Leicestershire County Council

Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 26 February 2026 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Euan Walters (Tel: 0116 305 6016)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. M. Squires CC (Chairman)

Barney Thorne	Kevin Allen-Khimani
Edd de Coverly	Fiona Barber
Harsha Kotecha	Siobhan Peters
Jane Moore	Mr. C. Pugsley CC
Mike Sandys	Cllr. J. Kaufman
Jon Wilson	Cllr Cheryl Cashmore
Jean Knight	Toby Sanders
Rachel Dewar	Mr. C. Abbott CC
Simon Pizzey	Matt Gaunt

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 4 December 2025.		(Pages 3 - 12)
2.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
3.	Declarations of interest in respect of items on the agenda.		
4.	Position Statement by the Chairman.		
5.	Election of Vice Chairman. Nominations will be sought from amongst the Board membership and a vote will take place.		

6.	Joint Local Health and Wellbeing Strategy update- Best Start for Life.	Director of Public Health, Law and Governance	(Pages 13 - 36)
7.	Joint Local Health and Wellbeing Strategy amendment, Easy Read and Delivery Plans.	Director of Public Health, Law and Governance	(Pages 37 - 74)
8.	Better Care Fund - Quarter 3 update.	Director of Adults and Communities	(Pages 75 - 88)
9.	Joint Strategic Needs Assessment Programme of Work.	Director of Public Health, Law and Governance	(Pages 89 - 92)
10.	University Hospitals of Leicester NHS Trust Clinical Strategy	University Hospitals of Leicester NHS Trust	(Pages 93 - 126)
11.	Integrated Care Board 5 Year Commissioning Strategy.	Integrated Care Board	(Pages 127 - 222)
12.	NHS Transformation and Transition.	Integrated Care Board	(Pages 223 - 244)
13.	Health and Wellbeing Board Terms of Reference Review.	Director of Public Health, Law and Governance	(Pages 245 - 256)

14. Date of next meeting.

The next meeting of the Health and Wellbeing Board will be held on Monday 15 June 2026 at 2.00 pm.

15. Any other items which the Chairman has decided to take as urgent.

Agenda Item 1

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 4 December 2025.

PRESENT

Leicestershire County Council

Mr. M. Squires CC (in the Chair)
Mr. C. Abbott CC
Mike Sandys
Jon Wilson
Nicci Collins

District Councils

Cllr. J. Kaufman
Cllr. C. Cashmore
Edd de Coverly

Integrated Care Board

Rachel Dewar
Yasmin Sidyot

University Hospitals of Leicester NHS Trust

Simon Pizzey

Leicestershire Partnership NHS Trust

Jean Knight

Office of the Police and Crime Commissioner

Siobhan Peters

Healthwatch Leicester and Leicestershire

Fiona Barber

Voluntary Action Leicestershire

Kevin Allen-Khimani

In attendance

Joshna Mavji – Leicestershire County Council
Abbe Vaughan – Leicestershire County Council
Lisa Carter – Leicestershire County Council
Tracy Ward – Leicestershire County Council

Fiona Grant, Public Health, Leicestershire County Council
Victoria Charlton, Public Health, Leicestershire County Council
Anuj Patel, Public Health, Leicestershire County Council
Amina Begum, Adults and Communities, Leicestershire County Council
Amita Chudasama, Integrated Care Board
Fay Bayliss, Director, LLR SEND & Inclusion Alliance
Mark Roberts, Director LLR SEND & Inclusion Alliance
Euan Walters – Leicestershire County Council

Apologies

Mr. C. Pugsley CC, Jane Moore, Matt Gaunt

32. Minutes of the previous meeting.

The minutes of the meeting held on 25 September 2025 were taken as read, confirmed and signed.

33. Urgent items.

There were no urgent items for consideration.

34. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Cllr. J. Kaufman declared a non-registerable interest in all substantive agenda items as he had a close relative that worked for NHS England.

35. Position Statement by the Chairman.

The Chairman presented a Position Statement on the following matters:

(i) vaccinations and immunisations;
(ii) adult social care;
(iii) pressures on urgent and emergency care;
(iv) Chair's engagement activity
(v) Local Area Co-ordination
(vi) Health and Wellbeing Board membership.

A copy of the position statement is filed with these minutes.

36. Mental Health Place-based Sub-group progress update.

The Board considered a report of the Director of Public Health which gave an update on progress in delivering against the Joint Local Health and Wellbeing Strategy priorities in relation to mental health. A copy of the report, marked 'Agenda Item 5', is filed with these minutes.

Arising from discussions the following points were noted:

(i) Within Leicestershire breast cancer screening coverage for all those eligible was around 70%, yet for those with Serious Mental Illness (SMI) it was 31%. Therefore, work was taking place to improve breast cancer screening uptake in people with SMI and understand what the barriers were to more people with SMI being screened. Outreach team colleagues were being consulted to see what insights they could provide. The work was currently at the stage of refining interventions. An evaluation stage was expected to begin in March 2026. The following outcomes were aimed for as part of the work:

- Mental health facilitators report no disengagement from individuals with SMI;
- People undertaking breast cancer screening feeling supported through the process including the waiting phase;
- Reducing the number of patients that do not attend appointments.

(ii) Data sharing between partners was a challenge. Sometimes it was even difficult for information to be shared between different departments of the NHS. The process of obtaining information from partners was slow but had improved recently. Partners were asked to help prioritise and escalate requests for information from other partners.

(iii) Concerns were raised that Talking Therapies were not able to access NHS records and as a result therapists did not always have the full picture of a patient's background and therefore it was more difficult to safeguard a patient. The Integrated Care Board agreed to look into this issue and report back after the meeting.

(iv) The mental health priorities set out in the Joint Local Health and Wellbeing Strategy were monitored using indicators and a dashboard, for example the amount of SMI healthchecks being carried out was one of the metrics. In addition, individual projects were monitored and evaluated. Case studies were also carried out to monitor the impact of interventions. However, it was sometimes challenging to obtain enough data to demonstrate that a difference had been made.

(v) It was suggested that leaflets could be placed in Mental Health cafes to raise awareness as it had worked for other campaigns.

(vi) The work of the Mental Health Place-based subgroup linked in with the Mental Health Collaborative and wider health system work. Key stakeholders from the wider system were represented on the subgroup. The subgroup doubled up as the Place-based group for the Mental Health Collaborative.

(vii) The Tomorrow Project provided bereavement support for those affected by suicide. An initial 6 sessions were offered and then a review took place and more sessions could be provided depending on need.

RESOLVED:

(a) That the progress that has been made over the past 12 months be noted;

(b) That the work of the group and priority actions be supported.

37. Leicester, Leicestershire and Rutland Joint Living Well Dementia Strategy.

The Board considered a report of the Director of Adults and Communities which provided an update on delivery of the Leicestershire, Leicester and Rutland (LLR) Joint Living Well Dementia Strategy 2024-28. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

Arising from discussions the following points were noted:

(i) It was estimated that around 10,500 people in Leicestershire were living with dementia. However, only about 6,400 had a formal diagnosis. A lot of awareness raising was required. Not everyone was digitally enabled therefore all methods of communication needed to be used.

(ii) Work was taking place to understand the barriers to dementia diagnosis in Leicestershire. Cultural issues were believed to be a factor, and people living in rural areas were thought less likely to be diagnosed, however the full picture needed to be understood.

(iii) The Dementia Support Service helped people before and after diagnosis. It was important to make the public aware that they could access dementia services without having a formal diagnosis. The Service was being re-procured in 2026. Partners were invited to feed in any comments on the service before the re-procurement took place.

(iv) Voluntary Action Leicestershire (VAL) offered to help spread information about Dementia services via their newsletters. The offer was welcomed.

(v) A one-stop memory assessment clinic trial was being piloted across Leicestershire and Leicester which was designed to deliver all key diagnostic steps in a single visit, rather than across multiple appointments. The contract was being delivered by Age UK and the clinics were run by volunteers. All the clinics were now in place and it was intended that they would operate for a further 12 months and then be evaluated to see if they had an impact on waiting lists.

(vi) In the past there had been concerns that most of the memory assessment clinics were in Leicester City. This was being addressed with the integrated service.

(vii) At paragraph 16 of the report there was a chart showing comparison of dementia diagnosis rates across Leicester City, East Leicestershire and Rutland, West Leicestershire. This data was based on the old Clinical Commissioning Group footprints. A request was made for the data to be broken down into smaller geographical areas, so that resources could be targeted towards the geographical areas with most need. In response it was explained that this was being worked on with the Integrated Care Board but if the data was broken down to Primary Care Network level there could be issues with anonymity and identifying individual patients from the data at that small a level.

(viii) The appendix to the report was a pathway map for the Dementia Support Service. Partners were welcome to share and disseminate the map amongst their own organisations.

(ix) Work was also taking place to investigate the wider determinants of dementia for example lifestyle and environmental factors that could contribute to someone being diagnosed with dementia later in life.

RESOLVED:

That the Board acknowledges progress made since February 2025, endorses continued collaboration to improve diagnosis rates and reduce inequalities, and supports commissioning plans that embed co-production, cultural competence, and carer support, with annual updates.

38. Neighbourhood Models of Care.

The Board considered a report of the Integrated Care Board which provided an update on the Neighbourhood actions taking place across Leicestershire, the work of the National Neighbourhood Health Implementation Programme and the Leicestershire respiratory Story. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

Arising from the report the following points were noted:

(i) The concept of neighbourhood working was not new, and NHS and partners in Leicestershire had done this in part for some time. Integrated Neighbourhood Teams (INTs) were already well established in Leicestershire. However, there was not consistency in approach to neighbourhood working across Leicestershire and an understanding of how much variation in approach was acceptable.

(ii) In July 2025 NHS England invited Integrated Care Boards to take part in the National Neighbourhood Health Implementation Programme (NNHIP). The aim of the NNHIP was to accelerate the work already being carried out in neighbourhoods. It was agreed with NHS England that West Leicestershire would be an implementer site and the work in that area would focus on respiratory illness. The reason for this was that respiratory illness was one of the leading causes of emergency admissions in England and 2% of people living in West Leicestershire had Chronic Obstructive Pulmonary Disease, whilst 13.7% had asthma. It was hoped that this work would reduce a significant amount of emergency admissions and ease winter pressures on health services.

(iii) Multidisciplinary Teams (MDTs) were now being created involving partners from University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT), Leicestershire County Council and the out of hours provider Derbyshire Health United. It was hoped that the INTs and MDTs would work closely together with a view to coming together as one team in the future. District Nurses and Senior Nurse for Complex Care were part of the MDTs. Consideration was still being given to what other roles would be required within the MDTs.

(iv) The NNHIP work looked to increase the number of patients undertaking Chronic Obstructive Pulmonary Disease (COPD) reviews, improve flu vaccine update, and improve inhaler technique.

(v) The work would also tackle air quality, damp homes and flooding in west Leicestershire. District Council housing services were part of the INTs so could help with this work.

(vi) The NNHIP work in Leicestershire did not currently cover children and young people because it was difficult to identify the children with the relevant conditions, but risk stratification work was taking place in this regard and it was expected that in future children would become part of the Programme.

(vii) The learning and resources from the West Leicestershire implementer programme would be shared with the rest of Leicestershire.

(viii) Board members welcomed the neighbourhood working and collaborative approach being used and recognised the impact that the respiratory work could have. It was understood why respiratory conditions were the focus of the NNHIP given the criteria set by NHS England and the short timescale for that particular programme. It was noted that there had been an early respiratory spike in Leicestershire for the winter 2025/26 which meant that there was likely to be a second spike and therefore urgent action needed to be taken. However, members suggested that partners might wish to focus on other health issues for the wider neighbourhood work being carried out across Leicestershire and particular localities might have their own priorities. In response it was clarified that the neighbourhood work was part of a 10 year programme which could evolve over the long term. It was unlikely that all the neighbourhoods in Leicestershire would focus on respiratory illnesses. Data packs would be issued to help identify what the focus should be for specific localities.

(ix) Concerns were raised by a Board member that with partners having different strategies there could be duplication or contradictory work. It was suggested that there needed to be a more long-term strategic approach and link up between strategies. In response reference was made to the Model Neighbourhood Plan which was due to be published shortly. Reassurance was also given that the refresh of the Joint Local Health and Wellbeing Strategy had taken into account the neighbourhood work and attempted to align the work from different strategies.

RESOLVED:

That the Board supports the work of the implementer neighbourhood site in West Leicestershire and the focus on respiratory illness, recognises the commitment to roll this out across the whole County, whilst also recognising there may be priority changes and a need to focus on different health issues in the future.

39. Office of the Police and Crime Commissioner.

The Board considered a report of the Office of the Police and Crime Commissioner (OPCC) which provided an overview of health-related activities commissioned, grant-funded or provided as part of the responsibilities of the OPCC. A copy of the report, marked ‘Agenda Item 8’, is filed with these minutes.

As part of discussions the following points were made:

(i) Government had announced that they intended to abolish the role of Police and Crime Commissioners when the Commissioners’ current term ended in 2028. It was not clear what would happen after 2028 to services commissioned by PCCs. Legal advice was being sought on this.

(ii) Consideration needed to be given to how the OPCC and the Police could work even more closely with health partners, make every contact count and maximise the

number of referrals from the Police into health services. Neighbourhood police officers were part of Integrated Neighbourhood Teams and this partnership working could be built upon.

(iii) The Police Neighbourhood Teams held 'one stop shops' in neighbourhoods which was an opportunity for health colleagues to be involved and engage with the public. One example of where the one stop shop approach was beneficial was Domestic Abuse which was underreported, particularly in some communities, and help could be given to overcome the cultural barriers to reporting.

(iv) The Staying Healthy Partnership membership included a representative from the OPCC.

(v) Whitwick & Ibstock were amongst the areas with the highest reports of violence against the person and Rape and Serious Sexual Offences (RASSO). It was suggested that these areas would benefit from a community intervention and prevention approach, and some of the organisations managed by Voluntary Action Leicestershire (VAL) could play a role in those areas.

(vi) The OPCC's Community Action Fund was currently open to bid into. This Fund focused on prevention and was intended to be used by small grassroots organisations who knew their neighbourhoods best to tackle the root causes of crime and vulnerability. VAL had been linked in with the Fund.

(vii) The Braunstone Blues project was an example of a multi-agency early intervention project which played a role in reducing emergency calls.

(viii) The OPCC funded the Community Safety Partnerships (CSPs) and was able to have some influence over the work the CSPs carried out. The OPCC would be providing CSPs with 'Problem Profiles' which would identify the top 3 crimes in each CSP area and enable CSPs to tackle priority issues.

(ix) Leicestershire Police, the Integrated Care Board, Integrated Neighbourhood Teams and local authorities all covered different footprints which made neighbourhood working more difficult. There was currently a lot of flux in the system, for example local authorities and Integrated Care Boards were restructuring, and this was an opportunity to align the footprints and improve neighbourhood working.

