance: Protection of Personal Data

- 8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall co-operate in exploring alternative strategies to avoid the use of Personal Data to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.
- 8.4. If any Partner becomes aware of:
  - 8.4.1. any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or
  - 8.4.2. any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:
  - 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only

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in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

- 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by Law or any regulatory body; and
  - 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining, and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:
- 8.6.1. take account of the nature, scope, context, and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
  - 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.
- 8.7. Each Partner shall:
- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
  - 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display, or distribution, of the Relevant Information;
  - 8.7.3. obtain prior written consent from the originating Partner to transfer the Relevant Information to any third party;
  - 8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors, or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and
  - 8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered in accordance with this Schedule.

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8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

## **9. Governance: Transmission of Information between the Partners**

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, to ensure that the correct patient record and/or data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received during this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

## **10. Governance: Quality of Information**

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

## **11. Governance: Retention and Disposal of Shared Information**

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted, and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy

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in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

- 11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated, or amended from time to time.
- 11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a crosscut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.
- 11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

## **12. Governance: Complaints and Access to Personal Data**

- 12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.
- 12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.
- 12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's publication scheme.

## **13. Governance: Single Points of Contact**

- 13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

## **14. Monitoring and review**

- 14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.



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**SCHEDULE 5: Appendix 1**

Dated: 1 April 2026

(1) NHS ENGLAND (SPECIALISED COMMISSIONING)

and

(2) **MIDLANDS NHS INTEGRATED CARE BOARD**

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Joint Controller Agreement for Delegated Specialised  
Services support via NHS England Commissioning Teams in  
Financial Year  
2026/27

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**THIS AGREEMENT** is made on the 1st day of April 2026

**Between**

(13) NHS Midlands Integrated Care Boards and NHS England.

(14)

**Introduction**

The ICBs and NHS England wish to enter into this Joint Controller Agreement (the “**Agreement**”) in respect of the administrative and management services (the “**Administrative and Management Services**”) to be provided by the NHS England regional teams currently commissioning Specialised Services (the “**Commissioning Teams**”) to the Midlands ICBs during the financial year 2026/27 (1 April 2026 – 31 March 2027) for all Delegated Specialised Services, as set out further in the Collaboration Agreement.

**Background**

- a) NHS England has statutory functions to arrange for the provision of prescribed services for the purposes of the NHS. This includes the services known as “**Specialised Services**”.
- b) The ICBs have statutory functions to arrange for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.
- c) NHS England has entered into a Delegation Agreement for Specialised Services with the ICB under Section 65Z5 of the NHS Act 2006, and also a Commissioning Team Agreement which outlines the scope and basis of the Administrative and Management Services which NHS England has agreed to provide to the ICB during the financial year 2026/27.
- d) This Agreement sets out the respective roles of the Parties in respect of Personal Data Processed in connection with the Administrative and Management Services, in accordance with the Data Protection Legislation.

**It is agreed:**

**1 Commencement, duration and status of this Agreement**

1.1 This Agreement shall come into force on the 1 April 2026 and continue until 31 March 2027 unless extended by written agreement from all Partners.

1.2 Termination of the Commissioning Team Agreement shall also have the effect of terminating this Agreement

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- 1.3 Unless otherwise provided, the words and expressions defined in the Delegation Agreement and Commissioning Team Agreement shall have the same meaning and effect in this Agreement.
- 1.4 The following definitions shall apply this Agreement:
- 1.4.1 **"Commissioning Support Data"** means the Personal Data and Non-Personal Data Processed in connection with the Administrative and Management Services, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – *"To Share or Not to Share?"*), and as further defined in clause 2 below;
- 1.4.2 **"Data Protection Impact Assessment"** shall have the same meaning as set out in the UK GDPR;
- 1.4.3 **"Joint Controller"** shall have the same meaning as set out in the UK GDPR; and
- 1.4.4 **"Personal Data Breach"** shall have the same meaning as set out in the UK GDPR.

## 2 Key principles and aims

- 2.1 The Parties agree and acknowledge that it is necessary for NHS England to Process certain Personal Data in for it to perform the Administrative and Management Services, as comprised within the Commissioning Support Data.
- 2.2 The Parties record their understanding and agreement in relation to the Commissioning Support Data as follows:

(a)

Subject matter	The performance of the Administrative and Management Services by NHS England so as to assist the ICBs in being able to perform the Delegated Functions.
Duration	This Parties agree that this Agreement applies for the duration of the Commissioning Team Agreement, but for the avoidance of doubt, the Parties acknowledge that their legal obligations under the UK GDPR in respect of the Commissioning Support Data survive expiry or termination of this Agreement, however arising.
Nature and purpose of the processing	The Commissioning Support Data enables NHS England to undertake analysis on, and otherwise take account of, the health needs of the ICB's local population and to provide tailored advice and support to the ICB in connection with the ICB's Delegated Functions.
Type of personal data	Patient level, and so directly identifiable, data is shared by NHS providers with NHS England via its national data landing platform, whereupon it is

	pseudonymised by the Arden and GEM DSCRO before it is made available to commissioners, including NHS England, as needed and relevant for their particular functions.
Categories of Data Subject	Patients in England.

(b)

2.3 The Parties have determined the following in respect of their roles under the Data Protection Legislation:

2.3.1 they will together determine the purpose and means for which the Commissioning Support Data is Processed in order for NHS England to provide the Administrative and Management Services and therefore that they are Joint Controllers in this context;

2.3.2 the ICB is an independent Data Controller for any Personal Data it Processes in order for it to perform the Delegated Functions; and

2.3.3 NHS England is an independent Data Controller for any Personal Data Processed in order for it to perform the Retained Functions.

2.4 The Parties agree that NHS England is the **"Lead Controller"** in respect of the Commissioning Support Data. As Lead Controller, NHS England has responsibility for ensuring that the Processing of the Commissioning Support Data is performed in accordance with Data Protection Legislation.

2.5 The Parties agree that this Agreement is necessary to enable NHS England to carry out the Administrative and Management Services. This Agreement defines the principles and procedures that the Parties shall adhere to and the responsibilities the Parties owe to each other and to Data Subjects, in accordance with the Data Protection Legislation.

### 3 Lead Controller obligations

3.1 The Lead Controller is responsible for providing the Data Subjects with clear and sufficient information as to the way in which the Commissioning Support Data will be processed.

3.2 To comply with its obligation at clause 3.1 of this Agreement, the Lead Controller shall provide the Data Subjects with a privacy notice where the circumstances so require. The Lead Controller is responsible for ensuring that its privacy notice addresses all matters required to be included by Articles 13 and/or 14 of the UK GDPR.

3.3 The Lead Controller is responsible for making available to Data Subjects the essence of the arrangements contemplated by this Agreement in accordance with Article 26(2) of the UK GDPR.

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#### 4 Joint Controller obligations

- 4.1 The Parties are jointly responsible for determining the purposes and means for and by which the Commissioning Support Data may be processed, in light of the collective and shared purpose arising out of NHS England's performance of the Administrative and Management Services for the benefit of the ICB. The Parties agree and acknowledge that the legal bases which apply to the Processing of the Commissioning Support Data are as follows:
- 4.1.1 Article 6(1)(e) UK GDPR, on the basis that it is necessary for NHS England to Process the Commissioning Support Data in order for it deliver the Administrative and Management Services and in reliance on NHS England's statutory powers under section 2(2) of the NHS Act 2006; and
- 4.1.2 Article 9(2)(h) UK GDPR, on the basis that is necessary for NHS England to Process the Commissioning Support Data in order for it to deliver the Administrative and Management Services as they relate to the management of health care systems and services.
- 4.2 The Parties agree to promptly inform each other if either Party becomes aware of any non-compliance with the terms of this Agreement or the Data Protection Legislation.
- 4.3 The Parties agree to cooperate and assist each other with fulfilling their obligations under the Agreement and complying with the Data Protection Legislation. In particular, it is agreed that:
- 4.3.1 NHS England shall assist the ICB as the Lead Controller with complying with Article 26 of the UK GDPR and as further set out in this Agreement;
- 4.3.2 the Parties shall promptly inform each other of any request they receive under the FOIA, UK GDPR or any other Applicable Law which involves any Commissioning Support Data, but in any event no later than two working days after receiving the request;
- 4.3.3 the Parties shall provide each other with such assistance as is necessary to enable each other to comply with any requests they receive under the FOIA, the UK GDPR or any other Applicable Law;
- 4.3.4 if requested, the Parties shall make available to each other all information necessary to comply with auditing requirements and/or demonstrate compliance with the Agreement and Data Protection Legislation;
- 4.3.5 To the extent permitted by law, the Parties shall promptly notify each other of any communication they receive or are made aware of that suggests non-compliance in

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respect of the way in which the Commissioning Support Data has or is being controlled or processed under this Agreement; and

- 4.3.6 Taking account of the nature of Processing and the Commissioning Support Data, the Parties undertake to assist each other with meeting their respective obligations relating to security of processing, the notification of Personal Data Breaches and the completion of Data Protection Impact Assessments.

