

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

Thursday 15 October 2026, 09:30 - 11:15  
LOROS, Groby Road, Leicester, LE3 9QE

## Agenda

09:30 - 09:30 **1. Welcome and Apologies**  
0 min  
Advisory Anu Singh

09:30 - 09:30 **2. Declarations of Interest relating to agenda items**  
0 min  
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 **3. Draft Minutes of previous meeting - 20 August 2026**  
0 min  
Approval Anu Singh  
Reference: ICBIC-26-50  
 ICBIC-26-50 Draft Minutes of previous meeting held 20 August 2026.pdf (9 pages)

09:30 - 09:35 **4. Matters arising and Action log**  
5 min  
Advisory Anu Singh  
Reference: ICBIC-26-51  
 ICBIC-26-51 Action Log.pdf (1 pages)

09:35 - 09:40 **5. Questions from members of the public**  
5 min  
Advisory Anu Singh  
Verbal

09:40 - 09:45 **6. Chair and Chief Executive updates**  
5 min  
Advisory Anu Singh / Toby Sanders  
Reference: ICBIC-26-52  
 ICBIC-26-52 Chief Exec report .pdf (6 pages)

09:45 - 09:50 **7. Board Assurance Framework Progress Report**  
5 min  
Advisory Matt Gaunt  
Reference: ICBIC-26-53  
 ICBIC-26-53 FS and report BAF Progress Report .pdf (5 pages)

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**09:50 - 10:05 8. Healthwatch Annual Reporting Position**

15 min

*Advisory Harsha Kotecha*

**Reference: ICBIC-26-54**

 ICBIC-26-54 Healthwatch Annual Reports.pdf (9 pages)

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**10:05 - 10:20 9. 2027/28 Commissioning Intentions**

15 min

*Approval Peter Burnett / Matt Gaunt*

**Reference: ICBIC-26-55**

 ICBIC-26-55 Comm Intentions report .pdf (52 pages)

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**10:20 - 10:30 10. LNR Neighbourhood Maturity Assessment - Update and Next Steps**

10 min

*Advisory Eileen Doyle*

**Reference: ICBIC-26-56**

 ICBIC-26-56 Neighbourhood Maturity Assessment paper.pdf (82 pages)

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**10:30 - 10:40 11. Quality and Performance Assurance Reports - LLR ICB and N ICB**

10 min

*Assurance Eileen Doyle / Maria Laffan*

**Reference: ICBIC-26-57**

 ICBIC-26-57 QPO report.pdf (13 pages)

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**10:40 - 10:55 12. Thirwall Inquiry Recommendations Report**

15 min

*Approval Maria Laffan / Nil Sanganee*

**Reference: ICBIC-26-58**

 ICBIC-26-58 Thirlwall Inquiry Implications Oct 26 v2.pdf (12 pages)

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**10:55 - 11:05 13. Finance Assurance Report - LLR ICB and N ICB**

10 min

*Assurance Matt Gaunt*

**Reference: ICBIC-26-59**

 ICBIC-26-59 finance report Month 5.pdf (7 pages)

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**11:05 - 11:15 14. Transition Assurance Report**

10 min

*Assurance Peter Burnett*

**Reference: ICBIC-26-60**

 ICBIC-26-60 Transition report Oct 2026.pdf (8 pages)

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**Chair's Closing Remarks**

**Date of next meeting: Thursday 17 December 2026**

Middlebrook, Claire  
08/10/2026 14:05:57

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

**Boards Meeting in Common in Public**

**Thursday 20 August 2026 at 09:30am**  
**Haylock House, Venture Park, Kettering, NN15 6EY**

**Present: Members jointly appointed across NHS Leicester, Leicestershire & Rutland ICB and NHS Northamptonshire ICB**

|                   |                         |
|-------------------|-------------------------|
| Anu Singh         | Chair                   |
| Toby Sanders      | Chief Executive Officer |
| Andrew Hammond    | Non-Executive Member    |
| Simone Jordan     | Non-Executive Member    |
| Liz Gaulton       | Non-Executive Member    |
| Afzal Ismail      | Non-Executive Member    |
| Prof Nil 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<br>Group Chief Executive University Hospitals of Leicester NHS Trust<br>and University Hospitals of Northamptonshire NHS Trust |
| Mike Sandys      | Local Authority Sector Representative<br>Director of Public Health Leicestershire County Council and Rutland<br>County Council                             |
| Dr James Ogle    | Primary Medical Services Sector Representative                                                                                                             |

**Present: Members - NHS Northamptonshire ICB**

|                  |                                                                                                                                                            |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Angela Hillery   | Community / Mental Health Sector Representative<br>Chief Executive Officer, Leicestershire Partnership and<br>Northamptonshire Healthcare Foundation Trust |
| Melanie Williams | Local Authority Representative<br>Executive Director Peoples Services West Northamptonshire Council                                                        |
| Dr Dipesh Naik   | Partner Member for Primary Medical Services                                                                                                                |

**In Attendance**

|                     |                                                |
|---------------------|------------------------------------------------|
| Tamara Hazell       | Corporate Governance Officer (minutes)         |
| Neil Boughton       | Director of Corporate Governance and Risk      |
| Harsha Kotecha      | LLNR Healthwatch Representative                |
| Kevin Allen-Khimani | VCSFE Representative                           |
| Pete Watson         | Assistant Director of Integrated Commissioning |
| Claire Ellwood      | Chief Pharmacist                               |

**Minute No: Agenda Item**

**ICBIC-26-38 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.

Anu Singh welcomed Dr Dipesh Naik and Dr James Ogle to their new roles as GP Partner Members, alongside Kevin Allen-Khimani as the VCSFE Sector Representative.

No apologies were received. There were 8 members of the Public in attendance.

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

- ICBIC-26-39 Declarations of Interest relating to agenda items**  
Standing declarations of interest were noted, however no exclusions from discussion were required.
- ICBIC-26-40 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 18 June 2026 were received and **APPROVED** as a true and accurate record of the meeting.
- ICBIC-26-40 Matters Arising and Action Logs**  
The Board received the Action Log and noted there were no outstanding actions.
- ICBIC-26-41 Questions from members of the public**  
There were no questions received from members of the Public.
- ICBIC-26-42 Chair and Chief Executive Updates**  
The Chair and Chief Executive presented updates on a range of current issues across the organisation. Toby Sanders highlighted the findings of the GP Patient Survey and noted the value of a dedicated Board development discussion to consider the current position of primary care and general practice, including emerging Federation and collaborative arrangements. The importance of ensuring a collaborative approach to patient and public voice arrangements, including engagement with Healthwatch, was also emphasised. It was agreed that these matters would be incorporated into a future Board development agenda.
- The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the Chair and Chief Executive Updates.
- ICBIC-26-43 LLR ICB and N ICB Annual Assessment of Performance and Annual Report 2025/26**  
Toby Sanders introduced the NHS England Annual Assessment letters for both ICBs, noting that they would be published alongside the Board papers and made available on the respective websites. The assessments provided a narrative review of performance during 2025/26, covering quality, operational performance, finance, leadership and governance. The letters were considered a balanced and fair reflection of the year, recognising both achievements and ongoing challenges. It was noted that

Middlebrook, Claire  
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no overall rating had been applied, with a new national performance framework expected to be introduced from 2026/27.

In response to a question regarding any notable findings, the Boards heard that the assessments reflected known challenges, including financial pressures and urgent and emergency care performance, particularly ambulance handover delays in Northamptonshire. The assessments also recognised the effective management of transition arrangements within the cluster and highlighted positive feedback from system partners.

Matt Gaunt advised that the Annual Report and Accounts had been approved by the Boards in a previous private session in accordance with statutory requirements. The Boards noted receipt and approval of the final documents, which would be published by the end of September 2026. It was further noted that the Annual Report provided a valuable summary of the breadth of work undertaken by the organisations during the year.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the approval and publication of the respective 2025/26 Annual Reports and Accounts, the NHS England Annual Assessments of each ICB's performance for 2025/26, and were **ASSURED** that statutory requirements had been satisfied for each ICB to present its Annual Report and Accounts at a meeting held in public before 30 September 2026.

#### **ICBIC-26-44    EPRR Update and Plans and Policies**

Eileen Doyle presented the annual EPRR update, including the Core Standards Assurance assessment and supporting policies and procedures. The Boards noted the statutory requirement for both ICBs, as Category 1 Responders, to review these arrangements annually and received assurance regarding compliance with core standards, preparedness, training and partnership working with providers, local authorities and other response agencies. It was noted that, whilst separate arrangements were in place for LLR and Northamptonshire, alignment of approaches would continue where appropriate.

In response to questions regarding operational readiness, assurance was provided that the combined EPRR team was now fully established, with ongoing training and exercising programmes in place to ensure staff were confident in their roles and responsibilities should plans need to be deployed. The significant progress made in strengthening EPRR arrangements in recent years was acknowledged.

The Boards noted the importance of EPRR in supporting multi-agency working across health, local authority, police and other partner organisations and approved the plans, policies and associated assurance documentation.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **RECEIVED** assurance that appropriate arrangements were in place to discharge their responsibilities as Category 1 Responders under the Civil Contingencies Act 2004 and to meet NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR), and **APPROVED** the EPRR, Pandemic, Business Continuity, Incident Response, Incident Coordination

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Centre and Incident Communications Plans and Policies for LLR ICB, Northamptonshire ICB and the LNR Cluster as set out in the report.

#### ICBIC-26-45 Phlebotomy Business Case

Eileen Doyle introduced the Phlebotomy business case, noting the longstanding challenges associated with access to phlebotomy services in Northamptonshire, which had been further highlighted following the withdrawal of the existing provider. The proposal, developed following consideration through the relevant committees, sought to establish a practice-based model, drawing on the approach successfully implemented in LLR, to improve accessibility and support delivery of services closer to patients' homes. Pete Watson outlined the proposed model, which would invest in primary care to provide phlebotomy services at neighbourhood level, with the aim of improving patient access, experience and service resilience.

Members of the Boards welcomed the proposal, recognising the significant impact that current waiting times and access challenges had had on local residents. The importance of effective patient engagement and communications during implementation was emphasised, alongside the need to measure patient satisfaction and broader service outcomes to assess the benefits of the new model.

The Boards received assurance that the proposed approach built on existing primary care capability and capacity, with GP representatives confirming that practices were well placed to deliver the service at scale. Assurance was also provided regarding the procurement approach, with an urgent award required to enable mobilisation ahead of the current provider's withdrawal, while longer-term arrangements would be developed.

The financial implications were noted, including that the investment had not formed part of the original financial plan and therefore required Boards approval in line with governance arrangements. Assurance was provided that the associated costs could be managed within the Northamptonshire financial position and that appropriate oversight had been undertaken through the Joint Finance and Contracting Committee.

The Boards noted the wider strategic considerations relating to service resilience, investment, value for money and future demand, and acknowledged the importance of incorporating patient insight and horizon scanning into future service planning.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the business case, including the associated risks, benefits and financial implication recognising the associated financial pressure.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **APPROVED:**

- Option 3 as the preferred delivery model
- Phase 1 urgent award to enable mobilisation from November 2026, noting and including the in-year financial impact
- 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.

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- The progression to Phase 2 business case and procurement development, to begin once Phase 1 has been awarded and mobilised

#### **ICBIC-26-46 Obesity Pathway Innovation Programme**

Nil Sanganee and Claire Ellwood presented an update on the Obesity Pathway Innovation Programme, which had secured Innovate UK funding through a nationally competitive process. The programme was described as a three-year neighbourhood-based initiative focused on obesity prevention, treatment and reducing health inequalities across the cluster population.

Members noted that the programme would establish an integrated pathway spanning all age groups, including support for transition between children's and adult services. It was expected to benefit approximately 20,000 patients and would seek to improve access to weight management support for underserved communities through closer partnership working with local authority public health teams, community pharmacy and the VCSFE sector.

The presentation highlighted the intention to test innovative models of delivery, supported by a robust outcomes and evaluation framework. The longer-term ambition was to demonstrate effectiveness and support the development of a sustainable commissioned service beyond the lifetime of the programme.

Discussion focused on the need to improve clarity for patients navigating existing weight management services, ensuring meaningful patient and community involvement in pathway design, and building on existing provision rather than duplicating services. The importance of establishing clear outcome measures and performance indicators from the outset was emphasised to support evaluation and future commissioning decisions.

It was confirmed that patient representatives were being identified and that a programme of engagement with patients, communities and partner organisations would commence in September 2026. Existing services and public health colleagues would be integral to the development of the pathway, with a particular focus on improving access, coordination and signposting.

Members also highlighted the importance of aligning implementation with existing neighbourhood initiatives to avoid overburdening local partners. Assurance was provided that learning from early implementation sites would inform future roll-out and contribute to the development of a sustainable model. An update on programme delivery, evaluation and emerging outcomes would be brought to a future meeting.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the successful OPIP bid for LNR ICBs, the benefit for our populations and plan for Neighbourhood level programme delivery, with the ICBs working with Northamptonshire Partnership NHS Trust (NHFT) as a Delivery Partner.

#### **ICBIC-26-47 Quality and Performance Assurance Reports – LLR ICB and N ICB**

Eileen Doyle presented the key messages from the reports, which had been taken as read. Members noted ongoing system pressures, including the impact of recent heatwaves on demand and capacity. Whilst some improvement had been seen,

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challenges remained in urgent and emergency care performance, ambulance handovers, community waits and diagnostics. Cancer waiting times were reported to be improving.

Angela Hillery highlighted sustained bed pressures across both systems and the potential impact of seasonal factors on service demand.

Toby Sanders noted that waiting list figures reflected a point-in-time position and advised that performance continued to be closely monitored, particularly at Kettering General Hospital. The Better Care Fund submission for West Northamptonshire was noted as having been approved, subject to local conditions relating to demand, capacity and flow.

Maria Laffan provided an update on quality priorities, advising that assurance and oversight arrangements remained in place as transformation programmes progressed. Members noted ongoing work to improve neurodevelopmental waiting times, SEND services, ADHD and autism assessment pathways, alongside support for children and families awaiting assessment. Assurance was also provided regarding intensive and assertive outreach arrangements.

Infant mortality in Leicester remained an area of concern. Members noted positive joint working with Public Health partners to understand and address the underlying causes, with emerging data indicating signs of improvement.

Angela Hillery requested updates to the provider oversight summary to reflect Leicestershire Partnership NHS Trust's current CQC rating and Northamptonshire Healthcare NHS Foundation Trust's expanded prison healthcare responsibilities.

Members discussed the importance of applying learning from national best practice to longstanding quality challenges and noted the opportunities presented through improvement networks and alternative models of care.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **RECEIVED** assurance from the Committees in Common for Quality, Performance and Outcomes which met on 11 August 2026.

#### **ICBIC-26-48 Board Briefing – Baroness Amos, Ockendon Maternity & Neonatal Quality**

Maria Laffan presented the briefing, noting that intensive oversight arrangements remained in place across maternity services at University Hospitals of Leicester, University Hospitals of Northamptonshire and Kettering General Hospital. Members noted that both organisations had comprehensive improvement programmes in place, with particular focus on culture, leadership, maternity triage, workforce and strengthening how the voices of women and families informed service improvement. The role of the Maternity and Neonatal Voices Partnership was highlighted, alongside engagement with the St Mary's local campaign group.

Members noted that the findings from the Amos and Ockenden reviews reflected themes already recognised locally and had reinforced existing areas of focus. It was also reported that oversight arrangements now included both nursing and medical leadership perspectives.

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In discussion, questions were raised regarding maternity workforce vacancies and opportunities to make Leicester, Leicestershire, Rutland and Northamptonshire an attractive place to train and work. Maria Laffan advised that recruitment of midwives was performing comparatively well, with vacancy levels influenced by factors including maternity leave and sickness absence. Consultant vacancies and job planning remained areas of focus.

*Richard Mitchell joined the meeting at 10:10am.*

Members also sought assurance that women, families and communities were actively involved in evaluating whether improvements were making a meaningful difference. It was noted that national reviews had emphasised the importance of co-production and that arrangements were in place to ensure patient and community voices continued to shape improvement activity.

Richard Mitchell advised that UHL welcomed participation in the Amos review and accepted its findings in full. He noted that the learning was applicable not only to maternity services but across all clinical services. Since publication of the report, UHL had undertaken community listening events, issued an open letter to the community and delivered staff briefings. Whilst progress had been made, further improvement was required. He also highlighted that the review team had recognised the commitment of leaders to improvement and engagement with local communities.

Toby Sanders noted the announcement regarding the move back to a single organisational structure across UHL and UHN. He emphasised the importance of maintaining strong leadership, partnership working and oversight arrangements throughout the transition and committed to supporting a managed and collaborative approach.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the Board Briefing and **RECEIVED ASSURANCE** regarding the ongoing oversight and improvement actions in response to the Baroness Amos and Ockenden Maternity and Neonatal Quality Reviews.

#### ICBIC-26-49 Board Briefing – St Andrews Healthcare Northamptonshire Quality Position

Maria Laffan presented an update on the quality position at St Andrew's Healthcare, noting that the provider remained subject to the highest level of quality oversight. Intensive national, regional and local governance arrangements remained in place, with regular oversight meetings involving NHS England, the ICBs and partner organisations. Members heard that, whilst St Andrew's had announced the transition of services to Northamptonshire Healthcare NHS Foundation Trust (NHFT), significant quality concerns remained and would continue to require close monitoring throughout the transition period.

It was reported that ICB-led governance arrangements were in place involving NHFT, St Andrew's, local authority partners and safeguarding colleagues. Key risks related to continuity of care, workforce retention, governance arrangements, operational resilience and the management of patients with highly complex needs were highlighted. Recent CQC inspections had identified some early signs of improvement, supported by the appointment of an interim Chief Nurse, although it was recognised that sustained improvement would take time. Assurance was provided that intensive

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oversight would remain in place following NHFT's assumption of responsibility for services.

Angela Hillery emphasised the complexity of the transition and noted that accountability for patient care would remain with St Andrew's until the formal transfer to NHFT. National oversight arrangements would continue to support the transition. Whilst patient safety remained the immediate priority, there was also recognition of the importance of restoring bed capacity given the national demand for medium secure services. Additional support and learning were being provided through partnership arrangements with specialist providers.

Discussion highlighted the importance of clear governance arrangements and explicit responsibilities between providers, the ICBs and national teams. Members also considered arrangements for patients who would not transfer to NHFT as part of the new service model, noting that a national clinical review process was underway to identify appropriate future provision for those complex individuals.

Members welcomed the close involvement of safeguarding partners and noted the benefits that would arise from NHFT's existing participation in local safeguarding and partnership structures. It was also recognised that the transition would place significant additional responsibilities on NHFT and that additional leadership and management capacity had been established to support the new forensic services arrangements.

The NHS Leicester, Leicestershire and Rutland ICB Board and NHS Northamptonshire ICB Board **NOTED** the update and **RECEIVED ASSURANCE** that appropriate oversight, governance and safeguarding arrangements remained in place to support patient safety and the safe transition of services from St Andrew's Healthcare to Northamptonshire Healthcare NHS Foundation Trust.

#### **ICBIC-26-50 Finance Assurance Report – LLR ICB and N ICB**

Matt Gaunt presented the Finance Assurance Report, noting that whilst Northamptonshire ICB reported a balanced position at Month 3, LLR ICB was £0.3 million adverse to plan. Members noted that, given the scale of the organisations, overall performance during the first quarter was broadly in line with plan, although significant underlying financial pressures remained.

It was reported that LLR ICB had planned for a deficit position prior to receiving NHS England deficit support funding and had utilised £1.3 million of that funding during Quarter 1. Members noted that the underlying financial position remained challenged and that a number of short-term mitigations had supported performance to date. However, there was concern that these mitigations may not be sustainable for the remainder of the financial year.

Key pressures were reported in relation to non-elective activity and neurodiversity pathways, reflecting challenges seen nationally. Potential mitigations had been identified through Continuing Healthcare and prescribing budgets, which could generate additional underspends during the second half of the year. Overall, a delivery risk of approximately £10 million remained across the two ICBs and would require further management during the year.

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An update was also provided on contractual disputes with providers outside the local system. One issue had been resolved in the ICBs' favour, whilst two further disputes, each valued at approximately £3 million, related to the application of NHS funding rules. Members noted that NHS England Midlands had supported the approach taken by the ICBs and that confirmation from NHS England East of England was awaited. If the disputes were resolved consistently with the Midlands decision, the financial risk to the ICBs would be substantially reduced.

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

#### **ICBIC-26-51 Transition Assurance Report**

Pete Burnett presented the Transition Assurance Report, which had been taken as read, and highlighted the key areas of progress.

Members noted that the ICBs had moved to a Joint Management Team structure and were progressing the implementation of the new operating model. Work continued to place colleagues into the new structure, which comprised approximately 420 posts. At the time of reporting, a number of staff had been ringfenced to roles, with 67 colleagues identified as at risk. It was noted that these figures continued to change as the process progressed. It was noted that the transition programme would likely result in a number of compulsory redundancies.

An update was provided on the transfer of functions, including the movement of digital services from Northamptonshire ICB to Leicestershire Partnership NHS Trust and the transfer of transactional HR and workforce services from the Commissioning Support Unit to University Hospitals of Leicester NHS Trust from 1 September. Progress was also reported in relation to procurement arrangements operating at scale.

Members were advised that a business case had been submitted to NHS England regarding the proposed merger of the two ICBs from April 2027, following engagement with partners and a period of consultation. A decision was expected during September 2026. It was noted that recent national political changes could potentially influence the wider timetable and approach, although the impact remained unclear at this stage.

Finally, members noted that the first all-staff conference would take place on 30 September and that Non-Executive Members would also be invited to support engagement and connectivity across the organisations.

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-26-52 Chair's Closing Remarks**

Anu Singh closed the meeting at 11:35am.

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## ACTION LOG

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

Updated 22 September 2026

| Minute No:                    | Agenda Item | Action | Lead | Status/Update | Timescale | RAG |
|-------------------------------|-------------|--------|------|---------------|-----------|-----|
| Meeting Date: 15 October 2026 |             |        |      |               |           |     |
| No actions recorded           |             |        |      |               |           |     |

Middlebrook, Claire  
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# LLR ICB and NICB Boards Meeting in Common in Public

## Chief Executive report

Thursday 15 October 2026

Middlebrook-Claire  
08/10/2026 14:28:57

|                          |                                                                          |
|--------------------------|--------------------------------------------------------------------------|
| <b>Presented by</b>      | <b>Toby Sanders, Chief Executive</b>                                     |
| <b>Report Author(s)</b>  | <b>Jenny Goodwin Director of Communications, Engagement and Insights</b> |
| <b>Executive Sponsor</b> | <b>Pete Burnett Chief Strategy Officer</b>                               |

| Executive Summary of the report                                                                                                                                                                                                                                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>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 Boards' oversight and discussion and will continue to be developed over time to ensure it remains focused and useful.</p> |  |

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

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

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

Thursday 15 October 2026

## LLR and Northamptonshire ICB Cluster Board in Common Update

### Management of Change and Operating Model

As the Management of Change programme progresses towards its final stages, colleagues from across the ICB came together to reflect on progress, support one another through the transition and help shape the organisations' future direction. This work focused on developing the culture, behaviours and priorities needed for success as the organisation evolves further into its role as a strategic commissioner.

### ICB future arrangements

NHS England has confirmed that plans to formally merge those Integrated Care Boards currently working together in shared arrangements have been paused until at least summer 2027. This reflects the Government's strengthened commitment to devolution and the potential for future NHS boundaries to align with one or more Strategic Authorities. As neither Leicester, Leicestershire and Rutland nor Northamptonshire currently has an agreed Strategic Authority geography, both ICBs will continue to operate in their current arrangements for the foreseeable future.

While this means that some of the benefits associated with moving to a single statutory body, including streamlined governance and corporate arrangements, will not be realised from April 2027 as anticipated, it does not change the direction of travel locally. The two organisations will continue to work together through a shared leadership team, common operating model and aligned priorities. Our focus remains on working as one team to improve health outcomes, reduce inequalities and deliver the best possible services for the populations we serve.

### Provider update

University Hospitals of Leicester NHS Trust (UHL) and University Hospitals of Northamptonshire (UHN) have now completed the transition from the Group model to separate leadership and governance arrangements, with each organisation operating under its own Board and executive team. Richard Mitchell continues as Chief Executive of UHL and Adam Carson has been appointed Chief Executive of UHN. While both organisations now have dedicated leadership and stronger local focus, they have reaffirmed their commitment to working collaboratively where this supports better care, stronger services, shared learning and improved outcomes for local communities. The ICB will continue to work closely with both trusts to support delivery of shared priorities and system-wide transformation.

### Hinckley Neighbourhood Health Centre

Following approval of the Hinckley Neighbourhood Health Centre Case for Change by the Joint Executive Team (JET), the programme has progressed into detailed planning and design. The proposed development will support the delivery of integrated neighbourhood-based care, bringing primary care, community services and wider partners together to better meet the needs of Hinckley's growing and ageing population. Planning permission has also been granted for the demolition of the vacant former day case building on the Hinckley and District Hospital site, enabling the first phase of site preparation to proceed.

### **Primary Care Transformation**

The Cluster continues to support primary care transformation across Leicester, Leicestershire, Rutland and Northamptonshire through implementation of primary care access recovery plans, development of modern primary care infrastructure and strengthening patient participation arrangements. Recent developments include approval of a new medical centre in Enderby and progress towards establishing a county-wide Patient Participation Group network in Northamptonshire.

### **Cardiovascular Disease Prevention**

A new British Heart Foundation-funded programme has launched across Northampton and Wellingborough to support working-age adults to better manage high blood pressure and reduce their risk of heart attack and stroke. The programme is particularly focused on supporting underserved communities and reducing health inequalities.

### **Vaccination and Immunisation**

Partners across both systems are supporting a regional catch-up programme following a review of childhood vaccination records. Targeted communications, local clinics and partnership working with primary care are helping improve uptake and reduce inequalities in access to vaccination services ahead of winter.

### **Suicide Prevention**

The Northamptonshire Suicide Prevention Strategy 2026-2031 has now been formally adopted. Developed jointly by local authorities, NHS organisations, voluntary sector partners and people with lived experience, the strategy places a strong emphasis on prevention, early intervention and community-based support.

### **Secure Mental Health Services Transfer**

Northamptonshire Healthcare NHS Foundation Trust successfully assumed responsibility for the former St Andrew's specialist secure services in September. The Cluster has maintained oversight of the transition and continues to receive assurance regarding continuity of care, workforce arrangements and patient safety.

### **Local Area SEND Inspection**

Leicestershire has been notified of a joint Ofsted and Care Quality Commission Local Area SEND inspection. The ICB is working closely with partners across education, health and social care to coordinate preparations and support the inspection process.

### **Paediatric Scoliosis Pathway Review**

University Hospitals of Leicester and Nottingham University Hospitals are undertaking a review of the Paediatric scoliosis pathway following concerns regarding monitoring arrangements for some patients awaiting treatment. The ICB continues to receive assurance regarding the actions being taken to support affected families and improve services.

Middlebrook, Claire  
08/10/2026 14:28:57

### **Winter Planning and Preparedness**

Planning for winter 2026/27 remains a key priority across both systems. Partners continue to refine plans covering urgent and emergency care, discharge pathways, elective recovery and community services, alongside coordinated communications and stakeholder engagement activity to support system resilience throughout the winter period. This includes delivery of the annual flu and Covid-19 vaccination programme and coordinated public awareness activity to support prevention and appropriate use of services during the winter period.

### **Children, Young People and Families Insight Review**

A review of engagement findings from across Leicester, Leicestershire, Rutland and Northamptonshire has been completed, drawing together insight from 34 reports published between 2014 and 2025. The findings will inform future pathway redesign, digital development and service improvement, particularly in relation to communication, transitions between services and coordination across organisational boundaries.

### **Recognition and Achievement**

A cancer screening programme delivered in partnership with General Practice Alliance received a national BAME Health and Care Award for Excellence in Community Partnerships, recognising its contribution to improving screening uptake and reducing health inequalities.

Northamptonshire Healthcare NHS Foundation Trust's adult acute inpatient mental health wards and psychiatric intensive care services have been rated Outstanding by the Care Quality Commission, recognising high-quality, person-centered care, strong leadership and a culture of continuous improvement.

Middlebrook, Claire  
08/10/2026 14:28:57

# Boards Meeting in Common in Public

## Board Assurance Framework Progress Report

Thursday 15 October 2026

Middlebrook, Claire  
08/10/2026 14:28:57

|                          |                                                                    |
|--------------------------|--------------------------------------------------------------------|
| <b>Presented by</b>      | <b>Matt Gaunt, Chief Finance Officer</b>                           |
| <b>Report Author(s)</b>  | <b>Emma Follis, Senior Manager Corporate Governance &amp; Risk</b> |
| <b>Executive Sponsor</b> | <b>Matt Gaunt, Chief Finance Officer</b>                           |

| Executive Summary of the report                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>This report provides an update on the implementation of the cluster-wide risk management approach, including:</p> <ul style="list-style-type: none"><li>• Development of the BAF and high-level strategic risk themes</li><li>• Next steps for further development of the BAF.</li></ul> |

Middlebrook, Claire  
08/10/2026 14:28:55

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

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

|            |     |
|------------|-----|
| Appendices | N/A |
|------------|-----|

| Who has been engaged and where else has this report been considered:                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------|
| Engagement has been undertaken through the Joint Management Team (JMT), directors and their relevant directorate teams.              |
| Engagement has also been undertaken through the Joint Executive Team (JET) and individual Chief Officers as described in this paper. |

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

Middlebrook, Claire  
08/10/2026 14:28:57

## Risk Management Update

### 1. Introduction

1.1. This paper is presented to the ICB Boards meeting in Common in Public to:

- **NOTE** the progress in developing the Cluster Board Assurance Framework (BAF) and planned next steps.

### 2. Board Assurance Framework Update

#### 2.1. High-Level Strategic Risk Themes

2.1.1. The two ICBs' Strategic risks were previously operated within two separate but aligned BAFs, the clustered ICBs are now progressing the development of a single BAF.

2.1.2. Engagement on the development of this single BAF has been undertaken with the Joint Executive Team (JET), with a focus on the identification of the high-level strategic risk theme areas and respective Chief Officer leads. This work has been informed by the content of the existing strategic risk entries across LNR Cluster and the wider Midlands Region. It was noted that whilst progress with the development of BAFs across the clustering ICBs varies, there remains commonality in risk theme areas and content, and this commonality flows through to the below.

2.1.3. **Table 1** below sets out the current outputs of this work, providing the Board with first sight of the proposed outline high-level strategic risk themes, the identified Chief Officer lead and proposed alignment to Committee oversight. It should be noted that the below represents the initial thinking of JET and will be subject to a period of further engagement to enable the defining and refining of content prior to presentation.

| Suggested Strategic Risk Theme                                                                                                                                                  | Chief Officer                              | Committee                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------|
| <b>Commissioning Strategy</b><br>Setting of long term, evidence based, outcome focused Commissioning Strategy.                                                                  | Pete Burnett,<br>Chief Strategy<br>Officer | Commissioning<br>Strategy               |
| <b>Quality</b><br>Establishing robust quality governance oversight and assurance processes in line with National Quality Board (NQB) guidance and statutory duties.             | Maria Laffan,<br>Chief Nursing<br>Officer  | Quality,<br>Performance and<br>Outcomes |
| <b>Quality</b><br>Strategically planning/ setting the framework to discharge the duty of continuous improvement of quality and safety and safeguarding.                         | Maria Laffan,<br>Chief Nursing<br>Officer  | Quality,<br>Performance and<br>Outcomes |
| <b>Outcomes</b><br>The establishment of informed fit for purpose outcomes within the context of strategic planning.                                                             | Nil Sanganee,<br>Chief Medical<br>Officer  | Quality,<br>Performance and<br>Outcomes |
| <b>Financial Sustainability</b><br>Ability to plan for and set a framework that supports delivery of financial sustainability of the ICBs in the short, medium and longer term. | Matt Gaunt, Chief<br>Finance Officer       | Finance and<br>Contracting              |

|                                                                                                                                                                 |                                      |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------|
| <b>Finance</b><br>Establishing alternative funding models and adjusting historic funding arrangements.                                                          | Matt Gaunt, Chief Finance Officer    | Finance and Contracting           |
| <b>Market Management</b><br>Identify/ establish a provider market with the capability and capacity to respond to the strategic intentions and deliver outcomes. | Matt Gaunt, Chief Finance Officer    | Finance and Contracting Committee |
| <b>Capacity and Capability</b><br>Capacity / capability of the ICB to undertake/ deliver the role, functions and duties of a strategic commissioner.            | Pete Burnett, Chief Strategy Officer | Remuneration and People Committee |
| <b>Cyber/Digital</b><br>Maintain / secure, and fit for purpose digital infrastructure, evolve to respond to the needs of strategic planning/ plans.             | Pete Burnett, Chief Strategy Officer | Commissioning Strategy Committee  |
| <b>Capacity and Demand</b><br>Establishing strategic direction that makes positive inroads to reducing inequality and disease prevalence.                       | Eileen Doyle, Chief Delivery Officer | Commissioning Strategy Committee  |
| <b>Reforms</b><br>The impact of national reforms agenda across the NHS, social care and local government.                                                       | Toby Sanders, Chief Executive        | Commissioning Strategy Committee  |

Table 1, Draft LNR Cluster BAF Content

## 2.2. BAF Development Next Steps

2.2.1. The outcome of the work to date will be presented to the Audit Committees in Common and ICB Boards in Common in October.

2.2.2. Further to the identification of the high-level strategic risk themes, the Corporate Governance team are working with the Chief Officer leads to fully populate draft BAF entries to enable the JET to consider a populated draft BAF. This work will be further informed by engagement with Non-Executive Member colleagues with the aim of initial presentations for discussion and comment being made to Committees in December.

2.2.3. The Audit Committees will receive further assurance on the implementation of the Risk Management Framework in December, and the fully populated BAF presented to the ICBs Boards Meeting in Common in December.

## 3.Recommendations

3.1. The Boards are asked to:

- **NOTE** the progress in developing the Cluster Board Assurance Framework (BAF) and planned next steps.

Middlebrook-Claire  
08/10/2026 14:28:57

# Boards Meeting in Common in Public

## Healthwatch Annual Reports

Thursday 15 October 2026

Middlebrook, Claire  
08/10/2026 14:28:57

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

|                            |                                           |                        |           |
|----------------------------|-------------------------------------------|------------------------|-----------|
| <b>Name of Meeting</b>     | <b>Boards Meeting in Common in Public</b> |                        |           |
| <b>Date of Meeting</b>     | <b>Thursday 15 October 2026</b>           |                        |           |
| <b>Report Title</b>        | <b>Healthwatch Annual Reports</b>         |                        |           |
| <b>Paper Reference No:</b> | <b>ICBIC-26-54</b>                        | <b>Agenda Item No:</b> | <b>8.</b> |

|                          |                                                                      |
|--------------------------|----------------------------------------------------------------------|
| <b>Presented by</b>      | <b>Harsha Kotecha Chair Healthwatch Leicester and Leicestershire</b> |
| <b>Report Author(s)</b>  | <b>Harsha Kotecha Chair Healthwatch Leicester and Leicestershire</b> |
| <b>Executive Sponsor</b> | <b>Pete Burnett, Chief Strategy Officer</b>                          |

### Select the Primary Purpose for the Report

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

## Recommendations

**The Boards are asked to:**

1. **Note** the statutory duties that could be lost or compromised.
2. **Consider** the current Healthwatch operating model and national proposals.
3. **Consider** the implications and risks of closure.
4. **Recognise** the evidence of Healthwatch's value.
5. Seek **assurance** that there will be genuine public engagement and co-production in designing replacement arrangements.
6. **Recommend** that the LLR and Northampton ICBs and local authorities jointly design and commission Independent Patient Voice Services to replace statutory Healthwatch

## Executive Summary of the report

This executive summary combines the key findings and themes across the 2025–26 annual reports from:

- Healthwatch West Northamptonshire [Healthwatch West Northamptonshire 2025-2026 Annual Report | Healthwatch West Northamptonshire](#)
- Healthwatch North Northamptonshire [Speaking up for better care: Our Annual Report 2025/26 | Healthwatch North Northamptonshire](#)
- Healthwatch Rutland [Speaking up for better care: HWR Annual Report 2025-26 | Healthwatch Rutland](#)
- Healthwatch Leicester and Leicestershire [Annual Report 2025/26 | Healthwatch Data](#)

The full reports are also available to Board members within the supplementary folder on Admin Control.

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

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

| Appendices |
|------------|
|            |

| Who has been engaged and where else has this report been considered: |
|----------------------------------------------------------------------|
| This report has not been received by any other meeting.              |

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

Middlebrook, Claire  
08/10/2026 14:28:57

## Annual Report Healthwatch LLNR Thursday 15 October 2026

### Introduction

1. This report presents the Annual reports 2025/26 for Healthwatch for Leicester, Leicestershire, Northamptonshire and Rutland for consideration by the Integrated Care Board.
2. The report provides an overview of Healthwatch activity during 2025-26, including public engagement, information and signposting services, Enter and View activity, and the impact of Healthwatch recommendations on local health and social care services.
3. The report also outlines key priorities and areas of focus for 2026-27

### Background

The Health and Social Care Act 2012 introduced statutory duties on local authorities to deliver effective local Healthwatch services. Healthwatch England is a statutory committee and regulated by the Care Quality Commission (CQC). Local Healthwatch is equally a statutory function and funded by and accountable to local authorities.

Healthwatch is the local independent statutory consumer champion for health and social care. Its role is to ensure that the views, experiences and concerns of patients / residents / service users/ carers and local communities inform the planning, commissioning, delivery and scrutiny of health and social care services.

### Healthwatch statutory duties include:

- Gathering views and experiences of local people on health and social care services;
- Influencing commissioning, redesign and scrutiny of service delivery;
- Assessing local services/provision and making recommendations for improvement;
- Providing information and signposting;
- Has powers to enter health and social care premises to undertake Enter and View visits;

Across all Healthwatch organisations, public feedback is consistent. Residents continue to value NHS and social care services but report significant challenges accessing timely care, particularly:

- GP appointments and continuity of care
- NHS dental services
- Mental health support
- Autism and ADHD assessment pathways
- Navigation of complex health and care systems
- Rural access and health inequalities
- Support for vulnerable and underserved communities

Middlebrook, Claire  
08/10/2026 14:28:57

## Healthwatch West Northamptonshire (HWW)

This was Healthwatch West Northamptonshire's first annual report following the separation of North and West Northamptonshire services

### Key achievements

- 551 people engaged with us to share their voices and experiences
- 115 people reached out for support and advice with health and social care services, helping to raise awareness of issues and help improve care
- 3 reports were published about the improvements people would like to see in health and social care services.
- Our most impactful report was the Health and Care Research for All: Strengthening Eastern European Voices project.
- We had 17 outstanding active volunteers. Our volunteers worked extremely hard throughout the year, giving up their own time to ensure that commissioners and health service providers heard the voice of the public.
- 436 hours were spent volunteering.

### How we made a difference:

- We visited Northampton General's Paediatric departments and Adult A&E to observe the services and the care they deliver, making recommendations to the hospital to change service delivery for the better
- We connected with students at the University of Northampton's Master of Public Health course, getting students involved in listening to the community's needs and experiences with health and social care locally
- We shared the findings of our research engagement work with the Eastern European community, which evidenced new approaches and best practices to connect with ethnically diverse communities, enabling lasting relationships and making accessible information available

### Priorities for 2026/27

- To prioritise Older People, Ageing Services and Dementia Care.
- To focus on the New Models of Care Programme and the impacts it has within West Northamptonshire's communities.
- To get connected with the work being delivered within the Local Area Partnerships and Neighbourhood level through integrated commissioning pathways

Full report available here: [Healthwatch West Northamptonshire 2025-2026 Annual Report | Healthwatch West Northamptonshire](#)

Middlebrook, Claire  
08/10/2026 14:28:57

## Healthwatch North Northamptonshire HNN

This was HNN first full year of activity.

### Key achievements

- 502 people shared experiences of health and social care,
- More than 200 people sought advice, information or support.
- Healthwatch published 5 reports, covering issues including primary care and hospital services. Its most prominent piece of work was an Enter & View report on Paediatric services at Kettering General Hospital (KGH).
- The organisation grew its local presence through 8 community surgeries,
- More than 30 community drop-ins
- 5 community health and wellbeing events.
- Helped facilitate 35 free NHS Health Checks, particularly targeting vulnerable groups.
- Established an 18-member Advisory Group bringing together people with lived experience and representatives from health, social care and the voluntary/community sector.

### What residents told Healthwatch

Access to primary care was a major theme. Of the experiences collected:

- 38% related to GP surgeries
- 20% reported difficulties booking GP appointments
- 7% reported difficulties using Anima, an online system used for accessing GP services.

### Priorities for 2026/27

- Public Health – targeted engagement with Black communities, particularly South Asian and African-Caribbean communities, to increase participation in NHS Health Checks.
- Primary Care – working with the East Northamptonshire New Models of Care Innovator to involve communities in shaping primary-care access points.
- Strategic Volunteering – developing a sustainable volunteer network capable of representing all communities, especially seldom-heard groups.

Full report available here: [Speaking up for better care: Our Annual Report 2025/26 | Healthwatch North Northamptonshire](#)

Middlebrook, Claire  
08/10/2026 14:28:57

## Healthwatch Rutland HWR

### Key Achievements

- 392 people shared their experiences of health and social care with us, helping to raise awareness of issues and improve care
- 1065 people came to us for clear advice and information e.g. how to make a formal complaint to the NHS, finding an NHS dentist, finding support and information after a bereavement, details of local seasonal vaccination programmes etc.
- 471 volunteer hours.

### Better care in Ophthalmology

Our joint Enter & View with HWLL at Leicester Royal Infirmary Ophthalmology led to several recommendations. Subsequently the hospital has made improvements by increasing capacity, using SMS and telephone reminders to improve communications, reviewing signage for visually impaired patients, progressing an electronic calling system and enhancing patient comfort through water provision and volunteer help with navigation.

### Keeping same-day care local

Our four-year programme of evidence gathering, consultation support and collaboration with partners secured tangible results. The new combined Minor Illness & Injury service for Oakham, opened April 1<sup>st</sup> 2026 with walk-in and bookable appointments, seven-day access and enhanced X-ray provision.

### Improving access for all communities

- Ensuring emergency information is accessible for deaf and deafblind residents

After a Rutland resident highlighted that “Right Care, Right Place” materials lacked guidance for deaf and BSL-using residents, HWR escalated the issue, resulting in updated ICB web content with clear instructions on NHS 111 textphone, the BSL interpreter service and Emergency SMS for 999, with a commitment to update the PDF guide.

- Strengthening support for self-funders

Research with 129 residents revealed confusion over financial thresholds, lack of guidance and navigation support and the emotional strain for carers in arranging care, with many unaware of their entitlement to local authority assessments or guidance.

Rutland County Council responded by redesigning Adult Social Care information, improving guidance and navigation tools, strengthening financial information, created “Waiting Well” packs and is now beginning work on a streamlined information hub.

- Fair access to repeat prescriptions

When a Rutland GP practice implemented a shift to online ordering of repeat prescriptions, HWR highlighted digital barriers and worked with the practice to ensure fair access,

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

including retaining a posting box for paper requests for those unable to use online methods.

### **Priorities for 2026–27**

- Assessing public awareness and patient experience of Pharmacy First.
- Investigating defibrillator awareness, accessibility, information and maintenance across Rutland.
- Understanding health and care inequalities in Rutland's farming community

Full report available here: [Speaking up for better care: HWR Annual Report 2025-26 | Healthwatch Rutland](#)

Middlebrook, Claire  
08/10/2026 14:28:57

## Healthwatch Leicester and Leicestershire (HWLL)

### Key achievements

- 15,046 residents shared their experiences of health and social care,
- 31,544 people received information, advice or signposting.
- published 19 reports based on public insight and evidence
- 38 Enter and View visits were carried out
- 24 Neighbourhood Mental Health Cafes visits

### Projects

- The Women and Girls' Health Programme involved engagement with 2,802 women and girls across Leicester, Leicestershire and Rutland. The key issues included access to specialist support, continuity of care, better information and more joined-up pathways.
- Supported Living Review, engaging with residents, carers and providers. Issues included communication, inclusion, housing suitability, social isolation and support planning.
- Hospital Discharge – gathered experiences from people moving from hospital back into community care and identified issues around decision-making, medication, follow-up support, discharge planning and communication. This work has contributed to wider quality-improvement discussions.
- Revisited its work on access to healthcare for Deaf and hard of hearing people. The review found that, despite some improvements, significant barriers remain around booking appointments, accessing BSL interpreters, receiving accessible information and communicating with healthcare professionals.

### Priorities for 2026–27

- Pharmacy First.
- Digital access to NHS services
- Tackling health inequalities - The first project under this theme will explore young people's experiences around healthy weight and lifestyle.