(x) Partners in Leicestershire had different strategies and it was important that the strategies complemented each other. The overall aim for all partner organisations in Leicestershire was to build prosperous and resilient communities. Further discussions needed to take place after the meeting about how the OPCC and Leicestershire Police could contribute to partnership working in the health arena.

RESOLVED:

(a) That the contents of the report including the areas where OPCC delivery links into the wider of partnership of the Health & Wellbeing Board priorities be noted, and where joint working could provide greater benefits;

(b) That the Board notes that the OPCC commissioning priority for 2026/27 is the re-commissioning of Domestic Abuse and Sexual Violence services for commencement in April 2027.

40. Better Care Fund - Quarter 2 2025/26.

The Board considered a report of the Director of Adults and Communities which provided the quarter 2, 2025/26 template report of the Better Care Fund (BCF). A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Arising from the report the following points were noted:

(i) Leicestershire was not meeting its discharge targets by a small amount and was below the national average for those, though equal to or better than the regional average. Partnership working was taking place with the Strategic Discharge Group to improve discharge rates. There was confidence that discharge would be on target by the end of the year.

(ii) Expenditure for Quarter 2 had been inputted and at month 6 was in line with the published plan and equated to 48% of the overall income.

(iii) Guidance was awaited from the BCF national team about the future of the BCF. There was still a lot of uncertainty. However, the Finance Uplifts for 2026/27 and 2027/28 had been announced. It was expected that the Plan would be on a yearly basis and there would be a move away from acute care towards community care and a neighbourhood model of delivery.

(iv) A provisional date of 27 January 2026 has been added to the calendar for a Better Care Fund (BCF) 2026/27 development session. This would be for members of the Board, the Integration Executive and the Integration Delivery and Commissioning Group to look at required changes to the current BCF to meet emerging national guidance and policy objectives. It was a provisional slot as national decision making had been delayed and the timing of the session could have to be amended to align with guidance from central government.

RESOLVED:

That the performance against the Better Care Fund outcome metrics, and the positive progress made in transforming health and care pathways up to quarter 2 be noted.

41. LLR SEND and Inclusion Alliance.

The Board considered a report of the Leicester, Leicestershire and Rutland SEND and Inclusion Alliance which provided a progress update of Phase 2 of the work of the Alliance. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

Arising from discussions the following points were noted:

(i) The SEND and Inclusion Alliance had been set up using funding from the Department for Education. The funding was for two years and the Alliance was four months into its work. The Alliance comprised of the 3 upper-tier local authorities in Leicester, Leicestershire and Rutland, the three parent carer forums, Leicestershire Partnership NHS Trust, the Integrated Care Board and the Schools Development Support Agency (SDSA) which was an LLR based organisation that supported regional development and schools in relation to SEND. University Hospitals of Leicester NHS Trust (UHL) was not currently a member of the SEND and Inclusion

Alliance and was welcome to engage with the Alliance, however the main thrust of the work was to enable people with SEND to thrive in the community. Consideration was being given to how the partnership could be developed further.

(ii) The SEND and Inclusion Alliance did not hold a commissioning budget but hoped to be able to influence those organisations that did commission services. The idea was that the Alliance worked in the gaps between partner organisations.

(iii) The strategy of the Alliance was to support people with SEND based on their level of need rather than on their specific diagnosis. People would be supported even if they did not have a diagnosis. Board members welcomed this approach and emphasised that the actual diagnosis was less important than the needs they presented with.

(iv) One of the priorities of the SEND Alliance was mental health. The work of the Alliance included tackling exam stress in people with SEND. Young people with SEND were also being linked in with Social Prescribers to improve their social life and address loneliness. In the future it was hoped to place social prescribers in schools.

(v) Another priority of the Alliance was preparing young people with SEND for adulthood and life post 16. There had been some success getting people with SEND into employment particularly apprenticeships. Kevin Allen-Khimani (VAL) chaired the Business and Skills Partnership and offered to link the SEND Alliance in with some of the organisations that were part of the Partnership.

(vi) Adults with SEND were disproportionately represented amongst prison inmates and therefore preventative work needed to take place with SEND children and young people early in their lives to stop them entering the criminal justice system. Some inmates had already had interventions from the Youth Justice Service which had not been fully successful. The SEND and Inclusion Alliance had identified a cohort of people aged 18-25 with learning disabilities and complex needs that needed to be worked with in this regard.

(vii) It would be useful to link the work of the SEND Alliance in with Neighbourhood Hubs. The Neighbourhood Board could give consideration to how to achieve this and the Chair of that Board Professor Aruna Garcea was very interested in developing that work.

(viii) Most parents were of the view that children with SEND were best placed in specialist schools. However, the SEND Alliance was of the view that the ideal venue for SEND children to receive their education was mainstream schools that were more adapted to the needs of SEND pupils. Conversations needed to be had with parents to explain to them the benefits of a mainstream education.

(ix) The SEND and Inclusion Alliance requested that the Health and Wellbeing Board scrutinised every report it considered for whether the proposals within the report improved access to services for people with disabilities particularly SEND. Board members welcomed this suggestion.

RESOLVED:

(a) That the progress of Phase 2 of the LLR SEND and Inclusion Alliance be noted along with the approach to Phase 3 and beyond;

(b) That the Board continues to support and work in partnership with the LLR SEND and Inclusion Alliance.

42. Pandemic Planning

The Board considered a report of Leicester, Leicestershire and Rutland (LLR) Integrated Care Board which provided an update on pandemic preparedness across LLR. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

RESOLVED:

(a) That the current status of pandemic planning across LLR, including governance, plans, capabilities and risks be noted;

(b) That the proposed next steps to strengthen multi-agency coordination and preparedness be endorsed.

(c) That the continued integration of pandemic planning with broader health protection, Local Resilience Forum and Emergency Preparedness, Resilience and Response frameworks be supported.

43. Joint Local Health and Wellbeing Strategy review.

The Board considered a report of the Director of Public Health which sought approval of the final version of the Joint Local Health and Wellbeing Strategy 2022-2032 (Reviewed and revised 2025). A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

The Board thanked Abbe Vaughan, Health and Wellbeing Board Manager, for her work co-ordinating the review of the Strategy.

The Board also noted that Joshna Mavji, Assistant Director – Public Health was leaving Leicestershire County Council and wished her well for the future.

RESOLVED:

That the Board approves the final version of the Joint Local Health and Wellbeing Strategy 2022-2032 (Reviewed and revised 2025).

44. Date of next meeting.

RESOLVED:

That the next meeting of the Board take place on Thursday 26 February 2026 at 2.00pm.

2.00 - 5.20 pm CHAIRMAN
04 December 2025

Agenda Item 6

HEALTH AND WELLBEING BOARD: 26 FEBRUARY 2026

REPORT OF THE CHILDREN & FAMILIES PARTNERSHIP

JOINT HEALTH & WELLBEING STRATEGY PROGRESS UPDATE ON BEST START FOR LIFE

Purpose of report

1. The purpose of the report is to:
    a) Provide an update to the Health and Wellbeing Board (HWB) on progress in relation to the Best Start for Life priority of the Joint Health and Wellbeing Strategy (JHWS) 2022-32.
    b) Seek approval from the Health and Wellbeing Board for proposed changes to the current relationship between the Children and Families Partnership, and the Health and Wellbeing Board.

Recommendation

2. The Board is requested to:

    a) Note the progress being made in relation to delivering against the Best Start for Life priority.
    b) Note the progress being made in relation to delivering against the cross-cutting priorities.
    c) Approve the proposed changes to the Operational Delivery Group of the Health and Wellbeing Board overseeing the Best Start for Life strategic priority.

Background

3. One of the statutory requirements of the HWB is to produce and deliver a Joint Health and Wellbeing Strategy (JHWS). A Joint Strategic Needs assessment (JSNA) was carried out to provide the evidence base to identify the health and wellbeing needs of the local population. The JSNA along with contributions from key partners and stakeholders, helped to inform the JHWS priorities.

4. The ten-year JHWS was approved in February 2022 and aims to improve the health, wellbeing and equity outcomes of Leicestershire. The strategy follows a life course approach:

    a. Best Start for Life;
    b. Staying Healthy, Safe and Well;
    c. Living and Supported Well;
    d. Dying Well.

5. Three HWB Operational Delivery Groups deliver the priorities within each specific life course. A fourth Operational Delivery Group was established in January 2023 to specifically address the mental health needs across Leicestershire, recognising it cuts across all life courses and requires a greater focus.

6. Reducing health inequalities remains a cross-cutting theme and underpins the work of all four Operational Delivery Groups.

7. The Best Start for Life strategic priority is split into three priority areas. Each priority area includes a set of commitments.

    a) First 1001 Critical Days;
    b) School Readiness;
    c) Preparing for Life.

8. The Children and Families Partnership (CFP) is the Operational Delivery Group that oversees the Best Start for Life strategic priority of the JHWS, contributing also towards cross-cutting priorities.

9. A report on progress was presented to HWB in February 2025: https://democracy.leics.gov.uk/documents/s188702/7%20HWB%20Report%20Best%20Start%20in%20Life%20Feb%202025%20002.pdf

10. This report provides an update on progress since the last report, challenges that would benefit from input from the HWB, and plans for the next 12 months in continuing to deliver against the Best Start for Life strategic priority of the JHWS.

Progress against the Best Start for Life strategic priority of the JLHWS

11. The table below details the progress being made against each of the priority areas and commitments:

JHSW Priority 1: First 1001 Critical Days
Embedding the Government's vision for 'The best start for life: a vision for the 1,001 critical days • Work continues to raise awareness of the importance of the first 1001 days for children's development across the children's workforce. Key messages were shared with newly qualified social workers and workshops continue to be delivered for midwifery students at De Montfort University. • The Children and Family Services (CFS) Family Help, along with Leicestershire Safeguarding Partnership, hosted its second 'Baby

Fortnight'/Start for Life campaign in 2025 aimed at practitioners, volunteers and families. Face to Face sessions were delivered in family hubs for families, with development and information sessions run for staff and volunteers on 1001 critical days, ICON (an evidence-based programme that delivers simple messages about infant crying and how to cope), working with Dads, choosing childcare and a range of other topics. The workshops were accessed by over 350 practitioners. 108 families and 126 children attended the sessions in hubs, which were based on 4 key topics; Tip Top Talkers, Little Senses, Let's get messy and Active Mums Club. Online social media messages during the fortnight had a total reach of 5,500.

Integrated Early Years Pathway

- Early years providers now complete an online questionnaire when concerns arise regarding a child's development within the setting. The purpose of this process is to strengthen communication between providers and health visitors. Health visitors are subsequently able to review the information shared and offer tailored advice and guidance for parents, ensuring timely and appropriate support for children.
- Training to support effective use of this system has been delivered to 130 early years providers**.** In addition, the relevant website has been updated with refreshed material, including a newly developed bitesize resource to support training for all staff.
- The CFS Early Years Inclusion and Childcare Service (EYICS) receive developmental data from the Healthy Together service for children not meeting expected milestones at age two. This data informs planning for sector-wide training and ensures that children who have not met milestones in four or five developmental domains are prioritised for support from the Early Years SEND team**.**
- EYICS has implemented Nasen (National Association for Special Educational Needs) reviewer training to strengthen inclusive practice across early years settings. This training supports providers to work effectively with their local Family Hubs and encourages consistent multiagency collaboration.
- As a result, providers are better equipped to create inclusive environments, and families benefit from improved support systems during their child's early years.
- To further enhance parental confidence and understanding, a new video resource has been produced. This video is designed to support parents of children with additional needs, helping them feel assured and informed about accessing Enhanced Resource provision within local mainstream schools.

Embedding additional checks into the public health nursing service

- A digital assessment for infants aged 3–4 months is now an established part of the 0–11 service. Parents receive essential information and guidance, along with clear signposting to relevant support services.

- The 3–3.5-year check was introduced on a pilot basis to understand whether an additional point of contact could strengthen readiness for school, add value for families and support early identification of need. Evaluation demonstrated that families with the highest levels of need had already received targeted support through the mandatory 2–2.5-year review and subsequent interventions. As a result, engagement with the 3–3.5-year review was lower than anticipated, with limited additional benefit identified for these families. This learning has been valuable, as it confirms that the existing 2–2.5-year offer is effectively identifying children requiring early support, and it helps ensure resources are directed where they have the greatest impact.

Breastfeeding support

- The LLR Infant feeding group has continued to meet on a quarterly basis, producing an action plan based on the recommendations from the Health Needs Assessment completed. There have been some further areas highlighted by the group which have been added into the action plan for consideration, which include universal colostrum collection and an increase in mothers with gestational diabetes mellitus. Alongside this the group has refreshed the terms of reference, reviewing membership and purpose of the group.

Childhood immunisation

- Coverage of childhood immunisations continues to exceed the national average. In line with the national trend, uptake continues to decline and is below the WHO target of 95% for many programmes.

- Timely vaccination remains an important priority, as does identifying and addressing inequalities in vaccination uptake.

- A multi-organisation project to improve childhood vaccination uptake in populations with historically low rates concluded that this was linked to access barriers and system factors. Best practice includes co-produced materials, flexible delivery, and trusted relationships- approaches we are scaling through the LLR multi-organisation project.

- Maternal vaccinations (Pertussis(Whooping Cough), RSV, and Seasonal Influenza) are available at selected community sites. Details can be found on the Integrated Care Board's vaccination hub. RSV vaccination is offered year-round and is recommended to pregnant women from 28 weeks gestation.

- Next steps include continuing the proactive MMR catch-up and to identify and address populations with lower vaccination uptake.

Empowering families to access the most appropriate health and wellbeing services

- In November 2025, Leicestershire County Council was awarded £3,919,300 by the Department for Education to deliver Best Start Family Hubs. This funding supports the government's Giving Every Child the Best Start in Life strategy, which reinforces its commitment to high-quality early years and family services. Integration of health services within Best Start Family Hubs is fundamental to achieving improved outcomes for babies, children, and families.
- Family Hubs remain a flagship national policy, now being scaled up with significant investment and updated guidance to deliver integrated, multi-agency support. Best Start Family Hubs provide a single access point for families, combining health, education, and social care services. They aim to reduce fragmentation, improve accessibility, and ensure families receive joined-up support at the earliest opportunity.
- The *Stable Homes, Built on Love* strategy sets out a clear ambition to shift from crisis intervention to prevention, embed family-led solutions and relational practice and deliver joined-up support through Family Help. Early parenting programmes are central to achieving these goals because they equip parents with practical skills and emotional resilience before challenges escalate and help prevent children entering care or child protection plans. They also strengthen family relationships, supporting Leicestershire's Relationships Matter pledge. Delivered through Best Start Family Hubs and community venues, evidence-based programmes such as, Triple P, PEEP, Making It Real and Solihull Approach will be an offer that spans from Targeted Early Help through to Child Protection Teams, strengthening our overall offer to families.
- General Practice Project – Data sharing agreement is now in the final stages of approval with LCC information governance meaning that if patients are seen in surgery a conversation with family hubs staff is agreed and understood by the patient meaning quicker support is reaching families. Briefings by the community and family navigators have been completed with 20 GP students this last quarter meaning a wide knowledge and understandings of Family Hubs is growing amongst the Primary Care Network.
- Libraries - Between July 2025-October 2025 libraries ran Wriggly Reader sessions. As many as 555 parents and 641 children engaged with these sessions, which also involved signposting to nearest Family Hubs. Parents and carers visiting the libraries have reported they feel more informed about the Hubs and about their local area, feeling more confident about which services are on offer.
- Numbers of families spoken/ connected with at other library sessions – 137 parents and 185 children.
- Parents and children booked onto Communication and Language sessions following speaking to family hubs staff in the libraries - 22 parents and 25 children.