## **5 Personal Data Breaches**

- 5.1 The Parties shall inform each other of any actual or suspected Personal Data Breach as soon as is practicable, but in any event no later than 24 hours after becoming aware of the actual or suspected Personal Data Breach, irrespective of whether there is a requirement to notify any Supervisory Authority or Data Subjects.
- 5.2 The Parties agree to provide each other with reasonable assistance to facilitate the handling of any Personal Data Breaches in an expeditious and compliant manner.

## **6 Effect of termination**

- 6.1 This Agreement shall continue in force unless and until it has expired or is otherwise terminated in accordance with clause 1 above.
- 6.2 Notwithstanding expiry of termination of this Agreement the Parties will continue to retain Commissioning Support Data in accordance with the Data Protection Legislation and subject to any applicable legal, regulatory or professional retention periods.

## **7 Transfers**

- 7.1 For the purposes of this clause 'transfers' means the sharing of the Commissioning Support Data by a Party (**Disclosing Party**) with a Third Party and shall include, but is not limited to, the following:
- 7.1.1 the Disclosing Party granting a Third Party access to the Commissioning Support Data; and/or
- 7.1.2 the Disclosing Party sub-contracting the processing of Commissioning Support Data.
- 7.2 The Data Discloser may only transfer the Commissioning Support Data in circumstances where it is lawful to do so in accordance with Data Protection Legislation. If the Data Discloser grants a Third Party access to the Commissioning Support Data it must comply with Articles 28 and 30 of the UK GDPR, as applicable, and shall remain liable for any acts and/or omissions of the Third Party.

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## SCHEDULE 6: COMMISSIONING TEAM ARRANGEMENTS

### 1. Introduction

This agreement sets out the purpose of the Office of Pan ICB Commissioning, how it will operate and how it will be governed from 1<sup>st</sup> April 2026 to 31<sup>st</sup> March 2027.

From April 27 (subject to approval by Parliament to necessary legislative changes) Integrated Care Boards (ICBs) will take over statutory responsibility from NHS England for commissioning suitable specialised Acute and Mental health, Learning Disability & Autism services; Health and Justice services; and Screening and Vaccination services. Collectively, these services account for circa £5bn within the Midlands in 2025/26.

Whilst it is intended that ICBs will be individually responsible, most of their new commissioning functions will require – due to the nature of the services and populations involved – a large planning and commissioning footprint. This will mean that ICBs will need to establish (or build upon existing) appropriate multi-ICB governance arrangements, such as a joint committee.

Seven ‘Offices for Pan-ICB Commissioning’ (OPICs) – one per NHS region - will be established to support all ICBs across a region in discharging these additional statutory functions. The OPIC model is designed to facilitate ICB collaboration and, where appropriate, ‘at scale’ commissioning as well as ensuring a critical mass of expert commissioning capability is maintained for these complex, high profile and often contentious areas of service provision.

The OPIC model is designed to facilitate ICB collaboration and, where appropriate, ‘at scale’ commissioning as well as ensuring a critical mass of expert commissioning capability is maintained for these complex, high profile and often contentious areas of service provision.

Staff currently delivering these commissioning functions within NHSE’s seven regional teams will transfer to the host ICBs in April 2027 (or, at the point legislative provisions transferring these functions to ICBs are commenced)

NHS England will continue to host staff working on behalf of ICBs for the commissioning of the Specialised Acute and MHLDA services that were delegated in April 2024 and April 2025.

This agreement will commence on 1<sup>st</sup> April 2026 for one year only. This will be a transition year to further develop the future operating model with NHSE remaining the employing organisation.

This agreement is between the following clusters of ICBs & NHS England:

#### Cluster 1

NHS Lincolnshire Integrated Care Board

NHS Nottingham & Nottinghamshire Integrated Care Board

NHS Derby & Derbyshire Integrated Care Board

#### Cluster 2

NHS Leicester, Leicestershire & Rutland Integrated Care Board

NHS Northamptonshire Integrated Care Board

#### Cluster 3

NHS Birmingham & Solihull Integrated Care Board

NHS Black Country Integrated Care Board

#### **Cluster 4**

NHS Herefordshire & Worcestershire Integrated Care Board

NHS Coventry & Warwickshire Integrated Care Board

#### **Cluster 5**

NHS Shropshire, Telford & Wrekin Integrated Care Board

NHS Staffordshire & Stoke-on-Trent Integrated Care Board

and

NHS England

This Joint Working Agreement should be read in conjunction with:

- Overarching governance documents
  - Delegation Agreement
  - Joint and Collaborative Committee Terms of Reference
  - OPIC Commissioning & Operating Framework
- National guidance relating to the roles and responsibilities of NHS England in relation to directly commissioning services.

## **2. Values and Principles**

In creating the Office of Pan ICB Commissioning we will create a new model of specialist commissioning, one that succeeds not through structural redesign alone, but through a fundamental shift in how we operate and work together. We will continue to transform the way health services are strategically commissioned across the Midlands, by creating a collaborative, resilient, and equity-driven system that works at scale while remaining responsive to local needs.

The Office of Pan ICB Commissioning will:

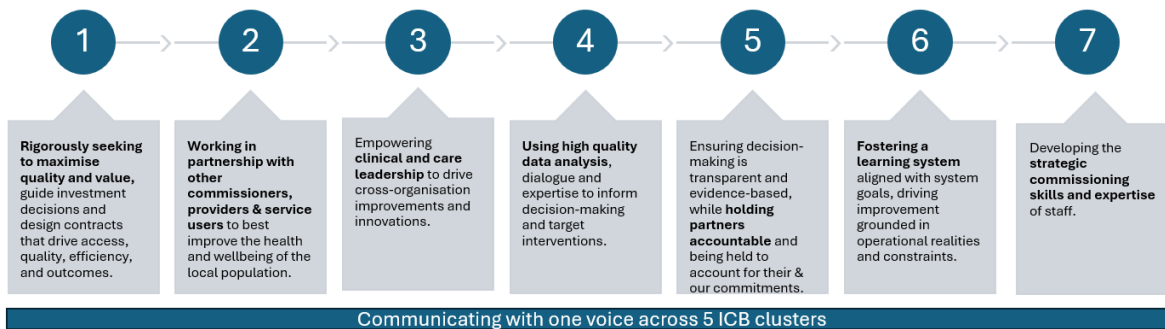
- Support a safe transfer / delegation of commissioning responsibilities and accountabilities from NHSE to ICBs from 2027.
- Bring together Strategic Commissioning of specialist services across the 5 cluster ICBs - Establishing a Midlands-wide centre of excellence that supports all ICBs equally, hosted by one ICB on behalf of all. Enabling consistent, high-quality commissioning through a shared operating model, while allowing flexibility for local decision-making.
- Improve Health Equity and Outcomes - Use data-driven planning to tackle health inequalities and improve outcomes for underserved populations. Shift focus from service fragility to population health, access, and equity.

Empower Clinical and Community Leadership - Embed clinical leadership and co-production at the heart of commissioning. Ensure services are shaped by patients, providers, and communities.

- Deliver Value-Based, Outcome-Focused Care - Align commissioning decisions with measurable outcomes, patient experience, and cost-effectiveness. Drive efficiency and sustainability across specialist services.
- Enable Integration and Innovation - Support pathway redesign and integration across care settings. Foster provider collaboration and innovation through shared governance and financial risk models.