Full report available here: [Annual Report 2025/26 | Healthwatch Data](#)

Middlebrook, Claire  
08/10/2026 14:28:57

# Boards Meeting in Common in Public

## LNR Year 2 Medium Term Planning and Commissioning Intentions Update for 2027/28

Thursday 15 October 2026

Middlebrook, Claire  
08/10/2026 14:28:57

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

|                            |                                                                                        |                        |           |
|----------------------------|----------------------------------------------------------------------------------------|------------------------|-----------|
| <b>Name of Meeting</b>     | <b>Boards Meeting in Common in Public</b>                                              |                        |           |
| <b>Date of Meeting</b>     | <b>Thursday 15 October 2026</b>                                                        |                        |           |
| <b>Report Title</b>        | <b>LNR Year 2 Medium Term Planning and Commissioning Intentions Update for 2027/28</b> |                        |           |
| <b>Paper Reference No:</b> | <b>ICBIC-26-55</b>                                                                     | <b>Agenda Item No:</b> | <b>9.</b> |

|                          |                                                                                                                                 |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Presented by</b>      | <b>Pete Burnett, Chief Strategy Officer</b>                                                                                     |
| <b>Report Author(s)</b>  | <b>Charlie Wood Deputy Director of Contracting,<br/>Bhavna Gosai Head of Strategy and Planning,<br/>JMT/Commissioning Leads</b> |
| <b>Executive Sponsor</b> | <b>Pete Burnett Chief Strategy Officer, Matt Gaunt Chief Finance Officer</b>                                                    |

| Select the Primary Purpose for the Report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                  |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>ADVISORY</b><br>To receive and note implications, may require discussion to help to shape/develop item.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> <b>ASSURANCE</b><br>To assure the Committees that controls and assurances are in place. | <input checked="" type="checkbox"/> <b>APPROVAL</b><br>Recommendation or particular course of action. |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                       |
| <p><b>The Board is asked to:</b></p> <ul style="list-style-type: none"> <li><b>APPROVE</b> the key principles of the report, to enable Commissioning Intentions and counting and coding letters to be distributed to the selected Providers on 30<sup>th</sup> September.</li> </ul> <p>There will be time for Chief Officers to propose further changes to the messages before circulation on 30<sup>th</sup> September.</p> <ul style="list-style-type: none"> <li><b>NOTE</b> the progress made to date in developing the LNR Medium-Term Planning approach and the commissioning intentions framework, including engagement with programme leads, quality, finance and operational teams across the system.</li> <li><b>NOTE</b> the commencement of the 2027/28 Medium Term planning process, with further refinement of activity, workforce, financial and commissioning assumptions to be undertaken following publication of national planning guidance</li> </ul> |                                                                                                                  |                                                                                                       |

## Executive Summary of the report

### Background

- It is intended that the Commissioning Intentions for 2027/28 signal a transition from activity-based commissioning towards strategic commissioning focused on outcomes, prevention, neighbourhood delivery and value. Collaborative partners will be expected to support the NHS 10 Year Plan shifts from hospital to community, analogue to digital and sickness to prevention.
- The key areas of focus include the development of neighbourhood-based models of care, elective and planned care transformation, recovery of urgent and emergency care performance, improved prevention and management of long-term conditions, expanded use of digital and AI-enabled solutions, and the continued development of integrated provider arrangements. Commissioners will increasingly seek to commission services that demonstrate measurable improvements in outcomes, reduce health inequalities, improve productivity and deliver care closer to home. Our key priorities remain prevention, frailty, children and young people, mental health, and community services.
- Across acute, community, mental health, primary care and voluntary sector partners, there is an expectation that services will support pathway redesign, collaborative delivery models and financial sustainability. Future commissioning approaches will increasingly utilise lead-provider, potentially IHO, neighbourhood and population-based arrangements where these deliver improved value, outcomes and system resilience. Financial sustainability and productivity improvement remain core expectations of all providers with contractual arrangements increasingly supporting and enabling pathway-based, lead-provider and population-based models of care.
- The detail of these programmes will be worked up through our internal 2027/28 Medium Term planning process which will be undertaken within the context of the NHS England Medium Term Planning Framework 2026/27 to 2028/29, which sets out a longer-term approach to improving population health outcomes, restoring operational performance, delivering financial sustainability, and supporting the transformation of health and care services.
- It is intended to use the contractual counting and coding letters, to communicate the strategic direction of travel to our key partners for 2027/28.

### Strategic Commissioning – Community/Mental Health

- Providers will be instrumental in delivering the ICBs commissioning intentions, we will explore integrated, joint or lead commissioning arrangements with population based approaches. This will include the development of proportionate risk and gain-share mechanisms, and outcome-based agreements that are grounded in the core expectations of provider financial sustainability and productivity. Benchmarking will be used for 2027/28 to baseline activity and services, to identify opportunities for improvement and to inform future commissioning, service redesign and investment
- Any agreed changes will be reflected in the appropriate contractual documentation. Neither party should assume acceptance of any proposed activity, financial, coding, counting, charging or contractual adjustment unless and until it has been formally agreed.

Miracle Book-Claire  
08/10/2026 14:28:57

## Strategic Commissioning – Acute

- Planned Care, which includes Elective, Cancer and Diagnostics will be commissioned in-line with National, Regional, and Neighbourhood objectives, noting the three shifts in the Ten Year Plan.
- These include moving services closer to citizens via the expansion of Diagnostics delivered via CDC capacity across the LNR Cluster. With both Northants and LLR opening a 3rd CDC in 27/28. The Elective Hub, scheduled to open in Northants in 27/28 will ensure the whole cluster have Elective capacity outside of the main acute footprint, joining the LLR EMPCC. Alongside investment in Neighbourhood Health Centres and Place Based Primary Care expansion (Rutland) the ICB Cluster will be able to roll out fully into Neighbourhood and Place planned Care services.
- Services more suited to Neighbourhood delivery models, such as Ophthalmology, MSK and Long Term Conditions will be transformed, including the utilisation of digital enablers. Contracts and plans will be aligned to develop lead provider and shared care delivery models, with whole budget commissioning utilised to enable left shift funding to take place without destabilising wider NHS provider partners.
- Traditional delivery models will be transformed with Service Specifications updated to include the use of technology to support new delivery models such as SPOA (A&G) rollout and Follow Up stratification. Supporting the ability to reinvest benefits into the wider Elective Recovery and genuine areas of growth. With a focus on reducing the Health Inequalities currently in place across the LNR Cluster. Where benefits are clearly identified, services will be put up for tender via PSR to encourage partner collaboration. With all existing contracts/activity having a full review and re-commissioned before the end of 28/29.
- The ICB wishes to work with providers to ensure that the 2027/28 activity and financial baseline reflects an agreed understanding of known coding and counting changes, service developments, SDEC activity and relevant planning assumptions.
- Undertake a comprehensive review of all funding arrangements, including fixed, historic and non-recurrent funding, to maximise value, transparency and outcomes.

## Key Principles

### The purpose of this report is agree the following key principles:

- To send out Commissioning Intention/Counting & Coding Letters to nominated Providers only:
  - University Hospitals of Northamptonshire (UHN)
  - University Hospitals of Leicester (UHL)
  - Northamptonshire Healthcare Foundation Trust (NHFT)
  - Leicestershire Partnership Trust (LPT)
- To continue to develop Year 2 of the Medium Term plan for the LNR Cluster with Providers as part of the 2027/28 planning process from October 2026, establishing regular Activity and Performance planning meetings with providers and establishing a Planning Assurance Forum to agree baseline activity levels, planning assumptions, performance trajectories and system priorities. This work will support local preparedness in anticipation of the national guidance.

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

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

| Appendices |
|------------|
|            |

| Who has been engaged and where else has this report been considered:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>The development of the commissioning intentions has been informed through collaborative input from commissioning, finance, quality, performance and operational delivery teams across LNR, ensuring alignment with strategic priorities, quality improvement objectives and financial sustainability requirements.</li> <li>The paper was reviewed by the Joint Executive Team, and feedback has been incorporated into the accompanying letter to providers.</li> <li>The commissioning intentions were formally approved by the Commissioning Committee on 6 October 2026.</li> </ul> |

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

Middlebrook, Claire  
08/10/2026 14:28:57

# LNR Year 2 Medium Term Planning and Commissioning Intentions Update for 2027/28

## Background

1. The Commissioning Intentions have been drafted as part of the Year 2 2027/28 Medium Term planning process which is being undertaken within the context of the NHS England Medium Term Planning Framework 2026/27 to 2028/29, which sets out a longer-term approach to improving population health outcomes, restoring operational performance, delivering financial sustainability, and supporting the transformation of health and care services. The framework marks a shift away from short term annual planning towards a more integrated and strategic approach, enabling systems to develop plans that balance immediate operational priorities with longer-term service transformation.
2. For 2027/28, organisations across the Leicestershire Rutland and Northamptonshire (LNR) will work collaboratively to develop a robust, evidence-based and financially sustainable plan that reflects both national priorities and local population needs. Planning will focus on delivering improvements in access, quality, productivity and outcomes, while supporting the strategic shifts outlined in the NHS 10 Year Health Plan, including moving care closer to home, increasing the focus on prevention, and accelerating digital transformation. Aligning to the LNR three priority areas: reducing preventable mortality, improving outcomes for people living with frailty, and enhancing the health and wellbeing of children and young people (CYP).
3. The Medium Term Planning process will bring together commissioners, providers and wider partners to ensure alignment of operational plans, workforce plans, financial plans and transformation programmes. Particular emphasis will be placed on reducing health inequalities, improving patient outcomes, delivering value for money, and ensuring services remain sustainable over the medium term.
4. The Year 2 2027/28 plan will demonstrate how the system will deliver national performance expectations, maintain financial balance, and progress the medium-term ambitions set out within the three-year planning framework, providing a clear roadmap for delivery and system assurance.

## Acute Commissioning Intentions

## Strategic Direction

5. Planned Care, including Elective Care, Cancer and Diagnostics, will be commissioned for next year in line with national, regional and neighbourhood priorities and support delivery of the NHS 10 Year Health Plan. Commissioning arrangements will increasingly focus on earlier diagnosis, prevention, digital enablement, productivity, and the delivery of care closer to home through neighbourhood and community-based models. Providers will be expected to collaboratively support transformation programmes that reduce unwarranted variation, improve outcomes and deliver

financial sustainability.

## Coding, Counting and Charging Intentions

6. Providers will be required to demonstrate robust data quality, counting and clinical coding arrangements, including routine validation and audit processes, to ensure activity is accurately recorded, transparently reported and reflects national standards. Variations in coding practice, pathway recording and activity counting will be subject to review to support value for money, effective commissioning and equitable resource allocation. Particular focus will be given to SDEC and where additional funding has supported the introduction of new SDEC pathways during 2026/27, evidence of their activity, outcomes and impact will be considered as part of the 2027/28 contracting process. Where continuation is agreed, the ICB expects these pathways to operate under an activity-based funding model unless alternative arrangements are agreed through the contracting process.

## Core Expectations for Acute Providers

7. All acute providers will be expected to:
  - Deliver agreed RTT recovery trajectories and constitutional standards.
  - Deliver cancer performance standards, including Faster Diagnosis, 31-day and 62-day standards.
  - Expand use of Advice and Guidance, Single Points of Access and digital pathways.
  - Reduce unnecessary outpatient follow-up activity and implement GIRFT best practice.
  - Support direct access diagnostics and straight-to-test pathways where clinically appropriate, linking with CDCs.
  - Work collaboratively with community, primary care and neighbourhood providers to redesign pathways and support activity shifts closer to home.
  - Demonstrate productivity improvements and value through pathway redesign and digital innovation.
  - Support reduction of health inequalities through improved access and earlier diagnosis.
  - Share data to establish clear baselines and coding on which to build prioritised programmes and workstreams.

## Provider-Specific Commissioning Approaches

### University Hospitals of Leicester (UHL)

8. The commissioning approach for UHL will focus on supporting delivery of the LLR Diagnostic Strategy through commissioning of the third Community Diagnostic Centre, development of straight-to-test pathways and earlier cancer diagnosis initiatives. UHL will be expected to support expansion of lung cancer screening and deliver planned

RTT and cancer recovery trajectories.

In addition, commissioning intentions include:

- Development of an LLR-wide lead-provider model for MSK services, incorporating existing contracts and budgets where appropriate.
- Progressive transfer of ophthalmology activity into community settings, retaining acute-based provision only for specialist, urgent and complex care.
- Greater use of digital solutions and AI-enabled service delivery.
- Adoption of hub-and-spoke and multidisciplinary delivery models across acute, community and primary care estate.
- Reduction in elective demand through prevention-focused commissioning and non-consultant-led models of care.
- Support implementation of the National Rehabilitation Centre (NRC) model, ensuring equitable access to specialist rehabilitation services for LNR residents and maximising opportunities to improve patient outcomes, reduce length of stay, and support recovery pathways.

### **University Hospitals of Northamptonshire (UHN)**

9. The commissioning approach for UHN will focus on elective recovery alongside development of the Northamptonshire Elective Hub and supporting infrastructure, enabling additional elective capacity outside of the acute hospital footprint.

Specific expectations include:

- Delivery of RTT and cancer recovery trajectories.
- Establishment of lead-provider arrangements for services delivered through the Elective Hub.
- Reduction in reliance on out-of-county and independent sector elective capacity through improved utilisation of local NHS capacity.
- Expansion of community ophthalmology models with only specialist and urgent activity remaining within acute settings.
- Increased adoption of digital technologies and AI-enabled pathways.
- Support for prevention and non-consultant-led care pathways to reduce future elective demand.

### **Community and Neighbourhood Delivery**

10. Across both systems, commissioners will increasingly commission services to support the shift left, such as MSK, ophthalmology, diagnostics, long-term condition management and follow-up care through neighbourhood and community-based models. Contractual arrangements may include lead-provider, alliance, delegated budget and subcontracting approaches to facilitate the transfer of activity and resources whilst maintaining provider sustainability. System partners working closely

together are key to the delivery of the transformation that is required to meet population needs and address health inequalities Commissioners will review all major elective pathways by 2028/29 to provide baselines for strategic commissioning plans, value-based healthcare principles and neighbourhood health delivery models. Benchmarking will be used, where appropriate, to identify opportunities for improvement and to inform future commissioning, service redesign and investment decisions. This will include the development of proportionate risk and gain-share mechanisms, and outcome-based agreements that are grounded in the core expectations of provider financial sustainability and productivity.

## Data

11. The ICB will require demonstrable improvements in data quality to support transparency and informed decision making. Providers will be expected to capture key data in performance outcomes, with particular focus on demographics and inequalities to enable oversight and assurance that services are being delivered in line with statutory obligations towards health inequalities and protected characteristics.

## Standardising Community Health Services

12. We will continue to work collaboratively with providers to strengthen integrated, multidisciplinary care through standardised service specifications and pathways. This includes reviewing urgent and reactive community services such as urgent community response, admission avoidance and virtual wards. Priority actions, outcomes and measures will be agreed through the contracting process.

## Finance

13. **Non-recurrent, Time-Limited and Unallocated Funding** - Continuation of non-recurrent, time-limited or unallocated funding beyond 2026/27 should not be assumed. Any ongoing investment will be considered through the 2027/28 planning and contracting process, based on demonstrated need, delivery, affordability, value for money, and the implications of continuation, redesign, transfer or cessation.
14. **Activity Planning Assumptions** - ICBs and providers are expected to increase the use of currency models to inform service development, planning, benchmarking and funding discussions.
15. **Deconstructing the Blocks** - The NHS 10-Year Plan signalled a move away from traditional block contracts towards payment arrangements more closely aligned to activity and patient need. A block deconstruction exercise undertaken in 2025 was unable to provide a sufficiently robust basis for change, primarily due to data quality limitations. A revised exercise completed in summer 2026 will inform 2027/28 planning and contracting discussions.

## Quality

## UHL / LPT

16. As a strategic commissioner, we will use quality schedules to support a shift from assurance and performance monitoring towards outcomes-focused improvement. Working in partnership with providers, we will develop meaningful quality and outcome measures in priority areas, including children and young people, frailty, and mortality, creating a foundation for continuous improvement, innovation, and transformation. Through this approach, we aim to improve population outcomes, reduce health inequalities, and drive sustainable improvements in the safety, effectiveness, and experience of care.

We will also implement the same approach with NHFT and UHN to support a consistent improvement framework across providers.

## Neighbourhoods

17. We will commission for outcomes, supporting neighbourhood providers to embed quality planning, improvement and learning within service delivery. Working in partnership with providers and communities, we will identify opportunities to strengthen commissioning, address gaps in services and redesign care where needed, ensuring neighbourhood models are fit for purpose, community-centred and focused on improving quality, experience, equity, and outcomes.
18. The overarching aim is to support a shift from assurance and performance monitoring towards outcomes-focused improvement across our local priority areas of Children and Young People (CYP), Cardiovascular Disease (CVD) and Frailty. During 2026/27, provider quality schedules will be used to establish baseline data, understand variation and identify opportunities for improvement. This intelligence will inform the development of targeted, system-wide quality improvement programmes from 2027/28 onwards, focused on improving outcomes, reducing health inequalities and enhancing the experience of care across LNR.

## Provider-specific matters

### NHFT

### Integrated Health Organisations (IHOs)

19. The NHS 10-Year Plan sets out a transition from traditional commissioning and contracting to population-based models that support neighbourhood care, reduce fragmentation, align incentives across organisations, and enable resources to shift from hospital to community services.
20. As part of our plans to implement this strategic vision and transformational approach we will continue to commission with NHFT using a combination of existing contract

approaches and lead provider models for subsets of the local population, pending transition to a potential full IHO coverage and contractual methodologies.

- Mental Health, Learning Disability and Autism (MHLDA)** -The Northamptonshire MHLDA Collaborative will continue to develop the existing Outcomes-Based Contract, extending the approach to additional fixed cost MH and LDA services where appropriate. Further work is required to review contract scope and determine options for incorporating variable-cost services while ensuring change remains manageable and safe. The LNR ADHD and Autism Assessment and Support Implementation Programme will develop the foundations for a sustainable, equitable and clinically effective assessment and support model, supported by future-state pathways, commissioning and assurance arrangements. By April 2027, the programme will have completed mobilisation and readiness planning, established commissioning and assurance mechanisms, and commenced phased implementation. This represents the first phase of a wider five-year transformation programme aimed at reducing variation, improving access and outcomes, and ensuring the long-term sustainability of neurodevelopmental services across LNR.
- Children and Young People (CYP) Lead Provider** -Following the establishment of the CYP Community Services Lead Provider foundation in 2026/27, work will continue to expand the model through the integration of agreed community CYP services. This will support more consistent, sustainable and equitable pathways across Northamptonshire, building on lessons learned from the MHLDA Outcomes-Based Contract.

## Performance Expectations

- Contracts will set out requirements for improvement plans, performance monitoring and assurance reporting in areas of concern, including:

### Community Health Waiting Times

NHFT will be expected to develop and deliver recovery plans for services experiencing excessive waiting times, with agreed milestones, trajectories and regular reporting to commissioners. For example continue addressing excessive waits for community health services, delivering sustained improvement against the ambition that at least 80% of community health service activity is undertaken within 18 weeks of referral.

### Talking Therapies

NHFT will be expected to demonstrate delivery against agreed improvement plans developed in response to previous performance concerns regarding completion of treatment trajectories and achievement of future targets.

### Looked After Children (LAC)

Improve the timeliness of Initial Health Assessments (IHAs) for Looked After

Middlebrook, Claire  
08/10/2026 14:28:57

Children remains a system priority. Building on service changes introduced through the CYP Lead Provider model, we will continue to monitor delivery against agreed action plans and associated risks.

## LPT

### Community Nursing Transformation

22. We recognise the significant transformation of Community Nursing services, including workforce restructuring and adoption of a neighbourhood-based model. Focus will remain on improving caseload management, workforce utilisation, clinical leadership and workforce sustainability. Progress will be monitored through contractual arrangements and aligned with wider community service standardisation work.
- **Community Health Waiting Times** - Reducing waiting times in community health services remains a priority. LPT will be expected to deliver recovery plans with clear milestones, trajectories and regular reporting to commissioners. Contracts will set out expectations for delivery, monitoring and assurance. For example, continue addressing excessive waits for community health services, delivering sustained improvement against the ambition that at least 80% of community health service activity is undertaken within 18 weeks of referral.
  - **Mental Health Collaborative and Lead Provider Model** - We will continue to work jointly through the Mental Health Collaborative to strengthen shared commissioning, governance and accountability arrangements. This includes developing a roadmap towards a lead provider model, supporting greater ownership of mental health delivery, consistent pathways, shared outcomes and more integrated ways of working across the system.

### Recommendation

23. The Board is asked to approve this approach to developing the 2027/28 Commissioning Intentions, building on the initial development of the LNR Strategic Commissioning Strategy. This approach will ensure that commissioning priorities are aligned to the NHS 10-Year Plan, population health needs, financial sustainability requirements, and the continued shift towards integrated, neighbourhood-based models of care. The Commissioning Intentions will provide a framework for contracting, service transformation and resource allocation, focusing on improving outcomes, reducing variation, strengthening prevention and supporting delivery of system-wide objectives across LNR. The principles being covered are listed below:

#### Key Principles

- a) To send out Commissioning Intention/Counting & Coding Letters to nominated Providers only:
  - University Hospitals of Northamptonshire (UHN)

- University Hospitals of Leicester (UHL)
  - Northamptonshire Healthcare Foundation Trust (NHFT)
  - Leicestershire Partnership Trust (LPT)
- b) To continue to develop Year 2 of the Medium Term plan for the LNR Cluster with Providers as part of the 2027/28 planning process from October 2026, establishing regular Activity and Performance planning meetings with providers and establishing a Planning Assurance Forum to agree baseline activity levels, planning assumptions, performance trajectories and system priorities. This work will support local preparedness in anticipation of the national guidance
- c) Establish a clear framework for the contracting round, incorporating enabling contractual levers to support achievement of the plan's objectives and outcomes.
- d) To align the financial allocation to the ambition of the plan to meet the aspirations of the shift left. For example, risk and gain share arrangements to support innovation and service transformation and incentivised delivery of agreed outcomes

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# Appendix 1 - LNR Year 2 Medium Term Planning and Commissioning Intentions Update for 2027/28

Charlie Wood Deputy Director of Contracting,  
Bhavna Gosai Head of Strategy and Planning  
ICB JMT / Commissioning Leads  
September 2026

08/10/2026 14:28:57  
Middlebrook, Claire

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

- Medium Term Planning update
- LNR Commissioning Intentions 2027/28
- Elective Care
- Urgent and Emergency Care
- Primary Care, Preventable Mortality, Neighbourhood and Community
- Children's and Young People
- Adult MHLDA
- Finance/ Quality Commissioning intentions

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The 2027/28 Annual Plan represents Year 2 of the NHS England Medium Term Planning Framework (2026/27-2028/29), which establishes a longer-term approach to improving outcomes, restoring performance, delivering financial sustainability and transforming health and care services.

The Framework is built around four key objectives:

- Improve population health outcomes and reduce health inequalities.
- Restore constitutional standards and improve access to services.
- Deliver financial sustainability and productivity improvements.
- Transform services through neighbourhood health and integrated care models.

The NHS 10 Year Health Plan supports three fundamental shifts:

- Hospital to Community Expanding neighbourhood health services and delivering more care closer to home.
- Treatment to Prevention Earlier intervention, improved population health management and reducing future demand.
- Analogue to Digital Increased use of digital technology, data, AI and innovation to improve care and productivity.

## LNR Strategic Transformational Priorities

- **Preventable Mortality** - Improve cardiovascular, kidney, vascular, metabolic and respiratory health outcomes through prevention, early intervention, proactive management of long-term conditions, increased screening and earlier diagnosis, reducing unwarranted variation and health inequalities.
- **Frailty** – Develop integrated neighbourhood-based frailty services that support proactive identification, admission avoidance, hospital at home, urgent community response, rehabilitation and discharge support, enabling more people to remain independent and receive care closer to home.
- **Children and Young People (CYP)** – Improve outcomes for children, young people and families through integrated neighbourhood delivery models, lead provider arrangements, improved access to ADHD and autism services, and more coordinated physical health, mental health and community support pathway

## Planning Position

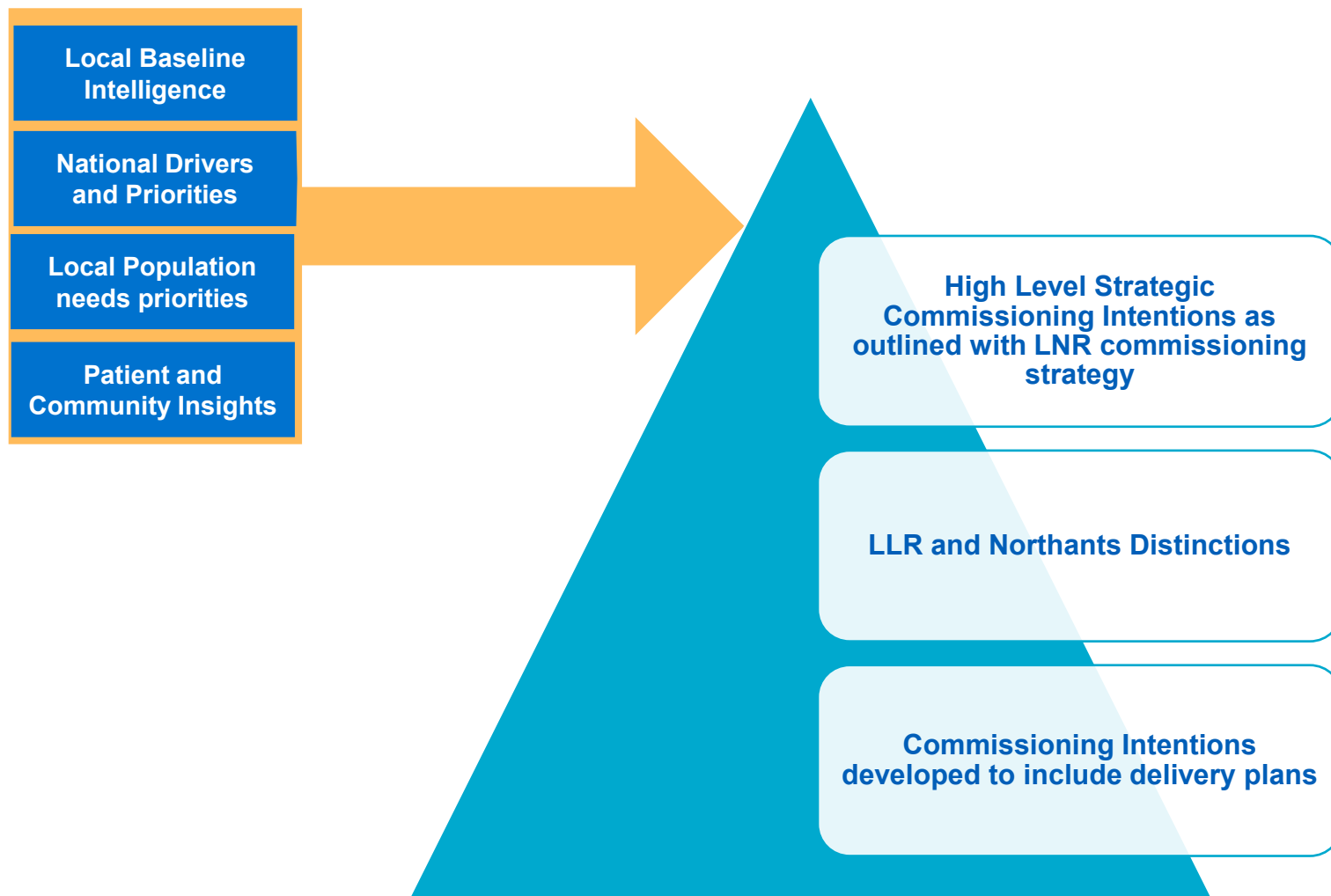
- National planning guidance is anticipated following the Government Budget announcement in October 2026.
- Detailed operational and financial requirements are expected thereafter.
- The ICB will commence the 2027/28 planning process from October 2026, establishing regular Activity and Performance planning meetings with providers and establishing a Planning Assurance Forum to agree baseline activity levels, planning assumptions, performance trajectories and system priorities. This work will support local preparedness in anticipation of the national guidance .
- This deck summarises the commissioning intentions developed across LNR to support delivery of medium-term system ambitions for 2027/28 and beyond.
- Further work will be undertaken to validate activity, workforce and financial assumptions and to align plans with national planning guidance once issued.

Middlebrook-Claire  
08/10/2026 14:28:57

# Development of commissioning intentions

Commissioning Intentions are a vehicle for improving care, transforming pathways, and improving health of our population. These intentions for 2027/28 are framed in the context of:

- NHS 10 Year Plan 3 Shifts Sickness to Prevention, Hospital to community and Analogue to Digital
- Building the foundations developed in 2026/27 which include Elective Care, Urgent and Emergency care, neighbourhood development and Commissioning for Value / Outcomes Based Commissioning (Appendix 1). Alongside the LNR commissioning strategy covering the three strategic priorities: Frailty, Preventable Mortality to include CVD, Respiratory and Cancer and Children and Young People
- Developing ICB Neighbourhood Model/ Delivery Plan aligned to the LNR 5year Commissioning Strategy
- Improving our strategic commissioning and how the ICB adds value in driving better outcomes, reducing health inequalities and improving efficiency
- Continuing challenged financial position and requirement to move towards financial balance



# LNR Commissioning Intentions 2027/28

The 2027/28 commissioning intentions represent the transition from transactional commissioning towards a strategic commissioning approach focused on improving population health outcomes, reducing health inequalities and securing long-term sustainability. The commissioning intentions support delivery of the NHS 10 Year Health Plan and Medium-Term Planning Framework through the three shifts from Hospital to Community, Treatment to Prevention and Analogue to Digital.

## Commissioning Principles

- We will increasingly commission services that are:
- Outcomes-led rather than activity-led.
- Focused on population health improvement and prevention.
- Delivered through integrated pathways and neighbourhood models.
- Digitally enabled and productivity focused.
- Designed to reduce unwarranted variation and inequalities.
- Supported by lead provider, alliance and partnership models where appropriate.

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# High Level Summary of Commissioning Intentions

The 2027/28 Commissioning Intentions are centred on LNR's three strategic priorities of Preventable Mortality, Frailty and Children & Young People, underpinned by Neighbourhood Health Transformation, Quality Improvement and Financial Sustainability, and supported through strategic commissioning, improved access and outcomes, and delivery of the NHS 10 Year Health Plan's three shifts from Hospital to Community, Treatment to Prevention and Analogue to Digital.

| Strategic Priority                                                     | Key Commissioning intentions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Elective, Cancer &amp; Diagnostics</b>                              | Reduce outpatient follow-ups and develop neighbourhood-based elective pathways supported by Advice & Guidance and direct access diagnostics. Develop community-based elective pathways (MSK, Ophthalmology and Rheumatology); support earlier cancer diagnosis through CDCs, straight-to-test pathways and screening uptake improvements. Aligned to redesigning outpatients we will develop capacity in primary care for amendable high-volume diagnostics such as Phlebotomy, Spirometry and FeNO (fractional exhaled nitric oxide) |
| <b>Urgent &amp; Emergency Care</b>                                     | Review UTC provision, performance and specification compliance across LNR.<br>Expand SDEC, UCR, virtual wards, community beds, develop in collaboration a Single Point of Access arrangements; reduce avoidable ED attendances and admissions through neighbourhood-based urgent care pathways                                                                                                                                                                                                                                        |
| <b>Frailty</b>                                                         | Expand Integrated Neighbourhood Teams, Urgent Community Response, virtual wards, Hospital at Home.continue with ageing well programme with Northamptonshire Expand the aging well programme with LLR                                                                                                                                                                                                                                                                                                                                  |
| <b>Neighbourhood Health Transformation</b>                             | Establish Integrated Neighbourhood Teams as the principal delivery model, commencing with the initial 1% priority population cohort in every neighbourhood, focused on population need for the population.                                                                                                                                                                                                                                                                                                                            |
| <b>Primary &amp; Community Care</b>                                    | Undertake a comprehensive review of the Primary Care portfolio, including General Practice, PCNs, Community Pharmacy, Dentistry and Optometry, to align services with population need, neighbourhood priorities and the NHS 10 Year Plan.                                                                                                                                                                                                                                                                                             |
| <b>Preventable Mortality</b>                                           | Strengthen prevention, early intervention and population health management, improving access to prevention programmes, diabetes technologies and evidence-based interventions. Develop neighbourhood-based CVKM, respiratory and obesity pathways                                                                                                                                                                                                                                                                                     |
| <b>Children &amp; Young People (CYP)</b>                               | Implement lead provider arrangements, redesign ADHD and Autism pathways. Mobilise agreed Northamptonshire Lead Provider arrangements from April 2027. Develop Case for Change for Lead Provider with LPT. Embed integrated physical health, mental health and VCSE pathways aligned to neighbourhoods and Family Hubs.                                                                                                                                                                                                                |
| <b>Mental Health, Learning Disability, Autism &amp; Women's Health</b> | Continue implementation and maturation of lead provider arrangements through NHFT.<br>Establish a case for change and roadmap for future lead provider requirements across MHLDA pathways in LPT<br>Develop neighbourhood-based care models                                                                                                                                                                                                                                                                                           |
| <b>Digital, Productivity &amp; Strategic Commissioning</b>             | Increase use of digital, AI and remote monitoring;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

# Elective Commissioning Intentions



Adam Andrews

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08/10/2026 14:28:57

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

# LNR Elective Care Commissioning Intentions 27/28 (1/3)



- Deliver agreed waiting list targets, Referral to Treatment (RTT) recovery trajectories and constitutional standards (LLR, 70.2%, Northamptonshire 73.4%)
- Work jointly with primary care, community providers and Integrated Neighbourhood Teams to identify priority specialties and pathways suitable for neighbourhood delivery, which will include a phased programme of elective transformation aligned to neighbourhood health priorities.
- Co-design and implement elective care models that improve patient outcomes, reduce waiting times and provide care closer to home where clinically appropriate, initially focused on MSK related specialties, Ophthalmology and Rheumatology and Pain
- Expand Single Points of Access including Advice and guidance, specialist outreach, consultant support and shared care arrangements between primary and secondary care.
- To support the successful roll out of Elective SPOAs, develop streamlined elective pathways, including direct access diagnostics, community-based assessment models and straight-to-test approaches where appropriate.
- In line with GIRFT guidelines and through improvements in pathways, and new models of delivery, reduce unnecessary outpatient follow up activity and maximise opportunities for patient-initiated follow-up and digital review.
- Develop and implement the contractual, workforce and funding mechanisms needed to support elective care in neighbourhood and community settings, including collaborative models such as subcontracting, delegated budgets and alliance arrangements, ensuring funding supports activity transfer, pathway transformation and care closer to home.
- Plan for and commission an Elective Hub in Northamptonshire, with an expected opening of 28/29
- Expand diagnostics including a third CDC, straight-to-test pathways for breathlessness, gastrointestinal symptoms and suspected cancer and community-based diagnostics such as phlebotomy, spirometry and FeNO testing.
- Deliver agreed Referral to Treatment (RTT) recovery trajectories and constitutional standards.
- Work jointly with primary care, community providers and Integrated Neighbourhood Teams to identify priority specialties and pathways suitable for neighbourhood delivery.
- Contract directly for SPOA and Advice and guidance services. With full roll in in 27/28.
- Increase direct access diagnostics, community-based assessment models and straight-to-test approaches where appropriate.
- reduce unnecessary outpatient follow up activity and maximise opportunities for patient-initiated follow-up and digital review, using GIRFT protocols as the standard.
- Identify the contractual, workforce and funding mechanisms required to support elective care delivery within neighbourhood settings.
- Develop and implement funding arrangements that facilitate the transfer of elective activity into community and neighbourhood-based models, including the use of subcontracting, delegated budgets, alliance arrangements or other collaborative contractual mechanisms where appropriate.

# LNR Elective Care Commissioning Intentions 27/28 (2/3)

- Achieve a cumulative reduction in follow-up costs over three years , to include "cost out" models via genuine reduction and removal of FU provision at current tariff/block arrangements.
- Reduce demand for elective services by expanding access to diagnostics (e.g. direct-to-test pathways) and increasing availability of community diagnostic services
- Apply thresholds and risk stratification to ensure services are targeted to those with greatest need, grounded in population insights, rather than provided universally. Underpinned by honest conversations with patients and communities.
- We will align national best practice guidance for the model of outpatient care with our local Neighbourhoods and New Models programmes for example developing our approach to Community Gynaecology.
- Aims to reduce number of follow ups in an acute setting radically over the next three years, aiming for 75% reduction (circa £22m) in follow up activity through improvements in pathways, and new models of delivery.
- We will commission enhanced optometry-led services for routine and preventative eye care, supporting patients to access care closer to home.
- Nationally 20% of Diagnostics are test only, i.e. there is no further appointment; and 13% are diagnostics following an outpatient appointment. Community Diagnostic Centres are central to early diagnosis and elective recovery. We will enhance CDC pathways by developing our straight-to-test models for breathlessness, GI symptoms, and suspected cancer, and integration with primary care, neighbourhoods and outpatient services.
- Aligned to redesigning outpatients we will develop capacity in primary care for amendable high-volume diagnostics such as Phlebotomy, Spirometry and FeNO (fractional exhaled nitric oxide)
- We will commission a Community Surgery Model for low-complexity procedures, amenable to delivery in a primary and community care setting. These will be delivered in accredited community settings, reducing pressure on acute theatres and improving access.
- Improving early diagnosis of cancer remains a key priority. In 2026/27, we will:
  - Expand use of AI-based risk stratification tools in primary care
  - Develop our approach to lung cancer screening and FIT testing
  - Expand our liver and lynch surveillance programmes
  - Review opportunities to support challenged sites by increasing resilience through model development
  - Use the learning from the ACE project in 2025/26 work to improve screening uptakes
  - Work with East Midlands Cancer Alliance to meet the 75% early diagnosis target by 2028

# Elective Care Commissioning Intentions 27/28 (3/3)

| LLR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Northamptonshire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <ul style="list-style-type: none"> <li>• Implement an LLR wide Diagnostic Strategy , supported via the commissioning of the 3rd CDC in 27/28 , incorporating straight to test, prevention and Cancer earlier diagnosis standard tests.</li> <li>• Commission the Y2 and Yr3 RTT recovery activity, aligned to the national allocations for 27/28 and 28/29 , noting any gap to delivery in Yr 1 26/27 will need to be delivered through the provider CIP.</li> <li>• Commission sufficient capacity and activity to deliver the FDS, 31 and 62 Day Cancer Standards, as detailed in the 27/28 and 28/29 provider plans.</li> <li>• Support the roll out of Lung Cancer Screening and the expansion of the Lung Cancer services to support increased diagnosis and treatments.</li> <li>• Commission a lead provider for MSK services, to include the existing budgets and contracts with OOC and IS providers.</li> <li>• Intention to move to a community based Ophthalmology services, with only essential, urgent and specialist Ophthalmology services delivered within the existing Acute Hospital Estate.</li> <li>• Develop services with optimal digitisation, including where best in class, the use of AI and Digital healthcare delivery solutions.</li> <li>• Maximise the existing estate across LLR including the Acute , Community and Primary Care facilities. Enabling a move to Hub and Spoke or Hub and MDT models of delivery.</li> <li>• Commission and contract services aligned to the use of the GIRFT best practice standards</li> <li>• Reduce demand for RTT led treatment through increased commissioning of services that better support prevention and non consultant led care and treatment, linked to the work well agenda of supporting patients to maintain health for longer.</li> </ul> | <ul style="list-style-type: none"> <li>• Implement an LLR wide Diagnostic Strategy , supported via the commissioning of the 3rd CDC in 27/28 , incorporating straight to test, prevention and Cancer earlier diagnosis standard tests.</li> <li>• Commission the Y2 and Yr3 RTT recovery activity, aligned to the national allocations for 27/28 and 28/29 . Noting any gap to delivery in Yr 1 26/27 will need to be delivered through the provider CIP</li> <li>• Commission sufficient capacity and activity to deliver the FDS, 31 and 62 Day Cancer Standards, as detailed in the 27/28 and 28/29 provider plans.</li> <li>• Support the roll out of Lung Cancer Screening and the expansion of the Lung Cancer services to support increased diagnosis and treatments.</li> <li>• Commission and contract a lead provider for services to be delivered via the UHN Elective Hub, due to be operational in 28/29.</li> <li>• Intention to move to a community based Ophthalmology services, with only essential, urgent and specialist Ophthalmology services delivered within the existing Acute Hospital Estate.</li> <li>• Develop services with optimal digitisation, including where best in class, the use of AI and Digital healthcare delivery solutions.</li> <li>• Work collaboratively across Northants to reduce reliance on unplanned IS and OOC elective capacity. Increasing the choice offer within the Acute Hospital setting.</li> <li>• Commission and contract services aligned to the use of the GIRFT best practice standards</li> <li>• Reduce demand for RTT led treatment through increased commissioning of services that better support prevention and non consultant led care and treatment, linked to the work well agenda of supporting patients to maintain health for longer.</li> </ul> |

# Urgent and Emergency Care Commissioning Intentions

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08/10/2026 14:28:57

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

# Urgent and Emergency Care Commissioning Intentions

## 27/28

- Deliver integrated neighbourhood-based urgent care models that provide timely access to assessment, treatment and support closer to home
- Deliver the co-located Urgent Treatment Centre at the LRI as per the national medium term Plan for UEC and the system Strategy for UEC
- Increase direct access to Same Day Emergency Care (SDEC) pathways to reduce Emergency Department attendances and avoid unnecessary admissions.
- Expand Urgent Community Response (UCR) services and alternatives to admission, including step-up beds, virtual wards and home-based support.
- Implement a Single Point of Access (SPA) across urgent and community care services to improve navigation and streamline patient pathways.
- Strengthen the Ageing Well programme and frailty pathways to support proactive care and reduce emergency admissions.
- Improve discharge pathways and patient flow through increased utilisation of Pathway 1, 2 and 3 capacity and reductions in length of stay.
- Increase the use of digital technology, remote monitoring and virtual care models to support self-management and care at home.
- Align urgent care services to neighbourhood footprints and Integrated Neighbourhood Teams to support delivery of the NHS 10 Year Health Plan.
- Commission services that reduce health inequalities and improve access for vulnerable and high-intensity users of urgent and emergency care.
- Ensure contractual arrangements incentivise admission avoidance, improved patient flow and delivery of agreed outcome measures.