JHWS Priority 2: School Readiness

Narrowing the development gap affecting children who are at the greatest disadvantage

- EYICS has partnered with local libraries to deliver Bookstart book packs to children living in areas of disadvantage. Through these sessions, staff model effective shared reading strategies and provide practical tips to both providers and parents. EYICS also contributed to the countywide Early Years Festival hosted in libraries, supporting families' engagement with early learning.-reading strategies and provide practical tips to both providers and parents. EYICS also contributed to the countywide Early Years Festival hosted in libraries, supporting families' engagement with early learning.
- Advisors attend the two-year pathway groups, Family Hubs, and Wriggly Readers library sessions to speak directly with parents about the benefits of early education and the processes for applying for funded entitlements.-year pathway groups, Family Hubs, and Wriggly Readers library sessions to speak directly with parents about the benefits of early education and the processes for applying for funded entitlements.
- EYICS offers training to support providers in promoting children's personal, emotional, and social development, with an emphasis on encouraging positive behaviour. A suite of home-learning materials has also been produced to help providers and parents support children's development at home; these materials are available to download from the Council's website.
- EYICS distributes emails and postcards to families receiving additional forms of government support to raise awareness of, and encourage take-up of, funded early education entitlements.
- Termly data sharing with children's social care helps identify caseload children who are not accessing their funded entitlements, enabling targeted support and intervention.
- Using Early Years Foundation Stage Profile (EYFSP) data and Early Years Pupil Premium (EYPP) take-up rates, EYICS has identified preschools where children eligible for free school meals are achieving below peers. Bespoke modelling sessions have been developed to support improvements in children's communication, physical, and social skills. Providers are encouraged to share best practice on the effective use of EYPP funding, and case studies will be disseminated through newsletters and web links.
- A new leaflet, *Choosing Quality Childcare*, has been produced to guide parents in selecting appropriate early education settings and to highlight the benefits of early learning. This resource is aligned with the *Best Start in Life* campaign.

Supporting families to get their children off to a good developmental start and Access to support early development of speech, language and communication.

(*links also to JHSW Priority 1, Critical Days and Covid recovery*)

- The 0-2 Pathway is currently undergoing a full review to align outcomes with new Department of Education guidelines from April 2026 in line with Best Start in Life expectations. The pathway will be entirely evidence based and will remain a targeted group for data driven cohorts.
- Plans are in place to create a new role called Best Start in Life Practitioners, and recruitment for this is planned from January 2026.
- The Maternity and Early Years partnership have identified that speech, language and communication skills remain low for Leicestershire children. Children with good communication skills are more likely to be school ready. A developmental roadmap has been created to help parents understand the importance of talking to their child from birth. Accompanying key messages have been produced to encourage parents to integrate communication-building activities into daily routines, promoting early language development.
- EYICS has prioritised communication and language training for early years providers working with children from nine months. Key elements include:
- Collaboration with Stronger Practice Hubs, funded by the Department for Education, giving providers access to evidence-based approaches.
- Training to help practitioners identify early signs of delay and apply effective strategies to support children's progress.
- Opportunities for practitioners to share strategies with parents, ensuring consistent support across settings.
- Speech, language and communication training is delivered to the Early Years workforce to help identify children at risk of delay. 141 providers have received training for Summer and Autumn term 2025, co-ordinated by EYICS.
- The Early Language Support for Every Child Toolkit has been launched and shared with all providers. Training is offered through the Speech and Language Service for children who require additional support.
- EYICS has four trained Raising Early Achievement in Literacy (REAL) advisors. 53 local authority colleagues and early years providers have been trained to deliver evidenced based home learning interventions to families.
- Communication and Language Workers continue to deliver sessions to universal parent-child groups through Family Hubs. These sessions support the development of speech, language and communication in pre-school children. These are planned to continue through 2026-29 and will be jointly funded through Family Hubs and Public Health.
- 97% of early years childcare providers in Leicestershire are rated by Ofsted as good or better.

- 75.9% percentage of Leicestershire children are reaching their age-appropriate milestones and achieving a good level of development at the 2-year health review.
- 121 children have not reached their milestone in 4 or more domains. These children are more likely to be referred to the Early Years SEND advisors and remain on their caseload until school and likely to need specialist support in the future.
- More children are achieving a good level of development at the end of their foundation stage than last year. Data has been released for 2024/25 cohort, 70.4% of Leicestershire children have achieved a good level of development which is above National (68.3%).

Embedding physical activity into children's lives

- National Child Measurement Programme dashboards are now live to identify areas/schools which may need to be targeted**.**
- Working with LCC Sport and Exercise Medicine Registrar and the School Sport and Physical Activity Network to review the offer for those Children and Young People with long-term health conditions.
- School Sport and Physical Activity Networks funded to deliver against the following priorities: fundamental movement, targeted physical activity programmes and active travel.
- Early Years Physical Activity Continuing Professional Development programme in place, with the next conference date set for March 2026
- Supported the development of a national children and young people physical activity training programme

Access to high-quality, inclusive and accessible childcare and early education

- A robust and sustained communications campaign is in place to promote the range of funded childcare offers available to families. This includes:
- Funded childcare hours for two-year-olds whose parents receive additional government support.
- Universal and extended funded entitlements for three- and four-year-olds.
- The working parents' entitlement for children from nine months to school age.

- Since September 2025, eligible working parents have been able to access up to 30 hours of funded childcare for children aged nine months and above. A termly promotional campaign encourages parents to obtain their HMRC codes to secure their entitlements with their chosen childcare provider. Campaign messaging is disseminated through the Family Hubs website and Family Hubs Facebook pages.

- Significant progress has been made in expanding places for children aged two and under, enabling parents to return to work or training. During the Autumn 2025 period:
- 4,903 two-year-olds accessed places under the new entitlement.

- 3,978 children aged under two accessed the new entitlement for working parents.

- Termly partnership meetings continue to be held with colleagues from: Family Hubs, Health services and Early Years Information and Childcare Service (EYICS). These meetings provide opportunities to share key messages, promote mutual understanding of services, and reinforce the benefits of early education as part of the Best Start in Life Plan.

- A number of parent-facing initiatives support awareness and uptake of early education:
- Birth registrars distribute postcards to new parents outlining funded entitlements and guidance on choosing quality childcare.
- A promotional video highlighting the benefits of early education has been developed and is now in circulation.
- A new autumn-term postcard encourages parents to access early education prior to starting school.

- The EYICS uses data from school admissions, and contacts parents who have given permission, to encourage them to take up a childcare place in an early years setting prior to starting school. Parents are encouraged to understand the benefits of early education so that they will be ready for school.

Improving maternal mental health and physical activity

- Active Mums Club continues to engage and empower pre-and post-natal women to be active
- Year 3 Impact Report (July 2024 – June 2025) has been developed. Some key headlines:
- Outcomes for women were positive: 67% increased physical activity levels, 47% achieved strength guidelines, 39% reported improved general health, 64% increased life satisfaction, 51% reduced anxiety.
- 308 Buggy Walks delivered, supported by 22 trained walk leaders
- The Active Mums Club website recorded 10,880 page views with 2,878 unique users
- Social media reach was recorded as: 105,754 people on Facebook and 22,942 on Instagram
  www.activemumsclub.org
  Funding has been secured for Year 4 of programme delivery

JHWS Priority 3: Preparing for Life

Increase Human Papilloma Virus (HPV) vaccination uptake

- HPV Coverage and trend:

- In 2023/24 (latest trend data available), Leicestershire's HPV one-dose coverage is 80.9% for females and 73.4% for males, both above the England average (72.9% females; 67.7% males).
- In East Midlands: For males, Leicestershire performs better than all areas apart from Rutland and North Northants. For females Leicestershire performs better than all others across East Mids. However, coverage remains below the 90% ambition, and longer-term declines from pre-pandemic levels have not fully recovered
- The adolescent programme moved to a one-dose schedule in September 2023, improving simplicity and catch-up potential. The ICB-led LLR HPV Project Group has a system-wide action plan across SAIS (School Aged Immunisation Service), schools, primary care and community outreach, aligned to the national cervical cancer elimination ambition.

Reducing levels of children in care

- There are key pathways to support reducing the levels of children in care. Right Support, Right Time implementation of Family Safeguarding and Family Help enabling intensive early intervention, and Families Together focus on working with children at risk of being looked after, offering intensive intervention.
- Authorisation levels and processes for children entering care is consistently used and children's care plans are considered by Independent Reviewing Officers.
- The focus on supporting children who are out of care continues, with the number of Special Guardianship Orders being achieved exceeding predicted numbers.
- There is also specific focus on supporting return home for children and achieving revocation of Care Orders when this is the best option for the child. A new CFS approach is in draft and being considered by the senior management team. If approved, CFS will take this into implementation in 2026.

Opportunities for 16-17 year olds to gain education, employment and training

- The CFS Care Leavers team have established a partnership with Leicestershire Cares and REED who are offering care leavers employment support and work experience. The development of a study support programme has also given further opportunity for care leavers who are not yet work ready to have work experience and support. The first cohort has supported 3 care leavers, and this will be rolled out again. Work needs to be undertaken with the Districts and all departments in LCC to increase the opportunities for work experience and apprenticeships. The care leaver service and virtual school are leading on this work.

Develop the public health offer for schools, to build informed, healthy and resilient young people

- In addition to being fully operational in all mainstream secondary schools, in Leicestershire, the Teen Health Service has expanded into 6th Form Colleges over the past year. There are 3 Health and Wellbeing Officers supporting post 16 age group with a weekly presence (1 day) at several further education colleges and post 16 school settings.
- Regular quarterly pop-ups and events are held at additional further education colleges. Work has just begun with events lined up starting this term. An online wellbeing group for post 16 is being piloted in the evenings to address engagement and logistical barriers, with evaluation scheduled for May.
- The Health Related Behaviour Survey of 2025 has been completed by 5,032 children and young people across 37 schools in Leicestershire. Insights from this on topics such as emotional health & wellbeing, substance use & alcohol, relationships, and physical activity have been shared with partners across the system to help inform their work.
- Public Health are mapping the offers and services available to schools by the department, and will be working with CFS on how best to communicate our support options with education settings.

Access to emotional and mental health support for children and young people

- Mental Health Support Team (MHST) Five Year Plan - MHST have a target of achieving 100% coverage by 2029/30. We have submitted and agreed a trajectory to achieve 100% coverage, we are expecting an additional 8 teams which will support a staggered expansion into all Leicestershire County and Rutland education settings. We are on track to meet the national medium term planning expectations in relation to coverage. There remains strong system commitment to the Government mandate of achieving 100% MHST coverage by 2029, which will equate to 25 funded teams across LLR.
- Current LLR position - Approximately 69% CYP population coverage and 49% of education settings covered. Against the Medium-Term Planning Framework targets (77% by 26/27 and 94% by 28/29), LLR remains on track.
- Whole School College Approach across Leicestershire and Rutland:
- 2024/25 Whole School/College Approach number of activities: 317
- 2024/25 Whole School/College Approach number of CYP/ Parents/ Carers: 17,034
- Current Coverage across Leicestershire and Rutland:
- 143 Education settings - 40.6% of Leicestershire County and Rutland total coverage
- 70,426 CYP - 53.7% based on total school capacity within Leicestershire County and Rutland. Please note this includes the Harborough district that is being onboarded in the new year 2026. This will ensure service provision in all Leicestershire County and Rutland localities/districts, at the current coverage detailed.

- Challenges - All MHSTs nationally are experiencing recruitment challenges, we have an ongoing advert and are implementing a pathway to support Education Mental Health Practitioners who have completed the training course an opportunity to register with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or British Psychological Society (BPS), this will increase our potential pool of candidates.

  We have experienced some challenge with a very small pool of education settings declining our offer when we have attempted onboarding, the rationale for this is school leadership capacity to facilitate. A smaller number have also not responded to repeated contact, telephone/email. We will attempt to onboard all of them again in the next wave of expansion/onboarding.

- Domestic abuse and sexual violence support for children and young people continues to be a high priority across our domestic abuse services through our specialised commissioned service offer. This support includes therapeutic support for children and families across a variety of settings as well as the development of survivor voice through project Echo whereby CYP voices are heard and utilised to adapt services dependent on feedback and need. To ensure the learning from Project Echo is carried forward a survivor group will be established to feed into the Leicestershire and Rutland Domestic Abuse Local Partnership Board, a representative from the group will sit on the Board.
- Reducing parental conflict training and information on the Family Hubs, alongside the Teen Health offer in schools, have been prioritised for DA services, particularly where working with children and young people on healthy relationships is a priority.
- Additionally, young people are supported by Health and Wellbeing officers within the Teen Health service with specific remit around promoting healthy relationships and emotional wellbeing, liaising closely with integrated sexual Health provider and system partners.
- youHQ Mental Health and Wellbeing App has embedded across 25 secondary schools across Leicestershire. There is an event planned for February 2026 to help promote and recruit secondary schools to sign up for the App. The youHQ App provides opportunities for young people to explore their emotions, access support, and develop self-management skills. YouHQ provides:

- Track and support student health and emotional wellbeing.
- Allow young people to set ‘value-based goals’
- Enable authorised staff such as class tutor, Safeguarding lead and Head of school to view children’s wellbeing scores.
- Provide safeguarding ‘flags’ and alerts to designated staff i.e. Class Tutor and Safeguarding leads.
- Provide insight to young people’s behaviours i.e. mental health and wellbeing in order to improve pastoral support.

- Provides support and signposts to local resources, including integration of Tellmi.

Access to appropriate support for children and young people to maintain an active lifestyle and healthy weight

- The Whole Systems Approach to Healthy Weight, Food and Nutrition is progressing, with the initial priority themes identified through stakeholder engagement now being tested with community groups and residents. Education has emerged as one of the key themes, encompassing school food provision and individuals' confidence and skills in preparing healthy meals. Leicestershire has also recently launched its ambition to achieve Gold Sustainable Food Place status. Several workstreams will begin over the coming months to support delivery of this aspiration which also takes a life course approach.
- HENRY workshops (Health, Exercise and Nutrition for the Really Young) continues to be delivered successfully within Family Hubs, with excellent uptake and retention figures.
- The Holiday Activities and Food programme (HAF) is a DfE funded national programme that supports school age children receiving free school meals (FSM) to access free holiday activity sessions with a meal during Easter, Summer, and Winter school holidays. The aims of the HAF programme include supporting children to receive healthy and nutritious meals and maintain a healthy level of physical activity. CFS, with support from Active Together, continue to co-ordinate the delivery of Leicestershire's HAF programme. DfE have confirmed funding for the national programme for 2026-29.

