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

Thursday 20 August 2026, 09:30 - 11:35

Haylock House, Venture Park, Kettering, NN15 6EY

Agenda

09:30 - 09:30
0 min

1. Welcome and Apologies

Advisory *Anu Singh*

09:30 - 09:30
0 min

2. Declarations of Interest relating to agenda items

Advisory *Anu Singh*

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

09:30 - 09:30
0 min

3. Draft Minutes of previous meeting - 18 June 2026

Approval *Anu Singh*

Reference: ICBIC-26-38

ICBIC-26-38 Draft Minutes of previous meeting held on 18 June 2026.pdf (9 pages)

09:30 - 09:35
5 min

4. Matters arising and Action log

Advisory *Anu Singh*

Reference: ICBIC-26-39

ICBIC-26-39 Matters Arising and Action Log.pdf (1 pages)

09:35 - 09:40
5 min

5. Questions from members of the public

Advisory *Anu Singh*

Verbal

09:40 - 09:45
5 min

6. Chair and Chief Executive updates

Advisory *Anu Singh / Toby Sanders*

Reference: ICBIC-26-40

ICBIC-26-40 Chief Executive Report.pdf (7 pages)

09:45 - 10:00
15 min

7. LLR ICB and N ICB Annual Assessment of Performance and Annual Report 2025/26

Advisory *Matt Gaunt / Toby Sanders*

Reference: ICBIC-26-41

ICBIC-26-41 LLR ICB and N ICB Annual Assessment of Performance and Annual Report 202526 2.pdf (19 pages)

10:00 - 10:10
10 min

8. EPRR Update and Plans and Policies

Approval *Eileen Doyle*

Reference: ICBIC-26-42

ICBIC-26-42 EPRR Update and Plans and Policies.pdf (8 pages)

10:10 - 10:20
10 min

9. Phlebotomy Business Case

Approval *Eileen Doyle*

Reference: ICBIC-26-43

ICBIC-26-43 Phlebotomy Business Case.pdf (68 pages)

10:20 - 10:35
15 min

10. Obesity Pathway Innovation Programme

Advisory *Nilesh Sanganee*

Reference: ICBIC-26-44

ICBIC-26-44 Obesity Pathway Innovation Programme (OPIP).pdf (14 pages)

10:35 - 10:45
10 min

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

Assurance *Eileen Doyle / Maria Laffan*

Reference: ICBIC-26-45

ICBIC-26-45 Quality and Performance Assurance Reports – LLR ICB and NICB.pdf (13 pages)

10:45 - 10:55
10 min

12. Board Briefing - Baroness Amos. Ockendon Maternity & Neonatal Quality

Advisory *Maria Laffan*

Reference: ICBIC-26-46

ICBIC-26-46 Board Briefing - Baroness Amos. Ockendon Maternity & Neonatal Quality.pdf (6 pages)

10:55 - 11:05
10 min

13. Board Briefing - St Andrews Healthcare Northamptonshire Quality Position

Advisory *Maria Laffan*

Reference: ICBIC-26-47

ICBIC-26-47 Board Briefing - St Andrews Healthcare Northamptonshire Quality Position.pdf (5 pages)

11:05 - 11:15
10 min

14. Finance Assurance Report - LLR ICB and N ICB

Assurance *Matt Gaunt*

Reference: ICBIC-26-48

ICBIC-26-48 M3 Finance Assurance Report for LNR Board 20 August 26.pdf (6 pages)

11:15 - 11:25
10 min

15. Transition Assurance Report

Assurance *Peter Burnett*

Reference: ICBIC-26-49

ICBIC-26-49 Transition Assurance Report.pdf (6 pages)

Chair's Closing Remarks

Date of next meeting: Thursday 15 October 2026

Minutes of the NHS Leicester, Leicestershire & Rutland ICB Board and NHS Northamptonshire ICB

Boards Meeting in Common in Public

Thursday 18 June 2026 at 09:30am
NSPCC Training centre, 3 Gilmour Close, Beaumont Leys, Leicester LE4 1EZ

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 Sanganee	Chief Medical Officer
Matt Gaunt	Chief Finance Officer
Pete Burnett	Chief Strategy Officer
Maria Laffan	Chief Nursing Officer
Eileen Doyle	Chief Delivery Officer

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

In Attendance	
Claire Middlebrook	Corporate Governance Officer (minutes)
Harsha Kotecha	LLNR Healthwatch representative

Present: Members - NHS Northamptonshire ICB	
David Williams	Community / Mental Health Sector Representative Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust *(deputising for Angela Hillery)*
Jane Bethea	Local Authority Sector Representative Director of Public Health, Communities & Leisure, North Northamptonshire Council *(deputising for Melanie Williams)*

In Attendance	
Emma Follis	Head of Corporate Governance
Harsha Kotecha	LLNR Healthwatch representative

Apologies	
Dr Jonathan Cox	Primary Medical Services Sector Representative and Chair, Local Medical Committee
Angela Hillery	Community / Mental Health Sector Representative

Melanie Williams	Chief Executive Officer, Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust Local Authority Sector Representative, Executive Director, People's Services West Northamptonshire Council

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

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

Apologies for absence were noted as above. There were 5 members of the public in attendance.

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

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

Standing declarations of interest were noted.

No specific declarations were note.

ICBIC-26-28 — **Draft Minutes of previous Board Meetings**

The minutes of the NHS Leicester, Leicestershire & Rutland ICB and NHS Northamptonshire ICB Boards meeting in common, held in public on 16 April 2026 were received and **APPROVED** as a true and accurate record of the meeting.

ICBIC-26-29 — **Matters Arising and Action Logs**

The Boards received the Action Log and noted that there were no outstanding actions. The Action Log was therefore **APPROVED**.

ICBIC-26-30 (Verbal) — **Questions from members of the public**

Anu Singh reported that no questions had been received from members of the public.

ICBIC-26-31 — **Submission of petition – provision of General Practice services, Melton Mowbray**

Cllr Sharon Butcher presented the petition to Anu Singh, which was acknowledged.

Toby Sanders confirmed to the members that the petition was in relation to the request for a second doctors' surgery in Melton Mowbray. A discussion took place at the recent Joint Scrutiny Board, with members agreeing that it was more appropriate for the petition to be handed in, at a Board meeting.

Anu Singh and Toby Sanders met with Latham House Medical Centre (LHMC) representatives on 23 April 2026, along with the local Member of Parliament (MP) to discuss the situation and agree options. This meeting was constructive, and actions agreed were.

- The ICBs committed to help LHMC to improve premises, access, appointments

and support staff.

- The ICB Communications and Engagement team are working with the public to ensure appropriate information about access to all services, including the Urgent Care Centre (UCC) and same day access is visible.
- All parties will work with Melton Borough Council (MBC) in relation to future housing developments in Melton Mowbray.

On 22 May 2026 Toby Sanders met with Cllr Brian Rowland, the Chief Executive Officer of Melton Borough Council? and the planning team to discuss future developments in Melton Mowbray. The ICB are working hard with MBC and LHMC to find solutions to the issues raised.

Anu Singh suggested that a fuller discussion about the issues be diarised for a future meeting.

Harsha Kotecha confirmed that Healthwatch had 600 responses to questions raised with the public over access at LHMC and would be happy to share with the ICBs.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **RECEIVED** the petition – provision of General Practice services, Melton Mowbray.

ICBIC26-32 (Verbal) **Chair and Chief Executive Updates**

Toby Sanders highlighted that this was the first written update presented to the Boards and feedback was welcomed. The report provided information at place level and information following the Health and Wellbeing Boards meetings.

It was highlighted that since the Management of Change (MoC) process commenced, over 100 staff will have left the two ICBs by the end of June 2026 and the impact of this was acknowledged.

The LLR Chronic Kidney Disease Integrated Care Delivery Project (LUCID) was recognised by the NHS England Excellence Awards, along with the Health Service Journal recognising the impact that digital innovation has had across LLR and Northamptonshire. Toby Sanders acknowledged the progress that Northamptonshire had made in recent years, in relation to digital innovation.

Liz Gaulton highlighted the recent visit from the House of Lords Special Inquiry Committee, as part of its national inquiry into falling childhood vaccination rates. Nil Sanganee noted the positive visit, where the challenge in Leicester City was highlighted, along with childhood vaccination rates. A pilot of new ways of working in preventative medicine has been positive.

Richard Mitchell welcomed the new style report, confirming that processes have been captured and asked which area had had the least progress.

It was confirmed that the performance report continues to highlight Urgent and Emergency Care (UEC) demand, against a '0' growth in the plan. The ICBs need to ensure transformation takes place now, to see change in the future. UEC has been challenged for a long time, with national discussions taking place, following May being

the busiest month across the whole country in UEC. It was suggested that UEC be a subject of a future board development session.

Harsha Kotecha asked about dental care and how the ICB measure if patients are aware of the correct pathways. It was confirmed that only 50% of the additional Units of Dental Activity (UDA) were being used and the challenge is to ensure patients are aware of the services on offer. It was suggested that a communications campaign may be required. Jane Bethea noted that the healthy schools programme informs children about good dental care and dental access.

Anu Singh suggested that information is made more widely available, as part of an engagement process, to include information on broader awareness of options available for patients. Action: Pete Burnett

Petet Burnett reported that there is a national push to increase urgent dental services, and he is already working with the City Council on this issue.

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

ICBIC-26-33 Quality and Performance Assurance Reports - LLR ICB and N ICB

Eileen Doyle spoke to the paper highlighting that the home birth service, run by Kettering General Hospital (KGH) had been paused for three months, due to safety concerns and is due to recommence in July. The service has been strengthened during the pause.

Following a Care Quality Commission (CQC) inspection of maternity services at KGH, the service continues to receive oversight from the national maternity and safety team.

It was confirmed that the Independent Review into maternity services, led by Donna Ockenden report is due to be published on 26 June 2026 and the National Maternity and Neonatal investigation, led by Baroness Amos report is due on 30 June 2026.

Richard Mitchell confirmed that he had had sight of the draft report which he considered to be balanced and fair, with Leicester being involved due to the number of births that happen each year in the Trust. Improvements have already taken place, however, there is more work to do.

It was reported that Short Breaks at The Squirrels had been paused, due to ongoing safety concerns and clinical risks. This site provides respite care for children who have complex needs under Continuing Health Care (CHC).

Eileen Doyle noted that work continues at pace in the background to try and find an alternative provider before the summer holidays and families are being kept informed. The team are working with the Local Authority and the Children's Trust. Historically this contract has been hard to manage. It was noted that work needs to start when children are very young to try and avoid them escalating.

St Andrews Health Care remains a concern, following NHS England informing all ICBs that all patients should be repatriated in March 2026. This was a national decision

made, however, due to the complexity of patients at the site, has been very hard to enact, with slow progress being made, quality oversight remains in place.

Within Children and Young People (CYP) long waits are still being experienced, especially in Speech and Language Therapy (SALT) and attention deficit hyperactivity disorder (ADHD).

Following a question asked, it was confirmed that assessment times have improved in certain areas, however, assessment times for ADHD are still challenged and some families rely on this help, particularly during the summer holidays.

CYP waits were discussed in more detail, noting that the impact on families can be significant. Digital solutions need to be considered. It was further noted that there is a national shortage of therapists who work in SALT, and this is causing some children to transition to the adult lists before receiving treatment.

A question was raised over emerging risks as a result of the GP collective action. It was confirmed that the Local Medical Committee has written to practices in relation to the engagement of medicines optimisation software. The proposed industrial action this week has been called off, whilst negotiations continue.

It was confirmed that James Ogle is chairing the LLR meeting for potential primary care providers, of which there is one for LLR and one for Northampton. The aim is to shift work into prevention, the main challenge will be ensuring compliance with the contract.

UEC is currently doing more work than in the past and therefore not achieving targets. A lot of the issue is flow and outflow, along with the number of patients presenting to the Emergency Departments (Eds). Increases have been noted in the 0–18-year age group and also for working aged adults, who often attend at the end of their working day. Conversations have taken place with East Midlands Ambulance Service (EMAS) about conversion rates. This is a complicated issue, with a lot of patients not realising there are different options available to them, apart from A&E.

Richard Mitchell agreed that that UEC is challenged, with national and midland teams aware of the issues. The two main issues are demand, and efficiency / productivity. At Northampton General Hospital (NGH) and Leicester Royal Infirmary (LRI) there are Urgent Treatment Centres (UTC) planned; however, it was suggested that this will only meet unmet demand. It was reported that during industrial action, acute services appear to work better and therefore this needs further investigation to understand the reasons.

Afzal Ismail joined the meeting.

It was reported that further discussions would take place tomorrow at the Health Partners Executive meeting around the UEC issues and CYP. There are a range of options to discuss including mental health support in the community and A&E departments. This is the time to pause, reflect and take stock. Partners, such as Derbyshire Health United and EMAS are important partners in the discussions.

The difficulties with transferring services such as the community paediatric service at

KGH were noted, with the option to have Northampton Hospital Foundation Trust (NHFT) taking over services. The impacts of the notice have been highlighted to appropriate Committees and further discussions will take place.

Nil Sanganee reported that at the recent NHS Confederation, he noted that other systems are also struggling with the neighbourhood programme. How services are transformed into the new way of working, without reverting back to previous ways will be key. Using data to inform decision will be important. A new system quality operating model will help to make changes and moving clinical teams to match the operating model may be required.

It was suggested that the reason the UEC system worked well during industrial action may be due to having senior clinicians on site, managing clinical risks.

Maria Laffan noted that within West Northamptonshire a CQC inspection is anticipated with regard to SEND improvements. The CQC will want to know what improvements have taken place, such as digital innovation.

The success of Corby Urgent Care Centre (UCC) was noted, as they offer a range of services and see over 250+ patients per day. Some of the patients could be seen by their GP, however, chose to go to the UCC, due to the quick service received at the site.

Changes seen in other areas were discussed, such as Lincoln, which have changed from a deficit to break even, with no additional deficit funding received. This is thought to be partly due to having UTCs across the county, where in Leicester they are concentrated at the Leicester Royal Infirmary (LRI).

It was suggested that it is important that strategic decisions are made for the cluster to ensure UEC is not in the same position in three years' time. The numbers attending GP practices is still challenged, with variable access to GP services. There needs to be a culture change within Leicester to ensure patients attend the most appropriate place for their care, not just UEC. Members agreed that data needs to be used to understand flows and drivers. It was suggested that time is put aside at a development session to look at the UEC data in more detail.

Liz Gaulton urged members to consider data available via the Care20 platform and to ensure faith leaders are involved with conversations to engage with their congregations on health matters etc.

Anu Singh summarised conversations, noting that the conversations about CYP long waits were difficult, along with the pause to short breaks, as families rely on both of these services. The discussions over UEC are worrying, noting that teams need to use data to look at the problem and try and find solutions, using innovations and interventions appropriately. The senior team also need to look at what support can be provided to ensure clinical risk decision making is appropriate.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **REVIEWED** and **NOTED ASSURANCE** from the Joint Quality, Performance and Outcomes Committee which met on 9 June 2026.

ICBIC-26-34 **Special Educational Needs and Disabilities Reforms: local area delivery plans and role of ICB**

Maria Laffan spoke to the paper highlighting that the report provides an update on Special Educations Needs and Disabilities (SEND) reforms and the draft policy. Following the publication of the white paper in early 2026, a new policy has been developed, in conjunction with five Local Authorities (LAs) and are due to be submitted tomorrow. Significant work has taken place to finalise the policy.

Feedback is due to be received in September and therefore further discussions will take place at the October Board meeting. The focus has been on workforce, SALT, Occupational Therapists and Physiotherapists etc. Using pathway redesign to focus on early support, with the emphasis on reducing the initial demand. There are risks around the submission, due to changes taking place with LAs, such as changes to boundaries and workforce. Capital funding may also affect the plans, even though the plans are led by the LAs.

David Williams noted that the main focus is CYP, with the recent Overview and Scrutiny Committee looking at waiting times and early language support as this can make a big difference. How patients access services is also high on the priority list.

Following questions, it was confirmed that this process is being led by the LAs, and some Councils have grouped with CYP teams to ensure voices are captured. Teams have also met with parents and carer forums.

Toby Sanders confirmed that teams have worked with the five LAs to get the plans to this stage and therefore plans are as good as possible, under the restraints listed already. The plans alone cannot solve long waits for CYP and therefore teams have to challenge themselves to find a suitable way forward. At the recent SEND Improvement Board, there were young people in attendance to present on how services had affected them, the messages heard were powerful.

It was noted that for Neuro Diverse patients there are different pathways across the cluster. Whilst work has taken place on CYP, families need to know what support they will receive now and in the future.

Anu Singh thanked everyone for their input, noting that finding the workforce for CYP appears to be a challenge. Ensuring changes made benefit patients across the cluster is key.

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

- Were **Assured** that the ICB leaders and health partners have fully engaged and contributed to the co-production of the draft SEND Reform local area partnership delivery plans, that the final draft documents will be submitted as planned on 19th June 2026.
- Were **Advised** that the ICB are responsible for joint commissioning with local authorities services for children with SEND, this will include the delivery of Expert at Hand (EaH) models.

ICBIC-26-35 **Finance Assurance Report - LLR ICB and NICB**

Matt Gaunt took the paper as read, noting that it is early in the reporting cycle for finance. Lengthy conversations have taken place at the Joint Finance and Contracting Committee (JFCC) over the situation with UEC. The report shows budgets split by Chief Officer roles, to ensure accountability.

At month 1, the Leicestershire, Northamptonshire and Rutland cluster (LNR) is reporting a year-to-date breakeven position (£0.0m after deficit support funding of £0.43m), which is in line with plan. The full year reported forecast is a breakeven position across LNR ICBs of £0.0m after £5.1m non-recurrent support (£5.1m LLR and £0m Northamptonshire), which is in line with planned spend of £5.2 billion.

There are currently three contracts still being disputed, which could impact the budgets, as noted in the report.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **RECEIVED and NOTED** the 2026/27 break even financial position at Month 1, the forecast outturn and the A&E and contractual risks to the position.

ICBIC-26-36 **Transition Assurance Report**

Pete Burnett spoke to the report, noting that following the consultation which took place in 2025, all staff have received their initial letter. Job descriptions are required for all staff before they receive their updated letter. It was confirmed that other ICBs are in similar positions. Within the cluster, all band 9, 8d and 8c staff have received their final letters, with 8b letters due this week and all other staff the following week.

Staff are split roughly into thirds, 1/3 slotted in, 1/3 ringfence and 1/3 at risk.

At the end of June there will have been 70 staff left due to voluntary redundancy and a further 20 later in the year. This has created gaps in teams; however, some staff may be eligible to look at vacant posts as part of suitable alternative employment. If posts are not filled in this way, the jobs will then go out to advert.

It was confirmed that CHC and Individual Funding Request teams are due to TUPE into the ICBs from July and the System Coordination Centre staff have TUPE'd into NHFT from 1 May 2026. The active bystander team will move to University Hospitals of Leicester NHS Trust (UHL) and Corporate IT is also transferring organisations.

It is hoped that by the end of September all staff changes under Management of Change will be completed.

Following a query about the current situation, it was confirmed that interviews are taking place next week for two Primary Medical Services Partner Members (one or LLR ICB and one for NICB). Organisational development is now starting to be considered, including the values of the organisation.

There has been positive progress on a potential move for the LLR ICB offices, within County Hall.

Simone Jordan noted the size and scale of the changes taking place and praised the

executives for managing the process, along with attending additional committees. The loss of the workforce and capacity needs to be recognised as an ongoing risk.

Peter Burnett confirmed that the team is almost on track, however, job banding has been the limiting factor. Within the region the cluster is on track, however, other ICBs are further behind. The key will be how teams come together to fill gaps.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the progress of the Cluster ICB Transition Programme, to achieve its mandated reductions and service transfers.

ICBIC-26-37 Transition Assurance Report ICB merger

Toby Sanders noted the appendix to the paper, which is a letter from Glen Burley, Deputy Chief Executive of NHS England, dated 1 April 2026, setting out the need for clustered ICBs to merge by 1 April 2027.

Having two statutory organisations is hard to manage, due to duplication and ensuring that we continue to comply with required governance arrangements. The message in the letter is clear, in that organisations need to merge to where they cover a population of 1.5m. This is a logical step forward and a response to the letter is due by 14 July 2026 and therefore updates will be shared outside of this meeting.

Toby Sanders will meet with the Chief Executives of the LAs in the next few days to discuss the potential changes. It was reported that some clustered ICBs have already merged from 1 April 2026. One potential issue was noted, in that the cluster does not align with LAs or strategic authorities.

Harsha Kotecha urged members to not let local nuances be forgotten as the team move forward to merging.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the instruction from NHSE for ICB clusters to become merged ICBs.

Chair's Closing Remarks

Anu Singh noted the good presence across the meeting, with discussions focussing on the problems that need to be resolved.

Toby Sanders acknowledged the reducing workforce and the pressure this puts on staff who remain in post.

The Chair brought the meeting to a close at 10:55am.

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

NHS
Northamptonshire
Integrated Care Board

ACTION LOG

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

Updated 4 August 2026

Minute No:	Agenda Item	Action	Lead	Status/Update	Timescale	RAG
Meeting Date: August 2026						
ICBIC-26-32	**Chair and Chief Executive Updates**	Information on urgent dental care availability, to be made more widely available, as part of an engagement process, to include information on broader awareness of options available for patients	Pete Burnett	Update to be provided as part of October 2026 Board update	**October 2026**	**AMBER**

Completed
On Track
Overdue
No further action

Boards Meeting in Common in Public

Chief Executive Report

Thursday 20 August 2026

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

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Chief Executive Report - LLR and Northamptonshire ICB Cluster Board in Common Update**		
Paper Reference No:	**ICBIC-26-40**	**Agenda Item No:**	**6.**

Presented by	**Toby Sanders, Chief Executive**
Report Author(s)	**Jenny Goodwin Director of Communications, Engagement and Insights**
Executive Sponsor	**Pete Burnett, Chief Strategy Officer**

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

Recommendations

The Boards are asked to:

- **Receive the Chief Executive Report – LLR and Northamptonshire Cluster Board in Common Update for information.**

Executive Summary of the report

Chief Executive Report LLR and Northamptonshire ICB Cluster Board in Common Update

This is the Chief Executive report to the LLR and Northamptonshire ICB Cluster Board in Common, bringing together key updates on organisational developments, priorities and emerging issues across the Cluster. It is intended to support the Board's oversight and discussion and will continue to be developed over time to ensure it remains focused and useful.

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

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

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

Board Assurance Framework Risk -	
LLR ICB BAF No: N/A	**NICB BAF No: N/A**

Appendices	N/A

Who has been engaged and where else has this report been considered:
N/A

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

Hazell, Tamara
20/08/2026 15:46:03

Chief Executive Report
LLR and Northamptonshire ICB Cluster Board in Common Update
Thursday 20 August 2026

Cluster Development and Management of Change

1. The Cluster's Management of Change (MoC) programme continues to progress following consultation on proposals to move to a single organisational structure. Implementation is underway, with staff progressing through slotting, ringfencing and recruitment processes.

2. Alongside organisational change, work continues with NHS England on the future development of the Cluster's operating model, ensuring the organisation is well positioned to deliver its strategic commissioning responsibilities whilst maintaining service delivery. Support arrangements remain in place to help colleagues through the transition process.

Strategic Commissioning and Neighbourhood Health Neighbourhood Health Development

3. In July, the Cluster hosted a visit from Dr Claire Fuller, NHS England's Director for Neighbourhood Health, to showcase progress across LLR and Northamptonshire.

4. The visit highlighted the development of Integrated Neighbourhood Teams, population health management approaches and strategic commissioning arrangements designed to improve outcomes and reduce inequalities across 21 neighbourhoods. While challenges remain around workforce, data sharing and financial constraints, the visit recognised the strong progress being made across the Cluster.

5. National guidance and funding arrangements to support neighbourhood health centre development are expected later in the autumn, providing greater clarity regarding future capital investment and infrastructure requirements.

Integrated Health Organisation

6. Following a nationally assessed process, Northamptonshire Healthcare NHS Foundation Trust (NHFT) has been confirmed as eligible to progress an Integrated Health Organisation (IHO) approach for Northamptonshire.

7. The model aims to strengthen partnership working across health and care organisations, with a greater focus on prevention, reducing inequalities and improving outcomes. The ICB is now working with NHFT to develop the business case required to take the proposal forward.

Community Mental Health Centres

8. Leicester, Leicestershire and Rutland and Northamptonshire will benefit from NHS England's national expansion of community mental health centres, supported by £343 million of national investment.

9. The programme will improve access to local mental health support, helping people access care earlier and reducing reliance on urgent and emergency services. Locally,

this includes the established Hello Help Hub in Loughborough, plans for a second hub in Leicester city centre, and progression of a co-located Mental Health Emergency Department at Leicester Royal Infirmary.

10. In Northamptonshire, three community mental health centres are being developed across Northampton and Wellingborough to improve access to support and strengthen neighbourhood-based mental health services.

Service Transformation and Improvement
Obesity Pathway Innovation Programme

11. LLR and Northamptonshire have secured £8 million through NHS England's Obesity Pathway Innovation Programme, becoming one of only twelve pilot areas nationally.

12. The three-year programme will develop neighbourhood-based weight management pathways, improving access to support and helping address health inequalities while contributing to future national learning.

WorkWell Programme

13. The Cluster welcomed senior representatives from the Department of Health and Social Care and Department for Work and Pensions to showcase the WorkWell programme in Leicester, Leicestershire and Rutland.

14. The programme continues to demonstrate how neighbourhood-based approaches can support people whose health is affecting their ability to remain in or return to employment while helping reduce health inequalities.

Family Vaccination Clinics

15. Family vaccination clinics have been launched across Leicester and Leicestershire to improve access to routine vaccinations and increase uptake ahead of winter.

16. The initiative supports the wider vaccination strategy and aims to reduce inequalities in access to vaccination services.

Quality, Safety and Service Assurance
St Andrew's Healthcare Service Transfer

17. Agreement has been reached for patients currently receiving care from St Andrew's Healthcare in Northampton to transfer to the care of NHFT from September 2026, subject to final commercial arrangements.

18. Partners continue to work closely together to ensure safe transition arrangements, continuity of care and ongoing support for patients, families and staff.

National Maternity Reforms

19. The publication of the Independent National Maternity and Neonatal Investigation and Ockenden Review has resulted in a national programme of maternity and neonatal improvement.

20. Partners across the Cluster are reviewing the recommendations and considering

implications alongside ongoing local maternity improvement work.

Winter Planning and Preparedness

21. Planning for winter 2026/27 remains a key priority for the Cluster. System partners are working together to strengthen resilience across urgent and emergency care, elective recovery, discharge pathways and community services ahead of the winter period.

22. While demand pressures are expected to remain significant, detailed plans are in place and continue to be refined through system-wide planning arrangements. More detailed operational updates are reported through the appropriate governance routes.

Patient and Public Voice

23. Work is underway across LLR and Northamptonshire to review future patient and public involvement arrangements as the Cluster transitions towards a strategic commissioning model.

24. Alongside this work, the Cluster is participating in national discussions regarding the future of Healthwatch. Particular focus has been placed on ensuring future arrangements retain independent patient voice, engagement with underserved communities and effective mechanisms for public feedback and challenge.

Local Service Developments
Hinckley Neighbourhood Health Centre Programme

25. NHS Property Services has proposed the demolition of the former Hinckley and District Hospital building later this year.

26. The demolition represents the first phase of the wider Hinckley Neighbourhood Health Centre programme and creates opportunities for future site development.

Hinckley Community Diagnostic Centre

27. The Hinckley Community Diagnostic Centre has marked its first year of operation, with around 60,000 patients accessing diagnostic tests since opening in June 2025.

28. The centre continues to improve access to diagnostics closer to home and has received positive national recognition for its contribution to earlier diagnosis and improved patient access

National and System Updates
GP Patient Survey 2026

29. The latest GP Patient Survey shows improving patient satisfaction nationally across general practice, pharmacy and dental services.

30. Patient experience in Leicester, Leicestershire and Rutland remains below the national average across a number of measures, particularly those relating to access, including contacting practices by phone and online. There continues to be variation across the system, with some Leicester City localities reporting lower levels of satisfaction and access than the national position.

31. Across Northamptonshire, patient experience is broadly in line with, and in some areas slightly above, the national average. Patients generally report positive experiences of care, with particularly strong performance in measures relating to confidence and trust in healthcare professionals. As in other parts of the country, key challenges remain around access to services, appointment availability and NHS dentistry.

32. The ICB continues to work closely with providers and primary care partners to deliver ongoing improvement plans focused on improving access, reducing variation and ensuring patients receive timely, high-quality care.

Recognition and Awards

33. The LLR ICB and LLR Academy's *Developing Diverse Leadership* programme has been shortlisted in the Workforce Initiative of the Year category at the HSJ Awards, recognising its contribution to advancing inclusive leadership across health and care.

34. Northamptonshire ICB has been shortlisted in the Digitising Patient Care category at the HSJ Awards, recognising its innovative work to digitise ReSPECT plans, improving access to patients' care preferences and supporting more coordinated, person-centred care across health and care services.

The Boards are asked to:

- Receive the Chief Executive Report – LLR and Northamptonshire Cluster Board in Common Update for information.

Boards Meeting in Common in Public

Report Title: NHS Leicester, Leicestershire and Rutland ICB (LLR ICB) Annual Report and Accounts 2025/26

NHS Northamptonshire ICB (NICB) Annual Report and Accounts 2025/26

NHS England Annual Assessment of Performance in 2025/26 for LLR ICB

NHS England Annual Assessment of Performance in 2025/26 for NICB

Date of Meeting: Thursday 20 August 2026

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**NHS Leicester, Leicestershire and Rutland ICB (LLR ICB) Annual Report and Accounts 2025/26** **NHS Northamptonshire ICB (NICB) Annual Report and Accounts 2025/26** **NHS England Annual Assessment of Performance in 2025/26 for LLR ICB** **NHS England Annual Assessment of Performance in 2025/26 for NICB**		
Paper Reference No:	**ICBIC-26-41**	**Agenda Item No:**	**7.**

Presented by	**Matt Gaunt, Chief Finance Officer (Annual Report and Accounts)** **Toby Sanders, Chief Executive Officer (Annual Assessment letters)**
Report Author(s)	**Emma Follis, Senior Manager Corporate Governance and Risk Corporate Governance and Finance Teams, LLR ICB** **Corporate Governance and Finance Teams, NICB**
Executive Sponsor	**Matt Gaunt, Chief Finance Officer**

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

Recommendations

The Boards are asked to:

- **NOTE** the approval of and publication of the NHS Leicester, Leicestershire and Rutland ICB (LLR ICB) Annual Report and Accounts 2025/26.
- **NOTE** the approval of and publication of the NHS Northamptonshire ICB (NICB) Annual Report and Accounts 2025/26.
- **NOTE** that the presentation of this item to the Boards fulfils the requirement for each ICB to present its annual report and accounts at a meeting in public before 30 September 2026.
- **NOTE** the NHS England Annual Assessment of LLR ICB's performance in 2025/26.
- **NOTE** the NHS England Annual Assessment of NICB's performance in 2025/26.