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08/10/2026 14:28:57

# Urgent and Emergency Care Commissioning Intentions 27/28

| Priority                                 | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Impact will be (activity)                                                                                                                                                                                                                                                                                            | Delivered by (Timeframe)                                     | Contractual implications                                                                                                                                                                                                                         |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Primary Care – Same Day Access (Cluster) | <ul style="list-style-type: none"> <li>Align existing provision to proposed neighbourhoods</li> <li>Consider changes to existing specification based on outcomes from Northants SDA model</li> <li>Evaluate utilisation across the week and referral/booking rates (ED, 111, CNH, GP practice)</li> <li>Consider UTC direct booking following winter pilot</li> </ul>                                                                                                                                                                                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>Increase SDA capacity in Primary Care</li> <li>Reduction in primary care presentations to ED and UTCs</li> </ul>                                                                                                                                                              | March 2027 to inform contractual arrangement from April 2027 | Consider Lead Provider Model through PCPC to align to neighbourhood health models                                                                                                                                                                |
| Merlyn Vaz Urgent Treatment Centre (LLR) | <ul style="list-style-type: none"> <li>Evaluate the utilisation of the additional capacity to inform future commissioning decisions and determine the longer-term service model.</li> <li>Undertake a clinical audit of activity to assess the effectiveness of point-of-care (POC) testing and extended appointment durations.</li> <li>Following evaluation, consider increasing triage capacity to support a higher volume of walk-in patients and improve patient flow.</li> <li>Estates development work is underway to convert non-clinical rooms into X-ray facilities and additional clinical consultation space. Plans also include the creation of an enhanced waiting area to better accommodate and manage walk-in patients.</li> </ul> | <ul style="list-style-type: none"> <li>Reduction in ED attends – type 3 activity</li> <li>Reduction in redirects to ED</li> <li>Increase in use of pharmacy first</li> </ul>                                                                                                                                         | Commence from March 2027                                     | Amend service specification to include POC, clinical triage see and treat capacity and longer appts. Subject to evaluation and funding approval                                                                                                  |
| Review of UTCs across LNR (Cluster)      | <ul style="list-style-type: none"> <li>Review UTC provision, performance and specification compliance across LNR.</li> <li>Assess alignment of UTC provision to neighbourhoods, place footprints and population access needs including co-located UTCs.</li> <li>Assess estate, workforce, infrastructure and diagnostics required at Merlyn Vaz to deliver a full UTC offer.</li> <li>Agree future UTC configuration and commissioning intentions across LLR.</li> </ul>                                                                                                                                                                                                                                                                           | <ul style="list-style-type: none"> <li>Redistribution of activity across UTC sites</li> <li>Changes to patient flows and referrals pathways</li> <li>Improved utilisation of UTC capacity appropriately</li> <li>Potential reduction in avoidable ED attends</li> <li>Increased diagnostic activity at MV</li> </ul> | March 2028                                                   | Review and align UTC specifications<br>Consider contract variations<br>Update activity, funding and performance assumptions<br>Agree commissioning requirements for MV<br>Consider future procurement options in line with contract expiry dates |

# Urgent and Emergency Care Commissioning Intentions 27/28

| Priority                                                           | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Impact will be (activity)                                                                                                                                                                                                                                                                                                                                                | Delivered by (Timeframe)                                                                                                                                                                               | Contractual implications                                                                                                            |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Pathway 2 Transformation (Northants)                               | <ul style="list-style-type: none"> <li>Revise skill mix and staffing models confusional bed pathways</li> <li>Increased specialist therapy for stroke, spinal, FND</li> <li>Increasing throughput through P2</li> </ul>                                                                                                                                                                                                                                                                           | <ul style="list-style-type: none"> <li>Decrease numbers on P3 and shift from P3 to P2</li> <li>Reduced LoS on pathways</li> </ul>                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>Implementation from Q3 2026 through to 2027</li> </ul>                                                                                                          | <ul style="list-style-type: none"> <li>Amend Service Specification</li> <li>Contract variation where required</li> </ul>            |
| Virtual wards and Remote monitoring (Cluster)                      | <ul style="list-style-type: none"> <li>Increase the number of people supported through remote health monitoring and VWs, enabling earlier identification of deterioration and proactive intervention.</li> <li>Acute medicine VW being tested from Oct 26-March 27- Evaluate impact and outcomes to inform delivery model for 27/28</li> <li>Evaluate the utilisation of the additional capacity to inform future commissioning decisions and determine the longer-term service model.</li> </ul> | <ul style="list-style-type: none"> <li>Reduction in LoS</li> <li>Improve ED flow</li> <li>Reduction in ED attends and admissions</li> </ul>                                                                                                                                                                                                                              | <ul style="list-style-type: none"> <li>Proof of concept being tested from 1st October 26, full implementation from 1st April 2027 for Acute medicine VW</li> <li>Remote monitoring- Q1 2027</li> </ul> | <ul style="list-style-type: none"> <li>Review and amend service specification</li> <li>Contract variation where required</li> </ul> |
| Adult Neurodisability Respiratory (no adult service currently) LLR | <ul style="list-style-type: none"> <li>Phase 1 will establish a specialist service for adults with neurodisability and/or severe learning disability who require specialist respiratory assessment, intervention and ongoing management- February 2027</li> <li>Recruitment of specialised role</li> <li>Training and competency support for delegated respiratory healthcare tasks</li> <li>Ensure seamless pathway from DIANA service into this service</li> </ul>                              | <ul style="list-style-type: none"> <li>Lower antibiotic use amongst patients receiving specialist respiratory management.</li> <li>reduced avoidable respiratory admissions and bed days. Unsupported cohort currently 1.45 per patient. When supported 0.2</li> <li>Unsupported cohort currently 475 bed days, when supported this will reduce to 61.05 days</li> </ul> | <ul style="list-style-type: none"> <li>Test from February 2027, into 2027/28</li> </ul>                                                                                                                | <ul style="list-style-type: none"> <li>Service specification</li> <li>Contract variation</li> </ul>                                 |

# Urgent and Emergency Care Commissioning Intentions 27/28



| Priority                                                                                                             | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                   | Impact will be (activity)                                                                                                                                                                                                                                                                                                                            | Delivered by (Timeframe)                                                                                                     | Contractual implications                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| Integrated Single Point of Access (LLR)                                                                              | Deliver a single access route into community urgent care services, improving navigation, reducing duplication and enabling timely access to the most appropriate community response.<br>Being tested from the 1st Oct 26- 31st March 2027.<br>improve patient flow across the urgent and emergency care pathway, and enable more people to receive care closer to home                                     | October 2026 to March 2027 -Expected to avoid an estimated 2,400 ED attendances and avoiding 1,800 admissions. 27/28 impact TBC once tested in 26/27.                                                                                                                                                                                                | 1st October 2026 phase 1<br>MSP process to conclude and inform Procurement decision<br>November 26 with full rollout in 2027 | 26/27 completed via contract modification. Need to consider contractual options once procurement decision made and process completed. |
| Community hospital beds review aligned to overall P2 pathway review and NHSE Delivery Model for Community Beds (LLR) | <ul style="list-style-type: none"> <li>Demand modelling for required P2 provision and potential options on how we reduce the P2 bed gap we have</li> <li>Review criteria, consider any gaps and mitigations for all P2 provision</li> <li>CoHo step up beds being tested in winter 26/27, evaluate the learning and impact to inform step up capacity required for 27/28</li> </ul>                        | <ul style="list-style-type: none"> <li>Improved flow from acute settings</li> <li>Reduction in LoS in UHL and LPT</li> <li>Implement step up capacity into community hospitals, reducing ED attendance and admissions</li> </ul>                                                                                                                     | Commencing January 2026, with any changes delivered by the end of Q2 2027                                                    | Review and amend specification<br>Contract variation                                                                                  |
| Integrated discharge hub (Cluster)                                                                                   | <ul style="list-style-type: none"> <li>Transfer to UHL in November 26- test new ways of working including clinical lead post</li> <li>Implementation of the hub into NHFT from November 26 and then full commencement in 2027.</li> <li>Optimise reablement, rehabilitation and recovery services, maximising short-term support to help people regain independence following illness or crisis</li> </ul> | <ul style="list-style-type: none"> <li>Impact in reduction in LoS</li> <li>Transfer of Care) 80% of transfers by 17:00 each day.</li> <li>Timely Discharge of P0 patients Achieve 66% of discharge by 17:00 each day.</li> <li>7-day Discharge Model discharge plans in place for 50 patients Monday-Friday, 30 patients Saturday-Sunday.</li> </ul> | Test from November 2026 then phased implementation into 2027                                                                 | Contract variation where required                                                                                                     |
| End of life                                                                                                          | <ul style="list-style-type: none"> <li>Full review of end of life provision to support discharge and step up provision</li> <li>Demand modelling and workforce requirements</li> <li>Plan to launch ReSPECT via the Shared care record</li> <li>Development of new data dashboard to better inform planning and performance</li> </ul>                                                                     | Reduce ED attends and admissions<br>Increase % in preferred place of death<br>Increase % in completion of ReSPECT plans                                                                                                                                                                                                                              | Commencing January 2026, with any changes delivered by the end of Q2 2027                                                    | Review and amend Specification<br>Contracting and procurement options                                                                 |

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# Frailty Commissioning Intentions 27/28 - Northants



| Priority                         | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                 | Impact will be (activity) | Delivered by (Timeframe)            | Contractual implications |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------|--------------------------|
| <b>Age Well Teams Expansion</b>  | Full year effect of new starters in March for NBCT, End of Life Nurses from September, MIND workers from October and additional local group programmes                                                                                                                                                                                                                                                   | Medium                    | Phased with completion in Q3        |                          |
| <b>Urgent Community Response</b> | Additional core hour provision 4 patients per day with further overnight capacity for 6 persons per day including night falls response. Additional night response vehicle and crew for winter                                                                                                                                                                                                            | Medium                    | 25% in Q1, 60% by Q3 and 100% in Q4 |                          |
| <b>Reduce Admissions</b>         | Continued expansion of SDEC including Frailty SDEC with access to overnight sitting services, greater use of virtual ward capacity as step up and use of neighbourhood P2 capacity for step up as alternative to hospital admission. These are alongside the go-live for NGH UTC                                                                                                                         | Low                       | Q3                                  |                          |
| <b>Reduced Readmission Rates</b> | Improved discharge arrangements with new integrated discharge hub. Alignment of Hospital Geriatricians with Neighbourhood Teams for pathway zero concern follow up and future joint working, actions to tackle deconditioning during hospital stays to increase persons returning to home successfully. Redesign of patient transport model to better meet requirements of safe and effective UEC system | Medium                    | By the end of Q2                    |                          |

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# Frailty Commissioning Intentions 27/28 - LLR

| Priority                                                                                   | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                    | Impact will be (activity)                                                                                                                                  | Delivered by (Timeframe)                                                            | Contractual implications                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Neighbourhood Frailty Management</b>                                                    | Introduce community frailty management through Integrated Neighbourhood Teams, supporting proactive identification of frailty and step up to reduce escalation . Full roll to all neighbourhoods by Q1 27.<br>Bringing together primary care, community, mental health, social care and VCFSE partners                                      | Medium<br>Commencing with min 1% of the population, increasing % over time.<br>Reduction in ED attends and admissions.<br>Actuals TBC once tested in 26/27 | 4 neighbourhoods by October 2026, remaining 7 neighbourhoods by the end of Q1 27/28 | Consider Lead Provider Model through PCPC to align to neighbourhood health models<br>Service specifications and outcome measures reviewed to support delivery through Integrated Neighbourhood Teams. |
| <b>Integrated Frailty Service (Hospital at Home)</b>                                       | Develop a coordinated frailty service that strengthens admission avoidance, supports earlier discharge and provides acute-level care within community settings. This includes, PTCDA, frailty VW, EoL and palliative care with dedicated consultant and ACP support.                                                                        | Medium<br>Expected to avoid an additional 1,164 ED attendances from 25/26 baseline                                                                         | Test from November 2026 then phased implementation into 2027                        | Need to consider contractual options for 2027/28 including specification and outcome measures.                                                                                                        |
| <b>48-Hour Post-Discharge Follow-Up 65+ frailty cohort with a high risk of readmission</b> | Provide proactive follow-up for high-risk patients following discharge to new location (care/nursing home) from Nov 26- March 27 and then full roll out, delivered by neighbourhoods for all high risk discharges to reduce avoidable readmissions and improve recovery outcomes. Reduction of readmissions by minimum 2%, currently at 22% | Medium<br>11,077 discharges in this cohort in 25/26. Impact being modelled to inform outcomes in 27/28                                                     | Test proof of concept from November 2026<br>Evaluation and roll-out in 2027/8       | Consider Lead Provider Model through PCPC to align to neighbourhood health models                                                                                                                     |

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# Primary and Community Care and Neighbourhoods Commissioning Intentions

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

## Primary Care Commissioning Intentions 27/28

- Undertake a comprehensive review of the Primary Care portfolio, including General Practice, PCNs, Community Pharmacy, Dentistry and Optometry, to align services with population need, neighbourhood priorities and the NHS 10 Year Plan.
- Align Primary Care services to Integrated Neighbourhood Teams, supporting closer integration with community, mental health, social care and VCSE partners.
- Commission and implement neighbourhood-based models for cardiovascular, kidney, vascular, metabolic and respiratory care, supporting earlier identification, optimisation and management of long-term conditions.
- Expand multidisciplinary team approaches and proactive case finding for patients at greatest risk, reducing unwarranted variation and improving outcomes.
- Strengthen prevention, early intervention and population health management, improving access to prevention programmes, diabetes technologies and evidence-based interventions.
- Develop innovative obesity and weight management pathways, including neighbourhood delivery models and community pharmacy involvement. • Improve access, continuity of care and management of long-term conditions through neighbourhood-based models of care.
- Progress towards outcomes-based commissioning, focusing on population health, prevention, patient experience and reducing health inequalities

## Community Care and Neighbourhoods Commissioning Intentions 27/28 (LPT / NHFT)

- Develop neighbourhood-based community services that support Integrated Neighbourhood Teams and deliver more care closer to home. • Redesign community services around priority populations including Frailty, Children and Young People, Women's Health and people living with long-term conditions.
- Implement a strategic commissioning approach for community services aligned to population health needs, outcomes and long-term sustainability. • Support elective recovery and outpatient transformation through community diagnostics, rehabilitation, outreach and follow-up models.
- Strengthen integration between community, primary care, mental health, social care, acute providers and VCSE partners through neighbourhood pathways. • Support proactive care, recovery and admission avoidance through integrated community services focused on frailty, complex care and long-term conditions.
- Develop provider arrangements that support delegated budgets, alliance models and integrated neighbourhood delivery. • Review, redesign and recommission community services to improve outcomes, reduce health inequalities and deliver better value and sustainability across LNR.

## Proposed Strategic Commitment

- We will undertake a comprehensive review of the wider Primary Care portfolio. This will include General Practice, Primary Care Networks, Community Pharmacy, Dental Services, Optometry, locally commissioned services and community-based provision.
- The review will ensure commissioned services are aligned to the emerging Neighbourhood Health Service model, the NHS 10 Year Plan, local population health needs and the ambitions set out within the LNR Primary Care Strategic Commissioning Framework.
- Through this work, we will seek to maximise the contribution of the entire Primary Care family, strengthen neighbourhood-based delivery, improve prevention and early intervention, reduce health inequalities, support care closer to home and develop more integrated, outcome-focused models of care. This will create a coherent and sustainable Primary Care portfolio that delivers improved population health outcomes, better patient experience and greater value for local communities

| Strategic Commitment                            | Proposed Approach                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Whole Primary Care Portfolio Review             | <ul style="list-style-type: none"> <li>• Undertake a comprehensive review of the wider Primary Care portfolio, including General Practice, PCNs, Community Pharmacy, Optometry, Dental Services, locally commissioned services and community-based services, to ensure services remain aligned to population need, neighbourhood health priorities and system objectives.</li> </ul> |
| Alignment to Neighbourhood Health Service Model | <ul style="list-style-type: none"> <li>• Align commissioned services to integrated neighbourhood teams and place-based models of care, supporting closer working across Primary Care, community services, mental health, social care and the voluntary sector.</li> </ul>                                                                                                            |
| Alignment to NHS 10 Year Plan Priorities        | <ul style="list-style-type: none"> <li>• Ensure services support the shift from hospital to community, treatment to prevention, analogue to digital and fragmented care to integrated neighbourhood-based care.</li> </ul>                                                                                                                                                           |
| Maximising the Contribution of the Primary Care | <ul style="list-style-type: none"> <li>• Review opportunities to optimise the role of all Primary Care sectors, ensuring services are delivered by the most appropriate provider, improving access, outcomes and patient experience</li> </ul>                                                                                                                                       |
| Prevention and Population Health                | <ul style="list-style-type: none"> <li>• Strengthen the contribution of all commissioned services to prevention, early intervention, long-term condition management and reducing health inequalities through a population health management approach.</li> </ul>                                                                                                                     |
| Pathway Integration and Service Redesign        | <ul style="list-style-type: none"> <li>• Review pathways across the wider Primary Care portfolio to reduce duplication, improve coordination and support more integrated models of care.</li> </ul>                                                                                                                                                                                  |
| Outcome-Based Commissioning                     | <ul style="list-style-type: none"> <li>• Move progressively towards commissioning based on outcomes, patient experience, prevention and population health impact rather than activity alone.</li> </ul>                                                                                                                                                                              |
| Financial Sustainability and Value              | <ul style="list-style-type: none"> <li>• Ensure commissioned services deliver value for money, maximise system resources and support the long-term sustainability of Primary Care provision across LNR.</li> </ul>                                                                                                                                                                   |

# Preventable Mortality Commissioning Intentions 27/28 (1/2)

| Priority                             |                                                                                                                                                                                                                            | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                           | Impact will be (activity )                                                                                                                                                                                                                                          | Delivered by (Timeframe) | Contractual implications                                                                                                                   |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Enhanced Universal CVKM Care Model   | Commission and implement a consistent enhanced Cardiovascular, Kidney, Vascular and Metabolic (CVKM) model across all neighbourhoods to support early identification, optimisation and management of long-term conditions. | <ul style="list-style-type: none"> <li>Extend the CVKM model across all neighbourhoods for all CVKM conditions.</li> <li>Develop and implement a neighbourhood respiratory pathway.</li> <li>Embed proactive case finding and optimisation of high-risk patients.</li> <li>Use population health management approaches to target unwarranted variation.</li> </ul> | <ul style="list-style-type: none"> <li>Delayed disease progression.</li> <li>Reduced emergency and urgent care demand.</li> <li>Reduced future demand for dialysis and specialist interventions.</li> <li>Improved patient outcomes and quality of life.</li> </ul> | March 2027               | Review and amend primary care service specifications and contracting arrangements to support enhanced CVKM delivery across neighbourhoods. |
| Targeted MDT Approach                | Expand integrated multidisciplinary team (MDT) models to provide proactive management of patients with complex cardiovascular, kidney and metabolic conditions.                                                            | <ul style="list-style-type: none"> <li>Expand LUCID MDT clinics across all neighbourhoods.</li> <li>Extend MDT provision to include diabetes, heart failure and CKD cohorts.</li> <li>Strengthen integration between primary, community and specialist services.</li> <li>Implement risk stratification to identify priority patients.</li> </ul>                  | <ul style="list-style-type: none"> <li>Reduced acute episodes and hospital admissions.</li> <li>Delayed progression to dialysis and transplantation.</li> <li>Improved clinical outcomes and patient experience.</li> <li>Enhanced care coordination.</li> </ul>    | March 2027               | Contract variations may be required to support MDT delivery models and multidisciplinary workforce provision.                              |
| Obesity Pathway Innovation Programme | Develop and test innovative obesity pathways to improve access, outcomes and reduce health inequalities through neighbourhood-based interventions.                                                                         | <ul style="list-style-type: none"> <li>Deliver Phase 2 testing in four neighbourhoods.</li> <li>Implement a Single Point of Access for obesity services.</li> <li>Test community pharmacy prescribing models.</li> <li>Evaluate outcomes and scale successful interventions.</li> </ul>                                                                            | <ul style="list-style-type: none"> <li>Delayed obesity-related disease progression.</li> <li>Increased access to evidence-based interventions.</li> <li>Reduced health inequalities.</li> <li>Improved population health outcomes.</li> </ul>                       | March 2028               | Potential procurement and commissioning of new obesity pathway elements and community pharmacy service arrangements.                       |

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# Preventable Mortality Commissioning Intentions 27/28 (2/2)

| Priority                             |                                                                                                                                                       | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                          | Impact will be (activity )                                                                                                                                                                                                                   | Delivered by (Timeframe) | Contractual implications                                                                                                                    |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Access to Prevention Offers          | Improve access to prevention programmes and diabetes technologies to support better long-term outcomes and reduce future demand on services.          | <ul style="list-style-type: none"> <li>Implement the LNR Healthier You single-provider model.</li> <li>Deliver Year 3 Hybrid Closed Loop technology programme.</li> <li>Harmonise diabetes technology pathways across LNR.</li> <li>Increase uptake of prevention programmes through targeted referrals.</li> </ul>                               | <ul style="list-style-type: none"> <li>Increased uptake of prevention services.</li> <li>Improved diabetes control.</li> <li>Reduced diabetes-related complications.</li> <li>Greater equity of access across the system.</li> </ul>         | January 2027             | Procurement and contract management of prevention services and implementation of diabetes technology agreements.                            |
| Address Strategic Commissioning Gaps | Develop and commission services that address identified gaps in the CVKM pathway and support delivery of operational and medium-term plan objectives. | <ul style="list-style-type: none"> <li>Commission a Northamptonshire insulin initiation service.</li> <li>Develop a business case for a specialist weight management service.</li> <li>Develop a strategic commissioning framework for CVKM services.</li> <li>Review current service provision and future commissioning requirements.</li> </ul> | <ul style="list-style-type: none"> <li>Improved access to specialist services.</li> <li>Reduced variation in service provision.</li> <li>Strengthened prevention and early intervention.</li> <li>Improved system sustainability.</li> </ul> | March 2027               | New commissioning arrangements, business case approvals, service specifications and potential procurement activity for specialist services. |

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# Neighbourhoods - Commissioning Intentions 27/28 (1/2)

| Priority                                                                 | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                     | Impact will be (activity)                                                                                                                                                         | Delivered by (Timeframe) | Contractual implications                                                                                                                            |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| Establish Integrated Neighbourhood Teams Focused on Priority Populations | Establish Integrated Neighbourhood Teams as the principal delivery model for neighbourhood health. Prioritise implementation for Women and Women's Health, Children and Young People, and Frailty. Develop multidisciplinary neighbourhood models bringing together primary care, community, mental health, social care and VCFSE partners. Support proactive, preventative and coordinated care for people with the greatest level of need. | Improved outcomes for priority populations. More coordinated and person-centred care. Reduced fragmentation between services. Greater focus on prevention and early intervention. |                          | Service specifications and outcome measures reviewed to support delivery through Integrated Neighbourhood Teams.                                    |
| Delegate Resources, Decision Making and Accountability to Neighbourhoods | Develop neighbourhood-based commissioning arrangements with increasing local accountability for outcomes and resource utilisation. Establish delegated budget approaches aligned to neighbourhood populations and agreed priorities. Align health and care investment with neighbourhood needs, prevention and wider determinants of health. Support neighbourhood partnerships to address health inequalities and population outcomes.      | Resources aligned to population need. Greater neighbourhood accountability and ownership. Improved value and responsiveness. Increased focus on prevention and outcomes.          |                          | Development of delegated budget arrangements, revised funding flows and outcome-based commissioning approaches aligned to neighbourhood populations |

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# Neighbourhoods - Commissioning Intentions 27/28 (2/2)

| Priority                                                                                                  | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Impact will be (activity)                                                                                                                                                                                                                                                                                                                                                                                                                               | Delivered by (Timeframe) | Contractual implications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Develop Multi-Neighbourhood Providers and establish integrator roles to deliver Integrated Models of Care | Support the development of providers capable of operating across multiple neighbourhoods whilst maintaining strong local delivery. Strengthen provider collaboration across community, primary care, mental health, social care, VCFSE and acute services. Develop integrated delivery models that reduce organisational boundaries and support seamless pathways of care. Build provider capability to manage delegated budgets, population health outcomes and neighbourhood accountability. Support the development of neighbourhood-based partnerships capable of delivering integrated models of care at scale, partnership through subcontracting arrangements. Early opportunities include phlebotomy and spirometry with a potential alignment of approach across the cluster, elective pathways led and commissioned by UHL and UHN and ADHD and Autism Support and Diagnostic pathway (potentially commissioned by NHFT and LPT) | Stronger provider collaboration and integration. Improved pathway coordination and patient experience. Greater resilience and sustainability of neighbourhood services. Improved accountability for neighbourhood outcomes. Increased capability to deliver neighbourhood health objectives.                                                                                                                                                            | March 2028               | Development of partnership, alliance, lead-provider and subcontracting arrangements where appropriate to support integrated neighbourhood delivery. Contractual arrangements aligned to neighbourhood outcomes, delegated budgets and population-based accountability.                                                                                                                                                                                                                                  |
| Assure Delivery and Value from Neighbourhood Investment                                                   | Create capacity for GPs to work within integrated neighbourhood models of care. Improve same-day access and reduce unwarranted variation in access to primary care. Develop enhanced models for long-term condition management, complex care and proactive care. Strengthen the interface between primary, community, mental health, social care and specialist services through integrated neighbourhood pathways. Evaluate existing pilots, transformation programmes and neighbourhood-based services to ensure they are delivering intended outcomes, improving patient experience and aligning with agreed strategic priorities. Use evaluation findings to inform future investment decisions, service redesign and the scaling of successful neighbourhood models across LNR                                                                                                                                                        | Increased primary care capacity to support neighbourhood health. Improved same-day access and continuity of care. Better management of long-term conditions and complex patients. Reduced avoidable demand on urgent and acute services. Evidence-based investment decisions aligned to neighbourhood priorities. Successful neighbourhood models identified, scaled and embedded across LNR. Improved value for money and delivery of agreed outcomes. | 5 year plan              | Review of existing transformation initiatives, pilot schemes and investment programmes to assess delivery against agreed outcomes and strategic priorities. Development of contractual and funding arrangements that support successful neighbourhood models, integrated multidisciplinary delivery and long-term sustainability. Future investment, commissioning, redesign or decommissioning decisions informed by demonstrable outcomes, value and contribution to neighbourhood health objectives. |

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# Community Commissioning Intentions 27/28 (1/2)

| Priority                                                                                                              | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Impact will be (activity)                                                                                                                                                                                                                                                                                                                                                                                                                            | Delivered by (Timeframe)                                                                                 | Contractual implications                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implement a strategic commissioning approach for Community Services across LNR                                        | Use the community services baseline, population health intelligence and demand analysis to agree priority outcomes and commissioning priorities across planned care, recovery care and long-term condition management. Establish a common LNR outcomes framework covering access, inequalities, experience, quality and outcomes. Develop a sustainable community services model that aligns workforce, activity and investment to population need and future demand. The sustaining community services work started with NHFT will be expanded to incorporate LPT and priority pathway improvement will be agreed with providers.<br>Move from historic service-based arrangements towards pathway and population-based commissioning. | Sustainable community services able to meet increasing demand and complexity. Reduced unwarranted variation across LNR.<br>Improved equity of access and outcomes. Better alignment of resources to population need. Clearer accountability for delivery of community service outcomes.<br>Recovery of waiting times in line with national requirements.                                                                                             | March 2029 (indicative)                                                                                  | Progressive alignment of specifications, KPIs and outcome measures. Contract changes where existing arrangements do not support the agreed strategic model. Impact of the 'unbundling' of the Community Contract                                                                                                                                                                                                                                            |
| Develop neighbourhood-based community services that support primary care transformation and integrated models of care | Redesign community services to support Integrated Neighbourhood Teams, initially focused on Women and Women's Health, Children and Young People, and Frailty. Deliver proactive, preventative and recovery-focused care closer to home through integrated community models. Support people with complex needs, long-term conditions and frailty through multidisciplinary neighbourhood teams. Integrate community, primary care, mental health, social care and acute services through seamless neighbourhood pathways. Develop sustainable workforce models and improve outcomes through coordinated, neighbourhood-based care.                                                                                                       | Stronger community services operating as a core component of Integrated Neighbourhood Teams. Improved outcomes for Women, Children and Young People, and Frailty populations. Enhanced management of people with complex needs and multiple long-term conditions. More care delivered closer to home. Reduced avoidable hospital utilisation and delayed transfers of care. Improved patient experience through more coordinated and proactive care. | INTs to start to form in all priority areas in 2027/28 and will continue to mature over the next 5 years | Community providers will be expected to develop neighbourhood-based delivery models, including delegated budgets, alliance arrangements, subcontracting and other partnership approaches that enable resources, workforce and decision-making to be deployed closer to communities. Service specifications, funding flows and outcome measures will be aligned to support delivery through Integrated Neighbourhood Teams and improved population outcomes. |

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# Community Commissioning Intentions 27/28 (2/2)

| Priority                                                                                    | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Impact will be (activity)                                                                                                                                         | Delivered by (Timeframe)   | Contractual implications                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Support elective recovery and outpatient transformation through community-based care models | Work with primary care and acute providers to identify services suitable for delivery within neighbourhood and community settings. Develop consultant-supported outreach, diagnostics, rehabilitation and follow-up models. Support implementation of neighbourhood elective pathways.                                                                                                                                                                                                      | Reduced waiting times. Reduced avoidable outpatient activity. Improved access closer to home. Improved patient experience and more sustainable elective pathways. | As per national timescales | Development of neighbourhood elective care models will require new contractual and funding arrangements, including delegated budgets, subcontracting and collaborative provider agreements where appropriate. Providers will be expected to work jointly to redesign pathways, transfer appropriate activity into community settings and align resources to support elective recovery and improved patient outcomes. |
| Commission for value, equity and sustainability across community services                   | Review historic commissioning arrangements, contracts and funding flows against population need, outcomes, strategy and value. Harmonise arrangements across LNR where appropriate. Implement decisions to redesign, consolidate, recommission or decommission services where required. Initial reviews to include community nursing, therapies, rehabilitation and end-of-life services (new national guidance expected in October 2026). See ICB procurement pipeline for further details | Resources aligned to highest-value interventions. Reduced duplication and variation. Sustainable commissioning arrangements aligned to the Five-Year Strategy.    | Ongoing                    | Contract renewal, variation, consolidation, recommissioning or decommissioning as required. Funding realignment following agreed commissioning decisions.                                                                                                                                                                                                                                                            |

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# Children and Young People Commissioning Intentions



Nicki Adams

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

## Commissioning Ambition

- The ICB's commissioning intentions for Children and Young People are focused on improving outcomes, reducing inequalities and developing integrated neighbourhood-based models of care. Providers will be expected to work collaboratively to deliver earlier intervention, improved access, better experience and sustainable pathways for children, young people and families.

## What This Means for Providers

- NHFT
  - Mobilise and embed the Northamptonshire CYP Lead Provider model from April 2027. Integrate physical health, mental health and VCSE services into neighbourhood and Family Hub delivery models.
  - Lead implementation of redesigned ADHD and Autism assessment and support pathways.
  - Strengthen community-based support and reduce unnecessary referrals to specialist services.
- LPT
  - Develop the case for change and future Lead Provider arrangements across Leicester, Leicestershire and Rutland.
  - Support integrated neighbourhood delivery models for CYP services aligned to Family Hubs.
  - Implement ADHD and Autism pathway redesign and improve access to support services.
  - Strengthen integration between community, mental health and specialist services

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| Priority                                                               | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                       | Impact will be (activity)                                                                                                                                                                                                                                                              | Delivered by (Timeframe)                                                                                                      | Contractual implications                                                                                                                                                           |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Implement a strategic commissioning approach for CYP across LNR</b> | <p>Use the LNR commissioning baseline and Five-Year Strategy to agree priority population outcomes and commissioning priorities.</p> <p>Establish a common LNR outcomes framework and core measures covering access, inequalities, experience and outcomes.</p> <p>Move from historic place/service-based arrangements towards population and pathway based commissioning.</p> | <p>Greater equity across LNR.</p> <p>Resources aligned to population need and outcomes.</p> <p>Reduced unwarranted variation and duplication.</p> <p>Clearer accountability for delivery of CYP outcomes</p>                                                                           | 2027/28 onwards                                                                                                               | Progressive harmonisation of specifications, KPIs and outcomes. Contract changes where existing arrangements do not support the agreed strategic model                             |
| <b>Implement and embed the CYP Lead Provider</b>                       | <p>Mobilise agreed Northamptonshire Lead Provider arrangements from April 2027. Develop Case for Change for Lead Provider with LPT. Embed integrated physical health, mental health and VCSE pathways aligned to neighbourhoods and Family Hubs.</p> <p>Establish strategic commissioner/Lead Provider governance, outcome measures and performance arrangements.</p>          | <p>Reduced fragmentation between services.</p> <p>Improved coordination for children and families. Greater provider responsibility for pathway integration and delivery within the agreed financial envelope. Enables the ICB to operate increasingly as a strategic commissioner.</p> | <p>April 2027 mobilisation embedding throughout 2027/28 for Northamptonshire.</p> <p>October 2027 for LLR case for change</p> | <p>Lead Provider contractual arrangements.</p> <p>Transfer/consolidation of existing contracts and grants where agreed. Outcome-based specification and performance framework.</p> |

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| Priority                                                                                              | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Impact will be (activity)                                                                                                                                                                                                                                                                                                                                                             | Delivered by (Timeframe)                                     | Contractual implications                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Commission an LNR ADHD and autism support and assessment service and improve access to support</b> | Implement the agreed LNR ADHD/ASD policy and programme delivery plan. Increase use of NHS capacity and address long waits through sustainable pathway redesign rather than standalone waiting list initiatives which will include the separation of the community paediatric pathway from the newly designed ADHD / ASD support and assessment service. Align Right to Choose arrangements with the agreed LNR pathway and commissioning policy. Development of Integrated Neighbourhood Teams.                                             | Children supported according to need rather than diagnosis alone. Reduced waiting times and avoidable diagnostic demand. Reduced variation across LNR. Improved family experience and more sustainable use of resources. A reduction in the number of children requiring referral for a diagnostic assessment, this will be reflected in Indicative Activity Plans where appropriate. | Phased implementation throughout 2027/28 (5 year programme). | Revised specifications and provider outcome requirements. Alignment of activity/funding flows and RtC expenditure with strategic commissioning approach. New accreditation process for RtC providers. Transformation requirements incorporated into provider arrangements. |
| <b>Commission for value, equity and sustainability across CYP</b>                                     | Use the completed baseline to review historic contracts, grants and funding arrangements against need, outcomes and strategic priorities. Implement agreed decisions for VCSE and other arrangements ending/requiring renewal from April 2027. Review services with significant variation, duplication or commissioning gaps and agree whether to stop, redesign, consolidate or invest. Apply this approach to specific decisions such as CEW following evaluation of the existing pilot. See ICB procurement pipeline for further details | Resources released or redirected to higher-value interventions. More consistent CYP offer across LNR. Improved transparency of spend and outcomes. Sustainable commissioning arrangements aligned to the Five-Year Strategy.                                                                                                                                                          | 2027/28 onwards                                              | Contract/grant renewal, variation, consolidation, recommissioning or decommissioning as required. Funding realignment following agreed commissioning decisions.                                                                                                            |

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# Adult MHLDA Commissioning Intentions



Nicki Adams

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

# For Letter have added to word document

- The ICB's commissioning intentions for Mental Health, Learning Disability and Autism are focused on improving access, reducing inequalities, strengthening community-based provision and supporting the shift from hospital-based care to neighbourhood-based models. Providers will be expected to work collaboratively to deliver integrated pathways, improve outcomes and develop sustainable models of care through Lead Provider and Mental Health Collaborative arrangements.

## NHFT

- Continue implementation and expansion of the Mental Health Collaborative to strengthen whole-pathway accountability and integrated delivery.
- Mobilise and mature Mental Health, Learning Disability and Autism Lead Provider arrangements.
- Expand community-based mental health services, crisis alternatives and recovery support to reduce reliance on inpatient care.
- Embed mental health services within Integrated Neighbourhood Teams, working alongside primary care, community services, local authorities and VCSE partners.
- Implement the LNR Adult ADHD and Autism programme, improving access to assessment, support and post-diagnostic services.

## LPT

- Develop the case for change and future Lead Provider arrangements across Leicester, Leicestershire and Rutland.
- Strengthen the Mental Health Collaborative model and improve pathway integration across community, mental health and acute services
- Expand neighbourhood-based mental health support, prevention and early intervention services.
- Support implementation of the Adult ADHD and Autism pathway redesign and improve access to support services.
- Develop community alternatives to admission and reduce out-of-area placements.

## UHL and UHN

- Support integrated mental health pathways within acute settings, including liaison psychiatry and crisis response services.
- Work with Lead Providers and Mental Health Collaborative partners to improve patient flow and discharge arrangements between acute and mental health services.
- Reduce avoidable acute admissions through improved community alternatives and neighbourhood-based care models.
- Strengthen physical and mental health integration, particularly for people with serious mental illness, learning disabilities and autism.

# Adult MHLDA Commissioning Intentions 27/28 (1/2)

| Priority                                                                                             | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Impact will be (activity)                                                                                                                                                                                                                                                                                                                     | Delivered by (Timeframe)                                                                       | Contractual Implications                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Progress Lead Provider Arrangements for Mental Health, Learning Disability and Autism Services       | Continue implementation and maturation of lead provider arrangements through NHFT.<br>Consolidate pathway accountability, performance management and outcome reporting across provider boundaries. Review commissioning, governance and financial arrangements to support further integration of services.<br>Establish a case for change and roadmap for future lead provider requirements across MHLDA pathways in LPT .                                                                                                                                                                                                                                                                                   | Improved accountability for quality, access and outcomes. Reduced fragmentation across provider organisations. Improved patient and carer experience.<br>More efficient use of system resources                                                                                                                                               | Northamptonshire subject to business case in January 2027<br><br>LLR case for change June 2027 | Development of lead provider contractual arrangements, including delegated budgets aligned to neighbourhood populations, subcontracting and partnership agreements where appropriate, enabling resources and decision-making to be deployed closer to communities and supporting integrated pathway delivery and neighbourhood health outcomes.                               |
| Commission an LNR Adult ADHD and Autism Support and Assessment Service and Improve Access to Support | Implement the agreed LNR Adult ADHD and Autism commissioning policy and programme delivery plan.<br>Increase use of NHS capacity and address long waits through sustainable pathway redesign rather than standalone waiting list initiatives.<br>Develop an integrated Adult ADHD and Autism support and assessment service that provides clear access to assessment, diagnosis, post-diagnostic support and ongoing management.<br>Align Right to Choose arrangements with the agreed LNR pathway and commissioning policy.<br>Strengthen links with Integrated Neighbourhood Teams and wider community support services to improve outcomes and reduce reliance on diagnosis as the sole route to support. | Adults supported according to need rather than diagnosis alone. Reduced waiting times and avoidable diagnostic demand.<br>Reduced variation across LNR. Improved service user and carer experience.<br>Improved access to support before, during and after assessment. More sustainable use of resources and improved pathway accountability. | Phased implementation throughout 2027/28 (5 year programme).                                   | Revised service specifications and provider outcome requirements.<br>Alignment of activity, funding flows and Right to Choose expenditure with the agreed strategic commissioning approach.<br>New accreditation and quality requirements for Right to Choose providers.<br>Transformation requirements incorporated into provider contracts and future provider arrangements |

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# Adult MHLDA Commissioning Intentions 27/28 (2/2)

| Priority                                                                             | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Impact will be (activity)                                                                                                                                                                                                                                                                                             | Delivered by (Timeframe) | Contractual implications                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Develop Neighbourhood-Based Models for Mental Health, Learning Disability and Autism | Embed MHLDA services within Integrated Neighbourhood Teams and neighbourhood health models. Expand community-based support, prevention, early intervention and recovery services in line with national planning guidance. Strengthen integration between mental health, learning disability, autism, primary care, community services, social care and voluntary sector providers. Develop alternatives to admission, reduce out-of-area placements and improve crisis response through neighbourhood-based models of care. Develop multidisciplinary approaches that support people with the most complex needs closer to home. | Improved access to support within local communities. Reduced reliance on inpatient and out-of-area services. Improved continuity of care across organisational boundaries. Better outcomes through earlier intervention and coordinated care planning. Delivery of national MHLDA and neighbourhood health objectives | On going                 | Service specifications, outcomes and performance measures reviewed to support delivery through Integrated Neighbourhood Teams and neighbourhood health models. MHLDA services will be expected to align with neighbourhood-based delivery arrangements and contribute to reducing reliance on inpatient care through community-based alternatives and integrated pathways. |
| Commission for Value, Integration and Sustainability Across MHLDA Services           | Review MHLDA services, contracts and investment against population need, outcomes and strategic priorities. Align commissioning arrangements to support future lead provider models and whole pathway accountability. Identify opportunities to reduce fragmentation, improve integration and maximise value from existing investment. Prioritise investment towards prevention, early intervention and community-based support. See ICB procurement pipeline for further details                                                                                                                                                | Improved value, quality and sustainability across MHLDA services. Reduced fragmentation and duplication across pathways. Stronger accountability for outcomes and patient experience. Resources aligned to population need and strategic priorities.                                                                  | Ongoing                  | Review of service specifications, outcome measures and funding arrangements to support future lead provider models. Contract variations, recommissioning or provider reconfiguration where required to support integrated pathway delivery and improved accountability.                                                                                                    |

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# Finance /Quality Commissioning Intentions

Rob Morgan / Miranda

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08/10/2026 14:28:57

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

# Financial Commissioning Intentions

- The LNR ICBs will prioritise commissioning decisions that support delivery of best value while improving outcomes for the population. This will align to the NHS 10 Year Plan which supports:
  - From Hospital to Community
  - From Analogue to Digital
  - From Sickness to Prevention
- Apply “Intelligent Payer” principles that prioritise overall value (quality, outcomes, equity, sustainability) rather than lowest unit cost.
- Adoption of value-based healthcare approaches including the implementation of IHO contracts based on population-based budgets and the deconstruction of block contracts.
  - For community and mental health providers the exercise performed in 26/27 is to be used to inform 27/28 planning. The ICBs will follow national guidance but will also look to agree shadow monitoring on agreed areas which will support the NHS 10 Year Plan
- Investments will be focused on prevention, reducing health inequalities, improving community-based care, developing neighbourhood models and delivering productivity improvements across the system. Per the 10 Year Plan, there is a deliberate intent to shift resource from acute settings into community and neighbourhood provision, aligned with population health insights.
- Explore and enact joint and lead commissioning opportunities with providers and other partners (including Local Authorities and the voluntary sector) to deliver better value through integrated neighbourhood service models and other joint strategic priorities.
- Risk/Gain shares will be co-produced as and when necessary in order to fulfil these commissioning intentions and appropriately recognise risk and reward
- Benchmarking against peer ICBs and local partner organisations will be performed to identify areas for improvement.

## Statutory NHS Providers

- As a strategic commissioner, the ICB will use quality schedules to support a shift from assurance and performance monitoring towards outcomes-focused improvement. Working in partnership with providers, we will develop meaningful quality and outcome measures in priority areas, including children and young people, frailty, and mortality, creating a foundation for continuous improvement, innovation, and transformation. Through this approach, we aim to improve population outcomes, reduce health inequalities, and drive sustainable improvements in the safety, effectiveness, and experience of care.

## Neighbourhoods

- The ICB will commission for outcomes, supporting neighbourhood providers to embed quality planning, improvement and learning within service delivery. Working in partnership with providers and communities, we will identify opportunities to strengthen commissioning, address gaps in services and redesign care where needed, ensuring neighbourhood models are fit for purpose, community-centred and focused on improving quality, experience, equity, and outcomes.
- The overarching aim is to support a shift from assurance and performance monitoring towards outcomes-focused improvement across our local priority areas of Children and Young People (CYP), Cardiovascular Disease (CVD) and Frailty. During 2026/27, provider quality schedules will be used to establish baseline data, understand variation and identify opportunities for improvement. This intelligence will inform the development of targeted, system-wide quality improvement programmes from 2027/28 onwards, focused on improving outcomes, reducing health inequalities and enhancing the experience of care across LNR.

# Women's Health Commissioning Intentions 27/28

| Priority                                                                                                      | 3-4 Key Delivery Actions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Impact will be (activity)                                                                                                                                                                                                      | Delivered by (Timeframe)                            | Contractual implications                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implement a strategic life course commissioning approach for Women's Health across LNR                        | Use the Women's Health Strategy, population health data and existing service analysis to agree priority outcomes across the life course. Establish a common LNR outcomes framework covering access, inequalities, experience, quality and outcomes. Move from historic programme/service based arrangements towards pathway and population-based commissioning.                                                                                                                                                                                                     | Improved equity across LNR. Resources aligned to population need and outcomes. Reduced unwarranted variation. Clearer accountability for delivery of Women's Health outcomes across the system.                                | 2027/28 onwards                                     | Progressive alignment of specifications, KPIs and outcome measures. Contract changes where existing arrangements do not support the agreed strategic model.                        |
| Shift more women's health care into neighbourhood and community settings                                      | Develop a consistent neighbourhood Women's Health offer across LNR, building on existing pilots and models. Redesign pathways so appropriate diagnostics, treatment and follow-up are delivered closer to home. Integrate primary, community and specialist services around agreed pathways rather than organisational boundaries.                                                                                                                                                                                                                                  | Reduced avoidable secondary care activity. Improved access closer to home. Earlier intervention and improved patient experience. More consistent pathways across LNR.                                                          | Phased implementation throughout 2027/28 and beyond | Revised community/primary care specifications. Acute contract implications where activity shifts. Potential resource transfer from secondary to community/neighbourhood provision. |
| Improve outcomes and reduce inequalities across reproductive, maternity and postnatal care                    | Commission pathways around agreed population outcomes, including reproductive health, pregnancy, birth, postnatal and pelvic health. Use population health and inequalities data to target variation in access and outcomes. Ensure maternity, neonatal and specialist pathways are commissioned as part of the wider Women's Health strategy rather than as standalone programmes. Embed women's voice and co-production within commissioning and service redesign.                                                                                                | Improved maternal and neonatal outcomes. Reduced inequalities in access, experience and outcomes. Better continuity across reproductive, maternity and postnatal pathways. Greater focus on prevention and early intervention. | 2027/28 onwards                                     | Provider specifications and improvement trajectories aligned to agreed outcomes. Contract variation / investment where gaps against agreed service models are identified.          |
| Commission for value, equity and sustainability across women's health services (see ICB procurement pipeline) | Review historic commissioning arrangements, contracts and funding flows against statutory duties, population need, outcomes and strategic priorities and value. Harmonise arrangements across LNR where this improves equity and value. Implement decisions to redesign, consolidate, recommission or decommission services where appropriate. Apply a consistent strategic commissioning approach to areas such as fertility, termination of pregnancy, pelvic health and specialist maternity/neonatal services. See ICB procurement pipeline for further details | Resources aligned to highest-value interventions. Greater consistency across LNR. Reduced duplication and unwarranted variation. Sustainable commissioning arrangements aligned to the Five-Year Strategy.                     | 2027/28 onwards                                     | Contract renewal, variation, consolidation, recommissioning or decommissioning as required. Funding realignment following agreed commissioning decisions.                          |

## **Boards Meeting in Common (Public)**

# **LNR Neighbourhood Health Maturity Assessment: Findings, Learning and Next Steps**

**Thursday 15 October 2026**

Middlebrook, Claire  
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|                          |                                                      |
|--------------------------|------------------------------------------------------|
| <b>Presented by</b>      | <b>Eileen Doyle, Chief Delivery Officer</b>          |
| <b>Report Author(s)</b>  | <b>Nisha Patel, Head of Integrated Commissioning</b> |
| <b>Executive Sponsor</b> | <b>Eileen Doyle, Chief Delivery Officer</b>          |

| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>The Board is asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>RECEIVE</b> the report outlining the outcomes of the National Neighbourhood Health assessment visit and subsequent self-assessment process across the LNR ICB cluster.</li> <li>• <b>NOTE</b> the findings of the assessment, including areas of recognised good practice, identified opportunities for further development, and how the findings will inform neighbourhood health planning across the cluster.</li> <li>• <b>SUPPORT</b> the development of the revised LNR Neighbourhood Plan, including the proposed priority focus areas and continued engagement with partners to support delivery and implementation across the Cluster.</li> </ul> |

| Executive Summary of the report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The Leicester, Leicestershire and Rutland and Northamptonshire Integrated Care Boards Cluster participated in the National Neighbourhood Health Maturity Assessment during July and August 2026 following an assessment visit led by Claire Fuller and the national Neighbourhood Health team. The assessment reviewed progress against the ten domains of the National Neighbourhood Health Framework and provided an opportunity to benchmark neighbourhood health development across the Cluster, identify areas of strength and highlight opportunities for further development.</p> <p>Following the visit, an initial assessment was produced by the national team. Feedback regarding the specificity of the assessment approach resulted in the development of a more detailed Place-level self-</p> |

assessment process, enabling a broader evidence base to be considered and providing a more comprehensive assessment of neighbourhood maturity across the Cluster. An aggregated LNR position was subsequently developed from the five Place self-assessments.

The assessment identified a number of strengths across LNR, including strong partnership working, established neighbourhood footprints, proactive and community-based models of care, Integrated Neighbourhood Team development and increasing use of shared intelligence and data. Examples of good practice recognised during the assessment included the Age Well Programme, Integrated Crisis Response services and other neighbourhood-based approaches supporting prevention, admission avoidance and improved outcomes for local populations.