Midlands ICBs are committed to collaborate and commission at scale, to maximise resilience and strategic commissioning capability in these important areas of healthcare provision. The Office for Pan ICB Commissioning will provide a Midlands wide centre of excellence focussing on specialist commissioning knowledge and expertise, connecting with and through colleagues at cluster, place and provider level. It will be built on the following principles of collaboration and co-production:

**As Strategic Commissioners Our Guiding Principles Are:**



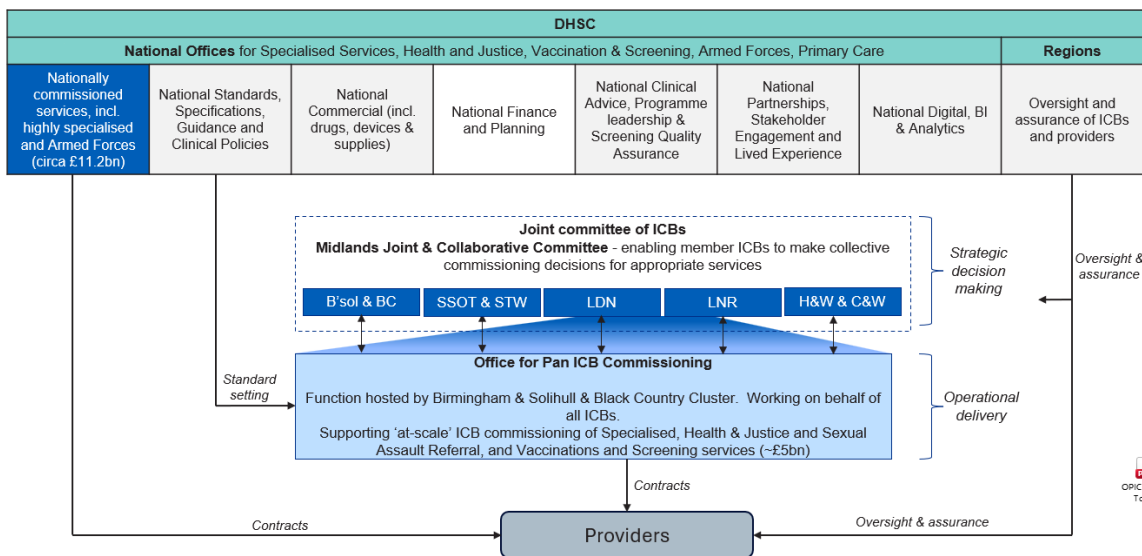
The Multidisciplinary Team will work coherently and consistently and will champion specialised care on behalf of the 12 commissioning partners. They will work as a part of a network of partners, enabling staff to deliver across complex geographies and as part of multi-layered systems and local collaboration.

### 3. Operating Model

The founding principles of the operating model are:

- Operate Midlands wide by default, whilst working at ICB Cluster or East/West footprints when it makes sense to do so.
- OPIC hosted by NHSE until transfer to the host ICB, so must fulfil its current statutory functions whilst being future proof and in line with ICBs development as strategic commissioners.
- Develop as a cohesive entity operating based on collaboration, co-production and transparency working with ICB leadership and guidance.
- Clear points of communication and relationship management across ICBs, OPIC and into national commissioning functions.
- The strategic commissioning framework, ICB blueprint and OPIC design toolkit will frame its core purpose.
- Financially sustainable within OPIC RCA envelope.

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### Delegated services

The Midlands Specialised Commissioning Team has been working with and on behalf of all Midlands ICBs since 2023/24 with a joint working agreement and subsequent set of delegation processes in April 2024 and April 2025.

#### We commission:

- Circa. 150 specialised services aligned to the prescribed service manual.
- Acute and Mental Health, Learning Disability and Autism Services (MHLDA).
- ICB delegated service responsibility and NHSE retained responsibility as well as contracting processes for current Highly Specialised Services (HSS).
- High-Cost Medicines, including medicines optimisation and care transformation.

#### We operate:

- A single integrated Midlands team working on behalf of ICBs and NHSE.
- Subject matter expertise aligned to 6 programmes of care (Women and Children's, Trauma, Internal Medicine, Cancer, Blood and Infection and MHLDA).

### NHS England Commissioned Services

#### Health and Justice

Commissioning of healthcare for a range of individuals in touch with the criminal justice system

- **Custodial healthcare services:** Male Prisons, Female Estate, Young Offenders Institutes, & Secure Holding Facilities. *16 contracts across 4 providers operating within 28 establishments.*
- **Non-custodial healthcare services:** Liaison and Diversion Services, RECONNECT, Mental Health Treatment Requirements (MHTRs) *across 9 providers.* Court Healthcare co-commissioned with the MoJ (PECS) by the Midlands H&J team covering the North of England and the Midlands regions (*1 contract, 1 provider*).
- **Children and Young Peoples (CYP) Services:** 2 x secure children's homes and 1 planned new safe centre (welfare only unit) *2 contracts across 2 providers.*

**Sexual Assault Referral Centres (SARCs)** for Adults and for Children and Young People. Co-commissioned with Police and Crime Commissioners / Police Forces. *12 locations, 8 contracts across 5 providers.*

#### Screening

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Responsibility for delivery of:

Cancer Programmes: Cervical Screening, Breast Screening, Bowel Screening

Adult Non-Cancer Programmes: Diabetic Eye Screening, Abdominal Aortic Aneurysm (AAA) Screening,

Antenatal and Newborn programme: Six separate programmes

Child Health Information Services (CHIS)

Commissioning functions include:

- Service transformation and improvement, develop innovative solutions and implementation plans to meet local need and ensure best value
- Coordinate management of screening incidents/issues.
- Oversee local end-to-end screening pathways to address gaps & ensure alignment Effective contract management, monitoring and development and delivery of improvement/equity plans
- Use data and insight to identify population needs

### **Vaccinations**

Through our well-established vaccination governance group, we work with all ICB vaccination leads to ensure alignment with system prevention strategies, making joint decisions on vaccination delivery for routine and seasonal programmes (see annex for detail):

**Childhood programmes** – Measles, Mumps, Rubella, Varicella (MMRV), Diphtheria, Pertussis, Meningococcal C etc

**Seasonal programmes** – Covid (spring/winter) & Flu (winter)

**School Age Programmes** - flu, Human Papilloma Virus (HPV), Meningococcal ACWY (Men-ACWY), Tetanus/Diphtheria/Polio (Td/IPV), MMR / MMRV (catch-up)

**Adult Programmes** - Pertussis, Respiratory Syncytial Virus (RSV), Pneumococcal, Shingles, MPOX/Gonorrhoea

**Maternal programmes** – Flu, Pertussis, RSV

**Neonatal Programmes** – BCG for TB prevention, Hepatitis B

### **Commissioning Support Services**

#### **Finance**

- Contract negotiation and management for all specialist services including all NHSE retained and delegated services – delivered, where appropriate through ICB lead contract arrangements.
- Development of activity plans for all contracts and services
- Management and processing of all contract variations.
- Provider relationships – contract management, review meetings across all NHS and Independent sector providers
- Management of payments for all specialist services
- Support to ICBs through finance and contracting governance groups, management of risk share arrangements, pricing policy
- Management of financial allocations including operational and strategic financial planning

Monthly reporting and ledger management

### **Healthcare Public Health**

The key public health functions embedded in OPIC

**Specialised commissioning:** At regional level, a full and integral member of specialised commissioning teams. Liaison with public health colleagues across the

system to assist in optimising prevention, service planning and quality across whole pathways of care.

- **Health and Justice:** Provide public health expert advice and guidance to HMPPS and NHSE, in commissioning of health services in the secure and detained estate. Health needs through data analysis and interpretation, service audits and reviews.
- **Dental public health:** Provide specialist dental public health & clinical leadership, advice and guidance for Local Integrated Care Systems supporting the commissioning of ICB Dental services
- **Screening and Immunisations:** Technical PH knowledge and operational experience in screening and immunisation pathways, including quality assurance, incident response, and compliance with national standards.