Support the workforce to embed a Trauma Informed Approach

- A Trauma Informed practice toolkit was developed for Health Visitors and Midwifery by Barnardo's and was circulated across both services. This is hosted on the County Council website. Midwifery have developed training offers and have Trauma Informed Champions within the workforce. Changes have been made to practice including additional documents such as a body map to help explain trauma and how it can affect individuals, and that birth plans can change dependent on needs/ emergencies. University Hospitals Leicester and Public Health work closely around new developments, including participating in the Reducing Parental Conflict work.
- The Early Help Competency Framework has recently been rebranded as Early Help Practice Guidance to ensure it is more user-friendly and accessible to practitioners.
- Further work is underway across the local authorities and Safeguarding Partnership to develop the learning offer for the partnership. This will result in a shared learning and resource platform being developed across LLR to support external lead practitioners, offering access to guidance, tools, and learning opportunities.

- Quick Thinking Plan Early Help Assessment (QTP) - Following approval of the new centrally based Partnership team, recruitment has been completed for a new Team Leader who will lead the team of Early Help Facilitators and is in due to start in January 2026. Ongoing recruitment is currently taking place to fill 3 Early Help Facilitators post with interviews taking place later this month. 4 schools are now using SharePoint to log Quick Thinking Plans (QTPs) with a further 2 currently planning to become part of phase 1. We have received our first QTP which averted a Multi-Agency Referral Form (MARF) being completed, and appropriate support was given to school and signposting provided. We have taken benchmarks for comparative data to ensure we can measure the reduction of MARFS received by these schools each term to measure impact.
- The Families First Partnership Programme is the name given to the national programme of reform for children's social care. Working with partners including police, health and education, work is underway to respond to national guidance, build on existing strengths, and ensure services and processes meet the needs of Leicestershire families. Building on a strengths based, trauma informed approach, the programme will help to ensure that wherever possible, preventative approaches will ensure children are supported to remain safe and thrive with their families.

Ensure that children with SEND and learning disabilities have access to support, including a seamless transition into adult services

- ICB LLR Continuing Care policy review group concluded work on the new local policy, with legal services oversight. CFS introduced a new role to support implementation, focusing on an improved process, providing quality information to inform the Continuing Care threshold decision and nurse assessor assessment.
- Work has been undertaken to develop an LLR joint protocol between Local Authorities and Health for packages for children in care and other children who are eligible under Section 117 to receive funding support.
- Improved processes for the early identification of children for consideration under the Continuing Care Framework and Section 117 have been implemented, improving timeliness of early discussions and consideration.

Proposal for the Year Ahead

Current Governance Structures

12. With the recognition that so many outcomes for children and young people other than health are also reliant on effective multi-agency working, the Children & Families Partnership (CFP) additionally works towards the delivery of the CFP Plan.

13. To coordinate the work across both the Joint Health and Wellbeing Strategy (JHWS) and the CFP Plan, the group has 5 priority areas:

    a) Ensure the best start for life (Early Years);

    b) Safe and free from harm;

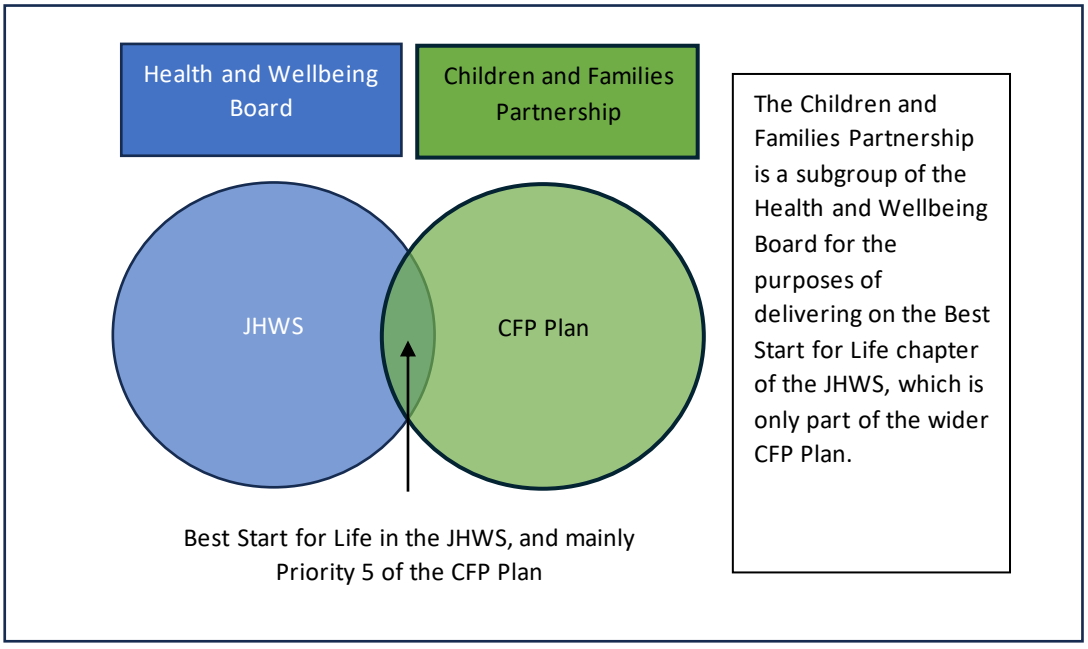
    c) Support families to be self-sufficient and resilient (Early Help);

    d) Ensure vulnerable families receive personalised, integrated care and support;

    e) Ensure good physical, emotional and mental health.

14. Priority area 5 ("Ensure good physical, emotional, and mental health") contains the majority of JHWS commitments, whilst most of priority areas 1-4 align instead to the wider CFP Plan.

Figure 1: Relationship between Health and Wellbeing Board, the Children and Families Partnership, and their respective strategies



15. The review of the JHWS (approved by the Health and Wellbeing Board at its meeting on 4 December 2025) has seen the Best Start for Life chapter have a greater health-related focus than previously. As part of this review, the JHWS has also been renamed the Joint Local Health and Wellbeing Strategy (JLHWS) as per the Health and Care Act 2022.

16. Under the current governance structure, the greater health focus would mean that oversight of the Best Start for Life chapter sits even more firmly within the Priority 5 subgroup as opposed to being distributed across the whole CFP.

Proposed Change

17. It is proposed that a new Operational Delivery Group of the Health and Wellbeing Board is created. This new group (provisionally named the "Children and Young People (CYP) Place Based Group") would oversee the Best Start for Life commitments.

18. We suggest that the newly formed CYP Place Based Group will:

    - Be chaired jointly by representatives from Leicestershire County Council Public Health, and the Integrated Care Board.
    - Consist of a broad range of partners from teams that include (but are not limited to) Public Health, Children & Family Services, Districts, the LLR Integrated Care Board, University Hospitals of Leicester, Leicestershire Partnership Trust, and primary care.

19. The CFP meanwhile would become independent of the Health and Wellbeing Board. It would retain ownership of the wider CFP Plan, focusing on those priorities requiring partnership working that are not directly related to health (broadly priorities 1-4 of the current CFP Plan).

20. There will, however, still be areas of overlap between the two groups. For example, having a higher proportion of children achieve Good Levels of Development is a key success measure of the JLHWS and is being delivered through the Priority 1 group of the CFP. In cases such as these, it would be appropriate for oversight of the work to remain with CFP (this would minimise disruption in areas where excellent work is already taking place) but for updates to be shared with the CYP Place Based Group. These updates will in turn be shared with the Health and Wellbeing Board through the CYP Place Based Group's annual update report.

21. To ensure that both groups are aligned and properly sighted on one another's work, there would need to be 'dotted lines' of communication between the two groups. It is proposed that senior leads of each group attend as members of the other, and that each group receive a minimum of one written progress report a year.

Benefits of the Proposed Change

22. Under the current structures, reporting is largely from the Priority 5 group, via the CFP, to the Health and Wellbeing Board. The proposed changes would mean that the group overseeing Best Start for Life commitments would now be able to instead report directly into the Health and Wellbeing Board.

23. By separating out health and non-health related issues into separate groups, membership can be more effectively tailored to the priorities and commitments

of each group. This will help ensure focussed discussions and further promote partner engagement.

Next Steps

24. These proposals for changes to the CFP governance were approved by the CFP on 22 January 2026. If the Health and Wellbeing Board approve these proposals today, the following actions will be taken:

- New Terms of Reference will be drafted for both the CFP and CYP Place Based Group, working with Democratic Services to ensure accuracy in describing the new relationships to the Health and Wellbeing Board.
- The new CYP Place-Based Group will develop a new delivery plan to ensure the commitments within the JLHWS Best Start for Life priority are delivered effectively.
- The CFP will refresh the existing CFP Plan and it will be cross-referenced and aligned to the new delivery plan for the CYP Place Based Group, ensuring clarity of roles and responsibilities.
- The updated governance arrangements will be implemented during March 2026.

Background Papers -

https://democracy.leics.gov.uk/documents/s188702/7%20HWB%20Report%20Best%20Start%20in%20Life%20Feb%202025%20002.pdf

Appendices

Appendix - Children and Families Partnership Terms of Reference

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Relevant Impact Assessments

Equality Implications

25. There are no equality implications arising from the recommendations in this report.

Human Rights Implications

26. There are no human rights implications arising from the recommendations in this report.

APPENDIX

CHILDREN AND FAMILIES PARTNERSHIP

TERMS OF REFERENCE

June 2022 Update

Vision

The vision of the Children and Families Partnership is for children and young people in Leicestershire to be safe and living in families where they can achieve their full potential and have good health and wellbeing.

Purpose of the Children and Families Partnership

The purpose of the Children and Families Partnership is to champion effective partnership working on shared outcomes and priorities that make a real difference to the lives of children and young people. By working together, the Partnership can also maximise resources and expertise, be more co-ordinated in the services provided and avoid duplication of effort.

It will achieve this purpose by providing leadership, direction and assurance on behalf of the Health and Wellbeing Board:

(i) To a Children and Families Partnership Plan that will focus on the following outcomes to deliver the Best Start for Life commitments of the Joint Health and Wellbeing Strategy delivery plan:

a. To ensure the best start for life for early years children and their families

b. To work proactively in partnership to keep children and young people safe and free from harm and child sexual and criminal exploitation

c. To support families to become self-sufficient and resilient

d. To enable children with special educational needs and/or disabilities and their families to become increasingly independent through personalised, integrated care and support

e. To enable children to experience good physical and mental health throughout their lives

(ii) To related boards and sub-groups contributing to the delivery of the above outcomes including:

a. Leicestershire Education Excellence Partnership (six monthly reports to CFP)

b. SEND and Inclusion Board (bi-monthly reports to CFP)

c. Youth and Justice Partnership Board (six-monthly reports to CFP)

d. Early Help Partnership (six-monthly reports to CFP)

e. Youth Campaign Group (six-monthly reports to CFP)

Terms of Reference

In order to deliver the vision set out above, the Children and Families Partnership will have the following role and duties:

(a) To oversee the delivery of the Best Start for Life commitments of the Joint Health and Wellbeing Strategy delivery plan through:

i. The development of a Children and Families Partnership Plan, identifying key areas of partnership work that will have the biggest impact on the lives of children and young people;
ii. Overseeing its implementation against agreed milestones and ensuring the plan is delivered effectively and in line with national policy and local priorities;
iii. Reporting to the Health and Wellbeing Board of any risks and issues that will impact on the delivery of the Best Start for Life priorities;
iv. Agreeing a SMART performance framework for the Partnership Plan, and monitoring performance against this framework;
v. Making recommendations as appropriate to the Health and Wellbeing Board on the allocation of resources;
vi. Developing pooled budget arrangements where appropriate;
vii. Directing a communication plan targeted to a wide range of stakeholders across the partnership, with particular emphasis on the needs of the public and local councillors.

(b) To ensure that the voice of children and families is represented in all the work of the Children and Families Partnership and that of partner organisations

(c) To consider and address any barriers to achieving the vision of the partnership, to ensure that children and young people in Leicestershire are safe and living in families where they can achieve their full potential and have good health and wellbeing

(d) To oversee the activity of sub-groups to ensure that they are delivering the required outcomes and meeting agreed milestones, and recommending action where delivery is not satisfactory

(e) To identify opportunities for integrated commissioning and/or delivery of services with other place/partner initiatives (Leicestershire and

wider) where there are identified benefits for doing so, and to ensure that this is planned and delivered to agreed outcomes

(f) To set delegated limits for approval of variation of expenditure within any pooled budgets developed by the Partnership and review these on an annual basis

(g) To work collaboratively with the other Health and Wellbeing Board sub-groups to ensure there are links between plans.

Membership of the Children and Families Partnership

- Cabinet Lead Member for Children and Families
- Department of Work and Pensions
- Director of Children and Families Services, LCC
- Director of Public Health representative
- Director representative from Leicester, Leicestershire and Rutland CCGs
- Director representative from LPT
- Director representative from UHL
- Education representatives
- National Probation Service representative
- Officer representative from District Councils
- Representative from Leicestershire Police
- Representative of Adults and Communities Department, LCC
- Representative of the Office of the Police and Crime Commissioner
- Voluntary Sector representatives

Membership will be regularly reviewed to ensure the effective operation of the Partnership

Meeting Frequency

Meetings will take place bi-monthly

Chair

Cabinet Lead Member for Children and Families at Leicestershire County Council

Meeting Administration

Meetings will be administered by Democratic Services at Leicestershire County Council

The agenda and papers will be issued no later than 4 working days in advance unless later circulation has been authorised by the Chair (exceptional circumstances).

Location of Meetings

A hybrid meeting model will be adopted for the January and July meetings, where the face-to-face element will be held at Leicestershire County Council Committee Rooms Meetings.
All remaining meetings will be held remotely via TEAMs.