The assessment also identified opportunities to further strengthen organisational ownership and accountability arrangements, neighbourhood approaches to elective care pathways, integration across health and care services and consistency of delivery across Places and neighbourhoods.

The findings will inform the development of a revised LNR Neighbourhood Plan, with a strengthened focus on Frailty, Children and Young People (including Neurodiversity), Women's Health and Primary Care. The plan will incorporate a phased programme of activity over the next 6, 12 and 18 months, building on areas of recognised strength whilst addressing opportunities for further development.

The assessment provides assurance that LNR has many of the building blocks required to support implementation of the National Neighbourhood Health Framework and a clear direction for the next phase of neighbourhood health development across the Cluster.

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

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

**Conflicts of interest – Please select**

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

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

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

**LLR ICB BAF No:**

**NICB BAF No:**

**Appendices**

Appendix 1 LNR Neighbourhood Maturity summary- single page summary  
 Appendix 2 Best practice examples  
 Appendix 3a-3e Place Self Assessments  
 Appendix 4 Next steps post self assessment

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

A version of this report was presented to the ICB Board on 15 September 2026 and The LLR Neighbourhood Programme Board on 24 September 2026.

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

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

Middlebrook-Claire  
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# LNR Neighbourhood Health Maturity Assessment: Findings, Learning and Next Steps

15 October 2026

## 1. Introduction

In July 2026 the National team for Neighbourhood Health, led by Claire Fuller, attended an in-person assessment visit to explore an initial review of the LNR Cluster's neighbourhood maturity and readiness for implementation of Neighbourhood Health. This was reviewed against the ten domains within the National Neighbourhood Health Framework. An initial scoring template was produced by the national team (Appendix 1), which was subsequently developed into a local self-assessment template and completed by system partners across the Cluster before being returned to the national team on 24 August.

The assessment process brought together representatives from health, local government, social care, primary care and voluntary, community and social enterprise (VCFSE) organisations to consider the maturity of neighbourhood working across Leicester, Leicestershire and Rutland (LNR). Discussions focused on existing neighbourhood arrangements, partnership working, delivery of care closer to home, population health management, prevention, workforce, digital capability and the infrastructure required to support implementation of the emerging national Neighbourhood Health model.

The assessment provided an opportunity to benchmark current neighbourhood development against national expectations, identify areas of strength and highlight opportunities for further improvement. The process also enabled LNR partners to showcase a number of established neighbourhood approaches, including programmes supporting frailty, admission avoidance, women's health, community diagnostics and proactive care.

Whilst the assessment recognised significant progress across the Cluster, it also identified opportunities to strengthen the consistency of neighbourhood delivery, further develop integrated neighbourhood teams, improve data and intelligence capabilities, and support the spread of successful models across all Places and neighbourhoods.

The outcomes will help inform future neighbourhood planning, strengthen the development of the LNR Neighbourhood Plan, and support alignment with the emerging national Neighbourhood Health model. The findings will also be used to shape the next phase of neighbourhood development, ensuring that existing examples of good practice can be scaled and embedded consistently across the Cluster.

## 2. Assessment Domains

The assessment was undertaken against the ten domains contained within the National Neighbourhood Health Framework. These domains are designed to assess the maturity of neighbourhood health arrangements and identify areas of strength and opportunities for further development across local systems.

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The ten domains assessed were:

| Code | Domain                                                | Description                                                                                                                      | The Model                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| S1   | <b>Urgent, rehabilitation and reablement capacity</b> | The extent to which neighbourhood teams support urgent care, admission avoidance, rehabilitation and recovery closer to home.    | An integrated care coordination centre across place. One contact point holding clinical risk takes referrals in from general practice but also 111, out of hours, discharge teams, and in the most mature the public. It admits directly out to the services that keep people at home, including social care reablement, extends to 24 hour operation.                                                                                                                                                                                         |
| S2   | <b>General practice access and variation</b>          | The involvement of communities, VCSE organisations and local partners in prevention, wellbeing and reducing health inequalities. | There is a named accountable person who reports at least quarterly in public Board on plans and progress related to GP core hours, phone access, urgent access and patient experience. There is also a named provider with improvement capability that is commissioned to support practices in difficulty with improvement. Public discussion is at place level; no item requires naming individual practices in public.                                                                                                                       |
| S3   | <b>Neighbourhood footprints</b>                       | Agreement and adoption of neighbourhood geographies that support planning and delivery around local populations.                 | ne agreed geography where there is alignment across general practice, PCNs, community and mental health teams, social care and voluntary sector. Footprints are grown from PCNs on JSNA evidence and post-LGR boundaries, signed off at the HWB. The full model includes co-location.                                                                                                                                                                                                                                                          |
| S4   | <b>INTs for priority cohorts and devolved budgets</b> | Development and maturity of multidisciplinary neighbourhood teams delivering coordinated care.                                   | The service for older complex adults, most often moderate to severe frailty, care home, housebound and end of life, consists of three components. The three components are proactive care, an MDT for those with elevated risk - which are covered in this stage - and a 24/7 reactive care component which is covered in Stage 1. The end-state model includes a delegated budget to support targeted interventions to drive healthy neighbourhood by tackling wider determinants for individuals or smaller cohorts within the neighbourhood |
| S5   | <b>Neighbourhood approach to elective pathways</b>    | Delivery of planned care through neighbourhood-based models and integrated pathways.                                             | There are four outpatient reform models emerging: (i) trust-run community specialist clinics; (ii) GPwER running community tier 2 often with specialist support; (iii) commissioned GP and consultant shared care as the mechanism for reviewing referrals, waiting lists and follow-up lists; and (iv) a population-based relationship model with consultants and specialist nurses aligned to neighbourhoods, delivering care and supporting GPs and their teams.                                                                            |
| S6   | <b>Community waits</b>                                | Approaches to improving access and reducing waiting times for community-based services.                                          | Community waits, meaning the pathways reported in the CHS SitRep, solved by redesign doing the heavy lifting with waiting list initiatives clearing legacy backlogs alongside. Demand shaped before referral, post-diagnostic follow-up delivered through commissioned shared care so specialists are free to assess and diagnose, support in place whilst waiting in line with the NHSE community waiting times action lists and checklist (March 2026), and the published standards met on the way through.                                  |

|     |                                                       |                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|     |                                                       |                                                                                                               | Neurodevelopmental waits are reported both included and excluded so positions are comparable across systems, and children's waits are identified separately: the same wait is a larger share of a child's life.                                                                                                                                                                                                                                                              |
| S7  | <b>Better Care Fund pooled funding</b>                | Alignment of resources and funding to support joined-up neighbourhood delivery.                               | Pooled money working at both place and neighbourhood level. BCF confirmed with every local authority; joint assessment and decisions grounded in the JSNA and joint local health and wellbeing strategy; funds delegated to the footprints; BCF investment demonstrably changed in response to the neighbourhood health plan guidance, implemented and contractually underpinned; and inequalities impact measured scheme by scheme, reported annually in public at the HWB. |
| S8  | <b>Primary and secondary care interface</b>           | How effectively primary, community and secondary care services work together to support neighbourhood health. | An interface working as one system. There is a documented priority plan, all providers and the full primary care family are in scope, operational and strategic meetings are in place, the red tape challenge changes are delivered in practice, and there is a shared workforce through joint leadership development and neighbourhood PAs in consultant job plans, with a named clinical SRO and PMO support.                                                              |
| S9  | <b>Organisational ownership</b>                       | Clarity of leadership, governance, responsibility and oversight for neighbourhood delivery.                   | Clear ownership. There is a named accountable lead for every stage, taken through the Board, with an overall delivery owner in the ICB; a host, anchor or integrator in every place; general practice coordinated across the Place; and accountability exercised through working governance.                                                                                                                                                                                 |
| S10 | <b>Data sharing for identification and evaluation</b> | The use of shared intelligence, data and population health approaches to plan, target and evaluate services.  | data sharing signed and used. Every sector signed up, general practice counted by share of practices, enabling the risk stratification and single patient record that are scored where they operate (S4 and S8). VCFSE and smaller partner sign-up is expected to come with information governance support from the system; the item scores the arrangement being in place, not unsupported compliance.                                                                      |

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The self-assessment process enabled each Place to review its current position against these domains, identify supporting evidence and determine priorities for future development. The findings from across the five Places were then combined to provide an aggregated LNR Cluster assessment.

### 3. Assessment Process and Outcomes

Following the assessment of the ten domains of the National Neighbourhood Health Framework outlined above, an initial summary report was produced by the national team. This provided an overall assessment of neighbourhood maturity across participating systems and identified a number of strengths, development opportunities and priority areas for future focus.

Challenges raised with the national team regarding the specificity and application of the assessment tool, particularly its ability to capture variation in maturity across individual domains, resulted in the development of a more detailed self-assessment process. This provided a richer understanding of neighbourhood maturity across the LNR Cluster and enabled a more granular review against the ten domains of the National Neighbourhood Health Framework. The outcomes of this self-assessment are summarised in Table 1.

**Table 1- LNR self-assessment**

| LLRN ICB | LEICS | LEICS CITY | RUTLAND | N.NORTHANTS | W.NORTHANTS |
|----------|-------|------------|---------|-------------|-------------|
|          | 8     | 8          | 8       | 8           | 8           |
|          | 6     | 6          | 6       | 6           | 6           |
|          | 7     | 7          | 7       | 6           | 6           |
|          | 0     | 0          | 1       | 7           | 7           |
|          | 3     | 3          | 3       | 1           | 1           |
|          | 5     | 5          | 5       | 3           | 3           |
|          | 4     | 4          | 4       | 3           | 5           |
|          | 4     | 4          | 4       | 4           | 4           |
|          | 2     | 2          | 2       | 2           | 2           |
|          | 5     | 5          | 5       | 7           | 7           |
| 46       | 44    | 44         | 45      | 47          | 49          |

The assessment demonstrated that many of the building blocks required to support implementation of Neighbourhood Health are already in place across the Cluster. Strong performance was evidenced across a number of domains, particularly Neighbourhood Footprints (S3), Urgent, Rehabilitation and Reablement Services (S1), Integrated Neighbourhood Teams (S4), and Data Sharing and Population Health Management (S10).

The assessment also identified examples of neighbourhood-based delivery which demonstrate the principles set out within the National Neighbourhood Health Framework. These include programmes supporting frailty, admission avoidance, integrated crisis response, women's health and community-based care, several of which were recognised by the national team as examples of good practice.

Whilst recognising these strengths, the assessment identified opportunities for further development in several areas, particularly Organisational Ownership and Accountability (S9), Neighbourhood Approaches to Elective Care (S5), and strengthening interfaces between primary care, community services, social care and secondary care services (S8).

A recurring theme from both the national visit and the self-assessment process was that the Cluster has developed a range of successful neighbourhood initiatives and innovative models of care. The next phase of development will focus on embedding, connecting and scaling these approaches to achieve a more consistent neighbourhood health model across all Places and neighbourhoods.

The self-assessment scores will be reviewed on a quarterly basis as implementation plans continue to progress. It is anticipated that maturity will continue to increase as neighbourhood health developments are implemented across the Cluster.

The detailed examples of good practice together with place-based strengths, opportunities for development and common themes emerging from the assessment are outlined in Sections 4 and 5 of this report.

#### 4. Examples of good practice

During the July visit, several initiatives were identified as examples of good practice, with further details subsequently shared with the national team as potential exemplars. The schemes highlighted through the assessment are listed in Appendix 2.

The examples presented reflected a range of neighbourhood health themes, including proactive and preventative care, admission avoidance, integrated community services, population health management and partnership working. For example, the Age Well Programme was recognised for its multidisciplinary approach to supporting older people with frailty and complex needs, whilst the Integrated Crisis Response Service demonstrated the benefits of coordinated interventions that support individuals to remain at home and avoid unnecessary hospital admission.

These initiatives demonstrate recognised areas of strength and innovation across the LNR Cluster and provide an opportunity to share learning and influence the wider development of the national Neighbourhood Health programme. They also provide evidence that many of the components of the National Neighbourhood Health Framework are already being delivered successfully across LNR.

A consistent theme emerging from the assessment was the opportunity to build on these successes by spreading learning more systematically across Places and neighbourhoods, supporting greater consistency of delivery and accelerating neighbourhood health implementation across the Cluster.

The learning from these examples will help inform the refresh of the LNR Neighbourhood Plan and support the next phase of neighbourhood health development.

#### 5. Place-Based Findings and Opportunities for Development

The findings below draw on both the national assessment visit led by Claire Fuller and the Place-level self-assessment process, highlighting key strengths and opportunities for development across the Cluster. Detailed self-assessments for each Place are provided in appendices 3a-3e.

##### Leicester, Leicestershire and Rutland (LLR)

##### Key Strengths

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The assessment identified several strengths across Leicester, Leicestershire and Rutland, demonstrating significant progress in developing neighbourhood-based approaches to care and support.

These included:

- Established neighbourhood footprints and Place-based partnership arrangements.
- Strong progress in programmes supporting frailty, admission avoidance and proactive care, including Integrated Crisis Response services.
- Development of Integrated Neighbourhood Team models and multidisciplinary working arrangements.
- Effective partnership working across health, local authority, social care and VCFSE organisations.
- Increasing maturity in relation to population health management, data sharing and neighbourhood intelligence.
- Innovative neighbourhood-based approaches that support prevention, early intervention and delivery of care closer to home.

### Areas for Further Development

Opportunities identified across LLR included:

- Strengthening organisational ownership and accountability arrangements (S9).
- Further development of neighbourhood approaches to elective and planned care pathways (S5).
- Continued strengthening of interfaces between primary care, community services, social care and acute services (S8).
- Increasing consistency of neighbourhood delivery arrangements across Places and neighbourhoods.
- Embedding governance arrangements that support delivery at scale.

In addition, maturity within several domains is expected to increase over the coming months through the implementation of planned developments across the cluster.

## Northamptonshire

### Key Strengths

The assessment identified a number of strengths across Northamptonshire, including:

- Established neighbourhood footprints and local delivery structures.
- Strong partnership working between health, care and local authority partners.
- Development of Integrated Neighbourhood Team approaches.
- Community-based models supporting prevention, proactive care and admission avoidance.
- Increasing use of population health intelligence and shared data to support planning and delivery.
- Delivery models focused on improving care closer to home and reducing reliance on acute services.

### Areas for Further Development

Opportunities identified across Northamptonshire included:

- Strengthening governance, organisational ownership and accountability arrangements.
- Further development of neighbourhood approaches to elective and planned care.
- Improving integration across primary, community and secondary care services.
- Increasing consistency in neighbourhood delivery arrangements.
- Continuing development of neighbourhood intelligence, outcomes measurement and reporting capabilities.

### Common Themes Across the Cluster

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

A number of themes emerged consistently across both the national assessment visit and the Place self-assessments.

### Common Strengths

- Strong partnership working across health, care, local authority and VCFSE organisations.
- Established neighbourhood footprints and Place-based delivery arrangements.
- Development of Integrated Neighbourhood Team models.
- Increasing focus on prevention, proactive care and admission avoidance.
- Growing use of population health management and shared intelligence.
- A wide range of innovative neighbourhood-based services already operating across the Cluster.

### Common Opportunities for Development

- Strengthening organisational ownership, accountability and governance arrangements.
- Further development of neighbourhood approaches to elective care pathways.
- Improving integration between primary care, community services, social care and secondary care.
- Increasing consistency of neighbourhood delivery across Places and neighbourhoods.
- Scaling successful neighbourhood models across a wider geography.
- Continuing development of outcomes, intelligence and evaluation capability.

Overall, both the national assessment visit and self-assessment process highlighted that many of the foundations required for Neighbourhood Health are already in place across the Cluster. The next phase will focus on strengthening consistency, governance and accountability, whilst scaling successful neighbourhood approaches across Places and neighbourhoods.

## 6. Next Steps

The Neighbourhood Plan is currently under review and will be revised, ready for a late Autumn publication, informed by the findings of the national assessment and self-assessment process. The revised plan will incorporate the key actions identified for delivery over the next 6, 12 and 18 months following the assessment visit, as detailed in Appendix 4.

The refreshed plan will strengthen the focus on four priority areas:

- Frailty, through the continued expansion of the *Age Well* approach.
- Children and Young People (CYP), with a particular focus on Neurodiversity.
- Women's Health.
- Primary Care approaches across the Cluster.

The plan will support delivery of neighbourhood health priorities, build on the areas of strength identified through the assessment and address opportunities for further development. It will be progressed through the appropriate governance and approval routes and further refined with health, care, local authority and VCFSE partners to ensure continued engagement, collective ownership and alignment across the Cluster.

The proposed actions build on the areas of strength identified through the assessment whilst addressing those domains where further development was identified. This approach supports continued progression towards the ambitions set out within the National Neighbourhood Health Framework.

### Key Milestone Summary

The detailed actions, milestones and delivery responsibilities are set out in Appendix 4. In summary, the next phase of development will focus on strengthening consistency across Places, embedding successful neighbourhood approaches and supporting delivery of the National Neighbourhood Health Framework across LNR.

#### Next 6 Months

- Finalise and agree the revised LNR health Neighbourhood Plan.
- Confirm governance, leadership and accountability arrangements for neighbourhood delivery.
- Strengthen neighbourhood intelligence, outcome measures and reporting arrangements.
- Continue development of Integrated Neighbourhood Team models and neighbourhood infrastructure.
- Progress delivery planning across the four identified priority programmes.
- Establish mechanisms to support the spread and adoption of successful neighbourhood initiatives across the Cluster.

#### Next 12 Months

- Embed delivery of the priority neighbourhood programmes.
- Further develop and strengthen Integrated Neighbourhood Team arrangements across Places.
- Expand successful proactive and preventative models of care.
- Strengthen population health management, partnership working and the use of neighbourhood intelligence.
- Improve integration across primary care, community services, social care, mental health and acute providers.
- Further develop neighbourhood approaches to planned and elective care pathways.

#### Next 18 Months

- Deliver neighbourhood health at greater scale and consistency across the Cluster.
- Embed sustainable governance, leadership and accountability arrangements.
- Continue the adoption and spread of successful neighbourhood models and approaches.
- Demonstrate measurable improvements in outcomes, patient experience and health inequalities.
- Reduce unwarranted variation between Places and neighbourhoods.
- Establish neighbourhood health as a sustainable delivery model across LNR.

#### Recommendations:

The Board is asked to:

- **RECEIVE** the report outlining the outcomes of the National Neighbourhood Health assessment visit and subsequent self-assessment process across the LNR ICB cluster.
- **NOTE** the findings of the assessment, including areas of recognised good practice, identified opportunities for further development, and how the findings will inform neighbourhood health planning across the cluster.
- **SUPPORT** the development of the revised LNR Neighbourhood Plan, including the proposed priority focus areas and continued engagement with partners to support delivery and implementation across the Cluster.

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NHS Leicester, Leicestershire and Rutland + NHS Northamptonshire Cluster ICB (LLRN)

ICB code QK1 / QPM | Midlands | Source pack v9.10 | Full cluster visit 24 July 2026 (baseline), post-visit build |

| ICB at a glance            |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                                                                                                                                                  |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ICB CEO                    | Joint CEO Toby Sanders (Interim LLR CEO from 1 July 2025, former Northamptonshire CEO)                                                                                                                                                                                                                                                                                                                                                                  | Local authorities       | 5 upper-tier local authorities, coterminous with 5 HWBs                                                                                                                                                                                                                                          |
| ICB Chair                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Providers               | Acute: University Hospitals of Leicester; University Hospitals of Northamptonshire Group (Kettering, Northampton). Community and MH: Leicestershire Partnership and Northamptonshire Healthcare, shared-CEO group model; NHFT is an Integrated Health Organisation frontrunner. Ambulance: EMAS. |
| Registered population      | just under 2 million (LLR approx 1.15m; Northamptonshire approx 0.83m);                                                                                                                                                                                                                                                                                                                                                                                 | Self-reported           | Board meetings in common, single executive team, unified staffing model near completion, two statutory bodies retained. Running-cost reductions of 33% (LLR) and 29% (Northamptonshire). Both ICBs reported as not viable alone.                                                                 |
| Places                     | 21 neighbourhoods across 5 Places against 42 PCNs (26 LLR, 16 Northamptonshire), so not coterminous.                                                                                                                                                                                                                                                                                                                                                    | Workforce               | SRO for Neighbourhood Health: Eileen Doyle, Chief Delivery Officer (ICB Board level).                                                                                                                                                                                                            |
| Post-visit notes           | LLR moves from three Place footprints to two unitaries, Leicester City expanding into part of the county and the remaining county combining with Rutland, shadow cabinet after May 2027 elections, so the cluster moves from five Places to four. Northamptonshire completed reorganisation already, which the cluster records as a structural benefit. Acute provider deficit of approximately GBP 200m reported as the dominant financial constraint. | Pilots and designations | NNHIP: West Leicestershire wave 1 (1 of 43 nationally). Pride in Place phase 2 in 6 neighbourhoods (3 Leicester, 3 North Northamptonshire). LGR affects LLR only.                                                                                                                                |
| Place level maturity score |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                                                                                                                                                  |

| Place (fill = maturity)   | Leicester City                                                                                                                                                                                                                                                                                                                                                               | SCORE 31 | Leicestershire                                                                                                                                                                                                                                                                                                                                                                                     | SCORE 29 | Rutland                                                                                                                                                                                                                                                                                                                                                          | SCORE 31 | West Northamptonshire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | SCORE 37 | North Northamptonshire                                                                                                                                                                                                                                                                                                                                                                        | SCORE 39 |
|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| Population                | 443,509                                                                                                                                                                                                                                                                                                                                                                      |          | 744,730                                                                                                                                                                                                                                                                                                                                                                                            |          | 41,443                                                                                                                                                                                                                                                                                                                                                           |          | approx 430,000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          | approx 361,000                                                                                                                                                                                                                                                                                                                                                                                |          |
| HWB sign-off              | Evidence provided<br>Minutes of the HWBB 25/9/25 presented initially 5/3/26 – signed off                                                                                                                                                                                                                                                                                     |          | Evidence Provided<br>Minutes of HWBB 29/5/25 initial presentation 4/12/25 – signed off                                                                                                                                                                                                                                                                                                             |          | Evidence Provided<br>Minutes of HWBB 7th July 2026                                                                                                                                                                                                                                                                                                               |          | Evidence Provided<br>Minutes of HWBB 3/10/25                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          | Evidence Provided<br>Minutes of HWBB 30/9/25 signed off                                                                                                                                                                                                                                                                                                                                       |          |
| NbH readiness             | 4 neighbourhoods co-terminous with MSOAs, each with a steering group in Place governance. Integrated Crisis Response Service CQC Outstanding across all five domains, 1,000+ falls per year, 80%+ managed without conveyance. Hypertension case-finding, 400+ BP readings. Pharmacy First referrals up 39%. Core20 51.4%. Named neighbourhood leads recorded as a next step. |          | NNHIP wave-1 site (West Leicestershire). Weekly COPD MDTs, 200+ patients supported. Outcomes Jan to May 2026: COPD review 64.4% to 71.0%; structured medication review 17.8% to 23.4%. Data sharing agreements and governance in place; logic model complete. 7 INTs, 7 Local Health and Wellbeing Partnerships, Neighbourhood Health Board. NWL Mental Health Hub approx 3,000 patients per year. |          | Single neighbourhood. 26.4% aged 65+ against England 18.7%, projected +45.2% by 2047. Healthy life expectancy falling: males 69.1 to 65.0, females 69.6 to 64.8. Health and Care Campus capital programme approx GBP 12.9m. Community Connectors across 5 villages. Full BCF outcome trajectories published. Proactive prevention MDTs at PSDA test-cycle stage. |          | 5 neighbourhoods. County-wide Ageing Well programme serving in excess of 1% of population: ICB holds circa GBP 4m and passes it out to deliver proactive care through community services, social care, ARRS and VCFSE alongside general practice. Approximately 200 acute beds removed some years ago, no subsequent activity growth. New Models of Care phase 1 live April 2026 in 2 pathfinder neighbourhoods on a two-year LES, +24.7 same-day GP appointments per 1,000. Kings Health NHC. Phase 2 at business case. |          | 4 neighbourhoods. County-wide Ageing Well programme serving in excess of 1% of population, published Q1 2026/27 feedback: 190 responses, 4.92 of 5 overall, 99% would recommend. Unplanned care demand falling: 9 fewer 65+ admissions per day than growth plan, equivalent to 94 acute beds. NBCT Black Communities service extended. 3 Pride in Place sites. HWB five priorities published. |          |
| HLE (M/ F)                | M 57.8 / F 57.9                                                                                                                                                                                                                                                                                                                                                              |          | M 61.5 / F 61.4                                                                                                                                                                                                                                                                                                                                                                                    |          | M 65.0 / F 64.8                                                                                                                                                                                                                                                                                                                                                  |          | M 61.6 / F 61.9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          | M 58.7 / F 58.3                                                                                                                                                                                                                                                                                                                                                                               |          |
| GP federation /integrator | 10 PCNs; no single at-scale vehicle confirmed. Expands post-LGR                                                                                                                                                                                                                                                                                                              |          | 15 PCNs; 4 GP Federations; LLR GP Provider Collaborative (reported at visit as significantly progressed). Splits post-LGR                                                                                                                                                                                                                                                                          |          | 1 PCN (Rutland Health PCN); single-PCN Place. May change post-LGR                                                                                                                                                                                                                                                                                                |          | 11 PCNs; 49 practices; 3 GP Federations and 1 super practice (county)                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          | 6 PCNs; 3 GP Federations and 1 super practice (county); Primary Care Collaborative                                                                                                                                                                                                                                                                                                            |          |

Examples of practice surfaced across Places

Leicestershire: NNHIP COPD cohort model, 200+ patients supported with quantified before-and-after outcomes and a completed logic model, the only Place-level outcome evidence in the cluster. Leicester City: Integrated Crisis Response Service, CQC Outstanding across all five domains, 1,000+ falls per year with 80%+ managed without conveyance. LLR-wide: PTCDa call-before-convey, 4,606 patients supported April 2025 to April 2026, 2,560 admissions avoided, estimated 23,040 bed days avoided, approximately 80% managed in community; UCR 20,539 referrals in 2025/26 at 92.8% against the two-hour standard with 90% managed in community; system-wide SPoA operating 24/7/365. West Northamptonshire: New Models of Care, 2 contractualised pathfinder neighbourhoods, +24.7 same-day GP appointments per 1,000. North Northamptonshire: Age Well Northamptonshire, 4.92 of 5 patient rating and 9 fewer 65+ admissions per day than growth plan. Rutland: Community Connectors across 5 villages and BCF outcome trajectories. Surfaced at the visit: LUCID, an MDT approach to CKD with a diabetes care model reported to reduce cost while improving quality; a VCFSE-run mental health crisis centre with a mature VCFSE alliance; CDC dementia diagnosis as dedicated single-day sessions. All cluster self-reported; visit items are testimony without artefact.

| Five Goals (RAG vs England; see Annex B for scores)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                   |                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------|----------------------------------------|
| G1 Health outcomes 2.59                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | G2 GP access and experience 1.06                                                                                                                                                                                                                                                                                                                                                                                                | G3 Planned care 2.06 | G4 Urgent and emergency care 2.73 | G5 Patient and staff satisfaction 2.75 |
| S1 Reduce non-elective admissions via UCR and reablement (IN PROGRESS) S2 Reduce variation; improve access to general practice (EARLY STAGE) S3 Neighbourhood footprints agreed (EARLY STAGE) S4 INTs for high-priority cohorts; devolved budgets (IN PROGRESS) S5 Neighbourhood approach to elective pathways (IN PROGRESS) S6 18-week community waits; eliminate 52-week waits (EARLY STAGE) S7 BCF pooled funding confirmed with LAs (IN PROGRESS) S8 Primary / secondary care interface (RTC) (EARLY STAGE) S9 Organisational ownership of deliverables (EARLY STAGE) S10 Data-sharing for patient identification (IN PROGRESS) |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                   |                                        |
| Overall: EARLY STAGE (NOT EVIDENCED 0, EARLY STAGE 5, IN PROGRESS 5, STRONG 0). Cluster-level. Access (G2 Red for both ICBs) is the binding constraint and no requirement reaches STRONG. Five at IN PROGRESS against five at EARLY STAGE, so the overall is held at EARLY STAGE rather than moved. Ten movements across two builds: seven at v9.5 on system-supplied material, three at v9.7 (S1, S4, S10) on visit-day testimony without artefact. S6 considered and held. See both companion notes.                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                   |                                        |
| Enablers (Section 4)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                   |                                        |
| Enabler (fill = rating)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Key point                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                   |                                        |
| Data                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LLR Care Record live; ACG segmentation (LLR) and PNG plus NARP (Northamptonshire). Visit reports a system IG portal enabling cross-organisation data sharing, coverage unevicenced. No cluster-wide shared care record- but each system does have SCR in place; CCIO is confirmed, Rowan Sil. FDP information-governance barriers carried as a national ask.                                                                    |                      |                                   |                                        |
| Workforce                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Staff experience diverges sharply: LLR G5 3.50 against Northamptonshire 2.00. Shared-CEO group model across LPT and NHFT is a spread route. ICB management of change at early stage, named by the cluster as a key challenge. No neighbourhood workforce plan evidenced for any Place.                                                                                                                                          |                      |                                   |                                        |
| Finance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Both ICBs reported as not viable alone. Reported at visit: acute provider deficit of approximately GBP 200m, the dominant financial constraint. NHFT moving to IHO status starting with CYP, SEND and neurodiversity as a devolved budget, the first named devolved-budget mechanism, with the shift that the provider becomes the commissioner and cannot seek funding elsewhere. Payment reform otherwise stated intent only. |                      |                                   |                                        |
| Digital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Reported at visit: a system information-governance portal enabling data sharing between organisations, the first cluster-level mechanism surfaced, Johns Hopkins segmentation focused on population need groups 10 and 11 with some at 5. Neighbourhood dashboard with cohort identification operating in Northamptonshire. Rutland reports multiple record systems that do not talk to each other.                             |                      |                                   |                                        |
| Estates                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 10 Neighbourhood Health Centre schemes submitted to NHSE, approx GBP 25m, from Rutland Memorial GBP 100k to Felilding Palmer GBP 15m. Asset mapping under way with partners. Opening-hours commitment – additional evidence provided to NHSE on this commitment on 15/6/26                                                                                                                                                      |                      |                                   |                                        |

| Framework readiness: Stage 1 (foundations) and Stage 2 (NbH Plan) |                                                                   |                     |
|-------------------------------------------------------------------|-------------------------------------------------------------------|---------------------|
| Ref                                                               | Stage 1 minimum requirement (2026/27): Ref fill shows rating      | Self-assessed score |
| S1                                                                | Reduce non-elective admissions via UCR and reablement             | 3                   |
| S2                                                                | Reduce variation; improve access to general practice              | 4                   |
| S3                                                                | Neighbourhood footprints agreed                                   | 6                   |
| S4                                                                | INTs for high-priority cohorts; devolved budgets                  | 2                   |
| S5                                                                | Neighbourhood approach to elective pathways                       | 2                   |
| S6                                                                | 18-week community waits; eliminate 52-week waits                  | 4                   |
| S7                                                                | BCF pooled funding plans confirmed with LAs                       | 4                   |
| S8                                                                | Primary / secondary care interface (RTC)                          | 3                   |
| S9                                                                | Organisational ownership of planned deliverables                  | 2                   |
| S10                                                               | Data-sharing arrangements for patient identification              | 3                   |
| Stage 1 overall:                                                  |                                                                   | 33                  |
| Ref                                                               | Stage 2 NbH Plan step (2027/28)                                   |                     |
| 1                                                                 | National objectives via the three reform agendas (Early stage)    |                     |
| 2                                                                 | Support wider local goals and public service reform (In progress) |                     |
| 3                                                                 | Local objectives informed by JSNA (Early stage)                   |                     |
| 4                                                                 | Confirm final geographies (Early stage)                           |                     |
| 5                                                                 | Confirm organisational delivery (Early stage)                     |                     |
| 6                                                                 | Confirm governance and operations (Early stage)                   |                     |
| 7                                                                 | Align other initiatives (Early stage)                             |                     |
| Stage 2 overall                                                   |                                                                   |                     |

| Forward look - Key actions over next 6 months: |                                                                                                                                                                                                                                                                                   | Forward look – Key actions over next 18 months |                                                                                                                                                                                                             |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.                                             | Development of Strategic Commissioning plan and contracting frameworks for Neighbourhood Health for proactive, rising risk and reactive care cohorts at scale across footprint, and for new models of planned care.                                                               | 1.                                             | Scale Provider development and delivery of neighbourhood services (ongoing)                                                                                                                                 |
| 2.                                             | Confirm local governance arrangements with system partners through Accountability and Governance Frameworks – developing place provider partnerships to deliver (tailored to each place) and supported by ICB in strategic commissioner role (to support consistency across LLNR) | 2.                                             | Embed provider partnership and neighbourhood governance arrangements.                                                                                                                                       |
| 3.                                             | Finalise Place-based Neighbourhood Health Plans (aligned to learning from NNHIP and self-assessments)                                                                                                                                                                             | 3.                                             | Funding plan in 2026/27 to support provider development or establishment of new models of neighbourhood health requiring significant shift in provider approaches                                           |
| 4.                                             | Confirm new neighbourhood footprint arrangements and transition plans for Local Government Reorganisation impacts across LLR.                                                                                                                                                     | 4.                                             | Confirm ICB & local authority plan to use pooled funding under the BCF in response to NbH plan guidance                                                                                                     |
| 5.                                             | Create a shared investment fund, social investment fund, system transformation grants to enable NbH to be commissioned                                                                                                                                                            | 5.                                             | Refresh LLNR Neighbourhood Needs Assessment and Outcome Framework                                                                                                                                           |
|                                                |                                                                                                                                                                                                                                                                                   | 6.                                             | Spread of learning, innovation and best practice across the cluster and nationally. (ongoing)                                                                                                               |
|                                                |                                                                                                                                                                                                                                                                                   | 11.                                            | Develop core inputs and outcomes expected for INTs and delivery of neighbourhood services e.g. delivery of integrated NbH that includes activity currently undertaken in acute settings/scaling of delivery |
|                                                |                                                                                                                                                                                                                                                                                   | 12.                                            | Demonstrate measurable reductions in non-elective admissions, improved access and increased care delivered outside hospital settings                                                                        |
|                                                |                                                                                                                                                                                                                                                                                   | 13.                                            | Demonstrate system-wide population health improvements through prevention-focused investment.                                                                                                               |
|                                                |                                                                                                                                                                                                                                                                                   | 14.                                            | Continuing spread of learning, innovation and best practice across the cluster and nationally. (ongoing)                                                                                                    |
|                                                |                                                                                                                                                                                                                                                                                   | 15.                                            | Use data dashboard to show impact on wait times, outcomes and conversion rates for key specialities.                                                                                                        |

|     |                                                                                                                                                      |     |                                                                                                                                   |     |                                                                                                                                                                                  |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6.  | Development of a priority plan to deliver the actions in the Red Tape Challenge to improve primary and secondary care interface                      | 7.  | Explore and secure medium-term funding opportunities supporting neighbourhood transformation.                                     | 16. | Mature integrated neighbourhood health models operate consistently across all NbH footprints (ongoing)                                                                           |
| 7.  | Implement agreed access improvement trajectories and evaluate Same Day Access programmes. (Ongoing)                                                  | 8.  | Review support arrangement for appropriate management & diversion of top 1% of service users                                      | 17. | Secure long-term sustainable investment and governance arrangements for neighbourhood health.                                                                                    |
| 8.  | Develop estates strategy (based on clinical strategy), establishing neighbourhood Health centres within 26/27 plan                                   | 9.  | Extend NMoC in Northants after successful business case and review arrangements in Leicestershire                                 | 18. | Work with system colleagues & providers to develop community pathways in line with expected direction of travel for secondary care providers, Final within a neighbourhood model |
| 9.  | Develop appropriate data-sharing and reporting arrangements to support robust patient identification and evaluation within a neighbourhood dashboard | 10. | Implement learning and development from Standardising Community services & potential IHO development into neighbourhood modelling |     |                                                                                                                                                                                  |
| 10. | Create mechanism to support Spread of Learning, best practice and evidence across programmes of work including reporting to Board                    |     |                                                                                                                                   |     |                                                                                                                                                                                  |

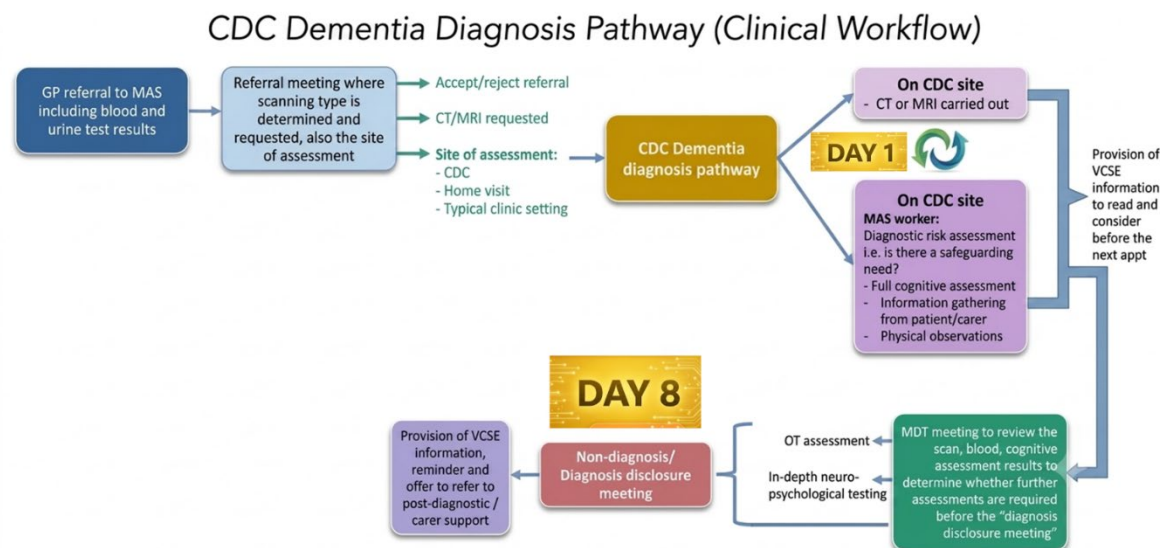
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### The CDC Dementia Pathway

Dementia diagnosis has historically been characterised by long waits, fragmented services, and significant patient anxiety. The CDC Dementia Pathway was designed to move beyond a purely clinical process and treat diagnosis as a **compassionate, person-centred life event**.

Work identified delays at each stage in the process with the primary bottleneck point being the diagnostic stage and the time waiting on scan results to be available and read. A revised pathway to provide dedicated scan clinics in designated 'quiet' days enabled the MDT tasks to coalesce around that fixed event. Visual below shows the new pathway achieving scan to result in eight days

### **Our redesigned MAS pathway...**



### Outcomes

#### **Reduced Waiting Times**

Median wait from GP referral to assessment dropped from 49 to 28 days, reducing patient anxiety.

#### **Accelerated Diagnosis Process**

Time from assessment to diagnosis disclosure fell from 52 to 11 days, speeding key diagnostic stages.

#### **Efficient One-Stop Model**

88% of scans completed on the same day as assessment, enhancing diagnostic efficiency and convenience.

#### **Improved Patient Outcomes**

Faster timelines enable earlier clarity, planning, and access to support for patients and carers.

Working with **Northamptonshire Black Communities Together (NBCT)**, the pathway actively reached communities where dementia stigma and cultural barriers had previously prevented engagement.

- Reached over **500 people** through 8 community events and 6 focus groups

- Dementia awareness rose from **49% to 88%** in surveyed groups
- Confidence to discuss dementia symptoms rose from **49% to 93%**
- Lived experience used to ensure cultural competence and reduce stigma

The CDC pathway demonstrates that integrating voluntary sector expertise into the diagnostic stage improves both clinical outcomes and the human experience of diagnosis.

**Strategic Impact:** Transitioning from identified neuro-imaging bottlenecks to leveraging the new **Corby Community Diagnostic Centre** drastically optimises the dementia assessment pathway and expands local clinical capacity.

### **Bowel Cancer Awareness – Targeted Community Engagement**

#### **Context**

Local data identified lower uptake of bowel cancer screening within a number of communities, including Beaumont Leys, Belgrave, Highfields, New Parks, St Matthews and Spinney Hill. This highlighted the need for a more targeted approach to raise awareness, address barriers to participation and support eligible people to engage with the bowel cancer screening programme.

#### **Action**

The ICB worked in partnership with Public Health, UHL and VCSE organisations to deliver targeted bowel cancer screening awareness sessions within local community and workplace settings, including NEXT plc, Wesley Hall and Spinney Hills Support Service.

The sessions focused on:

- raising awareness of bowel cancer screening and the importance of early detection
- explaining who is eligible for screening and how the home screening kit works
- providing practical guidance on completing and returning the kit
- explaining how to request a replacement kit where the original had been lost or discarded
- addressing common concerns, misconceptions and barriers through interactive Q&A sessions; and
- signposting participants to relevant healthcare and support services.

Working with community and NHS partners enabled the sessions to be tailored to the communities being reached, including delivery in English and Gujarati, helping to provide information in a culturally appropriate and accessible way.

#### **Impact**

Participant feedback was highly positive and demonstrated the value of taking health information directly into community and workplace settings.

Importantly, the sessions helped to address some of the practical and perceived barriers that had prevented people from completing their screening kits. Participants who had previously been hesitant about taking part reported that they now intended to complete their kit and encourage family and friends to participate. Individuals who had previously discarded their screening kit also reported that they would request a replacement and complete the test.

The work demonstrates how using local data to identify areas of lower uptake, combined with targeted partnership working and culturally appropriate community engagement, can help address barriers to screening and increase people's confidence and intention to participate.

## **Women's Health – Developing an Integrated Primary Care Women's Health Hub**

### **Context**

North West Leicestershire GP Federation has delivered the Women's Health Hub for Leicestershire since June 2024, providing women with access to a range of services closer to home, including menopause care, contraception, support for heavy menstrual bleeding and cancer prevention.

The model was developed to improve access to specialist women's health support within Primary Care, reduce avoidable referrals into secondary care and develop a more sustainable workforce model.

Feedback from women attending the initial menopause pilot also highlighted the importance of looking beyond medical treatment and providing more holistic support that considered the wider factors affecting women's health and wellbeing.

### **Action**

The Women's Health Hub has developed a Primary Care-led model which brings specialist women's health expertise closer to local communities.

The service is predominantly delivered by specialist nurses and pharmacists, with oversight from GP clinical leads. Investment has been made in developing and accrediting the local workforce, including expanding access to British Menopause Society specialist expertise within Leicestershire. Over time, the workforce model has shifted from being predominantly GP-delivered towards greater use of specialist pharmacy capacity, providing a more sustainable model while maintaining clinical oversight and standards.

In response to feedback from women, the Federation has also worked with the North West Leicestershire Integrated Neighbourhood Team (INT) to broaden the offer beyond clinical appointments. Women's health group sessions have been delivered within local Neighbourhoods, alongside the development of My Active Menopause, a locally funded programme providing group-based support across a range of health and wellbeing topics.

A targeted approach has also been taken to improve cervical screening among women who had previously not responded to screening invitations. A Cancer Care Coordinator proactively contacted women to discuss screening and encourage attendance. Access was made more flexible through appointments available six days a week, including a Saturday walk-in offer.

Women attending for cervical screening are provided with additional appointment time where needed, enabling nurses to offer reassurance and support and address concerns that may previously have prevented attendance.

### **Impact**

The model has demonstrated significant activity and impact:

- 7,000 women have been seen through the Women's Health Hub since June 2024 – approximately 50% higher than anticipated activity.
- Patient satisfaction is 99%.
- Monitoring of practices using the Hub has identified a 35% reduction in first outpatient Gynaecology referrals over the period measured.
- The model has supported development of specialist women's health skills within the local Primary Care workforce and a shift towards a more sustainable multidisciplinary workforce model.

- 1,225 cervical smears have been completed through the Hub among women who had previously not responded to screening invitations.
- Among this group, cervical screening was overdue by an average of 9.2 years, with the longest period being 24 years.

The cervical screening work is particularly important in demonstrating the impact of moving beyond a traditional appointment-based model. Proactive contact, additional time to address individual concerns and more flexible access have enabled the service to reach women who had remained outside routine screening for significant periods of time.

### **Best Practice and Wider Learning**

The Women's Health Hub demonstrates how a Primary Care-led model can provide specialist women's health support closer to home while reducing reliance on secondary care.

Key elements of the approach include:

- using a multidisciplinary workforce to provide specialist care sustainably
- investing in workforce development and accreditation
- using patient feedback to shape and broaden the service offer
- working through Integrated Neighbourhood Teams and community settings to provide more holistic support
- proactively identifying and engaging women who are less likely to access routine services
- providing flexible access and additional support where traditional approaches have not worked; and
- monitoring activity, patient experience and secondary-care referrals to understand impact.

The model provides an opportunity to consider how the approach could be adapted and delivered more widely, recognising the importance of local population need, existing Primary Care capacity and connectivity with developing Neighbourhood arrangements.

### **Integrated Working Enabled Through Digital Governance Solution**

Northamptonshire Leads for Information Governance and Data Sharing worked together to create system IG portal where evidence of compliance with national standards and best practice from each Partner could be deposited and held alongside an overarching set of principles, agreed reasons and intent for sharing information, to support the creation of data sharing agreements. Initially focused on statutory health and social care partners the portal was able to expand to also house evidence of Voluntary Sector partners, who could evidence compliance to the core standards required.