### Clinical and Quality

**Delivery of Statutory Quality Duties** for commissioned services through three separate Clinical & Quality teams:

- Acute Specialised Commissioning
- Mental Health, Learning Disability & Autism (MHLDA) Specialised Commissioning
- Health & Justice (Custodial and Non-Custodial) and Vaccination & Screening
- **Quality Surveillance (Control):** through Provider Contract Review Meetings
- **Quality Assurance:** Undertaking Desktop/Peer Reviews, Clinical Quality Visits (CQVs), Audits **Quality Improvement & Quality Planning:** Working with Clinical Networks/Programme of Care, including thematic learning e.g. from Deaths in Custody (DICs) and PSIRF
- **Clinical Leadership:** providing specialist advice and support

### Corporate and Governance

Ensure all activities across commissioning are aligned, efficient and well-managed, as the operational backbone for governance and delivery.

- **Programme Management** – Ensures projects and initiatives are coordinated, managed and deliver outcomes.
- **Change Management** – Designing and implementing change programmes, managing people, processes and transitions.
- **OD, EDI and HR** - Improving directorate effectiveness and capability
- **Comms and Engagement** - Media and stakeholder advice, incident & issue management, proactive media management
- **Corporate Governance** - – Ensure accountability, transparency and compliance
- **Business coordination** - Risk and issue management, reporting and assurance

## 3.NHSE Hosting

NHSE commissioning team (working on delegated ICB services and NHSE commissioned services) will operate seamlessly across NHSE and cluster ICBs. NHSE will meet all associated costs of employing staff commissioning NHSE services working jointly with ICBs and hosting staff who support services already delegated to ICBs, this will include but not limited to the following

- Corporate support will be provided by NHSE as the host organisation including estates, IT, legal support, HR and business administration.

- The Multidisciplinary Team will link with NHSE Regional and National directorates regarding risk management where this is appropriate.
- Although the responsibility for commissioning of the 59 specialised services is delegated to the Midlands ICBs on 1<sup>st</sup> April 2024, accountability remains with NHSE. This will be managed by the NHSE Midlands regional team through an Oversight and Assurance Framework informed by subject matter expertise provided by the Multidisciplinary Team and wider regional commissioning integration team.
- The team will work to ensure consistency of communication through the established governance model, recognising the different populations and system issues in the Midlands. The team will remain pan-Midlands in structure.

### Liabilities

NHS England shall be liable for any losses arising out of negligent acts or omissions in respect of the provision of Administrative and Management Services except where such losses arise as a result of action taken in accordance with instruction from any ICB or a failure of an ICB to provide on request appropriate instruction.

NHS England will meet the liabilities as a result of:

- Death or personal injury caused by its negligence.
- Fraud
- Fraudulent misrepresentation

### MaST training and professional development

The costs associated with the provision of agreed ongoing learning and development including mandatory (MaST) training will be met by NHSE.

100% compliance is required by all staff for the MaST training detailed below:

#### Equality, Diversity and Inclusion

As part of the system leadership arrangements for the NHS, we recognise the importance of becoming a role model for the rest of the NHS in respect of issues relating to equality, diversity, and inclusion in the workplace.

#### Fraud Awareness

This course focuses on providing you with awareness of the key aspects of fraud and corruption in the NHS and help you know your responsibilities to combat it.

#### Data Security Awareness

This course focuses on the importance of data security in health and social care. It will help you understand how to comply with the law, define potential threats and how to identify and avoid breaches.

#### Health and Safety

This course focuses on health and safety in the workplace. You will gain an understanding for responsibilities under Health and Safety Law, different types of safety signage, basic fire safety principle, basic moving, and handling techniques and why incident reporting is so important.

#### Safeguarding Children & Adults at Risk of Harm or Abuse

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This course introduces safeguarding children and adults at risk of harm or abuse. It focuses on safeguarding in the NHS, data sharing, domestic abuse, and associated legislation as well as what you can do when raising a concern.

### **Records Management**

This course introduces you on the importance of records management, legal and contractual requirements, and guidance on how to keep information secure.

### **Patient Safety**

This course introduces patient safety for all NHS staff. It focuses on the essentials for creating patient safety and helps recognise that the NHS is a system of essential and interconnected parts; a team with a common goal.

### **Appraisal and Dynamic Conversations**

NHSE will meet all costs and requirements of ensuring all members of the have regular performance and development through regular Appraisal & Dynamic Conversations.

Appraisals are an opportunity for both line managers and team members to have meaningful, fluid, and organic 1:1s. Dynamic Conversations put wellbeing at the forefront of initial conversations and will help to support colleagues through change.

NHSE will ensure that monthly 1:1s with line managers are regularly scheduled.

#### **(c) Freedom of Information and Parliamentary Requests**

(d) All Freedom of Information and Parliamentary Requests relating to Delegated Services should be forwarded to the NHSE commissioning team will ensure the appropriate handling, management, and response, ensuring where appropriate that ICBs are informed and engaged. The team will also ensure they provide reasonable support to ICBs in responding to freedom of information and parliamentary correspondence as required.

(e)

#### **(f) Incident Response and Management**

(g) The NHSE commissioning team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Services and NHSE commissioning services.

(h)

#### **(i) Provider Selection and Procurement**

(j) The NHSE commissioning team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Services.

### **Escalations**

If an ICB has cause to raise concerns regarding the performance, actions or conduct of a member of the Multi-Disciplinary Team the ICB will in the first instance contact by email the Director of Specialised & Collaborative Commissioning, who will where possible provide an acknowledgement within 7 days of receipt.

The Director of Specialised & Collaborative Commissioning will provide the ICB with feedback and action taken with 30 days.

If for any reason the ICB is unhappy with the response the concerns can be escalated to the NHS England Regional Director of Commissioning

**Confidential information**

The ICBs and NHSE shall always use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner.

If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

The ICBs and NHSE will not make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way. The ICBs and NHSE shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

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# Board Meetings in Common in Public

Report Title: Quality Assurance – LNR

ICB Cluster

Date of Meeting: 19 February 2026

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>Thursday 19 February 2026</b>		
<b>Report Title</b>	<b>Quality, Performance Outcomes Assurance Reports – LLR ICB and N ICB</b>		
<b>Paper Reference No:</b>	<b>ICBIC-26-07</b>	<b>Agenda Item No:</b>	<b>12.</b>

<b>Presented by</b>	<b>Maria Laffan, Chief Nursing Officer, LNR ICB</b>
<b>Report Author(s)</b>	<b>Miranda Tapfumanei, Director of Nursing, N ICB Mandy Staples, Director of Nursing, N ICB Chris West, Deputy Chief Nursing Officer, LLR ICB</b>
<b>Executive Sponsor</b>	<b>Maria Laffan, Chief Nursing Officer, LNR ICB</b>

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input checked="" type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.
<b>Recommendations</b>		
<b>The Boards are asked to:</b> <ul style="list-style-type: none"> <li><b>REVIEW</b> and <b>NOTE ASSURANCE</b> from the Committees in Common for Quality, Performance and Outcomes which met on 10 February 2026.</li> </ul>		

<b>Executive Summary of the report</b>
<p>This report presents an overview of the cluster quality and performance system. Ther report follows the AAA governance approach:</p> <ul style="list-style-type: none"> <li><b>Alert</b> – Key risks/issues requiring escalation and action.</li> <li><b>Assure</b> – Areas where progress is being made but targets are not yet met.</li> <li><b>Advise</b> – Positive developments and achievements impacting outcomes.</li> </ul> <p>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.</p> <p>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.</p>

The main alerts this month are as follows:

**Quality**

NHS Northamptonshire Integrated Care Boards

- University Hospitals of Northampton (UHN) Maternity services issued with a S29a warning notice
- Diagnostic Immunology at UHN – provision and access to timely results
- Prevention of Future Death reports in Northamptonshire x 3
- St Andrews Large Scale Enquiry has now concluded but work continues with statutory bodies.

No providers across LNR are in intensive level monitoring.