Quoracy

In order to meet and conduct routine business 6 members must be present of which at least:

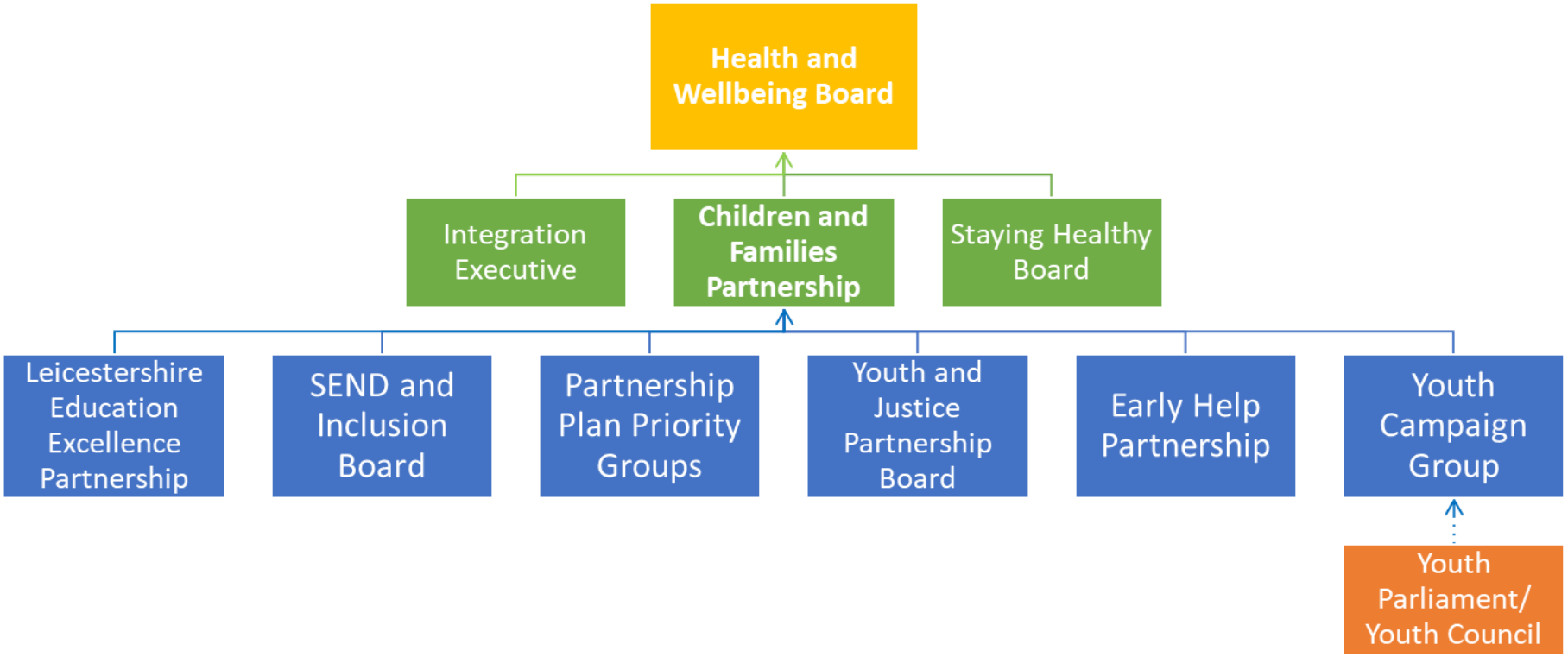
- 1 must be a health representative
- 1 must be a representative from Leicestershire County Council
- 4 must be from partner organisations not named in the previous 2 bullet points.

Reporting Arrangements

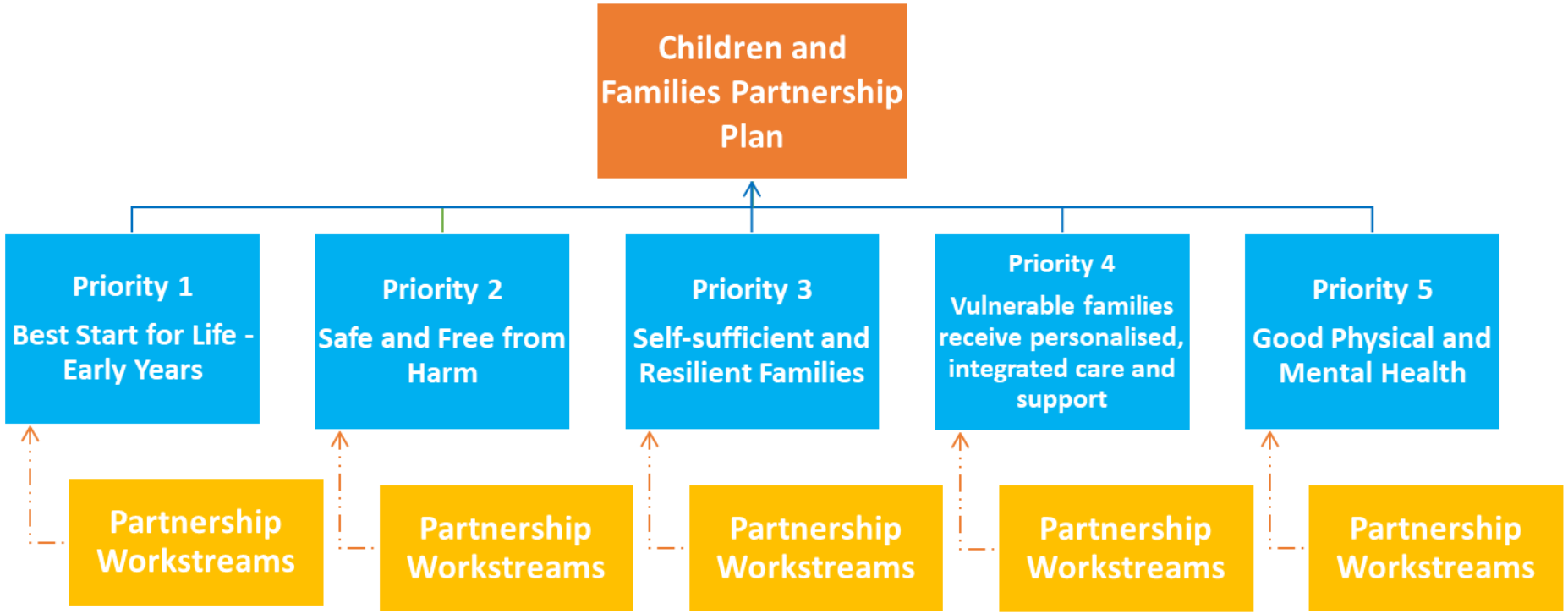
The Children and Families Partnership will submit:

- quarterly reports on performance against the Best Start for Life commitments to the Health and Wellbeing Board
- an annual deep dive analysis on an agreed to the Health and Wellbeing Board
- an annual highlight report on the 'sponsor' workstreams. (the list of "sponsor" and "watch" workstreams will be reviewed on an annual basis by the Partnership.
  The 'watch' list will be reviewed on an annual basis and each workstream will have a Board link to ensure escalation to the Health and Wellbeing Board is made as needed.
- an annual report on performance against the Children and Families Partnership Plan to Leicestershire County Council's Cabinet and Children's Scrutiny Committee

Children and Families Partnership Board Governance



Children and Families Partnership Plan Priority Delivery Groups



Leicestershire County Council

HEALTH AND WELLBEING BOARD: 26 FEBRUARY 2026

REPORT OF THE DIRECTOR OF PUBLIC HEALTH, LAW & GOVERNANCE

JOINT LOCAL HEALTH AND WELLBEING STRATEGY AMENDMENT, EASY READ VERSION AND DELIVERY PLAN

Purpose of report

1. The purpose of this report is to enable the Board to:
   a. amend wording of a commitment in the Joint Local Health and Wellbeing Strategy (JLHWS) (Reviewed and Revised 2022-2032) and;
   b. approve the easy read document of the JLHWS;
   c. note the first iteration of the delivery plan.

Recommendation

2. The HWB is recommended to:

   - Approve changes of wording to the 'healthy homes' commitment in the Staying Healthy Safe & Well life course priority within the Joint Local Health and Wellbeing Strategy 2022-2032 (Reviewed and revised 2025).
   - Approve the easy read document of the JLHWS;
   - Note the Joint Local Health & Wellbeing Strategy Delivery Plan.

Policy Framework and Previous Decision

3. At its meeting on the 4 December 2025, the HWB approved the final version of the Joint Local Health & Wellbeing Strategy 20022-2032 (reviewed and revised 2025).

Background

4. Following approval of the Joint Local Health & Wellbeing Strategy, the Board endorsed the commencement of phase 2 of the strategy review. This phase included the development of an Easy Read version of the strategy, the development of a delivery plan and a review of governance arrangements to support effective implementation of the strategy.

Progress Update & Proposals

5. During phase two of the review, it was identified that a commitment within the Staying Healthy, Safe and Well section of the recently approved strategy required an amendment. The proposed change is to revise the wording from:

   a. **Healthy homes**: We will work together to make sure homes are affordable, safe, warm and of suitable quality and type, to support lifelong health and wellbeing.

   To:

   b. **Healthy homes**: We will work together to make sure homes are safe, warm and of suitable quality and type, to support lifelong health and wellbeing.

   The term 'affordable' has been removed from the strategy as the partnership cannot directly influence housing market prices. The updated wording therefore reflects the areas within the partnership's sphere of influence.

6. Progress has been made on the development of an Easy Read version of the strategy. With support from Easy Read Online and feedback sought from the Joint Local Health & Wellbeing Strategy Steering Group, the final version of the document can be viewed in **appendix 1**.

7. The easy read version of the revised Strategy has been developed, recognising the importance of making the Strategy more accessible and easier to understand for a wider audience. To support effective dissemination, a comprehensive communication and engagement plan is being developed as part of the project, to ensure the strategy reaches its intended audiences. This will make use of existing communication channels and partner organisations to help promote and share the strategy widely.

8. The delivery plan underpinning the strategy can be viewed in **appendix 2**. Each subgroup has been responsible for collaboratively developing the plan for their lead areas. This has included developing actions aligned to revised commitments, identifying links to other strategies and setting out how success will be measured to assess impact. This process will be iterative and ongoing, and this plan represents the start of that work. Going forward, the delivery plan will be attached to annual reports to support ongoing monitoring and accountability.

9. Following the revised strategy and the development of the accompanying delivery plan the programme is now well positioned to align with wider system priorities and partnership plans. Work will now commence on the development of neighbourhood plans as an addendum to the delivery plan, setting out local priorities and supporting delivery at place level.

10. Subject to approval, the proposal is that each subgroup will provide an update on progress against actions within the delivery plan at least once per year to Health and Wellbeing board. These updates will include, as a minimum, a narrative overview, relevant case studies and performance data to demonstrate progress and impact.

Next Steps

11. Subject to approval of the delivery plan:

- The revised JLHW Strategy will be launched and embedded within partner organisations from 1 April 2026 with the approved amendment.
- Review of governance arrangements will continue
- Progress reports to HWB will commence from 1 April 2026:
  - June 2026 - Staying Healthy Safe & Well
  - September 2026 - Living and Supported Well & Dying Well
  - December 2026 – Mental Health
  - February 2027 – Best Start for Life

Background papers

Report considered by Health and Wellbeing Board on 4 December 2025:

https://democracy.leics.gov.uk/documents/s193416/HWB%20Report%20JLHWS%20Strategy%20Review%20Dec%202025%20DRAFT1.pdf

Appendices

Appendix 1 – JLHWS Easy Read version

Appendix 2 – JLHWS Delivery Plan

Officers to contact

Mike Sandys, Director of Public Health

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Abbe Vaughan, Health & Wellbeing Board Manager

Email: Abbe.Vaughan@leics.gov.uk

Relevant Impact Assessments

Equality Implications

12. An EHIRA has been completed as part of the JLHWS review during 2025

Human Rights Implications

13. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

14. The JLHWS review focuses on the commitment from partners in delivering the strategic objectives to improve the health and wellbeing of Leicestershire residents.

15. Partnership working will be fundamental to the success of the next phase of the strategy review. Building on the strong collaborations already established, continued collaboration will ensure the successful progression of priorities and collective ownership of delivery. By working together, partners can draw on their combined skills, insights and resources to drive the work forward and achieve better outcomes for our residents.

Risk Assessment

16. A full risk assessment has been managed as part of the project

Easy Read

LEICESTERSHIRE Health & Wellbeing Board

Health and wellbeing strategy 2022 to 2032

Giving everyone in Leicestershire the chance to thrive and live happy, healthy lives

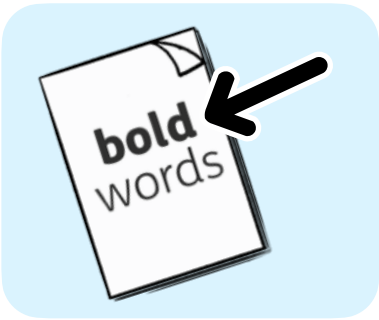
Updated in 2025

Easy Read

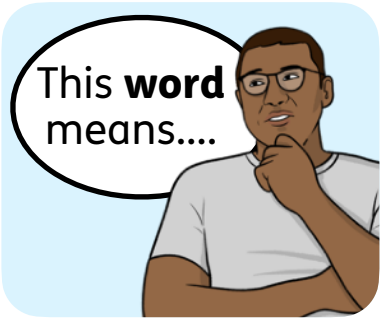
This is an Easy Read version of some information.

It uses easier words and pictures.

Some people may still want help to read it.



Some words are **bold** to show that they may be hard to understand.



We will explain what the bold words mean.

What is in this booklet

You can fill in a quick survey to say what you think about this Easy Read booklet: https://www.easy-read-online.co.uk/easy-read-feedback-survey

About this booklet

This booklet is from **Leicestershire Health and Wellbeing Board** (the **Board**).

The **Board** is a group made up of people from local health and care organisations.

We work to make sure health and care services are right for local people and support them to live happy, healthy lives.

In 2025, we made some changes to our **health and wellbeing strategy.**

This is our plan for health and care services. It runs from 2022 to 2032.

We made these changes so that we can continue to meet the needs of people in Leicestershire.

Please read this Easy Read booklet to learn about the updated plan.

Health and wellbeing in Leicestershire

Health and wellbeing means feeling happy and healthy in your body and mind.

Leicestershire is mostly countryside, but most people live in towns.

People in Leicestershire are living longer.

This means there will be more older people who need health and care services in the next 10 years.

Best start for life

We want children in Leicestershire to be healthy so that they can:

- Have good relationships with family and friends.

- Have good mental health and learn how to deal with difficult feelings.

- Help and take part in their local area as they get older.

- Learn the skills they need to live good lives.

- Learn and do well in school.

We are committed to:

- Helping women to be healthy before, during and after pregnancy.

- Making it easier for families to find advice and support for dealing with small health problems.

- Helping families and young people find the right health and wellbeing services in their area, when they need them.

- Making sure that local health and wellbeing services are easy to use and suitable for people with different needs.

We are also committed to:

- Giving families the support they need to look after their baby's health and help their child learn and grow.

- Giving families the support they need to get their children ready for school.

- Making sure it is easy for young people to move from children's services to adult services.

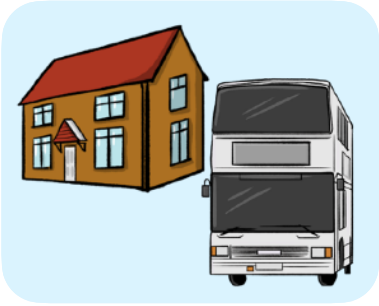
- Helping young people look after their own health.

Staying healthy, safe and well

We want people in Leicestershire to live healthy, happy and long lives.

People are more likely to live longer if they:

- Live and work in healthy and safe places.