Specific data sharing agreements created on the platform are then submitted to the portal for the partner IG leads to access and approve, and through their SIRO arrangements receive senior approval on behalf of each individual organisation.

The Community Healthcare Trust acts as lead provider for those partner organisations whose service delivery is covered under the sharing agreement. It ensures IG training compliance for the Community Trust as well as that held by the person for their own employer organisation. The Community Trust then provides NHS digital equipment, phone / laptop to enable the team member to update to the patient record. Partner team members also have to ensure applicable information is recorded correctly in their own organisation's records e.g. charity log.

Northamptonshire has established the Northamptonshire Shared Care Record (NCR) which is a read only presentation of key information pulled through interoperability solutions from providers patient record systems. This improves clinical safety and outcomes allowing authorised persons to see a broader set of available information to help with decision making and actions. The system also holds key information such as RESPECT forms which are created within the NCR.

The below shared part of the CF visit

The New models of care programme across Northamptonshire is providing an increase in same day GP appointments and proactive management of rising risk patients, supporting a neighbourhood based model of care

The LUCID model of care for Chronic Kidney Disease, proactively identifying patients at risk of exacerbation and enabling a whole-system MDT approach to management of patients with CKD in the community

The Age Well programme in North Northamptonshire which is showing evidence of managing acute demand, with 9 fewer emergency admissions per day than plan for your 65+ cohort and achieving a 4.92/5 patient rating

In LLR, the Pre-Transfer Clinical Decision and Assessment service which provides neighbourhood based care for your most vulnerable patients, avoiding hospital admission where safe to do so and upskilling your clinical community through active learning with senior GP's and Geriatricians. This service has been running for a number of years and has maintained an 80%+ non-conveyance rate.

Across Leicester City, the tailored place-based Integrated Crisis Response services support admission avoidance through neighbourhood based integrated health and care services, and post-admission, support vulnerable cohorts of patients home quickly and safely. These jointly commissioned services evidence the power of place-based commissioning across local government and the NHS

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**Neighbourhood health Stage 1 self-assessment: S1 to S10 scoring instrument**

*Neighbourhood Health Framework, 17 March 2026. Self-assessment for each Place: ten factors per requirement, 1 point each: 10 per stage, 100 in total, per Place. Final review version, August 2026.*

Purpose. This self-assessment replaces the earlier (RAG rated) place maturity assessments. Please tick what is evidenced and sum for each stage and overall. It is a development tool that helps identify progress over a multi-year plan - we are expecting most systems to score 20-30 points currently - but have plans that will increase points over the coming 6-18 months. This self-assessment was developed by the national neighbourhood health team through the 2026 baseline visit programme and refined through co-creation with ICB, NHS England regional and clinical, and DHSC colleagues. The ten requirements in Section 1 are verbatim from the Neighbourhood Health Framework (17 March 2026). Section 6 references the NHSE community health services waiting times action lists and checklist (March 2026). Items that touch local authority or voluntary sector delivery are completed jointly with those partners.

Comments, completed test self-assessments and suggestions are welcome and should be sent to the national neighbourhood health team, and will inform the next iteration.

**1. The ten Stage 1 minimum requirements**

These are the ten stages from the Neighbourhood Health Framework, in published order. S-codes follow that order.

| Code      | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                                           |
|-----------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S1</b> | <b>Urgent, rehabilitation and reablement capacity</b> | Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.                     |
| <b>S2</b> | <b>General practice access and variation</b>          | Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements. |
| <b>S3</b> | <b>Neighbourhood footprints</b>                       | Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).                                                                                                         |
| <b>S4</b> | <b>INTs for priority cohorts and devolved budgets</b> | Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.                                                                                                         |
| <b>S5</b> | <b>Neighbourhood approach to elective pathways</b>    | Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.   |
| <b>S6</b> | <b>Community waits</b>                                | Confirm plans to meet 18-week community waits and eliminate 52-week waits.                                                                                                                                                             |

| Code       | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                    |
|------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S7</b>  | <b>Better Care Fund pooled funding</b>                | Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care. |
| <b>S8</b>  | <b>Primary and secondary care interface</b>           | Continue to improve the primary and secondary care interface in line with the red tape challenge.                                                                                                               |
| <b>S9</b>  | <b>Organisational ownership</b>                       | Confirm organisational ownership of planned deliverables.                                                                                                                                                       |
| <b>S10</b> | <b>Data sharing for identification and evaluation</b> | Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.                                                                                 |

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## 2. The self-assessment for each Place

### S1. Urgent, rehabilitation and reablement capacity

*Framework requirement: Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.*

The model: an integrated care coordination centre across place. One contact point holding clinical risk takes referrals in from general practice but also 111, out of hours, discharge teams, and in the most mature the public. It admits directly out to the services that keep people at home, including social care reablement, extends to 24 hour operation.

| Factor                               | Item (1 point each)                                                                                                                                                                                              | Tick                     | Points       |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S1-F1</b>                         | Single professional contact point (urgent care SPoA / integrated coordination centre): one call gives a professional access to multiple services for their patient (e.g. UCR / rapid response, hospital at home) | √                        | 1            |
|                                      | A named clinician on duty in the integrated coordination centre holds the clinical risk                                                                                                                          | √                        | 1            |
| <b>S1-F2</b>                         | Core professional referral routes in place: general practice, 111/CAS, GP out of hours and hospital discharge teams.                                                                                             | √                        | 1            |
|                                      | Core referral routes out in place: the centre is able to admit to, or directly deploy: UCR, rapid response, step-up and step-down intermediate care, virtual ward, hospital at home, and social care reablement. | √                        | 1            |
| <b>S1-F3</b>                         | Centre is open at least 12 hours a day, 7 days a week                                                                                                                                                            | √                        | 1            |
|                                      | Centre is open 24 hours a day, 7 days a week                                                                                                                                                                     | √                        | 1            |
| <b>S1-F4</b>                         | Gold line is in place: direct public access line for patients / carers of the end-of-life care cohort                                                                                                            | <input type="checkbox"/> | 1            |
|                                      | Silver line is in place: direct public access line for patients / carers of the adult complex care cohort                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S1-F5</b>                         | Impact is being measured: place-wide non-elective activity baseline defined and in place.                                                                                                                        | √                        | 1            |
|                                      | Impact is being reported: non-elective activity data produced and reviewed at least quarterly to assess impact against the baseline and goes through the board at least twice a year.                            | √                        | 1            |
|                                      |                                                                                                                                                                                                                  |                          |              |
| <b>S1 stage total (sum of ticks)</b> |                                                                                                                                                                                                                  | <b>8</b>                 | <b>of 10</b> |

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## S2. General practice access and variation

*Framework requirement: Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements.*

The model: there is a named accountable person who reports at least quarterly in public Board on plans and progress related to GP core hours, phone access, urgent access and patient experience. There is also a named provider with improvement capability that is commissioned to support practices in difficulty with improvement. Public discussion is at place level; no item requires naming individual practices in public.

| Factor       | Item (1 point each)                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S2-F1</b> | Accountability: a named accountable person in place responsible for tracking and improving unwarranted variation                              | √                        | 1            |
|              | There is a report on general practice variation taken to public Board outlining plans and progress at least quarterly.                        | <input type="checkbox"/> | 1            |
| <b>S2-F2</b> | Core hours: the data is collected and reviewed monthly                                                                                        | √                        | 1            |
|              | Core hours: position discussed in public                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S2-F3</b> | Urgent access: the data reviewed, with a tracker in place                                                                                     | √                        | 1            |
|              | Urgent access position discussed in public                                                                                                    | <input type="checkbox"/> | 1            |
| <b>S2-F4</b> | Patient experience: the GPPS data on phone access and overall experience are reviewed with discussions held with the practices in difficulty. | √                        | 1            |
|              | Patient experience position and plans for part of the public board discussions                                                                | <input type="checkbox"/> | 1            |
| <b>S2-F5</b> | Improvement support: a named provider in the place with the capability to support improvement in general practice                             | √                        | 1            |
|              | That provider commissioned to provide support to practices in difficulty                                                                      | √                        | 1            |
|              | <b>S2 stage total (sum of ticks)</b>                                                                                                          | <b>6</b>                 | <b>of 10</b> |

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### S3. Neighbourhood footprints

*Framework requirement: Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).*

The model: one agreed geography where there is alignment across general practice, PCNs, community and mental health teams, social care and voluntary sector. Footprints are grown from PCNs on JSNA evidence and post-LGR boundaries, signed off at the HWB. The full model includes co-location.

| Factor       | Item (1 point each)                                                                                   | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S3-F1</b> | Footprints agreed across the system and with the local authority.                                     | √                        | 1            |
|              | Footprints have been signed off at a public meeting of the HWB.                                       | √                        | 1            |
| <b>S3-F2</b> | PCNs aligned to the neighbourhood footprints with very few exceptions.                                | √                        | 1            |
|              | A clear named accountable leader is in place for each neighbourhood                                   | √                        | 1            |
| <b>S3-F3</b> | Community health services are organised with a dedicated team for each neighbourhood                  | <input type="checkbox"/> | 1            |
|              | Mental health services are organised with a dedicated team for each neighbourhood                     | √                        | 1            |
| <b>S3-F4</b> | A named VCFSE lead, or an agreed VCFSE representation arrangement is in place for each neighbourhood. | √                        | 1            |
|              | A named adult social care lead is in place for each neighbourhood                                     | √                        | 1            |
| <b>S3-F5</b> | There is co-location of teams (beyond general practice and PCNs) in some neighbourhoods               | <input type="checkbox"/> | 1            |
|              | There is co-location of teams (beyond general practice and PCNs) in the majority of neighbourhoods    | <input type="checkbox"/> | 1            |
|              | <b>S3 stage total (sum of ticks)</b>                                                                  | <b>7</b>                 | <b>of 10</b> |

### S4. INTs for priority cohorts and devolved budgets

*Framework requirement: Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.*

The model: the service for older complex adults, most often moderate to severe frailty, care home, housebound and end of life, consists of three components. The three components are proactive care, an MDT for those with elevated risk - which are covered in this stage - and a 24/7 reactive care component which is covered in Stage 1. The end-state model includes a delegated budget to support targeted interventions to drive healthy neighbourhood by tackling wider determinants for individuals or smaller cohorts within the neighbourhood.

| Factor       | Item (1 point each)                                                                                                        | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S4-F1</b> | Proactive care (model): GP-led proactive care for older adults with complex needs operating in at least one neighbourhood. | <input type="checkbox"/> | 1      |
|              | Proactive care model operating across all neighbourhoods.                                                                  | <input type="checkbox"/> | 1      |
| <b>S4-F2</b> | Proactive care (contract): a contract is in place, e.g. PCN DES variant, LES for all neighbourhoods.                       | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
|              | The proactive care contract contains a variable payment element linked to patient coverage or outcomes                                                                                        | <input type="checkbox"/> | 1            |
| <b>S4-F3</b> | Proactive care (volume): service has been commissioned for more than 0.5 percent of the registered population                                                                                 | <input type="checkbox"/> | 1            |
|              | Proactive care has been commissioned for at least 1 percent of the registered population                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S4-F4</b> | Elevated risk INT (model): an MDT of primary care, community, mental health and social care staff, with VCFSE, operating in at least one neighbourhood.                                       | <input type="checkbox"/> | 1            |
|              | The MDT model for elevated risk is operating across all neighbourhoods.                                                                                                                       | <input type="checkbox"/> | 1            |
| <b>S4-F5</b> | Healthy neighbourhood: local authority and VCFSE supporting individuals with targeted interventions that focus on wider determinants, e.g. youth workers, housing support, employment support | <input type="checkbox"/> | 1            |
|              | Delegated budget is in place to commission healthy neighbourhood partnership work addressing wider determinants                                                                               | <input type="checkbox"/> | 1            |
|              | <b>S4 stage total (sum of ticks)</b>                                                                                                                                                          | 0                        | <b>of 10</b> |

## S5. Neighbourhood approach to elective pathways

*Framework requirement: Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.*

The model: there are four outpatient reform models emerging: (i) trust-run community specialist clinics; (ii) GPwER running community tier 2 often with specialist support; (iii) commissioned GP and consultant shared care as the mechanism for reviewing referrals, waiting lists and follow-up lists; and (iv) a population-based relationship model with consultants and specialist nurses aligned to neighbourhoods, delivering care and supporting GPs and their teams.

| Factor       | Item (1 point each)                                                                                                                                | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S5-F1</b> | A plan is in place that maps the four models to named specialties, stating how each model's impact will be measured.                               | <input type="checkbox"/> | 1      |
|              | There is a named accountable lead for delivering the outpatient reform plan.                                                                       | <input type="checkbox"/> | 1      |
| <b>S5-F2</b> | There are trust-run subcontracted clinics, e.g. ENT (microsuction, tinnitus) or gynaecology (complex coils, pessaries), operating in one specialty | <input type="checkbox"/> | 1      |
|              | There are trust-run subcontracted clinics operating in more than one specialty                                                                     | <input type="checkbox"/> | 1      |
| <b>S5-F3</b> | There are GPwER tier 2 services commissioned in one specialty.                                                                                     | √                        | 1      |
|              | There are GPwER tier 2 services commissioned in more than one specialty                                                                            | √                        | 1      |

| Factor       | Item (1 point each)                                                                                                                              | Tick                     | Points       |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S5-F4</b> | There are commissioned GP and consultant shared care services operating in one specialty: reviewing referrals, waiting lists and follow-up lists | <input type="checkbox"/> | 1            |
|              | There are commissioned GP and consultant shared care services operating in multiple specialties                                                  | <input type="checkbox"/> | 1            |
| <b>S5-F5</b> | There is a population-based relationship model operating in one speciality.                                                                      | √                        | 1            |
|              | There is a population-based relationship model operating across all neighbourhoods in the place.                                                 | <input type="checkbox"/> | 1            |
|              | <b>S5 stage total (sum of ticks)</b>                                                                                                             | 3                        | <b>of 10</b> |

## S6. Community waits

*Framework requirement: Confirm plans to meet 18-week community waits and eliminate 52-week waits.*

The model: community waits, meaning the pathways reported in the CHS SitRep, solved by redesign doing the heavy lifting with waiting list initiatives clearing legacy backlogs alongside. Demand shaped before referral, post-diagnostic follow-up delivered through commissioned shared care so specialists are free to assess and diagnose, support in place whilst waiting in line with the NHSE community waiting times action lists and checklist (March 2026), and the published standards met on the way through. Neurodevelopmental waits are reported both included and excluded so positions are comparable across systems, and children's waits are identified separately: the same wait is a larger share of a child's life.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                                                      | Tick                     | Points |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S6-F1</b> | Trajectories confirmed and minuted for 18-week performance and 52-week elimination across the community pathways reported in the CHS SitRep, with adult and children's waits identified separately and stated both including and excluding neurodevelopmental pathways (autism and ADHD) | √                        | 1      |
|              | The data supporting the plan has been data quality assured through a quarterly technical and clinical validation process.                                                                                                                                                                | √                        | 1      |
| <b>S6-F2</b> | A plan agreed naming which pathways are to be redesigned in line with the NHSE community waiting times action lists and checklist (March 2026)                                                                                                                                           | √                        | 1      |
|              | Demonstrated progress on at least two pathways to give reassurance the plan is deliverable.                                                                                                                                                                                              | √                        | 1      |
| <b>S6-F3</b> | Post-diagnostic follow-up delivered through commissioned shared care arrangements on at least one pathway                                                                                                                                                                                | √                        | 1      |
|              | On the two longest-wait community pathways on published data, released specialist time evidenced                                                                                                                                                                                         | <input type="checkbox"/> | 1      |
| <b>S6-F4</b> | Demonstrated progress to the 2026/27 objective of 78 percent of waits under 18 weeks met with over 65 percent of waits under 18 weeks today.                                                                                                                                             | <input type="checkbox"/> | 1      |
|              | The 2026/27 objective of 78 percent of waits under 18 weeks met, or trajectory exceeded, on published data                                                                                                                                                                               | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S6-F5</b> | 52-week count falling on published data, or board-approved path to zero within the planning period | <input type="checkbox"/> | 1            |
|              | Zero 52-week waits                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S6 stage total (sum of ticks)</b>                                                               | 5                        | <b>of 10</b> |

### S7. Better Care Fund pooled funding

*Framework requirement: Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care.*

The model: pooled money working at both place and neighbourhood level. BCF confirmed with every local authority; joint assessment and decisions grounded in the JSNA and joint local health and wellbeing strategy; funds delegated to the footprints; BCF investment demonstrably changed in response to the neighbourhood health plan guidance, implemented and contractually underpinned; and inequalities impact measured scheme by scheme, reported annually in public at the HWB.

| Factor       | Item (1 point each)                                                                                                                                                          | Tick                     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S7-F1</b> | Joint BCF position confirmed with local authority.                                                                                                                           | √                        | 1            |
|              | Minimum mandated NHS contribution to adult social care has been met                                                                                                          | √                        | 1            |
| <b>S7-F2</b> | Joint assessment and decision-making route documented, with the assessment incorporating JSNA, the joint local health and wellbeing strategy, and NHS and social care demand | √                        | 1            |
|              | At least two funding decisions minuted in the last 12 months, including winter capacity planning                                                                             | √                        | 1            |
| <b>S7-F3</b> | At least one pooled scheme aligned to the neighbourhood footprints, with spend recorded                                                                                      | <input type="checkbox"/> | 1            |
|              | Changes to BCF investment planned in response to the neighbourhood health plan guidance, with the changes named                                                              | <input type="checkbox"/> | 1            |
| <b>S7-F4</b> | Those BCF investment changes implemented: the changed schemes in operation                                                                                                   | <input type="checkbox"/> | 1            |
|              | Underpinned by signed agreements (Section 75 or variation), operating                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S7-F5</b> | A named health inequalities measure per scheme, relating back to the JSNA                                                                                                    | <input type="checkbox"/> | 1            |
|              | Reported at least annually at the HWB in public, with results feeding the next funding round                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S7 stage total (sum of ticks)</b>                                                                                                                                         | 4                        | <b>of 10</b> |

## S8. Primary and secondary care interface

*Framework requirement: Continue to improve the primary and secondary care interface in line with the red tape challenge.*

The model: an interface working as one system. There is a documented priority plan, all providers and the full primary care family are in scope, operational and strategic meetings are in place, the red tape challenge changes are delivered in practice, and there is a shared workforce through joint leadership development and neighbourhood PAs in consultant job plans, with a named clinical SRO and PMO support.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                            | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S8-F1</b> | There is a documented interface priority plan aligned to the GIRFT checklist and red tape challenge, covering medicines management, digital and estates, with the full primary care family in scope (general practice, community pharmacy, dental, optometry). | <input type="checkbox"/> | 1            |
|              | All provider organisations, including community and mental health, have completed the self-assessment and use the data to target improvement.                                                                                                                  | √                        | 1            |
| <b>S8-F2</b> | Operational interface meetings are in place with the priority organisations identified through self-assessment, with agendas and action tracking.                                                                                                              | √                        | 1            |
|              | An agreed meeting cycle is operating with each provider organisation, with actions closing.                                                                                                                                                                    | √                        | 1            |
| <b>S8-F3</b> | Red tape challenge and GIRFT checklist changes are being delivered in at least one organisation.                                                                                                                                                               | <input type="checkbox"/> | 1            |
|              | Red tape challenge and GIRFT checklist changes are delivered by every provider, including a single patient record accessible for direct care.                                                                                                                  | <input type="checkbox"/> | 1            |
| <b>S8-F4</b> | A strategic interface meeting is held at least quarterly, with a named clinical SRO, PMO support and executive governance.                                                                                                                                     | √                        | 1            |
|              | An agreed clinical leadership development programme is in place, with participants active in the interface forums.                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S8-F5</b> | Job planning policy provides for neighbourhood PAs, with at least one signed job plan in the 10 high volume specialties.                                                                                                                                       | <input type="checkbox"/> | 1            |
|              | Local job planning rounds have resulted in neighbourhood PAs in more than half of specialties with neighbourhood-facing work.                                                                                                                                  | <input type="checkbox"/> | 1            |
|              | <b>S8 stage total (sum of ticks)</b>                                                                                                                                                                                                                           | <b>4</b>                 | <b>of 10</b> |

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## S9. Organisational ownership-

*Framework requirement: Confirm organisational ownership of planned deliverables.*

The model: clear ownership. There is a named accountable lead for every stage, taken through the Board, with an overall delivery owner in the ICB; a host, anchor or integrator in every place; general practice coordinated across the Place; and accountability exercised through working governance.

| Factor       | Item (1 point each)                                                                                                                                                           | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S9-F1</b> | There is a named accountable lead for at least 8 of the 10 Stage 1 requirements of the Neighbourhood Health Framework                                                         | √                        | 1            |
|              | There is a named accountable lead for all 10 stages which has been taken through the Board with an overall delivery owner in the ICB.                                         | <input type="checkbox"/> | 1            |
| <b>S9-F2</b> | A host, anchor or integrator is named in every place that is able to co-ordinate INT and neighbourhood development.                                                           | <input type="checkbox"/> | 1            |
|              | The host, anchor or integrator organisation has been commissioned.                                                                                                            | <input type="checkbox"/> | 1            |
| <b>S9-F3</b> | The general practice foundation for neighbourhoods is organised and coordinated across Place through an organisation which has the support of the vast majority of practices. | √                        | 1            |
|              | The organisation that is coordinating general practice has been commissioned.                                                                                                 | <input type="checkbox"/> | 1            |
| <b>S9-F4</b> | Scheme of delegation or terms of reference documented for the integrator                                                                                                      | <input type="checkbox"/> | 1            |
|              | Exercised, with decisions minuted                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S9-F5</b> | Delivery reporting established                                                                                                                                                | <input type="checkbox"/> | 1            |
|              | At least two consecutive cycles with actions and escalation recorded                                                                                                          | <input type="checkbox"/> | 1            |
|              | <b>S9 stage total (sum of ticks)</b>                                                                                                                                          | <b>2</b>                 | <b>of 10</b> |

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## S10. Data sharing for identification and evaluation

*Framework requirement: Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.*

The model: data sharing signed and used. Every sector signed up, general practice counted by share of practices, enabling the risk stratification and single patient record that are scored where they operate (S4 and S8). VCFSE and smaller partner sign-up is expected to come with information governance support from the system; the item scores the arrangement being in place, not unsupported compliance.

| Factor        | Item (1 point each)                                                                         | Tick                     | Points       |
|---------------|---------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S10-F1</b> | More than 90 percent of practices signed up to the data sharing arrangements.               | √                        | 1            |
|               | More than 99 percent of practices signed up to data sharing arrangements.                   | √                        | 1            |
| <b>S10-F2</b> | Acute trusts signed up, with data in active use, particularly in emergency department areas | √                        | 1            |
|               | Community services signed up and data in active use                                         | √                        | 1            |
| <b>S10-F3</b> | Mental health trust signed up to data sharing arrangements and data in active use           | <input type="checkbox"/> | 1            |
|               | Social care signed up to data sharing arrangements and data in active use                   | √                        | 1            |
| <b>S10-F4</b> | VCFSE signed up and data in active use                                                      | <input type="checkbox"/> | 1            |
|               | Other partners including community pharmacy signed up and data in active use                | <input type="checkbox"/> | 1            |
| <b>S10-F5</b> | Optometry signed up and data in active use                                                  | <input type="checkbox"/> | 1            |
|               | Dental signed up and data in active use                                                     | <input type="checkbox"/> | 1            |
|               | <b>S10 stage total (sum of ticks)</b>                                                       | <b>4</b>                 | <b>of 10</b> |

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### 3. Glossary

Terms as used in this self-assessment.

| Term              | Meaning                                                                                      |
|-------------------|----------------------------------------------------------------------------------------------|
| <b>BCF</b>        | Better Care Fund                                                                             |
| <b>CAS</b>        | Clinical assessment service (within NHS 111)                                                 |
| <b>CHS SitRep</b> | Community health services situation report (the national community waiting times collection) |
| <b>DES / LES</b>  | Directed enhanced service / local enhanced service (general practice contract routes)        |
| <b>GIRFT</b>      | Getting It Right First Time                                                                  |
| <b>GMS</b>        | General medical services (the national GP contract)                                          |
| <b>GPPS</b>       | GP Patient Survey                                                                            |
| <b>GPwER</b>      | GP with an extended role                                                                     |
| <b>HWB</b>        | Health and wellbeing board                                                                   |
| <b>INT</b>        | Integrated neighbourhood team                                                                |
| <b>JSNA</b>       | Joint strategic needs assessment                                                             |
| <b>MDT</b>        | Multidisciplinary team                                                                       |
| <b>PAs</b>        | Programmed activities (consultant job plan sessions)                                         |
| <b>PCN</b>        | Primary care network                                                                         |
| <b>RTT</b>        | Referral to treatment (the 18-week elective standard)                                        |
| <b>PMO</b>        | Programme management office                                                                  |
| <b>SRO</b>        | Senior responsible owner                                                                     |
| <b>SPoA</b>       | Single point of access                                                                       |
| <b>UCR</b>        | Urgent community response                                                                    |
| <b>VCFSE</b>      | Voluntary, community, faith and social enterprise sector                                     |

**Neighbourhood health Stage 1 self-assessment: S1 to S10 scoring instrument**

*Neighbourhood Health Framework, 17 March 2026. Self-assessment for each Place: ten factors per requirement, 1 point each: 10 per stage, 100 in total, per Place. Final review version, August 2026.*

Purpose. This self-assessment replaces the earlier (RAG rated) place maturity assessments. Please tick what is evidenced and sum for each stage and overall. It is a development tool that helps identify progress over a multi-year plan - we are expecting most systems to score 20-30 points currently - but have plans that will increase points over the coming 6-18 months. This self-assessment was developed by the national neighbourhood health team through the 2026 baseline visit programme and refined through co-creation with ICB, NHS England regional and clinical, and DHSC colleagues. The ten requirements in Section 1 are verbatim from the Neighbourhood Health Framework (17 March 2026). Section 6 references the NHSE community health services waiting times action lists and checklist (March 2026). Items that touch local authority or voluntary sector delivery are completed jointly with those partners.

Comments, completed test self-assessments and suggestions are welcome and should be sent to the national neighbourhood health team, and will inform the next iteration.

**1. The ten Stage 1 minimum requirements**

These are the ten stages from the Neighbourhood Health Framework, in published order. S-codes follow that order.

| Code      | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                                           |
|-----------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S1</b> | <b>Urgent, rehabilitation and reablement capacity</b> | Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.                     |
| <b>S2</b> | <b>General practice access and variation</b>          | Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements. |
| <b>S3</b> | <b>Neighbourhood footprints</b>                       | Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).                                                                                                         |
| <b>S4</b> | <b>INTs for priority cohorts and devolved budgets</b> | Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.                                                                                                         |
| <b>S5</b> | <b>Neighbourhood approach to elective pathways</b>    | Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.   |
| <b>S6</b> | <b>Community waits</b>                                | Confirm plans to meet 18-week community waits and eliminate 52-week waits.                                                                                                                                                             |

| Code       | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                    |
|------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S7</b>  | <b>Better Care Fund pooled funding</b>                | Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care. |
| <b>S8</b>  | <b>Primary and secondary care interface</b>           | Continue to improve the primary and secondary care interface in line with the red tape challenge.                                                                                                               |
| <b>S9</b>  | <b>Organisational ownership</b>                       | Confirm organisational ownership of planned deliverables.                                                                                                                                                       |
| <b>S10</b> | <b>Data sharing for identification and evaluation</b> | Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.                                                                                 |

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## 2. The self-assessment for each Place

### S1. Urgent, rehabilitation and reablement capacity

*Framework requirement: Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.*

The model: an integrated care coordination centre across place. One contact point holding clinical risk takes referrals in from general practice but also 111, out of hours, discharge teams, and in the most mature the public. It admits directly out to the services that keep people at home, including social care reablement, extends to 24 hour operation.

| Factor                               | Item (1 point each)                                                                                                                                                                                              | Tick                     | Points       |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S1-F1</b>                         | Single professional contact point (urgent care SPoA / integrated coordination centre): one call gives a professional access to multiple services for their patient (e.g. UCR / rapid response, hospital at home) | √                        | 1            |
|                                      | A named clinician on duty in the integrated coordination centre holds the clinical risk                                                                                                                          | √                        | 1            |
| <b>S1-F2</b>                         | Core professional referral routes in place: general practice, 111/CAS, GP out of hours and hospital discharge teams.                                                                                             | √                        | 1            |
|                                      | Core referral routes out in place: the centre is able to admit to, or directly deploy: UCR, rapid response, step-up and step-down intermediate care, virtual ward, hospital at home, and social care reablement. | √                        | 1            |
| <b>S1-F3</b>                         | Centre is open at least 12 hours a day, 7 days a week                                                                                                                                                            | √                        | 1            |
|                                      | Centre is open 24 hours a day, 7 days a week                                                                                                                                                                     | √                        | 1            |
| <b>S1-F4</b>                         | Gold line is in place: direct public access line for patients / carers of the end-of-life care cohort                                                                                                            | <input type="checkbox"/> | 1            |
|                                      | Silver line is in place: direct public access line for patients / carers of the adult complex care cohort                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S1-F5</b>                         | Impact is being measured: place-wide non-elective activity baseline defined and in place.                                                                                                                        | √                        | 1            |
|                                      | Impact is being reported: non-elective activity data produced and reviewed at least quarterly to assess impact against the baseline and goes through the board at least twice a year.                            | √                        | 1            |
|                                      |                                                                                                                                                                                                                  |                          |              |
| <b>S1 stage total (sum of ticks)</b> |                                                                                                                                                                                                                  | <b>8</b>                 | <b>of 10</b> |

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## S2. General practice access and variation

*Framework requirement: Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements.*

The model: there is a named accountable person who reports at least quarterly in public Board on plans and progress related to GP core hours, phone access, urgent access and patient experience. There is also a named provider with improvement capability that is commissioned to support practices in difficulty with improvement. Public discussion is at place level; no item requires naming individual practices in public.

| Factor       | Item (1 point each)                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S2-F1</b> | Accountability: a named accountable person in place responsible for tracking and improving unwarranted variation                              | √                        | 1            |
|              | There is a report on general practice variation taken to public Board outlining plans and progress at least quarterly.                        | <input type="checkbox"/> | 1            |
| <b>S2-F2</b> | Core hours: the data is collected and reviewed monthly                                                                                        | √                        | 1            |
|              | Core hours: position discussed in public                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S2-F3</b> | Urgent access: the data reviewed, with a tracker in place                                                                                     | √                        | 1            |
|              | Urgent access position discussed in public                                                                                                    | <input type="checkbox"/> | 1            |
| <b>S2-F4</b> | Patient experience: the GPPS data on phone access and overall experience are reviewed with discussions held with the practices in difficulty. | √                        | 1            |
|              | Patient experience position and plans for part of the public board discussions                                                                | <input type="checkbox"/> | 1            |
| <b>S2-F5</b> | Improvement support: a named provider in the place with the capability to support improvement in general practice                             | √                        | 1            |
|              | That provider commissioned to provide support to practices in difficulty                                                                      | √                        | 1            |
|              | <b>S2 stage total (sum of ticks)</b>                                                                                                          | <b>6</b>                 | <b>of 10</b> |

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### S3. Neighbourhood footprints

*Framework requirement: Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).*

The model: one agreed geography where there is alignment across general practice, PCNs, community and mental health teams, social care and voluntary sector. Footprints are grown from PCNs on JSNA evidence and post-LGR boundaries, signed off at the HWB. The full model includes co-location.

| Factor       | Item (1 point each)                                                                                   | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S3-F1</b> | Footprints agreed across the system and with the local authority.                                     | √                        | 1            |
|              | Footprints have been signed off at a public meeting of the HWB.                                       | √                        | 1            |
| <b>S3-F2</b> | PCNs aligned to the neighbourhood footprints with very few exceptions.                                | √                        | 1            |
|              | A clear named accountable leader is in place for each neighbourhood                                   | √                        | 1            |
| <b>S3-F3</b> | Community health services are organised with a dedicated team for each neighbourhood                  | <input type="checkbox"/> | 1            |
|              | Mental health services are organised with a dedicated team for each neighbourhood                     | √                        | 1            |
| <b>S3-F4</b> | A named VCFSE lead, or an agreed VCFSE representation arrangement is in place for each neighbourhood. | √                        | 1            |
|              | A named adult social care lead is in place for each neighbourhood                                     | √                        | 1            |
| <b>S3-F5</b> | There is co-location of teams (beyond general practice and PCNs) in some neighbourhoods               | <input type="checkbox"/> | 1            |
|              | There is co-location of teams (beyond general practice and PCNs) in the majority of neighbourhoods    | <input type="checkbox"/> | 1            |
|              | <b>S3 stage total (sum of ticks)</b>                                                                  | <b>7</b>                 | <b>of 10</b> |

### S4. INTs for priority cohorts and devolved budgets

*Framework requirement: Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.*

The model: the service for older complex adults, most often moderate to severe frailty, care home, housebound and end of life, consists of three components. The three components are proactive care, an MDT for those with elevated risk - which are covered in this stage - and a 24/7 reactive care component which is covered in Stage 1. The end-state model includes a delegated budget to support targeted interventions to drive healthy neighbourhood by tackling wider determinants for individuals or smaller cohorts within the neighbourhood.

| Factor       | Item (1 point each)                                                                                                        | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S4-F1</b> | Proactive care (model): GP-led proactive care for older adults with complex needs operating in at least one neighbourhood. | <input type="checkbox"/> | 1      |
|              | Proactive care model operating across all neighbourhoods.                                                                  | <input type="checkbox"/> | 1      |
| <b>S4-F2</b> | Proactive care (contract): a contract is in place, e.g. PCN DES variant, LES for all neighbourhoods.                       | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
|              | The proactive care contract contains a variable payment element linked to patient coverage or outcomes                                                                                        | <input type="checkbox"/> | 1            |
| <b>S4-F3</b> | Proactive care (volume): service has been commissioned for more than 0.5 percent of the registered population                                                                                 | <input type="checkbox"/> | 1            |
|              | Proactive care has been commissioned for at least 1 percent of the registered population                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S4-F4</b> | Elevated risk INT (model): an MDT of primary care, community, mental health and social care staff, with VCFSE, operating in at least one neighbourhood.                                       | <input type="checkbox"/> | 1            |
|              | The MDT model for elevated risk is operating across all neighbourhoods.                                                                                                                       | <input type="checkbox"/> | 1            |
| <b>S4-F5</b> | Healthy neighbourhood: local authority and VCFSE supporting individuals with targeted interventions that focus on wider determinants, e.g. youth workers, housing support, employment support | <input type="checkbox"/> | 1            |
|              | Delegated budget is in place to commission healthy neighbourhood partnership work addressing wider determinants                                                                               | <input type="checkbox"/> | 1            |
|              | <b>S4 stage total (sum of ticks)</b>                                                                                                                                                          | 0                        | <b>of 10</b> |

## S5. Neighbourhood approach to elective pathways

*Framework requirement: Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.*

The model: there are four outpatient reform models emerging: (i) trust-run community specialist clinics; (ii) GPwER running community tier 2 often with specialist support; (iii) commissioned GP and consultant shared care as the mechanism for reviewing referrals, waiting lists and follow-up lists; and (iv) a population-based relationship model with consultants and specialist nurses aligned to neighbourhoods, delivering care and supporting GPs and their teams.

| Factor       | Item (1 point each)                                                                                                                                | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S5-F1</b> | A plan is in place that maps the four models to named specialties, stating how each model's impact will be measured.                               | <input type="checkbox"/> | 1      |
|              | There is a named accountable lead for delivering the outpatient reform plan.                                                                       | <input type="checkbox"/> | 1      |
| <b>S5-F2</b> | There are trust-run subcontracted clinics, e.g. ENT (microsuction, tinnitus) or gynaecology (complex coils, pessaries), operating in one specialty | <input type="checkbox"/> | 1      |
|              | There are trust-run subcontracted clinics operating in more than one specialty                                                                     | <input type="checkbox"/> | 1      |
| <b>S5-F3</b> | There are GPwER tier 2 services commissioned in one specialty.                                                                                     | √                        | 1      |
|              | There are GPwER tier 2 services commissioned in more than one specialty                                                                            | √                        | 1      |

| Factor       | Item (1 point each)                                                                                                                              | Tick                     | Points       |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S5-F4</b> | There are commissioned GP and consultant shared care services operating in one specialty: reviewing referrals, waiting lists and follow-up lists | <input type="checkbox"/> | 1            |
|              | There are commissioned GP and consultant shared care services operating in multiple specialties                                                  | <input type="checkbox"/> | 1            |
| <b>S5-F5</b> | There is a population-based relationship model operating in one speciality.                                                                      | √                        | 1            |
|              | There is a population-based relationship model operating across all neighbourhoods in the place.                                                 | <input type="checkbox"/> | 1            |
|              | <b>S5 stage total (sum of ticks)</b>                                                                                                             | 3                        | <b>of 10</b> |

## S6. Community waits

*Framework requirement: Confirm plans to meet 18-week community waits and eliminate 52-week waits.*

The model: community waits, meaning the pathways reported in the CHS SitRep, solved by redesign doing the heavy lifting with waiting list initiatives clearing legacy backlogs alongside. Demand shaped before referral, post-diagnostic follow-up delivered through commissioned shared care so specialists are free to assess and diagnose, support in place whilst waiting in line with the NHSE community waiting times action lists and checklist (March 2026), and the published standards met on the way through. Neurodevelopmental waits are reported both included and excluded so positions are comparable across systems, and children's waits are identified separately: the same wait is a larger share of a child's life.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                                                      | Tick                     | Points |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S6-F1</b> | Trajectories confirmed and minuted for 18-week performance and 52-week elimination across the community pathways reported in the CHS SitRep, with adult and children's waits identified separately and stated both including and excluding neurodevelopmental pathways (autism and ADHD) | √                        | 1      |
|              | The data supporting the plan has been data quality assured through a quarterly technical and clinical validation process.                                                                                                                                                                | √                        | 1      |
| <b>S6-F2</b> | A plan agreed naming which pathways are to be redesigned in line with the NHSE community waiting times action lists and checklist (March 2026)                                                                                                                                           | √                        | 1      |
|              | Demonstrated progress on at least two pathways to give reassurance the plan is deliverable.                                                                                                                                                                                              | √                        | 1      |
| <b>S6-F3</b> | Post-diagnostic follow-up delivered through commissioned shared care arrangements on at least one pathway                                                                                                                                                                                | √                        | 1      |
|              | On the two longest-wait community pathways on published data, released specialist time evidenced                                                                                                                                                                                         | <input type="checkbox"/> | 1      |
| <b>S6-F4</b> | Demonstrated progress to the 2026/27 objective of 78 percent of waits under 18 weeks met with over 65 percent of waits under 18 weeks today.                                                                                                                                             | <input type="checkbox"/> | 1      |
|              | The 2026/27 objective of 78 percent of waits under 18 weeks met, or trajectory exceeded, on published data                                                                                                                                                                               | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S6-F5</b> | 52-week count falling on published data, or board-approved path to zero within the planning period | <input type="checkbox"/> | 1            |
|              | Zero 52-week waits                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S6 stage total (sum of ticks)</b>                                                               | 5                        | <b>of 10</b> |

### S7. Better Care Fund pooled funding

*Framework requirement: Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care.*

The model: pooled money working at both place and neighbourhood level. BCF confirmed with every local authority; joint assessment and decisions grounded in the JSNA and joint local health and wellbeing strategy; funds delegated to the footprints; BCF investment demonstrably changed in response to the neighbourhood health plan guidance, implemented and contractually underpinned; and inequalities impact measured scheme by scheme, reported annually in public at the HWB.

| Factor       | Item (1 point each)                                                                                                                                                          | Tick                     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S7-F1</b> | Joint BCF position confirmed with local authority.                                                                                                                           | √                        | 1            |
|              | Minimum mandated NHS contribution to adult social care has been met                                                                                                          | √                        | 1            |
| <b>S7-F2</b> | Joint assessment and decision-making route documented, with the assessment incorporating JSNA, the joint local health and wellbeing strategy, and NHS and social care demand | √                        | 1            |
|              | At least two funding decisions minuted in the last 12 months, including winter capacity planning                                                                             | √                        | 1            |
| <b>S7-F3</b> | At least one pooled scheme aligned to the neighbourhood footprints, with spend recorded                                                                                      | <input type="checkbox"/> | 1            |
|              | Changes to BCF investment planned in response to the neighbourhood health plan guidance, with the changes named                                                              | <input type="checkbox"/> | 1            |
| <b>S7-F4</b> | Those BCF investment changes implemented: the changed schemes in operation                                                                                                   | <input type="checkbox"/> | 1            |
|              | Underpinned by signed agreements (Section 75 or variation), operating                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S7-F5</b> | A named health inequalities measure per scheme, relating back to the JSNA                                                                                                    | <input type="checkbox"/> | 1            |
|              | Reported at least annually at the HWB in public, with results feeding the next funding round                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S7 stage total (sum of ticks)</b>                                                                                                                                         | 4                        | <b>of 10</b> |

## S8. Primary and secondary care interface

*Framework requirement: Continue to improve the primary and secondary care interface in line with the red tape challenge.*

The model: an interface working as one system. There is a documented priority plan, all providers and the full primary care family are in scope, operational and strategic meetings are in place, the red tape challenge changes are delivered in practice, and there is a shared workforce through joint leadership development and neighbourhood PAs in consultant job plans, with a named clinical SRO and PMO support.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                            | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S8-F1</b> | There is a documented interface priority plan aligned to the GIRFT checklist and red tape challenge, covering medicines management, digital and estates, with the full primary care family in scope (general practice, community pharmacy, dental, optometry). | <input type="checkbox"/> | 1            |
|              | All provider organisations, including community and mental health, have completed the self-assessment and use the data to target improvement.                                                                                                                  | √                        | 1            |
| <b>S8-F2</b> | Operational interface meetings are in place with the priority organisations identified through self-assessment, with agendas and action tracking.                                                                                                              | √                        | 1            |
|              | An agreed meeting cycle is operating with each provider organisation, with actions closing.                                                                                                                                                                    | √                        | 1            |
| <b>S8-F3</b> | Red tape challenge and GIRFT checklist changes are being delivered in at least one organisation.                                                                                                                                                               | <input type="checkbox"/> | 1            |
|              | Red tape challenge and GIRFT checklist changes are delivered by every provider, including a single patient record accessible for direct care.                                                                                                                  | <input type="checkbox"/> | 1            |
| <b>S8-F4</b> | A strategic interface meeting is held at least quarterly, with a named clinical SRO, PMO support and executive governance.                                                                                                                                     | √                        | 1            |
|              | An agreed clinical leadership development programme is in place, with participants active in the interface forums.                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S8-F5</b> | Job planning policy provides for neighbourhood PAs, with at least one signed job plan in the 10 high volume specialties.                                                                                                                                       | <input type="checkbox"/> | 1            |
|              | Local job planning rounds have resulted in neighbourhood PAs in more than half of specialties with neighbourhood-facing work.                                                                                                                                  | <input type="checkbox"/> | 1            |
|              | <b>S8 stage total (sum of ticks)</b>                                                                                                                                                                                                                           | <b>4</b>                 | <b>of 10</b> |

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## S9. Organisational ownership

*Framework requirement: Confirm organisational ownership of planned deliverables.*

The model: clear ownership. There is a named accountable lead for every stage, taken through the Board, with an overall delivery owner in the ICB; a host, anchor or integrator in every place; general practice coordinated across the Place; and accountability exercised through working governance.

| Factor       | Item (1 point each)                                                                                                                                                           | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S9-F1</b> | There is a named accountable lead for at least 8 of the 10 Stage 1 requirements of the Neighbourhood Health Framework                                                         | √                        | 1            |
|              | There is a named accountable lead for all 10 stages which has been taken through the Board with an overall delivery owner in the ICB.                                         | <input type="checkbox"/> | 1            |
| <b>S9-F2</b> | A host, anchor or integrator is named in every place that is able to co-ordinate INT and neighbourhood development.                                                           | <input type="checkbox"/> | 1            |
|              | The host, anchor or integrator organisation has been commissioned.                                                                                                            | <input type="checkbox"/> | 1            |
| <b>S9-F3</b> | The general practice foundation for neighbourhoods is organised and coordinated across Place through an organisation which has the support of the vast majority of practices. | √                        | 1            |
|              | The organisation that is coordinating general practice has been commissioned.                                                                                                 | <input type="checkbox"/> | 1            |
| <b>S9-F4</b> | Scheme of delegation or terms of reference documented for the integrator                                                                                                      | <input type="checkbox"/> | 1            |
|              | Exercised, with decisions minuted                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S9-F5</b> | Delivery reporting established                                                                                                                                                | <input type="checkbox"/> | 1            |
|              | At least two consecutive cycles with actions and escalation recorded                                                                                                          | <input type="checkbox"/> | 1            |
|              | <b>S9 stage total (sum of ticks)</b>                                                                                                                                          | <b>2</b>                 | <b>of 10</b> |

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S10. Data sharing for identification and evaluation

Framework requirement: Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.