Executive Summary of the report

Annual Report and Accounts for 2025/26

At the private meeting of the NHS Leicester, Leicestershire and Rutland ICB and NHS Northamptonshire ICB Boards on 18 June 2026, the Annual Report and Accounts of the ICBs were approved. The LLR ICB Board approved the LLR Annual Report and Accounts for 2025/26, noting the section 30 letter issued by the external auditors in relation to the year-end deficit position. The NICB Board approved the NICB Annual Report and Accounts for 2025/26.

The Annual Report and Accounts for both ICBs were submitted to NHS England ahead of the submission deadline of 19 June 2026. The Annual Report and Accounts have now been published on the respective websites and may be accessed via the following links:

- Leicester, Leicestershire and Rutland annual report
- Northamptonshire annual report

National guidance states that each ICB is required to present its annual report and accounts at a meeting in public before 30 September 2026. The Boards are asked to **NOTE** that the presentation of this item is intended to fulfil this requirement.

NHS England Annual Assessment of Performance in 2025/26

Under NHS Act legislation (Section 14Z59) NHS England is required to conduct a performance assessment of each ICB with respect to each financial year against those specific objectives set for it by:

- NHS England and the Secretary of State for Health and Social Care;
- Statutory duties defined in the Act
- Wider role within your Integrated Care System across the 2025/26 financial year.

The Annual Assessment of Performance in 2025/26 letters received by the ICBs from the NHS England Midlands Regional Team are included at Appendix 1 and Appendix 2 of this paper. The Boards are asked to **NOTE** the content of the letters. The letters will be published in accordance with the mandated process alongside the ICB Annual Report for 2025/26 on the ICB websites.

- Annual Assessment of Performance in 2025/26 for Leicester, Leicestershire and Rutland ICB.
- Annual Assessment of Performance in 2025/26 for Northamptonshire ICB.

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

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

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

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

Appendices	
Appendices	**Appendix 1: Letter NHSE England's Annual Assessment of LLR ICB Performance in 2025/26** **Appendix 2: Letter NHSE England's Annual Assessment of NICB Performance in 2025/26**

Who has been engaged and where else has this report been considered:
Annual Report and Accounts – engagement has been undertaken across key teams within the ICBs and with senior leaders. The Annual Report and Accounts were approved by the respective Boards t the private meeting of the Boards in June 2026. Annual Assessment Letters – engagement undertaken by NHSE Midlands Regional Team with ICBs' Senior Leadership.

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

NHS England Midlands

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Sent via email

Anu Singh
ICB Chair, Leicester,
Leicestershire & Rutland ICB

3 August 2026

Dear Anu

Annual assessment of Leicester, Leicestershire & Rutland Integrated Care Board's performance in 2025/26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, we recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. We also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, we have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners and stakeholders, and discussions held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, we have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

We remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

We would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. We look forward to continuing to work with you in the year ahead.

Yours sincerely

Rebecca Farmer
Director of System Co-ordination and Oversight, NHS England, Midlands

Cc. Dale Bywater, Regional Director Midlands, NHS England
Toby Sanders, Chief Executive Officer, Leicester, Leicestershire & Rutland ICB
Hayley Jackson, Deputy Director of System Co-ordination and Oversight, Midlands, NHS England

Section 1: ICB performance assessment

The ICB has a well-developed and continuing population health management (PHM) approach, supported by a person-level linked dataset, secure NHS data platform, and established information governance arrangements. A cross-system intelligence function and strong partnership working with public health colleagues are established strengths across the system, with national and regional recognition of the ICB's approach.

Outcomes show incremental improvement since 2023, including improvements in lipid-lowering therapy, hypertension treatment and a 5% increase in patients with severe mental illness (SMI) receiving all six health checks. SMI health check performance was reported at 70.8%; national datasets indicated 76% for quarter 4 (Q4), with both figures above regional and national benchmarks. However, some inequalities persist, alongside data quality challenges, including a 10% increase in unusable ethnicity data. Vaccination uptake also remains variable, with 46.2% of people over 65 unvaccinated for flu and 44.1% unvaccinated for COVID-19, while the deprivation gap in early cancer diagnosis remains at 8.43%. Taken together, this reflects a strengthening and established PHM approach, with improvement in selected outcomes but ongoing work needed to reduce variation and inequality.

ICB delivery against annual objectives for elective care showed some improvement during 2025/26, moving from below average in quarter 1 (Q1) to above average in the remaining quarters for waiting list growth, although this was not sustained at year-end, with a Q4 dip and core elective standards remaining unmet. In Q4, Leicester, Leicestershire & Rutland (LLR) ICB delivered 59.81% for 18-week waits, below the national average but improved on the previous year, with University Hospitals of Leicester (UHL) achieving 59.1% against a plan of 62.3%, while 52-week waits were 1.1% against a plan of 0.9%. A 65-week backlog remains, with no clear trajectory to elimination. Overall, the Access domain remains below average, reflecting a broadly unchanged position from last year, with some improvement but sustained recovery not yet demonstrated.

The ICB has established a recovery approach for cancer, supported by £505,600 of Cancer Alliance funding and engagement. However, this has not yet translated into improved performance. The ICB did not plan to meet the 62-day standard, aiming to achieve 70%, with performance remaining at 58.8% in Q4, below the 75% national target. Faster Diagnosis Standard performance was 11.7% below target and declined by 13.8% year-on-year. This represents a deterioration from the 2024/25 position, where Faster Diagnosis Standard performance was stronger and backlog reductions were achieved.

In urgent and emergency care delivery, the ICB has taken positive and sustained action to improve flow, discharge, same-day access and coordination, supported by national programmes and £2 million of capital at UHL. Performance improved to 77.7% in Q4, from 76.1%; however, the 78% standard was not met. Demand, operational

pressures and ambulance handover delays continued, mirroring 2024/25 fragility despite improvement. Overall, UHL shows year-on-year improvement.

The ICB has delivered strongly in primary care against most national requirements, including GP Connect, online consultation and online registration, with patient experience remaining positive and no national outlier position for access or continuity. Dentistry performance also improved, with 90.5% of urgent dental appointments delivered, although workforce challenges continue. This builds on a strong 2024/25 position, where the ICB was among the top performers regionally for primary care access and delivery metrics. Overall, the ICB demonstrates sustained strong delivery in primary care, with some workforce constraints impacting capacity.

Mental health outcomes have been variable, with strong delivery in children and young people (CYP) access at 104%, length of stay at 52 days, Talking Therapies outcomes at 103% reliable improvement and 100% recovery, alongside zero out-of-area placements. Improvement activity includes suicide prevention, CYP crisis pathways and more culturally responsive care models. However, challenges remain in Talking Therapies and Individual Placement and Support (IPS), with delivery falling short in IPS at 94%, perinatal access at 99.6% and completed treatments at 89%. There is strong underlying performance in Physical Health Checks for people with Severe Mental Illness and Core20Plus5. Overall, this reflects an unchanged but variable position since 2024/25, with continued strong delivery in selected areas alongside some ongoing performance challenges.

Performance has been strong across several metrics in learning disabilities and autism, including adult inpatient rate of 27 per million (5th out of 42) and health checks exceeding plan by 14%. However, the inpatient plan was narrowly missed and risks remain around capacity, local government reorganisation, housing and capital planning. Strong headline performance is offset by sustainability risks.

In relation to Special Educational Needs and Disabilities statutory duties, the ICB remains actively engaged in system collaboration and strengthened governance. Delivery is variable, with Leicestershire subject to statutory intervention, ongoing concerns in Rutland, and Leicester City awaiting inspection. Regional improvement support is in place across local area partnerships. Capacity pressures and system reorganisation increase delivery risk.

The ICB has built stronger foundations in the shift to community-based care through expanded primary care, community and Voluntary, Community and Social Enterprise provision and redesigned pathways, with visible progress in moving care closer to home. This builds on 2024/25 progress in neighbourhood working and pathway redesign, though reductions in hospital demand have not yet been fully realised.

The ICB has made progress in digital transformation, with full cloud-based telephony rollout and improved NHS App integration, although it is not yet fully compliant, particularly on prospective record access.

Governance is in place for effectiveness and safety through the Quality and Performance Improvement Strategy. However, the disestablishment of the Quality and Safety Committee, alongside gaps in Continuing Healthcare (CHC) reporting and limited triangulation, reduces clarity in elements of assurance.

There is a strong commitment to service experience and patient engagement through Citizens' Panels, Patient Participation Groups, self-referral, and expanded access, with complaints embedded in oversight. This builds on 2024/25 evidence of strong stakeholder engagement and public involvement, though system pressures continue to impact performance and outcomes across some services.

Safeguarding duties and arrangements remain stable, with effective partnership working and statutory compliance, reflecting a consistent and secure position.

Wider system performance shows a mixed picture. LLR ranked highly for Experience and Workforce, while Safety and Population Health were below average, and Access and Finance were in the lowest quartile. Strengths include CHC referrals completed within 28 days at 88%, access to a preferred GP at 86.1% and learning disability annual health checks at 82.34%, alongside low out-of-area bed days at 1.0% and reduced antibiotic prescribing for children aged 0–9 at 26.5%. Access and Finance performance in Q4 remained in the lowest quartile, reflecting continued challenges. Accident and Emergency (A&E) four-hour performance at 77.7%, 18-week Referral to Treatment at 59.81% and 62-day cancer performance at 58.8% remain below target, with A&E and cancer deteriorating year-on-year. Performance is further constrained by elective waiting list growth at 6.5%, reduced GP booking satisfaction at 66.4% and waning diabetes care processes at 42.5%.

Review of key ICB metrics showed that LLR ICB's performance in the Finance domain within the NOF was assessed as below average nationally in Q4 of 2025/26, and its Finance System Performance Indicator was in the lowest-performing quartile nationally in Q4. Underlying finance metrics reflected a challenging position, with the combined finance score deteriorating from 2 to 3 in Q4 despite productivity growth of 4.7%. The ICB reported a £30.8 million deficit against a planned £15.5 million deficit. There was a system-wide deficit of £115.8 million, £35.8 million above plan, alongside an in-year system deficit of £23.3 million against a planned deficit of £0.3 million. Performance was further impacted by under-delivery of efficiency targets, with £66.8 million delivered against a £70.2 million plan, and a £22.9 million system shortfall. The ICB did not meet its financial duties, and providers also did not deliver financial or efficiency plans. Productivity initiatives, including the use of population health management to target investment and actions to reduce avoidable admissions and shift care closer to home, were in place; however, there was limited quantified evidence linking these initiatives to financial savings or demonstrating monetised productivity gains. Productivity improved by 4.7%, exceeding the regional average of 2.4%, and initiatives including population health management, reducing avoidable admissions and shifting care closer to home were reported. However, limited quantified evidence was provided to demonstrate the financial impact of these

initiatives, monetised productivity gains, clear deficit drivers or quantified future efficiency trajectories.

Although governance arrangements were in place, these did not prevent deterioration, and the ICB did not meet its statutory financial duties or wider system financial responsibilities. Overall, the position reflects significant financial pressure and reduced delivery against plan.

The ICB has a structured approach to tackling inequalities, aligned with national frameworks, with targeted interventions including outreach, Core20 Connectors and £2.8m of primary care investment. This builds on a strong 2024/25 focus on health inequalities and PHM-led planning, although assurance is constrained by gaps in some datasets and the completeness of reporting.

Section 2: ICB Capability assessment

The ICB has discharged its specialised commissioning responsibilities through proactive engagement in formal joint committee arrangements and supporting sub-groups with NHS England. These forums enable consistent, system-wide decision-making across delegated services, supported by a single integrated NHS England ICB commissioning team. This model ensures alignment and transactional effectiveness; however, strategic commissioning capability remains in development, with further maturation planned through 2026/27.

The ICB has established a comprehensive and clearly defined governance framework, including its Constitution, Standing Orders and Schemes of Delegation, which set out accountability across Board, committees and officers. These are reinforced through an established committee structure and System Executive Committee oversight, supporting effective escalation, assurance and timely decision-making. Board effectiveness is evidenced through consistent quoracy, strong attendance and ongoing development. Partnership working with local authorities and system partners is well embedded, including place-based arrangements that support joint planning and delivery. These arrangements provide a clear and well-established framework for governance, decision-making and access to appropriate expertise, supporting consistent oversight and assurance across the system.

The ICB has worked constructively with system and government partners, with evidence of positive engagement and productive relationships. However, feedback suggests further work is required to strengthen and reset some partnerships, including developing a shared understanding of the ICB's revised role and ensuring collective priorities are consistently translated into delivery. Continued focus on engagement and relationship-building will support more effective partnership working across the system.

The ICB's delivery across innovation, research and sustainability demonstrates a structured contribution to social and economic value, with strong examples of service innovation, established research collaboration and clinical leadership shaping

pathways. Sustainability maturity is incomplete, including the absence of a published Green Plan, with emissions reductions positioned mid-range nationally. Consequently, while the breadth of delivery is clear, scale and consistency remain limited.

The ICB has primarily contributed to the government's 'health and work' policy by securing funding for and launching the 'WorkWell' service, driving this policy forward through several local strategies and operational plans. In addition, the ICB is a core partner in the 'Get Leicester, Leicestershire & Rutland Working' Plan, a joint 10-year strategy launched alongside local authorities and the Department for Work and Pensions.

Finally, the ICB has embedded the Triple Aim within its strategic and planning frameworks, including the Integrated Care Strategy, Joint Forward Plan and Five-Year Plan, supported by a population health management approach. Governance and assurance processes ensure decisions are routinely tested for their impact on population health, service quality, value and inequalities. This provides a robust and structured basis for balanced, evidence-informed decision-making across population health, service quality, value and inequalities.

Section 3: Support and intervention

The ICB did not operate under any formal legal enforcement or statutory intervention during 2025/26, and no system-level financial or recovery interventions were applied during the reporting period. Oversight was provided through established regional and national arrangements rather than formal escalation processes. However, this should be viewed alongside evidence of significant financial challenges during the year, including deficits above plan, under-delivery of efficiency targets and failure to meet financial duties.

The ICB has maintained active engagement with national and regional oversight processes, including provider tiering arrangements for acute services. These have supported focused scrutiny and constructive challenge across elective, cancer and diagnostic pathways. Provider-level discussions demonstrate increasing operational grip, with targeted actions in place to address long waits, pathway bottlenecks, and workforce constraints, alongside the use of mutual aid, insourcing and productivity initiatives. There is also evidence of effective commissioner–provider collaboration in managing pressures and supporting recovery trajectories.

Conclusion

In forming this assessment, we have sought to take a balanced and proportionate view of your performance, recognising both what has been delivered and the complexity of the operating environment in which ICBs continue to function. We are encouraged by progress towards a more mature system of integrated care, with decision-making increasingly informed by, and responsive to, the needs of local people and communities.

We recognise that, for some systems, this assessment relates to an ICB that has since merged or transitioned into a new organisational form. This letter therefore reflects performance for the statutory body in place during the period assessed. NHS England acknowledges the pace of change across systems and is committed to working with you in your current configuration, supporting continuity, learning from predecessor organisations, and continued improvement as the new ICB develops and embeds its responsibilities.

I ask that you share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with our statutory responsibilities, NHS England will also publish a summary of the outcomes of all ICB annual performance assessments.

Rebecca Farmer
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Sent via email

Anu Singh
Chair of Northamptonshire
Integrated Care Board

3 August 2026

Dear Anu

Annual assessment of Northamptonshire Integrated Care Board's performance in 2025/26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, we recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. We also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, we have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners and stakeholders, and discussions held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, we have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

We remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

We would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. We look forward to continuing to work with you in the year ahead.

Yours sincerely

Rebecca Farmer
Director of System Co-ordination and Oversight, Midlands, NHS England

Cc: Dale Bywater - Regional Director, Midlands, NHS England
Toby Sanders - ICB Chief Executive, Northamptonshire ICB
Hayley Jackson, Deputy Director of System Co-ordination and Oversight, Midlands, NHS England

Section 1: ICB performance assessment

Northamptonshire ICB and its partners delivered improvement in several priority areas during 2025/26, but overall performance remained variable. Progress was strongest where there was clear focus on primary care access, population health management, neighbourhood care and internal financial control. However, this did not translate consistently across core services, with ongoing challenges in urgent and emergency care (UEC), elective recovery, cancer, Special Educational Needs and Disabilities (SEND), and learning disability and autism.

Overall service performance was mixed. Continuing Healthcare referrals completed within 28 days improved from 69.46% in quarter 1 to 90.0% in quarter 4, and annual health checks for people on general practice (GP) learning disability registers increased from 12.65% to 78.18%. Primary care access improved, with online registration above target at 79.6%, all but one GP offering online consultations, and 85% of patients with a preferred GP professional able to get an appointment with that professional in quarter 4, placing the ICB in the upper quartile of the National Oversight Framework (NOF). However, diabetes care processes declined, cervical screening showed limited change, and the national GP Patient Survey improved by 2.6% to 70.5% but remained below the national average of 75.4%.

Northamptonshire ICB's UEC position remained pressured in 2025/26, despite system-wide work on collaboration, neighbourhood care and emergency preparedness. Accident and emergency (A&E) four-hour performance was 75.6%, below target but improved on 2024/25, with continued pressure on 12-hour waits, ambulance handovers and long trolley waits. The ICB did not submit a compliant UEC plan because of non-compliance with the 12-hour standard, with delivery constrained by flow and discharge inefficiencies, particularly Pathway 2, and gaps in front door and community pathways. A system-wide discharge improvement plan is in place for 2026/27.

18-week Referral to Treatment performance remained below target at 62.94%. Although there was some delivery against elective plans, the ICB did not reduce 52-week waits below 1%. Cancer performance remained a concern, with both the 62-day standard and Faster Diagnosis Standard below national ambitions. The 62-day standard was in the lower quartile and Faster Diagnosis Standard performance deteriorated during the year. Despite pathway improvement plans and £40,552 of Cancer Recovery Funding, expected improvement has not yet come through.

SEND, learning disability and autism continue to require focused attention. While annual health checks and children's inpatient performance showed good practice, adult learning disability and autism inpatient reductions were not delivered, with Northamptonshire ending the year with 34 inpatients against a plan of 22 and ranked 38th of 42 systems nationally. Both local area partnerships remain under statutory intervention for SEND. Mental health performance was also variable: the ICB was unable to eliminate out of area placements but delivered stronger performance in Children and Young People +1 contacts at 123% of plan, perinatal access at 115% of plan, and talking therapies improvement and recovery targets above plan.

The ICB has set a clear direction on neighbourhood care, with pilot neighbourhoods in Wellingborough and Rural South and East focused on same-day access, complex care and long-term conditions. This supports the wider ambition to shift care closer to home and strengthen proactive, integrated support, although evidence of measurable impact remains limited. The ICB has also shown strategic commitment to prevention, inequalities and quality, supported by the Northants Care Record, analytical platforms and dashboards to identify priority cohorts and target Core20PLUS5 populations at neighbourhood level. This provides a stronger basis for evidence-led commissioning, but more is needed to demonstrate improvements in access, quality and outcomes for disadvantaged communities.

The ICB delivered a £10m surplus against a planned balanced position and achieved its £88m efficiency requirement in 2025/26. However, the wider system finance and productivity position remained challenged, with productivity deteriorating by 1.7%, compared with a regional average improvement of 2.4%, and Northamptonshire placed in the lowest performing quartile nationally for Finance and System Finance in quarter 4. This shows good internal financial control but highlights the need to translate this into stronger system-wide productivity and sustainability.

Review of NOF metrics showed stronger performance on selected Safety and Experience measures, including Continuing Healthcare timeliness, discharge-ready to actual discharge date, patient-reported GP satisfaction, annual health checks for people on GP learning disability registers and the myocardial infarction admission deprivation gap. However, Northamptonshire remained in the lowest quartile for the 62-day cancer standard and A&E four-hour standard and scored comparatively poorly on implied productivity growth.

The ICB demonstrated consideration of the Triple Aim through its focus on improving population health, strengthening quality and experience of care, and supporting financial sustainability. This is reflected in its work on population health management, health inequalities, quality improvement and financial delivery. For example, Digital Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), delivered through the Northamptonshire Care Record, had 5,279 live plans by January 2026 and supports personalised emergency care planning, improved information sharing and reduced duplication.

On the Green Plan, further improvement is required in sustainability governance and strategy, as the cluster has not published a Green Plan. The ICB reports implementation of net zero supplier roadmap policies, with monthly inhaler emissions in 2025/26 45% lower than in 2019/20, and monthly nitrous oxide emissions 35% lower, both within the middle 50% of reductions achieved nationally by ICBs.

Section 2: ICB Capability assessment

Northamptonshire ICB continued to operate in a highly pressured environment and broadly maintained the core arrangements expected of a statutory organisation. Governance and decision-making were supported through Board and committee structures, the Board Assurance Framework, risk registers and performance reporting, strengthened from October 2025 through cluster governance arrangements. These provided visibility of key system risks, including UEC, SEND

and financial sustainability. Quality oversight was supported by 83 provider monitoring visits in 2025, used to identify risks, share good practice and support targeted improvement. Patient experience and complaint intelligence were considered through quality governance arrangements, with oversight maintained through the Patient Experience Team; however, evidence could be stronger on how complaint learning informs service change and quality improvement.

The ICB discharged its responsibilities through direct, delegated, and collaborative commissioning arrangements. For delegated specialised services, it used the formal Joint Committee and supporting decision-making sub-groups, with services governed in line with delegation arrangements. The integrated NHS England and ICB commissioning team provides a consistent platform for these responsibilities. However, the evidence describes the governance model more clearly than the impact of commissioning decisions. In 2026/27, the ICB should further develop its strategic commissioning capability by showing how commissioning choices respond to local need, improve access and quality, and deliver measurable outcomes for Northamptonshire residents.

The ICB worked constructively with system partners, aligning to the Northamptonshire Integrated Care Partnership's "Live Your Best Life" strategy, the Joint Forward Plan and both Health and Wellbeing Boards. It considers the government's health and work ambitions through commissioning and partnership decisions, including the 'Get South Midlands Working' plan, developed with local authorities and the ICB to reduce health-related economic inactivity. Aligned with the national WorkWell programme, the ICB is focusing on early intervention pathways to support residents with long-term conditions to start, stay and succeed in work.

Quarterly reporting, dashboards and oversight meetings support delivery tracking, alongside primary care digital delivery, including online consultations, GP Connect and NHS App uptake. Registrations increased by 2.4% from quarter 3 to quarter 4 and repeat prescriptions increased by 38% from quarter 3. Partner feedback describes a positive and improving relationship, strengthened by leadership links, the ICB Vice Chair role at place, and collaboration on data, analytics and joint programmes. However, partners note that strategic alignment is not yet consistently translating into delivery, with more work needed to strengthen shared accountability at place, enable earlier engagement on commissioning decisions and clarify the role of place-based partners in neighbourhood and prevention priorities. This is reflected in the smoking cessation service, where local government partners raised concern that the priority had not progressed into delivery.

The ICB's local government partner considered that engagement and the working relationship were not yet as effective as they could be, reflecting significant changes in membership and roles. They highlighted the need to strengthen relationships with new teams, clarify their respective roles and develop a work plan. Further focus is needed to improve engagement, build understanding of ICB structures and ensure partner-specific issues are better reflected.

The ICB has taken steps to involve local people through public Board meetings, published papers, Healthwatch, voluntary sector routes and opportunities for

residents to submit questions. The co-produced Community Engagement Framework, developed with local partners and people, sets expectations for involving communities in the design, delivery and improvement of services, with progress monitored by the ICB. Board discussions also show consideration of patient experience and affected groups, including SEND. This supports the view that the ICB has had regard to its public involvement and consultation duties.

The ICB obtained appropriate advice in conducting its functions, with clinical input embedded through Board and committee arrangements. Primary care, nursing, medical, provider and wider professional leadership inform discussions on quality, safety, access and service change, and quality reports show clinical risks and patient safety issues are discussed with actions to manage or mitigate risks. This supports confidence that decisions are clinically informed. Examples include targeted clinical and operational actions in cancer recovery, such as gynaecology pathway work, skin pathway improvement, minor operations capacity and quality improvement.

The Board recognises that workforce capacity, capability and sustainability are central to delivery, and workforce risks are considered alongside quality and performance. During organisational transition, the ICB put in place weekly joint staff briefings from July, moving to bi-weekly from September, alongside financial and career planning workshops and a dedicated staff portal. A cluster-level organisational development programme is now established to support the shift from transition to transformation.

Section 3: Support and intervention

There were no formal legal enforcement actions or undertakings in place for Northamptonshire ICB from NHS England during 2025/26. However, both acute trusts were subject to undertakings. While the ICB was not itself in receipt of dedicated support interventions during the year, it participated in national and regional tiering oversight arrangements relating to the two acute trusts, focused on UEC, elective recovery and cancer performance.

During the year, the ICB and wider system were also engaged in a range of improvement and oversight activity including across mental health, learning disability and autism, SEND, maternity and quality oversight, and performance recovery. This included NHS England improvement input, a Getting It Right First-Time review, statutory SEND intervention with Department for Education and enhanced maternity oversight.

Wider support and oversight activity also included work with system partners in relation to St Andrew's Healthcare, safeguarding partnerships, emergency preparedness and cluster transition. Overall, these arrangements reflected wider system oversight and improvement support, rather than formal targeted support or intervention directed at Northamptonshire ICB.

Conclusion

In forming this assessment, we have sought to take a balanced and proportionate view of your performance, recognising both what has been delivered and the

complexity of the operating environment in which ICBs continue to function. We are encouraged by progress towards a more mature system of integrated care, with decision-making increasingly informed by, and responsive to, the needs of local people and communities.

We recognise that, for some systems, this assessment relates to an ICB that has since merged or transitioned into a new organisational form. This letter therefore reflects performance for the statutory body in place during the period assessed. NHS England acknowledges the pace of change across systems and is committed to working with you in your current configuration, supporting continuity, learning from predecessor organisations, and continued improvement as the new ICB develops and embeds its responsibilities.

I ask that you share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with our statutory responsibilities, NHS England will also publish a summary of the outcomes of all ICB annual performance assessments.

Boards Meeting in Common in Public

Report Title: EPRR Update and Plans and Polices

Date of Meeting: Thursday 20 August 2026

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

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**EPRR Update and Plans and Policies**		
Paper Reference No:	**ICBIC-26-42**	**Agenda Item No:**	**8.**

Presented by	**Amita Chudasama, Head of EPRR, LNR ICB**
Report Author(s)	**Amita Chudasama, Head of EPRR, LNR ICB**
Executive Sponsor	**Eileen Doyle, Chief Delivery Officer and Accountable Emergency Officer. LNR ICB**

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

Recommendations

The Board are asked to:

- **RECEIVE** assurance of the ICB's processes that meet the responsibilities of being a Category 1 responder under the Civil Contingencies Act (2004) and to meet the NHS England Core Standards for EPRR.

- **APPROVE** the following LLR ICB and NICB EPRR Plans
  - LLR ICB Pandemic Plan June 2026
  - NICB Pandemic Plan July 2026
  - LLR ICB EPRR Policy June 2026
  - LLR ICB Incident Coordination Centre Plan June 2026
  - LLR ICB Business Continuity Management Policy June 2026
  - LLR ICB Business Continuity Management Plan June 2026
  - LNR ICB Cluster Incident Communications Plan May 2026
  - LLR ICB Incident Response Plan May 2026
  - NICB Incident Response Plan June 2026
  - NICB Business Continuity Plan June 2026

Executive Summary of the report
1. The EPRR workstream supports the ICB to meet our responsibilities as Category 1 responders under the Civil Contingencies Act (2004) (CAA) and NHS England's Core Standards for EPRR which are audited on an annual basis. 2. This report provides the Board assurance that the ICB is meeting its obligations under the Civil Contingencies Act 2002, Civil Contingencies Act 2002 (Contingency Planning) Regulations 2005, NHS Act 2006, Health and Care Act 2022 and the NHS Core Standards for EPRR with regards to their duty to maintain plans and ensure they meet current guidance and legislation. 3. This report seeks approval to the changes made to the ICB EPRR Plans and Polices as part of the Core Standards annual review process. 4. The Board are asked to approve the plans and policies to meet the ICB obligations against the NHS Core Standards.

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

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

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

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No: 6	**NICB BAF No: 8**

Appendices	**Due to the substantial volume of the appendices, they have not been included within the published Board papers. The appendices listed below are available to members of the public upon request. Board members are asked to access these documents via the Supplementary Information section within Admin Control.** • Appendix 1 - LLR ICB Pandemic Plan June 2026 • Appendix 2 - N ICB Pandemic Plan July 2026 • Appendix 3 - LLR ICB EPRR Policy June 2026 • Appendix 4 - LLR ICB Incident Coordination Centre Plan June 2026 • Appendix 5 - LLR ICB Business Continuity Management Policy June 2026 • Appendix 6 - LLR ICB Business Continuity Management Plan June 2026 • Appendix 7 - LNR ICB Cluster Incident Communications Plan May 2026 • Appendix 8 - LLR ICB Incident Response Plan May 2026 • Appendix 9 - NICB Incident Response Plan June 2026 • Appendix 10 - NICB Business Continuity Plan June 2026

Who has been engaged and where else has this report been considered:
There has been consultation on all the plans and policies with ICB staff and teams, the LRF and NHSE Regional EPRR team as per the requirements of the EPRR Core Standards process. The Plans and Polices have been to the ICB Joint Executive Team in July 2026 to seek approval and to recommend the plans and policies for Board sign off.