**Performance**

- Challenges remain across the Urgent and Emergency Care pathways across all providers and partners. It is acknowledged that the systems are much more resilient than last winter with clear indications that new schemes have supported this response.
- Elective and Cancer performance is challenged for some pathways with plans in-place to recover the position

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 10 February 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?**

<input checked="" type="checkbox"/>	<b>Improve Outcomes</b> - Improve outcomes in population health and healthcare	<input checked="" type="checkbox"/>	<b>Health Inequalities</b> - Tackle inequalities in outcomes, experience, and access
<input checked="" type="checkbox"/>	<b>Value for money</b> - Enhance productivity and value for money	<input checked="" type="checkbox"/>	<b>NHS Constitution</b> - Deliver NHS Constitutional and legal requirements
<input type="checkbox"/>	<b>Social and economic development</b> - Help the NHS support broader social and economic development		

**Conflicts of interest – Please select**

<input type="checkbox"/>	No conflict identified
<input checked="" type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision
<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	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**

<b>LLR ICB BAF No: 5</b>	<b>NICB BAF No: 1</b>
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**Appendices**

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**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 10 February 2026.

**Implications: Select which of the following implications need to be considered**

<input checked="" type="checkbox"/>	Quality & Patient Safety	<input checked="" type="checkbox"/>	Legal	<input checked="" type="checkbox"/>	Equality, Diversity & Inclusion		
<input checked="" type="checkbox"/>	Environmental	<input checked="" type="checkbox"/>	Data & Digital	<input checked="" type="checkbox"/>	Financial	<input checked="" type="checkbox"/>	Workforce

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# Performance Report – LLR Executive Summary Feb 25

## Alert

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

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

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

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

## Assure

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

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

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

## Update, risk and learning on Plans

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

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

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

## Advise

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

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

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

# Performance Report – Northamptonshire Executive Summary

## Alert

- Ambulance Handovers: Month on Month improved, with KGH achieving an improved position. NGH achieving a decrease in performance, however both remained below plan.
- Patients NC2R: Remains challenged at KGH & NGH. NGH OPEL 4 with 17% - 28% NC2R, KGH OPEL 3 & OPEL 4 18% - 34% NC2R.
- NGH and KGH distance from RTT plan, recovery plan in place to support recovery, but underlying risk.
- Cancer 62-days, Delivery of FDS (28 days) remains challenged locally.
- Overall elective activity remains behind plan with a recovery plan in place.
- Reduction in premium diagnostics activity at UHN will further impact on performance in 2025/26. This puts further pressure on performance recovery in 2026/27.

## Update, risk and learning on Plans

- Challenges non-elective in demand, high levels of attendances & admissions with numbers of MFFD patients. Winter schemes are the mitigation and are performing well.
- NGH and KGH distance from RTT plan, recovery plan in place to support recovery, but underlying risk.
- Capacity within UHN to deliver required amounts of elective activity to deliver RTT performance requirements.
- Mental Health capacity constrained due to overall capacity and numbers of patients ready to leave bed-based care.

## Assure

- Bed Occupancy: Although this remains high, both Trusts below plan.
- Additional winter schemes implemented. Despite a difficult post-Christmas period result performance at NGH has significantly improved since schemes commenced.
- Implementation of no 45 min ambulance breaches has been largely successful apart from during parts of January.
- Mental Health Discharge to Assess winter scheme now live.
- 65-week position is being carefully managed but current maintaining 0 position.
- 52-week cohort also reducing in line with plans.
- Community and Mental Health delivery remains good.

## Advise

- Continued delivery of the UEC schemes and those proposed for 26/27 will be crucial
- Planned Care meeting established across cluster to support overview and planning of Elective.
- System Capital bids including investment for Diagnostics submitted.
- System work underway to address end-to-end CYP Neuro Diversity, Speech and Language Communication Needs and Community Paediatric pathways.

# Quality Report – LNR Executive Summary

NOF Scores	UHL	NGH	KGH	LPT	NHFT
Q2 25/26 (Q1 if different)	3	4(down from 3)	3	2	2 (down from 1)

Quality Risk	Trajectory & Impact	Key Issues	Actions & Grip
Regulatory Oversight & CQC	Amber/Red – Mixed trajectory	CQC actions, Section 29A, Intensive Oversight, media attention	IOAG oversight, improvement plans, Board assurance checkpoints
Patient Safety & Harm Signals	Amber – Persistent themes	Prevention of Future Deaths across MH, emergency care, records, nutrition & hydration	Countywide Patient Safety Group, Trust & system actions
Urgent & Emergency Care Quality	Red – Worsening during pressure	Ambulance handover delays, No Criteria To Reside, dignity & safety risks	UEC escalation, winter schemes, flow actions
Mental Health Inpatient Quality	Amber/Red – Flow related risk	Length of Stay is increasing, Clinically Ready for Discharge delays, Court of Protection	Operational escalation, discharge focus, system grip
SEND Quality & Inequalities	Amber – Persistent	Inconsistent experiences, Long waiting times.	Joint priority action plans, SEND partnership oversight

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# Quality Report – LNR Executive Summary

NOF Scores	UHL	NGH	KGH	LPT	NHFT
Q2 25/26 (Q1 if different)	3	4(down from 3)	3	2	2 (down from 1)

Provider	NOF Level	Key NQB quality concerns
Leicestershire Partnership NHS Trust	NOF 2	<ul style="list-style-type: none"> <li>Section 29A Warning Notice (July 2025) – community-based services</li> <li>PFD (Sept 2025) under routine ICB oversight</li> </ul>
Kettering General Hospital FT	NOF 3	<ul style="list-style-type: none"> <li>Maternity: MSSP designation (June 2024)</li> <li>Section 31 escalation (Sept 2024)</li> <li>Section 29A concerns linked to workforce and quality</li> <li>PFD (media case)</li> </ul>
Northampton General Hospital Trust	NOF 4	<ul style="list-style-type: none"> <li>UEC / Medicine: Section 29A Warning Notice (March 2025)</li> <li>Ongoing quality risks in 2025/26</li> <li>PFDs and B2B escalation Feb 2026</li> </ul>
Northamptonshire Healthcare FT	NOF 2	<ul style="list-style-type: none"> <li>NHSE Gender Identity Review (Nov 2024)</li> <li>Immediate actions required in community services</li> </ul>
University Hospitals Leicester Trust	NOF 3	<ul style="list-style-type: none"> <li>Section 29A Warning Notice (July 2025) – community-based services</li> <li>PFD (Sept 2025) under routine ICB oversight</li> </ul>
St Andrew’s Healthcare	Not formally NOF-rated	<ul style="list-style-type: none"> <li>Intensive scrutiny arrangements in place</li> <li>Significant IPC concerns under enhanced oversight</li> </ul>

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# Quality Report – LNR Executive Summary

## Alert

- St Andrew's Healthcare (Northampton) Intensive Oversight and Assurance continues. CQC report published Dec '25 requires Improvement which has raised significant media attention.
- 8 Prevention of Future Deaths (Regulation 28) reports highlight recurring risks across mental health pathways, emergency care, access to records, escalation of severe infection, and nutrition and hydration in frail patients. These are reviewed at Trust level and via the system Countywide Patient Safety Group, with coordinated action and Board oversight.
- Immunology diagnostics (NGH) – Following the June 2025 immunology interface fix, a secondary incident identified, re-mis-assigned results from identifier reuse during re-issue affecting (242 GP patients/32 practices; 75 NGH patients). Reconciliation and harm reviews are underway; ICB-led with NHSE updates via SQG/RQG.
- UHN Kettering, Maternity –Regulatory/CQC: Section 29A issued 18 Dec 2025, Trust making representations and tracked through IOAG. Maternity (UHL & KGH)Continued monitoring of culture, consent and safety themes via MSSP, IOAG frameworks and the Amos Review.
- **Short Breaks** The Squirrels – an updated improvement activity and recovery plan is in place following a regulation 44 visit in November and subsequent joint quality visit with NICB & NCT. Concerns include leadership & governance; quality of care and safeguarding. Joint weekly oversight visits with NICB & NCT are in place. The Clinical Lead and Registered Manager are both currently working notice periods; recruitment processes are in place. Contract review meetings have been scheduled monthly for The Squirrels, with operational meetings focusing on wider short breaks.