The model: data sharing signed and used. Every sector signed up, general practice counted by share of practices, enabling the risk stratification and single patient record that are scored where they operate (S4 and S8). VCFSE and smaller partner sign-up is expected to come with information governance support from the system; the item scores the arrangement being in place, not unsupported compliance.

| Factor | Item (1 point each)                                                                         | Tick                     | Points |
|--------|---------------------------------------------------------------------------------------------|--------------------------|--------|
| S10-F1 | More than 90 percent of practices signed up to the data sharing arrangements.               | √                        | 1      |
|        | More than 99 percent of practices signed up to data sharing arrangements.                   | √                        | 1      |
| S10-F2 | Acute trusts signed up, with data in active use, particularly in emergency department areas | √                        | 1      |
|        | Community services signed up and data in active use                                         | √                        | 1      |
| S10-F3 | Mental health trust signed up to data sharing arrangements and data in active use           | <input type="checkbox"/> | 1      |
|        | Social care signed up to data sharing arrangements and data in active use                   | √                        | 1      |
| S10-F4 | VCFSE signed up and data in active use                                                      | <input type="checkbox"/> | 1      |
|        | Other partners including community pharmacy signed up and data in active use                | <input type="checkbox"/> | 1      |
| S10-F5 | Optometry signed up and data in active use                                                  | <input type="checkbox"/> | 1      |
|        | Dental signed up and data in active use                                                     | <input type="checkbox"/> | 1      |
|        | S10 stage total (sum of ticks)                                                              | 5                        | of 10  |

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### 3. Glossary

Terms as used in this self-assessment.

| Term              | Meaning                                                                                      |
|-------------------|----------------------------------------------------------------------------------------------|
| <b>BCF</b>        | Better Care Fund                                                                             |
| <b>CAS</b>        | Clinical assessment service (within NHS 111)                                                 |
| <b>CHS SitRep</b> | Community health services situation report (the national community waiting times collection) |
| <b>DES / LES</b>  | Directed enhanced service / local enhanced service (general practice contract routes)        |
| <b>GIRFT</b>      | Getting It Right First Time                                                                  |
| <b>GMS</b>        | General medical services (the national GP contract)                                          |
| <b>GPPS</b>       | GP Patient Survey                                                                            |
| <b>GPwER</b>      | GP with an extended role                                                                     |
| <b>HWB</b>        | Health and wellbeing board                                                                   |
| <b>INT</b>        | Integrated neighbourhood team                                                                |
| <b>JSNA</b>       | Joint strategic needs assessment                                                             |
| <b>MDT</b>        | Multidisciplinary team                                                                       |
| <b>PAs</b>        | Programmed activities (consultant job plan sessions)                                         |
| <b>PCN</b>        | Primary care network                                                                         |
| <b>RTT</b>        | Referral to treatment (the 18-week elective standard)                                        |
| <b>PMO</b>        | Programme management office                                                                  |
| <b>SRO</b>        | Senior responsible owner                                                                     |
| <b>SPoA</b>       | Single point of access                                                                       |
| <b>UCR</b>        | Urgent community response                                                                    |
| <b>VCFSE</b>      | Voluntary, community, faith and social enterprise sector                                     |

Neighbourhood health Stage 1 self-assessment: S1 to S10 scoring instrument

Neighbourhood Health Framework, 17 March 2026. Self-assessment for each Place: ten factors per requirement, 1 point each: 10 per stage, 100 in total, per Place. Final review version, August 2026.

Purpose. This self-assessment replaces the earlier (RAG rated) place maturity assessments. Please tick what is evidenced and sum for each stage and overall. It is a development tool that helps identify progress over a multi-year plan - we are expecting most systems to score 20-30 points currently - but have plans that will increase points over the coming 6-18 months. This self-assessment was developed by the national neighbourhood health team through the 2026 baseline visit programme and refined through co-creation with ICB, NHS England regional and clinical, and DHSC colleagues. The ten requirements in Section 1 are verbatim from the Neighbourhood Health Framework (17 March 2026). Section 6 references the NHSE community health services waiting times action lists and checklist (March 2026). Items that touch local authority or voluntary sector delivery are completed jointly with those partners.

Comments, completed test self-assessments and suggestions are welcome and should be sent to the national neighbourhood health team, and will inform the next iteration.

1. The ten Stage 1 minimum requirements

These are the ten stages from the Neighbourhood Health Framework, in published order. S-codes follow that order.

| Code | Short label                                    | Framework wording (verbatim)                                                                                                                                                                                                           |
|------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| S1   | Urgent, rehabilitation and reablement capacity | Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.                     |
| S2   | General practice access and variation          | Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements. |
| S3   | Neighbourhood footprints                       | Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).                                                                                                         |
| S4   | INTs for priority cohorts and devolved budgets | Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.                                                                                                         |
| S5   | Neighbourhood approach to elective pathways    | Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.   |
| S6   | Community waits                                | Confirm plans to meet 18-week community waits and eliminate 52-week waits.                                                                                                                                                             |

| Code       | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                    |
|------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S7</b>  | <b>Better Care Fund pooled funding</b>                | Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care. |
| <b>S8</b>  | <b>Primary and secondary care interface</b>           | Continue to improve the primary and secondary care interface in line with the red tape challenge.                                                                                                               |
| <b>S9</b>  | <b>Organisational ownership</b>                       | Confirm organisational ownership of planned deliverables.                                                                                                                                                       |
| <b>S10</b> | <b>Data sharing for identification and evaluation</b> | Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.                                                                                 |

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## 2. The self-assessment for each Place

### S1. Urgent, rehabilitation and reablement capacity

*Framework requirement: Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.*

The model: an integrated care coordination centre across place. One contact point holding clinical risk takes referrals in from general practice but also 111, out of hours, discharge teams, and in the most mature the public. It admits directly out to the services that keep people at home, including social care reablement, extends to 24 hour operation.

| Factor                               | Item (1 point each)                                                                                                                                                                                              | Tick                     | Points       |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S1-F1</b>                         | Single professional contact point (urgent care SPoA / integrated coordination centre): one call gives a professional access to multiple services for their patient (e.g. UCR / rapid response, hospital at home) | √                        | 1            |
|                                      | A named clinician on duty in the integrated coordination centre holds the clinical risk                                                                                                                          | √                        | 1            |
| <b>S1-F2</b>                         | Core professional referral routes in place: general practice, 111/CAS, GP out of hours and hospital discharge teams.                                                                                             | √                        | 1            |
|                                      | Core referral routes out in place: the centre is able to admit to, or directly deploy: UCR, rapid response, step-up and step-down intermediate care, virtual ward, hospital at home, and social care reablement. | √                        | 1            |
| <b>S1-F3</b>                         | Centre is open at least 12 hours a day, 7 days a week                                                                                                                                                            | √                        | 1            |
|                                      | Centre is open 24 hours a day, 7 days a week                                                                                                                                                                     | √                        | 1            |
| <b>S1-F4</b>                         | Gold line is in place: direct public access line for patients / carers of the end-of-life care cohort                                                                                                            | <input type="checkbox"/> | 1            |
|                                      | Silver line is in place: direct public access line for patients / carers of the adult complex care cohort                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S1-F5</b>                         | Impact is being measured: place-wide non-elective activity baseline defined and in place.                                                                                                                        | √                        | 1            |
|                                      | Impact is being reported: non-elective activity data produced and reviewed at least quarterly to assess impact against the baseline and goes through the board at least twice a year.                            | √                        | 1            |
|                                      |                                                                                                                                                                                                                  |                          |              |
| <b>S1 stage total (sum of ticks)</b> |                                                                                                                                                                                                                  | <b>8</b>                 | <b>of 10</b> |

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## S2. General practice access and variation

*Framework requirement: Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements.*

The model: there is a named accountable person who reports at least quarterly in public Board on plans and progress related to GP core hours, phone access, urgent access and patient experience. There is also a named provider with improvement capability that is commissioned to support practices in difficulty with improvement. Public discussion is at place level; no item requires naming individual practices in public.

| Factor       | Item (1 point each)                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S2-F1</b> | Accountability: a named accountable person in place responsible for tracking and improving unwarranted variation                              | √                        | 1            |
|              | There is a report on general practice variation taken to public Board outlining plans and progress at least quarterly.                        | <input type="checkbox"/> | 1            |
| <b>S2-F2</b> | Core hours: the data is collected and reviewed monthly                                                                                        | √                        | 1            |
|              | Core hours: position discussed in public                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S2-F3</b> | Urgent access: the data reviewed, with a tracker in place                                                                                     | √                        | 1            |
|              | Urgent access position discussed in public                                                                                                    | <input type="checkbox"/> | 1            |
| <b>S2-F4</b> | Patient experience: the GPPS data on phone access and overall experience are reviewed with discussions held with the practices in difficulty. | √                        | 1            |
|              | Patient experience position and plans for part of the public board discussions                                                                | <input type="checkbox"/> | 1            |
| <b>S2-F5</b> | Improvement support: a named provider in the place with the capability to support improvement in general practice                             | √                        | 1            |
|              | That provider commissioned to provide support to practices in difficulty                                                                      | √                        | 1            |
|              | <b>S2 stage total (sum of ticks)</b>                                                                                                          | <b>6</b>                 | <b>of 10</b> |

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### S3. Neighbourhood footprints

*Framework requirement: Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).*

The model: one agreed geography where there is alignment across general practice, PCNs, community and mental health teams, social care and voluntary sector. Footprints are grown from PCNs on JSNA evidence and post-LGR boundaries, signed off at the HWB. The full model includes co-location.

| Factor       | Item (1 point each)                                                                                   | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S3-F1</b> | Footprints agreed across the system and with the local authority.                                     | √                        | 1            |
|              | Footprints have been signed off at a public meeting of the HWB.                                       | √                        | 1            |
| <b>S3-F2</b> | PCNs aligned to the neighbourhood footprints with very few exceptions.                                | √                        | 1            |
|              | A clear named accountable leader is in place for each neighbourhood                                   | √                        | 1            |
| <b>S3-F3</b> | Community health services are organised with a dedicated team for each neighbourhood                  | <input type="checkbox"/> | 1            |
|              | Mental health services are organised with a dedicated team for each neighbourhood                     | √                        | 1            |
| <b>S3-F4</b> | A named VCFSE lead, or an agreed VCFSE representation arrangement is in place for each neighbourhood. | √                        | 1            |
|              | A named adult social care lead is in place for each neighbourhood                                     | √                        | 1            |
| <b>S3-F5</b> | There is co-location of teams (beyond general practice and PCNs) in some neighbourhoods               | √                        | 1            |
|              | There is co-location of teams (beyond general practice and PCNs) in the majority of neighbourhoods    | <input type="checkbox"/> | 1            |
|              | <b>S3 stage total (sum of ticks)</b>                                                                  | 8                        | <b>of 10</b> |

### S4. INTs for priority cohorts and devolved budgets

*Framework requirement: Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.*

The model: the service for older complex adults, most often moderate to severe frailty, care home, housebound and end of life, consists of three components. The three components are proactive care, an MDT for those with elevated risk - which are covered in this stage - and a 24/7 reactive care component which is covered in Stage 1. The end-state model includes a delegated budget to support targeted interventions to drive healthy neighbourhood by tackling wider determinants for individuals or smaller cohorts within the neighbourhood.

| Factor       | Item (1 point each)                                                                                                        | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S4-F1</b> | Proactive care (model): GP-led proactive care for older adults with complex needs operating in at least one neighbourhood. | √                        | 1      |
|              | Proactive care model operating across all neighbourhoods.                                                                  | <input type="checkbox"/> | 1      |
| <b>S4-F2</b> | Proactive care (contract): a contract is in place, e.g. PCN DES variant, LES for all neighbourhoods.                       | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
|              | The proactive care contract contains a variable payment element linked to patient coverage or outcomes                                                                                        | <input type="checkbox"/> | 1            |
| <b>S4-F3</b> | Proactive care (volume): service has been commissioned for more than 0.5 percent of the registered population                                                                                 | <input type="checkbox"/> | 1            |
|              | Proactive care has been commissioned for at least 1 percent of the registered population                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S4-F4</b> | Elevated risk INT (model): an MDT of primary care, community, mental health and social care staff, with VCFSE, operating in at least one neighbourhood.                                       | <input type="checkbox"/> | 1            |
|              | The MDT model for elevated risk is operating across all neighbourhoods.                                                                                                                       | <input type="checkbox"/> | 1            |
| <b>S4-F5</b> | Healthy neighbourhood: local authority and VCFSE supporting individuals with targeted interventions that focus on wider determinants, e.g. youth workers, housing support, employment support | <input type="checkbox"/> | 1            |
|              | Delegated budget is in place to commission healthy neighbourhood partnership work addressing wider determinants                                                                               | <input type="checkbox"/> | 1            |
|              | <b>S4 stage total (sum of ticks)</b>                                                                                                                                                          | 1                        | <b>of 10</b> |

### S5. Neighbourhood approach to elective pathways

*Framework requirement: Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.*

The model: there are four outpatient reform models emerging: (i) trust-run community specialist clinics; (ii) GPwER running community tier 2 often with specialist support; (iii) commissioned GP and consultant shared care as the mechanism for reviewing referrals, waiting lists and follow-up lists; and (iv) a population-based relationship model with consultants and specialist nurses aligned to neighbourhoods, delivering care and supporting GPs and their teams.

| Factor       | Item (1 point each)                                                                                                                                | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S5-F1</b> | A plan is in place that maps the four models to named specialties, stating how each model's impact will be measured.                               | <input type="checkbox"/> | 1      |
|              | There is a named accountable lead for delivering the outpatient reform plan.                                                                       | <input type="checkbox"/> | 1      |
| <b>S5-F2</b> | There are trust-run subcontracted clinics, e.g. ENT (microsuction, tinnitus) or gynaecology (complex coils, pessaries), operating in one specialty | <input type="checkbox"/> | 1      |
|              | There are trust-run subcontracted clinics operating in more than one specialty                                                                     | <input type="checkbox"/> | 1      |
| <b>S5-F3</b> | There are GPwER tier 2 services commissioned in one specialty.                                                                                     | √                        | 1      |
|              | There are GPwER tier 2 services commissioned in more than one specialty                                                                            | √                        | 1      |

| Factor       | Item (1 point each)                                                                                                                                                                                             | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S5-F4</b> | There are commissioned GP and consultant shared care services operating in one specialty: reviewing referrals, waiting lists and follow-up lists                                                                | <input type="checkbox"/> | 1            |
|              | There are commissioned GP and consultant shared care services operating in multiple specialties                                                                                                                 | <input type="checkbox"/> | 1            |
| <b>S5-F5</b> | There is a population-based relationship model operating in one specialty. From Julie S- I would argue that kidney disease and LUCID fits this definition although possibly a sub speciality- discuss with Yas. | √                        | 1            |
|              | There is a population-based relationship model operating across all neighbourhoods in the place.                                                                                                                | <input type="checkbox"/> | 1            |
|              | <b>S5 stage total (sum of ticks)</b>                                                                                                                                                                            | 3                        | <b>of 10</b> |

## S6. Community waits

*Framework requirement: Confirm plans to meet 18-week community waits and eliminate 52-week waits.*

The model: community waits, meaning the pathways reported in the CHS SitRep, solved by redesign doing the heavy lifting with waiting list initiatives clearing legacy backlogs alongside. Demand shaped before referral, post-diagnostic follow-up delivered through commissioned shared care so specialists are free to assess and diagnose, support in place whilst waiting in line with the NHSE community waiting times action lists and checklist (March 2026), and the published standards met on the way through. Neurodevelopmental waits are reported both included and excluded so positions are comparable across systems, and children's waits are identified separately: the same wait is a larger share of a child's life.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                                                      | Tick                     | Points |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S6-F1</b> | Trajectories confirmed and minuted for 18-week performance and 52-week elimination across the community pathways reported in the CHS SitRep, with adult and children's waits identified separately and stated both including and excluding neurodevelopmental pathways (autism and ADHD) | √                        | 1      |
|              | The data supporting the plan has been data quality assured through a quarterly technical and clinical validation process.                                                                                                                                                                | √                        | 1      |
| <b>S6-F2</b> | A plan agreed naming which pathways are to be redesigned in line with the NHSE community waiting times action lists and checklist (March 2026)                                                                                                                                           | √                        | 1      |
|              | Demonstrated progress on at least two pathways to give reassurance the plan is deliverable.                                                                                                                                                                                              | √                        | 1      |
| <b>S6-F3</b> | Post-diagnostic follow-up delivered through commissioned shared care arrangements on at least one pathway                                                                                                                                                                                | √                        | 1      |
|              | On the two longest-wait community pathways on published data, released specialist time evidenced                                                                                                                                                                                         | <input type="checkbox"/> | 1      |
| <b>S6-F4</b> | Demonstrated progress to the 2026/27 objective of 78 percent of waits under 18 weeks met with over 65 percent of waits under 18 weeks today.                                                                                                                                             | <input type="checkbox"/> | 1      |
|              | The 2026/27 objective of 78 percent of waits under 18 weeks met, or trajectory exceeded, on published data                                                                                                                                                                               | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S6-F5</b> | 52-week count falling on published data, or board-approved path to zero within the planning period | <input type="checkbox"/> | 1            |
|              | Zero 52-week waits                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S6 stage total (sum of ticks)</b>                                                               | 5                        | <b>of 10</b> |

### S7. Better Care Fund pooled funding

*Framework requirement: Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care.*

The model: pooled money working at both place and neighbourhood level. BCF confirmed with every local authority; joint assessment and decisions grounded in the JSNA and joint local health and wellbeing strategy; funds delegated to the footprints; BCF investment demonstrably changed in response to the neighbourhood health plan guidance, implemented and contractually underpinned; and inequalities impact measured scheme by scheme, reported annually in public at the HWB.

| Factor       | Item (1 point each)                                                                                                                                                          | Tick                     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S7-F1</b> | Joint BCF position confirmed with local authority.                                                                                                                           | √                        | 1            |
|              | Minimum mandated NHS contribution to adult social care has been met                                                                                                          | √                        | 1            |
| <b>S7-F2</b> | Joint assessment and decision-making route documented, with the assessment incorporating JSNA, the joint local health and wellbeing strategy, and NHS and social care demand | √                        | 1            |
|              | At least two funding decisions minuted in the last 12 months, including winter capacity planning                                                                             | √                        | 1            |
| <b>S7-F3</b> | At least one pooled scheme aligned to the neighbourhood footprints, with spend recorded                                                                                      | <input type="checkbox"/> | 1            |
|              | Changes to BCF investment planned in response to the neighbourhood health plan guidance, with the changes named                                                              | <input type="checkbox"/> | 1            |
| <b>S7-F4</b> | Those BCF investment changes implemented: the changed schemes in operation                                                                                                   | <input type="checkbox"/> | 1            |
|              | Underpinned by signed agreements (Section 75 or variation), operating                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S7-F5</b> | A named health inequalities measure per scheme, relating back to the JSNA                                                                                                    | <input type="checkbox"/> | 1            |
|              | Reported at least annually at the HWB in public, with results feeding the next funding round                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S7 stage total (sum of ticks)</b>                                                                                                                                         | 4                        | <b>of 10</b> |

## S8. Primary and secondary care interface

*Framework requirement: Continue to improve the primary and secondary care interface in line with the red tape challenge.*

The model: an interface working as one system. There is a documented priority plan, all providers and the full primary care family are in scope, operational and strategic meetings are in place, the red tape challenge changes are delivered in practice, and there is a shared workforce through joint leadership development and neighbourhood PAs in consultant job plans, with a named clinical SRO and PMO support.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                            | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S8-F1</b> | There is a documented interface priority plan aligned to the GIRFT checklist and red tape challenge, covering medicines management, digital and estates, with the full primary care family in scope (general practice, community pharmacy, dental, optometry). | <input type="checkbox"/> | 1            |
|              | All provider organisations, including community and mental health, have completed the self-assessment and use the data to target improvement.                                                                                                                  | √                        | 1            |
| <b>S8-F2</b> | Operational interface meetings are in place with the priority organisations identified through self-assessment, with agendas and action tracking.                                                                                                              | √                        | 1            |
|              | An agreed meeting cycle is operating with each provider organisation, with actions closing.                                                                                                                                                                    | √                        | 1            |
| <b>S8-F3</b> | Red tape challenge and GIRFT checklist changes are being delivered in at least one organisation.                                                                                                                                                               | <input type="checkbox"/> | 1            |
|              | Red tape challenge and GIRFT checklist changes are delivered by every provider, including a single patient record accessible for direct care.                                                                                                                  | <input type="checkbox"/> | 1            |
| <b>S8-F4</b> | A strategic interface meeting is held at least quarterly, with a named clinical SRO, PMO support and executive governance.                                                                                                                                     | √                        | 1            |
|              | An agreed clinical leadership development programme is in place, with participants active in the interface forums.                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S8-F5</b> | Job planning policy provides for neighbourhood PAs, with at least one signed job plan in the 10 high volume specialties.                                                                                                                                       | <input type="checkbox"/> | 1            |
|              | Local job planning rounds have resulted in neighbourhood PAs in more than half of specialties with neighbourhood-facing work.                                                                                                                                  | <input type="checkbox"/> | 1            |
|              | <b>S8 stage total (sum of ticks)</b>                                                                                                                                                                                                                           | <b>4</b>                 | <b>of 10</b> |

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## S9. Organisational ownership

*Framework requirement: Confirm organisational ownership of planned deliverables.*

The model: clear ownership. There is a named accountable lead for every stage, taken through the Board, with an overall delivery owner in the ICB; a host, anchor or integrator in every place; general practice coordinated across the Place; and accountability exercised through working governance.

| Factor       | Item (1 point each)                                                                                                                                                           | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S9-F1</b> | There is a named accountable lead for at least 8 of the 10 Stage 1 requirements of the Neighbourhood Health Framework                                                         | √                        | 1            |
|              | There is a named accountable lead for all 10 stages which has been taken through the Board with an overall delivery owner in the ICB.                                         | <input type="checkbox"/> | 1            |
| <b>S9-F2</b> | A host, anchor or integrator is named in every place that is able to co-ordinate INT and neighbourhood development.                                                           | <input type="checkbox"/> | 1            |
|              | The host, anchor or integrator organisation has been commissioned.                                                                                                            | <input type="checkbox"/> | 1            |
| <b>S9-F3</b> | The general practice foundation for neighbourhoods is organised and coordinated across Place through an organisation which has the support of the vast majority of practices. | √                        | 1            |
|              | The organisation that is coordinating general practice has been commissioned.                                                                                                 | <input type="checkbox"/> | 1            |
| <b>S9-F4</b> | Scheme of delegation or terms of reference documented for the integrator                                                                                                      | <input type="checkbox"/> | 1            |
|              | Exercised, with decisions minuted                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S9-F5</b> | Delivery reporting established                                                                                                                                                | <input type="checkbox"/> | 1            |
|              | At least two consecutive cycles with actions and escalation recorded                                                                                                          | <input type="checkbox"/> | 1            |
|              | <b>S9 stage total (sum of ticks)</b>                                                                                                                                          | <b>2</b>                 | <b>of 10</b> |

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## S10. Data sharing for identification and evaluation

*Framework requirement: Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.*

The model: data sharing signed and used. Every sector signed up, general practice counted by share of practices, enabling the risk stratification and single patient record that are scored where they operate (S4 and S8). VCFSE and smaller partner sign-up is expected to come with information governance support from the system; the item scores the arrangement being in place, not unsupported compliance.

| Factor        | Item (1 point each)                                                                         | Tick                     | Points       |
|---------------|---------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S10-F1</b> | More than 90 percent of practices signed up to the data sharing arrangements.               | √                        | 1            |
|               | More than 99 percent of practices signed up to data sharing arrangements.                   | √                        | 1            |
| <b>S10-F2</b> | Acute trusts signed up, with data in active use, particularly in emergency department areas | √                        | 1            |
|               | Community services signed up and data in active use                                         | √                        | 1            |
| <b>S10-F3</b> | Mental health trust signed up to data sharing arrangements and data in active use           | <input type="checkbox"/> | 1            |
|               | Social care signed up to data sharing arrangements and data in active use                   | √                        | 1            |
| <b>S10-F4</b> | VCFSE signed up and data in active use                                                      | <input type="checkbox"/> | 1            |
|               | Other partners including community pharmacy signed up and data in active use                | <input type="checkbox"/> | 1            |
| <b>S10-F5</b> | Optometry signed up and data in active use                                                  | <input type="checkbox"/> | 1            |
|               | Dental signed up and data in active use                                                     | <input type="checkbox"/> | 1            |
|               | <b>S10 stage total (sum of ticks)</b>                                                       | <b>5</b>                 | <b>of 10</b> |

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### 3. Glossary

Terms as used in this self-assessment.

| Term              | Meaning                                                                                      |
|-------------------|----------------------------------------------------------------------------------------------|
| <b>BCF</b>        | Better Care Fund                                                                             |
| <b>CAS</b>        | Clinical assessment service (within NHS 111)                                                 |
| <b>CHS SitRep</b> | Community health services situation report (the national community waiting times collection) |
| <b>DES / LES</b>  | Directed enhanced service / local enhanced service (general practice contract routes)        |
| <b>GIRFT</b>      | Getting It Right First Time                                                                  |
| <b>GMS</b>        | General medical services (the national GP contract)                                          |
| <b>GPPS</b>       | GP Patient Survey                                                                            |
| <b>GPwER</b>      | GP with an extended role                                                                     |
| <b>HWB</b>        | Health and wellbeing board                                                                   |
| <b>INT</b>        | Integrated neighbourhood team                                                                |
| <b>JSNA</b>       | Joint strategic needs assessment                                                             |
| <b>MDT</b>        | Multidisciplinary team                                                                       |
| <b>PAs</b>        | Programmed activities (consultant job plan sessions)                                         |
| <b>PCN</b>        | Primary care network                                                                         |
| <b>RTT</b>        | Referral to treatment (the 18-week elective standard)                                        |
| <b>PMO</b>        | Programme management office                                                                  |
| <b>SRO</b>        | Senior responsible owner                                                                     |
| <b>SPoA</b>       | Single point of access                                                                       |
| <b>UCR</b>        | Urgent community response                                                                    |
| <b>VCFSE</b>      | Voluntary, community, faith and social enterprise sector                                     |

**Neighbourhood health Stage 1 self-assessment: S1 to S10 scoring instrument**

*Neighbourhood Health Framework, 17 March 2026. Self-assessment for each Place: ten factors per requirement, 1 point each: 10 per stage, 100 in total, per Place. Final review version, August 2026.*

Purpose. This self-assessment replaces the earlier (RAG rated) place maturity assessments. Please tick what is evidenced and sum for each stage and overall. It is a development tool that helps identify progress over a multi-year plan - we are expecting most systems to score 20-30 points currently - but have plans that will increase points over the coming 6-18 months. This self-assessment was developed by the national neighbourhood health team through the 2026 baseline visit programme and refined through co-creation with ICB, NHS England regional and clinical, and DHSC colleagues. The ten requirements in Section 1 are verbatim from the Neighbourhood Health Framework (17 March 2026). Section 6 references the NHSE community health services waiting times action lists and checklist (March 2026). Items that touch local authority or voluntary sector delivery are completed jointly with those partners.

Comments, completed test self-assessments and suggestions are welcome and should be sent to the national neighbourhood health team, and will inform the next iteration.

**1. The ten Stage 1 minimum requirements**

These are the ten stages from the Neighbourhood Health Framework, in published order. S-codes follow that order.

| Code      | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                                           |
|-----------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S1</b> | <b>Urgent, rehabilitation and reablement capacity</b> | Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.                     |
| <b>S2</b> | <b>General practice access and variation</b>          | Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements. |
| <b>S3</b> | <b>Neighbourhood footprints</b>                       | Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).                                                                                                         |
| <b>S4</b> | <b>INTs for priority cohorts and devolved budgets</b> | Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.                                                                                                         |
| <b>S5</b> | <b>Neighbourhood approach to elective pathways</b>    | Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.   |
| <b>S6</b> | <b>Community waits</b>                                | Confirm plans to meet 18-week community waits and eliminate 52-week waits.                                                                                                                                                             |

| Code       | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                    |
|------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S7</b>  | <b>Better Care Fund pooled funding</b>                | Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care. |
| <b>S8</b>  | <b>Primary and secondary care interface</b>           | Continue to improve the primary and secondary care interface in line with the red tape challenge.                                                                                                               |
| <b>S9</b>  | <b>Organisational ownership</b>                       | Confirm organisational ownership of planned deliverables.                                                                                                                                                       |
| <b>S10</b> | <b>Data sharing for identification and evaluation</b> | Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.                                                                                 |

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## 2. The self-assessment for each Place

### S1. Urgent, rehabilitation and reablement capacity

*Framework requirement: Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.*

The model: an integrated care coordination centre across place. One contact point holding clinical risk takes referrals in from general practice but also 111, out of hours, discharge teams, and in the most mature the public. It admits directly out to the services that keep people at home, including social care reablement, extends to 24 hour operation.

| Factor       | Item (1 point each)                                                                                                                                                                                              | Tick     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------|
| <b>S1-F1</b> | Single professional contact point (urgent care SPoA / integrated coordination centre): one call gives a professional access to multiple services for their patient (e.g. UCR / rapid response, hospital at home) | ✓        | 1            |
|              | A named clinician on duty in the integrated coordination centre holds the clinical risk                                                                                                                          | ✓        | 1            |
| <b>S1-F2</b> | Core professional referral routes in place: general practice, 111/CAS, GP out of hours and hospital discharge teams.                                                                                             | ✓        | 1            |
|              | Core referral routes out in place: the centre is able to admit to, or directly deploy: UCR, rapid response, step-up and step-down intermediate care, virtual ward, hospital at home, and social care reablement. | ☐        | 1            |
| <b>S1-F3</b> | Centre is open at least 12 hours a day, 7 days a week                                                                                                                                                            | ✓        | 1            |
|              | Centre is open 24 hours a day, 7 days a week                                                                                                                                                                     | ☐        | 1            |
| <b>S1-F4</b> | Gold line is in place: direct public access line for patients / carers of the end-of-life care cohort                                                                                                            | ✓        | 1            |
|              | Silver line is in place: direct public access line for patients / carers of the adult complex care cohort                                                                                                        | ✓        | 1            |
| <b>S1-F5</b> | Impact is being measured: place-wide non-elective activity baseline defined and in place.                                                                                                                        | ✓        | 1            |
|              | Impact is being reported: non-elective activity data produced and reviewed at least quarterly to assess impact against the baseline and goes through the board at least twice a year.                            | ✓        | 1            |
|              | <b>S1 stage total (sum of ticks)</b>                                                                                                                                                                             | <b>8</b> | <b>of 10</b> |

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## S2. General practice access and variation

*Framework requirement: Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements.*

The model: there is a named accountable person who reports at least quarterly in public Board on plans and progress related to GP core hours, phone access, urgent access and patient experience. There is also a named provider with improvement capability that is commissioned to support practices in difficulty with improvement. Public discussion is at place level; no item requires naming individual practices in public.

| Factor       | Item (1 point each)                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S2-F1</b> | Accountability: a named accountable person in place responsible for tracking and improving unwarranted variation                              | ✓                        | 1            |
|              | There is a report on general practice variation taken to public Board outlining plans and progress at least quarterly.                        | <input type="checkbox"/> | 1            |
| <b>S2-F2</b> | Core hours: the data is collected and reviewed monthly                                                                                        | ✓                        | 1            |
|              | Core hours: position discussed in public                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S2-F3</b> | Urgent access: the data reviewed, with a tracker in place                                                                                     | ✓                        | 1            |
|              | Urgent access position discussed in public                                                                                                    | <input type="checkbox"/> | 1            |
| <b>S2-F4</b> | Patient experience: the GPPS data on phone access and overall experience are reviewed with discussions held with the practices in difficulty. | ✓                        | 1            |
|              | Patient experience position and plans for part of the public board discussions                                                                | <input type="checkbox"/> | 1            |
| <b>S2-F5</b> | Improvement support: a named provider in the place with the capability to support improvement in general practice                             | ✓                        | 1            |
|              | That provider commissioned to provide support to practices in difficulty                                                                      | ✓                        | 1            |
|              | <b>S2 stage total (sum of ticks)</b>                                                                                                          | <b>6</b>                 | <b>of 10</b> |

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### S3. Neighbourhood footprints

*Framework requirement: Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).*

The model: one agreed geography where there is alignment across general practice, PCNs, community and mental health teams, social care and voluntary sector. Footprints are grown from PCNs on JSNA evidence and post-LGR boundaries, signed off at the HWB. The full model includes co-location.

| Factor       | Item (1 point each)                                                                                   | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S3-F1</b> | Footprints agreed across the system and with the local authority.                                     | ✓                        | 1            |
|              | Footprints have been signed off at a public meeting of the HWB.                                       | ✓                        | 1            |
| <b>S3-F2</b> | PCNs aligned to the neighbourhood footprints with very few exceptions.                                | ✓                        | 1            |
|              | A clear named accountable leader is in place for each neighbourhood                                   | <input type="checkbox"/> | 1            |
| <b>S3-F3</b> | Community health services are organised with a dedicated team for each neighbourhood                  | <input type="checkbox"/> | 1            |
|              | Mental health services are organised with a dedicated team for each neighbourhood                     | ✓                        | 1            |
| <b>S3-F4</b> | A named VCFSE lead, or an agreed VCFSE representation arrangement is in place for each neighbourhood. | <input type="checkbox"/> | 1            |
|              | A named adult social care lead is in place for each neighbourhood                                     | ✓                        | 1            |
| <b>S3-F5</b> | There is co-location of teams (beyond general practice and PCNs) in some neighbourhoods               | ✓                        | 1            |
|              | There is co-location of teams (beyond general practice and PCNs) in the majority of neighbourhoods    | <input type="checkbox"/> | 1            |
|              | <b>S3 stage total (sum of ticks)</b>                                                                  | 6                        | <b>of 10</b> |

### S4. INTs for priority cohorts and devolved budgets

*Framework requirement: Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.*

The model: the service for older complex adults, most often moderate to severe frailty, care home, housebound and end of life, consists of three components. The three components are proactive care, an MDT for those with elevated risk - which are covered in this stage - and a 24/7 reactive care component which is covered in Stage 1. The end-state model includes a delegated budget to support targeted interventions to drive healthy neighbourhood by tackling wider determinants for individuals or smaller cohorts within the neighbourhood.

| Factor       | Item (1 point each)                                                                                                        | Tick | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------|------|--------|
| <b>S4-F1</b> | Proactive care (model): GP-led proactive care for older adults with complex needs operating in at least one neighbourhood. | ✓    | 1      |
|              | Proactive care model operating across all neighbourhoods.                                                                  | ✓    | 1      |
| <b>S4-F2</b> | Proactive care (contract): a contract is in place, e.g. PCN DES variant, LES for all neighbourhoods.                       | ✓    | 1      |

| Factor       | Item (1 point each)                                                                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
|              | The proactive care contract contains a variable payment element linked to patient coverage or outcomes                                                                                        | <input type="checkbox"/> | 1            |
| <b>S4-F3</b> | Proactive care (volume): service has been commissioned for more than 0.5 percent of the registered population                                                                                 | ✓                        | 1            |
|              | Proactive care has been commissioned for at least 1 percent of the registered population                                                                                                      | ✓                        | 1            |
| <b>S4-F4</b> | Elevated risk INT (model): an MDT of primary care, community, mental health and social care staff, with VCFSE, operating in at least one neighbourhood.                                       | ✓                        | 1            |
|              | The MDT model for elevated risk is operating across all neighbourhoods.                                                                                                                       | <input type="checkbox"/> | 1            |
| <b>S4-F5</b> | Healthy neighbourhood: local authority and VCFSE supporting individuals with targeted interventions that focus on wider determinants, e.g. youth workers, housing support, employment support | ✓                        | 1            |
|              | Delegated budget is in place to commission healthy neighbourhood partnership work addressing wider determinants                                                                               | <input type="checkbox"/> | 1            |
|              | <b>S4 stage total (sum of ticks)</b>                                                                                                                                                          | <b>7</b>                 | <b>of 10</b> |

## S5. Neighbourhood approach to elective pathways

*Framework requirement: Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.*

The model: there are four outpatient reform models emerging: (i) trust-run community specialist clinics; (ii) GPwER running community tier 2 often with specialist support; (iii) commissioned GP and consultant shared care as the mechanism for reviewing referrals, waiting lists and follow-up lists; and (iv) a population-based relationship model with consultants and specialist nurses aligned to neighbourhoods, delivering care and supporting GPs and their teams.

| Factor       | Item (1 point each)                                                                                                                                | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S5-F1</b> | A plan is in place that maps the four models to named specialties, stating how each model's impact will be measured.                               | <input type="checkbox"/> | 1      |
|              | There is a named accountable lead for delivering the outpatient reform plan.                                                                       | ✓                        | 1      |
| <b>S5-F2</b> | There are trust-run subcontracted clinics, e.g. ENT (microsuction, tinnitus) or gynaecology (complex coils, pessaries), operating in one specialty | <input type="checkbox"/> | 1      |
|              | There are trust-run subcontracted clinics operating in more than one specialty                                                                     | <input type="checkbox"/> | 1      |
| <b>S5-F3</b> | There are GPwER tier 2 services commissioned in one specialty.                                                                                     | <input type="checkbox"/> | 1      |
|              | There are GPwER tier 2 services commissioned in more than one specialty                                                                            | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                                                              | Tick                     | Points       |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S5-F4</b> | There are commissioned GP and consultant shared care services operating in one specialty: reviewing referrals, waiting lists and follow-up lists | <input type="checkbox"/> | 1            |
|              | There are commissioned GP and consultant shared care services operating in multiple specialties                                                  | <input type="checkbox"/> | 1            |
| <b>S5-F5</b> | There is a population-based relationship model operating in one speciality.                                                                      | <input type="checkbox"/> | 1            |
|              | There is a population-based relationship model operating across all neighbourhoods in the place.                                                 | <input type="checkbox"/> | 1            |
|              | <b>S5 stage total (sum of ticks)</b>                                                                                                             | 1                        | <b>of 10</b> |

## S6. Community waits

*Framework requirement: Confirm plans to meet 18-week community waits and eliminate 52-week waits.*

The model: community waits, meaning the pathways reported in the CHS SitRep, solved by redesign doing the heavy lifting with waiting list initiatives clearing legacy backlogs alongside. Demand shaped before referral, post-diagnostic follow-up delivered through commissioned shared care so specialists are free to assess and diagnose, support in place whilst waiting in line with the NHSE community waiting times action lists and checklist (March 2026), and the published standards met on the way through. Neurodevelopmental waits are reported both included and excluded so positions are comparable across systems, and children's waits are identified separately: the same wait is a larger share of a child's life.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                                                      | Tick                     | Points |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S6-F1</b> | Trajectories confirmed and minuted for 18-week performance and 52-week elimination across the community pathways reported in the CHS SitRep, with adult and children's waits identified separately and stated both including and excluding neurodevelopmental pathways (autism and ADHD) | ✓                        | 1      |
|              | The data supporting the plan has been data quality assured through a quarterly technical and clinical validation process.                                                                                                                                                                | ✓                        | 1      |
| <b>S6-F2</b> | A plan agreed naming which pathways are to be redesigned in line with the NHSE community waiting times action lists and checklist (March 2026)                                                                                                                                           | ✓                        | 1      |
|              | Demonstrated progress on at least two pathways to give reassurance the plan is deliverable.                                                                                                                                                                                              | <input type="checkbox"/> | 1      |
| <b>S6-F3</b> | Post-diagnostic follow-up delivered through commissioned shared care arrangements on at least one pathway                                                                                                                                                                                | <input type="checkbox"/> | 1      |
|              | On the two longest-wait community pathways on published data, released specialist time evidenced                                                                                                                                                                                         | <input type="checkbox"/> | 1      |
| <b>S6-F4</b> | Demonstrated progress to the 2026/27 objective of 78 percent of waits under 18 weeks met with over 65 percent of waits under 18 weeks today.                                                                                                                                             | <input type="checkbox"/> | 1      |
|              | The 2026/27 objective of 78 percent of waits under 18 weeks met, or trajectory exceeded, on published data                                                                                                                                                                               | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S6-F5</b> | 52-week count falling on published data, or board-approved path to zero within the planning period | <input type="checkbox"/> | 1            |
|              | Zero 52-week waits                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S6 stage total (sum of ticks)</b>                                                               | 3                        | <b>of 10</b> |

### S7. Better Care Fund pooled funding

*Framework requirement: Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care.*

The model: pooled money working at both place and neighbourhood level. BCF confirmed with every local authority; joint assessment and decisions grounded in the JSNA and joint local health and wellbeing strategy; funds delegated to the footprints; BCF investment demonstrably changed in response to the neighbourhood health plan guidance, implemented and contractually underpinned; and inequalities impact measured scheme by scheme, reported annually in public at the HWB.

| Factor       | Item (1 point each)                                                                                                                                                          | Tick                     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S7-F1</b> | Joint BCF position confirmed with local authority.                                                                                                                           | ✓                        | 1            |
|              | Minimum mandated NHS contribution to adult social care has been met                                                                                                          | ✓                        | 1            |
| <b>S7-F2</b> | Joint assessment and decision-making route documented, with the assessment incorporating JSNA, the joint local health and wellbeing strategy, and NHS and social care demand | <input type="checkbox"/> | 1            |
|              | At least two funding decisions minuted in the last 12 months, including winter capacity planning                                                                             | <input type="checkbox"/> | 1            |
| <b>S7-F3</b> | At least one pooled scheme aligned to the neighbourhood footprints, with spend recorded                                                                                      | ✓                        | 1            |
|              | Changes to BCF investment planned in response to the neighbourhood health plan guidance, with the changes named                                                              | <input type="checkbox"/> | 1            |
| <b>S7-F4</b> | Those BCF investment changes implemented: the changed schemes in operation                                                                                                   | <input type="checkbox"/> | 1            |
|              | Underpinned by signed agreements (Section 75 or variation), operating                                                                                                        | ✓                        | 1            |
| <b>S7-F5</b> | A named health inequalities measure per scheme, relating back to the JSNA                                                                                                    | <input type="checkbox"/> | 1            |
|              | Reported at least annually at the HWB in public, with results feeding the next funding round                                                                                 | ✓                        | 1            |
|              | <b>S7 stage total (sum of ticks)</b>                                                                                                                                         | 5                        | <b>of 10</b> |

## S8. Primary and secondary care interface

*Framework requirement: Continue to improve the primary and secondary care interface in line with the red tape challenge.*

The model: an interface working as one system. There is a documented priority plan, all providers and the full primary care family are in scope, operational and strategic meetings are in place, the red tape challenge changes are delivered in practice, and there is a shared workforce through joint leadership development and neighbourhood PAs in consultant job plans, with a named clinical SRO and PMO support.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                            | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S8-F1</b> | There is a documented interface priority plan aligned to the GIRFT checklist and red tape challenge, covering medicines management, digital and estates, with the full primary care family in scope (general practice, community pharmacy, dental, optometry). | <input type="checkbox"/> | 1            |
|              | All provider organisations, including community and mental health, have completed the self-assessment and use the data to target improvement.                                                                                                                  | ✓                        | 1            |
| <b>S8-F2</b> | Operational interface meetings are in place with the priority organisations identified through self-assessment, with agendas and action tracking.                                                                                                              | ✓                        | 1            |
|              | An agreed meeting cycle is operating with each provider organisation, with actions closing.                                                                                                                                                                    | ✓                        | 1            |
| <b>S8-F3</b> | Red tape challenge and GIRFT checklist changes are being delivered in at least one organisation.                                                                                                                                                               | <input type="checkbox"/> | 1            |
|              | Red tape challenge and GIRFT checklist changes are delivered by every provider, including a single patient record accessible for direct care.                                                                                                                  | <input type="checkbox"/> | 1            |
| <b>S8-F4</b> | A strategic interface meeting is held at least quarterly, with a named clinical SRO, PMO support and executive governance.                                                                                                                                     | ✓                        | 1            |
|              | An agreed clinical leadership development programme is in place, with participants active in the interface forums.                                                                                                                                             |                          | 1            |
| <b>S8-F5</b> | Job planning policy provides for neighbourhood PAs, with at least one signed job plan in the 10 high volume specialties.                                                                                                                                       | <input type="checkbox"/> | 1            |
|              | Local job planning rounds have resulted in neighbourhood PAs in more than half of specialties with neighbourhood-facing work.                                                                                                                                  | <input type="checkbox"/> | 1            |
|              | <b>S8 stage total (sum of ticks)</b>                                                                                                                                                                                                                           | <b>4</b>                 | <b>of 10</b> |

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## S9. Organisational ownership

*Framework requirement: Confirm organisational ownership of planned deliverables.*

The model: clear ownership. There is a named accountable lead for every stage, taken through the Board, with an overall delivery owner in the ICB; a host, anchor or integrator in every place; general practice coordinated across the Place; and accountability exercised through working governance.

| Factor       | Item (1 point each)                                                                                                                                                           | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S9-F1</b> | There is a named accountable lead for at least 8 of the 10 Stage 1 requirements of the Neighbourhood Health Framework                                                         | ✓                        | 1            |
|              | There is a named accountable lead for all 10 stages which has been taken through the Board with an overall delivery owner in the ICB.                                         | <input type="checkbox"/> | 1            |
| <b>S9-F2</b> | A host, anchor or integrator is named in every place that is able to co-ordinate INT and neighbourhood development.                                                           | <input type="checkbox"/> | 1            |
|              | The host, anchor or integrator organisation has been commissioned.                                                                                                            | <input type="checkbox"/> | 1            |
| <b>S9-F3</b> | The general practice foundation for neighbourhoods is organised and coordinated across Place through an organisation which has the support of the vast majority of practices. | ✓                        | 1            |
|              | The organisation that is coordinating general practice has been commissioned.                                                                                                 | <input type="checkbox"/> | 1            |
| <b>S9-F4</b> | Scheme of delegation or terms of reference documented for the integrator                                                                                                      | <input type="checkbox"/> | 1            |
|              | Exercised, with decisions minuted                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S9-F5</b> | Delivery reporting established                                                                                                                                                | <input type="checkbox"/> | 1            |
|              | At least two consecutive cycles with actions and escalation recorded                                                                                                          | <input type="checkbox"/> | 1            |
|              | <b>S9 stage total (sum of ticks)</b>                                                                                                                                          | <b>2</b>                 | <b>of 10</b> |

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S10. Data sharing for identification and evaluation

Framework requirement: Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.