Implications: No specific implications in relation to this report.							
☐	**Quality & Patient Safety**	☐	**Legal**	☐	**Equality, Diversity & Inclusion**		
☐	**Environmental**	☐	**Data & Digital**	☐	**Financial**	☐	**Workforce**

EPRR Update and Plans and Policies
20 August 2026

Introduction

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

Compliance with the EPRR Core Standards Assurance Process

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

5. The assurance process uses organisational self-assessments of compliance with the NHS Core Standards for EPRR. The outcome of this process is used by organisations to identify areas of good practice and issues that require further development. Organisations use their self-assessment to guide their annual work plan and prioritise the development of local arrangements. As the ICBs are clustered and not merged, they remain as two distinct statutory organisations and so there will be two submissions of self-assessments against the NHS Core standards for EPRR in August 2026.

Training and Exercising

6. The ICB EPRR team have continued to offer role relevant training with a focus on the On-Call roles (Strategic and Tactical), EPRR and System Coordination Centre team roles as well as general awareness training. This training is provided through internally led sessions and external courses through partners such as the Local Resilience Forums including JESIP training, immersive TCG/SCG exercises, Loggist training and workshop sessions around subjects including Martyn's Law. All ICB staff are asked to maintain a Personal Development Portfolio (PDP) which aligns training to the National Occupation Standards (NOS).

7. ICB and external partner exercising also continues with the ICB exercising Incident Response Plans and Business Continuity Plans, as well as taking part in wider LRF and NHSE Regional exercising, including NHSE Regional Security, Evacuation and Lockdown Exercise and LRF Exercises covering fires and flooding. The ICB have also identified Executive Team members to undertake Multi-Agency Gold Incident Command Training (MAGIC) led by the College of Policing to ensure the ICB have staff able to lead the organisation as a Strategic Commander during a major incident or civil emergency.

Business Continuity

8. The ICB continues to develop integrated business continuity planning as a cluster with the development of new ICB teams to ensure we have robust plans in place to ensure critical health services can continue during disruptions. As part of the core standards the ICB EPRR team are also working with our supply chain to check that our commissioned providers including primary care have business continuity plans in place that are current, include action cards and have clear escalation processes in place. The ICB business continuity exercise also took place in August 2026.

Incidents

9. The ICB have experienced a number of incidents over recent months, some of these have been Fire/Police focused incidents, with minimal impact to Health, but have also included business continuity incidents within NHS Providers requiring ICB support. The ICBs have represented Health as invited at all Local Resilience Forum led Strategic Coordinating Groups (SCGs) and Tactical Coordinating Groups (TCGs) and provided feedback to health partners on actions and updates that may have an impact on their service users and service delivery. In all incidents, but especially the recent heatwaves, vulnerable residents were prioritised and the ICBs ensured medical needs were being considered, with support from provider organisations. The ICBs continue to contribute to LRF debriefs and support improvements to our collaborative planning. The ICBs are also actively engaged in any subsequent incident recovery groups.

10. The ICB coordinated and supported system planning and response to BMA members industrial action and provided assurance to NHSE regional teams for national reporting, escalating any capacity issues and system pressures during industrial action. It should be noted that there was an increased focus on UEC performance and pressures during the recent periods of industrial action, particularly around ambulance delays.

Lessons Identified and Continuous Improvement

11. The ICB and wider systems continue to take learning from all events, with debriefs taking place following all incidents, and changes made to plans as appropriate. The ICB continues to support system partners in their management and response to incidents.

EPRR Plans and Policies

12. The NHS Core standards for EPRR stipulate that EPRR Plans should be

    a. Current (reviewed in the last 12 months)
    b. In line with current national guidance
    c. In line with risk assessment
    d. Tested regularly
    e. Signed off by the appropriate mechanism
    f. Shared appropriately with those required to use them
    g. Outline any equipment requirements
    h. Outline any staff training required
    i. Consultation process in place
    j. Changes to arrangements as a result of consultation are recorded.

13. The Plans attached to this paper have been reviewed in line with the above and consultation has taken place with relevant ICB staff and teams, the LRF and NHSE. All feedback from consultation has been logged as part of the ICB EPRR consultation process and changes to plans and polices are referenced in the change log.

14. As part of the Core Standards process there is a requirement for the ICB Board to approve and sign off all EPRR plans and policies.

15. The ICB EPRR team are currently working on alignment of all EPRR plans and policies with the aim of having a EPRR single plan or policy for the ICB cluster. This will support future training for on call staff, clarify processes and actions regardless of which ICS footprint an incident takes place and support any future merger of the ICBs.

Recommendations:

RECEIVE assurance of the ICB's processes that meet the responsibilities of being a Category 1 responder under the Civil Contingencies Act (2004) and to meet the NHS Core standards for EPRR.

APPROVE the following LLR ICB and NICB EPRR Plans

- LLR ICB Pandemic Plan June 2026
- NICB Pandemic Plan July 2026
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- NICB Business Continuity Plan June 2026

Boards Meeting in Common in Public

Report Title: Phlebotomy Business Case

Date of Meeting: Thursday 20 August 2026

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

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Phlebotomy Business Case**		
Paper Reference No:	**ICBIC-26-43**	**Agenda Item No:**	**9.**

Presented by	**Nicki Adams, Director of Integration** **Peter Watson, Assistant Director of Integrated Commissioning, Community, CYP and Women's**
Report Author(s)	**Peter Watson, Assistant Director of Integrated Commissioning, Community, CYP and Women's** **Megan Fielding, Senior Strategic Commissioning Manager**
Executive Sponsor	**Eileen Doyle, Chief Delivery Officer**

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

Recommendations

Board is asked to:

- Review the business case, noting associated risks and benefits
- Approve Option 3 as the preferred delivery model
- Approve Phase 1 urgent award to enable mobilisation from November 2026, noting and including the in-year financial impact
- Recognise the associated financial pressure
- Approve the delegation of decision making around any change to the financial envelope required for the indicative UHN residual GP-requested Phlebotomy service to the ICB's Joint Executive Team.
- Approve progression to Phase 2 business case and procurement development, to begin once Phase 1 has been awarded and mobilised

Executive Summary of the report

University Hospitals of Northamptonshire served 12 months' notice on community (usually GP-requested) Phlebotomy in January 2026. This does not include secondary-care initiated phlebotomy, urgent phlebotomy (for example A&E), Community Diagnostic Centre (CDC) activity, pathology lab or transportation of samples. Access to Phlebotomy is a critical enabler for diagnostic pathways and the initiation and monitoring of medications. There are significant patient safety and clinical risks should the notice period end without a viable alternative service in place.

Current Model

The model of delivery in Northamptonshire is mixed. UHN primarily deliver non-urgent phlebotomy for North Northamptonshire via a hub and spoke model, and for the Northampton town area in West Northamptonshire via Northampton General Hospital's Blood Taking Unit. Primary Care also undertake a large amount of Phlebotomy via their in-house services, contracted under a Locally Enhanced Services (LES) contract. However, not all practices are signed up to the LES or deliver activity. There are currently long waits across the county, which have peaked at approximately 8-12 weeks, and poor patient experience under this model.

Finance

UHN are commissioned under a Block contract arrangement.

The tariff payment under the Primary Care LES service is £2.50 per adult test, which is less than is paid in both Leicestershire, Oxfordshire and Cambridge & Peterborough, therefore there is little incentive to run Phlebotomy services at practice level. The new service options are modelled on using the Leicestershire tariff, which was an analysis-based tariff developed by LLR. Due to its well-researched development and successful implementation, the commissioning team are satisfied that the tariff is appropriate for deployment throughout Northamptonshire. The business case explores the financial position in more detail, providing financial and activity forecasts for in year impact, 12-18m impact (Phase 1 of preferred model) and 5 year impact.

The table below shows the financial pressure in-year impact for month 8-12 2026/27 (year 1), and recurrent impact from 2027/28 (year 2). This will be reflected into Month 4 Forecast Outturn (FOT) position.

	Impact Against Budget				
£'000s	Year 1 (PYE M8-12)	Year 2	Year 3	Year 4	Year 5
Current Cost	£295,301	£1,186,965	£1,186,965	£1,186,965	£1,186,965
New Service Cost	£1,292,458	£2,713,578	£2,732,991	£2,752,954	£2,772,938
Notional UHN residual	£8,333	£50,000	£51,015	£52,051	£53,107
Cost Pressure	**£1,005,490**	**£1,576,613**	**£1,597,041**	**£1,618,039**	**£1,639,081**

Nb: Year 1 (2026/27) includes cost of dual running and recovery of waiting times to no longer than two weeks

Options

The business case sets out the opportunity to “left-shift” services into the Community, at practice and/or Neighbourhood level, in line with local and national strategic direction. It sets out a range of options for consideration and has modelled activity and cost for the preferred proposed option, Option 3. Option 3 is a practice or neighbourhood-based service. This will be commissioned via a Primary Care at scale provider, to meet local population need, and is intended to be delivered in two phases:

Phase 1: 12 month (+6 month extension) Urgent Award to stabilise services and ensure viability of model and improve access, experience and outcomes. Weekend operation may be limited.

Phase 2: Procurement of medium-term service (term to be confirmed) and potential bundling with other diagnostic testing to form a Neighbourhood-based, Primary Care-led (list-based) diagnostic service. Renegotiation of Pathology lab operating times and sample transportation arrangements may be required to support 7 day operating and equitable access.

There is a potential to move to a block funding arrangement after Phase 2, once there is enough robust data in place to assume an appropriate contract value.

The LNR Provider Selection Delivery Group approved the approach for Phase 1 on 19 June 2026. There is a risk of challenge to the Urgent Award, however this is believed to be low.

The Community commissioning team propose a new service would need to go live in November 2026 to allow for stress testing and waiting list reduction prior to the notice period ending. A residual service will likely be required in UHN to manage certain population groups and esoteric testing. The business case proposes a notional amount of funding is set aside for this, if required, following negotiation with UHN.

Board is asked to note that funding this new service will incur a cost pressure, however, this has been highlighted in previous papers to JET, who have endorsed the position that “right-sizing” of funding is required. UHN served notice once the 2026/27 financial plan had been agreed and therefore the cost pressure is not within the financial plan.

Risk

This programme has a number of risks. Some of these are inherent to the commissioning process, but many have emerged as Commissioners work through the process to design, gain approval for a and award a new service, at pace, under constrained timeframes.

A risk log is in place and key risks are below. An ICB phlebotomy steering group meets weekly and is cited on risk.

Risk / Issue	Impact	Mitigation
Lack of service for GP-requested phlebotomy from January 2027	Patient harm through delayed access to diagnostics Reputational risk	Commissioning of new service

	Inability to provide critical function and discharge statutory duties Lack of business continuity Increased referrals to/attendance at acute hospital setting Increased GP demand causing unsustainable activity.	
Limited service or reduced availability during transition period between service	Gap in service Reduced capacity Increased waiting list Exacerbation of current issues	Working groups set up with both incoming and outgoing provider to manage transition. UHN committed to sustain service until end date.
Unwarranted overactivity under new contract(s) – this includes UHN residual service	Financial exposure Patient experience impacted as blood test requests not consolidated	Monitoring routes being established as part of contract development
Legal challenge on procurement process	Urgent award decision overturned Re-evaluation or restart of the procurement procedure Payment of damages to incoming provider for loss of profit Payment of civil penalties Shorten duration of unlawful contract Break in service	Procurement advice followed Publish transparency notice citing future plans
Potential ICB exposure to TUPE of staff	Incoming provider would bear risks of TUPE, which may impact willingness to take on contract. Clarity regarding redundancy risks upon contract end	ICB seeking formal clarification from UHN as to whether TUPE applies with a dispersed staffing model
Challenges in sourcing reliable, accurate and readily available data	Service demand and capacity difficult to forecast Modelling work done at speed once data is released and therefore more prone to error Financial exposure as forecast based on unreliable data set Data provided manually counted due to lack of data capture system, and therefore more prone to human error Development of residual service is slower than anticipated Limited ability to capture outcomes in new service due to transactional nature of service	Working groups set up with both incoming and outgoing provider. This is supporting provision and review of data and is beginning to reduce the risk Data requests escalated.
Nerve Centre (NGH) / Order Comms (KGH) deployment means GPs will be unable to view UHN-requested phlebotomy requests	Shared care will be more difficult to achieve, with immediate workaround required for immunosuppressed patients NGH patients requiring community blood tests will need to be handed a paper form KGH patients with secondary-care requested blood tests will not be able to access these in the community UHN's core blood taking service may be larger than anticipated Size of community phlebotomy service may be smaller than anticipated	Comms requested from UHN Commissioners joined session with UHN advising of changes. JET briefed by Dr Naomi Caldwell, Deputy CMO.
Community Diagnostic Centre (CDC) activity may fall below plan	Reduction in performance against CDC activity plan	Monitored at working group. UHN to take a strategic approach in planning their core

	Potential clawback of funding by NHSE, worsening system financial position as CDC phlebotomy tariff is significantly enhanced.	and residual activity to ensure CDC targets and financial flows are maintained

Progression of the Business Case

The business case was presented to the cluster's Provider Selection Delivery Group on 19 June 2026. This group **endorsed** the Urgent Award approach requested for Phase 1.

It was then presented to JET on 24 June 2026. They formally **supported** the business case, and for it to progress to Committee stage.

Both the Joint Finance & Contracting Committee (JFCC) and the Joint Commissioning Strategy Committee (JCSC) received this business case for consideration on 7 July 2026 and **endorsed** progression to ICB Board.

The cluster ICB's Chief Finance Officer also raised this matter at Spend Review Panel in July 2026.

ICB Board is the final step in the approval process. Noting that the Business Case will be presented to Board for approval in line with the ICB's Schedule of Reservation and Delegation (SORD) as approved by the Board in March 2026, due to this being outside of budget and noting that the full year and part year impact this year will be reflected in to the Month 4 Financial position (which will be presented to this meeting under a separate agenda item).

The authors thank the Board for their consideration of this matter.

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

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

Conflict noted for the Partner Member for Primary Medical Services for the NICB Board, as a GP who is currently practicing, or holds financial interest in any GP Practices, Primary Care Networks, or Federations in Northamptonshire.
Conflict noted for the Partner Member for NHS Trusts/Foundation Trusts for the NICB Board, who is a member of the 3Sxity Federation Board representing NHFT.
Conflict noted for Partner Member for NHS Trusts/Foundation Trusts for the LLR ICB Board, who is in attendance at the NICB Board, as the party who served notice on the current service and is provider of the residual service.

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No:	**NICB BAF No:**
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare. **BAF 2 – Health Inequalities** Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR. **BAF 3 – Demand and Capacity** Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care. **BAF 5 – Quality and Safety** Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients. **BAF 10 – NHS Reforms and lack of financial**	**BAF 1 -** Failure to provide robust quality governance oversight and assurance processes in line with the National Quality Board (NQB) Standards and Statutory Duties. **BAF 2 -** The ICS fails to deliver an effective People Strategy and operational delivery plan that meets the current and future workforce requirements. **BAF 3 -** Failure to ensure delivery of clinical and/or operational performance standards and ensure access to services meets the need of the population and regulators. **BAF 8** – Failure to deliver longer term financial sustainability. **BAF 9** - ICB fails to deliver scope and pace of NHS Reforms.

resources The ICB is unable to enact and deliver the required NHS Reforms due to a lack of additional financial resources to support implementation.	**BAF 10** - ICB fails to deliver against its strategic objectives and operational plans, and risks non-compliance with statutory duties.

Appendices	**Appendix 1 - Business case Presentation** **Appendix 2 - Draft NICB Adult & CYP Phlebotomy v0.4 specification** **Appendix 3 – Initial Equality, Quality and Health Inequalities Impact Assessment (EQHIA)** ***Note: Appendices embedded within Appendix 1 are available upon request.***

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

LNR Procurement Group endorsed the approach for Urgent Award on 19 June 2026

Joint Executive Team (JET) supported the business case, including the preferred model option on 24 June 2026. Amendments have been made to the business case in line with feedback, to give more detail on the 2026/27 in year financial impact.

Both the Joint Finance & Contracting Committee (JFCC) and the Joint Commissioning Strategy Committee (JCSC) received this business case for consideration on 7 July 2026 and endorsed progression to ICB Board. The JFCC confirmed that the service will be funded in 2027/28 through funding growth and this was discussed as part of a pre-planning discussion at the JFCC on 4 August 2026.

There is a programme group which has contributed to this business case, including representatives from:

- Population Health and BI
- Finance
- Contracting
- Primary Care (Northamptonshire and Leicestershire)
- Communications & Engagement
- Quality and Nursing
- Procurement
- Integration

Dr Azhar Ali is the assigned clinical lead. The Business Case has been signed by key leads.

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

Appendix 1

NHS
Northamptonshire
Integrated Care Board

Northamptonshire Phlebotomy Long Form Business Case

August 2026

Version: Final v0.3

Business Case Checklist

Cover sheet fully completed including: • **High level financial summary** • **Governance Approval** • **Review & Sign off**	Page 4. Initial Director/Heads of Approval
Has the source of funding been identified?	The additionality for this business case is outside of the 2026/27 financial plan as notice was received after the plan was submitted. Therefore, additionality will require sign off via the agreed ICB sign off route, with ultimate approval at ICB Board.
Is the business case consistent with a core service specification for Northamptonshire ?	Yes – aligned to draft Northamptonshire Adult & CYP Phlebotomy Service Specification (Appendix 3) and based on LLR model.
Is this a new clinical pathway ?	No – this is a redesign of an enabling diagnostic service supporting multiple clinical pathways.
If this is a new clinical pathway has it been approved / supported by the appropriate clinical group ?	N/A
If no, please state the date when the service specification will be completed?	Complete and appendices, based on existing LLR specification
Confirmation that this service does not duplicate other services commissioned by the ICB?	Confirmed – excludes CDC and district nursing services; complements existing diagnostic pathways and replaces UHN provision.
Are Benefits / KPIs clearly stated and measurable ?	YES
What procurement approach will be taken ?	Two-phase approach: • Phase 1: Urgent Award (12 + 6 months) to GP Federation Lead Provider • Phase 2: Most Suitable Provider or Competitive Tender (5 + 3 years)
What is Length of Contract (including option to extend?	Phase 1: 12 months (+6 month extension) Phase 2: 5 years (+3 year extension option) Standard NHS Contract break clauses apply (termination for convenience and breach).
Option to terminate – what is the break clause?	As per NHS Standard Contract

Business Case Cover Sheet

Unique Ref. No.		Version	xxxxxx

Scheme Title	Northamptonshire Phlebotomy Service
One Line Description	Commissioning of Phlebotomy (venepuncture) services in Northamptonshire
Scheme SRO	Eileen Doyle
Scheme Lead	Julie Lemmy/ Peter Watson

One-off or Recurring Investment	Recurring
Funding Source	Existing budget and additional funding

Target Start Date	November 2026	Target End Date	Recurrent

High-Level Financial Summary:

	Impact Against Budget				
£'000s	Year 1 (PYE M8-12)	Year 2	Year 3	Year 4	Year 5
Current Cost	£295,301	£1,186,965	£1,186,965	£1,186,965	£1,186,965
New Service Cost	£1,292,458	£2,713,578	£2,732,991	£2,752,954	£2,772,938
Notional UHN residual	£8,333	£50,000	£51,015	£52,051	£53,107
Cost Pressure	**£1,005,490**	**£1,576,613**	**£1,597,041**	**£1,618,039**	**£1,639,081**

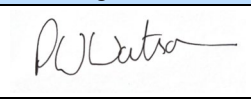
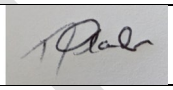
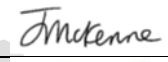
Governance

(By which forums has the business case been reviewed? What was the outcome of the review?)

Forum	Date Reviewed	Status	Conditions / Comments from Forum
LNR Procurement Group	19th June 2026	Approved	Noting risks re urgent award
Joint Executive Management Team	24th June 2026	Endorsed	
Strategic Commissioning Committee	7th July 2026	Endorsed	
Finance Committee	7th July 2026	Endorsed	
Board	August 2026		Final version with amends in line with feedback from sign off process and working groups

Review & Sign off

(Which stakeholders have been consulted and have approved the case ?)

	Mandatory			
	Name	Position	Signature	Date
Budget Holder	Peter Watson	Assistant Director of Integration: Community, Women's Health and CYP		11th June 2026
Primary Care	Julie Lemmy	Director of Primary Care		16th June 2026
Primary Care	Keiren Leigh	Head of Primary Care		17th June 2026
Finance Lead	Nigel Mander	Interim Deputy CFO		12th June 2026
Procurement	Andrew Taylor	Procurement Specialist	Andrew Taylor	08 June 26
Contracting	Jo McKenna	Assistant Director of Contracts and Procurement		19th June 2026
Population Health	Paul Birch	AD Population Health and Intelligence		18th June 2026
Quality	Mandy Staples	Director of Nursing		03 June 26

	Other stakeholders relevant to the scheme			
	Name	Position	Signature	Date
Clinical Lead	Az Ali	Clinical Lead for Cancer Elective Care and Respiratory		12th June 2026

Business Case – Long Form

1. Executive Summary

Background

On 15 January 2026, UHN served 12 months' notice on non-urgent GP requested Phlebotomy, which forms part of their block contract, citing rising demand. Phlebotomy is delivered via a mixed model in Northamptonshire, via both acute hospital sites under a block contract, and Primary Care via a Locally Enhanced Servies (LES) contract, on a local tariff. The mixed model is inequitable, with long waits of 2-3 months in places and reliance on acute hospital blood taking units in more urban areas, where there are significant access challenges.

Phlebotomy is a critical enabler for diagnostic pathways and condition management; therefore, this has promoted an urgent need to recommission a single service which incorporates both UHN activity and non-urgent GP requested phlebotomy undertaken in Primary Care. It has been accepted, via previous papers to Joint Executive Team (JET), that Northamptonshire ICB has historically underinvested in phlebotomy, and it is appropriate for a new, tariff-based model to match the tariff paid to Primary Care in Leicestershire & Rutland.

Proposal & Preferred Option

Commissioners have provided a number of options for consideration but have evaluated Option 3 (see Section 3: Economic Case and Options Appraisal), to commission a practice/ neighbourhood service at scale, through a Lead Provider model, to be the most appropriate. There are significant clinical, patient harm and reputational risks attached to a "do nothing" approach.

Commissioners are seeking permission to procure this service in two phases:

Phase 1: an **Urgent Award for 12 months** (plus an optional 6-month extension) to a **GP Federation.**

The service will be provided locally by GP Practices, moving towards a Neighbourhood-based model. To stress-test the new model and enable waiting lists to be reduced prior to the cessation of the UHN service, Commissioners propose a period of double running, with a **new service going live, in phases, from November 2026.** Alongside this, LES activity will also be wound down, with this ceasing on 31 March 2027.

Phase 2: procure a **medium-term service** (suggested 5years + an optional 3-year extension) for a practice/ neighbourhood service via **Primary Care** at scale. Via either the Most Suitable Provider or Competitive tender process.

The model will be equitable and fully aligned to Neighbourhoods using learning from the Urgent Award period and may also extend the scope of the service to cover weekend activity (which may require renegotiation and subsequent investment into pathology lab and blood sample transport with UHN to increase capacity and remodelling of Extended Access).

An assessment of the available options is made within this business case. Option 3 (a primary care at scale offer) is assessed as the most appropriate as it provides the most robust and deliverable solution by:

- ensuring rapid mobilisation within required timescales
- delivering consistent, equitable access across the county by practices
- providing system-level coordination through a Lead Provider, with practice level delivery

- aligning with neighbourhood care and diagnostic strategies
- Alternative options were discounted due to risks of fragmentation, insufficient coverage, or inability to mobilise at scale.

The proposed model represents a recurrent cost pressure, increasing total annual spend from c.£1.18m to c.£2.7m by Year 2. This reflects correction of historic underinvestment, increased activity and demand growth, and transition from block to tariff-based model. The investment is currently unfunded within the financial plan and requires Board approval.

Early engagement suggests Commissioners' preferred option to be viable, and broader engagement will be undertaken as part of Phase 2. Five-year activity and finance forecasts have been undertaken to support model development, and specification development is underway.

Commissioners thank all involved for their contributions in developing this business case at pace, and JET and all relevant Committees for their consideration of, and support in this matter.

Key Delivery Timescales

Indicative key delivery timescales, along with the proposed phased procurement approach are outlined below, subject to business case approval.

Proposed Phase	**Indicative Timescale**	**Proposed Procurement approach**
Phase 1 Go Live	November 2026	Urgent Award 12+6m
Phase 2 Go Live	November 2027 *(May 2028 if 6m extension invoked)*	MSP/Competitive process 5+3y

Funding

Based on 2025/26 the ICB currently spends £1.18m on Phlebotomy services across UHN and Primary Care as per below table.

Provider	**Contract Type**	**Baseline 2025/26** *for information*	
		Activity	**Cost**
		ea	**£**
Current scheme			
NGH	Block	53,226	352,282
KGH	Block	209,864	18,986
LES	Activity	323,727	809,935
		586,817	1,181,203

2025/26 activity and spend has been used as the baseline for the business case, with demographic growth applied to future years. Finance assumptions are listed in the financial summary at the start of this business case, and within the finance section.

As notice came part way through January 2026, funding of the new model was not included in the 2026/27 plan. As the funding of the new model is outside of the financial plan, and mitigations cannot be identified to offset, final approval of the case via the ICB Board will be required.

Key benefits

- Delivery of programme ambitions
- Delivery of national policy
- Delivery of ICB strategic priorities
- Enhanced outcomes for patients
- Reduced referrals into secondary care
- Improved patient satisfaction with access
- More sustainable approach to surge during winter
- Reduction in routine waiting times from 2–3 months to ≤2 weeks
- Delivery of >600,000 tests annually within primary care settings
- Improved access through practice and/or neighbourhood-based provision
- Reduced reliance on acute hospital sites
- Better support for long-term condition management and early diagnosis

Key risks

- Lack of service for non-urgent GP requested phlebotomy from 15 January 2027
- Limited service or reduced availability during transition period
- Unwarranted overactivity and financial impact
- Legal challenge on procurement process
- Potential ICB exposure to Transfer of Undertakings Protection of Employment (TUPE) of staff.
- Logistical capacity via Pathology block contract

These risks are mitigated through phased implementation, dual running, and planned procurement of a longer-term solution.

Decision Required
The Board is asked to:

1. Approve Option 3 as the preferred delivery model
2. Approve Phase 1 urgent award to enable mobilisation from November 2026
3. Approve the associated financial pressure
4. Endorse progression to Phase 2 procurement

2. Strategic Case

2.1 Problem Statement & Case for Change

Background

- There is currently, and has historically been a mixed model of Phlebotomy delivery in Northamptonshire, with significant amounts undertaken in both Primary Care and at University Hospitals Northamptonshire (UHN), although proportions vary between North and West Northamptonshire, and between urban and rural areas.
- UHN has been funded on a “block”, with minimal specific funding identified against the service line.
- Primary Care has been funded on a “cost x activity” model, but feedback from GPs is that the funding levels are not sufficient to cover costs and are less than neighbouring counties. For

example, NICB currently pays £2.50 per adult, whereas LLR is £4.38 and Oxfordshire is over £5.00.

UHN Notice

- On 15 January 2026 UHN served 12 months' notice on the provision of "Community" requested Phlebotomy in the county (venepuncture blood sample activity requested outside of the hospital) (Appendix 1).
- The notice letter cites "sustained and escalating demand" as a key driver for serving notice, and that "last year (2025) the phlebotomy service across UHN bled over 400,000 community and OPD patients. (293,000 at KGH and 107,000 at NGH) The majority of referrals (74.4% KGH 57% NGH) originate from GPs, with daily averages exceeding 1,100 GP-related tests." Phlebotomy activity data from UHN over the 2025-26 period shows that **263,090** tests were carried out. This is in addition to practice-based activity of **323,727** tests over the same period.
- Please note higher levels in the North of the system are due to the "hub and spoke" model provided by KGH.
- Provision of community Phlebotomy is critical within the local health economy. Therefore, Northamptonshire ICB needs to rapidly commission a viable alternative service to ensure continuation of service and create a model which is both fit for purpose now and aligned to future direction of travel as outlined in both national policy and local strategic aims.
- Joint Executive Management Team (JET) were briefed on three occasions following notice being served (Appendix 2) and endorsed the approach outlined in the business case of exploring options based on the LLR model.

Furthermore, and strengthening the case for change:

- The current arrangements for Phlebotomy in Northamptonshire are fragmented. Delivery is split between Primary Care and UHN and patients often face considerable waits (2-3 months) to access non-urgent Phlebotomy. Patient experience is variable, with many now having to travel to an acute hospital site to access Primary Care requested Phlebotomy due to an imbalance between increasing demand and Primary Care capacity. Patients also face the challenge of finding suitable parking in time for their appointment when travelling to an acute site.
- Current arrangements are seen to exacerbate health inequalities with specific impact on patients with multiple conditions who are likely to require multiple annual blood tests and through access and financial pressures in relation to travelling to and parking at Acute sites
- The data available to effectively monitor and manage capacity and demand is also variable and does not always provide sufficient insight.
- The majority of ICBs in England use Primary Care to provide Phlebotomy services for Primary/Community requested blood samples.

In deciding the ICB's next steps, there is an opportunity to improve the Phlebotomy pathway, improving patient experience, enabling flexibility in response to seasonal demand and Quality Outcomes Framework (QoF) related fluctuation in activity, and to optimise venepuncture episodes by using data-driven insights to rationalise testing at patient level. This business case presents the options available to the ICB, assessing these using the ICB business case criteria and presents a preferred option for ICB consideration and agreement.

System Impact, Interdependencies & Opportunity Statement

Failure to implement a replacement model before January 2027 will have system-wide consequences:

- Increased pressure on urgent and emergency care due to unmanaged conditions
- Delays across diagnostic and elective pathways
- Reduced GP capacity as clinicians manage risk without timely diagnostics
- Worsening health inequalities due to access barriers
- Increased reputational and regulatory risk to the ICB

This is not a contained service issue. It represents a critical risk to the functioning of the wider health system.