## Advise

- Cardiac Surgery – UHL De-escalated to Level 2 following progress against QIP – January stocktake has highlighted continued concerns and ICB seeking further assurance from UHL in March 26
- **Holistic ADHD Solutions** – Norfolk and Waveney ICB issued a Suspension Notice to Holistic ADHD Solutions Ltd on 03 December 2025 due to provider failings, with a plan in place to remedy requirements. . Highlights wider risk of independent ADHD provider failures and lack process to monitoring Non-Contract Activity / Right to Choose contracts.
- **PODs** - From a safeguarding perspective there is a continued risk agreed across the region. The ICB's cannot be assured about the adequacy of the safeguarding arrangements as required by the NHSE Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance.
- **NHS Oversight Framework indicator % of Children (0–9 years) prescribed antibiotics in Primary Care** - 95 practices meet the national target; 31 practice exceed target;; action being picked up via the NHSE Provider Review Meetings
- Infection Prevention & Control: Enhanced IPC oversight in place due to rising Gram-Negative infections, Improvement plan oversight gained via System IPC Group, Trust and ICB Governance.
- SEND Pathways Significant waits remain, especially for neurodiversity assessments, but improvement work progressing. Requires strategic commissioner decisions on prioritisation and funding.
- St Mary's Birth Centre (Melton) – Patient engagement live to (responses close 1 Feb 2026). Assurance focus: safe alternatives, access and experience impact.
- Willows Health GP practice – de-escalated to enhanced level monitoring of in-house ED/111/UTC activity, workforce data and patient experience

# Quality Report – LNR Executive Summary

## Assure

- CHC/CCC In-Housing Programme Board established with dedicated workstreams (workforce, digital, governance, finance). Regular reporting and escalation mechanisms continue.
- CHC/CCC CNO-led Improvement and efficiency Board now established. Efficiency tracking now in place with £6.8 million transacted/ delivered.
- CQC Warning Notice: LPT was required to make significant improvements to outpatient waiting times. Progress was evidenced to the ICB ahead of report submission in November 2025. LPT is currently awaiting formal outcome and feedback from the CQC.
- **LLR JTAI: Inspection completed December 2025; draft report responded to, final report due 12 February, with a multi-agency action plan in development.**
- LLR SEND (City): Inspection Sept 2025; report published Nov 2025. Progress and strong partnership acknowledged, but inconsistent SEND experiences and outcomes identified. Joint improvement required. Next full inspection due within 3 years.
- IHA/RHA (Northamptonshire): Performance remains below standard, but December data shows significant improvement (~85%) following NHFT recovery actions (daily oversight, job plan reviews, Magic Notes AI). Further system support is required to achieve a sustained 0-breach position, with Board oversight.

## Update, risk and learning on Plans

- UEC flow – NGH ambulance handovers peak 28–42% >1hr; KGH improved since May 2025 but fragile; dignity/flow risks persist.
- Coroner Inquest – Media interest on several case
- UHL – Baroness Amos Investigation (UHL): Baroness Amos engagement completed: feedback is awaited, Trust-specific report with comprehensive findings in Q1 2026.
- SEND LLR and Northamptonshire
- Osted & CQC led a North Northants Area SEND Engagement session in January 2026. Discussion focussed on the SEF and a non-evaluative summary report will be issued to the partnership. West Northants will be undertaking the same activity in February.
- Work is underway to conduct a LNR SEND summit in March 2026 and there are opportunities for system learning from the SEND Alliance

# 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: SEND Update – LNR ICB  
Cluster

Date of Meeting: 19 February 2026

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13/02/2026 11:50:19

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>Thursday 19 February 2026</b>		
<b>Report Title</b>	<b>SEND Update – LNR ICB Cluster</b>		
<b>Paper Reference No:</b>	<b>ICBIC-26-08</b>	<b>Agenda Item No:</b>	<b>13.</b>

<b>Presented by</b>	<b>Maria Laffan, Chief Nursing Officer, LNR ICB</b>
<b>Report Author(s)</b>	<b>Miranda Tapfumanei Director of Nursing, Chris West, Deputy Chief Nurse, LNR ICB</b>
<b>Executive Sponsor</b>	<b>Maria Laffan, Chief Nursing Officer, LNR ICB</b>

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input checked="" type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.

<b>Recommendations</b>
<p>This report provides assurance regarding SEND performance, inspection outcomes, system risks and improvement activity across the LNR ICB Cluster.</p> <p><b>The Boards are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>NOTE</b> the current SEND position across the LNR ICB Cluster</li> <li>• <b>ACKNOWLEDGE</b> the scale of system challenges, particularly waiting times and workforce capacity</li> <li>• <b>SUPPORT</b> the proposed LNR Cluster SEND Summit as a key mechanism to accelerate improvement and collective action</li> </ul>

<b>Executive Summary of the report</b>
<p>This paper provides a joint update on Special Educational Needs and Disabilities (SEND) across the Leicester, Leicestershire and Rutland (LLR) and Northamptonshire system within the LNR ICB Cluster. It summarises recent Area SEND inspection activity, including inspections, revisits and Stocktake engagement, and outlines ongoing system challenges, particularly sustained waiting times for assessment and intervention across key children and young people's health pathways.</p> <p>The report also sets out current and planned improvement activity across the cluster, including delivery of Priority Action Plans, workforce and service transformation initiatives, strengthened governance and a proposed cluster-wide SEND Summit in Spring 2026. The Summit aims to agree shared priorities, metrics and</p>

milestones to accelerate improvement across the LNR footprint. (See sections 1–9 of the report)

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

<input checked="" type="checkbox"/>	<b>Improve Outcomes</b> - Improve outcomes in population health and healthcare	<input checked="" type="checkbox"/>	<b>Health Inequalities</b> - Tackle inequalities in outcomes, experience, and access
<input type="checkbox"/>	<b>Value for money</b> - Enhance productivity and value for money	<input checked="" type="checkbox"/>	<b>NHS Constitution</b> - Deliver NHS Constitutional and legal requirements
<input type="checkbox"/>	<b>Social and economic development</b> - Help the NHS support broader social and economic development		

**Conflicts of interest – Please select**

<input checked="" type="checkbox"/>	No conflict identified
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision
<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	Conflict noted, conflicted party to be excluded from the meeting

**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: 1

NICB BAF No: 1

**Appendices**

N/A

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

This report reflects engagement across local authorities, education, health and social care partners, including Area SEND Local Area Partnerships, SEND Assurance Groups and system transformation programmes.

The report has not previously been presented to another formal Board or Committee and is provided directly to the Boards Meeting in Common for assurance.

**Implications: Select which of the following implications need to be considered**

<input checked="" type="checkbox"/>	<b>Quality &amp; Patient Safety</b>	<input checked="" type="checkbox"/>	<b>Legal</b>	<input checked="" type="checkbox"/>	<b>Equality, Diversity &amp; Inclusion</b>		
<input type="checkbox"/>	<b>Environmental</b>	<input type="checkbox"/>	<b>Data &amp; Digital</b>	<input checked="" type="checkbox"/>	<b>Financial</b>	<input checked="" type="checkbox"/>	<b>Workforce</b>

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## SEND Update – LNR ICB Cluster 19 February 2026

### Executive Summary

1. This paper provides the Board with a joint update on Special Educational Needs and Disabilities (SEND) across the Leicester, Leicestershire and Rutland (LLR) and Northamptonshire system within the LNR ICB Cluster. It summarises recent Area SEND inspection activity including inspections, revisits and stocktake engagement, outlines ongoing system challenges particularly waiting times for assessment and intervention, and sets out planned actions to accelerate improvement, including a cluster wide SEND Summit scheduled for 27 March 2026.

### Purpose of the Paper

2. The purpose of this paper is to provide assurance to the Board regarding SEND performance and improvement activity across the LNR ICB Cluster, including regulatory oversight, system risks and planned collective actions.

### LNR ICB Cluster Context

3. The LNR ICB Cluster spans multiple local authority areas, each operating statutory Area SEND Local Area Partnerships across education, health and social care. The cluster footprint includes Leicester City, Leicestershire County, Rutland, North Northamptonshire and West Northamptonshire. SEND demand continues to increase across all areas, reflecting national trends, with pressure on education provision, health assessment pathways and workforce capacity.