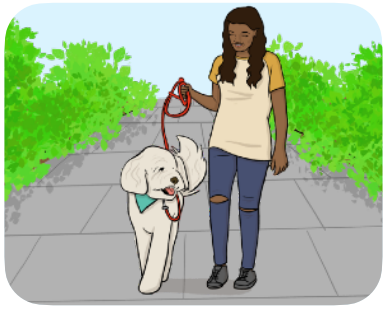


- Have good schools, jobs, homes and transport in their local area.

- Have healthy habits, like being active and eating a healthy diet.

We are committed to:

- Making sure that health and fairness are part of everything we do.



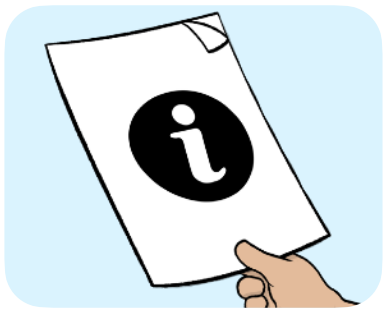
- Working together to have healthy places where people can live good lives.

- Working with businesses to make sure people can find and stay in work, and have healthy places to work.

- Making sure people's homes are safe and warm.

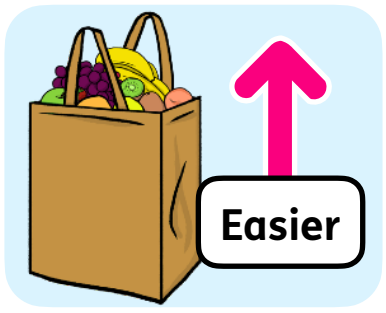
We are also committed to:

- Building healthy and safe communities where people feel supported.



- Giving people support and information to help them make healthy choices.

- Helping people eat a healthy diet and stay a healthy weight.



- Making it easier for people to get healthy food.

Living and supported well

We want to help people live good lives and stay independent as they get older or their health gets worse.

We are committed to:

- Helping people manage their ill health in a way that is best for them.

- Keep making sure people get the health and care services they need, when they need them.

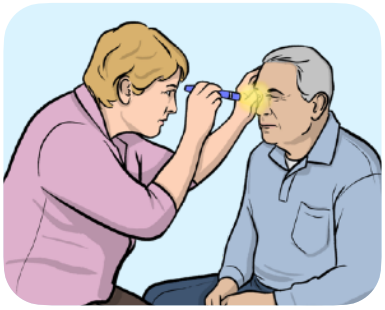
- Helping people with disabilities and ill health to be independent and live in their own home.

We are also committed to:

- Supporting people if they fall over.

- Supporting **carers**.

  Carers are people who care for their family member, partner or friend.



- Finding out what support people need early on, to stop their health from getting worse.

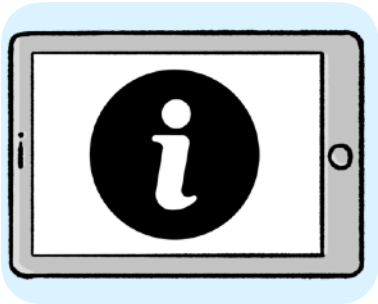
- Providing local health and care services closer to people's homes.

Dying well

We want to make sure people in Leicestershire can choose the care they get at the end of their life.

This care is called **end-of-life care** or **palliative care**.

We are committed to:



- Making sure people can find information to help them make decisions about their end-of-life care.

- Asking people what they would want from their end-of-life care.

- Helping people plan and talk about their end-of-life care.

We are also committed to:

- Helping health and care services work together to give people the right end-of-life care.

- Supporting carers after the person they care for has died.

Improving mental health

Mental health is about health issues that affect the way you think, feel and behave.

Having good mental health means being able to cope with your emotions.

We want to give people in Leicestershire the mental health support they need at the right time.

We are committed to:

- Helping people have good mental health so they do not become ill.

- Making sure that mental health is just as important as **physical health**.

  Physical health is about health issues that affect your body.

We are also committed to:

- Making it easier for people of all ages to get mental health support.

- Making it easier for young people to move from children's mental health services to adult mental health services.

- Doing more to support people who have **dementia**.

  Dementia is a disease in the brain. It can affect your memory and behaviour.

- Reducing **suicide** by making it easier for people to get help early.

  Suicide is when a person ends their own life.

Reducing health inequality

Health inequality is where some groups of people have worse health than others.

We want to reduce health inequality by making healthcare in Leicestershire fairer for everyone.

We are committed to making sure that people from all groups can get the health and care services they need.

Protecting people's health and being ready for emergencies

We want to make sure that:

- We are protecting people's health.

- We are as ready as we can be for health emergencies.

We are committed to protecting people's health in a way that is fair and helps us deal with problems in the future.

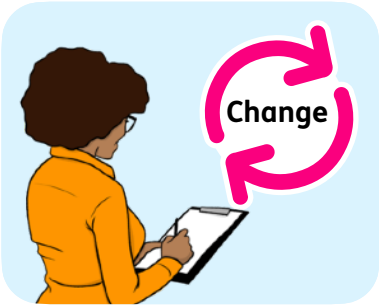
Next steps

We will work with local services and the public to make sure this plan works well.

We will talk to local people and communities to find out if they feel that the plan is working well.

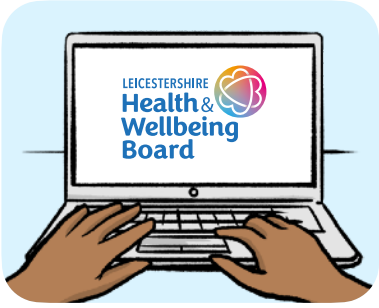
We will have regular checks to make sure we do everything in our plan and that the plan is working well.

Smaller groups will be in charge of different parts of the plan.

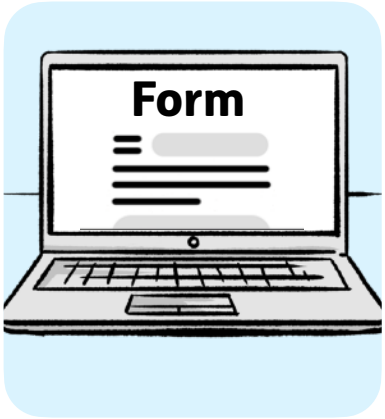


We will do other checks to see if we need to change the plan.

Find out more



You can look at our website here:
https://www.leicestershire.gov.uk/health-and-wellbeing/leicestershire-health-and-wellbeing-board



You can fill out an online form to contact us here:

https://www.leicestershire.gov.uk/health-and-wellbeing/leicestershire-health-and-wellbeing-board/get-in-touch-with-the-health-and-wellbeing-board

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APPENDIX 2

BEST START FOR LIFE

	Ref	Commitment	Actions	Links to other Plans/Strategies	What does success look like?	Dashboard Indicators
First 1001 Critical Days	A1	We will help families feel confident in managing minor health issues, by making it easier to find trusted advice and local support.	**A1.1** We will work with system partners to develop a coordinated approach for supporting families to access the most appropriate health service for their needs, recognising that in many instances this will not be A&E.	Strategic Approach to Food - in development - Fit for the Future: 10 Year Health Plan for England - LLR ICB 5 Year Plan - LCC Strategic Plan - Best Start in Life - Staying Healthy Partnerhsip Delivery Plan	Sustained reduction in A&E attendances for 0-4 yrs - Reduction in maternal obesity - Reduction in alcohol related hospital admissions. - Reduction in the proportion of caesarean section births. - Sustained improvement in the proportion of new birth visits within 14 days. - Sustained reduction in hospital admissions of babies under 14 days old. - Improvement in the breastfeeding rate. - Improvement in vaccination coverage at 1 and 2 years. - Improvement in the percentage of children achieving a good level of development at 2-2½ years.	A& E attendances (Under 1 year), (0-4 years) & admissions of (Babies under 14 days) - C03a - Obesity in early pregancy - C07 -Proportion of new birth visits completed within 14 days - Breast Feeding prevalance 6-8 weeks - Caesarean Section % females - Population vaccination coverage IPV Hib Hep B (1 year old) & (2 years old) - Population vaccination coverage Hepititus B (1year old) & (2 years old) - Population vaccination coverage Hib & Menc Booster (2 years old) - Population vaccination coverage MMR (2 years old) - Population vaccination coverage PCV - B02a - Child development - precentage of children achieving a good level of development in communication skills, expected level of personal social skills, problem solving skills, fine/gross motor skills at 2 and 2.5 years
	A2	We will support women to find and use local services that will help them understand how to care for their health and wellbeing before and during pregnancy, and after birth.	**A2.1** We will work with the Staying Healthy, Safe & Well Partnership in their expansion of a Whole System Approach to Healthy Weight, Food & Nutrition, to ensure that the needs of women before, during and after pregnancy are accounted for.			
	A3	We will support families to find and use local services that will help them understand how to care for their baby's health and support their child's early development.	TBC			
	A4	We will ensure the right health and wellbeing services are available locally and in a joined-up way, so families can get the support they need, when they need it.	**A4.1** We will contribute towards an LLR workshop to understand and identify actions we can take to reduce infant mortality rates.			
School Readiness	B1	We will help families to build the foundations for school readiness, emotional wellbeing and good health by making it easier to find trusted advice and local support.	**B1.1** We will work in partnership to develop, and deliver, a Best Start in Life Plan to ensure more children achieve a Good Level of Development by age 5 years.	Strategic Approach to Food - in development - Fit for the Future: 10 Year Health Plan for England - LLR ICB 5 Year Plan - LCC Strategic Plan - Best Start in Life	Sustained improvement in the percentage of children achieving a good level of development at the end of reception - Improvement in the percentage of physically active children and young people - Reduction in the prevalence of overweight in reception children - Reduction in the prevalence of overweight in Year 6 children - Leicestershire & Rutland Sexual Health Strategic Plan - in development	School readiness percentage of children achieving a good level of development at the end of reception - Reception prevalance of overweight (including obesity) & underweight - C10 - percentage of physically inactive children and young people - Year 6 prevalance of overweight (including obesity) and underweight
	B2	We will support families to find and use local services to support healthy development and wellbeing.	**B2.1** We will work with the Staying Healthy, Safe & Well Partnership in their expansion of a Whole System Approach to Healthy Weight, Food & Nutrition, to ensure that the needs of children and young people are accounted for.			
	B3	We will ensure the right health and wellbeing services are available locally and in a joined-up way, so families can get the support they need, when they need it.	TBC			
Preparing for Life	C1	We will help young people (with support from their families, carers and professionals) to take charge of their own health and wellbeing, by giving them the confidence, knowledge and encouragement to make healthy choices, look after their own health and wellbeing and support life-long health and resiliance	**C1.1** We will work with young people, families and professionals to improve uptake of immunisations and boosters, supporting life-long health & resilience.	Strategic Approach to Food - in development - Fit for the Future: 10 Year Health Plan for England - LLR ICB 5 Year Plan - LCC Strategic Plan - Best Start in Life - Leicestershire & Rutland Sexual Health Strategic Plan - in development - Staying Healthy Partnerhsip Delivery Plan	Improvement in the uptake of HPV vaccination in males and females - Sustained reduction in hospital admissions due to substance use. - Improvement in levels of chlamydia testing. - Reduction in teenage pregnancies - Increased proportion of young people successfully transitioning from children's to adult health & wellbeing services.	D04e - population vaccination coverage HPV vaccination (Males & Females) - Hospital Admission due to Substance use - Chlamydia detection rate per 100,00 - Health transitioning data
	C2	We will work together with young people, families, schools and other professionals to make sure young people can find and use local health and wellbeing services to meet their needs.	**C2.1** We will develop and deliver substance use prevention and brief intervention pathways for stakeholders working with young people, as well as a training programme for the public, young people and their parents.			
	C3	We will ensure the right health and wellbeing services are available locally and in a joined-up way, so young people can get the support they need, when they need it, particularly as they move into adulthood. These services will support all young people, including those with disabilities, to stay healthy, build resilience, and feel part of their community.	**C3.1** We will work to review and improve Chlamydia detection rates, including by ensuring appropriate screens are taking place.			

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STAYING HEALTHY, SAFE AND WELL

	Ref	Commitment	Actions	Links to other plans/strategies	What does success look like?	Dashboard Indicators
Building strong foundations	D1	**Health and equity in all policies**: We will prioritise a health & equity in all policies approach to all we do.	**D1.1** Increase awareness of Health in All Policies (HIAP) principles and increase the use of Health Impact Assessment (HIA) processes across decision-making, strategies and policies within Leicestershire Health and Wellbeing Board member organisations, ensuring training, implementation and shared learning are integrated throughout	NHS 10 Year Plan - ICB 5 Year Plan - LCC Strategic Plan - Transport Planning Strategy (2025 – 2040) - Supports the Local Nature Recovery Strategy - LCC Environment Strategy - LCC Action for Nature - 2050 Net Zero Leicestershire Action Plan	Health and Equity in all policies approach successfully embedded across the Leicestershire Health and Wellbeing Board member organisations. - Evidence that appropriate, equitable infrastructure (including health services) is in place for the planned housing growth addressing health inequality through design and use of health impact assessments. - Routine use of health impact assessments in planning, transport and development. - Collaboration with planners & licensing officers to influence the local environment, including limiting clustering of fast food, alcohol and gambling outlets, and assessing their potential impacts on the local community. - Increased access to and availability of green community assets & green spaces. - Expansion and/or improvement of active travel infrastructure with increased uptake of walking, cycling and sustainable transport - Reduction in air pollution and its impact on health. - Sustained improvement in the employment rate. - Sustained improvement in the percentage of working days lost to sickness absence and improved employee wellbeing. - Reduction in fuel poverty and fewer households living in cold or energy inefficient homes (affordable warmth) - Stronger community cohesion with increased local participation	B16 -Utlisation of outdoor space for exercise of health reasons - Percentage of adults cycling for travel at least 3 day sper week - percentage of adults walking for travel at least 3 day sper week - D001 - Fraction of mortality attributable to paticulate air pollution - Air pollution fine particle matter - Percentage of peoplein employment - Bo9b - Sickness absence - the percentage working days lost due to sickness absence - Fuel Poverty - Violent crime - violence offences per 1,000 population
	D2	**Healthy placemaking:** We will work together to shape healthy places and create strong, connected and resilient communities where everyone can thrive	**D2.1** Strengthen routine health and wellbeing considerations in planning and policy through the use of health impact assessments, alongside pilot approaches and shared learning. **D2.2** Creating places that support health and wellbeing by shaping environments where people can connect, participate and thrive. Including social and community factors, environmental conditions, and access to amenities improving travel and active design, enhancing access to nutritious food and supporting active lifestyles through collaboration with local stakeholders. **D2.3** We will deliver the Physical Activity Framework, by working with our partners to create a high quality network of formal and informal spaces to live, work, travel and play.			
	D3	**Healthy workplaces and local economy:** We will work with employers and local organisations to create fair, inclusive and healthy workplaces, helping more people to get into work and thrive in their jobs.	**D3.1** We will strengthen system-wide understanding and coordination of employment and healthy workplace programmes, support the sharing of information/insights, help unlock delivery challenges and link to wider support services to help people stay in or return to work.			
	D4	**Healthy homes:** We will work together to make sure homes are affordable, safe, warm and of suitable quality and type, to support lifelong health and wellbeing.	TBC			
	D5	**Healthy & safe communities:** We will work together to build communities where people feel connected, supported and able to live healthy and well.	**D5.1** Partners will work together to support cohesive communities through joined-up working, shared learning, collaborative engagement approaches and delivering coordinated support to existing and emerging initiatives that aim to build strong, resilient and connected communities.			
g Healthy Choices	E1	**Supporting healthy choices and behaviours**: We will offer support, information and opportunities that create conditions that make it easier for people to make healthy choices and reduce behaviours that cause harm to health.	**E1.1** We will work in partnership to deliver the sexual health and drug & alcohol strategic plans collectively addressing challenges and championing integration **E1.2** We will work in partnership to prevent harmful gambling and promote screening and signposting for those in need of treatment and support **E1.3** We will strengthen system wide support to make sure our approach embeds making every contact count across our collective organisations including supporting investment in healthy conversation skills training **E1.4** We will deliver the Physical Activity Framework, by working in partnership to create appropriate opportunities and pathways across the life-course and supporting others to consider their role and how they facilitate physical activity in their decisions.	NHS 10 Year Plan - ICB 5 Year Plan - Leicestershire Food Plan - LCC Strategic Plan -	Implementation of healthy conversation skills training across the network with frontline staff equipped to have health promoting conversations. - Reduction in the percentage of adults who are overweight - Sustained improvement in the percentage of active adults. - Sustained reduction in the percentage of inactive adults - Reduction in alcohol related hospital admissions - Sustained reduction in smoking prevalence -	C16 - Overweight prevalance in adults - Percentage of Physically active adults - Percentage of active and inactive adults - Admission episodes for alcohol-related conditions - Hospital admissions due to substance use - C18 - Smoking prevalence in adults -