The phlebotomy service is a key dependency for community diagnostic pathways, long-term condition management programmes, elective recovery and outpatient transformation, and virtual wards and proactive care models. Failure to resolve phlebotomy capacity will directly constrain delivery of these programmes.

This change is not solely a mitigation response but an opportunity to standardise and modernise diagnostic access, embed neighbourhood-based care delivery, improve data visibility and demand management, and create a platform for wider community diagnostics transformation.

2.2 Commissioning Approach

Given the time available to establish the new service, and to ensure the ICB meets Provider Selection Regime (PSR) procurement rules, it will be necessary to carry out a two phased approach.

- Phase One, Urgent Award: An urgent award for an initial 12-month period with the option to invoke a 6-month contract extension as required allowing the Commissioner time to stabilise the service while an MSP or Competitive process is undertaken for a long-term solution. This business case will set out the options available to the ICB for the urgent award and make a recommendation on preferred approach. Noting that Community Diagnostic Centre (CDC) related Phlebotomy is outside of the scope of Phase One as notice has not been received on this. Also out of scope are transport and laboratory costs.

- Phase Two, Community Phlebotomy Service: A recurrent long-term (5 years Plus 3) solution is established and procured via MSP or Competitive process during Phase 1. Commissioners may want to consider a block contract at this point, should the service have stabilised. Commissioners would need to be satisfied that there is enough reliable current and historical data to undertake demand forecasting to determine an appropriate contract value. Additional weekend UHN lab activity and associated transport costs capacity may also need to be renegotiated at this point, if engagement shows that weekend activity is key to ensuring equitable service access and a flexible, resilient model.

2.3 Current Contractual Arrangements

2.3.1 UHN

UHN is predominantly funded through a “block” (i.e. they receive a fixed financial amount) to deliver Phlebotomy. This excludes Pathology, Transport costs. Notice has been served and this service will cease in January 2027.

UHN provide an element of Phlebotomy through “Oakleaf” Community Diagnostic Centre (CDC) in Corby. Notice has not been served on this element of the service. Activity is paid for on a cost per case basis, with a specific allocation received from NHS England (NHSE). It is expected that, in time, the allocations for CDC will move into ICB baseline and therefore the required expansion to support incorporation of this activity should be considered when selecting the most appropriate delivery model. However, CDC activity is outside of the scope of phase one.

2.3.2 Northamptonshire Primary Care

Phlebotomy is delivered through a Locally Enhanced Service (LES). The majority of practices are signed up to the LES; however active utilisation is predominantly in the West of the County. This contract is renewed annually, and ceases at the end of March 2027, unless renewed.

2.3.3 Northamptonshire Community Care

District Nursing at Northamptonshire Healthcare NHS Foundation Trust (NHFT) for “Phlebotomy for patients on existing caseload”. This is provided to people who find it extremely difficult to attend a health care setting to receive treatment. This is not within the scope of this business case at this stage. Noting there needs to be further review and understanding of referrals into this service and how this is commissioned, this is outside of the scope of this business case.

2.3.4 Leicester, Leicestershire & Rutland (LLR)

For reference, LLR have two Locally enhanced services (LES) in place with Primary Care, one for 12–15-year-olds, and one for 16+. Children under the age of 12 are seen by Leicestershire Partnership Trust (LPT). To inform their tariff a significant amount of analysis and modelling was undertaken.

2.4 Clinical Pathways

Whilst Phlebotomy/Venepuncture is not a clinical pathway in its own right; timely and reliable access to blood taking is a critical enabler for the effective delivery of multiple pathways across primary and community care. It underpins early and accurate diagnosis by supporting essential investigations and is equally important for the ongoing management and monitoring of long-term conditions such as Diabetes, Cardiovascular Disease (CVD), Chronic Kidney Disease (CKD), and inflammatory disorders (for example Arthritis and Crohn’s Disease).

Delays or constraints in access to phlebotomy can directly impact clinical decision making, treatment optimisation, and continuity of care, while efficient provision helps Primary/ Community care teams to manage patients closer to home, ensure quality of referrals, and support proactive, preventative care models.

The current model drives avoidable utilisation of acute hospital sites for routine blood testing. Transitioning activity into Primary Care will reduce footfall in acute outpatient departments, improve patient flow and reduce congestion and release acute workforce capacity for higher-acuity care. This supports system priorities to reduce avoidable hospital use and optimise resource allocation.

Phlebotomy/ Venepuncture aligns closely with the emerging neighbourhood care agenda within Northamptonshire, which seeks to organise care around proactive, place based multidisciplinary teams serving defined local populations. Neighbourhood models depend on timely diagnostic and monitoring information to support shared decision-making, anticipatory care, and coordinated management of people with complex and long-term conditions. Locally accessible Phlebotomy enables clinicians to intervene earlier, monitor risk more effectively, and reduce avoidable escalation to acute services. By supporting population health management, continuity of care, and care closer to home, phlebotomy acts as a key operational enabler of neighbourhood teams.

2.5 Service Model

- Deliver access to routine phlebotomy tests for Children and Young People (CYP) (those between 12 – 15 years and 364 days of age) and adults (aged 16+) in General Practice to negate patients needing to go to an acute trust.
- Build on the model to ensure that services are practice led, localised, convenient, integrated and easily accessible for patients. This should include options to book tests on specific days, for example, tests required at a specific point in a patient's hormonal cycle.
- Provide a robust, flexible and patient-focused high-quality phlebotomy service.
- The Providers will advertise how patients can access the service in waiting areas and any leaflet which promotes the ranges of all services that are delivered, in a format that is accessible and inclusive.
- The procedure should be undertaken utilising best practice guidelines including as a minimum hand washing, cleanliness (alcohol) of the insertion site, correct equipment / consumables and documentation.
- Responsibility for clinical interpretation and action remains with the requesting clinician.
- Clinically warranted as part of acute or chronic health concern indicating the need for venepuncture for the investigation or monitoring of confirmed or suspected illness. The contract specification will include a range of included tests, which is attached at Appendix 3.
- Please note due to storage/ handling requirements it is expected that small number of tests will need to continue to be done at UHN. An initial assessment indicates that these are unlikely to be requested directly by Primary Care. These include, but are not limited to:
    - Acute Porphyria Screen
    - Bullous Porphyria Screen
    - Cytogenetics
    - EPO
    - Quantiferon
    - White Cell Enzymes

The Provider must transcribe Anglian ICE pathology laboratory results into the patients' clinical records in the timeframes set put in the providers workflow policy. The service will be sensitive to individual patient needs, ensuring that adherence to the protected characteristics. The service should be offered within Core hours and/or enhanced access hours by a suitably qualified person, qualified to undertake venepuncture procedures.

Noting the ICB will require ongoing work with UHN regarding Phlebotomy services for GP requested phlebotomy for 0–11-year-olds. Currently data for this is not available.

2.6 Population profile

2.6.1 Joint Strategic Needs Assessments (JSNAs)

Both the North and West Northamptonshire's JSNAs describe a population that is growing faster than the national average and ageing, increasing demand for healthcare services, particularly for diagnosis, monitoring, and long-term condition management in primary and community care.

Key Population Health Issues

The JSNAs identify a high and rising burden of long-term conditions including cardiovascular disease (CVD), cancer, chronic respiratory disease, musculoskeletal conditions, and poor mental health. These are major drivers of ill-health and premature mortality and require regular monitoring, often through blood testing.

Significant inequalities exist linked to deprivation, rurality, and inclusion health groups. Areas such as Corby, Wellingborough, and Northampton experience lower life expectancy and poorer outcomes. Barriers such as travel, work constraints, and system complexity affect access to care.

The system relies heavily on hospital-based care and is stronger at treating established illness than preventing it. Increasing demand highlights the need for earlier intervention and prevention.

The JSNAs emphasise strengthening prevention, early diagnosis, and population health management, particularly for conditions detectable through routine testing such as diabetes, hypertension, kidney, and liver disease. Core20PLUS5 priorities reinforce early diagnosis and chronic disease management.

Taken together, both JSNAs describe a population with:

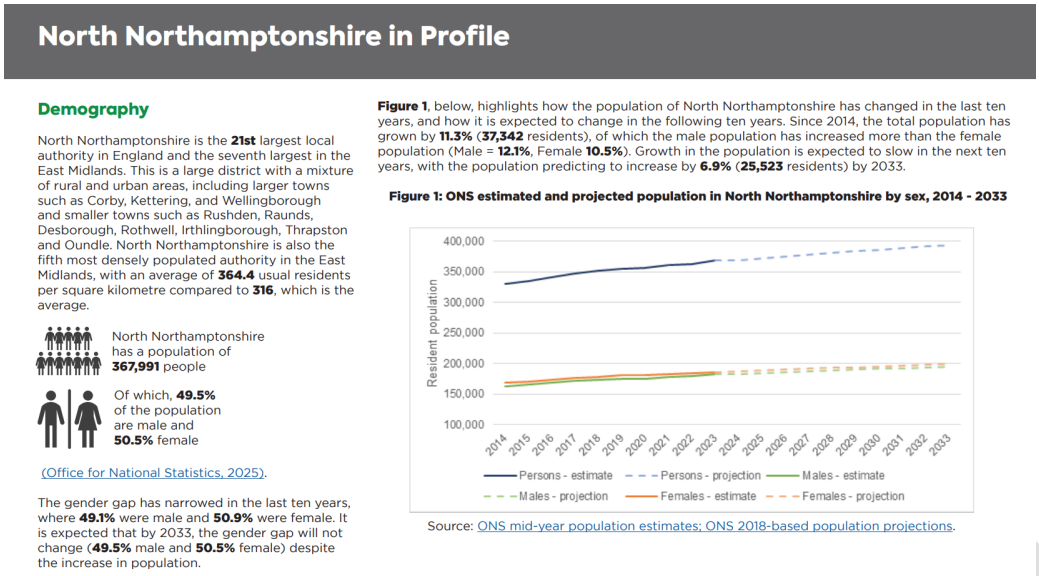
- Growing and ageing demographics
- High and rising long-term condition burden
- Significant health inequalities
- A strategic shift from reactive to preventative care

Within this context, Phlebotomy is a critical enabling service supporting early diagnosis, proactive long term condition management, health inequality reduction, and the wider shift from hospital-based to community-based care. While not a pathway, its accessibility and capacity directly influence the system's ability to respond effectively to the population health needs identified across Northamptonshire.

Figure 2.6.1 West Northamptonshire Council JSNA

Source: https://www.westnorthants.gov.uk/health-and-wellbeing-board/joint-strategic-needs-assessment-jsna

Figure 2.6.2 North Northamptonshire Council Demography Profile



North Northamptonshire in Profile

Demography

North Northamptonshire is the **21st** largest local authority in England and the seventh largest in the East Midlands. This is a large district with a mixture of rural and urban areas, including larger towns such as Corby, Kettering, and Wellingborough and smaller towns such as Rushden, Raunds, Desborough, Rothwell, Irthlingborough, Thrapston and Oundle. North Northamptonshire is also the fifth most densely populated authority in the East Midlands, with an average of **364.4** usual residents per square kilometre compared to **316**, which is the average.

North Northamptonshire has a population of **367,991** people

Of which, **49.5%** of the population are male and **50.5%** female

(Office for National Statistics, 2025).

The gender gap has narrowed in the last ten years, where **49.1%** were male and **50.9%** were female. It is expected that by 2033, the gender gap will not change (**49.5%** male and **50.5%** female) despite the increase in population.

Figure 1, below, highlights how the population of North Northamptonshire has changed in the last ten years, and how it is expected to change in the following ten years. Since 2014, the total population has grown by **11.3%** (**37,342** residents), of which the male population has increased more than the female population (Male = **12.1%**, Female **10.5%**). Growth in the population is expected to slow in the next ten years, with the population predicting to increase by **6.9%** (**25,523** residents) by 2033.

Figure 1: ONS estimated and projected population in North Northamptonshire by sex, 2014 - 2033

Source: ONS mid-year population estimates; ONS 2018-based population projections.

Source: https://www.northnorthants.gov.uk/health-and-wellbeing-board/reports-assessments-and-strategies/public-health-reports

2.6.2 Initial Equality, Quality & Health Inequalities Impact Assessment (EQHIA)

An initial EQHIA assessment has been undertaken by the ICB Population Health Team (Appendix 4). This has highlighted the following key areas in relation to engagement, human rights, quality and Core20plus.

- Inequitable access for Core20+ groups
- Insufficient capacity leading to delays
- Disproportionate access burden for patients requiring frequent testing

The provider(s) of services will be expected to undertake a full EQHIA and ensure that all issues and risk identified are addressed in their final solution.

2.6.3 Recommended Engagement Approach

- Primary Care (Local Medical Committee (LMC), Primary Care Networks (PCNs), Practices)
  - Providers (existing and potential)
  - Voluntary, Community, and Social Enterprise **(**VCSE) sector (to reach underserved groups)
- Co-production to focus on: Access barriers (travel, booking, repeat visits), Experience of high-frequency users. Further engagement required as part of procurement design.

As part of the implementation of the urgent award engagement will take place with primary care. Co-production will be challenging for the urgent award given time scales, but we will work with the successful providers to maximise the available opportunities. As part of the ongoing commissioning of a Community Phlebotomy Service co-production and engagement will be embedded.

2.6.4 Human Rights Impact

The proposed redesign offers an opportunity to improve equity of access for high-need groups, including older people, those with long-term conditions, and deprived or rural populations, through

more localised, integrated and flexible provision. However, there is a risk that inequalities could worsen if access becomes more limited, overly centralised, or reliant on digital systems. This could lead to increased travel, delays, and missed monitoring, particularly for frequent users. These risks can be mitigated through an equity-led specification, including proportionate provision based on need, non-digital access routes, integrated delivery with wider services, and monitoring of access and outcomes across different groups.

2.6.5 Quality Impact

The proposed change presents both risks and opportunities for service quality. There are potential benefits if provision becomes more local, integrated, and aligned to care pathways, improving patient experience and timeliness of testing. However, there are important quality risks to address, including ensuring sufficient activity levels to maintain staff competency in venepuncture, particularly in smaller or distributed models, and maintaining robust sample handling processes. Timely transport of samples to laboratories will be critical to avoid degradation and delays in results, which could impact clinical decision-making and patient safety. Additional risks include inconsistent standards across providers, fragmentation from wider clinical pathways, and capacity pressures leading to delays in appointments or reporting. These risks can be mitigated through a clear service specification setting minimum quality standards, workforce competency requirements, integrated pathways, and defined expectations for logistics, turnaround times, and performance monitoring.

These risks will be mitigated through delivery in line with the new service specification, and through management of the contract with the successful provider.

Between December 2025 and June 2026 the ICB has received 14 complaints around access to Phlebotomy, of these three have come from Member of Parliament (MPs) reflecting wider scale concerns from constituents. It is anticipated that this business case will rectify the underlying access issue driving these complaints.

2.6.6 Core20PLUS Populations

The proposed service redesign has significant implications for Core20PLUS populations, who are likely to be among the highest users of phlebotomy due to greater prevalence of long-term conditions and poorer baseline health outcomes. There is an opportunity for the new model to reduce inequalities by improving local access, integrating testing with wider care, and proactively targeting underserved groups. However, there is a material risk that inequalities could widen if the service is not designed with these populations in mind, for example through reduced local availability, transport barriers, limited appointment flexibility, or reliance on digital systems. Providers will therefore need to demonstrate how their model identifies and responds to variation in need and access, including targeted provision for deprived and inclusion groups, proactive outreach where appropriate, and routine monitoring of access, utilisation and outcomes to ensure equitable service delivery.

Current access arrangements disproportionately disadvantage patients in rural areas required to travel to acute sites, individuals with limited transport or financial means and patients requiring frequent blood testing (e.g. LTC cohorts). The proposed model provides a direct mechanism to reduce these inequalities through neighbourhood-based access and flexible delivery.

2.6.7 Strategic Links

The proposed model directly supports:

ICB Priorities:
• Prevention and proactive care
• Reducing health inequalities

• Care closer to home

System Objectives:
• Improved access and waiting times
• Reduced pressure on acute services
• Delivery of neighbourhood care model

National Policy:
• NHS Long Term Plan (diagnostics and community shift)
• Diagnostics Recovery Plan
• Fuller Stocktake (integrated neighbourhood teams)

Phlebotomy is a foundational enabler of all three.

2.6.7.1 Five- Year Strategic Commissioning Plan 2026-27 to 2030-31

The strategy emphasises a shift from hospital centred care to neighbourhood based, preventative, and integrated models, with diagnostics delivered closer to home. Community Phlebotomy underpins this shift by allowing blood tests to be carried out in primary care and neighbourhood hubs rather than acute hospitals, supporting the plan's ambition to rebalance care away from hospitals and into local settings.

The strategy explicitly highlights the need to expand "test-only" and straight-to-test pathways, reduce outpatient follow-ups, and tackle diagnostic capacity challenges. Community phlebotomy is strongly correlated with these aims because timely and accessible blood tests are essential for early diagnosis, chronic disease monitoring and rapid clinical decision making.

The strategy makes clear that poor access to primary and community services drives avoidable escalation to urgent and emergency care, particularly for people with frailty and multimorbidity. Community phlebotomy supports proactive monitoring of long-term conditions and earlier intervention, helping to prevent deterioration. This aligns closely with neighbourhood led proactive care, urgent community response models, and the ambition to reduce avoidable hospital use for high need populations.

Community Phlebotomy contributes to health inequalities reduction and workforce productivity, both highlighted as critical system challenges. By locating Phlebotomy services in accessible community settings, particularly in deprived or underserved neighbourhoods, barriers to access are reduced for Core20PLUS5 populations. At the same time, shifting routine blood tests out of hospitals releases acute workforce capacity, reduces congestion in outpatient departments, and supports the financial sustainability aims of the strategy by enabling more efficient use of resources.

2.6.7.2 Integrated Care Northamptonshire "Live Your Best Life" A 10 Year Strategy 2023-2033

The strategy emphasises prevention, early intervention, and reducing health inequalities, particularly for vulnerable groups. A key barrier identified is missed opportunities in screening and monitoring, where accessible phlebotomy (blood testing) is essential for early diagnosis and ongoing management of conditions such as cardiovascular disease, cancer, diabetes, respiratory and liver disease.

Currently, the system performs well in treating illness after deterioration but is less effective in preventing escalation, leading to increased hospital use. Timely, community-based phlebotomy is critical to enabling proactive care, supporting medication management, monitoring conditions, and responding early to deterioration.

The strategy prioritises:

- Care closer to home and reducing avoidable hospital admissions
- Supporting older and frail populations to remain independent
- Improving access to services and reducing delays
- Local phlebotomy services support these goals by enabling diagnostics outside hospital settings, strengthening virtual wards and neighbourhood care, and improving patient experience—especially for those with mobility or transport challenges.

2.6.8 National & Strategic Alignment

The importance of phlebotomy is reinforced by national policy:

- NHS 10 Year Plan: Highlights early diagnosis, prevention, and shifting care from hospital to community—dependent on accessible diagnostics like blood testing.
- Diagnostics Recovery & CDC Programme: Promotes moving diagnostic services, including pathology, into community settings.
- Fuller Stocktake (2022): Supports integrated neighbourhood teams relying on timely diagnostic access for proactive care. Lack of timely blood testing would undermine the proactive and preventative offer described in the Fuller vision.
- Neighbourhood Health Model (NHSE): Identifies diagnostics as essential for population health management, early intervention, and multidisciplinary working.

In terms of operational importance, Phlebotomy is a critical enabler of:

- Prevention and early detection
- Long-term condition management
- Reduced hospital demand
- Improved care pathway flow
- Within the Medium-Term Planning Framework, improving diagnostic access is vital to:
- Reducing waiting times
- Addressing backlogs
- Meeting the six-week diagnostic standard

Accessible, timely community phlebotomy is a foundational service underpinning both local and national healthcare strategies, enabling the shift from reactive hospital care to proactive, preventative, community-based care.

2.7 Medium Term Planning Framework

In the Medium-Term Planning Framework / NHS operational planning guidance, waiting time recovery is positioned as a core system priority, with a strong emphasis on addressing diagnostic and elective backlogs as an enabler of pathway recovery. This includes restoring performance against the six-week diagnostic waiting time standard and preventing delays earlier in pathways that can cascade into longer outpatient and treatment waits.

3. Economic Case and Options Appraisal

3.1 Options appraisal

The economic case sets out the options for this business case as described in the table below:

Option 1	Do Nothing
Option 2	Contract Variation of existing Primary Care Local Enhanced Service contract (LES)
Option 3	Commission a practice/ neighbourhood service via an 'at scale' Primary Care Lead Provider Phlebotomy Model
Option 4	Commission Primary Care Network (PCN) level Primary Care based Phlebotomy Model

3.1.1 Option 1 – do nothing / minimum approach

The "do nothing option" would see the current contract cease on 15 January 2027 without a local mechanism in place for delivery of Primary Care requested non-urgent phlebotomy. The residual service currently delivered by Primary Care and the CDC would not come close to meeting demand and risks more providers declining the current Phlebotomy LES contract as demand and pressure rises. There will be a seismic impact on the local NHS and wider health and care economy if the service is allowed to cease without a viable alternative, exposing patients, services and the ICB to significant patient safety and reputational risks. Commissioners, therefore, cannot safely recommend that this option is endorsed.

An assessment of risk and benefit is outlined below:

Benefits	Risks
• Supports the current financial position of the ICB	• Unable to mitigate against lack of business continuity • Delayed diagnosis, treatment, potential patient harm, and ability for some people to return to work leading to poorer patient outcomes • Reduces GP ability to monitor for adverse reactions to prescribed medications • Compromises the ability of the ICB to achieve its strategic priorities • Reputational risk to the ICB

3.1.2 Option 2 – Commission a Practice Based Phlebotomy Model

This option enables provision of a countywide Primary Care service as outlined in the Strategic Case, provided, at practice level via a variation of the existing Primary Care LES contract, which subject to confirmation, is in line with PSR regulations.

As per the equivalent LES contract in LLR, practices will be given the ability to nominate an "at scale" provider to arrange delivery on their behalf if they are unable to do so themselves, using the LLR tariff. Practices would be required to run suitable clinic volume to meet demand with patients waiting no longer than two weeks for a test. It would be at Practice discretion as to how the clinics are organised, however weekend activity would be initially excluded as this would likely require negotiation with UHN over transport and lab capacity, which would likely incur more cost to the ICB and is not in scope for Phase 1.

Reporting and payment would take place at Practice level. It may be possible to include this within a LES "basket" of services which providers must fully opt in or out of, in order to reduce the risk of incomplete countywide coverage.

Benefits	Risks

• Facilitates development of a model of care which is sustainable. • Implementation of national guidance on care closer to home. • Supports reduced waiting times and pathway flow. • Diverts activity from secondary care. • Emphasises the importance of improved access which should improve patient outcomes and experience. • Emphasises the importance of dual running to ensure business continuity. • Enhances the ability of the ICB to achieve its strategic priorities. • Alignment with other ICBs regionally and nationally. • May be mobilised reasonably quickly if the tariff is attractive. • Builds on the relationship between patient and practice. • Maximises use of local knowledge and patient population to deliver service.	• Delivery timescale. • ICB capacity to deliver the programme. • Potential for increased costs. • Premises availability. • UHN service existing capacity resulting in increasing waiting lists for new service go live. • Proposed collective action may impact data sharing abilities for anything other than direct patient care. • Lack of fully competent staff to enable delivery of a quality service and associated training costs. • Challenge within the system over proposed approach. • ICB capacity for monitoring multiple LES contracts. • Potential for incomplete countywide coverage. • Allows unwarranted variation through putting responsibility on GP Practices to choose to arrange at scale delivery. • Workforce displacement and redundancy affecting staff and the local economy. • Challenges in monitoring and validating invoices due to volume. • Limited model resilience as no central provider coordination and too many potential points of failure. • Requires change to current monitoring processes to provide required assurance. • Significant increase in tariff-based activity which could pose financial risk. • Increased number of practices participating in phlebotomy may put current transport arrangements under strain.

3.1.3 Option 3 – Commission a practice/ neighbourhood service via an ‘at scale’ Primary Care based Lead Provider Phlebotomy Model

This option enables provision of a countywide Primary Care service, at practice/neighbourhood level, managed by a Lead Provider working with practices and as outlined in the Strategic Case, but funded on a tariff basis, at the LLR rates. This will require an urgent award to ensure continuity of

service on a critical function of healthcare, followed by a competitive procurement process to secure a longer-term provider. It would also allow flexibility for future design, alignment and contracting.

The Lead Provider would be responsible for the delivery of the service in an equitable way across Northamptonshire, making best use of existing primary care assets including trained staff and estate. The Lead Provider would be required to ensure that fluctuations in demand due to patterns in seasonal variation can be anticipated and effectively responded to, to ensure that waiting times are no longer than two weeks. As with option 2, weekend provision will be excluded in Phase 1 so that Commissioners can evaluate the need for longer term weekend clinics and limit the exposure to the ICB of running weekend clinics as core activity instead of through the nationally funded Extended Access programme. The Lead Provider would validate practice activity and act as a single point of assurance for Commissioners, moving to a more strategic commissioning model, and developing a blueprint for future delivery of Primary Care based diagnostic services.

Benefits	Risks
• Emphasises an urgent award will best ensure continuity of service on a critical function of healthcare. • Facilitates development of a model of care which is sustainable. • Implementation of national guidance on care closer to home. • Supports reduced waiting times and pathway flow. • Diverts activity from secondary care. • Emphasises the importance of improved access which should improve patient outcomes and experience. • Emphasises the importance of dual running to ensure business continuity. • Enhances the ability of the ICB to achieve its strategic priorities. • Flexibility for future design and contracting using the new neighbourhood contract when published. • Aligns with move to strategic commissioning. • Enables Lead Provider to begin transition into neighbourhood-based models of care. Working with GP practices to provide a service using local patient population knowledge to ensure equity of access. • Lead Provider can work with primary care to deploy resource, as required, to ensure a more resilient model which can adapt at times of increased activity (winter pressures, QoF).	• Delivery Timescale. • ICB capacity to deliver the programme. • Potential for increased costs. • Length of investment for Primary Care. followed by competitive, open procurement process. • Potential legal challenge on procurement approach. • Premises availability. • UHN service existing capacity resulting in increasing waiting lists for new service go live. • Potential workforce displacement and redundancy affecting staff and the local economy. • Proposed collective action may impact data sharing abilities for anything other than direct patient care. • Challenge within the system over proposed approach. • Lead provider may pass on a lower tariff cost to practices to cover central monitoring and service coordination. • Requires change to current monitoring processes to provide required assurance and enable Lead Provider to pass through payment. • ICB have less control over whether service is delivered at Practice level. Contract will contain some key deliverables, but the Lead Provider would be responsible for how this is executed. • Significant increase in tariff-based activity which could pose financial risk.

Challenges are:

- Primary Care partners need to be on board for this to progress. Discussions are ongoing with the LMC and GP Federations
- Resistance to change for legitimate reasons
- Digital interoperability and activity / finance reporting
- Revision of patient pathways which need to be integrated
- Potential or perceived workforce displacement

3.1.4 Option 4 – Commission Primary Care Network (PCN) level Primary Care based Phlebotomy Model

The most recent NHS England guidance (from the 2026/27 PCN Direct Enhanced Service (DES) variation) introduces a significant new mechanism—the "Local Variation Arrangement" (LVA), which allows ICBs, for the first time, to formally seek approval to vary elements of the nationally specified PCN DES. This represents a shift from a largely fixed national specification to a more flexible, locally adaptable framework. However, this flexibility is controlled: ICBs cannot unilaterally amend the DES but must submit a request to NHS England, which retains approval authority. The scope of permitted variation is also tightly defined, limited to specific sections of the DES—principally those covering service requirements, workforce (ARRS), and financial entitlements. While core features such as eligibility, participation rules, and the underlying GMS/PMS contracts remain unchanged. This means the DES continues to operate as a national contract, but with a structured route for place-based adaptation where existing commissioning mechanisms are insufficient.

In practice, this creates an opportunity for ICBs to use the PCN DES as a commissioning vehicle for services such as community phlebotomy. Through an approved local variation, an ICB could amend the "service requirements in Section 8" to include delivery of a standardised, at-scale phlebotomy offer across a neighbourhood footprint, potentially shifting activity out of general practice or acute settings into a coordinated PCN-delivered model. It could also adjust "ARRS workforce rules (Section 7)" to support recruitment of phlebotomists or nursing roles aligned to this pathway and refine "payment mechanisms (Section 10)" to incentivise access, productivity, or quality outcomes. This approach effectively allows the ICB to deliver what would historically have required a Local Enhanced Service or a separate procurement, but within a national funding and contractual envelope, reducing fragmentation and accelerating implementation. Crucially, because LVAs are time-limited and require ongoing approval, they also allow the ICB to test and iterate the model—providing a controlled, reversible route to scaling community phlebotomy in line with neighbourhood health system objectives.