### Northamptonshire

4. Ofsted and the CQC carried out local area SEND and Alternative Provision inspections in close succession for North Northamptonshire (January 2024) and West Northamptonshire (March 2024). Both local areas received Outcome 3, identifying widespread and systemic failings leading to significant concerns about the experiences and outcomes of children and young people with SEND.
5. Priority Action Plans have been agreed with Ofsted and the CQC for North and West Northamptonshire. A schedule of monitoring visits with DfE and NHS England regional advisers is in place. We are now in the period where Ofsted and the CQC are expected to return to assess local area progress against the priority actions.
6. The latest Northamptonshire SEND Health Indicators (December 2025) demonstrate sustained pressure across key pathways. CAMHS Community initial average waits are 7 weeks with 328 children waiting. CAMHS Community secondary average waits are 27 weeks with 217 children waiting. Children's Speech and Language Therapy initial average waits are 27 weeks with 1,646 children waiting. Neurodevelopmental (ASD and ADHD) diagnostic waits remain the most significant concern with 4,464 young people waiting on the 11 to 18 pathway and an average wait of 92 weeks. Community Paediatrics initial average waits are reported at 49 to 59 weeks with 4,023 children waiting.

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7. A new Ofsted framework for local area SEND inspections was launched in January 2023 and all local areas in England must be assessed on this framework by 1 January 2027.
8. Rutland local area was assessed in May 2023 and was found to have good outcomes. Leicester City was assessed in September 2025 and was found to have inconsistent outcomes. Leicestershire is awaiting inspection on the new framework in 2026 and continues improvement work in accordance with an Accelerated Progress Plan aligned to 2020 inspection findings.

**Area SEND Inspection Overview**

4.1 Inspection Activity and Outcomes				
Local area	Inspection date(s)	Inspection outcome	Revisit or follow up	Current status
Leicester City	September 2025 (report published November 2025)	Inconsistent experiences and outcomes	Full inspection within 3 years; DfE progress review September 2026	Multi agency Action Plan submitted; system wide briefing planned February 2026
Leicestershire County	February 2020; revisit November 2022	Written Statement of Action on Joint Commissioning and quality of EHCPs	Progress monitored quarterly by DfE and CQC; full inspection anticipated Spring 2026	Accelerated Progress Plan in place; inspection readiness activity underway
Rutland	May 2023	Positive experiences and outcomes	Full inspection within 5 years	Improvement work continues; contributes to LLR activity and meetings
North Northamptonshire	8 to 26 January 2024	Outcome 3 widespread and systemic failings	Monitoring inspection after 18 months now due	Priority Action Plan delivery with DfE and NHS England oversight
West Northamptonshire	4 to 22 March 2024	Outcome 3 widespread and systemic failings	Monitoring inspection after 18 months now due	Priority Action Plan delivery with DfE and NHS England oversight

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## Revisits, ASEND and Stocktake Engagement

9. Where inspections have identified significant concerns or areas requiring improvement, the system has engaged in formal revisits, Accelerated SEND activity and joint stocktakes with DfE and NHS England. These mechanisms provide additional oversight and support and are intended to accelerate delivery of improvement plans.

Area	Type of engagement	Date(s)	Key outputs and actions
Leicestershire	Progress meetings quarterly plus annual conversation	September 2025 onwards	DfE adviser supporting improvement and inspection readiness for anticipated early 2026 inspection
North Northamptonshire	Stocktake	18 November 2025	Progress reported against four priority action areas; focus on implementation and evidence of improved lived experience and outcomes
West Northamptonshire	Stocktake	5 February 2026	Report awaited

## Ongoing System Challenges

10. Despite focused improvement activity, SEND remains a significant system challenge across the LNR ICB Cluster. Common themes include timeliness and quality of Education, Health and Care Plans, access to specialist education placements, and extended waiting times for health assessments and therapeutic interventions.

### Children Waiting for Assessment and Support (Northamptonshire)

11. The latest Northamptonshire SEND Health Indicators (December 2025) show sustained pressure across core children's pathways, with long waits particularly in neurodevelopmental assessment and community pediatrics.

Pathway or service	Number of children waiting (Dec 2025)	Current average wait (Dec 2025)	Baseline average wait (Jan 2024)	Target
CAMHS Community initial	328	7 weeks	14 weeks	18 weeks
CAMHS Community secondary	217	27 weeks	54 weeks	Not specified
Children's Speech and	1,646	27 weeks	23 weeks	18 weeks

Language Therapy initial				
ASD and ADHD diagnostic assessment (11 to 18)	4,464	92 weeks	39 weeks	18 weeks
Community Paediatrics initial	4,023	49 to 59 weeks	32 weeks	18 weeks

12. Locality level data indicates variation across North and West Northamptonshire, with neurodevelopmental waiting times remaining substantially above target in both areas and the longest waits seen in West Northamptonshire for younger age cohorts.

### System Improvement Activity

#### Current Improvement Actions

13. Improvement actions are underway across the cluster, including strengthened governance, delivery of Priority Action Plans, workforce initiatives and participation in national programmes such as Delivering Better Value.

#### Northamptonshire

14. The Integrated Care Northamptonshire Children and Young People Transformation Programme has been strategically reviewed and refocused. There are clear links to and alignment with the North and West Northamptonshire SEND Strategies, delivery and governance. Key transformation priorities include whole system pathways for ASD and ADHD, health provision in schools and speech, language and communication needs, and a single lead provider for community pediatrics.

15. Oversight and reporting of health-related SEND improvements and priority action plans are undertaken by the North and West Northants Right Support Right Place Right Time workstreams and the Northamptonshire ICB SEND Assurance Group.

16. Speech and Language Therapy transformation is underway following investment and recruitment. Increased workforce is delivering more initial assessment clinics and as additional specialist therapists are onboarded the offer will continue to increase. The impact of this additional staffing is expected to be demonstrated in Q4 2025/26. A new Speech and Language Therapy service for children with EHCPs is operational with targeted implementation in schools with the highest need. This service will grow to support 600 children by September 2026. Recruitment has been challenging, and operational capacity is currently at 50 percent. A skill mix plan is in place.

17. CAMHS initial waits have improved and are currently reported as reduced from 18 to 6 weeks. Secondary waits remain high at 35 weeks but have halved since inspection. Mitigations include person-centred clinical risk reviews for children and young people awaiting treatment and proactive contact with families. The Saints Foundation, REACH and other partners continue to provide stepped support.

18. ASD and ADHD diagnostic waiting times remain an area of concern. Investment is in place to fund an additional 600 assessments countywide and deliver emotional coaching support to 150 families from the backlog. Assessments have been targeted at children

and young people approaching transition who have been waiting over three years. NHFT are leading this work and Healios have been contracted to deliver backlog assessments by end of March 2026. A two phase data stratification programme has been undertaken to prioritise children at highest risk on ASD and ADHD waiting lists. Phase 2 will support a system view of need and risk through information sharing and a new children and young people SEND system dashboard.

19. Support while waiting has been strengthened through co-produced support maps for emotional wellbeing and mental health, speech language and communication needs, and ASD and ADHD, with alignment to Local Offers and a communications plan.
20. The PINS programme is operational across both North and West Northamptonshire to support inclusive practice and improved experience for neurodiverse children and young people.

### LLR

21. The LLR SEND and Inclusion Alliance (9IA) was established in 2025 to drive system change across education, health and care so that children and young people with SEND experience more coordinated, inclusive and outcomes focused support. In 2025/26 the focus has been on establishing effective governance and supporting policy making through the Change Programme Partnership.
22. Key priorities for 2026/27 include delivering the SEND Joint Commissioning Strategy, embedding the Local Integrated Service Offer as the central model for school facing support, rolling out the Shaping SEND Futures community inclusion programme across all localities, and aligning major programmes such as PINS, ELSEC and neurodiversity inclusion into a coherent system wide offer. Work is also underway to strengthen coproduction through a shared Coproduction Charter and a Children and Young People Senate.
23. Leicestershire has reported improvement in EHCP quality with Good or Outstanding plans increasing from 15.8 percent to 47.8 percent, alongside governance and process improvements. Leicester City has confirmed five priority improvement areas following the September 2025 inspection, including EHCP annual review quality, sufficiency of provision, neurodevelopmental pathways, Preparing for Adulthood and quality of disabled children plans.