Enabling	**E2**	**Healthy weight, food & nutrition**: We will work together to create healthier food environments and promote good nutrition.	**E2.1** We will work together with partners, businesses and communities to achieve Gold Sustainable Food Places status for Leicestershire. **E2.2** We will continue to strengthen and expand the Whole System Approach to Healthy Weight, Food & Nutrition (including the role of physical activity) by engaging the most appropriate stakeholders	Strategic Approach to Food – in development - Living & Supported Well Delivery Plan	Reduction in the rate of abortions - Achievement of the sustainable food places gold standard award. - Improvement in the percentage of adults meeting the '5 a day' fruit and vegetable consumption recommendation.	Achievement & maintaining gold standard food award - Chylamidyia testing, HIV Testing, abortion rate - 5 a day fruit and vegetable data -

LIVING AND SUPPORTED WELL

	Ref	Commitment	Actions	Links to other Plans/Strategies	What does success look like?	Dashboard Indicators
Upscalaing prevention and self care	F1	**Empowering self-care** - We will work together to support people to manage their long-term health conditions in ways that work best for them. This includes offering different types of local support to meet different needs.	**F1.1** Developing and implementing proactive care service delivery within neighbourhood models of care **F1.2** Implementing Integrated Neighbourhood Team offer to support Multi Disciplinary Team's and work with Patient need groups 1-5	Staying Healthy Partnership delivery plan - Neighbourhood Plans - NHS 10 Year Plan - Carers Strategy	Qualitative feedback that suggests that multi-disciplinary, holistic care planning and self-management support packages, enable people to live well with long term conditions for longer, with less need for acute care. - Producing care plans for people with multi co-morbidities to reduce the need for urgent or emergency care. - Reduction in permanent admissions to residential and nursing homes. - Increase in the use of technology to support people to live independently - Evidence that an asset-based approach is being taken to recognise and build on the strengths of individuals, families and communities. - Sustained reduction in the rate of admissions due to falls for people aged 65+. - Sustained reduction in the rate of hip fractures. - Reduction in the percentage of adult carers reporting loneliness or social isolation.	E13 - Hip fractures in people aged over 65 and over - Percentage reporting at least two long-term conditions, at least one of which is MSK related - Permanent admissions to residential and nursing care homes per 100,000 - BCF Indicators / NHS OF - Unplanned hospital admissions for chronic ambulatory care sensitive conditions - NHS OF emergency admissions for acute conditions that should not require hospital admission
	F2	**Access to care services** - We will make the best use of our resources to improve access to health and care services to ensure people get the support they need, when they need it.	**F2.1** Development of a system wide single point of access **F2.2** Improving access to Integrated locality teams aligned to include crisis response services **F2.3** Improve responsiveness to community Stroke services linked to locality teams functions			
	F3	**Supporting independence** - We will support people with disabilities and long-term health conditions to live independently. This includes making sure they can access suitable housing, care, equipment, adaptations, technology and personalised support that meet their needs.	**F3.1** Expanding Lighbulb integrated housing service delivery including Disabled facilities grant's **F3.2** Assisted technology and equipment review across partners			
	F4	**Falls prevention & management** - We will strengthen support to reduce the impact of falls and reduce their impact, particularly on hospital admissions, to help people stay safe and well.	**F4.1** Recommission and / or develop falls car service and link to single point of access to reduce long-lies and hospital admissions **F4.2** Increase step-up services linked to frailty and reducing admissions due to effective triage and treatment at hospital attendance			
	F5	**Support for carers** - We will support carers to improve their quality of life by making sure they are included in decisions about the person they care for and can easily find the information they need, when they need it.	**F5.1** Delivery of the carers strategy and improving comms to residents in order for them to access appropriate support Develop support for carers and those that they care for is in place when a hospital attendance or admission is required			
t of frailty and complex care	G1	**Early identification of need** - We will build on the local population health management (PHM) framework to create a proactive care model that identifies people's needs earlier, helping to prevent crises before they happen.	**G1.1** Develop Neighbourhood care models derived from Population Health Management data against highest needs and likelihood for crises. **G1.2** Develop Integrated Neighbourhood Team prevention focused neighbourhood care models based on Population Health Management data	NHS 10 Year Plan -	Early identification of individuals at high risk of hospitalisation and social care needs using a Population Health Management approach and delivering outcomes within a neighbourhood care model. - Reduction in emergency admissions for those aged 65+. - Reduction in emergency bed day usage for those with 5 or more Long Term Conditions. - Improved timeline of discharges across all pathways - Increased utilisation of reablement - 95% of people identified as vulnerable have a co-produced care plan, which takes into account their wider needs e.g., multiple LTCs, social/psychological elements and carer arrangements - Improvement in the percentage of patients aged 65+ discharged back to their Usual Place of Residence - Reduction in long-term admissions to residential care homes and nursing homes	B18b - Social isolation - percntage of sdult carers who have had as much social contact as they would like - BCF Indicator/NHS/OF - unplanned admissions for chronic ambulatory care sensitive conditions - BCF Indcator/NHS/OF - Proportion of older people (65+) who were still at hom 91 days after discharge from hospital into rehab/reablement - BCF indicator - percentage of people discharged from acute to normal place of residence - BCF Indicator - percentage of patients who have been an inpatient in acute care for more than 14 and 21 days - Home first outcome - To ensure 95% of patients who are identified as vulnerable have an agreed care plan
	G2	**Supporting independent living** - We will provide joined up health and care services that help people, and their carers live independently for as long as possible in the place they call home. This will be supported by a joined-up workforce that will make sure people get the right support at the right time.	**G2.1** Development of integrated care teams linked to Single Point of Access and crisis response services **G2.2** Increased capacity in Intermediate care services both in Home First including expansion of Homecare Assessment and Reablement Team reablement and step-up admission avoidance **G2.3** Continued development of the Integrated Personalised Care Framework			

Effective management	G3	**Care in the community** - We will develop community-based health and care models that proactively support people to manage their long-term health conditions. These models will build on local strengths and work closely with voluntary and community organisations wherever possible.	**G3.1** Develop consistent Neighbourhood care models for all people with Long Term Conditions across Leics **G3.2** Design a hub and spoke model of Voluntary sector support to neighbourhood services Link utilisation of frailty virtual wards to support neighbourhood and crisis response services		for people aged 65+. - Improvement in the number of people aged 65+ still at home 91 days after discharge into rehabilitation/reablement services - Reduction in delayed transfers of care from hospital and reduced non-elective admissions into hospital. - Improved patient satisfaction and coordination in the complex care pathway and care coordination across the system especially for those with multimorbidity (5+ chronic conditions). - Improved identification of people with moderate or severe frailty in the short term, followed by a reduction in the number of people with moderate or severe frailty as a result of proactive action. - Reduction in unplanned admissions for those with ambulatory care conditions	- Home first outcome - To stablise ED attends for complex patients at 19/20 levels - Home First outcome - to increase 2 hour urgent community response compliance to 80% across all providers - BCF Indicator - Residential & Nursing admissions planed rate of 519 = 3% reductions across all providers - Home first target - to increase 2 day reablement compliance to 80% across all providers

DYING WELL

Effective end of life planning & transitions

Ref	Commitment	Actions	Links to other Plans/Strategies	What does Success Look Like?	Dashboard Indicators
H1	**Joined-up support** - We will improve how health and care services work together at the end of life, making support more joined-up, easier to navigate, and better tailored to people's needs.	**H1.1** We will implement a shared digital platform for ReSPECT so that all appropriate professionals can access, update and create plans in one place, supporting people to die in their preferred place and enhancing efficiency of care teams by reducing duplication of plans. **H1.2:** We will strengthen cross-organisational planning and coordination through the six multi-agency Palliative and End of Life Care Taskforce workstreams, driving consistent and joined-up improvements across the system.	LLR Palliative and End of Life Care Strategy	Increased proportion of people planning for late stages and end of life at a time when they are still able. - Increase in the number of people dying in their place of choice. - Care plans offered to all people that may benefit from having one. This should include a ReSPECT plan. - Increased take up of care plans/ReSPECT plans with people specifically opting out of having a plan in place rather than being missed from the offer of one.	Percentage of deaths that occur at home - Percentage of deaths that occur in care homes - Percentage of deaths that occur in hospice - Percentage of deaths that occur in hospital - Life expectancy data - Home first outcome - to ensure 95% of patients who are identified as vulnerable have an agreed care plan - Number of ReSPECT care plans in place - Home first outcome - to reduce deaths in hospital from 40% to 35%
H2	**Making end-of-life conversations a normal part of life** - We will work with people, health and care staff, and community groups to make conversations on care at the end of life easier and more common. By encouraging open and honest discussions, we can help people make choices that are right for them and ensure they are treated with dignity and respect.	**H2.1** We will expand Ante-mortem education classes as a proactive public engagement offer, using the comms and engagement workstream to normalise end-of-life conversations and empower people to plan with confidence, dignity and informed choice.			
H3	**Understanding what matters at the end of life** - We will use data and insights to better understand what matters most to people at the end of life. This will help shape how care and support are planned and delivered, making sure people's needs are recognised and met with compassion.	**H3.1** We will enhance our ability to plan and improve end-of-life care by developing integrated data systems and dashboards that provide clear insight into current activity, future demand and gaps across place and system. **H3.2** We will expand proven interventions (such as the new medications delivery service) to reduce delays in care and support families and carers to remain with their loved ones, enabling more people to die at home where this is their wish. **H3.3** We will introduce a cultural and spiritual care toolkit, informed by staff insights and community expertise, to equip healthcare professionals with accessible guidance that supports diverse needs at the end of life.			
H4	**Access to information** - We will make sure that people, families, carers and professionals have the right information and support to make clear and confident decisions on end-of-life care to ensure smoother transitions and better experiences for everyone involved.	**H 4.1** We will enhance the accessibility, readability and relevance of end-of-life information by working with carers through targeted focus groups to identify the content and formats that best support their needs. **H4.2** We will develop a unified professional information portal, providing clear access to clinical guidance, referral routes, training and CPD resources, mirroring best practice from neighbouring systems.			
H5	**Support with end-of-life planning** - We will make end-of-life planning a key part of personalised care and ensure that professionals/staff feel informed, confident, and supported to have open and compassionate conversations, making planning a natural part of life.	**H5.1** We will strengthen proactive end-of-life planning by using the Mortality Risk Score and other key metrics to help GPs identify and prioritise people who would benefit from ReSPECT discussions and personalised care planning. **H5.2** We will equip staff to initiate timely, compassionate end-of-life conversations by embedding a Making Every Contact Count (MECC) approach and widening access to high-quality communication training delivered by LOROS.			
H6	**Bereavement support for carers** - We will make sure carers receive timely and compassionate support during bereavement. This support will recognise the emotional impact of losing a caring role and help carers through the transition.	**H6.1** We will address gaps in bereavement provision by using insight from our Mapping and Equity of Access workstream to identify unmet needs and ensure services are promoted clearly and consistently across the system **H6.2** We will enhance awareness of bereavement support by improving how services are communicated and promoted and we will monitor the impact through ongoing engagement with carers and communities.			

HEALTH INEQUALITIES

	Ref	Commitment	Actions	Links to other Plans/Strategies	What does success look like?	Dashboard Indicators
Improved Health Inequalities	J1	We will provide a universal offer of health and care services to all, with justifiable variation in response to differences in need between groups of people	**J1.1** Work with partners to ensure that all actions and enabling activities within delivery plans are designed and delivered in ways that focus on groups and communities experiencing the greatest disadvantage		Reduction in the slope index of inequality or 'levelling up' of the social gradient - A greater rate of improvement in life expectancy and healthy life expectancy in the most deprived communities and vulnerable groups across Leicestershire. - Improvement in the percentage of children with free school meal status achieving a good level of development at the end of reception. - Improvement in the number of looked after children having a health check. - Improvement in the proportion of children in care who are up to date with their routine vaccinations. - Improvement in emotional wellbeing of looked after children - Improvement in health outcomes of children and young people with learning disabilities. - Improvement in the percentage of adult carers who have as much social contact as they would like. - Narrowing of the gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate.	Index of Inequality Indicators - Life expectancy Indicators & Inequality in life expectancy Indicators - B02a - School Readiness - percentage of children with free school meals status achieving a good level of development at the end of reception - Health check data & SMI data - MH dashboard - Vaccination Data - Percentage of looked after children whose emotional wellbeing is a cause for concern - B18b - Social Isolation - percentage of adult carers who have as much social contact as they would like - B08a - Gap in the employment rate between those with a physical or mental long term condition (16-64) and the overall employment rate - Gap in the employment rate for those who are in contact with secondary mental health services (18-65) and o the Care Plan Approach) and the overall employment rate - Adults in contact with secondary mental health services who live in stable and appropriate accommodation

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HEALTH PROTECTION AND EMERGENCY PREPAREDNESS

Improved health Protection & Emergency Preparedness

Ref	Commitment	Actions	Links to other plans/strategies	What does Success Look Like	Dashboard Indicators
K1	We will work collaboratively to ensure our health protection approach and response is proactive, equitable and resilient.	**K1.1** Partners will work together to support vaccination and screening programmes by sharing insights, addressing challenges and enabling consistent approaches including co-production that encourage inclusive positive behaviour change.	Resilience Strategy	Proactive identification of vulnerable populations as part of preparedness for extreme weather events and other similar emergencies - Improvement in MMR uptake - Sustained improvement in flu vaccination coverage - Improvement in RSV vaccination coverage - Improvement in occupational vaccination rates across the health and social care workforce - Improvement in cervical screening uptake with reduced variation by age, deprivation and ethnicity. - Sustained improvement in uptake of bowel screening - Sustained improvement in cancer diagnoses at stages 1 and 2 (early stages).	Emergency Preparedness data - Population vaccination coverage MMR - Population vaccination coverage Flu - Population vaccination coverage RSV - Occupational vaccination coverage data - Cervical Screening population data - Canver scrrening coverage (bowle cancer) - C23 Percentage of cancers diagnosed at stages 1 & 2

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Leicestershire County Council

HEALTH AND WELLBEING BOARD – 26 FEBRUARY 2026

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

BETTER CARE FUND QUARTER 3, 2025/26 RETURN

Purpose of report

1. The purpose of this report is to provide the Board with the Quarter 3, 2025/26 template report of the Better Care Fund (BCF). The report sets out performance against BCF metric targets, spend and activity and statements as to whether the national conditions continue to be met.