Benefits	Risks
• Uses existing national funding and contract framework • Allows local flexibility within a standard model • Improves patient access through local, PCN-based delivery • Helps reduce GP workload via shared services • Supports workforce expansion through ARRS • Avoids creating multiple fragmented local contracts • Enables a test-and-learn approach with ability to adapt over time	• Delivery remains at PCN level, which can limit true system-wide standardisation and create variation between networks • Risk of inconsistent adoption and service models across different PCNs without strong coordination • Requires NHS England approval, so ICBs do not have full control over whether a variation can proceed • Uncertain and potentially lengthy approval timelines, making it harder to respond quickly to operational pressures

	• Approach is relatively new and untested, with limited precedent on what will be approved or how it will work in practice • Difficult to plan with confidence due to uncertainty around approval outcomes and implementation • PCNs are not standalone provider organisations, so capability to deliver at-scale services (workforce, estates, governance) may vary • DES funding model may be less aligned to activity-based commissioning, creating challenges around incentives and demand management • Can blur boundaries between national entitlements and local commissioning, adding governance complexity • Variations are typically time-limited and subject to ongoing oversight, reducing long-term certainty compared to standard contracts • Geographical alignment • Future role of PCNs

Challenges are:

- Delivery is still at PCN level, limiting consistency and true system-wide scale
- Requires NHS England approval, reducing ICB control and flexibility
- Uncertain and potentially slow timelines for approval and implementation
- New and untested mechanism, with limited precedent or assurance of success
- Variable PCN capability to deliver (workforce, estates, governance)
- Potential misalignment with wider system services and existing provision
- Significant contract management resource required

3.2 Options Overview

3.2.1 Assessment criteria for options

Area	Criteria	Weighting	Rationale	Scoring
Outcomes	Improved access and experience of care Reduced waiting times Reduced inequity of care	30%	Embed before UHN notice date of January 2027	1 to 5, where 5 fully meets the criteria / offers best outcome and 1 does not fulfil the criteria / offers the lowest outcome
Resources	Builds on existing infrastructure Left-shift of resources	30%	Improve countywide resources from a work a workforce or economic perspective	
Risk	See Risk Matrix	20%	Options come with significant risks within procurement and delivery which	

			require close management	
Strategy	Aligns to national and local strategic direction	20%		

3.2.2 Results - assessment of options against key areas

Area	Criteria	Weighting	Option 1	Option 2	Option 3	Option 4
Outcomes	*Improved access and experience of care*	*30%*	*0*	*4*	*4*	*3*
	Reduced waiting times					
	Reduced inequity of care					
Weighted Score			*0*	*1.2*	*1.2*	*0.9*
Resources	*Builds on existing infrastructure*	*30%*	*0*	*3*	*3*	*3*
	Left-shift of resources					
Weighted Score			*0*	*0.9*	*0.9*	*0.9*
Risk	*Finance*	*20%*	*1*	*3*	*3*	*3*
	Legal		*0*	*4*	*4*	*4*
	Quality		*4*	*4*	*5*	*4*
	Strategic		*0*	*3*	*5*	*3*
	Operational		*1*	*5*	*4*	*3*
Weighted Score			*1.2*	*3.8*	*4.2*	*3.4*
Strategy	*Aligns to national and local strategic direction*	*20%*	*0*	*3*	*5*	*2*
Weighted Score			*0*	*0.6*	*1*	*0.4*
Total Score		***100%***	**2**	**6.5**	**7.3**	**5.6**

A highlight version of a risk matrix for all options, as referred to in the above table, is displayed below.

Options	Risk Area					Overall RAG
	Finance	Legal	Quality	Strategy	Operational	
Option 1						1.2
Option 2						3.8
Option 3						4.2
Option 4						3.4

The matrix for overall key programme risks is in Section 6.

3.2.3 Recommended Option

Option 3 - Commission a practice/ neighbourhood service via an "at scale" Primary Care Lead Provider Phlebotomy Model

The recommended option is Option 3, provision of a countywide Primary Care service, delivered by practices/ neighbourhoods via an scale by a Lead Provider. Using the same tariff as is commissioned in LLR. This will require an urgent award to ensure continuity of service on a critical function of healthcare. It will also allow flexibility for future design and contracting using the new neighbourhood contract when published.

This option would be broken down into 2 phases as follows:

Phase 1
An urgent award for an initial 12-month period with the option to invoke a 6-month contract extension as required allowing the Commissioner time to stabilise the service while an MSP or Competitive process is undertaken for a long-term solution, which may or may not cover the whole LLNR cluster. The Lead Provider would be responsible for delivering key operational and patient outcomes, arranging delivery of practice clinics accordingly, whilst also moving towards delivery over a neighbourhood footprint. Equitable access is an important feature of this service and therefore the delivery model may vary at a neighbourhood level to reflect the patient population.

This approach also provides the opportunity for Commissioners to explore whether to bundle community requested Phlebotomy with other diagnostic services, such as Spirometry, to procure a neighbourhood diagnostic service to complement and enhance the national Community Diagnostic Centre (CDC) programme, and enables Commissioners to work strategically, with Primary Care, in this area.

The existing LES runs until March 2027, however it is expected to be superseded in-year by the new service, i.e. spend will shift from the LES to the new contract.

Phase 2
A recurrent long-term solution is established and procured via MSP or Competitive process during Phase 1. Using learning from the Phase one approach and considering options available such as block contracts. Additional weekend UHN lab activity and associated transport costs capacity may also need to be renegotiated at this point, if engagement shows that weekend activity is key to ensuring equitable service access and a flexible, resilient model.
This will also include CDC related Phlebotomy activity.

4. Financial Case

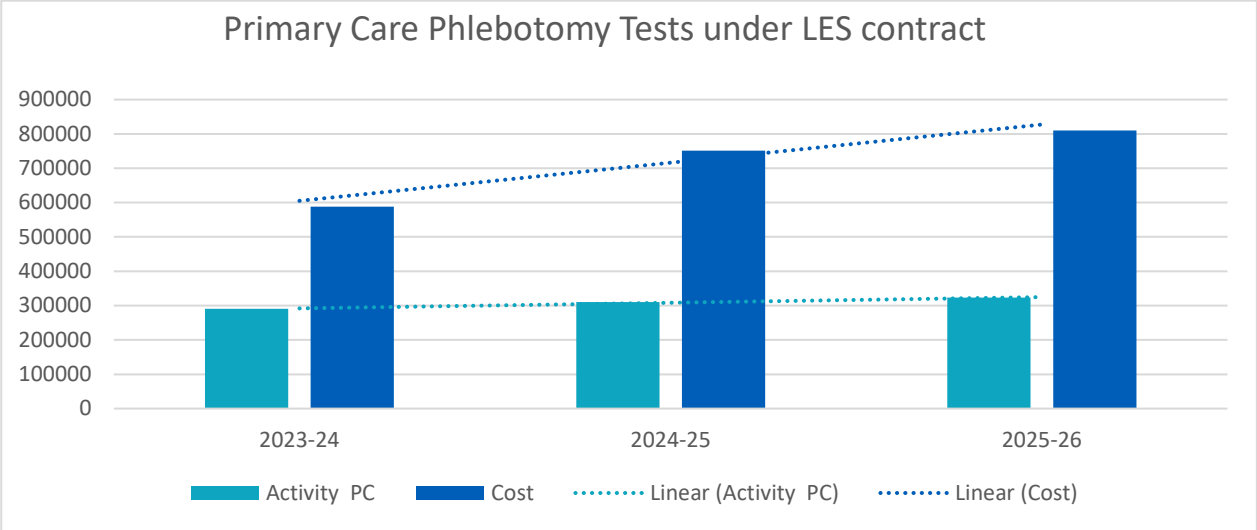
4.1 Financial appraisal of the preferred option

Data from UHN Phlebotomy service and the LES GP contracts have been used as a basis for activity information to support activity and finance assumptions and forecasting. The data comes with notable caveats:

- The LES data is a manual count and may be influenced by human error. It is proposed to monitor the new service via the Ardens system.
- UHN data is significantly limited, with variations in activity reported dependent on methodology used to develop reports.
- UHN cannot currently break down age at more detail than under/over 16 years of age, so assumed under 16s activity has been included, based on local data.

To ensure consistency for UHN projections, the activity identified in the UHN's notice letter has been used as the basis for activity calculations. LES returns have been used as a basis for Primary Care activity, and these figures have been combined to give a countywide total. Population growth information, provided by ICB BI team, has been applied from year 2 onwards, and additional activity within year 1 to reduce waiting times.

The graph below shows the last three years of Phlebotomy activity and spend under the LES contract.



4.2 How the scheme will be funded, its affordability and how revenue costs will be managed

All financial modelling uses the current LLR tariff as a basis for cost forecasting. This tariff was developed following significant analysis, and has been successfully applied in Leicestershire, therefore Commissioners are satisfied that the payment is appropriate and its development has been well informed. The below table shows financial assumptions for the initial urgent award under Phase 1 of the proposed preferred option:

	12 month award – 1 November 2026 – 31 October 2027	18 month award – 1 November 2026 – 30 April 2028
Projected contract value	£2,875,379	£4,233,785.
UHN residual service	£37,500	£62,584.25
Total	**£2,912,879**	**£4,296,370**
Cost Pressure	**£1,925,181**	**£2,715,190**

Please note that these figures will appear out of line with financial year projections below as they span different time periods in line with proposed contractual timelines.

Further detail is provided in the below table about the financial impact for **2026-27 only**:

		Year 1 Nov 26- Mar 27 Activity ea	Cost £
Proposed scheme			
Legacy Costs			
Adults	Block	43,848	61,878
Children	Block	2,649	-
New Scheme Costs			
Adults	Activity	271,484	1,189,101
Children	Activity	5,297	41,478
Sub total		**323,279**	**1,292,458**
Assumed residual UHN service			**8,333**
Cost pressure			**1,005,490**

This breakdown comes with some assumptions:

Current Scheme

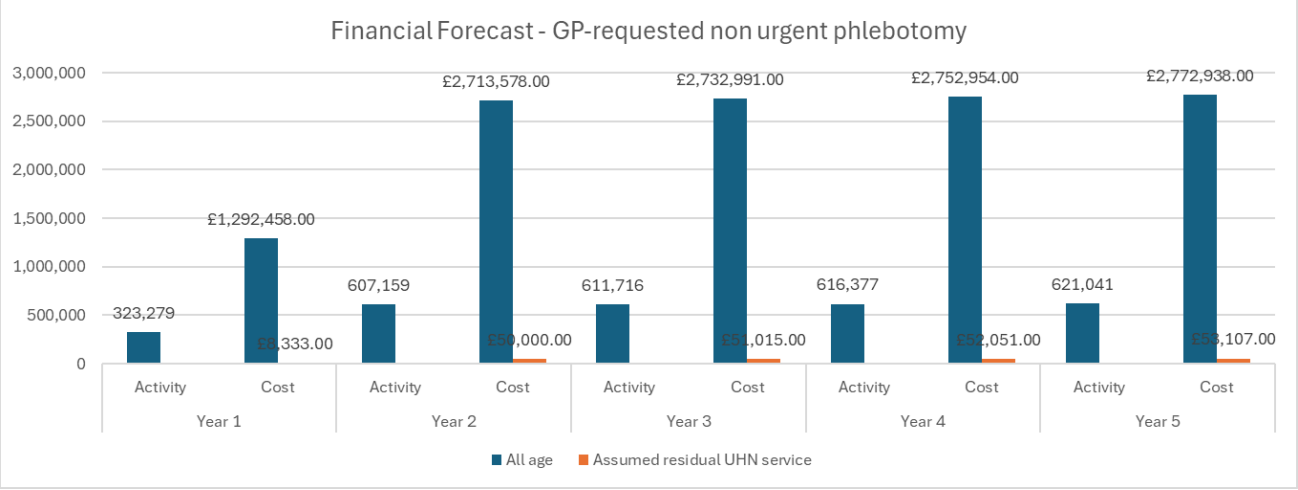
- Assumed current schemes do not attract any increase to fees payable
- Increased activity relates to projected list growth only
- There is currently a two month waiting list for this service due to capacity issues, it is assumed this would continue if the scheme were to continue "as is".

Proposed Scheme

- No increases in fees are assumed in proposed scheme
- It is assumed the two months' waiting list would be addressed in Year 1
- It is assumed the waiting list would reduce by 50% during the dual running period November to end December. We have therefore added in additional activity (equivalent to 1 month)to support the reduction
- It is assumed GP services would move to the new rate immediately
- Includes allocation for residual serve for young children and "hard to bleed", this is subject to final agreement
- Two months double running has been allocated for to enable stress testing of the new model alongside waiting list reduction

Looking further ahead for a more medium term projection, the below table and graph show activity and finance assumptions for years one to five

	Year 1 (PYE M8-12)		Year 2		Year 3		Year 4		Year 5	
	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost	Activity	Cost
All age	323,279	£1,292,458	607,159	£2,713,578	611,716	£2,732,991	616,377	£2,752,954	621,041	£2,772,938
UHN residual service		£8,333		£50,000		£51,015		£52,051		£53,107



As previously referenced, as notice came part way through January 2026, funding of the new model was not included in the 2026/27 plan. As the funding of the new model is outside of the financial plan, and mitigations cannot be identified to offset, final approval of the case via the ICB Board will be required.

Financial Assumptions

Current Scheme	Proposed Scheme

Assumed current schemes do not attract any increase to fees payable	No increases in fees are assumed in proposed scheme (these will be managed through planning rounds)
Increased activity relates to projected list growth only	It is assumed the two months' waiting list would be addressed in Year 1
There is currently a circa two month waiting list for this service due to capacity issues, it is assumed this would continue if the scheme were to continue "as is"	It is assumed the waiting list would reduce by 50% during the dual running period November to end December. This case has therefore added in additional activity (equivalent to 1 month)
The LES will continue until March 2027. But claims will slow down and stop as practices align to the new contract	It is assumed GP services would move to the new rate immediately
UHN residual service to be negotiated	Includes £50,000 p.a. for residual service for young children and "hard to bleed", this is subject to final agreement

N.B. Year 1 is not the total cost of providing the service for the full year, it is simply the additional funding pressure from moving to the proposed scheme in year and dual running costs noted above.

A full finance and activity workbook is attached at Appendix 5**.** This shows activity down to Primary Care Network (PCN) and Practice level. It is expected that Practices who currently use KGH sites are likely to see a larger increase in activity delivered in Primary Care than practices closer to NGH. This is because West Northamptonshire is a proportionally higher user of Primary Care delivered phlebotomy.

The contract will be paid on a tariff basis, via a Lead Provider who will then distribute to practices accordingly to reimburse for activity undertaken. Activity validation will be required for payment, and the tracking and validation of this activity will be the responsibility of the Lead Provider, potentially via the phlebotomy Ardens template. Time limits on invoicing will be imposed to prevent significantly retrospective charging.

The Lead Provider may intend to draw down management costs from the tariff funding, although some funding is already in place to enable Federations to deliver at scale services. In order to safeguard individual practices who would deliver phlebotomy services under the proposed model, the Lead Provider would need to negotiate the amount, per test, that is drawn down to cover management cost with subcontracted parties. This is likely to be minimal due to the anticipated volume and associated value. The specification will reflect that any charges levied must be applied equally and should be pence, rather than pounds, of the tariff cost.

Exemptions

Extended Access: Weekend phlebotomy activity in Primary Care is currently delivered through Extended Access, which attracts its own charge, paid via national funding, and is not factored in as part of this model. Weekend activity will be excluded from Phase 1 of the contract to; avoid double charging, preserve the Extended Access route and enable Commissioners to model the impact of extending core services into the weekend to test feasibility for Phase 2. Replacing Extended Access phlebotomy with core service may increase overall activity levels and associated costs and may also require renegotiation of UHN pathology lab costs and sample transport as they are not equipped for high levels of community activity at the weekend. This would worsen the financial impact but enable a more equitable service.

Community Diagnostic Centres (CDC): Data forecasting does not include CDC activity. CDC Phlebotomy is currently funded at a higher tariff via NHS England, which includes transport and lab costs. At a point in the future, this will revert to ICB baseline to manage. ICB payment at the CDC tariff is unlikely to be feasible unless fully accounted for in revised ICB allocations, and therefore the model commissioned will need sufficient flexibility to be scaled according to changing demand.

Future Plans

In time, once Commissioners have a more detailed understanding of demand and capacity for primary care requested non-urgent phlebotomy and the service is stabilised, most likely during Phase 2, the ICB may wish to explore moving to a block payment mechanism, adjusted annually for inflation in line with other NHS Standard Contracts. This would incentivise the provider to ensure blood taking is optimised at patient level, skills for efficient and accurate blood taking are maintained and clinics are well utilised. It would also stabilise the financial impact to the ICB, with a proposal that any savings used to offset additional weekend lab capacity and associated sample transport, or other incentives required to deliver an equitable service.

The service specification covers delivery of some phlebotomy that relates to secondary care and shared care. For example pre-referral "work up", post outpatient follow up and ongoing shared care management. Therefore as part of phase two further work will be undertaken to assess the financial model and any scope for secondary care contribution.

Affordability Statement

The proposed model introduces a recurrent cost pressure rising to c.£2.7m per annum. This is currently unfunded within the financial plan and will require:
• Use of primary care underspend where available
• Reprioritisation through planning rounds
• Board approval of residual gap
No fully offsetting savings have been identified at this stage, although system benefits (reduced acute demand and improved pathway flow) are expected.

4.3 Governance and Sign Off

The process will be for the Phlebotomy business case:

- Agreement at Procurement Delivery Group: June 19th
- Reviewed by Joint Executive Team (JET): June 24th
- Strategic Commissioning Committee: July 7th
- Finance Committee: July 7th
- Board: August 20th

4.4 What effect the scheme will have on efficiency and productivity

There is an opportunity to maximise efficiency in community requested Phlebotomy by specifying that, as far as possible, requesting is rationalised at patient level in accordance with NHS guidance[1]. The NHS England guidance promotes careful planning and sequencing of blood tests, encouraging clinicians to only request tests that are clinically necessary and timed appropriately. It emphasises avoiding premature or repeated testing by following minimum retesting intervals, checking for recent results before re-ordering, and ensuring tests will influence management. It also advises sequencing and combining investigations, using the same sample for different assays where possible, and adding tests onto existing samples. This coordinated approach reduces unnecessary venepuncture, minimises duplicate testing, and supports more efficient use of laboratory and phlebotomy resources, while improving patient experience and reducing harm from over-investigation.

[1] B0960-optimising-blood-testing-primary-care.pdf

The Provider, in liaison with Commissioners, will be required to arrange community Phlebotomy services in such a way as to minimise access challenges and provide a service for all eligible patients, taking into account each neighbourhood's population and geography. Moving community requested Phlebotomy into Primary Care will also ensure use of existing strategic estate and provides an opportunity to create and enhance neighbourhood based diagnostic testing pathways.

5. Commercial Case

Commissioners have discussed this business case with members from both Contracting & Procurement teams to identify suitable options available to Commissioners, and the associated risk.

5.1 Procurement

A review of the UK Government Find a Tender Service (FTS) shows very few examples of Phlebotomy procurement under the Provider Selection Regime (PSR) which are not provided via LES or by Acute or Community hospital trusts. While other areas have deployed a similar approach to community Phlebotomy as identified in this business case, this likely predates the introduction of the PSR 2023 regulations. The Procurement team have identified the following options as appropriate for Commissioners:

5.1.1 Most Suitable Provider (MSP)

The only available example of an ICB using an MSP process for Phlebotomy services is in Bromley.

Commencing an MSP process requires Commissioners to have good working knowledge of the market including Primary Care, wider NHS services and commercial providers. Market engagement will be required and if providers in the wider healthcare market show interest in the service, Commissioners will likely be required to undertake a competitive process to evaluate them. There is a risk that this will be the case, as commercial providers already provide diagnostic healthcare services (Alliance Medical, In Health etc) and run Community Diagnostic Centres (CDC).

The new contract will be required for signature in late Summer 2026 to secure a phased launch from November 2026. Key documents such as service specification and activity data are in draft, but there is now very limited time available to undertake a compliant PSR process and mobilise prior to UHN service cessation in January 2027. This would leave limited opportunity to stress test such a critical service and would raise the risk exposure of this approach.

5.1.2 Urgent Award

An alternative approach would be to award the service to Primary Care Federations via Urgent Award for 12 months (maximum term 12 months + 6 months), commencing in November 2026, allowing the Commissioner time to stabilise the service while an MSP or Competitive process is undertaken for a longer-term solution.

The urgent award is justified on the basis that:
- UHN service cessation creates a time-critical patient safety risk
- Insufficient time remains to undertake a full competitive process and safely mobilise
- Continuity of a critical diagnostic function must be maintained
- A full PSR-compliant competitive process will be undertaken in Phase 2.

There are still risks to this approach. Other providers could submit challenge that the Urgent Award criteria has not been met in this instance as the incumbent provider has given the ICB 12 months' notice. This could be inferred as a reasonable timeframe to implement alternative arrangements using an appropriate PSR process. However, the only formal route an Urgent Award could be

challenged is via Judicial Review, so as long as the ICB keeps the Urgent Award duration as short as possible and makes it clear in the published Transparency notice of the ICBs intention to undertake an appropriate PSR-compliant process to implement a new longer term arrangement, the likelihood of a provider commencing Judicial Review proceedings is considered to be low. A drafted process map and checklist for an urgent award under PSR 2023 providing suitable justification is included as Appendix 6 in this report. Once an agreement is in place with the provider(s) a. F.03 contract award notice will need to be published to Find a Tender Service.

Current Procurement Approach Assessment (PAA) form for sign of by the LNR Procurement Group's June meeting can be found in Appendix 7.

Please refer to Section 3.2.3 of this business case which highlights the two recommended phases of procurement and delivery of Phlebotomy services.

5.1.3 Local Enhanced Services (LES)

Other areas, including LLR, commission community requested Phlebotomy services via a Primary Care LES. Using a LES would circumvent the PSR process however, as individual practices have a choice about whether they sign up, this carries a risk that not all providers would deliver a service, even with a higher tariff, and leave gaps in service that would be challenging to close. It also allows for unwarranted variation at practice level, putting the responsibility on practices to arrange at-scale delivery if they choose to do so and does not align to a neighbourhood model of delivery. Also, from a practical perspective, the reduction in ICB workforce and the transition to roles as Strategic Commissioners does not make the management of a high number of LES arrangements viable.

Commissioners suggest the most appropriate procurement route to enable rapid mobilisation of service and secure longer-term delivery is the two-phase approach outlined in Section 3.2.3 of the business case, summarised below:
Phase 1 - Urgent Award for 12 months (+ optional 6-month extension) to a GP Federation on a Lead Provider model for Primary Care at scale delivery
Phase 2 – Longer term contract, suggested term 5 years (+ optional 3-year extension), procured via an MSP or Competitive tender process.
This approach provides a window of time for Commissioners to also explore whether to bundle GP-requested non-urgent Phlebotomy with other diagnostic services, such as Spirometry. This would lead to procurement of a neighbourhood diagnostic service to complement and enhance the national Community Diagnostic Centre (CDC) programme and enable Commissioners to work more strategically with Primary Care providers.

Once an option is agreed the service will be presented at the LNR Procurement Group to confirm a compliant approach under the PSR 2023 regulations.

5.2 Contracting

Both Phase 1 (urgent award) and Phase 2 (MSP / Competitive tender) would be commissioned using the NHS Standard Contract. Using the NHS Standard Contract provides an ICB with a robust, nationally standardised framework that balances consistency with local flexibility. The contract's established mechanisms for performance management, pricing variation, and service change support help the ICB manage demand, address operational pressures (e.g. GP workload and diagnostics access), and ensure value for money. At the same time, its provisions for collaboration, variation, and termination allow the service model to evolve or be exited if it proves ineffective, ensuring the ICB can scale provision efficiently while retaining control over quality, financial risk, and system integration.

Phase One would be for 12 months with an option to extend for six months to enable the procurement of the substantive community phlebotomy service. Learning from the early part of Phase 1 will inform the requirements of the substantive service.

There has been no indication that staff will be affected by their serving notice, or that there will be estates related consequences from serving notice. Pathology analysis and reporting of blood samples taken through the proposed community service are expected to remain within the UHN contract, so long as operational hours and volume do not significantly differ. The ICB will work with UHN to ensure that this is the understood shared position. In the event that there are members of staff in UHN who are eligible to transfer to the new provider (under Transfer of Undertakings Protection of Employment (TUPE) arrangements), this will be the responsibility of the incoming provider to manage. This incoming provider would need to ensure they are clear on the position regarding TUPE, and potential for this to cause concerns or delays.

Transport for blood samples collected at community sites remains with UHN, forming part of wider logistics arrangements undertaken by the Trust at community locations. As the operational details of the new model of care provision are confirmed, the arrangements may need to be revisited (for instance, if new sites, routes, or collection times are added to the community collection service). The service specification should make clear the expectations of the community provider of phlebotomy in terms of arranging collection logistics with the transport provider.

Contract management in Phase 1 is expected to be "light touch", focused on exception and incident reporting where required, and payment validation. It will be the responsibility of the at-scale provider to develop systems and processes for collating and reporting practice level activity data and to submit invoices directly to commissioners. Sub-contracting arrangements (and associated reporting, payments or quality matters) will be the responsibility of the lead provider.

The proposed service model relates to users aged 12 years and above. UHN have been approached to quantify the level of demand for GP-referred phlebotomy for children below 12 years old to ascertain whether there may be a commissioning gap under the new arrangements. The volumes are expected to be minimal, and pending clarification, further discussions may be required with UHN to seek their agreement to continue to provide services to this cohort (which may in turn impact on the financial implications). A notional value has been provided for in the financial forecast for any retained service.

UHN continue to provide some phlebotomy services under CDC arrangements. The Trust have not served notice on this activity. Commissioner will need to consider how this capacity aligns with the model of provision under the proposed service and develop commissioning intentions to guide future contracting requirements for the current CDC phlebotomy.

Reporting will be the responsibility of the Lead Provider, including implementing the infrastructure for practices, and to be able to quantify performance and outcome delivery and invoice accurately. Reporting will also cover outputs/outcomes identified in EQHIA with the provider responsible for demonstrating how the model delivers measurable reductions in health inequalities not just improved access overall (see section 6.3).

ICB Contract and Finance to finalise and process for payments between ICB and provider, however this is assumed to be monthly retrospective PO invoicing.

5.3 Conflicts of Interest

Conflicts of Interest (CoI) will be managed in line with the ICB's Conflicts of Interest policy. As part of any procurement process all decision makers and evaluators will be required to complete a CoI form to ensure their suitability for the procurement and support the transparency and governance of the process.

5.4 Exit Strategy

The NHS Standard Contract contains a number of structured mechanisms that allow either the ICB or the provider to exit or bring a service to an end where it is no longer viable or acceptable. At a core level, this is managed through provisions on contract termination, suspension, and remedial action plans. Where quality or safety concerns arise, the commissioner (ICB) can invoke contractual performance management processes, including issuing a Contract Performance Notice (CPN), requiring a Remedial Action Plan, and—if the issues are not resolved—moving to termination for breach. In more serious cases, particularly where there is a risk to patient safety, the contract allows for immediate suspension or termination. Similarly, there are explicit clauses allowing termination for persistent failure to meet key performance indicators, regulatory non-compliance (e.g. CQC concerns), or material breach, thereby protecting the system from ongoing quality or operational risks.

From a financial and operational perspective, the contract also provides more flexible exit routes that do not rely on breach. Both parties can agree to termination by mutual agreement, often used where a service model proves unsustainable or demand assumptions were incorrect. In addition, there are provisions for termination for commissioner convenience (with appropriate notice), allowing ICBs to reconfigure services in line with changing system priorities. Providers are also not locked in indefinitely; they may terminate under defined circumstances, such as non-payment or significant commissioner failure. Importantly, all termination routes are supported by notice periods, exit planning requirements, and continuity obligations to ensure safe patient handover and minimise disruption, meaning that while exit is possible due to quality, operational or financial failure, it must be managed in a controlled and clinically safe way.

6. Management Case

6.1 Programme Profile

This business case has set out an ambition to establish a Primary Care service for the delivery of community requested phlebotomy/ venepuncture. **Our preferred option is option 3, which is commission a practice/ neighbourhood service via an 'at scale' Lead Provider Phlebotomy Model**, delivering a Primary Care service with care delivered closer to home, improved access, experience and outcomes whilst ensuring the sustainability of health care delivery.

To deliver the programme at pace, GP Federations may need additional funding to support the resources required to manage and monitor activity and payment mechanisms.

Section 5 touches on some of the challenges that we may face from a commercial perspective. We need to draw on the expertise within Procurement & Contracts/ Finance Teams to support us to move forward rapidly.

6.2 Measuring Outcomes, Quality Oversight & Assurance

The Northamptonshire Service will be based on the service specifications used for LLR Community Phlebotomy (Appendix 3). Core contractual reporting will cover both outputs and outcome data. Outputs will inform commissioners about activity volume, clinic utilisation, waiting times, DNA rates and any onward referrals to secondary care as well as inequalities in access and outcome by Core20PLUS groups. The Lead Provider will not be paid for failed venepuncture attempts.

Outcomes will largely be in relation to patient experience and provision of practice/neighbourhood-based care in way that delivers consistent and equitable access across geographies and Core20PLUS groups as well as a safe high quality service which minimises harm. It is imperative that the service meets the needs of the local population as identified in the initial EQHIA. This indicates that the successful provider should undertake a full EQHIA process as part of the process of development and implementation of their service model. Patient engagement at neighbourhood level is also encouraged alongside ICB strategic engagement.

Commissioners will also seek to obtain information from UHN about haemolysed / spoiled sample test rates and an appropriate threshold or upper tolerance limit for this.

In addition to data reporting, the Lead Provider will also be required to submit a quality schedule, giving commissioners robust but proportionate information around service safety, including incidents and harm, safeguarding reports, complaints and compliments, audit and assurance that staff are appropriately trained and venepuncture is undertaken in a clinically safe environment. It will also inform commissioners about how the service is developing at neighbourhood level. This will be developed in conjunction with partners to ensure proportionate.

Contract meetings between Commissioners and the Lead Provider will enable further discussion around key metrics and impart further information to inform service design, function and delivery. and locations, within the bounds of blood transportation and lab arrangements.

Responsibility for acting on the outcomes of tests remains with the requestor or the test. Where there are operational issues with the process of reporting, governance will remain with the relevant responsible party, for example if pathology results not reported from lab, or if digital issues with at scale provider beyond the scope of GP's control.

6.3 Benefits Realisation

The business case for Community Phlebotomy is designed to ensure sustainable delivery of a Phlebotomy service for the population of Northamptonshire.

Key benefits will be in relation to waiting times, geographic and equitable access and greater coordination of blood testing to reduce duplication leading to increased patient satisfaction. These will be aligned to the EQHIA, and support demonstration of delivery of improvements in quality and equality, ensuring that the new service meets the needs of the local population, and is accessible in line with population needs.

As per the measurements and reporting outlined in sections 6.2 and 6.3 key outputs will be measured and managed by the ICB. We also expect the Lead Provider to play a key role in ensuring a quality service, aligned to neighbourhoods and delivered by practices in line with local population need. This could lead to appropriate variation in service delivery across the neighbourhoods to reflect equity considerations and reduce health inequalities. The Lead Provider should ensure the voice of the local population is considered when establishing service in each area. If needs cannot be met through the current contract limitations, this should be fed back to the ICB, for consideration in Phase 2 of the preferred option.

In addition to this financial spend will be monitored and managed via the relevant contractual process in line with the ICB standing financial instructions (SFIs).