The model: data sharing signed and used. Every sector signed up, general practice counted by share of practices, enabling the risk stratification and single patient record that are scored where they operate (S4 and S8). VCFSE and smaller partner sign-up is expected to come with information governance support from the system; the item scores the arrangement being in place, not unsupported compliance.

| Factor | Item (1 point each)                                                                         | Tick | Points |
|--------|---------------------------------------------------------------------------------------------|------|--------|
| S10-F1 | More than 90 percent of practices signed up to the data sharing arrangements.               | ✓    | 1      |
|        | More than 99 percent of practices signed up to data sharing arrangements.                   | ✓    | 1      |
| S10-F2 | Acute trusts signed up, with data in active use, particularly in emergency department areas | ✓    | 1      |
|        | Community services signed up and data in active use                                         | ✓    | 1      |
| S10-F3 | Mental health trust signed up to data sharing arrangements and data in active use           | ✓    | 1      |
|        | Social care signed up to data sharing arrangements and data in active use                   | ✓    | 1      |
| S10-F4 | VCFSE signed up and data in active use                                                      | ✓    | 1      |
|        | Other partners including community pharmacy signed up and data in active use                | ☐    | 1      |
| S10-F5 | Optometry signed up and data in active use                                                  | ☐    | 1      |
|        | Dental signed up and data in active use                                                     | ☐    | 1      |
|        | S10 stage total (sum of ticks)                                                              | 7    | of 10  |

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### 3. Glossary

Terms as used in this self-assessment.

| Term              | Meaning                                                                                      |
|-------------------|----------------------------------------------------------------------------------------------|
| <b>BCF</b>        | Better Care Fund                                                                             |
| <b>CAS</b>        | Clinical assessment service (within NHS 111)                                                 |
| <b>CHS SitRep</b> | Community health services situation report (the national community waiting times collection) |
| <b>DES / LES</b>  | Directed enhanced service / local enhanced service (general practice contract routes)        |
| <b>GIRFT</b>      | Getting It Right First Time                                                                  |
| <b>GMS</b>        | General medical services (the national GP contract)                                          |
| <b>GPPS</b>       | GP Patient Survey                                                                            |
| <b>GPwER</b>      | GP with an extended role                                                                     |
| <b>HWB</b>        | Health and wellbeing board                                                                   |
| <b>INT</b>        | Integrated neighbourhood team                                                                |
| <b>JSNA</b>       | Joint strategic needs assessment                                                             |
| <b>MDT</b>        | Multidisciplinary team                                                                       |
| <b>PAs</b>        | Programmed activities (consultant job plan sessions)                                         |
| <b>PCN</b>        | Primary care network                                                                         |
| <b>RTT</b>        | Referral to treatment (the 18-week elective standard)                                        |
| <b>PMO</b>        | Programme management office                                                                  |
| <b>SRO</b>        | Senior responsible owner                                                                     |
| <b>SPoA</b>       | Single point of access                                                                       |
| <b>UCR</b>        | Urgent community response                                                                    |
| <b>VCFSE</b>      | Voluntary, community, faith and social enterprise sector                                     |

**Neighbourhood health Stage 1 self-assessment: S1 to S10 scoring instrument**

*Neighbourhood Health Framework, 17 March 2026. Self-assessment for each Place: ten factors per requirement, 1 point each: 10 per stage, 100 in total, per Place. Final review version, August 2026.*

Purpose. This self-assessment replaces the earlier (RAG rated) place maturity assessments. Please tick what is evidenced and sum for each stage and overall. It is a development tool that helps identify progress over a multi-year plan - we are expecting most systems to score 20-30 points currently - but have plans that will increase points over the coming 6-18 months. This self-assessment was developed by the national neighbourhood health team through the 2026 baseline visit programme and refined through co-creation with ICB, NHS England regional and clinical, and DHSC colleagues. The ten requirements in Section 1 are verbatim from the Neighbourhood Health Framework (17 March 2026). Section 6 references the NHSE community health services waiting times action lists and checklist (March 2026). Items that touch local authority or voluntary sector delivery are completed jointly with those partners.

Comments, completed test self-assessments and suggestions are welcome and should be sent to the national neighbourhood health team, and will inform the next iteration.

**1. The ten Stage 1 minimum requirements**

These are the ten stages from the Neighbourhood Health Framework, in published order. S-codes follow that order.

| Code      | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                                           |
|-----------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S1</b> | <b>Urgent, rehabilitation and reablement capacity</b> | Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.                     |
| <b>S2</b> | <b>General practice access and variation</b>          | Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements. |
| <b>S3</b> | <b>Neighbourhood footprints</b>                       | Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).                                                                                                         |
| <b>S4</b> | <b>INTs for priority cohorts and devolved budgets</b> | Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.                                                                                                         |
| <b>S5</b> | <b>Neighbourhood approach to elective pathways</b>    | Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.   |
| <b>S6</b> | <b>Community waits</b>                                | Confirm plans to meet 18-week community waits and eliminate 52-week waits.                                                                                                                                                             |

| Code       | Short label                                           | Framework wording (verbatim)                                                                                                                                                                                    |
|------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S7</b>  | <b>Better Care Fund pooled funding</b>                | Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care. |
| <b>S8</b>  | <b>Primary and secondary care interface</b>           | Continue to improve the primary and secondary care interface in line with the red tape challenge.                                                                                                               |
| <b>S9</b>  | <b>Organisational ownership</b>                       | Confirm organisational ownership of planned deliverables.                                                                                                                                                       |
| <b>S10</b> | <b>Data sharing for identification and evaluation</b> | Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.                                                                                 |

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## 2. The self-assessment for each Place

### S1. Urgent, rehabilitation and reablement capacity

*Framework requirement: Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis.*

The model: an integrated care coordination centre across place. One contact point holding clinical risk takes referrals in from general practice but also 111, out of hours, discharge teams, and in the most mature the public. It admits directly out to the services that keep people at home, including social care reablement, extends to 24 hour operation.

| Factor       | Item (1 point each)                                                                                                                                                                                              | Tick                     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S1-F1</b> | Single professional contact point (urgent care SPoA / integrated coordination centre): one call gives a professional access to multiple services for their patient (e.g. UCR / rapid response, hospital at home) | ü                        | 1            |
|              | A named clinician on duty in the integrated coordination centre holds the clinical risk                                                                                                                          | ü                        | 1            |
| <b>S1-F2</b> | Core professional referral routes in place: general practice, 111/CAS, GP out of hours and hospital discharge teams.                                                                                             | ü                        | 1            |
|              | Core referral routes out in place: the centre is able to admit to, or directly deploy: UCR, rapid response, step-up and step-down intermediate care, virtual ward, hospital at home, and social care reablement. | <input type="checkbox"/> | 1            |
| <b>S1-F3</b> | Centre is open at least 12 hours a day, 7 days a week                                                                                                                                                            | ü                        | 1            |
|              | Centre is open 24 hours a day, 7 days a week                                                                                                                                                                     | <input type="checkbox"/> | 1            |
| <b>S1-F4</b> | Gold line is in place: direct public access line for patients / carers of the end-of-life care cohort                                                                                                            | ü                        | 1            |
|              | Silver line is in place: direct public access line for patients / carers of the adult complex care cohort                                                                                                        | ü                        | 1            |
| <b>S1-F5</b> | Impact is being measured: place-wide non-elective activity baseline defined and in place.                                                                                                                        | ü                        | 1            |
|              | Impact is being reported: non-elective activity data produced and reviewed at least quarterly to assess impact against the baseline and goes through the board at least twice a year.                            | ü                        | 1            |
|              | <b>S1 stage total (sum of ticks)</b>                                                                                                                                                                             | <b>8</b>                 | <b>of 10</b> |

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## S2. General practice access and variation

*Framework requirement: Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements.*

The model: there is a named accountable person who reports at least quarterly in public Board on plans and progress related to GP core hours, phone access, urgent access and patient experience. There is also a named provider with improvement capability that is commissioned to support practices in difficulty with improvement. Public discussion is at place level; no item requires naming individual practices in public.

| Factor       | Item (1 point each)                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S2-F1</b> | Accountability: a named accountable person in place responsible for tracking and improving unwarranted variation                              | ü                        | 1            |
|              | There is a report on general practice variation taken to public Board outlining plans and progress at least quarterly.                        | <input type="checkbox"/> | 1            |
| <b>S2-F2</b> | Core hours: the data is collected and reviewed monthly                                                                                        | ü                        | 1            |
|              | Core hours: position discussed in public                                                                                                      | <input type="checkbox"/> | 1            |
| <b>S2-F3</b> | Urgent access: the data reviewed, with a tracker in place                                                                                     | ü                        | 1            |
|              | Urgent access position discussed in public                                                                                                    | <input type="checkbox"/> | 1            |
| <b>S2-F4</b> | Patient experience: the GPPS data on phone access and overall experience are reviewed with discussions held with the practices in difficulty. | ü                        | 1            |
|              | Patient experience position and plans for part of the public board discussions                                                                | <input type="checkbox"/> | 1            |
| <b>S2-F5</b> | Improvement support: a named provider in the place with the capability to support improvement in general practice                             | ü                        | 1            |
|              | That provider commissioned to provide support to practices in difficulty                                                                      | ✓                        | 1            |
|              | <b>S2 stage total (sum of ticks)</b>                                                                                                          | <b>6</b>                 | <b>of 10</b> |

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### S3. Neighbourhood footprints

*Framework requirement: Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).*

The model: one agreed geography where there is alignment across general practice, PCNs, community and mental health teams, social care and voluntary sector. Footprints are grown from PCNs on JSNA evidence and post-LGR boundaries, signed off at the HWB. The full model includes co-location.

| Factor       | Item (1 point each)                                                                                   | Tick                       | Points       |
|--------------|-------------------------------------------------------------------------------------------------------|----------------------------|--------------|
| <b>S3-F1</b> | Footprints agreed across the system and with the local authority.                                     | ü                          | 1            |
|              | Footprints have been signed off at a public meeting of the HWB.                                       | ü                          | 1            |
| <b>S3-F2</b> | PCNs aligned to the neighbourhood footprints with very few exceptions.                                | ✓                          | 1            |
|              | A clear named accountable leader is in place for each neighbourhood                                   | <input type="checkbox"/>   | 1            |
| <b>S3-F3</b> | Community health services are organised with a dedicated team for each neighbourhood                  | <input type="checkbox"/>   | 1            |
|              | Mental health services are organised with a dedicated team for each neighbourhood                     | ü                          | 1            |
| <b>S3-F4</b> | A named VCFSE lead, or an agreed VCFSE representation arrangement is in place for each neighbourhood. | <input type="checkbox"/>   | 1            |
|              | A named adult social care lead is in place for each neighbourhood                                     | ü <input type="checkbox"/> | 1            |
| <b>S3-F5</b> | There is co-location of teams (beyond general practice and PCNs) in some neighbourhoods               | ✓                          | 1            |
|              | There is co-location of teams (beyond general practice and PCNs) in the majority of neighbourhoods    | <input type="checkbox"/>   | 1            |
|              | <b>S3 stage total (sum of ticks)</b>                                                                  | 6 4                        | <b>of 10</b> |

### S4. INTs for priority cohorts and devolved budgets

*Framework requirement: Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area.*

The model: the service for older complex adults, most often moderate to severe frailty, care home, housebound and end of life, consists of three components. The three components are proactive care, an MDT for those with elevated risk - which are covered in this stage - and a 24/7 reactive care component which is covered in Stage 1. The end-state model includes a delegated budget to support targeted interventions to drive healthy neighbourhood by tackling wider determinants for individuals or smaller cohorts within the neighbourhood.

| Factor       | Item (1 point each)                                                                                                        | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S4-F1</b> | Proactive care (model): GP-led proactive care for older adults with complex needs operating in at least one neighbourhood. | ü                        | 1      |
|              | Proactive care model operating across all neighbourhoods.                                                                  | ü                        | 1      |
| <b>S4-F2</b> | Proactive care (contract): a contract is in place, e.g. PCN DES variant, LES for all neighbourhoods.                       | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                                                                                                           | Tick                     | Points       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
|              | The proactive care contract contains a variable payment element linked to patient coverage or outcomes                                                                                        | <input type="checkbox"/> | 1            |
| <b>S4-F3</b> | Proactive care (volume): service has been commissioned for more than 0.5 percent of the registered population                                                                                 | ü                        | 1            |
|              | Proactive care has been commissioned for at least 1 percent of the registered population                                                                                                      | ü                        | 1            |
| <b>S4-F4</b> | Elevated risk INT (model): an MDT of primary care, community, mental health and social care staff, with VCFSE, operating in at least one neighbourhood.                                       | ✓                        | 1            |
|              | The MDT model for elevated risk is operating across all neighbourhoods.                                                                                                                       | ✓                        | 1            |
| <b>S4-F5</b> | Healthy neighbourhood: local authority and VCFSE supporting individuals with targeted interventions that focus on wider determinants, e.g. youth workers, housing support, employment support | ü                        | 1            |
|              | Delegated budget is in place to commission healthy neighbourhood partnership work addressing wider determinants                                                                               | <input type="checkbox"/> | 1            |
|              | <b>S4 stage total (sum of ticks)</b>                                                                                                                                                          | <b>7</b>                 | <b>of 10</b> |

### S5. Neighbourhood approach to elective pathways

*Framework requirement: Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population.*

The model: there are four outpatient reform models emerging: (i) trust-run community specialist clinics; (ii) GPwER running community tier 2 often with specialist support; (iii) commissioned GP and consultant shared care as the mechanism for reviewing referrals, waiting lists and follow-up lists; and (iv) a population-based relationship model with consultants and specialist nurses aligned to neighbourhoods, delivering care and supporting GPs and their teams.

| Factor       | Item (1 point each)                                                                                                                                | Tick                     | Points |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S5-F1</b> | A plan is in place that maps the four models to named specialties, stating how each model's impact will be measured.                               | <input type="checkbox"/> | 1      |
|              | There is a named accountable lead for delivering the outpatient reform plan.                                                                       | ü                        | 1      |
| <b>S5-F2</b> | There are trust-run subcontracted clinics, e.g. ENT (microsuction, tinnitus) or gynaecology (complex coils, pessaries), operating in one specialty | <input type="checkbox"/> | 1      |
|              | There are trust-run subcontracted clinics operating in more than one specialty                                                                     | <input type="checkbox"/> | 1      |
| <b>S5-F3</b> | There are GPwER tier 2 services commissioned in one specialty.                                                                                     | <input type="checkbox"/> | 1      |
|              | There are GPwER tier 2 services commissioned in more than one specialty                                                                            | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                                                              | Tick                     | Points       |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S5-F4</b> | There are commissioned GP and consultant shared care services operating in one specialty: reviewing referrals, waiting lists and follow-up lists | <input type="checkbox"/> | 1            |
|              | There are commissioned GP and consultant shared care services operating in multiple specialties                                                  | <input type="checkbox"/> | 1            |
| <b>S5-F5</b> | There is a population-based relationship model operating in one speciality.                                                                      | <input type="checkbox"/> | 1            |
|              | There is a population-based relationship model operating across all neighbourhoods in the place.                                                 | <input type="checkbox"/> | 1            |
|              | <b>S5 stage total (sum of ticks)</b>                                                                                                             | 1                        | <b>of 10</b> |

## S6. Community waits

*Framework requirement: Confirm plans to meet 18-week community waits and eliminate 52-week waits.*

The model: community waits, meaning the pathways reported in the CHS SitRep, solved by redesign doing the heavy lifting with waiting list initiatives clearing legacy backlogs alongside. Demand shaped before referral, post-diagnostic follow-up delivered through commissioned shared care so specialists are free to assess and diagnose, support in place whilst waiting in line with the NHSE community waiting times action lists and checklist (March 2026), and the published standards met on the way through. Neurodevelopmental waits are reported both included and excluded so positions are comparable across systems, and children's waits are identified separately: the same wait is a larger share of a child's life.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                                                      | Tick                     | Points |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| <b>S6-F1</b> | Trajectories confirmed and minuted for 18-week performance and 52-week elimination across the community pathways reported in the CHS SitRep, with adult and children's waits identified separately and stated both including and excluding neurodevelopmental pathways (autism and ADHD) | <input type="checkbox"/> | 1      |
|              | The data supporting the plan has been data quality assured through a quarterly technical and clinical validation process.                                                                                                                                                                | <input type="checkbox"/> | 1      |
| <b>S6-F2</b> | A plan agreed naming which pathways are to be redesigned in line with the NHSE community waiting times action lists and checklist (March 2026)                                                                                                                                           | <input type="checkbox"/> | 1      |
|              | Demonstrated progress on at least two pathways to give reassurance the plan is deliverable.                                                                                                                                                                                              | <input type="checkbox"/> | 1      |
| <b>S6-F3</b> | Post-diagnostic follow-up delivered through commissioned shared care arrangements on at least one pathway                                                                                                                                                                                | <input type="checkbox"/> | 1      |
|              | On the two longest-wait community pathways on published data, released specialist time evidenced                                                                                                                                                                                         | <input type="checkbox"/> | 1      |
| <b>S6-F4</b> | Demonstrated progress to the 2026/27 objective of 78 percent of waits under 18 weeks met with over 65 percent of waits under 18 weeks today.                                                                                                                                             | <input type="checkbox"/> | 1      |
|              | The 2026/27 objective of 78 percent of waits under 18 weeks met, or trajectory exceeded, on published data                                                                                                                                                                               | <input type="checkbox"/> | 1      |

| Factor       | Item (1 point each)                                                                                | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S6-F5</b> | 52-week count falling on published data, or board-approved path to zero within the planning period | <input type="checkbox"/> | 1            |
|              | Zero 52-week waits                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S6 stage total (sum of ticks)</b>                                                               | 3                        | <b>of 10</b> |

### S7. Better Care Fund pooled funding

*Framework requirement: Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care.*

The model: pooled money working at both place and neighbourhood level. BCF confirmed with every local authority; joint assessment and decisions grounded in the JSNA and joint local health and wellbeing strategy; funds delegated to the footprints; BCF investment demonstrably changed in response to the neighbourhood health plan guidance, implemented and contractually underpinned; and inequalities impact measured scheme by scheme, reported annually in public at the HWB.

| Factor       | Item (1 point each)                                                                                                                                                          | Tick                     | Points       |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S7-F1</b> | Joint BCF position confirmed with local authority.                                                                                                                           | <input type="checkbox"/> | 1            |
|              | Minimum mandated NHS contribution to adult social care has been met                                                                                                          | <input type="checkbox"/> | 1            |
| <b>S7-F2</b> | Joint assessment and decision-making route documented, with the assessment incorporating JSNA, the joint local health and wellbeing strategy, and NHS and social care demand | <input type="checkbox"/> | 1            |
|              | At least two funding decisions minuted in the last 12 months, including winter capacity planning                                                                             | <input type="checkbox"/> | 1            |
| <b>S7-F3</b> | At least one pooled scheme aligned to the neighbourhood footprints, with spend recorded                                                                                      | <input type="checkbox"/> | 1            |
|              | Changes to BCF investment planned in response to the neighbourhood health plan guidance, with the changes named                                                              | <input type="checkbox"/> | 1            |
| <b>S7-F4</b> | Those BCF investment changes implemented: the changed schemes in operation                                                                                                   | <input type="checkbox"/> | 1            |
|              | Underpinned by signed agreements (Section 75 or variation), operating                                                                                                        | <input type="checkbox"/> | 1            |
| <b>S7-F5</b> | A named health inequalities measure per scheme, relating back to the JSNA                                                                                                    | <input type="checkbox"/> | 1            |
|              | Reported at least annually at the HWB in public, with results feeding the next funding round                                                                                 | <input type="checkbox"/> | 1            |
|              | <b>S7 stage total (sum of ticks)</b>                                                                                                                                         | 3                        | <b>of 10</b> |

## S8. Primary and secondary care interface

*Framework requirement: Continue to improve the primary and secondary care interface in line with the red tape challenge.*

The model: an interface working as one system. There is a documented priority plan, all providers and the full primary care family are in scope, operational and strategic meetings are in place, the red tape challenge changes are delivered in practice, and there is a shared workforce through joint leadership development and neighbourhood PAs in consultant job plans, with a named clinical SRO and PMO support.

| Factor       | Item (1 point each)                                                                                                                                                                                                                                            | Tick                     | Points       |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S8-F1</b> | There is a documented interface priority plan aligned to the GIRFT checklist and red tape challenge, covering medicines management, digital and estates, with the full primary care family in scope (general practice, community pharmacy, dental, optometry). | <input type="checkbox"/> | 1            |
|              | All provider organisations, including community and mental health, have completed the self-assessment and use the data to target improvement.                                                                                                                  | ✓                        | 1            |
| <b>S8-F2</b> | Operational interface meetings are in place with the priority organisations identified through self-assessment, with agendas and action tracking.                                                                                                              | ✓                        | 1            |
|              | An agreed meeting cycle is operating with each provider organisation, with actions closing.                                                                                                                                                                    | ✓                        | 1            |
| <b>S8-F3</b> | Red tape challenge and GIRFT checklist changes are being delivered in at least one organisation.                                                                                                                                                               | <input type="checkbox"/> | 1            |
|              | Red tape challenge and GIRFT checklist changes are delivered by every provider, including a single patient record accessible for direct care.                                                                                                                  | <input type="checkbox"/> | 1            |
| <b>S8-F4</b> | A strategic interface meeting is held at least quarterly, with a named clinical SRO, PMO support and executive governance.                                                                                                                                     | ✓                        | 1            |
|              | An agreed clinical leadership development programme is in place, with participants active in the interface forums.                                                                                                                                             |                          | 1            |
| <b>S8-F5</b> | Job planning policy provides for neighbourhood PAs, with at least one signed job plan in the 10 high volume specialties.                                                                                                                                       | <input type="checkbox"/> | 1            |
|              | Local job planning rounds have resulted in neighbourhood PAs in more than half of specialties with neighbourhood-facing work.                                                                                                                                  | <input type="checkbox"/> | 1            |
|              | <b>S8 stage total (sum of ticks)</b>                                                                                                                                                                                                                           | 40                       | <b>of 10</b> |

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## S9. Organisational ownership

*Framework requirement: Confirm organisational ownership of planned deliverables.*

The model: clear ownership. There is a named accountable lead for every stage, taken through the Board, with an overall delivery owner in the ICB; a host, anchor or integrator in every place; general practice coordinated across the Place; and accountability exercised through working governance.

| Factor       | Item (1 point each)                                                                                                                                                           | Tick                     | Points       |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------|
| <b>S9-F1</b> | There is a named accountable lead for at least 8 of the 10 Stage 1 requirements of the Neighbourhood Health Framework                                                         | ü                        | 1            |
|              | There is a named accountable lead for all 10 stages which has been taken through the Board with an overall delivery owner in the ICB.                                         | <input type="checkbox"/> | 1            |
| <b>S9-F2</b> | A host, anchor or integrator is named in every place that is able to co-ordinate INT and neighbourhood development.                                                           | <input type="checkbox"/> | 1            |
|              | The host, anchor or integrator organisation has been commissioned.                                                                                                            | <input type="checkbox"/> | 1            |
| <b>S9-F3</b> | The general practice foundation for neighbourhoods is organised and coordinated across Place through an organisation which has the support of the vast majority of practices. | ü                        | 1            |
|              | The organisation that is coordinating general practice has been commissioned.                                                                                                 | <input type="checkbox"/> | 1            |
| <b>S9-F4</b> | Scheme of delegation or terms of reference documented for the integrator                                                                                                      | <input type="checkbox"/> | 1            |
|              | Exercised, with decisions minuted                                                                                                                                             | <input type="checkbox"/> | 1            |
| <b>S9-F5</b> | Delivery reporting established                                                                                                                                                | <input type="checkbox"/> | 1            |
|              | At least two consecutive cycles with actions and escalation recorded                                                                                                          | <input type="checkbox"/> | 1            |
|              | <b>S9 stage total (sum of ticks)</b>                                                                                                                                          | <b>2</b>                 | <b>of 10</b> |

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S10. Data sharing for identification and evaluation

Framework requirement: Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.

The model: data sharing signed and used. Every sector signed up, general practice counted by share of practices, enabling the risk stratification and single patient record that are scored where they operate (S4 and S8). VCFSE and smaller partner sign-up is expected to come with information governance support from the system; the item scores the arrangement being in place, not unsupported compliance.

| Factor | Item (1 point each)                                                                         | Tick | Points |
|--------|---------------------------------------------------------------------------------------------|------|--------|
| S10-F1 | More than 90 percent of practices signed up to the data sharing arrangements.               | ü    | 1      |
|        | More than 99 percent of practices signed up to data sharing arrangements.                   | ✓    | 1      |
| S10-F2 | Acute trusts signed up, with data in active use, particularly in emergency department areas | `ü   | 1      |
|        | Community services signed up and data in active use                                         | ü    | 1      |
| S10-F3 | Mental health trust signed up to data sharing arrangements and data in active use           | ü    | 1      |
|        | Social care signed up to data sharing arrangements and data in active use                   | ✓    | 1      |
| S10-F4 | VCFSE signed up and data in active use                                                      | ✓    | 1      |
|        | Other partners including community pharmacy signed up and data in active use                | □    | 1      |
| S10-F5 | Optometry signed up and data in active use                                                  | □    | 1      |
|        | Dental signed up and data in active use                                                     | □    | 1      |
|        | S10 stage total (sum of ticks)                                                              | 7    | of 10  |

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### 3. Glossary

Terms as used in this self-assessment.

| Term              | Meaning                                                                                      |
|-------------------|----------------------------------------------------------------------------------------------|
| <b>BCF</b>        | Better Care Fund                                                                             |
| <b>CAS</b>        | Clinical assessment service (within NHS 111)                                                 |
| <b>CHS SitRep</b> | Community health services situation report (the national community waiting times collection) |
| <b>DES / LES</b>  | Directed enhanced service / local enhanced service (general practice contract routes)        |
| <b>GIRFT</b>      | Getting It Right First Time                                                                  |
| <b>GMS</b>        | General medical services (the national GP contract)                                          |
| <b>GPPS</b>       | GP Patient Survey                                                                            |
| <b>GPwER</b>      | GP with an extended role                                                                     |
| <b>HWB</b>        | Health and wellbeing board                                                                   |
| <b>INT</b>        | Integrated neighbourhood team                                                                |
| <b>JSNA</b>       | Joint strategic needs assessment                                                             |
| <b>MDT</b>        | Multidisciplinary team                                                                       |
| <b>PAs</b>        | Programmed activities (consultant job plan sessions)                                         |
| <b>PCN</b>        | Primary care network                                                                         |
| <b>RTT</b>        | Referral to treatment (the 18-week elective standard)                                        |
| <b>PMO</b>        | Programme management office                                                                  |
| <b>SRO</b>        | Senior responsible owner                                                                     |
| <b>SPoA</b>       | Single point of access                                                                       |
| <b>UCR</b>        | Urgent community response                                                                    |
| <b>VCFSE</b>      | Voluntary, community, faith and social enterprise sector                                     |

## NHS LNR ICB

## Planned Trajectory - Key Next steps over the next 6, 12 and 18 months

Trajectory in development and currently being socialised - yet to be taken via ICB formal governance.

| 6 Months (work commences and continues beyond)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 12 Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 18 Months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Development of Strategic Commissioning approach and contracting frameworks for Neighbourhood Health</li> <li>Confirm local governance arrangements with system partners</li> <li>Accountability and Governance Frameworks – enabling place provider partnerships to deliver (tailored to each place) and supported by ICB in strategic commissioner role (to support consistency across LLNR)</li> <li>Place-based Neighbourhood Health Plans (including NNHIP delivery)</li> <li>Provider development and readiness (including clarity regarding Integrator role)</li> <li>Create mechanism to support Spread of Learning, best practice and evidence across programmes of work including reporting to Board</li> <li>Confirm neighborhood footprint arrangements and develop transition plans for Local Government Reorganisation impacts across LLR.</li> <li>Exploration of emerging funding opportunities – shared investment fund, social investment fund, system transformation grant.</li> <li>Development of a priority plan to support primary and secondary care interface</li> <li>Implement agreed access improvement trajectories and evaluate Same Day Access programmes. (Ongoing)</li> <li>Establish neighbourhood Health centers within 26/27 plan</li> <li>Develop appropriate data-sharing arrangements support robust patient identification and evaluation</li> </ul> | <ul style="list-style-type: none"> <li>Provider development and delivery of neighbourhood services (ongoing)</li> <li>Formalise provider partnership and neighbourhood governance arrangements where required.</li> <li>Funding flows - Limited funding in 2026/27 to support provider development or establishment of new models of neighbourhood health requiring significant shift in provider approaches to delivery and commissioning.</li> <li>Confirmed ICB and local authority plan to use pooled funding under the Better Care Fund in response to the neighbourhood health plan guidance</li> <li>Refresh LLNR Neighbourhood Needs Assessment and Outcome Framework.</li> <li>Spread of learning, innovation and best practice across the cluster and nationally. (ongoing)</li> <li>Explore and secure medium-term funding opportunities supporting neighbourhood transformation and prevention programmes.</li> <li>Review support arrangement across the cluster for appropriate management &amp; diversion of top 1% of service users</li> <li>Extend NMoC in Northamptonshire after successful business case and review arrangements in Leicestershire</li> <li>Implement learning and development from Standardising Community services &amp; potential IHO development into neighbourhood modelling</li> <li>Develop core inputs and outcomes expected for INTs</li> </ul> | <ul style="list-style-type: none"> <li>Development and delivery of neighbourhood services e.g. <ul style="list-style-type: none"> <li>delivery of integrated Neighbourhood Health that includes activity currently undertaken in acute settings</li> <li>scaling of delivery</li> </ul> </li> <li>Demonstrate measurable reductions in non-elective admissions, improved access and increased care delivered outside hospital settings.</li> <li>Embed outcomes-based commissioning and funding arrangements supporting neighbourhood health delivery.</li> <li>Demonstrate system-wide population health improvements through neighbourhood delivery and prevention-focused investment.</li> <li>Continuing spread of learning, innovation and best practice across the cluster and nationally. (ongoing)</li> <li>Use data dashboard to demonstrate trends in patient and referral behavior and evidence impact on wait times, patient outcomes and conversion rates for key specialties.</li> <li>Mature integrated neighbourhood health models operate consistently across all neighbourhood footprints. (ongoing)</li> <li>Secure long-term sustainable investment and governance arrangements for neighbourhood health.</li> <li>Work with system colleagues &amp; providers to develop community pathways in line with expected direction of travel for secondary care providers, Final within a neighbourhood model</li> </ul> |

- |                                                                                                                          |  |  |
|--------------------------------------------------------------------------------------------------------------------------|--|--|
| <ul style="list-style-type: none"><li>• Develop data and reporting mechanisms within a neighbourhood dashboard</li></ul> |  |  |
|--------------------------------------------------------------------------------------------------------------------------|--|--|

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# Boards Meeting in Common in Public Quality and Performance Assurance – LNR ICB Cluster

Thursday 15 October 2026

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|                            |                                                                   |                        |            |
|----------------------------|-------------------------------------------------------------------|------------------------|------------|
| <b>Name of Meeting</b>     | <b>Boards Meeting in Common in Public</b>                         |                        |            |
| <b>Date of Meeting</b>     | <b>Thursday 15 October 2026</b>                                   |                        |            |
| <b>Report Title</b>        | <b>Quality and Performance Assurance Report – LNR ICB Cluster</b> |                        |            |
| <b>Paper Reference No:</b> | <b>ICBIC-26-57</b>                                                | <b>Agenda Item No:</b> | <b>11.</b> |

|                          |                                                                                                                                                                                                                                   |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Presented by</b>      | Maria Laffan, Chief Nursing Officer<br>Eileen Doyle, Chief Delivery Officer                                                                                                                                                       |
| <b>Report Author(s)</b>  | Miranda Tapfumanei, Director of Nursing, Quality Assurance and Deputy Chief Nurse<br>Chris Pallot, Director of Operations and Deputy Chief Operating Officer<br>Julie Croysdale, Assistant Director of Nursing, Quality Assurance |
| <b>Executive Sponsor</b> | Maria Laffan, Chief Nursing Officer<br>Eileen Doyle, Chief Delivery Officer                                                                                                                                                       |

| Select the Primary Purpose for the Report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                         |                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>ADVISORY</b><br>To receive and note implications, may require discussion to shape or develop the item.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input checked="" type="checkbox"/> <b>ASSURANCE</b><br>To assure the Boards that controls and assurances are in place. | <input type="checkbox"/> <b>APPROVAL</b><br>Recommendation or particular course of action. |
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                         |                                                                                            |
| <p><b>The Boards are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>RECEIVE</b> the combined Quality and Performance Alert, Advise and Assure report.</li> <li>• <b>TAKE ASSURANCE</b> from the improvements and oversight arrangements described, while recognising that delivery and quality assurance remain incomplete in the highest-risk areas.</li> <li>• <b>NOTE</b> the sustained pressures in urgent and emergency care, elective recovery, diagnostics, mental health community services, secure care, mortality and CYP pathways.</li> <li>• <b>SUPPORT</b> continued executive oversight, targeted recovery action, independent triangulation of quality assurance and development of the LNR Quality and Outcomes Framework and integrated dashboard.</li> </ul> |                                                                                                                         |                                                                                            |

| Executive Summary of the report                                                                                                                                                                                                                                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>This report provides the October 2026 Quality and Performance position across the LNR ICB Cluster and highlights the principal areas requiring Board attention, assurance and oversight. Using an Alert, Advise and Assure framework, it describes both the risks facing the system and the actions being taken to improve outcomes, strengthen assurance and maintain delivery.</p> |  |

## Performance

Urgent and Emergency Care remains the most significant system challenge, with emergency department performance, ambulance responsiveness, discharge delays and patient flow pressures continuing across ICB cluster. Elective and diagnostic recovery continue to improve but remain off trajectory in several areas due to workforce, capacity and data-quality challenges. Mental health, community and children and young people's pathways continue to experience significant waiting-time pressures requiring sustained oversight.

## Quality

Quality concerns remain most significant in secure care services, mortality and health inequalities, children and young people's pathways and the impact of UEC pressures on patient experience and safety. The transfer of former St Andrew's services to NHFT, increasing CYP mortality concerns in Northamptonshire, infant mortality in LLR, and persistent neurodevelopmental waits require continued executive focus. The implications of the Thirlwall Inquiry and NHS England's five immediate actions are being incorporated into the LNR quality assurance approach through strengthened triangulation, professional curiosity and evidence-based assurance.

## Assurance and Improvement

The overall regulatory position remains broadly stable, with positive progress reported in maternity services, ambulance handovers, elective recovery, cancer pathways and community alternatives to hospital admission. Established provider, system and regional governance arrangements continue to identify, escalate and monitor risks, with targeted improvement plans in place for all high-risk areas. Development of the LNR Quality and Outcomes Framework and integrated Quality Intelligence and Outcomes Dashboard will further strengthen strategic oversight and assurance.

## Board Attention

The Boards are asked to note the continued risks associated with urgent and emergency care, secure care transition, mortality outcomes, health inequalities and CYP pathways, and take assurance that robust oversight, recovery and escalation arrangements are in place. Boards are also asked to support the continued implementation of the NHS England immediate actions arising from the Thirlwall Inquiry and the development of the LNR Quality and Outcomes Framework to strengthen future assurance and improvement.

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

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

### Conflicts of interest – Please select

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

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

|                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Who has been engaged and where else has this report been considered:</b></p> <p>The report reflects the September 2026 quality and performance position presented through the LNR Board Quality and Performance Summary for October 2026. Detailed oversight continues through the Quality, Performance and Outcomes Committee and established provider, system and regional governance arrangements.</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

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# Performance Executive Summary

## Alert

- UEC remains under significant pressure across both systems. Four-hour ED performance is below plan; ambulance performance remains particularly challenged in Northamptonshire, while LLR continues to experience demand, flow and discharge pressures.
- Elective recovery remains off trajectory in key areas. LLR total waiting list and 52-week waits are above plan; Northamptonshire recovery is being managed alongside data-quality issues following the NGH Nerve Centre migration.
- Diagnostics remain challenged. LLR is adverse to plan in MRI, Urodynamics and Echocardiography; Northamptonshire continues to experience workforce, capacity and validation issues across several modalities.
- Mental health and community waits require continued focus, including Talking Therapies, Individual Placement and Support, LDA inpatient discharge, CYP pathways and adult/CYP waits over 52 weeks.

## Risks

- Sustained emergency demand, winter pressures and constrained flow may affect UEC delivery and elective recovery across both systems.
- Workforce and capacity constraints remain significant across diagnostics, mental health, community services and selected cancer pathways.
- Data quality and reconciliation issues limit assurance in diagnostics, Northamptonshire RTT and CYPMH waiting-time reporting.
- Long waits in CYP neurodevelopmental and adult community services continue to affect experience, outcomes and system capacity.

## Assure

- LLR ambulance handover improvements have been maintained despite system pressures. Northamptonshire has improved average discharge delays and length of stay at NGH, and the new co-located UTC is operational.
- LLR 18-week performance continues to improve month on month. Northamptonshire reports reductions in 52-week waits and a narrowing gap to the waiting-list plan.
- Cancer has areas of positive delivery: LLR 31-day performance is forecast above plan; Northamptonshire reports improvement in 62-day performance and delivery above plan in selected pathways.
- Primary Care activity continues to grow across both ICBs, with access and strategic commissioning arrangements progressing.

## Advise

- Maintain executive oversight of UEC flow, discharge improvement and winter readiness across both ICBs.
- Continue targeted elective and diagnostic recovery, including validation, productivity, additional capacity and management of the longest waits.
- Sustain focus on mental health, LDA and community recovery, particularly workforce mobilisation, discharge barriers, CYP pathways and 52-week waits.
- Progress the LNR Primary Care Access Strategy and Strategic Commissioning Framework to sustain access improvements and reduce unwarranted variation.

# Quality Report – LNR Executive Summary

| Quality Risk                         | Trajectory & Impact                      | Key Issues                                                                                                                                                                                                                                                | Actions & Grip                                                                                                           |
|--------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Secure care and regulatory oversight | <b>Red – intensive oversight</b>         | Former St Andrew's services transferred to NHFT with inherited quality and regulatory concerns.                                                                                                                                                           | NHSE incident response, intensive oversight, weekly assurance and ICB quality visits continue.                           |
| Mortality and inequalities           | <b>Red/Amber – enhanced surveillance</b> | Increase in CYP deaths in Northamptonshire; infant mortality remains a priority in LLR.                                                                                                                                                                   | Nine-action improvement plan, mortality governance and independent CDOP review; multi-agency infant mortality programme. |
| Children and young people pathways   | <b>Red – sustained pressure</b>          | Long waits across neurodevelopmental pathways and complex CYP remaining in acute settings.                                                                                                                                                                | Executive oversight, recovery plans, pathway redesign and system working group on complex cases.                         |
| Urgent and emergency care quality    | <b>Red/Amber – challenged</b>            | Delayed discharge, handovers, corridor care, overcrowding and access to specialist mental health support.                                                                                                                                                 | Recovery programmes, System Quality Group oversight and focus on measurable patient impact.                              |
| Regulatory and service assurance     | <b>Green/Amber – broadly stable</b>      | Positive maternity inspection feedback for UHN, NGH rated Good; KGH positive feedback, awaiting final report. Good rating for the Agnes Unit, LPT; targeted concerns remain however and full report expected following CQC visit to some other LPT wards. | Provider governance, NQB oversight and enhanced monitoring remain in place where required.                               |

# Quality Report – LNR Executive Summary

| Provider                                    | NHS Oversight Framework (NOF) Level - Q1* | Quality Oversight Arrangements                                                                                                                                                                                                                                                                                                                                                                                                               | Key National Quality Board (NQB) concerns                                                                                                                                             |
|---------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Leicestershire Partnership NHS Trust</b> | NOF 2                                     | <ul style="list-style-type: none"> <li>Provider quality committee (bimonthly)</li> <li>System Quality Group (ICB led Oversight NHSE attend)</li> <li>New Quality schedule to start reporting in Q3</li> </ul>                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>Under Routine monitoring</li> <li>Awaiting CQC report for some MH wards following visit in September 26</li> </ul>                             |
| <b>Kettering General Hospital FT</b>        | NOF 3                                     | <ul style="list-style-type: none"> <li>Provider Review Meetings (monthly)</li> <li>NHSE-Improvement &amp; Oversight Assurance Group</li> <li>IPC Enhanced monitoring</li> <li>Maternity MSSP</li> <li>Provider quality committee (bimonthly)</li> <li>Quality Schedule reporting</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>Maternity: MSSP designation (June 2024)</li> <li>Maternity Neonatal Improvement Support Team</li> </ul>                                        |
| <b>Northampton General Hospital</b>         | NOF 4                                     | <ul style="list-style-type: none"> <li>Provider Review Meetings (monthly)</li> <li>NHSE Quality Improvement Group meeting to focus on Quality Improvement and not other NoF domains</li> <li>IPC Enhanced monitoring</li> <li>Provider quality committee (bimonthly)</li> <li>Quality Schedule reporting</li> </ul>                                                                                                                          | <ul style="list-style-type: none"> <li>UEC / Medicine: Section 29A Warning Notice (March 2025)</li> <li>Ongoing quality risks in 2025/26</li> <li>1 PFD</li> </ul>                    |
| <b>Northamptonshire Healthcare FT</b>       | NOF 2                                     | <ul style="list-style-type: none"> <li>Provider Review Meetings (quarterly)</li> <li>System Quality Group (ICB led Oversight NHSE attend)</li> </ul>                                                                                                                                                                                                                                                                                         | <ul style="list-style-type: none"> <li>IPC reporting (outbreaks V category) -requires validating</li> <li>Immediate actions required in community services (CYP dietetics)</li> </ul> |
| <b>University Hospitals Leicester (UHL)</b> | NOF 3                                     | <ul style="list-style-type: none"> <li>Provider Review Meetings (bi- monthly)</li> <li>Maternity UHL Enhanced oversight through 6 monthly touch point meetings, Chaired by Trust, Regional Chief Nursing Officer / Regional Chief Midwifery Officer attends.</li> <li>Provider quality committee (bimonthly)</li> <li>System Quality Group (ICB led Oversight NHSE attend)</li> <li>New Quality schedule to start reporting in Q3</li> </ul> | <ul style="list-style-type: none"> <li>Independent Maternity – X3 MOSS alerts (since March 26 – 1 requiring external review (L2)</li> <li>1PFD</li> </ul>                             |

**IMPORTANT NOTE** NOF reporting methodology has changed; current performance is not directly comparable with previous reporting due to the move from benchmarking and quartiles to threshold-based monitoring. The Medium Low Secure Service (formerly known as St Andrews will now form part of NHFT reporting)

| Impact | Issue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| N      | <b>St Andrew’s healthcare transition</b><br>NHFT has assumed responsibility for the Medium Low Secure services. The inherited service carries significant historical quality and regulatory concerns. Intensive national and local oversight remains necessary to assure safety, safeguarding, workforce stability, regulatory compliance and sustainable improvement.                                                                                                                                                                                                                                                                 |
| N      | <b>Children and Young People</b><br>The quality risk is red following an increase in deaths, including unexpected deaths. The local signal supports enhanced surveillance and thematic review but does not establish causation. The review found that agencies often held separate parts of the risk picture, without consistent whole-system visibility.<br><br>A nine-action improvement plan, six-month Quality Improvement Group, new System Mortality Group and independent CDOP review are in place. The risk will be monitored through established governance, with consideration of the link to the Board Assurance Framework. |
| LLR    | <b>Infant Mortality</b><br>Infant mortality remains a significant quality and inequalities priority. Multi-agency improvement arrangements are in place, with a continued focus on modifiable factors, prevention, outcomes and wider determinants.                                                                                                                                                                                                                                                                                                                                                                                    |
| LNR    | <b>Neurodevelopmental Delays</b><br>Demand continues to exceed capacity across ADHD, autism and community pediatric pathways, affecting outcomes, experience and equity for children and families.                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| N      | <b>The Squirrels Overnight Short Breaks</b><br>Overnight short breaks at The Squirrels remain paused. Expansion of the JGS home with Action for Children is planned from January 2027, subject to Ofsted approval, but cannot accommodate continuing care eligible children who require CQC regulated care. The ICB is providing interim support and developing alternative provision for these families.                                                                                                                                                                                                                              |

| Impact | Issue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| LNR    | <b>Urgent and Emergency Care Quality impacts</b><br>Pressures continue across discharge, ambulance handovers, corridor care, overcrowding and access to specialist mental health support. Improvement and recovery arrangements are established, but sustained oversight is required to demonstrate safer flow, better experience and reduced variation. Deep Dive at SQG highlighted specific Quality Improvement actions to be taken forward.                                       |
| LNR    | <b>Thirlwall Inquiry Response</b><br>The Inquiry found that commissioners and oversight bodies accepted provider reassurance without sufficient challenge or corroborating evidence. The five NHS England immediate actions form the LNR response and assurance framework. Assurance will be strengthened through professional curiosity and triangulation of mortality, safeguarding, incidents, complaints, speaking-up, family experience and staff intelligence. (see appendix 2) |
| LNR    | <b>NHS Quality Strategy 2026</b><br>Future oversight should retain provider assurance while placing greater emphasis on outcomes, improvement, health inequalities, unwarranted variation and the impact of strategic commissioning decisions.                                                                                                                                                                                                                                        |
| LNR    | <b>End of Life Care</b><br>Medical Examiner intelligence has identified variation in access to symptom control medication, community support and wider support for patients and carers. System review and assurance should continue through existing governance. Deep Dive to be arranged for November at SQG.                                                                                                                                                                        |
| LNR    | <b>Families First Safeguarding Reforms (Multi-Agency Child Protection Teams)</b><br>Senior health practitioners must be embedded in Multi-Agency Child Protection Teams by March 2027. Funding and workforce implications for health under review being considered by ICB CNO Team.                                                                                                                                                                                                   |
| N      | <b>UHN Executive Leadership</b><br>Significant executive changes: new Chief Executive in post; recruitment ongoing to Chief Nursing, Finance and Operating Officer roles.                                                                                                                                                                                                                                                                                                             |

| Impact | Issue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| LNR    | <b>Regulatory Position</b><br>The overall position is broadly stable. Positive KGH maternity inspection feedback has been received, and NGH and Agnes Unit were rated Good. Targeted enhanced oversight continues where required.                                                                                                                                                                                                                                                                                            |
| LNR    | <b>Quality Governance</b><br>Significant risks continue to be identified, escalated and monitored through established provider, system and regional arrangements. Improvement programmes remain in place for the highest-risk areas.                                                                                                                                                                                                                                                                                         |
| LNR    | <b>DHU Service Development</b><br>The Northamptonshire Night Response Service reports an estimated 82.2% ambulance deflection rate. The planned LLR Single Point of Access is intended to strengthen pathway coordination and alternatives to hospital care.                                                                                                                                                                                                                                                                 |
| LNR    | <b>Assertive Outreach and Antimicrobial Stewardship</b><br>Regional self-assessment provides positive assurance on governance and multidisciplinary working. Further work is focused on data maturity, outcome measurement and integrated strategic oversight.                                                                                                                                                                                                                                                               |
| LLR    | <b>Leicestershire Area SEND Inspection</b><br>An Ofsted and CQC area inspection of Special Educational Needs and Disabilities (SEND) in Leicestershire is underway. The ICB is participating as a statutory partner; the outcome will be reported on publication.                                                                                                                                                                                                                                                            |
| LNR    | <b>Local SEND Reform Plans Approved</b><br>The Department for Education (DfE) has approved all five Local SEND Reform Plans across Leicester, Leicestershire, Rutland, North Northamptonshire and West Northamptonshire, recognising progress in leadership, governance and partnership working. The focus now turns to implementation and delivery, with progress monitored through ongoing DfE engagement and an emphasis on tangible improvements in the experiences and outcomes of children and young people with SEND. |

# Board is asked to

RECEIVE

the Quality, Performance and Outcomes report.