### LNR Cluster SEND Summit – Spring 2026

24. A cluster wide SEND Summit is scheduled for Spring 2026 to bring together system leaders, providers, local authorities, parent carer forums and national partners. The summit will focus on shared ownership of SEND challenges, agreement of collective priorities and alignment of improvement activity across the LNR footprint.
  - Agreed cluster wide SEND improvement priorities
  - Shared metrics and reporting arrangements
  - Clear milestones for 2026/27 delivery
  - Strengthened escalation and assurance routes

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## Risks and Mitigations

Risk	Impact	Mitigation
Extended waiting times	Quality, safety, statutory compliance and experience impacts	Backlog reduction, capacity investment, support while waiting, clinical risk review processes
Workforce capacity	Delivery risk and sustainability	Recruitment, retention, skill mix planning, service redesign and productivity improvement
Financial pressure	Constraints on transformation and capacity	Prioritisation through planning, joint commissioning and alignment of investment to greatest risk and need

## Board Assurance and Ask

25. The Board is asked to note the SEND position across the LNR ICB Cluster, acknowledge the ongoing system wide challenges, and support the proposed cluster wide SEND Summit as a key mechanism to accelerate improvement.

### The Boards are asked to:

- **NOTE** the current SEND position across the LNR ICB Cluster
- **ACKNOWLEDGE** the scale of system challenges, particularly waiting times and workforce capacity
- **SUPPORT** the proposed LNR Cluster SEND Summit as a key mechanism to accelerate improvement and collective action

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# Board Meetings in Common in Public

Report Title: Finance Assurance  
Reports - LLR ICB and N ICB

Date of Meeting: 19<sup>th</sup> February 2026

Gormley Charlotte  
13/02/2026 11:50:19

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

<b>Name of Meeting</b>	<b>Board Meetings in Common in Public</b>		
<b>Date of Meeting</b>	<b>19<sup>th</sup> February 2026</b>		
<b>Report Title</b>	<b>Finance Assurance Reports - LLR ICB and N ICB</b>		
<b>Paper Reference No:</b>	<b>ICBIC-26-09</b>	<b>Agenda Item No:</b>	<b>14.</b>

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

<b>Select the Primary Purpose for the Report</b>		
<input type="checkbox"/> <b>ADVISORY</b> To receive and note implications, may require discussion to help to shape/develop item.	<input checked="" type="checkbox"/> <b>ASSURANCE</b> To assure the Committees that controls and assurances are in place.	<input type="checkbox"/> <b>APPROVAL</b> Recommendation or particular course of action.

<b>Recommendations</b>
<p><b>The Boards are asked to be advised by the report to:</b></p> <p><b>RECEIVE and NOTE</b> the 2025/26 financial position at Month 10 and the forecast outturn.</p>

<b>Executive Summary of the report</b>
<p>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 10 of £8.8m (after non-recurrent deficit support funding of £7.6m), which is worse than plan by £16.0m. The position reflects:</p> <ul style="list-style-type: none"> <li>• LLR deficit of £16.2m, which is £16.0m worse than plan</li> <li>• Northamptonshire surplus of £7.4m, which is breakeven against plan</li> </ul> <p>At month 10, LLR ICB has formally reported a change to the annual forecast position. 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:</p>

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

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

At month 10, £5.1m 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.

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

- Following the implementation of the new national ledger system (ISFE2) the ICBs are closely monitoring the Better Payment Practice Code and cash positions to identify risk.
- Within a challenging financial context, the Committee endorses the need to balance focus on core delivery while building transformation and driving innovation, to do this will require clarity on Board risk appetite.

The January Finance and Contracting Committee of the LNR Cluster ICBs noted the following to be raised with Board:

- The Committee were not assured of delivery of the 2025/26 LLR ICB Financial Plan, and therefore proposes the risk adjusted outturn, as the most likely financial scenario, would be presented from M10 as the LLR ICB forecast position.
- As the ICB Cluster works through organisational Management of Change, the need to remain focused on ICB teams capability and capacity to manage service alongside implementing change must be carefully monitored.

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

<input type="checkbox"/>	<b>Improve Outcomes</b> - Improve outcomes in population health and healthcare	<input type="checkbox"/>	<b>Health Inequalities</b> - Tackle inequalities in outcomes, experience, and access
<input checked="" type="checkbox"/>	<b>Value for money</b> - Enhance productivity and value for money	<input checked="" type="checkbox"/>	<b>NHS Constitution</b> - Deliver NHS Constitutional and legal requirements
<input type="checkbox"/>	<b>Social and economic development</b> - Help the NHS support broader social and economic development		

**Conflicts of interest – Please select**

<input checked="" type="checkbox"/>	No conflict identified
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion and decision
<input type="checkbox"/>	Conflict noted, conflicted party can participate in discussion but not in decision
<input type="checkbox"/>	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision
<input type="checkbox"/>	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
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<b>Appendices</b>	
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**Who has been engaged and where else has this report been considered:**

This report has not been received at any other meeting.

**Implications: Select which of the following implications need to be considered**

<input type="checkbox"/>	<b>Quality &amp; Patient Safety</b>	<input type="checkbox"/>	<b>Legal</b>	<input type="checkbox"/>	<b>Equality, Diversity &amp; Inclusion</b>		
<input type="checkbox"/>	<b>Environmental</b>	<input type="checkbox"/>	<b>Data &amp; Digital</b>	<input checked="" type="checkbox"/>	<b>Financial</b>	<input type="checkbox"/>	<b>Workforce</b>

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## Finance Report Month 10 (January) 2025/26

Headlines Table 1 LNR – M10 ICB Financial Position

Net Position		Plan	Actual	Variance	Plan	Actual	Variance
		YTD	YTD	YTD	FOT	FOT	FOT
		£m	£m	£m	£m	£m	£m
LLR ICB	Position before support	(12.9)	(23.8)	(10.9)	(15.5)	(30.9)	(15.4)
	Deficit Support	12.6	7.6	(5.1)	15.2	7.6	(7.6)
	<b>Net Position after support</b>	<b>(0.3)</b>	<b>(16.2)</b>	<b>(16.0)</b>	<b>(0.3)</b>	<b>(23.3)</b>	<b>(23.0)</b>
Northants ICB	Position before support	7.4	7.4	0.0	10.0	10.0	(0.0)
	Deficit Support	-	-	-	-	-	-
	<b>Net Position after support</b>	<b>7.4</b>	<b>7.4</b>	<b>0.0</b>	<b>10.0</b>	<b>10.0</b>	<b>(0.0)</b>
LNR ICB Cluster Total	Position before support	(5.5)	(16.4)	(10.9)	(5.5)	(20.9)	(15.4)
	Deficit Support	12.6	7.6	(5.1)	15.2	7.6	(7.6)
	<b>Net Position after support</b>	<b>7.1</b>	<b>(8.8)</b>	<b>(16.0)</b>	<b>9.7</b>	<b>(13.3)</b>	<b>(23.0)</b>

- Table 1 above details the position before and after deficit support funding. At month 10, LNR is reporting a year-to-date deficit of £8.8m (after deficit support funding of £7.6m), which is £16.0m worse than plan.
- The year-to-date variance to plan is driven by the following key areas:
  - Non receipt of Q3 & Q4 deficit support funding at LLR (£5.1m)
  - Prescribing, CHC and ADHD growth in excess of planned levels at LLR
- The full year reported forecast is a deficit position across LNR ICBs of £13.3m, after £7.6m non-recurrent support (£7.6m LLR and £0m Northamptonshire), which is £23.0m adverse to plans.
- LLR ICB has reported a forecast £5.2m 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.
- Table 2 below shows the total level of forecast financial risk reported by each organisation as part of month 10 reporting. There is currently no net risk after mitigations across the LNR ICB cluster.

Table 2 – M10 LNR Financial Risk

	Unidentified Mitigations	Efficiency Risk	Other risks/ mitigations to delivery of forecast	Total risks & unidentified mitigations
	£m	£m	£m	£m
LLR ICB	(0.0)	4.4	(4.4)	-
Northants ICB	(0.0)	-	-	(0.0)
<b>LNR Cluster Total</b>	<b>(0.0)</b>	<b>4.4</b>	<b>(4.4)</b>	<b>(0.0)</b>

**Recommendations:**

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

- **RECEIVE and NOTE** the financial position as at month 10.

Gormley Charlotte  
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