Benefits Summary

The service will use the NHS standard contract, therefore key elements in relation to quality and safety will be covered by the relevant contract schedule:

- Quality reporting is based on defined indicators (operational standards, national and local quality requirements) in Schedule 4
- Providers must submit a regular Service Quality Performance Report covering all quality metrics
- Reports must highlight breaches, patient safety incidents, Never Events, and duty of candour
- There is a structured framework of national central, national local, and locally agreed reporting (Schedule 6A)
- Strong focus on data quality (accuracy, completeness, timeliness) with improvement plans (DQIPs)
- Quality reporting must cover safety, clinical outcomes, and patient experience
- Requires analysis of performance gaps and action plans
- Links to contract levers and financial consequences where standards are breached
- Supports continuous improvement and audit, including use of feedback and incident data
- Forms part of ongoing contract governance and performance review processes between commissioners and providers

Specific Quality and Population Health Metrics:

Benefit	Type	Measure	Data Source	Baseline	Target	Timescale
Patient Experience	Quantitative Qualitative	Patient satisfaction with service	Patient surveys	N/A		Phase 1
Quality	Quantitative Qualitative	Quality oversight and assurance- patient safety, including safeguarding, IPC, quality	Validated data, contract meetings, quality meetings			Ongoing throughout development and delivery
EQHIA	Quantitative	Access by Core20Plus	Validated data, contract meetings, quality meetings	N/A	Meets population need	Phase 1 and Phase 2
EQHIA	Quantitative	DNAs by Core20Plus	Validated data, contract meetings, quality meetings	N/A	Meets population need	Phase 1 and Phase 2
EQHIA	Quantitative	Access coverage	Distance of travel	N/A	Meets population need	Phase 1 and Phase 2
EQHIA	Quantitative	Access by non-digital route	Number of appointments booked by non digital routes	N/A	Access	Phase 1 and Phase 2

Delivery of model designed around population need and inequality	Quantitative	Improved access, reduced waiting times, earlier diagnosis and reduced preventable mortality with a focus on CVD, Cancer & Respiratory disease, neighbourhood alignment	Validated data and insights, contract meetings			Both phases
	Qualitative					

[editable KPI schedule available here: Phlebotomy KPI Schedule v0.1.docx]

There are many further anticipated benefits which will be quantified and baselined throughout the design phase, in collaboration with the provider(s) and stakeholders. These are expected to include:

- Delivery of the programme ambition
- Delivery of national policy
- Delivery of ICB strategic priorities
- Enhanced outcomes for patients
- Reduced referrals into secondary care
- Improved patient satisfaction with access
- More sustainable approach to surge during winter

6.4 Governance

The process will be for the Phlebotomy business case to initially be reviewed by Joint Executive Team (JET). There will be a revised spend review panel across the cluster and as such they will have permission to sign off the case. If there is a cost pressure that cannot be covered by existing budgets it will then go the Finance and Contracting Committee.

6.5 Timescales for Delivery

Action	Owner	Indicative Timescale	Output
Agree approach JET and draft formal project documentation, initiate project governance	Commissioning Lead	April 2026	Approach agreed and mapped out with input from relevant colleagues across ICB and system as required
Block review to determine actual funding available within UHN contract	Finance Lead	April 2026	Amounts listed do not necessarily represent the total actual costs and UHN has not provided details of the service model. Further work is needed to understand if

			any funding is included in the block contract element that can be agreed to remove by NICB and UHN
Finance and Activity Modelling of Primary Care Approach	Finance Lead	April 2026	Understand financial impact to ICB and likely capacity requirements
Informal engagement with LMC re situation and potential LES solutions	Commissioning/ Primary Care Leads	April- May 2026	Scope ability to step up required capacity
Develop business case for phase one solution	Working group	May-June 2026	Formal business case finalised including financial, activity, operational and quality impacts
PDG Sign Off	Commissioning/ Procurement Lead	June 2026	Agreement of Procurement Approach
Business Case sign off	Commissioning/ Primary Care Leads	June 2026	Joint Executive Team sign off
Strategic Commissioning Committee Sign Off	Commissioning/ Finance Lead	July 2026	7 July 2026
Finance Committee Sign Off	Commissioning/ Finance Lead	July 2026	7 July 2026
Negotiations and contract agreement with primary care	Commissioning/ Primary Care Leads	July-August 2026	Updated contracts agreed
Implementation/ roll out	Primary Care	August – October 2026	Primary Care undertake necessary recruitment/training etc
Go Live Phase One	Primary Care	November 2026	Phased “new” service live
UHN Ceases	Contract Team	January 2027	Residual service at UHN for “hard to bleed” and under 12s remains
Ongoing Management of Phase One service	All	January 2027	
Phase 2 procurement	Commissioning Lead	October 2026 Onwards	Procurement process including time for market engagement, evaluation and mobilisation period prior to new contract start.

To ensure no gaps in service provision, a new service must be in place by January 2027 (Phase 1). This timescale aligns with the 12 months' notice served by UHN on the provision of "community" requested phlebotomy in the county (venepuncture blood sample activity requested outside of the hospital), (Appendix 1).

Phase 1 will be for an initial 12-month period with the option to invoke a 6-month contract extension as required allowing the Commissioner time to stabilise the service while an MSP or Competitive process is undertaken for a long-term solution.

This also provides the opportunity for Commissioners to explore whether to bundle community requested Phlebotomy with other diagnostic services, such as Spirometry, to procure a neighbourhood diagnostic service to complement and enhance the national Community Diagnostic Centre (CDC) programme, and enables Commissioners to work strategically, with Primary Care, in this area.

Phase 2 implementation will be by January 2028 at the earliest, or, if a 6-month contract extension option is invoked, by July 2028. The ICB would need to start to develop the process immediately for Phase 2, as a medium to long term mobilisation period will be likely. The ICB would need to begin market engagement and development of the service specification first.

6.6 Programme Risks

The matrix below provides a probability and severity risk matrix; providing a high-level overview of the programme risks and their consequences (Impact). It provides the likelihood (or probability) of the risk occurring (X axis) and the impact (or severity) if the risk were to materialise (Y axis).

		LIKELIHOOD		
		Unlikely to happen	Possibility could happen	Likely to happen
IMPACT	Significant Consequence		Unwarranted overactivity due to increased payment tariff for new model Lack of suitable estates Potential lack of enough trained staff to meet the phlebotomy demand under new contract Potential for legal challenge should the Urgent Award process be used	Lack of service for non-urgent GP requested phlebotomy from 15 January 2027 Potential patient harm due to lack of practice based service Potential gap in phlebotomy service or a reduced availability during transition between providers, or the chosen model enabling practices to "opt out" and leave gaps in countywide coverage Data from UHN is significantly limited with variations dependent on methodology to develop reports Exclusion of weekend operating would exclude patient population groups from service, not meeting population need and worsening health inequalities
	Moderate Consequence		GP National collective action ICB ability to deliver with available capacity	Provider lack of interest in bidding due to procurement options

	Low Consequenc			
RAG	Low Risk	Moderate Risk	High Risk	Critical Risk

The Steering Group will oversee risk management for the programme by reviewing the project risks, approving mitigation strategies, and intervening when issues escalate.

Key risks of the Programme:

- Lack of service for non-urgent GP requested phlebotomy from 15 January 2027. The impact of this includes potential patient harm through delayed diagnosis and access to treatment; reputational risk; inability to provide critical function and discharge statutory duties; lack of business continuity; increased referrals to/ attendance at acute hospital settings and increased GP demand causing unstainable activity.
- Limited service or reduced availability during transition period. The impact of this includes a gap in service; reduced capacity; increased waiting lists and exacerbation of current issues.
- Unwarranted overactivity leading to financial exposure and reduction in patient experience.
- Legal challenge on procurement process. The impact of this includes the potential for the urgent award decision to be overturned; re-evaluation or restart of the procurement procedure properly; payment of damages to the disappointed provider for lost profit and payment of civil penalties and shorten the duration of the unlawful contract.
- Potential exposure to Transfer of Undertakings Protection of Employment (TUPE) of staff.

For the full risk log, with rationale and mitigations, where in place, see Appendix 8.

Appendices: (to view Open in Desktop)

Appendix 1	UHN Phlebotomy Notice letter	Phlebotomy Notice letter.pdf
Appendix 2	JET updates SBAR Phlebotomy UHN Notice NICB Phlebotomy JET update April 2026 NICB Phlebotomy JET next steps April 2026	Northamptonshire_ICB_SBAR_Phleb_UHN NICB%20Phlebotomy%20JET%20Update NICB%20Phlebotomy%20JET%20Next%2
Appendix 3	Draft NICB Adult & CYP Phlebotomy v0.4 specification	NICB Adult & CYP Phlebotomy Spec - v
Appendix 4	EQHIA	Stage%201%20-%20EQHIA%20Initial%20

Appendix 5	Finances – Phlebotomy Northants Work v5	[OBJ]
Appendix 6	Urgent award process map & decision-making record	Urgent%20Circumstances%20-%20Proc Urgent%20Circumstances%20-%20Decis
Appendix 7	PAA	PAA%20-%20Procurement%20Approach
Appendix 8	Risk Log	Risk log v0.1.xlsx

Appendix 2

1.Phlebotomy – Adults and Children -Primary and Neighbourhood Care

Primary and Secondary initiated bloods service in general practice for children and adults.

Including blood tests for Glucose Tolerance Testing and Annual surveillance of at-risk individuals from Prostate Cancer

1. Phlebotomy – Primary and Neighbourhood care			
Clinical Lead: **Management Lead:**			
	Payment Mechanism	**Amount**	**SNOMED Code**
1a. Phlebotomy – Primary and secondary care **Adults**	Item of service (Monthly claims)	£4.38	Blood sample taken: (313334002) **AND** If sample requested from secondary care: (165791000000107)
1b. Phlebotomy – Primary and secondary care **Children**	Item of service (Monthly claims)	£7.82	Blood sample taken: (313334002) **AND** If sample requested from secondary care: (165791000000107) With a search setup with age added

01a. Service Specification - Adults

01b. Service Specification - Children

To Note:

- Search criteria will be based on the age as per the specification.
- Payment will be made according to age.

Service Specification No.	Northamptonshire Community Phlebotomy Service 01a
Service	Primary and Secondary Care-Initiated Phlebotomy - Adults
Commissioner Lead	Northamptonshire ICB
Period	
Date of Review	Annually

1. Population Needs

1.1 Local context

The primary and secondary care-initiated (where appropriate) blood testing service provides capacity for patients to receive diagnostic tests in a locally accessible primary care / neighbourhood setting.

Previously the phlebotomy service was commissioned as a Local Enhanced Service, and via secondary care. This model supports secondary care pathways, providing care closer to home. Its continued provision is in-line with the concept of "left shift" to deliver services in the most appropriate setting, by the most appropriate clinician. The service is in line with the principle of "by working with others and making most effective use of resources, we will provide the best possible care for our patients and empower them to make informed decisions about their health."

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 2.2 Local defined outcomes

The Provider shall offer a patient-focused and easily accessible service.

The Provider will work as part of Primary Care in Neighbourhoods to ensure that practices can deliver a service that is:

- Available to 100% of the clinically appropriate Northamptonshire population
- To support secondary care delivery of virtual outpatient appointments and pathways that require ongoing/routine monitoring
- Care closer to home
- Increased level of patient satisfaction, access and experience
- Reduced health inequalities
- More cost-effective care

3. Service Outline

3.1 Service Model

- Coordinate and manage access to routine phlebotomy tests for adults aged 16+ in General Practice/ Neighbourhoods to negate patients needing to go to an acute trust.
- Build on the model to ensure that services are localised, convenient, integrated and easily accessible for patients, improving patient experience and reducing health inequalities.
- Work towards development of services which align to neighbourhood footprints
- Provide a practice delivered, primary-care based, robust, flexible and patient-focused high-quality phlebotomy service that meets local population need.
- The provider will make best use of available workforce in Primary Care through training and development and utilisation of staff in flexible roles.
- The Provider will advertise how patients can access the Service in waiting areas and any leaflet which promotes the ranges of all services that are delivered.
- The procedure should be undertaken utilising best practice guidelines including as a minimum hand washing, cleanliness (alcohol) of the insertion site, correct equipment /consumables and documentation.
- Clinically warranted as part of acute or chronic health concern indicating the need for venepuncture for the investigation or monitoring of confirmed or suspected illness. The following list includes a range of tests, but not limited to:
    - Full Blood Count
    - Urea & Electrolytes
    - INR
    - Thyroid Function Test
    - Liver Function Test
    - Fasting Glucose Tolerance
    - PSA monitoring
    - Glucose sensing
    - CRP
    - HBA1C
    - Ferritin and Folate
    - B12
    - Plasma Viscosity
    - Urate
    - Lipids

- All immunology tests
- Other tests by confirmation and discussion with provider

The Provider must transcribe Anglian ICE pathology laboratory results into the patient's clinical records in the timeframes set out in the providers workflow policy.

The service will be sensitive to individual patient needs, ensuring adherence to the protected characteristics. Reasonable adjustments should be made, where needed, to support patient attendance and experience.

The service should be offered within Core hours (hours of operation to be agreed with the Commissioner) by a suitably qualified person, qualified to undertake venepuncture procedures. Any additionality in hours will be subject to the provider agreeing relevant logistical support for transport of blood samples and analysis of those samples with the relevant provider (usually University Hospitals Northamptonshire). The Commissioner will not be liable for costs incurred for provision of services outside core hours.

3.2 Care Pathways

- GP/healthcare professional, having decided a blood sample is required, will ensure the patient does not fall within the exclusion criteria for the service and will complete the appropriate requisition/blood form with GP Practice details.
- Secondary care requests a blood test via discharge letter for any reason, but not exclusive to ongoing monitoring of a health condition or as part of blood test monitoring for shared care. This also includes patients directly being given a blood form following a secondary care appointment or based on advice given to the GP through advice and guidance platforms.
- Patient will have their appointment booked either by the referring healthcare professional, or by contacting their relevant practice either online or via telephone, whichever is most appropriate, noting that arrangements may differ by practice.
- The patient should be offered an appointment within 10 working days for routine blood tests, and within 2 working days for urgent blood tests. Practices should accommodate patients who require their testing to be specifically timed (for example female hormones)
- Patient attends appropriate appointment and venepuncture undertaken; the provider records the procedure on the patient record and the phlebotomy Ardens template.
- Collection of specimens taken to pathology department through existing arrangements as commissioned by UHN.
- Pathology results will be returned to patient's GP practice (for their record) and referrer (community and secondary care)
- Appointments should be flexible for patients specifically for those with additional needs such as learning difficulties where best practice should be followed.
- Responsibility for acting on the outcomes of tests remains with the requestor of the test. Where there are operational issues with the process of reporting, governance will remain with the relevant responsible party, for example if pathology results not reported from lab, or if digital issues with at scale provider beyond the scope of GP's control.

3.3 Population covered

Patients aged 16 years and over and registered with a primary medical provider in Northamptonshire.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria:

- Patients aged 16 and over
- Patients registered with a Northamptonshire GP Practice (noting practices should support registration where required)

Exclusion criteria:

- Patients under 16
- Secondary care ongoing monitoring of a health condition.
- Patients from whom venepuncture is “difficult” and are classed as “hard to bleed” in accordance with local definition.
- Patients on a secondary care 2WW/urgent pathway where a blood test is deemed clinically appropriate on the same day.
- Patients within a secondary care outpatient clinic where a blood test is deemed clinically appropriate on the same day.
- Patients requiring blood testing with specific sample management, which cannot reasonably be undertaken in Primary Care. Please see UHN’s Direct Access Service specification for the list of tests included.
- Patients under the care of Accident & Emergency or Inpatients.
- Services provided / appointments under Enhanced / Extended Access arrangements

3.5 Onward referral for advice/ escalation

Patients who are hard to bleed, in accordance with the locally agreed definition, those with established and recorded needle phobia, and those requiring reasonable adjustments beyond the scope of this service can be referred to the UHN Direct Access Service. Please note the UHN Direct Access Service is unable to provide sedation and patients requiring this should be referred through established specialist pathways.

3.6 Interdependence with other services/providers

To ensure the patients experience is a streamlined journey and a good experience, the provider must work collaboratively with the following to deliver services in an organised and cohesive manner:

- The Commissioner
- Primary Care Medical Providers, Federations, PCNs
- Pathology departments
- Sample transport service (commissioned by UHN)
- Northamptonshire NHS Foundation Trust
- University Hospitals of Northamptonshire
- Patient Transport services (both commissioned and voluntary)

4 Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

B0960-optimising-blood-testing-primary-care.pdf (england.nhs.uk)

4.2 NICE Guidelines - https://www.nice.org.uk/guidance/cg139

4.3 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

See 4.1 above.

4.4 Applicable local standards

- The provider must be CQC registered.
- The Provider will be expected to deal with any complaints received from patients about the service provided in line with the NHS Complaints Regulations (NHS Complaint Standards 2022).
- The Provider will have in place a robust incident reporting and investigation procedure in place for all clinical and non-clinical incidents and will give notification, in line with the current policy for reporting and handling of serious incidents within 24 hours of the information becoming known to them, to Northamptonshire ICB Patient Safety Team.
- Adherence to the NHSE Patient Safety Incident Response Framework (PSIRF) (2023).
- Patient data is kept confidential, with adherence to the 8 Caldicott principles (2020) and Data Protection Act (2018).
- Have regard to the principles in the Code of Practice on Confidentiality and Disclosure of Information.
- Must comply with relevant health and safety regulations that apply to all NHS providers.
- The Provider must ensure that it has appropriate arrangements in place for infection control and decontamination. The Provider is required to provide the services in accordance with national guidance i.e. National Institute of Health and Clinical Excellence (NICE) clinical guidelines 139 Prevention and control of healthcare-associated (March 2012).

The Provider will:

- Take measures to minimise the risk and spread of infection between patients and staff.
- Ensure the environment and equipment used for patient care is fit for purpose and decontaminated in line with national guidelines.
- Ensure all staff receive suitable and sufficient training and have been assessed as competent to ensure they are complying with national guidelines.

- Be required to participate in random unannounced audits if required by the commissioners e.g., environmental, cleanliness and infection prevention and control
- They must comply in full with recommendations made subsequent to these visits. Should demonstrate good infection control and hygiene practice and must ensure evidence-based protocols are in place to facilitate.
- Sub-contracted providers will have access to the ICE system to view and action pathology results, and the Ardens system for recording venepuncture appointments
- Minimise rates of spoiled and haemolysed samples by maintaining training standards and ensuring good blood sample control whilst the sample is within their care.

4.4 Electronic Medical Record Coding

The Provider is to ensure that they code the below accurately for payment and activity purposes and do not use any other codes.

The Provider must ensure that the patient record is coded with the following SNOMED codes:

- **Blood Sample taken 313334002**
- **AND if requested by secondary care- add 165791000000107 Phlebotomy generated from secondary care done by practices**

The Provider should also complete the appropriate Phlebotomy template on Ardens for each appointment.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements Monitoring and Reporting

The Provider must ensure that the service is delivered in accordance with current NHS standards, professional guidance, statutory requirements, and best practice relating to the provision of phlebotomy services. The Provider shall maintain appropriate arrangements to demonstrate compliance with these requirements throughout the contract term.
The Provider must:

- Deliver the service in accordance with relevant NHS England guidance, NICE guidance, professional standards, and local pathways.
- Ensure that all staff undertaking venepuncture are appropriately trained, competent and authorised to carry out the procedure, with competency maintained and reviewed in accordance with local workforce policies.
- Maintain appropriate clinical governance arrangements, including systems for incident reporting, learning, escalation, and implementation of improvement actions.
- Comply with the NHS Patient Safety Incident Response Framework (PSIRF), ensuring that all Patient Safety Incident Investigations (PSIIs) where required, are reported, managed, investigated, and acted upon in accordance with national and local requirements, with evidence of learning and improvement maintained.

- Maintain robust arrangements for infection prevention and control, health and safety, information governance and safeguarding in line with applicable legislation and NHS requirements.
- Ensure services are delivered in a manner which promotes equity of access, supports reasonable adjustments, and meets the needs of patients with protected characteristics, learning disabilities, autism, communication needs or other additional requirements.
- Participate in any commissioner-led quality review, audit, service evaluation or assurance process reasonably required to demonstrate compliance with this specification.
- Take all reasonable steps to ensure that blood samples are collected, handled, stored, and transported in accordance with agreed laboratory and clinical protocols to support sample integrity and patient safety.
- Hold and make available, on request, evidence of compliance with the requirements of this specification, including policies, procedures, staff training records, competency assessments and clinical governance documentation
- Accept the local Phlebotomy contract on Ardens and complete the Ardens template for each venepuncture episode

Monitoring and Reporting (as a part of the wider Primary Care Quality Schedule)

- The Lead provider, acting on behalf all subcontracted providers will supply Commissioners with an analysis of:
  - Number of complaints received, serious incidents, significant events or complications relating to this service.
  - Any further data which could better inform service design, function or delivery with Commissioners.
  - All providers (Lead and subcontracted, where involved in direct patient delivery), will be required to accept the local Phlebotomy contract on Ardens and complete the Ardens template for each venepuncture episode

6. Location of Provider Premises

The Service will be delivered from any premises accredited to provide primary care services within the Northamptonshire commissioned geography.

7. Reimbursement of Service

Pricing and Payment

- The rate of payment is £4.38 per adult blood test appointment.

- The Lead Provider will be paid on a cost per case based on appointment. They will then renumerate subcontracted providers accordingly.

- The Lead Provider is entitled to make a fair and reasonable deduction on the cost of each test performed, by agreement with subcontracted providers, to discharge the duties of Lead Provider in terms of management, quality assurance and financial validation.

- The Lead Provider will be required to submit monthly, validated, retrospective invoices to the ICB on behalf of all subcontracted providers. The time limit on raising invoices will be …… days/weeks following month end

- Providers **will not** be paid for failed venepuncture attempts; and invoices must not be raised which include these.

- Providers **will not** be paid under this contract for any phlebotomy carried out through Extended / Enhanced Access arrangements, as these are separately renumerated.

- Claims can only be made once. i.e. any duplications submitted under any existing LES will only be paid under this contract.

- Providers **will not** be paid under this contract for any phlebotomy carried out by NHFT Community Nursing teams, which are taken to GP practices for onward conveyance to the Pathology lab.

- It is important that practices use the codes stipulated above, to ensure all activity is reported correctly.

Service Specification No.	Northamptonshire Community Based Services 01b
Service	Children and Young People Phlebotomy Service – 12 – 15 years and 364 days
Commissioner Lead	Northamptonshire ICB
Period	
Date of Review	Annually

1. Population Needs

1.1 Local context

The primary and secondary care-initiated blood testing service provides capacity for patients to receive diagnostic tests in a locally accessible primary care / Neighbourhood setting.

Previously the phlebotomy service was commissioned as a Local Enhanced Service, and via secondary care. This model supports secondary care pathways, providing care closer to home. Its continued provision is in-line with the concept of "left shift" to deliver services in the most appropriate setting, by the most appropriate clinician. The service is in line with the principle of "by working with others and making most effective use of resources, we will provide the best possible care for our patients and empower them to make informed decisions about their health."

2. Outcomes

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

The Provider shall offer a patient-focused and easily accessible service. The Provider will work as part of Primary Care to ensure that practices deliver a service that is:

- Available to 100% of the clinically appropriate Northamptonshire population
- To support secondary care delivery of virtual outpatient appointments and pathways that require ongoing/routine monitoring
- Care closer to home
- Increased level of patient satisfaction
- More cost-effective care

3. Service Outline

3.1 Service Model

- Support access to routine phlebotomy tests for CYP 12 – 15 years and 364 days across Northamptonshire General Practice/ Neighbourhoods to negate patients needing to go to an acute trust/specialist service.
- Build on the model to ensure that services are localised, convenient, integrated and easily accessible for patients.
- Provide a practice delivered-primary care based robust, flexible and patient-focused high-quality phlebotomy service that meets local population need.
- The Provider will advertise how patients can access the Service in waiting areas and any leaflet which promotes the ranges of all services that are delivered.
- The provider will make best use of available workforce in Primary Care through training and development and utilisation of staff in flexible roles.
- The procedure should be undertaken utilising best practice guidelines including as a minimum hand washing, cleanliness (alcohol) of the insertion site, correct equipment / consumables and documentation.
- Provide patients with age-appropriate information including:
- What to expect during the appointment
- How to prepare
- Who to contact with any queries/concerns before and after the appointment including how to access result
- If additional need for support is highlighted when the appointment is booked, a support plan is agreed with the parent carer.
- Clinically warranted as part of acute or chronic health concern indicating the need for venepuncture for the investigation or monitoring of confirmed or suspected illness.
- The service will be sensitive to individual patient needs, including gender, age, culture, and religious beliefs.

3.2 Care Pathways

- GP/healthcare professional, having decided a blood sample is required, will ensure the patient does not fall within the exclusion criteria for the service and will complete the appropriate requisition/blood form with GP Practice details

- Secondary care requests a blood test via discharge letter for any reason but not exclusive to ongoing monitoring of a health condition or as part of blood test monitoring for shared care. This also includes patients directly being given a blood form following a secondary care appointment or based on advice given to the GP through advice and guidance platforms.
- Patient attends appropriate appointment and venepuncture undertaken; the provider records the procedure on the patient records.
- Collection of specimens – taken to pathology department through existing arrangements
- Pathology results will be returned to patient's GP practice (for their record) and referrer (community and secondary care)
- Appointments should be flexible for patients specifically for those with additional needs such as learning difficulties where best practice should be followed

3.3 Population covered

Patients aged 12 – 15 years and 364 days and registered with a primary medical provider in Northamptonshire.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance criteria:

- Patients aged 12 – 15 years and 364 days.
- Patients registered with a Northamptonshire GP Practice (noting practices should support registration where required)

Exclusion criteria:

- Children and Young people under 12
- Secondary care ongoing monitoring of a health condition
- Patients from whom venepuncture is difficult.
- Patients on a secondary care 2WW/urgent pathway where a blood test is deemed clinically appropriate on the same day.
- Patients within a secondary care outpatient clinic where a blood test is deemed clinically appropriate on the same day.
- Patients under the care of Accident & Emergency or Inpatients.

3.5 Onward referral for advice/escalation

Patients who are hard to bleed/require specialist support can be referred to UHN Phlebotomy Service who manage ALL children 0-11 and 364 days plus up to 16 years where specialist support is required.

3.6 Interdependence with other services/providers

To ensure the patient's experience is a streamlined journey and a good experience, the provider must work collaboratively with the following to deliver services in an organised and cohesive manner:

- The Commissioner
- Primary Care Medical Providers
- Pathology departments
- Northamptonshire Healthcare NHS Foundation Trust
- University Hospitals Northamptonshire

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- B0960-optimising-blood-testing-primary-care.pdf (england.nhs.uk)
- CG139 - Healthcare-associated infections: prevention and control in primary care (2011)
- CG89 – Child maltreatment: when to suspect maltreatment in under 18s (2017) PH52 - Needle and syringe programmes (2014)
- PH43 – Hepatitis B and C testing: people at risk of infection (2013) PH28 – Looked after children and young people (2015)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

See 4.1 above.

4.3 Applicable local standards

- The provider must be CQC registered.
- The Provider will be expected to deal with any complaints received from patients about the service provided in line with the NHS Complaints Regulations (NHS Complaint Standards 2022).
- The Provider will have in place a robust incident reporting and investigation procedure in place for all clinical and non-clinical incidents and will give notification, in line with the current policy for reporting and handling of serious incidents within 24 hours of the information becoming known to them, Northamptonshire Patient Safety Team.
- Adherence to the NHSE Patient Safety Incident Response Framework (PSIRF) (2023).
- Patient data is kept confidential, with adherence to the 8 Caldicott principles (2020) and Data Protection Act (2018).
- Have regard to the principles in the Code of Practice on Confidentiality and Disclosure of Information.
- Must comply with relevant health and safety regulations that apply to all NHS providers.

- The Provider must ensure that it has appropriate arrangements in place for infection control and decontamination. The Provider is required to provide the services in accordance with national guidance i.e. National Institute of Health and Clinical Excellence (NICE) clinical guidelines 139 Prevention and control of healthcare-associated (March 2012).
- The practice, as the data controller, is responsible for liaising with their Data Protection Officer to ensure the necessary information governance arrangements, such as a Data Sharing Agreement, are put in place to cover any new delegation arrangements.

The Provider will:

- Take measures to minimise the risk and spread of infection between patients and staff.
- Ensure the environment and equipment used for patient care is fit for purpose and decontaminated in line with national guidelines.
- Ensure all staff receive suitable and sufficient training and have been assessed as competent to ensure they are complying with national guidelines.
- Be required to participate in random unannounced audits if required by the commissioner's e.g., environmental cleanliness and infection prevention and control. They must comply in full with recommendations made subsequent to these visits.
- Should demonstrate good infection control and hygiene practice and must ensure evidence-based protocols are in place to facilitate.
- Practices will have access to the ICE system to view and action pathology results.

4.4 Electronic Medical Record Coding

The provider is to ensure that they code the below accurately for payment and activity purposes and do not use any other codes.

The Provider must ensure that the patient record is coded with the following SNOMED codes:

- **Blood Sample taken 313334002**
- **AND if requested by secondary care- add 165791000000107 Phlebotomy generated from secondary care done by practices**

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Monitoring and Reporting – Quarterly

- The Commissioners will extract data via LHIS from the providers to support the quarterly claims process. This will include:
  - Site of where the event was done (practice code)

- Month and year of test
- Number of tests
- Type of test (primary or secondary care initiated)

Monitoring and Reporting (as a part of the wider Primary Care Quality Schedule)

- The providers will supply Commissioners with an analysis of:
  - Number of complaints received, serious incidents, significant events or complications relating to this service.
  - Any further data which could better inform service design, function or delivery with Commissioners.

6. Location of Provider Premises

The Service will be delivered from any premises accredited to provide primary care services within the Northamptonshire commissioned geography.

7. Reimbursement of Services

7.1 Pricing and Payment

This service will be funded via an NHS Standard Contract

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate

Not applicable to this service.