TAKE ASSURANCE

from the quality governance, oversight and escalation arrangements in place across LNR, recognising that assurance is not complete in the highest-risk areas.

NOTE

the significant quality risks relating to secure care transition, urgent and emergency care, neurodevelopmental waits, infant mortality, CYP deaths, paused overnight short breaks and the unfunded Families First child protection reforms.

NOTE

the Thirlwall Inquiry implications and the five immediate actions forming the LNR response and assurance framework.

SUPPORT

development of the LNR Quality and Outcomes Framework and integrated Quality Intelligence and Outcomes Dashboard.

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# Appendix 1: Glossary of terms

Terms and abbreviations used in the LNR Board Quality and Performance Summary slides (1 of 2).

| Term                          | Meaning                                        |
|-------------------------------|------------------------------------------------|
| ADHD                          | Attention Deficit Hyperactivity Disorder       |
| CDOP                          | Child Death Overview Panel                     |
| CQC                           | Care Quality Commission                        |
| CYP                           | Children and Young People                      |
| CYPMH                         | Children and Young People's Mental Health      |
| DHU                           | DHU Healthcare                                 |
| ED                            | Emergency Department                           |
| ICB / ICBs                    | Integrated Care Board / Integrated Care Boards |
| IPC                           | Infection Prevention and Control               |
| Kettering General Hospital FT | Kettering General Hospital Foundation Trust    |
| L2                            | Level 2                                        |
| LDA                           | Learning Disability and Autism                 |
| LLR                           | Leicester, Leicestershire and Rutland          |
| LNR                           | Leicestershire, Northamptonshire and Rutland   |
| LPT                           | Leicestershire Partnership NHS Trust           |
| MH                            | Mental Health                                  |
| MOSS                          | Maternity Outcomes Signal System               |
| MRI                           | Magnetic Resonance Imaging                     |

# Appendix 1: Glossary of terms

Terms and abbreviations used in the LNR Board Quality and Performance Summary slides (2 of 2).

| Term                                         | Meaning                                               |
|----------------------------------------------|-------------------------------------------------------|
| MSSP                                         | Maternity Safety Support Programme                    |
| N                                            | Northamptonshire                                      |
| NGH                                          | Northampton General Hospital                          |
| NHFT                                         | Northamptonshire Healthcare NHS Foundation Trust      |
| NHS                                          | National Health Service                               |
| NHSE                                         | NHS England                                           |
| NHSE-Improvement & Oversight Assurance Group | NHS England Improvement and Oversight Assurance Group |
| NHS Oversight Framework (NOF)                | NHS Oversight Framework                               |
| NQB                                          | National Quality Board                                |
| PFD / PFDs                                   | Prevention of Future Deaths report / reports          |
| Q1 / Q3                                      | Quarter 1 / Quarter 3                                 |
| RTT                                          | Referral to Treatment                                 |
| SQG                                          | System Quality Group                                  |
| UEC                                          | Urgent and Emergency Care                             |
| University Hospitals Leicester (UHL)         | University Hospitals Leicester                        |
| UHN                                          | University Hospitals of Northamptonshire              |
| UTC                                          | Urgent Treatment Centre                               |

# **Boards Meeting in Common in Public**

## **The Thirlwall Inquiry:**

### **Recommendations and Implications for LNR ICB**

**Thursday 15 October 2026**

Middlebrook, Claire  
08/10/2026 14:28:57

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

|                            |                                                                            |                        |            |
|----------------------------|----------------------------------------------------------------------------|------------------------|------------|
| <b>Name of Meeting</b>     | <b>Boards Meeting in Common in Public</b>                                  |                        |            |
| <b>Date of Meeting</b>     | <b>Thursday 15 October 2026</b>                                            |                        |            |
| <b>Report Title</b>        | <b>The Thirlwall Inquiry: Recommendations and Implications for LNR ICB</b> |                        |            |
| <b>Paper Reference No:</b> | <b>ICBIC-26-58</b>                                                         | <b>Agenda Item No:</b> | <b>12.</b> |

|                          |                                                                                                   |
|--------------------------|---------------------------------------------------------------------------------------------------|
| <b>Presented by</b>      | <b>Maria Laffan, Chief Nursing Officer, LNR ICB</b>                                               |
| <b>Report Author(s)</b>  | <b>Miranda Tapfumanei, Director of Nursing, Quality Assurance and Deputy Chief Nurse, LNR ICB</b> |
| <b>Executive Sponsor</b> | <b>Maria Laffan, Chief Nursing Officer, LNR ICB</b>                                               |

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

| <b>Recommendations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>The Boards are asked to:</b></p> <ul style="list-style-type: none"> <li>• <b>RECEIVE</b> and <b>NOTE</b> the Thirlwall Inquiry findings and recommendations, including the implications for commissioners and oversight bodies.</li> <li>• <b>NOTE</b> the alignment with the Amos investigation and that the common themes will be addressed through the existing maternity and neonatal assurance programme.</li> <li>• <b>APPROVE</b> the five NHS England immediate actions as the framework for the LNR ICB system response and assurance, with progress overseen by the Joint Quality, Performance and Outcomes Committee and existing safeguarding governance.</li> <li>• <b>SUPPORT</b> strengthened speaking up and safeguarding assurance, including Board self-assessments of professional curiosity and Freedom to Speak Up.</li> <li>• <b>NOTE</b> the key strategic risks proposed for the Board Assurance Framework.</li> <li>• <b>NOTE</b> that a consolidated system gap analysis will return to the Joint Quality, Performance and Outcomes Committee within three months, with material exceptions escalated to the Boards sooner.</li> </ul> |

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### Executive Summary of the report

The Thirlwall Inquiry, published on 15 September 2026, found profound failures of leadership, safeguarding, culture and oversight that allowed concerns about the safety of babies at the Countess of Chester Hospital to persist despite repeated warnings. Failures lay not only within the hospital but within commissioning and oversight, where provider reassurance was accepted without challenge or corroborating evidence. The Inquiry makes 17 recommendations (paragraphs 2 to 4, Appendix 1).

NHS England has directed every Trust and ICB Board to consider the report at its next public meeting and to complete five immediate actions: Board review; SUDIC compliance; improved bereavement care; insulin security on neonatal units; and assurance of safeguarding training, escalation and culture (Table 1). The findings closely mirror the Amos investigation (Appendix 2). LNR ICB now holds the commissioning, quality oversight and safeguarding responsibilities the Inquiry criticised, and will seek assurance from all relevant providers (paragraphs 5 to 9).

The principal lesson for the Boards is that assurance must be based on evidence, rooted in professional curiosity and tested through triangulation of intelligence from providers, safeguarding partners, families, staff and system quality surveillance. The proposed response uses the five actions as its framework and strengthens speaking up, safeguarding assurance, mortality governance and maternity and neonatal quality surveillance. Oversight will sit with the Joint Quality, Performance and Outcomes Committee, with a consolidated system gap analysis due within three months (paragraphs 10 to 13).

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

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

### Conflicts of interest – Please select

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

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

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

LLR ICB BAF No: 5

NICB BAF No: 1

### Appendices

Appendix 1: Thirlwall Inquiry recommendations and implications for LNR ICB  
Appendix 2: Alignment of the Amos and Thirlwall investigations

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

This report has been prepared by the ICB nursing and quality team, drawing on the Inquiry report and recommendations, the NHS England letter of 21 September 2026 and the Regional Perinatal Services Board of 24 September 2026.

The full report was considered by the Joint Quality, Performance and Outcomes Committee on 13 October 2026, which supported it forming the basis of this item.

Provider, safeguarding, medical, digital and finance colleagues, and the Maternity and Neonatal Voices Partnerships, will be engaged through the response set out in paragraph 12.

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

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

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# The Thirlwall Inquiry: Recommendations and Implications for LNR ICB

October 2026

## Introduction

1. NHS England requires every ICB Board to consider the Thirlwall Inquiry at its next public meeting. This report summarises the Inquiry findings and recommendations, considers them alongside the Amos investigation, NHS England's immediate actions and the local picture, and sets out a single system response for the Boards to approve.

## The Thirlwall Inquiry

2. The Inquiry, chaired by Lady Justice Thirlwall, examined events at the Countess of Chester Hospital from 2015 to 2018, where former neonatal nurse Lucy Letby murdered and attempted to murder babies in her care. It was also asked to identify lessons for the wider NHS. The report, in three volumes, was presented to Parliament on 15 September 2026.
3. The Inquiry's central findings include:
  - a. consultants' concerns were not acted on, and concerns raised by staff were not consistently handled as patient safety issues;
  - b. suspected deliberate harm by a member of staff was not treated as a safeguarding matter; SUDIC was not used; and police involvement was delayed until May 2017;
  - c. Inquiry found that executives prioritised organisational reputation and provided incomplete and, in places, misleading information to commissioners, regulators, the coroner and families; and
  - d. commissioners and oversight bodies accepted provider reassurance without sufficient challenge: the lead clinical commissioning group closed a Serious Incident investigation as adequate, and regional commissioners returned surveillance to routine before the underlying evidence had been established.
4. The Inquiry makes 17 recommendations (Appendix 1), which fall into five groups:
  - a. security and care on neonatal units: in cot cameras, insulin security and bereavement care (Recommendations 1 to 3);
  - b. safeguarding and the response to suspected harm by staff: training, contracts, SUDIC, a national Suspicion of Deliberate Harm Protocol and an independent expert panel (Recommendations 4 and 8 to 10);
  - c. safety intelligence and death review: interoperable systems, Board monitoring of all deaths of babies and children, MBRRACE reporting,

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- medical examiners and perinatal pathology (Recommendations 5 to 7, 11 and 12);
- d. leadership accountability and speaking up: regulation and an individual duty of candour for managers, and transfer of National Guardian's Office functions to the Ombudsman (Recommendations 13 and 16); and
  - e. regulation and implementation: CQC inspection and scrutiny, and National Audit Office audit of inquiry recommendations (Recommendations 14, 15 and 17).

## Alignment with the Amos investigation

5. The Regional Perinatal Services Board considered the Inquiry on 24 September 2026. Its comparison (Appendix 2) identifies common themes with the Amos investigation, including listening to families, safety culture, speaking up, safety intelligence, safeguarding vigilance and workforce capability. LNR ICB will address these through the existing maternity and neonatal assurance programme, aligned to the 10 Point Plan, rather than creating a separate action plan.

## NHS England immediate actions

6. NHS England's letter of 21 September 2026 requires every Trust and ICB Board to consider the report at its next public meeting and sets five immediate actions (Table 1). These actions provide the framework for the LNR ICB response.

Table 1: NHS England immediate actions (letter of 21 September 2026)

| Action                                                                                                                         | Deadline                                   |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. Board review of the report and local assurance arrangements                                                                 | Next public Board meeting                  |
| 2. SUDIC: Trusts with a neonatal unit confirm to staff and the Board that SUDIC applies to unexpected deaths on neonatal units | 28 September 2026                          |
| 3. Improve bereavement care (National Bereavement Care Pathway); support parents and staff                                     | Immediate; Inquiry deadline 31 August 2027 |
| 4. Insulin security: CCTV on neonatal insulin storage, recordings kept at least 28 days; GIRFT access and storage requirements | CCTV 30 November 2026; GIRFT 31 March 2027 |
| 5. Safeguarding training compliance for all staff and Board members; staff know how to raise and escalate concerns             | Immediate                                  |

## Local picture

7. LNR ICB now holds the commissioning, quality oversight and statutory safeguarding responsibilities relevant to the Inquiry's findings, including the designated doctor for child deaths function previously held within the clinical commissioning group. The key implication is that assurance should be evidence

based and independently triangulated, rather than relying on provider reassurance alone.

8. Providers are developing their responses. LNR ICB will seek evidence of Board consideration, gap analyses, implementation progress and resource implications from relevant providers.
9. The System CYP Deaths Rapid Quality Review, convened in July 2026 following a notable increase in unexpected child deaths in Northamptonshire, is a recent local test of how unusual patterns are detected and escalated. Its learning will inform this response.

## LNR ICB response to the five immediate actions

10.

### 1. Board review and professional curiosity

- consider the Inquiry at the Joint Quality, Performance and Outcomes Committee (13 October 2026) and in public at the Boards;
- complete a Board self-assessment of professional curiosity, drawing on the Insightful Provider Board guide, to test whether current quality, safety and safeguarding governance would identify similar patterns; and
- strengthen triangulation of incidents, complaints, mortality reviews, safeguarding reports, CDOP intelligence, staff survey results and Freedom to Speak Up data.

### 2. SUDIC

- seek confirmation from UHL, Northampton General Hospital and Kettering General Hospital that the required SUDIC communication has been completed;
- ensure SUDIC is applied to every sudden and unexpected death of a child aged 0 to 18, including babies who never left hospital, and across relevant pediatric, emergency and children's mental health settings; and
- review designated doctor and CDOP arrangements across Leicester, Leicestershire and Rutland and Northamptonshire, and include SUDIC compliance in routine safeguarding assurance reporting.

### 3. Bereavement care and family confidence. LNR ICB will seek assurance on provider progress with the National Bereavement Care Pathway, use Maternity and Neonatal Voices Partnership insight to understand family experience after neonatal and child loss, reinforce Martha's Rule and escalation routes, and include bereavement care and staff support in maternity and neonatal quality oversight.

### 4. Insulin security. LNR ICB will request provider gap analyses against GIRFT requirements, monitor CCTV and access control milestones through provider quality review, and assess system level financial and digital implications, escalating risks where required.

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5. Safeguarding and raising concerns. The Inquiry found that concerns were known but were not consistently heard, escalated or acted on. For LNR ICB, speaking up is a patient safety and safeguarding function, not solely a workforce matter. Assurance will therefore test effectiveness, not simply the existence of policies and processes.
  - confirm safeguarding training compliance for all ICB staff and Board members, and seek provider assurance on safeguarding competency, escalation routes and staff confidence to raise concerns;
  - ensure concerns about possible deliberate harm by staff are managed through safeguarding processes, not HR processes alone, and that those raising concerns are protected from detriment;
  - complete a Board self-assessment against the national Freedom to Speak Up guide for leaders and confirm Guardian capacity, the executive lead and the non-executive champion across the cluster;
  - report provider speaking up data, including evidence of learning, staff confidence and detriment, through quality governance, and ensure staff in primary care and smaller commissioned services have an independent route to speak up; and
  - ensure concerns raised directly with the ICB are recorded, acted on and escalated, and prepare for the transfer of National Guardian's Office functions to the Ombudsman.

## Wider recommendations

11. The remaining recommendations have four main implications for LNR ICB:

- Deaths and safety intelligence (Recommendations 5 to 7): seek evidence that Trust Board monitoring of all deaths of babies and children is effective and that MBRRACE lead reporters are in place.
- Specialist capacity (Recommendations 10 to 12): understand local access to neonatal expertise through medical examiner arrangements and access to pediatric and perinatal pathology.
- Leadership accountability (Recommendation 13): understand the implications for ICB managers of the proposed barring system, checks on senior manager moves and individual duty of candour.
- Resources: costs for cameras, insulin controls, interoperability, contracts and training are not yet quantified and will be considered through system financial planning.

12. The Chief Nursing Officer will lead the response with the Chief Medical Officer and safeguarding, workforce, digital and finance leads. LNR ICB will seek written confirmation from UHL, Northampton General Hospital, Kettering General Hospital and relevant community and mental health providers on the immediate actions, Board consideration and gap analyses. Progress will be overseen by the Joint Quality, Performance and Outcomes Committee and existing safeguarding governance, with a consolidated system gap analysis returning to the Committee within three months. Assurance will be reported to the Boards through the Quality and Performance Alert, Advise and Assure report, with material exceptions escalated sooner.

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## Key strategic risks

13. The key strategic risks proposed for inclusion in the Board Assurance Framework (LLR ICB BAF 5; NICB BAF 1), are:

- reliance on provider assurance without sufficient independent verification;
- failure to identify emerging patterns across maternity, neonatal and child safety intelligence;
- weaknesses in speaking up culture delaying escalation of concerns;
- failure to meet NHS England's immediate actions and deadlines;
- unfunded digital, workforce and infrastructure costs; and
- regulatory and reputational risk if system partners cannot demonstrate effective oversight of maternity and neonatal safety.

## Recommendations: the Boards are asked to:

- **RECEIVE** and **NOTE** the Thirlwall Inquiry findings and recommendations, including the implications for commissioners and oversight bodies.
- **NOTE** the alignment with the Amos investigation and that the common themes will be addressed through the existing maternity and neonatal assurance programme.
- **APPROVE** the five NHS England immediate actions as the framework for the LNR ICB system response and assurance, with progress overseen by the Joint Quality, Performance and Outcomes Committee and existing safeguarding governance.
- **SUPPORT** strengthened speaking up and safeguarding assurance, including Board self-assessments of professional curiosity and Freedom to Speak Up.
- **NOTE** the key strategic risks proposed for the Board Assurance Framework.
- **NOTE** that a consolidated system gap analysis will return to the Joint Quality, Performance and Outcomes Committee within three months, with material exceptions escalated to the Boards sooner.

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## Appendix 1: Thirlwall Inquiry recommendations and implications for LNR ICB

| No. | Recommendation (summary)                                                                                                                                         | Lead and deadline                                        | Implication for LNR ICB                                                           |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1   | In cot cameras with livestreaming on all neonatal cots and incubators, centrally funded                                                                          | NHS England roadmap by 31 March 2027                     | Support provider readiness once the roadmap is published                          |
| 2   | Digital access controls for insulin; GIRFT requirements; CCTV on storage until biometric access; mandatory laboratory guidance for insulin and C-peptide testing | Trusts; CCTV by 30 November 2026; GIRFT by 31 March 2027 | Assurance from neonatal providers                                                 |
| 3   | National Bereavement Care Pathway for neonatal death in all Trusts                                                                                               | Trusts by 31 August 2027                                 | Commissioning intentions                                                          |
| 4   | Safeguarding training for all staff and Board members, covering harm by staff; contracts to require adherence to safeguarding guidance and the Protocol          | Trusts; contracts by March 2027                          | ICB Board and staff compliance; provider assurance, including bank and agency     |
| 5   | Route to harmonised NHS systems by December 2028 and a mandatory information standard                                                                            | NHS England by 31 March 2027                             | ICB digital strategy; maternity and neonatal data flows                           |
| 6   | Board level monitoring of all deaths of babies and children; predetermined escalation route                                                                      | Hospital Trusts by 31 March 2027                         | Seek evidence of effectiveness; triangulate intelligence                          |
| 7   | Named MBRRACE lead reporter, reporting to the Board at least six monthly                                                                                         | Trusts                                                   | Confirm lead reporters are named                                                  |
| 8   | SUDIC applies to babies who never left hospital; revised national guidelines                                                                                     | NHS England (28 September 2026); DHSC by 31 March 2027   | Apply SUDIC to all children aged 0 to 18; align designated doctors and both CDOPs |
| 9   | Suspicion of Deliberate Harm Protocol: act immediately on concerns raised in good faith, moving staff is neutral, safeguarding steps and police                  | NHS England by 31 March 2027; Trusts to embed            | Assure embedding; reflect in ICB safeguarding procedures and contracts            |
| 10  | Panel of independent experts for swift technical investigation                                                                                                   | DHSC to consider                                         | Note                                                                              |
| 11  | Medical examiner neonatal guidance, safeguarding questions and pool of neonatologists                                                                            | National Medical Examiner by 31 March 2027               | Understand local access to neonatal expertise                                     |
| 12  | 37 paediatric and perinatal pathologists in training by June 2033                                                                                                | DHSC and NHS England                                     | Note regional pathology dependencies                                              |

| No. | Recommendation (summary)                                                                                                                        | Lead and deadline                       | Implication for LNR ICB                       |
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------|
| 13  | Barring system for managers by September 2027; checks on senior manager moves; individual duty of candour; patients first in the managers' code | DHSC and NHS England                    | Applies to ICB managers                       |
| 14  | CQC without notice inspections with practising experts, testing effectiveness                                                                   | CQC                                     | Share intelligence with CQC                   |
| 15  | Regular review of CQC performance by the Health and Social Care Committee                                                                       | Parliament                              | Note                                          |
| 16  | National Guardian's Office functions to transfer to the Ombudsman, with powers on whistleblowing                                                | Government                              | See paragraph 10 (action 5)                   |
| 17  | National Audit Office to audit implementation of statutory inquiry recommendations                                                              | National Audit Office by September 2027 | Maintain auditable evidence of implementation |

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# Appendix 2: Alignment of the Amos and Thirlwall investigations

## Common themes across Amos & Thirlwall

Two independent investigations. One shared mission: safer care, listening to families and a health service that learns and ads.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                              |                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <div><h2>BARONESS AMOS REVIEW</h2><p>Independent Review of Maternity Services (2026)</p><div><h3>FOCUS</h3><ul style="list-style-type: none"><li>• Maternity care safety and outcomes</li><li>• Reducing inequalities and addressing bias</li><li>• Personalised, woman-centred care</li><li>• Family engagement and involvement</li><li>• Compassionate leadership and support for staff</li></ul></div></div> | <div><h2>SHARED THEMES</h2><p>The priorities both investigations place at the centre of safer care</p><div><ul style="list-style-type: none"><li>• Listening to families</li><li>• Culture of safety</li><li>• Speaking up</li><li>• Data and safety intelligence</li><li>• Learning, not blame</li><li>• Safeguarding vigilance</li><li>• Workforce capability</li></ul></div></div> | <div><h2>LADY THIRLWALL INQUIRY</h2><p>Independent Inquiry into Neonatal Care (2026)</p><div><h3>FOCUS</h3><ul style="list-style-type: none"><li>• Detection of harm and deterioration in neonatal care</li><li>• Safeguarding failures and missed opportunities</li><li>• Acting on concerns and responding effectively</li><li>• Governance, assurance and oversight</li><li>• Systems, processes and accountability that protect babies</li></ul></div></div> |                                                                                                                              |                                                                                                                                        |
| <h2>OUR SHARED COMMITMENT</h2>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                              |                                                                                                                                        |
| <div><h3>PUT FAMILIES FIRST</h3><p>Listen, involve and partner with women, babies and families in every decision.</p></div>                                                                                                                                                                                                                                                                                     | <div><h3>ACT EARLY</h3><p>Recognise risks, escalate concerns and take timely, decisive action to prevent harm.</p></div>                                                                                                                                                                                                                                                              | <div><h3>BE OPEN AND HONEST</h3><p>Be transparent, share evidence and communicate clearly with families and staff.</p></div>                                                                                                                                                                                                                                                                                                                                     | <div><h3>LEARN AND IMPROVE</h3><p>Use data and insight to learn, improve and drive continuous improvement in care.</p></div> | <div><h3>BE ACCOUNTABLE</h3><p>Leaders at all levels must take responsibility and be held to account for safety and quality.</p></div> |

Different inquiries. Shared lessons. One purpose: Every baby. Every family. Every time.

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# **LLR ICB and NICB Boards Meeting in Common in Public**

## **Finance Assurance Reports – LLR ICB and N ICB**

**Thursday 15 October 2026**

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

|                            |                                                            |                        |            |
|----------------------------|------------------------------------------------------------|------------------------|------------|
| <b>Name of Meeting</b>     | <b>LLR ICB and NICB Boards Meeting in Common in Public</b> |                        |            |
| <b>Date of Meeting</b>     | <b>Thursday 15 October 2026</b>                            |                        |            |
| <b>Report Title</b>        | <b>Finance Assurance Report - LLR ICB and N ICB</b>        |                        |            |
| <b>Paper Reference No:</b> | <b>ICBIC-26-59</b>                                         | <b>Agenda Item No:</b> | <b>13.</b> |

|                          |                                                               |
|--------------------------|---------------------------------------------------------------|
| <b>Presented by</b>      | <b>Matt Gaunt, Chief Finance Officer, LLR ICB and NICB</b>    |
| <b>Report Author(s)</b>  | <b>Dan Guest, Head of Corporate Finance, LLR ICB and NICB</b> |
| <b>Executive Sponsor</b> | <b>Matt Gaunt, Chief Finance Officer, LLR ICB and NICB</b>    |

| Select the Primary Purpose for the Report                                                                                                                                                                                                                     |                                                                                                                  |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <input checked="checked" type="checkbox"/> <b>ADVISORY</b><br>To receive and note implications, may require discussion to help to shape/develop item.                                                                                                         | <input type="checkbox"/> <b>ASSURANCE</b><br>To assure the Committees that controls and assurances are in place. | <input type="checkbox"/> <b>APPROVAL</b><br>Recommendation or particular course of action. |
| Recommendations                                                                                                                                                                                                                                               |                                                                                                                  |                                                                                            |
| <p><b>The Boards are asked to:</b></p> <p><input type="checkbox"/> <b>RECEIVE and NOTE</b> the update provided on the 2026/27 financial positions at month 5 and forecast outturns, and the items noted at the October Finance and Contracting Committee.</p> |                                                                                                                  |                                                                                            |

| Executive Summary of the report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>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 break-even financial position at month 5.</p> <p>The full year reported forecast is achievement of plan across the LNR cluster, after £5.1 non-recurrent deficit support funding (DSF). At month 5, £1.3m of DSF has been received and the remaining £3.8m is anticipated.</p> <p>The Financial position and forecast reported in this paper was discussed and noted at the October Finance and Contracting Committee of the LNR Cluster ICBs.</p> |

A financial stocktake took place in early October to identify mitigations to action in second half of the year amounting to £21m in order to achieve a balanced financial position for the year.

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

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

|                   |                                                                                             |
|-------------------|---------------------------------------------------------------------------------------------|
| <b>Appendices</b> | Month 5 Financial Position by Chief Officer and Service Area for LLR and NICB individually. |
|-------------------|---------------------------------------------------------------------------------------------|

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

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## LNR Cluster Finance Report Month 5 (August) 2026/27

Thursday 15 October 2026

### Headlines

- Table 1 below details the position by Chief Officer and Service Area. At month 5 the LNR Cluster is reporting a break-even year-to-date position.

Table 1 – Month 5 LLR/NICB Financial Position by Chief Officer and Service Area

| Officer                | Service Area                           | YTD Plan<br>£m | YTD Actual<br>£m | YTD Variance<br>£m | Full Year Plan<br>£m | Full Year Forecast<br>£m | Forecast Variance<br>£m |
|------------------------|----------------------------------------|----------------|------------------|--------------------|----------------------|--------------------------|-------------------------|
| Chief Delivery Officer | ACUTE                                  | 953.8          | 967.1            | (13.4)             | 2,330.2              | 2,350.2                  | (20.0)                  |
|                        | COMMUNITY & MENTAL HEALTH SERVICES     | 342.4          | 340.7            | 1.7                | 821.1                | 826.5                    | (5.3)                   |
|                        | PRIMARY CARE INCLUDING CO-COMM AND POD | 291.9          | 289.2            | 2.6                | 716.7                | 716.0                    | 0.6                     |
|                        | SPECIALISED SERVICES                   | 215.7          | 216.7            | (1.0)              | 538.5                | 540.9                    | (2.3)                   |
|                        | OTHER PROGRAMME SERVICES               | 2.6            | 2.6              | (0.0)              | 6.5                  | 6.5                      | (0.0)                   |
| Chief Finance Officer  | RESERVES                               | (2.0)          | 5.3              | (7.3)              | 4.1                  | (1.4)                    | 5.6                     |
|                        | MONTH 5 STOCKTAKE                      | -              | (8.7)            | 8.7                | -                    | (21.0)                   | 21.0                    |
| Chief Medical Officer  | PRESCRIBING                            | 156.7          | 155.5            | 1.3                | 379.4                | 378.9                    | 0.5                     |
|                        | PRIMARY CARE                           | 1.9            | 2.2              | (0.3)              | 4.9                  | 5.4                      | (0.5)                   |
|                        | OTHER PROGRAMME SERVICES               | 0.8            | 0.8              | 0.0                | 1.8                  | 1.8                      | 0.0                     |
| Chief Nursing Officer  | CONTINUING HEALTH CARE                 | 128.4          | 122.2            | 6.2                | 308.1                | 302.9                    | 5.2                     |
|                        | MENTAL HEALTH (S117 & AHP)             | 31.5           | 31.2             | 0.2                | 75.5                 | 78.2                     | (2.6)                   |
|                        | OTHER PROGRAMME SERVICES               | 0.1            | 0.1              | -                  | 0.4                  | 0.4                      | -                       |
| Chief Strategy Officer | OTHER PROGRAMME SERVICES               | 0.5            | 0.6              | (0.2)              | 1.1                  | 1.5                      | (0.4)                   |
| All                    | CORPORATE COSTS                        | 22.8           | 21.5             | 1.4                | 52.4                 | 54.1                     | (1.7)                   |
|                        |                                        | 2,147.0        | 2,147.0          | (0.0)              | 5,240.8              | 5,240.8                  | 0.0                     |

- The year-to-date variances are driven by the following key areas:

- Acute contracts (£13.4m) over plan – UHL (£12.9m) over, out of county (£1m) over, other areas £0.5m under (largely under activity in the independent sector).
- POD and co-commissioning £2.7m under plan.
- Personalised commissioning £6.6m under plan (NICB £5.2m under plan).
- Prescribing £1.2m under plan.
- Reserves £1.4m under plan.

- The cluster is reporting a breakeven forecast position.

- At month 5 the cluster is reporting a year-to-date £0.08m under-delivery against the efficiency plan of £54.95m. The cluster is forecasting full delivery against the £142.07m efficiency plan by the end of the financial year.

5. At month 5 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 £19.3m have been identified in relation to diagnostic imaging activity, urgent care and variable elective care at UHL. These are partially offset by £4.8m of underperformance for variable drugs and devices.
- The ICBs have received the Elective Recovery Fund (ERF) allocation of £17.0m from NHSE that was anticipated in the plan.
- 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 financial stocktake performed in early October identified £21m requirement in order to achieve a balanced Plan. This is reported in the CFO line of the report to ensure that budgetary responsibility is maintained in delivery areas. As mitigations are identified this will be removed from this line.

#### **Recommendations:**

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

- **RECEIVE and NOTE** the financial position at month 5.
- **NOTE** the financial stocktake requirement of £21m mitigations to break-even position.

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## Appendices

### Appendix 1 - Month 5 LLR Financial Position by Chief Officer and Service Area

| Officer                | Service Area                           | YTD Plan<br>£m | YTD Actual<br>£m | YTD Variance<br>£m | Full Year Plan<br>£m | Full Year Forecast<br>£m | Forecast Variance<br>£m |
|------------------------|----------------------------------------|----------------|------------------|--------------------|----------------------|--------------------------|-------------------------|
| Chief Delivery Officer | ACUTE                                  | 542.9          | 554.9            | (12.0)             | 1,313.2              | 1,328.7                  | (15.5)                  |
|                        | COMMUNITY & MENTAL HEALTH SERVICES     | 205.0          | 202.6            | 2.4                | 488.3                | 488.8                    | (0.6)                   |
|                        | PRIMARY CARE INCLUDING CO-COMM AND POD | 171.8          | 171.3            | 0.5                | 416.7                | 417.7                    | (1.1)                   |
|                        | SPECIALISED SERVICES                   | 133.9          | 134.9            | (1.0)              | 334.4                | 336.7                    | (2.3)                   |
|                        | OTHER PROGRAMME SERVICES               | -              | -                | -                  | -                    | -                        | -                       |
| Chief Finance Officer  | RESERVES                               | 0.1            | 0.1              | (0.0)              | (12.6)               | (12.6)                   | (0.0)                   |
|                        | MONTH 5 STOCKTAKE                      | -              | (8.7)            | 8.7                | -                    | (21.0)                   | 21.0                    |
| Chief Medical Officer  | PRESCRIBING                            | 100.1          | 100.0            | 0.0                | 240.2                | 240.1                    | 0.1                     |
|                        | PRIMARY CARE                           | -              | -                | -                  | -                    | -                        | -                       |
|                        | OTHER PROGRAMME SERVICES               | 0.5            | 0.5              | 0.0                | 1.1                  | 1.1                      | 0.0                     |
| Chief Nursing Officer  | CONTINUING HEALTH CARE                 | 77.1           | 75.7             | 1.4                | 185.1                | 185.2                    | (0.1)                   |
|                        | MENTAL HEALTH (S117 & AHP)             | 25.0           | 24.3             | 0.7                | 59.9                 | 59.7                     | 0.2                     |
|                        | OTHER PROGRAMME SERVICES               | -              | -                | -                  | -                    | -                        | -                       |
| Chief Strategy Officer | OTHER PROGRAMME SERVICES               | -              | -                | -                  | -                    | -                        | -                       |
| All                    | CORPORATE COSTS                        | 13.2           | 13.9             | (0.7)              | 31.6                 | 33.3                     | (1.7)                   |
|                        |                                        | 1,269.5        | 1,269.5          | (0.0)              | 3,057.9              | 3,057.9                  | (0.0)                   |

### Appendix 2 – Month 5 NICB Financial Position by Chief Officer and Service Area

| Officer                | Service Area                           | YTD Plan<br>£m | YTD Actual<br>£m | YTD Variance<br>£m | Full Year Plan<br>£m | Full Year Forecast<br>£m | Forecast Variance<br>£m |
|------------------------|----------------------------------------|----------------|------------------|--------------------|----------------------|--------------------------|-------------------------|
| Chief Delivery Officer | ACUTE                                  | 410.9          | 412.3            | (1.4)              | 1,016.9              | 1,021.4                  | (4.5)                   |
|                        | COMMUNITY & MENTAL HEALTH SERVICES     | 137.4          | 138.1            | (0.7)              | 332.8                | 337.6                    | (4.8)                   |
|                        | PRIMARY CARE INCLUDING CO-COMM AND POD | 120.0          | 117.9            | 2.1                | 300.0                | 298.3                    | 1.7                     |
|                        | SPECIALISED SERVICES                   | 81.7           | 81.7             | (0.0)              | 204.1                | 204.1                    | (0.0)                   |
|                        | OTHER PROGRAMME SERVICES               | 2.6            | 2.6              | (0.0)              | 6.5                  | 6.5                      | (0.0)                   |
| Chief Finance Officer  | RESERVES                               | (2.1)          | 5.2              | (7.3)              | 16.7                 | 11.2                     | 5.6                     |
|                        | MONTH 5 STOCKTAKE                      | -              | -                | -                  | -                    | -                        | -                       |
| Chief Medical Officer  | PRESCRIBING                            | 56.7           | 55.4             | 1.2                | 139.2                | 138.8                    | 0.4                     |
|                        | PRIMARY CARE                           | 1.9            | 2.2              | (0.3)              | 4.9                  | 5.4                      | (0.5)                   |
|                        | OTHER PROGRAMME SERVICES               | 0.3            | 0.3              | 0.0                | 0.7                  | 0.7                      | 0.0                     |
| Chief Nursing Officer  | CONTINUING HEALTH CARE                 | 51.3           | 46.5             | 4.8                | 123.0                | 117.7                    | 5.3                     |
|                        | MENTAL HEALTH (S117 & AHP)             | 6.5            | 6.9              | (0.4)              | 15.6                 | 18.5                     | (2.8)                   |
|                        | OTHER PROGRAMME SERVICES               | 0.1            | 0.1              | -                  | 0.4                  | 0.4                      | -                       |
| Chief Strategy Officer | OTHER PROGRAMME SERVICES               | 0.5            | 0.6              | (0.2)              | 1.1                  | 1.5                      | (0.4)                   |
| All                    | CORPORATE COSTS                        | 9.6            | 7.5              | 2.1                | 20.8                 | 20.8                     | -                       |
|                        |                                        | 877.4          | 877.4            | (0.0)              | 2,182.9              | 2,182.9                  | 0.0                     |

# Board Meetings in Common in Public

## Transition Assurance Report

Thursday 15 October 2026

Middlebrook-Claire  
08/10/2026 14:28:57

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

|                     |                                    |                 |     |
|---------------------|------------------------------------|-----------------|-----|
| Name of Meeting     | Board Meetings in Common in Public |                 |     |
| Date of Meeting     | Thursday 15 October 2026           |                 |     |
| Report Title        | Transition Assurance Report        |                 |     |
| Paper Reference No: | ICBIC-26-60                        | Agenda Item No: | 14. |

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>The Boards are asked to:</p> <ul style="list-style-type: none"><li><b>NOTE</b> the progress of the Cluster ICB Transition Programme, to achieve its mandated reductions and service transfers.</li><li><b>RECEIVE</b> the Transformation Programme update as assurance that appropriate arrangements are in place to support the successful development of the future organisation(s), its staff, and stakeholders.</li></ul> |

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

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

| Board Assurance Framework Risk |                |
|--------------------------------|----------------|
| 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<br>October 2025 - Board in Common assurance report<br>December 2025 - Board in Common assurance report<br>February 2026 - Board in Common assurance report<br>March 2026 - Board in Common assurance report<br>April 2026 - Board in Common assurance report<br>May 2026 - Board in Common assurance report<br>June 2026 - Board in Common assurance report<br>Remuneration Committee – October, December, January, February, for decisions in relation to Redundancy and Management of Change<br>Monthly Transition Committee meetings<br>Monthly Transition updates to Joint Executive Team |

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

Middlebrook, Claire  
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## Joint Transition Assurance Report

October 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 the majority of service areas, 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. Confirmation on merger arrangements awaited from NHSE.
6. The Transition and Transformation Committee retains oversight of the programme and will escalate any decisions as required to the Board. A Programme Director oversees this change to support the Executive Team in its duties to deliver a new type of organisation, see table one.

Table One

|                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Designing functions for a new Cluster ICB | <p>Implementation of Management of change nears its final stages as we move between suitable alternative employment (SAEs) to internal and external interviews. Currently 395 (79%) people are now in post. 60 people are 'at risk' and we have c113 vacancies. This position is subject to weekly change.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Functions that have another destination   | <p>There were 17 functions that were identified in the Model ICB framework that ICBs currently undertake that are due to be undertaken by another public body in the future, these functions are listed within the Model ICB and are broadly described as:</p> <ul style="list-style-type: none"> <li>- Going to an NHS Provider</li> <li>- Going to NHSE/DHSC regional offices</li> <li>- To be explored further</li> </ul> <p>In December 2025, further guidance was received by NHS England regarding these functions, and it was confirmed that as many of the functions are described within primary legislation. The design of the structures has incorporated this updated guidance and assurances have been provided to NHS England (NHSE) that the ICB will continue to be able to discharge its functions in full, whilst reducing its annual costs in line with the new financial allocations.</p> <p><b>Transfer to Provider or Partner Organisations.</b> The following functions have transferred to provider or partner organisations:</p> <ul style="list-style-type: none"> <li>➤ HR and Transactional Workforce – Transferred to University Hospital Leicester. Complete.</li> <li>➤ GP and Corporate IT (Northamptonshire) – Transferred to Leicestershire Health Informatics, Leicestershire Partnership Trust. Complete.</li> </ul> <p><b>Functions Transitioning to the Region.</b> The following functions are due to transition to the regional team:</p> <ul style="list-style-type: none"> <li>➤ Business Intelligencer (Anonymised data service).</li> </ul> <p><b>Transfer Progress - extended</b></p> |

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|                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                         | <ul style="list-style-type: none"> <li>Complex Mental Health – CSU staffing remain in place to ensure safe transfer of service until MoC completion. Transfer due to complete November.</li> </ul> <p>This extension reflects the complexity of service transfer arrangements, and capacity considerations to ensure a safe and effective transition.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Functions that could be done at a ‘supra’ cluster level | <p>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 aim is to increase the efficiency, attract expertise and improve quality.</p> <p><i>Pharmacy, Optometry and Dental (PODs) Service:</i> continue to be hosted by Derbyshire, Nottinghamshire and Lincolnshire (DNL) ICB cluster on an interim arrangement. There remains a clear ambition to develop a scaled, sustainable, and equitable service model across the region. Progress underway, timescales to be re-confirmed.</p> <p><i>Midlands Procurement Hub:</i> Preparation for mobilisation of the service December 2026. Transition planning and governance arrangements remain in place to oversee implementation. Mitigating actions and contingency options are being explored to support continuity of procurement services. Timescales may be subject to change.</p> <p>Executive oversight continues through the established transition governance arrangements</p> |

Transformation Programme

- Alongside the transition programme, a transformation programme is designed to strengthen commissioning capability, organisational effectiveness, stakeholder engagement and change readiness, ensuring the ICB cluster is fit for purpose and able to deliver its future strategic and statutory responsibilities.
- The transformation programme encompasses three interdependent workstreams: Strategic Commissioning Development, Communications and Engagement, and Organisational Development. Collectively, these workstreams provide the enabling infrastructure required to support the formation of the new organisation, drive transformational change at scale, and ensure the future ICB cluster has the leadership, capability, operating model and stakeholder support necessary to deliver its statutory functions and strategic ambitions.
- Strategic Commissioning Development:** To provide oversight and leadership for the development and implementation of the national Commissioning Development

Programme across the cluster. The programme aims to ensure that commissioning teams are equipped with the skills, capabilities, tools and support required to deliver the future strategic commissioning remit and respond effectively to the changing landscape.

10. A key focus is ensuring that staff have access to the national development offer available through the Commissioning Academy and other recognised learning and development opportunities. This will support the development of a modern commissioning workforce with the capabilities required to lead transformation, improve outcomes, reduce inequalities and maximise value across the system.
11. **Strategic Commissioning Target Operating Model:** Development of a Strategic Commissioning Target Operating Model (TOM) is currently underway to ensure the cluster can operate effectively across all commissioning functions and deliver its responsibilities in line with the full commissioning cycle.
12. The Target Operating Model is being co-designed with staff and will continue to be shaped through engagement with key stakeholders across the system. The model will support a consistent and scalable approach to commissioning across the cluster and provide the foundations for a more integrated, intelligence-led and outcomes-focused commissioning function.
13. **Communications and Engagement:** The Communications and Engagement Programme is a critical enabler of the wider transition and transformation agenda. Its purpose is to ensure that staff, partners, stakeholders and the public are informed, involved and engaged throughout the development of the new organisations' remit.
14. The programme will provide a coordinated and strategic approach to communications across the ICB cluster, ensuring consistent messaging, transparency of decision-making and alignment with organisational objectives. It aims to support both internal and external audiences, recognising the importance of engaging staff and leaders alongside system partners, provider organisations, local authorities, voluntary sector organisations, patients and communities
15. **Organisational Development Programme:** The Organisational Development (OD) Programme has been established to support the development of a high-performing, values-led and resilient organisation capable of delivering its future strategic and statutory responsibilities. Recognising the scale of change associated with the transition to a clustered ICB model, the programme is focused on creating the culture, leadership, behaviours and organisational environment required to support successful transformation.

16. The programme will ensure that organisational development is embedded throughout the transition process, supporting leaders, teams and individuals to adapt to new ways of working while maintaining service delivery and organisational performance. It will also help create a shared identity and vision across the cluster, fostering collaboration, inclusion and collective ownership of the future organisation.
17. *Office Space redesign*: A LNR Working Group has been established to codesign officer space at both County Hall and Haylock House sites, ensuring the environment supports collaboration, wellbeing, inclusion and productivity, while creating the right conditions for agile, flexible and effective ways of working.
18. The Organisational Development Programme works closely with the Strategic Commissioning Development and Communications and Engagement programmes to ensure that workforce capability, cultural development, staff engagement and organisational design are aligned. Together, these programmes will support the creation of an organisation that is adaptable, collaborative and equipped to deliver improved outcomes for local populations.

#### Recommendations:

The Board is asked to:

- **NOTE** the progress of the Cluster ICB Transition Programme, to achieve its mandated reductions and service transfers.
- **RECEIVE** the Transformation Programme update as assurance that appropriate arrangements are in place to support the successful development of the future organisation(s), its staff, and stakeholders.

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