Appendix 3

Initial Equality, Quality & Health Inequalities Impact Assessment (EQHIA)

NHS 75
Northamptonshire
Integrated Care Board

Section 1: Proposal Details

Proposal/Project Title:
Lead Officer: Email:
Department/Service: Date:
Brief Description of Proposal: *Describe the current situation and what you are proposing to change*

UHN has given 12 months' notice to cease provision of community-requested phlebotomy services, currently delivering a high-volume service (~279,000 appointments annually) with known challenges including long waits and complaints.

Current provision is fragmented, with:

- Hospital-led services under pressure
- A Local Enhanced Service (LES) in primary care that is variably implemented
- Inconsistent access across practices and geographies

The proposal is to:

- Develop and procure a new community-based phlebotomy model
- Use an initial stabilisation phase via primary care (LES) followed by a longer-term neighbourhood-based model
- Design a service specification and evaluation criteria that require providers to address:
    - Access inequalities
    - Capacity constraints
    - Patient experience and waits
    - Integration with wider care pathways

This EQHIA relates primarily to the design of the future service specification and procurement approach, rather than a fixed delivery model.

Who will be affected by this proposal? *Consider patients, service users, staff, partners, communities, identified numbers affected where possible*

Staff	Service User/ Patients	Carers	Partner Organisations	Voluntary Groups/ Communities/unions
☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No
Other:	Patients with specific and multiple LTC and health needs will access the service significantly more than the "average" patient.			

Section 3: Decision and Next Steps (please complete Section 2 prior to this)

Based on this initial assessment, do you believe a full EQHIA is required?
☑ Yes - because: Significant service with key issues to be addressed by provider
☐ No - because: No negative impacts on communities, project aim is to be inclusive.
☐ Unsure - I need advice on: _____
What engagement do you plan to undertake before implementing this proposal? *Who will you speak to and how? Engagement with Neighbourhood and Patient groups as well as GP and clinical bodies.*

Sign-off:
Project Lead:
Date:
Line Manager:
Date:
EQHIA Panel:
Submit completed form to: northantsicb.icbeqia@nhs.net

Engagement Approach: *Describe the engagement undertaken including co-production. Identify groups engaged with and how their input has been actioned.*
Engagement with:

- Primary Care (LMC, PCNs, practices)
    - Providers (existing and potential)
    - VCSE sector (to reach underserved groups)
- Co-production to focus on: Access barriers (travel, booking, repeat visits), Experience of high-frequency users. Further engagement required as part of procurement design.

Initial Equality, Quality & Health Inequalities Impact Assessment (EQHIA)

Section 2 Impact and Risk Assessment

Northamptonshire Integrated Care Board

A. Equality and Human Rights Impact

- **Could this proposal affect people differently based on their protected characteristics?** *Consider age, disability, gender, race, religion, sexual orientation, pregnancy/maternity, marriage/civil partnership*
- **Are there any other groups who might be particularly affected?** *Consider carers, people experiencing homelessness, people with addictions, refugees, people in poverty*
- **Are there any human rights considerations?** *Right to life, liberty, privacy, family life, freedom from discrimination*

Briefly describe the impact focus on potential negative impacts and mitigation.

Human Rights Considerations

- Right to access healthcare (timely and equitable)
- Risk that poor access could indirectly impact:
  - Disease management
  - Safety (missed monitoring)
- Requirement to ensure non-discriminatory access design

The proposed redesign offers an opportunity to improve equity of access for high-need groups, including older people, those with long-term conditions, and deprived or rural populations, through more localised, integrated and flexible provision. However, there is a risk inequalities could worsen if access becomes more limited, overly centralised, or reliant on digital systems. This could lead to increased travel, delays, and missed monitoring, particularly for frequent users. These risks can be mitigated through an equity-led specification, including proportionate provision based on need, non-digital access routes, integrated delivery with wider services, and monitoring of access and outcomes across different groups.

Equality Characteristic		Equality Characteristic	
Age	☑ +ve☐ -ve ☐ Neutral	Sex	☐ +ve☐ -ve ☑ Neutral
Disability	☑ +ve☐ -ve ☐ Neutral	Sexual Orientation	☐ +ve☐ -ve☑ Neutral
Gender	☐ +ve☐ -ve ☑ Neutral	Human Rights	☐ +ve☐ -ve ☑ Neutral
Marriage & Civil Partnership	☐ +ve☐ -ve ☑ Neutral	Community Cohesion & Social Inclusion	☑ +ve☐ -ve ☐ Neutral
Pregnancy & Maternity Status	☑ +ve☐ -ve ☐ Neutral	Safeguarding	☐ +ve☐ -ve ☑ Neutral
Religion & Belief	☐ +ve☐ -ve ☑ Neutral	Other Health Inclusion Groups at Risk	☑ +ve☐ -ve ☐ Neutral

B. Quality Impact

- **How might this proposal affect the quality of care or services?** *Consider patient safety, experience, clinical effectiveness, staff wellbeing.*
- **Are there any regulatory or compliance considerations?** *CQC standards, NICE guidance, professional standards*

The proposed change presents both risks and opportunities for service quality. There are potential benefits if provision becomes more local, integrated, and aligned to care pathways, improving patient experience and timeliness of testing. However, there are important quality risks to address, including ensuring sufficient activity levels to maintain staff competency in venepuncture, particularly in smaller or distributed models, and maintaining robust sample handling processes. Timely transport of samples to laboratories will be critical to avoid degradation and delays in results, which could impact clinical decision-making and patient safety. Additional risks include inconsistent standards across providers, fragmentation from wider clinical pathways, and capacity pressures leading to delays in appointments or reporting. These risks can be mitigated through a clear service specification setting minimum quality standards, workforce competency requirements, integrated pathways, and defined expectations for logistics, turnaround times, and performance monitoring.

Quality Impact Screen (Provide evidence for scoring)

Patient Safety	☐ +ve☐ -ve ☑ Neutral	Risk if access delays monitoring; opportunity if local access improves
Clinical Effectiveness	☑ +ve☐ -ve ☐ Neutral	Better integration with care pathways
Patient Experience - personalised	☑+ve☐ -ve ☐ Neutral	Reduced travel, improved convenience (if designed well)
Well-led	☐ +ve☐ -ve ☑ Neutral	Dependent on provider capability
Sustainable	☑ +ve ☐ -ve ☐ Neutral	Reduced travel, other aspects dependent on workforce and capacity model
Addresses Inequalities	☑ +ve☐ -ve ☐ Neutral	Significant potential to improve

C. Core20PLUS Populations

- **Will this proposal affect the most deprived 20% of communities in Northamptonshire?** *Consider access, experience, outcomes for people in our most deprived areas*
- **Will this proposal affect any of the national or local 'PLUS' populations?** *See guidance sheet for full list. Consider: Learning disabilities/autism, racialised communities, homeless, rural communities, military veterans, Gypsy/Roma/Traveller communities, contact with criminal justice*

The proposed service redesign has significant implications for Core20PLUS populations, who are likely to be among the highest users of phlebotomy due to greater prevalence of long-term conditions and poorer baseline health outcomes. There is an opportunity for the new model to reduce inequalities by improving local access, integrating testing with wider care, and proactively targeting underserved groups. However, there is a material risk that inequalities could widen if the service is not designed with these populations in mind, for example through reduced local availability, transport barriers, limited appointment flexibility, or reliance on digital systems. Providers will therefore need to demonstrate how their model identifies and responds to variation in need and access, including targeted provision for deprived and inclusion groups, proactive outreach where appropriate, and routine monitoring of access, utilisation and outcomes to ensure equitable service delivery.

Health Inequalities Impact Screen (Provide evidence for scoring)

Core20 (Most Deprived) Populations	☐ **+ve**☐ -ve ☐ Neutral	More use due to higher disease burden. Issues: • Risk of:Travel/access barriers • Lower engagement if service model is complex
PLUS Populations (Including Racialised Communities)	☐ **+ve**☐ -ve ☐ Neutral	• Racialised communities • Rural populations
Health Inclusion Groups	☐ **+ve**☐ -ve ☐ Neutral	• People with learning disabilities/ • Homeless

D: Risk and Mitigation

- **What are the main risks or concerns you have identified?** *List the key potential negative impacts*
- **What actions could be taken to reduce negative impacts or increase positive ones?** *Think about design changes, additional support, alternative approaches*
- **Are there any gaps in your knowledge or understanding?** *What don't you know that you need to find out?*

The risk scoring matrix below should be used to assess impact of any negative risks associated with Equality, Quality and Health Inequalities:

	Probability ⇨				
Impact ⇩	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

NICB CA01 Risk Management and Board Assurance Framework Policy

	Risk Description	Actions to Minimise Adverse or Negative Impacts	Any other comments or recommendations from Project Lead	Impact (I) x Likelihood (L)		
				I	L	Impact x Likelihood
1	Inequitable access	1. Ensure specification is clear around access requirements 2. Engagement to inform spec				
2	Insufficient Capacity Leading to Delays	1. Population based forecasting of future need 2. Ensure specification is flexible to allow additional activity				
3	Disproportionate access burden for patients requiring frequent testing	1. Patient group engagement 2. Analysis of high need /high frequency patient cohorts				

Boards Meeting in Common in Public

Report Title: Obesity Pathway Innovation Programme (OPIP)

Date of Meeting: Thursday 20 August 2026

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

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Obesity Pathway Innovation Programme (OPIP)**		
Paper Reference No:	**ICBIC-26-44**	**Agenda Item No:**	**10.**

Presented by	**Claire Ellwood, Chief Pharmacist**
Report Author(s)	**Claire Ellwood, Chief Pharmacist**
Executive Sponsor	**Nilesh Sanganee, Chief Medical Officer**

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

Recommendations

The Boards are asked to:

- **NOTE** the successful OPIP bid for LNR ICBs, the benefit for our populations and plan for Neighbourhood-level porgramme delivery, with the ICB working with Northamptonshire Partnership NHS Trust (NHFT) as a Delivery Partner.

Executive Summary of the report

The Obesity Pathway Innovation Programme (OPIP) in LNR will deliver a Neighbourhood-based obesity model that integrates prevention, early intervention, behavioural support, pharmacological management and specialist services. The programme seeks to move obesity care closer to communities through a neighbourhood health approach that reduces inequalities whilst improving accessibility, patient experience and health outcomes.

OPIP will deliver all-age pathways, aiming to impact on 20,000 children, adolescents and adults by March 2029, with up to 5000 receiving pharmacological management. It is additional to existing weight management services. It will be rolled out sequentially to neighbourhoods across both ICBs.

The LNR OPIP plan specifically targets reducing inequalities in accessing and benefiting from services and will utilise neighbourhood delivery to address needs of our specific communities and

patient groups, including both rural and urban communities.

LNR ICBs will act as the Strategic Commissioner and Grant Holder for OPIP, with NHFT as the Delivery Partner responsible for tactical and operational commissioning arrangements, implementation, programme management and coordination of partners and sub-contractors.

Other anticipated delivery partners include NHS providers, Primary Care providers, Community Pharmacy providers, Local Authority Public Health teams, Voluntary, Community and Social Enterprise (VCSE) organisations and Health Innovation East Midlands (HIEM). The University of Leicester is a key partner in supporting programme evaluation.

The programme will:

- Develop and implement a Neighbourhood Access and Management Service, including a Single Point of Access, for obesity pathway delivery and evaluation.
- Develop, implement and evaluate integrated neighbourhood-based obesity pathways across Leicester, Leicestershire and Northamptonshire.
- Improve access for underserved populations through targeted and culturally appropriate interventions.
- Deliver workforce development and training activities to support obesity pathway implementation.
- Embed digital infrastructure to support referral, triage, population health management, monitoring and evaluation.
- Provide a robust evaluation programme to generate evidence for future commissioning and national learning.
- Generate evidence to inform future obesity pathway development, commissioning decisions and potential wider adoption

Funding for OPIP is provided through Innovate UK and was awarded through a competitive bidding process, with LNR one of only 12 successful bids across the UK. LNR has been awarded £8 million funding between May 26 and March 29 through Innovate UK, with additional funding for medicines from NHS England

Independent grant funding has been provided by Eli Lilly and Company Limited in addition to the funding contributed by the Department for Science Innovation and Technology. The programme is being delivered through Innovate UK

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

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

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

Board Assurance Framework Risk - Please insert BAF risk identified in report	
LLR ICB BAF No:1, 2 and 5	**NICB BAF No: 3**

Appendices	Appendix 1 - Obesity Pathway Innovation Programme (OPIP) Presentation

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

This report has not been received by any other meeting.

The decision to bid for Innovate UK funding was agreed through Joint Executive Team (JET) and grant acceptance supported by JET. Appointment of NHFT as OPIP Delivery Partner was agreed through JET and NHFT governance structures.

The bid was developed with support from all partner organisations.

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

Appendix 1

Obesity Pathway Innovation Programme (OPIP)

20th August 2026

Bridging the Gap:

Delivering obesity pathways that reduce inequality in Northamptonshire and Leicester, Leicestershire and Rutland

Our OPIP Programme

- Delivered through Innovate UK
- One of 12 successful bids across the UK
- £8m funding over 3 years, plus additional NHSE funding for drugs
- Strong focus on innovation, evaluation and demonstrating ROI
- LNR focus on all-age pathways, delivered at Neighbourhood in collaboration with partner organisations
- Aim to be sustainable at end of project period
- Additional to existing services

Project Overview

Leicester, Leicestershire, Rutland and Northamptonshire face significant and persistent challenges associated with obesity and overweight, with substantial variation in prevalence, access to services and health outcomes between communities.

Obesity contributes significantly to the burden of long-term conditions including type 2 diabetes, cardiovascular disease, musculoskeletal disorders, respiratory disease and poor mental wellbeing.

Health inequalities are particularly pronounced amongst people living in deprived communities, ethnic minority populations, rural populations, children and young people, and people living with severe obesity.

Project Objectives

The LNR OPIP programme will:

- Develop and implement a Neighbourhood Access and Management Service (N-AMS), including a Single Point of Access, for obesity pathway delivery and evaluation.
- Develop, implement and evaluate integrated neighbourhood-based obesity pathways across Leicester, Leicestershire, Rutland and Northamptonshire.
- Improve access for underserved populations through targeted and culturally appropriate interventions.
- Deliver workforce development and training activities to support obesity pathway implementation.
- Embed digital infrastructure to support referral, triage, population health management, monitoring and evaluation.
- Provide a robust evaluation programme to generate evidence for future commissioning and national learning.
- Generate evidence to inform future obesity pathway development, commissioning decisions and potential wider adoption.

Our LNR Partnership

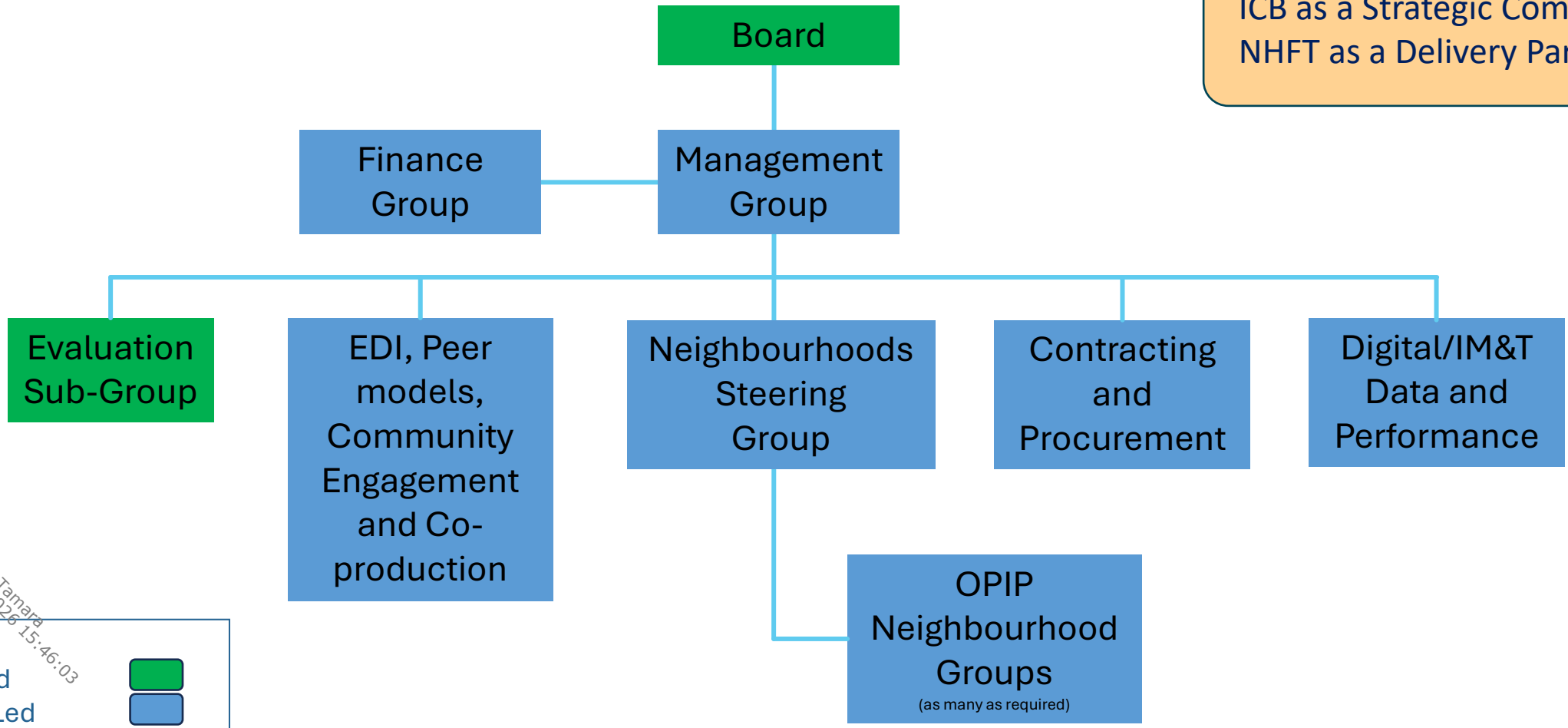
- Executive Lead: Prof Nil Sanganee, Chief Medical Officer
- SRO: Claire Ellwood, Chief Pharmacist
- ICB Programme Leads: Jade Atkin and Carly McDonald
- Delivery Programme Leads: Mark Roberts and Laura Rodman – Provider Trust

LLR and Northamptonshire ICB cluster	Northamptonshire Healthcare Foundation Trust (NHFT)	Health Innovation East Midlands	Specialist Adult and Paediatric Obesity Services
Applied Research Collaboration East Midlands	University of Leicester	Local Authority Public Health (across all LAs)	Community Pharmacy

Improving access - Reducing inequalities - **Generating learning**

LNR OPIP Programme Governance Structure

ICB as a Strategic Commissioner
NHFT as a Delivery Partner



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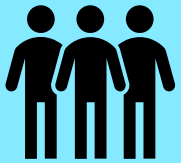
Key Benefits & Value

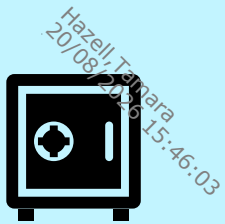


Patients, families and communities:

- Improved access to coordinated obesity care delivered closer to home
- More consistent support across neighbourhood, community and pharmacy settings
- Culturally responsive delivery and co-production embedded across the pathway

The NHS and the system:

- Reduced pressure on general practice and specialist services
- More efficient use of community pharmacy, VCSE and neighbourhood partners
- Improved system oversight through digital monitoring and reporting



Commissioning and future adoption:

- A fully operational, tested and commissioning-ready pathway
- Robust real-world evidence to support commissioning and scale
- A model suitable for adoption by other Integrated Care Systems

What Makes OPIP Innovative?

OPIP introduces a fully integrated, neighbourhood-based obesity system to tackle fragmentation, inequity and capacity gaps in current NHS services.

- 🏘️ **Neighbourhood MDT Hubs:**

Integrated MDTs uniting NHS, pharmacy, public health, Family Hubs & VCSE under shared governance

- 🔗 **Digital Single Access & Data Integration:**

Digitally integrated triage (EMIS/SystmOne) improving equity, automation & GP capacity

- 💊 **Pharmacy-Led Treatment:**

Neighbourhood-based pharmacotherapy delivered within enhanced shared-care governance.

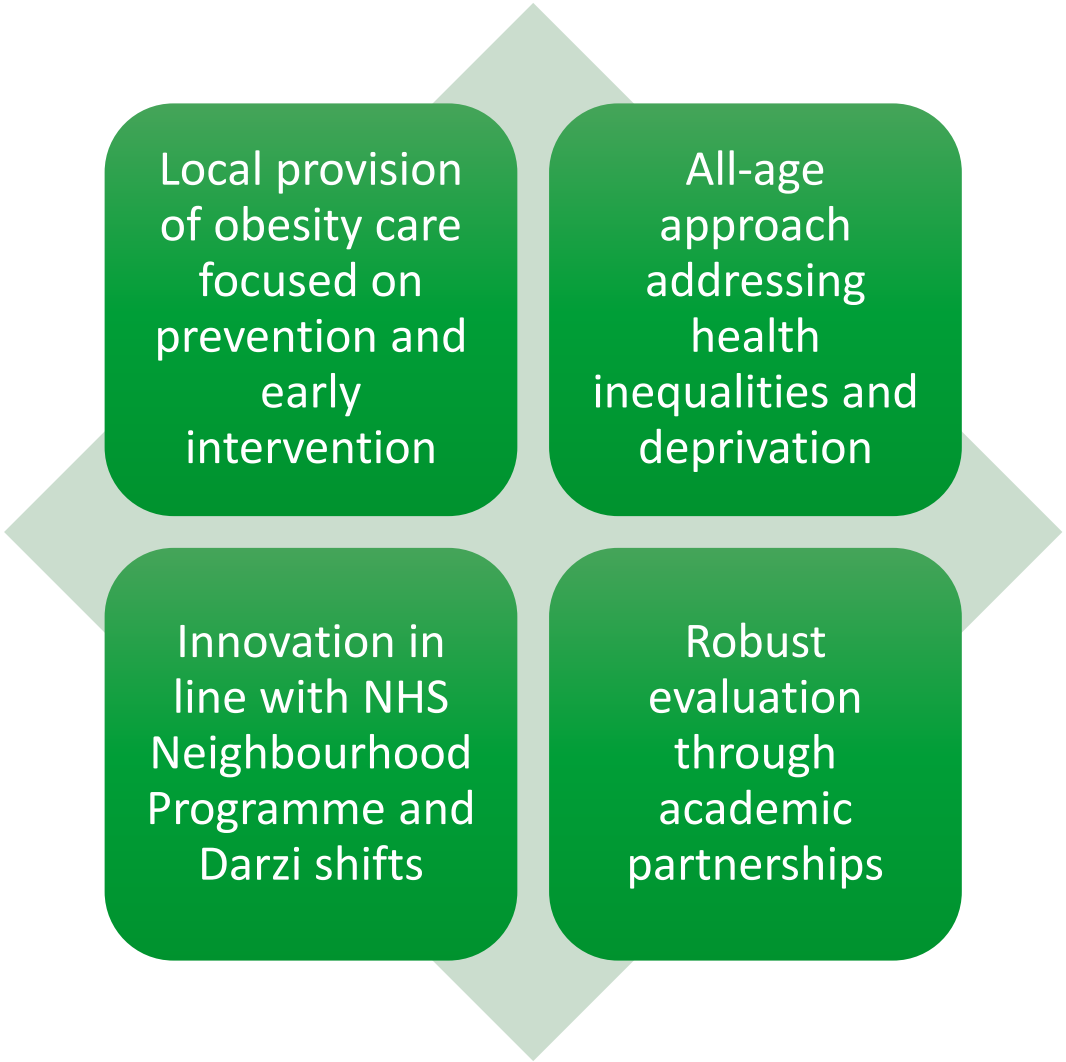
- 👨‍👩‍👧 **Life-Course Family Pathway:**

Joined-up support for children, young people and families – from schools to paediatric services.

- 📱 **Unified Digital Behaviour Change:**

Gamified, multilingual tools with consistent maintenance support across neighbourhoods.

Our Vision



Boards Meeting in Common in Public

Report Title: Quality and Performance Assurance Reports – LLR ICB and NICB

Date of Meeting: Thursday 20 August 2026

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

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Quality and Performance Assurance Reports – LLR ICB and NICB**		
Paper Reference No:	**ICBIC-26-45**	**Agenda Item No:**	**11.**

Presented by	**Maria Laffan, Chief Nursing Officer, LNR ICB** **Eileen Doyle, Chief Delivery Officer, LNR ICB**
Report Author(s)	**Miranda Tapfumanei, Director of Nursing for Quality Assurance and Deputy Chief Nurse LNRICB** **Chris Pallot, Director of Operations and Deputy COO, NICB**
Executive Sponsor	**Maria Laffan, Chief Nursing Officer, LNR ICB**

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

Recommendations

The Boards are asked to:

REVIEW and **NOTE ASSURANCE** from the Committees in Common for Quality, Performance and Outcomes which met on 11th August 2026

Executive Summary of the report

This report provides the August 2026 quality and performance assurance position for the Leicester, Leicestershire, Rutland and Northamptonshire (LNR) ICB Cluster, incorporating the assurances received through the Committees in Common for Quality, Performance and Outcomes (QPO) on 11 August 2026. The report is structured using the Alert, Advise and Assure framework to highlight key risks, areas requiring ongoing oversight, and areas where improvement activity is demonstrating progress.

The Committee noted continued operational and quality pressures across a number of priority areas. From a performance perspective, urgent and emergency care services continue to experience significant demand and flow pressures, with challenges relating to emergency department performance, ambulance handover delays, community waits and aspects of mental health performance. However, improvements were noted in ambulance handovers at UHL, 12-hour waits, referral to treatment performance, cancer pathways, diagnostics delivery and primary care access. System partners remain actively engaged in recovery activity across key

pathways.

From a quality perspective, continued focus remains on urgent and emergency care, children and young people's services, and the ongoing management of St Andrew's Healthcare. Particular attention continues to be given to neurodevelopmental waiting times, infant mortality improvement, Pharmacy, Optometry and Dentistry (PODS) governance arrangements, and the implementation of recovery and improvement programmes across maternity and emergency care services.

The Committee also received assurance regarding progress in a number of areas, including maternity improvement programmes, SEND reform implementation, Assertive Outreach services, audiology improvement activity, antimicrobial stewardship and provider oversight arrangements. Enhanced governance and monitoring arrangements remain in place where appropriate, with evidence that improvement actions are being progressed and risks actively managed.

Overall, the Committee was assured that robust governance, oversight and quality improvement arrangements are in place across the LNR Cluster. Whilst significant operational and quality pressures remain, particularly in relation to urgent and emergency care, children and young people's pathways, and workforce and capacity constraints in some services, risks are understood, actively monitored and subject to established recovery, improvement and assurance processes.

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

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

If conflicted identified, please list conflicted party and nature of conflict:
Peter Burnett, Chief Strategy Officer, declaration that spouse is Director of Midwifery and Deputy Chief Nurse University Hospitals Leicester.

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

Appendices	Appendix 1 – Quality and Performance August 2026 Presentation

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 11th August 2026.

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

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Appendix 1

Executive Summary - Performance

Alert

- 4-hour ED performance for all types at UHN has deteriorated significantly in June. UHL is also behind plan. All sites have seen an increase in attendances which are partially believe to be heat related. Paediatric and working age adult attendances are up at all ED's.
- Ambulance handovers at NGH are significantly off-plan (55 mins 58 secs against plan of 36 mins). Response times in Northants are off-plan.
- KGH diagnostic performance is behind plan with recovery actions being agreed. Both UHL and NGH performance exceed plan.
- Both LPT and NHFT are both behind plan for the majority of metrics in the quarterly Mental Health and Learning Disability table.
- Community waits of >52 weeks exceed plan for both adults and CYP in Northamptonshire but are on-plan in LLR.

Assure

- 12-hour ED performance is on-plan at both UHL and NGH.
- The number of available primary care appointments exceeds plan in both counties.
- Ambulance handover times at UHL have improved with corresponding favourable impact on response times.
- All Health Partners engaged across the cluster in work to address performance concerns across the UEC pathway.
- RTT – Improvement noted in the 18 weeks and 52 weeks noting that both remain just under plan. Overall waiting list numbers at ICB level are close to plan.
- Cancer waiting times improved and exceed plan at KGH and UHL. NGH close to plan.

Risks

- Operational pressures due to the emergency demand impacting upon elective activity – both ICBs continue to see significant operational pressure.
- Impact of court of protection delays due to MoJ impact on timelines adversely impacting on LOS – particularly LDA and Autistic Adults
- Planned GP Collective Action – awaiting further details – IG and Digital leads assessing impact. Communication out to General Practice.
- Risks for UEC delivery and elements of elective remain.

Advise

- MH – TT reliable improvement performance continues to be strong
- Continued improvement in delivery of diagnostics plan
- Delivery of the dental activity in LLR but behind plan in Northamptonshire
- Better Care Fund submissions agreed with Local Authorities signed-off by NHSE for both counties.
- Note the significant increase in the use of Pharmacy First with LLR seeing the most improved position in the region.

Quality Report – LNR Executive Summary

Quality Risk	Trajectory & Impact	Key Issues	Actions & Grip
Regulatory Oversight & CQC	Amber/Red – active oversight	StAH repatriation and inadequate rating; KGH maternity CQC inspection 07/2026; PODS oversight transfer due March 2026- deferred to Sep 2026	Intensive oversight of St Andrew's; KGH maternity improvement programme and CQC engagement; transition planning for PODS arrangements
Maternity & Infant Outcomes	Amber – ongoing scrutiny	Implementation of Ockenden, Amos and NHS England maternity actions; Leicester infant mortality remains a system priority	Multi-agency improvement programme, maternity assurance structures, enhanced governance and delivery oversight
Children & Young People Quality	Amber/Red – sustained pressure	Significant waits across neurodevelopmental, ADHD, autism and SALT pathways; SEND pressures; increase in unexpected child deaths under review	Recovery plans, pathway redesign, SEND reforms, system-wide child deaths review and strengthened oversight through CYP governance arrangements
Urgent & Emergency Care Quality	Amber/Red – improving but challenged	UHN emergency care pressures, corridor care, handover delays and patient flow risks	Section 29 assurance actions, system escalation, flow improvement programmes and ongoing quality oversight
Mental Health & Community Assurance	Amber – monitored risk	St Andrew's patient repatriation programme; Assertive Outreach review identified opportunities to strengthen data and outcome measurement	National and local oversight, repatriation planning, improvement plan for Assertive Outreach services and continued executive oversight

Quality Report – LNR Executive Summary

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

Quality Report – LNR Executive Summary July 2026

Alert

St Andrew's Healthcare (StAH): As Host Commissioner, NICB continues to participate in NHSE-led commissioner meetings to ensure accurate commissioner and keyworker information, oversight of placements, and support for repatriation and discharge planning, with a continued focus on quality and safety for remaining inpatients.

NHFT is undertaking due diligence and is expected to assume a caretaker delivery model from September 2026. Meanwhile, quality oversight continues through national and local assurance groups, weekly PEISG meetings, commissioner oversight arrangements, and ongoing NICB quality visits.

Recent developments include changes within the StAH executive team and a further CQC inspection scheduled for July 2026.The local multi-agency incident response established to monitor impacts on the wider community and local economy is expected to be stepped down due to minimal impact being identified.

Pharmacy, Optometry and Dentistry (PODS)
The current delegated arrangements for Pharmacy, Optometry and Dentistry (POD) services are under review. The ICB is working with partners to understand the implications of any changes and to ensure continuity of arrangements, clear accountability and appropriate governance, while minimising disruption for patients and providers.

Alert

System Child Deaths Rapid Quality Review was convened on 13 July 2026 to examine whether any immediate quality or safety concerns were associated with an increase in unexpected child deaths in Northamptonshire. The identified areas of development such as strengthening governance, pathways and communication. An oversight group continues to work through identified learning and areas of development.

Infant Mortality
A review of infant mortality trends for Leicester has highlighted ongoing challenges in improving outcomes for babies and families. Analysis has identified a range of contributing factors, including perinatal and neonatal causes, maternal health factors and wider determinants of health. A multi-agency improvement programme has been established with NHS England support and oversight through established quality governance arrangements. The focus is on coordinated system-wide action, robust governance and delivery of a shared improvement plan to drive better outcomes.

Children and Young People (CYP) SALT and ASD/ADHD waiting lists remain significant pressure areas, driven by sustained demand and capacity constraints, requiring continued senior oversight and delivery focus. Planned recruitment, pathway transition, digital access and measurable improvement actions should strengthen capacity, governance and support while families wait. Delays are impacting children and young people, particularly those with SEND, by increasing the risk of unmet need escalating into school exclusion, family crisis and urgent intervention

Quality Report – LNR Executive Summary

Advise

Short Breaks -The Squirrels
The Squirrels remains closed following concerns about clinical governance, care planning, assurance processes and training compliance. While the provider improvement activity is underway, the ICB does not yet have consistent assurance that the service can operate safely and sustainably. We recognise the significant impact on children, young people and families.
The ICB is working with families exploring alternative support, including other short-break providers, increased care and support packages, through Personal Health Budgets where appropriate.

UHN UEC
Urgent and Emergency Care pressures remain a significant system challenge, although improvements in patient flow and 12-hour waits are evident. Enhanced oversight and recovery actions remain in place to address emergency department performance, ambulance handover delays and patient experience risks

Ockenden Review and Baroness Amos Investigation
The LNR ICB Cluster and provider trusts continue to respond to the findings of the Ockenden Review and Baroness Amos Investigation through established maternity quality and assurance arrangements. Work is underway to implement the NHS England maternity and neonatal improvement actions, supported by robust governance, ongoing quality improvement activity, and system-wide collaboration. These arrangements provide assurance that maternity and neonatal risks are being actively monitored and managed, with a continued focus on improving outcomes for women, babies and families across Leicester, Leicestershire, Rutland and Northamptonshire.

Advise

KGH - Homebirth
The UHN county-wide homebirth service recovery programme is progressing through a controlled, phased introduction.
KGH has been integrated into the NGH service, providing assurance of safe delivery during the soft-launch phase. A full relaunch remains dependent on sustained assurance in relation to workforce resilience, competence, policy harmonisation, second midwife availability, and governance requirements.
Since June, KGH mothers wishing to have a home birth have been accommodated and onboarded during the soft launch, with full workforce recruitment expected to be concluded by September.

CQC Maternity Inspection (KGH)
Kettering General Hospital maternity services underwent a CQC inspection in July 2026. Initial feedback was positive, recognising progress against the service improvement programme and highlighting strengths in leadership, patient experience, clinical practice and governance. No new concerns were identified beyond those already recognised by the service. The inspection process remains ongoing, with the Trust continuing to engage with the CQC and provide additional evidence and assurance through established governance arrangements.

Other System Quality Maternity Updates
KGH continues to be subject to enhanced surveillance and intensive support through the MatNeoIST programme.
NGH is awaiting the formal CQC report following the inspection visit undertaken earlier this year.
UHL, NGH and KGH are also reviewing the recently published Amos and Ockenden reports and their associated recommendations. This work includes providing updates on the implementation of recommendations arising from the Fuller Report, ensuring alignment with national learning and continued improvement across maternity services.

Quality Report – LNR Executive Summary

Assure

LLR Audiology Bronze Cell
The LLR Audiology Bronze Cell continues to provide oversight of service improvement and assurance activity. Good progress has been made across governance, estates and service delivery, supported by strong partnership working between providers. A small historical issue remains under review, with no evidence of patient harm identified to date. An Audiology Steering Group is overseeing longer-term service development. Northamptonshire services are not affected and continue to meet national standards.

SEND Reform and System Readiness
The LNR SEND Reform Plan was submitted as scheduled, with feedback from the Department for Education anticipated in September 2026. Positive progress and strong partnership working have been recognised through Leicester City's post-inspection engagement with the DfE. Preparations for future inspections across the wider LNR system continue, supported by established governance arrangements, including the LNR Children and Young People Strategic Transformation Board. Whilst challenges remain in relation to demand, waiting times and workforce capacity across a number of pathways, system partners continue to work collaboratively to drive improvement and improve outcomes for children and young people with SEND.

Assure

Performance against Initial Health Assessment
Compliance to statutory timescales has not been sustained, driven by capacity pressures and administrative recording issues. NHFT has implemented recovery actions, including capacity reviews, active management of appointment availability and a focused data validation programme. Weekly oversight arrangements are in place to monitor performance, workforce risks and recovery progress, with escalation through established governance processes to support improvement and timely access to assessments.

Antimicrobial Resistance (AMR)
In response to the Act No: protect our present, secure our future; AMR performance across the Cluster is generally positive, with both ICBs performing well against key national antimicrobial stewardship metrics, including antibiotic prescribing in children, overall antibiotic use and Access antibiotic prescribing. However, the AMR self-assessment identified gaps in governance, assurance and oversight arrangements, including the absence of a single cluster-wide AMR strategy, governance framework and integrated assurance process. The report therefore provides an honest baseline position and proposes three priority areas for improvement, including strengthening governance and assurance arrangements. Development of a single integrated AMR and IPC reporting and assurance framework will be a key focus over the next 12 months.

Assertive Outreach Review
LLR and Northamptonshire have completed the Midlands Intensive and Assertive Outreach self-assessment and can provide assurance that effective arrangements are in place to support people with the most complex mental health needs. The review highlighted established and mature arrangements in LLR and strong progress in Northamptonshire. Both systems have identified opportunities to further strengthen data quality, cohort tracking and outcome measurement, which will form the focus of a joint improvement plan during 2026/27. Governance and oversight arrangements remain in place to monitor delivery and support continued service improvement.

Glossary of Terms

ADHD	Attention Deficit Hyperactivity Disorder	**IHA**	Initial Health Assessment	**NOF**	NHS Oversight Framework
AMR	Antimicrobial Resistance	**IPC**	Infection Prevention and Control	**NQB**	National Quality Board
AMS	Antimicrobial Stewardship	**KGH**	Kettering General Hospital	**PFD**	Prevention of Future Deaths
ASD	Autism Spectrum Disorder	**LDA**	Learning Disability and Autism	**PEISG**	Patient Experience Incident Steering Group
CAMHS	Child and Adolescent Mental Health Services	**LLR**	Leicester, Leicestershire and Rutland	**PIR**	Provider Information Return
CQC	Clinically Ready for Discharge	**LNR**	Leicester, Leicestershire and Northamptonshire	**PODS**	Pharmacy, Optometry and Dentistry
CYP	Children and Young People	**MatNeoIST**	Maternity and Neonatal Improvement Support Team	**QPO**	Quality and Performance Oversight
DfE	Department for Education	**MH**	Mental Health	**SALT**	Speech and Language Therapy
ED	Emergency Department	**MoJ**	Ministry of Justice	**SEND**	Special Educational Needs and Disabilities
EMAS	East Midlands Ambulance Service	**MOSS**	Maternity Outcomes Signal System	**SQG**	System Quality Group
FDS	Faster Diagnosis Standard	**MSSP**	Maternity Safety Support Programme	**StAH**	St Andrew's Healthcare
FT	Foundation Trust	**NGH**	Northampton General Hospital	**TT**	Talking Therapies
GP	General Practitioner	**NHSE**	NHS England	**UEC**	Urgent and Emergency Care
IAO	Intensive and Assertive Outreach	**NICB**	Nottingham and Nottinghamshire Integrated Care Board	**UHL**	University Hospitals of Leicester
ICB	Integrated Care Board	**NNU**	Neonatal Unit	**UHN**	University Hospitals of Northamptonshire

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

Boards Meeting in Common in Public

Report Title: Board Briefing - Baroness Amos. Ockendon Maternity & Neonatal Quality

Date of Meeting: Thursday 20 August 2026

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Board Briefing - Baroness Amos. Ockendon Maternity & Neonatal Quality**		
Paper Reference No:	**ICBIC-26-46**	**Agenda Item No:**	**12.**

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

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

Recommendations

The Boards are asked to:

REVIEW and **NOTE ASSURANCE** from the Committees in Common for Quality, Performance and Outcomes which met on 11th August 2026.

Executive Summary of the report

The Ockenden Review, Baroness Amos review, National Maternity and Neonatal Investigation (NMNI) findings and the NHS England 10-Point Action Plan have collectively increased the level of scrutiny on maternity and neonatal services nationally. The emphasis has moved beyond whether organisations have action plans in place and now focuses on whether there is demonstrable evidence that women, babies and families are experiencing safer care, improved outcomes and a more compassionate experience

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

Conflicts of interest – Please select	
☒	No conflict identified
☐	Conflict noted, conflicted party can participate in discussion and decision
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☐	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: 5	**NICB BAF No: 1**

Appendices	N/A

Who has been engaged and where else has this report been considered:
N/A

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

Current Quality Position

1. Both University Hospitals Leicester (UHL) and University Hospitals Northamptonshire (UHN) have undertaken significant programmes of work to respond to these requirements and have established robust governance arrangements to ensure sustained oversight and delivery.

2. The principal challenge identified by the national reviews relates to the need for organisations to listen effectively to women and families, respond rapidly to concerns, ensure timely escalation when risks emerge, maintain safe staffing levels, strengthen organisational culture and reduce inequalities in access, experience and outcomes. National reviews also identified the importance of learning from incidents and complaints, ensuring psychological safety for staff to speak up, and having strong Board accountability for maternity safety performance.

3. Across both Leicester and Northamptonshire, there is no evidence of systemic maternity safety failure. However, both organisations continue to face challenges relating to workforce sustainability, operational pressures, variation in outcomes and health inequalities. Workforce pressures remain the most significant risk. UHN continues to experience midwifery and neonatal workforce shortages, with April 2026 vacancy rates reported at 10.7% for midwifery staff and 9.6% within neonatal services. UHL similarly identifies workforce resilience, specialist staffing and maintaining safe services during periods of significant demand as ongoing concerns. These pressures can impact the reliability of care pathways, escalation processes and continuity of care.

4. Operationally, both systems remain under pressure. Maternity triage responsiveness, timely senior clinical review, induction and elective pathway flow, neonatal capacity and escalation arrangements continue to require close oversight. UHN reports intermittent OPEL 2 escalation and significant numbers of maternity red flag events, demonstrating continued operational fragility despite overall service stability. Delays within induction pathways and artificial rupture of membranes pathways continue to be monitored through governance structures and improvement programmes.
   Another significant issue is unwarranted variation in outcomes. Whilst overall maternity safety indicators remain stable, variation persists in areas including preterm birth rates, low Apgar scores, smoking during pregnancy and neonatal outcomes. These variations are particularly evident within Kettering General Hospital and continue to require focused investigation and improvement activity. Both organisations recognise that reducing variation is a key priority if they are to demonstrate the sustained improvements expected through Ockenden and AMOS.

5. Health inequalities remain a considerable concern across both systems. Data continues to demonstrate variation in outcomes associated with ethnicity, deprivation, smoking prevalence and late booking for antenatal care. Both organisations acknowledge that inequalities contribute to poorer outcomes for some women and babies and that more evidence is required to demonstrate that interventions are having a measurable impact. UHN has joined the national

Perinatal Equity and Anti-Discrimination Programme and has reported improvements in early engagement with Black women, supported by targeted outreach and community engagement programmes.

6. In response to these challenges, both UHL and UHN have developed an integrated assurance framework that brings together Ockenden recommendations, AMOS findings, NMNI requirements, the NHS England 10-Point Action Plan, local CQC actions and Perinatal Safety Improvement Programme requirements into a single governance structure. This is intended to avoid duplication, strengthen oversight and ensure there is one coherent mechanism for monitoring delivery and impact. The Perinatal Assurance Committee now acts as the principal forum for challenge, oversight and escalation, supported by a strengthened Perinatal Assurance and Accountability Framework that provides a clear line of sight from frontline services to Trust Boards.

7. A key area of work has been strengthening safety culture and improving the voice of women and families. Martha's Rule has been implemented, escalation pathways have been strengthened, and there is greater focus on ensuring families can raise concerns and obtain rapid clinical review when necessary. Organisations are also participating in the "Amos into Action" staff listening programme, designed to understand staff experiences, improve psychological safety and strengthen organisational learning. Joint accountability has been established between Chief Nurses and Medical Directors for maternity and neonatal safety performance.

8. Significant progress has also been made in governance and quality oversight. UHN reports substantial improvement in incident management, action tracking and thematic review of learning from incidents. Regional maternity oversight scores have improved and there is evidence of strengthening governance maturity across maternity and neonatal services. Operational performance has remained resilient despite workforce and demand pressures, and patient experience measures continue to be positive, with satisfaction rates exceeding 97% across both Northampton hospitals. Improvements have been demonstrated in areas such as postpartum haemorrhage and severe perineal trauma rates, while breastfeeding initiation rates remain above target.

9. Both organisations have also responded to the national concerns regarding bereavement services, post-death care and mortuary governance that emerged through the Nottingham maternity review and Fuller Inquiry. Reviews of mortuary governance, Human Tissue Authority compliance, bereavement pathways and safeguarding arrangements have been undertaken. Action plans are being progressed to address remaining gaps, including physical security measures, oversight mechanisms and assurance processes.

10. There is Board-level oversight of these actions and assurance has been provided that governance arrangements remain robust.

11. The most significant challenge moving forward is not the development of further action plans but providing evidence that existing improvements are fully embedded, sustainable and resulting in measurable benefits. National reviewers are increasingly focused on outcomes rather than processes. Consequently, both organisations are now concentrating on demonstrating reductions in unwarranted variation, improvements in equity, stronger patient experience, sustained

workforce resilience and measurable improvements in safety outcomes for women and babies.

12. Overall, the Board can take reasonable assurance that both UHL and UHN have comprehensive programmes in place to respond to the Ockenden Review, Baroness Amos findings, NMNI recommendations and NHS England requirements. Governance and oversight arrangements have strengthened considerably, there is evidence of improving safety performance and organisational learning, and no evidence of systemic safety failure. However, continued Board attention is required in relation to workforce sustainability, operational resilience, inequalities, variation in maternity outcomes and demonstrating evidence of sustained improvement and impact for women, babies and families across Leicester, Leicestershire, Rutland and Northamptonshire.

Recommendations:

The Boards are asked to:

- **REVIEW** and **NOTE ASSURANCE** from the Committees in Common for Quality, Performance and Outcomes which met on 11th August 2026.

Boards Meeting in Common in Public

Report Title: Board Briefing – St Andrews Healthcare Northamptonshire Quality Position

Date of Meeting: Thursday 20 August 2026

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Board Briefing - St Andrews Healthcare Northamptonshire Quality Position**		
Paper Reference No:	**ICBIC-26-47**	**Agenda Item No:**	**13.**

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

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

Recommendations

The Boards are asked to:

REVIEW and **NOTE ASSURANCE** from the Committees in Common for Quality, Performance and Outcomes which met on 11th August 2026

Executive Summary of the report

St Andrew's Healthcare remains under significant quality pressure and continues to be subject to enhanced oversight arrangements through the Integrated Oversight and Assurance Group (IOAG). While there has been continued progress in reducing the inpatient population and stabilising key workforce indicators, quality and operational risks remain significant, particularly in relation to the planned transfer of services to NHFT and the management of a small number of highly complex patients requiring alternative placements. Earlier this month, St Andrew's Healthcare and NHFT confirmed that a number of secure and specialist services at the Northampton site will transfer to NHFT in September. Enhanced oversight arrangements remain in place throughout the transition period.

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

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

If conflicted identified, please list conflicted party and nature of conflict:
Peter Burnett, Chief Strategy Officer, declaration that spouse is Director of Midwifery and Deputy Chief Nurse University Hospitals Leicester.

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

Appendices	N/A

Who has been engaged and where else has this report been considered:
N/A

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

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Board Briefing - St Andrews Healthcare Northamptonshire quality position
Thursday 20 August 2026

Current Quality Position

1. St Andrew's Healthcare continues to experience a high level of quality stress and remains subject to enhanced quality oversight through the IOAG. Whilst improvements have been seen across a number of indicators, significant risks remain associated with service sustainability, workforce resilience, patient flow and the forthcoming transfer of services to NHFT.

Service Transition to NHFT

2. Services transferring in September include the Midlands Male Inpatient Medium and Low Secure Services, National Secure Male Deaf Services and National Secure Male Acquired Brain Injury Services. The transition remains a significant area of quality and operational risk and is subject to weekly multi-agency oversight meetings.

Patient Flow and Capacity

3. The organisation has continued to make progress in reducing inpatient occupancy and supporting patient discharge, with a substantial reduction in the inpatient population over the past year. A small cohort of patients with highly complex needs continues to require focused commissioner support to secure safe and appropriate future placements.

Workforce Position

4. Workforce indicators continue to show gradual improvement, including reductions in sickness absence and continued low reliance on agency staffing. Maintaining workforce stability during a period of significant organisational change remains an important consideration.

Oversight and Next Steps

5. Enhanced quality oversight arrangements will remain in place throughout the service transition period. The Chief Nurse for the ICB continues to provide updates regarding St Andrew's Healthcare through the Northamptonshire Safeguarding Adults Board to ensure partner organisations remain sighted on risks and mitigations.

Assurance Statement

6. The organisation remains in a position of significant quality concern and continues to require enhanced oversight. Although progress has been made in reducing inpatient occupancy and improving aspects of workforce performance, risks associated with the service transition, patient discharge and organisational sustainability remain. Since the appointment of interim chief nurse on secondment from an NHS trust in the Northeast into a senior leadership role at St Andrew's Healthcare, system partners have observed increased openness, transparency and engagement in relation to quality concerns and organisational challenges. Whilst the organisation remains under

considerable pressure, this strengthened leadership approach has supported improved system working and provided early indications of positive progress. The ICB, NHFT, NHS England, local authority partners and the CQC continue to work closely together to provide assurance that patient safety and quality of care are maintained throughout the transition period.

Recommendations:

The Boards are asked to:

- **REVIEW** and **NOTE ASSURANCE** from the Committees in Common for Quality, Performance and Outcomes which met on 11th August 2026

LLR ICB and NICB Boards Meeting in Common in Public

Finance Assurance Reports – LLR ICB and N ICB

Thursday 20th August 2026

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

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

Name of Meeting	**LLR ICB and NICB Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Finance Assurance Report - LLR ICB and N ICB**		
Paper Reference No:	**ICBIC-26-48**	**Agenda Item No:**	**14.**

Presented by	**Matt Gaunt, Chief Finance Officer, LLR ICB and NICB**
Report Author(s)	**Dan Guest, Head of Corporate Finance, LLR ICB and NICB**
Executive Sponsor	**Matt Gaunt, Chief Finance Officer, LLR ICB and NICB**

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

Recommendations

The Boards are asked to:

- ☐ **RECEIVE and NOTE** the update provided on the 2026/27 financial positions at month 3 and forecast outturns, and the items noted at the August Finance and Contracting Committee.

Executive Summary of the report

This report confirms that NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) and NHS Northamptonshire Integrated Care Board (NICB), collectively termed the Leicester, Leicestershire, Rutland and Northamptonshire (LNR) Cluster reported a collective deficit financial position at month 3 of £0.3m. The position reflects:

- LLR deficit of £0.3m.
- Northamptonshire breakeven position.

The full year reported forecast is achievement of plan across the LNR cluster, after £5.1 non-recurrent deficit support funding (DSF). At month 3 £1.3m of DSF has been received and the remaining £3.8m is anticipated.

The Financial position and forecast reported in this paper was discussed and noted at the August Finance and Contracting Committee of the LNR Cluster ICBs.
The Committee also received an update from Spend Control and Risk Assurance group, which confirmed areas of focus for executive review:

- Urgent and Emergency Care cost pressure crystallising in M3.
- ADHD emerging cost pressure highly likely.
- CHC potential stretch CIP opportunity.
- Prescribing potential underspends in 2nd half year.

Mitigations of £10m need to be identified to be assured of delivery of a balanced financial position for the year. Further Board review through a financial stocktake at month 4 was agreed and is scheduled in private session.

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

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

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

Appendices	N/A

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

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

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LNR Cluster Finance Report Month 3 (June) 2026/27

Thursday 20 August 2026

Headlines

1. Table 1 below details the position by Chief Officer and Service Area. At month 3 the LNR Cluster is reporting a year-to-date deficit of £0.3m.

   Table 1 – Month 3 LLR/NICB Financial Position by Chief Officer and Service Area

Officer	Service Area	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Forecast Variance
		£m	£m	£m	£m	£m	£m
Chief Delivery Officer	ACUTE	568.7	574.8	(6.1)	2,324.3	2,340.2	(15.9)
	COMMUNITY & MENTAL HEALTH SERVICES	205.1	204.3	0.8	817.1	818.8	(1.7)
	PRIMARY CARE INCLUDING CO-COMM AND POD	174.0	172.6	1.5	719.8	721.1	(1.3)
	SPECIALISED SERVICES	130.0	130.0	0.0	538.2	538.2	-
	OTHER PROGRAMME SERVICES	1.3	1.3	-	5.2	5.2	-
Chief Finance Officer	RESERVES	(1.1)	(3.6)	2.5	(2.0)	(9.1)	7.1
	MITIGATIONS TO BE IDENTIFIED	-	-	-	-	(10.6)	10.6
Chief Medical Officer	PRESCRIBING	95.1	94.8	0.3	381.4	381.4	0.0
	OTHER PROGRAMME SERVICES	0.5	0.5	-	1.7	1.7	-
Chief Nursing Officer	CONTINUING HEALTH CARE	76.9	74.9	2.0	307.7	304.5	3.1
	MENTAL HEALTH (S117 & AHP)	19.0	19.2	(0.2)	75.7	76.7	(1.0)
	OTHER PROGRAMME SERVICES	0.1	0.1	-	0.4	0.4	-
Chief Strategy Officer	OTHER PROGRAMME SERVICES	0.3	0.4	(0.1)	1.1	1.5	(0.4)
All	CORPORATE COSTS	14.0	15.0	(1.0)	52.4	53.1	(0.7)
		1,283.8	1,284.1	(0.3)	5,223.0	5,223.0	0.0

2. The year-to-date variances are driven by the following key areas:

   - Acute pressures of £6.1m relating to urgent care and variable elective care, in excess of planned levels – predominantly at University Hospitals of Leicester (UHL).
   - Primary Care (including Co-commissioning) & Pharmacy, Optometry & Dental (POD) £1.5m below plan, largely relating to POD & co-commissioning.
   - Continuing Healthcare (CHC) activity £2m below planned levels as a result of budget phasing.
   - Reserves support the position by a further £2.5 which represents release of LLR contingencies.

3. The cluster is reporting a breakeven forecast position.

4. At month 3 the cluster is reporting a year-to-date £0.07m under-delivery against the efficiency plan of £31.64m. The cluster is forecasting full delivery against the £142.07m efficiency plan by the end of the financial year.

5. At month 3 the cluster has the following risks to breaking even against plan:

Accident & Emergency (A&E) attendances and admissions

- A&E attendances and non-elective admissions continue to be above the planned zero growth.
- Potential forecast pressures of £21m have been identified in relation to diagnostic imaging activity, urgent care and variable elective care at UHL. These are partially offset by £6.4m of underperformance for variable drugs and devices.
- The Executive team and system partners have committed significant time and resource to understand changes in patient behaviour and the implications on service delivery and mitigations in the remainder of the financial year.

ADHD

- Financial risk in Northamptonshire of c.£5m due to increasing referrals. This is part of a national pattern of escalating expenditure. In place of a national service framework, each ICB is building a strategy and framework to manage cost growth. The CDO has put in place a policy framework, endorsed by the Executive, which establishes the platform for contractual control. We now need a clear clinical policy to enable a better understanding of clinical risk, treatment thresholds and market capacity required to meet population health need. These enablers are required to support contracting and service delivery teams to manage population demand and mitigate service and financial risk.

Contract Risk

- The contractual position has now been resolved in the ICB's favour for one of the contract escalations; George Eliot Hospital. There are two further escalations requiring agreement between Midlands and East of England region; the Midlands region is supporting a position that if agreed by East of England will have no financial impact for the ICB Cluster.

6. The ICB should identify £10m mitigations to be fully assured of meeting financial delivery.

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

- **RECEIVE and NOTE** the financial position at month 3.
- **SUPPORT** the executive in securing an additional £10m of mitigations to secure break-even position.

Boards Meeting in Common in Public

Report Title: Transition Assurance Report

Date of Meeting: Thursday 20 August 2026

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

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

Name of Meeting	**Boards Meeting in Common in Public**		
Date of Meeting	**Thursday 20 August 2026**		
Report Title	**Transition Assurance Report**		
Paper Reference No:	**ICBIC-26-49**	**Agenda Item No:**	**15.**

Presented by	**Pete Burnett, Chief Strategy Officer**
Report Author(s)	**Louise Young, Programme Director – ICB Transition**
Executive Sponsor	**Toby Sanders, Chief Executive Officer**

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

Recommendations

The Boards are asked to:

- Note the progress of the Cluster ICB Transition Programme, to achieve its mandated reductions and service transfers.

Executive Summary of the report

The Joint Transition Committee has responsibility to ensure the safe transition in 2025/26 for the ICB cost reduction programme and 20026/27 safe transfer of services as we move to Model ICB. The Board receives a regular assurance report on the committee and will have decisions escalated as appropriate.

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

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

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

Who has been engaged and where else has this report been considered:
August 2025 - Separate ICB Board, assurance report and approach to transition *October 2025 - Board in Common assurance report* *December 2025 - Board in Common assurance report* *February 2026 - Board in Common assurance report* *March 2026 - Board in Common assurance report* *April 2026 - Board in Common assurance report* *May 2026 - Board in Common assurance report* *June 2026 - Board in Common assurance report* *Remuneration Committee – October, December, January, February, for decisions in relation to Redundancy and Management of Change* *Monthly Transition Committee meetings* *Monthly Transition updates to Joint Executive Team*

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

Transition Assurance Report
Thursday 20 August 2026

Introduction

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

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

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

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

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

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

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

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

Progress Against Programmes of Work

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

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

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

Table 1

Designing functions for a new Cluster ICB	Implementation of Management of change continues as we move out of the ring fence stage to identifying SAEs for displaced people. We are also recruiting to priority vacancies internally and externally. Currently 236 people are now in post. 67 people are 'at risk' and we have c100 vacancies. This position is changing weekly as we move through the stages.
Functions that have another destination	There were 17 functions that were identified in the Model ICB framework that ICBs currently undertake that were going to be undertaken by another public body in the future, these functions are listed within the Model ICB and are broadly described as: - Going to an NHS Provider - Going to NHSE/DHSC regional offices - To be explored further In December 2025, further guidance was received by NHS England regarding these functions, and it was confirmed that as many of the functions are described within primary legislation. The design of the structures has incorporated this updated guidance and assurances have been provided to NHS England that the ICB will continue to be able to discharge its functions in full, whilst reducing its annual costs in line with the new financial allocations. **Transfer to Provider or Partner Organisations.** The following functions have transferred to provider or partner organisations: • Strategic Digital Leadership - LPT • System Control Centres – NHFT The following functions are due to transfer to provider or partner organisations: • HR and Transactional Workforce **Functions Transitioning to the Region.** The following functions are transitioning to the regional team: • Provider Oversight • Operational Workforce Planning **Transfer Progress**

	Several functions have had their transfer dates extended to 01 October 2026. These include: • GP IT and Corporate IT • Complex Mental Health • Procurement These extensions reflect the lead-in time required, the complexity of service transfer arrangements, and capacity considerations to ensure a safe and effective transition.
Functions that could be done at a 'supra' cluster level	As part of the review of functions it was identified that some of the corporate and statutory functions could be delivered on a footprint that is larger than the Cluster. The primary aims would be to increase the efficiency, attract expertise and improve quality. Pharmacy, Optometry and Dental (PODs) Service is planned to transfer to Derbyshire, Nottinghamshire and Lincolnshire (DNL) cluster ICB, operating at as a midlands wide service. Transfer due 30 Sep 2026. A Midlands Procurement Service is expected to be mobilised December 2026. However, this is not without risk. Workforce reductions through voluntary redundancy have significantly reduced specialist procurement capacity and available capability across the Midlands. A detailed review is underway to ascertain the level of risk and to prioritise the procurement workplan across Midlands ICBs to ensure resource is set against it.

Recommendations:

The Boards are asked to:

- ***NOTE*** the progress of the Cluster ICB Transition Programme, to achieve its mandated reductions and service transfers.