Recommendation

2 It is recommended that the performance against the Better Care Fund (BCF) outcome metrics, and the positive progress made in transforming health and care pathways up to Quarter 3 be noted.

Policy Framework and Previous Decision

3. Nationally, the BCF plan for 2025/26 for Leicestershire was officially approved by NHS England (NHSE) in June 2025.

4. The Chief Executive of Leicestershire County Council approved the BCF Quarter 3 report under powers of delegation for the NHSE submission deadline of 30 January 2026.

Background

5. In December 2025, the national BCF team published the Quarter 3 template for reporting the position, which requires approval by the Health and Wellbeing Board (HWB) or respective governance.

6. The aim of the report and template is to inform the Board of progress against BCF delivery. BCF quarterly reporting can be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including Integrated Care Boards, local authorities and service providers).

7. The completed Quarter 3 template is attached to this report as an Appendix. The NHSE submission deadline was 30 January 2026.

8. The template consists of tabs that update progress against the following:

- Whether the four national conditions detailed in the BCF planning requirements for 2025-26 continue to be met through the delivery of the plan.
- A confidence assessment on achieving the metric targets for each of the BCF metrics which includes a brief commentary outlining any goals met or challenges faced in achieving the target along with any support needs and successes that have been achieved. It also provides an opportunity to revise any targets published in the 2025/26 plan.
- An update against income and expenditure.

Update against national conditions for the 2025/26 Plan

National conditions

9 All national conditions are being met. These are:

- National Condition 1: A jointly agreed plan;
- National Condition 2: Implementing the objectives of the BCF;
- National Condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care;
- National Condition 4: Complying with oversight and support processes.

BCF Metrics

10. The table below shows the BCF metrics for this financial year, the targets and outturns up to November 2025, where available:

Metric	Target Q3	Actual	Commentary
Indirectly standardised rate (ISR) of admissions per 100,000 population	1,581	1,430 (Oct/Nov only)	Quarter 3 data so far shows improved performance against the plan. Year to date (YTD) shows that the average rate of admissions is 1,432 per month against a plan of 1,653.
Average length of discharge delay for all acute adult patients, derived from a combination of: Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	0.41 86.5%	0.6 84.9%	Data for Quarter 3 so far shows that off target by 2.4% against planned performance. YTD, 1.6% off target. However, data shows Leics HWB performing better against both the England and East Midlands average. Data is currently only available until November 25.

For those adult patients not discharged on DRD, average number of days from DRD to discharge.	3.22 days	4.6 days	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	217	213	The plan for Quarter 3 was 217 admissions and actual data shows this to be 213 up until Quarter 2. YTD performance is 421 against a target of 434.

Updated spend and activity

11. This section updates income and expenditure for the quarter.

12. Information is required on the differing income streams of the BCF and if there have been any changes to this against the published planned income.

13. Expenditure for Quarter 3 has been inputted and is in line with the published plan and equates to 73% of the overall income.

Circulation under the Local Issues Alert Procedure

14. None

Background papers

Better Care Fund Planning Requirements 2025-26:
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#planning-expectations-meeting-national-conditions

Better Care Fund Policy Framework 2025-26:
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026#bcf-objectives

Officers to Contact

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Telephone: 0116 3050786
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Appendix

BCF Quarter 3 template 25-26

Relevant Impact Assessments

Equality and Human Rights Implications

15. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

16. An equalities and human rights impact assessment has been undertaken which is accessible via the following link - http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf. This concluded that the BCF will have a neutral impact on equalities and human rights.

17. A review of the assessment was undertaken as part of the BCF submission for 2021.

Partnership Working and associated issues

18. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

19. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the HWB.

20. The delivery of the Leicestershire BCF ensures that several key integrated services are in place and contributing to the system wide changes being implemented through the five-year plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships http://www.bettercareleicester.nhs.uk/

Better Care Fund 2025-26 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing the objectives of the BCF
National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)
National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):
1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.
Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Planned Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'Q3 Year-to-Date Actual Expenditure' should include total amount that has been spent in Q3, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan.

Please also use this section to provide the aggregate year-to-date spend at Q3. This tab will also display what percentage of planned income this constitutes; [if this is 50% exactly then please provide some context around how accurate this figure is or whether there are limitations.]

Better Care Fund 2025-26 Q3 Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist Complete:
Health and Wellbeing Board:	Leicestershire	Yes
Completed by:	Lisa Carter	Yes
E-mail:	lisa.carter@leics.gov.uk	Yes
Contact number:	1163050786	Yes
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Leicestershire

Confirmation of Nation Conditions			Checklist Complete:
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

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Better Care Fund 2025-26 Q3 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Leicestershire

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,484.0	1,576.1	1,633.3	1,649.2	1,677.8	1,525.3	1,592.0	1,553.9	1,598.4	1,595.2	1,506.2	1,655.6
	Number of Admissions 65+	2,335	2,480	2,570	2,595	2,640	2,400	2,505	2,445	2,515	2,510	2,370	2,605
	Population of 65+	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0

Assessment of whether goal has been met in Q3:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	When comparing actuals with planned performance, the data for the year so far shows that we are currently on target. Quarter 3 data (up to Nov 25) shows improved performance against the plan, as well as YTD. It shows that the average rate is 1432 against a target of 1591. Leicestershire performance is comparable to the England average and is better than the average for the East Midlands in Oct 25. Data is currently only available until Oct 25.

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.45	0.44	0.43	0.42	0.41	0.40	0.38	0.38	0.36	0.35	0.34	0.33
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.0%	85.4%	85.7%	86.1%	86.5%	86.8%	87.2%	87.5%	87.9%	88.3%	88.6%	89.0%

For those adult patients not discharged on DRD, average number of days from DRD to discharge	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

Assessment of whether goal has been met in Q3:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	YTD data up until Nov 25, shows that we are currently off target by 1.4% against planned performance. Nov 25 data shows Leics HWB is comparable with the England average and better than the East Midlands average.

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q3 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	509.8	523.7	132.2	137.9	137.9	137.3
	Number of admissions	785.0	824.0	208.0	217.0	217.0	216.0
	Population of 65+*	157349.0	157349.0	157349.0	157349.0	157349.0	157349.0

Better Care Fund 2025-26 Q3 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Leicestershire

Source of Funding	2025-26 Planned Income	Updated Total Plan Income for 25-26	DFG Q3 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£5,518,288	£5,518,288	£2,702,789	Yes
Minimum NHS Contribution	£57,070,979	£57,070,979		Yes
Local Authority Better Care Grant	£21,824,275	£21,824,275		Yes
Additional LA Contribution	£0	£0		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£84,413,542**	**£84,413,542**		

	Original	Updated	% variance	
Planned Expenditure	**£84,413,542**	£84,413,542	**0%**	Yes

		% of Planned Income	
Q3 Year-to-Date Actual Expenditure	£61,507,339	**73%**	Yes

If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	N/A	Yes

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HEALTH AND WELLBEING BOARD: 26th FEBRUARY 2026

REPORT OF LEICESTERSHIRE COUNTY COUNCIL – DIRECTOR OF PUBLIC HEALTH, LAW AND GOVERNANCE

JOINT STRATEGIC NEEDS ASSESSMENT PROGRAMME OF WORK

Purpose of report

1. The purpose of this report is:
   - to provide an update on the Joint Strategic Needs Assessment (JSNA) work completed during 2025 using the revised dashboard led approach.
   - to present proposals for establishing a JSNA Steering group and for the prioritisation and sequencing of future JSNA work programme
   - to present the updated demography dashboard which will be relevant for all life course priorities.

Recommendation

2. The board is recommended to:

   (a) approve the establishment of a JSNA steering group to undertake the prioritisation and sequencing of JSNA topics which will guide the ongoing development of the JSNA programme of work.

   (b) note and provide feedback on the new demography dashboard.

Policy Framework and Previous Decision

3. The Joint Strategic Needs Assessment (JSNA) is a process which assesses the current and future health and wellbeing needs of the population and underpins local planning for health and care services, in particular the development of the Joint Health and Wellbeing Strategy (JHWS). It involves working with local partners to ensure a broad approach to assessing issues affecting health, including key social and economic determinants of health, where appropriate. Since 2013, the statutory responsibility for the development of the JSNA lies with the local Health and Wellbeing Board.

4. It should be 'viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.'

5. In December 2024, the Board approved a new approach for the JSNA process from 2025 onwards, concentrating on updateable data dashboards on broader life course topics aligned to the Joint health and wellbeing strategy themes.

Background

6. The Business Intelligence (BI) Service within the County Council currently leads on the JSNA chapters, working with other agencies and analysts as appropriate, as the holders of the data or intelligence related to health.

7. Health data availability and tools and methods of presentation have moved on greatly from 2013 when JSNAs became a mandate of the HWB. Data is much more available and updated more frequently. Therefore, awaiting traditional chapters to be completed can mean they are out of date when published or not updated quickly enough when new data emerges.

8. At the HWB meeting on 5 December 2024 the board approved a move to a core data dashboard based JSNA approach allowing data to be updated in line with data releases. This comprehensive supporting data/dashboard based JSNA intelligence set, that will focus on up-to-date dashboards, profiles and self-serve tools based on a variety of data sources including OHID (Office for Health Improvement and Disparities) fingertips, ONS and NHS Digital sources. This enables the JSNA intelligence set to support commissioning across the county, without awaiting publication of longer, harder to interpret written chapters.

9. Since moving to the data dashboard-based approach, the refreshed JSNA work during 2025 has consisted of:

    a. the development of a comprehensive needs assessment to inform the Joint health and wellbeing strategy review.
    b. the creation of a demography dashboard. This dashboard includes demographic breakdowns on a variety of topics including ethnicity, age, gender and language for the whole of Leicestershire. The dashboard also displays data visualisations as well as written narrative. https://public.tableau.com/app/profile/r.i.team.leicestershire.county.council/viz/DemographyJSNADashboard/Introduction?publish=yes
    c. updating the existing inequalities dashboard previously developed as part of the JSNA for 2022-2025. The dashboard provides the middle super output area level data on both demographic and health indicators for the whole of Leicestershire. https://public.tableau.com/app/profile/r.i.team.leicestershire.county.council/viz/InequalitiesJSNA/Titlecard?publish=yes

Proposals/Options

10. The next phase of the JSNA programme of work will focus on agreeing the priority themes for future JSNA dashboard development. It is proposed that those themes align with the recently revised JLHWS to ensure the JSNA programme of work continues to support and inform strategic planning, commissioning and partnership priorities across the system.

11. It is proposed to establish a JSNA steering group comprising of partners from across system, place and neighbourhood including representatives from the Health and Wellbeing Boards operational delivery groups. The steering group will agree the prioritisation and sequencing of JSNA dashboard development and consider whether any topics outside of the life course framework require further analysis, either through a full JSNA dashboard or shorter targeted data pack.

Resource Implications

12. The principal resourcing for the development of the Leicestershire JSNA is provided by the County Council's Business Intelligence Service, funded by the public health grant, and staff in the Public Health Department. The new approach will allow analytical resources to be dedicated to priority analytical work and a more strategic approach, rather than trying to cover everything in detail over a 3-year cycle regardless of priority.

Background papers

Report considered by Health and Wellbeing Board at meeting on 5 December 2024:

https://democracy.leics.gov.uk/documents/s186893/New%20approach%20to%20JSNA.%20HWBv5.pdf

Officer to contact

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Relevant Impact Assessments

Equality Implications

13. The JSNA takes due regard and assesses need and health inequalities in relation to the equality and human rights of different population groups. In particular, it examines sources of Health Inequalities. By moving to the pilot approach, it will allow us to look at topics in more depth, including inequalities data where available.

Human Rights Implications

14. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

15. The JSNA is a statutory function of the HWB, but it's success depends on collective responsibility from the HWB organisations and departments. A collaborative approach ensures that the JSNA remains a shared responsibility of the entire system, emphasising that it is not merely a public health function but a fundamental HWB function, requiring active ownership and contribution from all stakeholders. Providing appropriate data and self-serve tools, that meet the needs of the board and partners, will support effective and appropriate usage.

16. The LLR Data Cell will continue to oversee overall intelligence delivery for the ICB/LLR area and join up to avoid duplication to ensure that intelligence resources are deployed to best effect.

HEALTH AND WELLBEING BOARD: 26 FEBRUARY 2026

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UHL-UHN GROUP CLINICAL STRATEGY 2025-30

Purpose of report

1. The purpose of this report is to provide an overview of University Hospitals of Leicester (UHL) and University Hospitals of Northamptonshire (UHN)'s Group Clinical Strategy (2025-35).

Recommendation

2. The Board is requested to:
   - Note the Clinical Strategy, implementation progress to-date and key next steps;
   - Consider the strategy's alignment with the Joint Health and Wellbeing Strategy, and any opportunities to support or enhance its delivery impact through partnership working.

Background

National Context

3. The NHS and wider healthcare system are facing significant challenges, as highlighted by the 2024 investigation led by Professor Lord Darzi which concluded that the NHS is in 'critical condition', with the nation's health deteriorating, people struggling to access GP services, and acute waiting lists rising. There is a widening gap between NHS revenue growth and surging demand, driven by an ageing population, complex, long-term health conditions, and post-pandemic pressures. In addition, there has been chronic underinvestment in capital, leading to significant backlogs of maintenance as well as outdated IT, equipment, and buildings - affecting staff productivity and patient experience.

4. The 10 Year Health Plan for England (July 2025) set out a clear vision to reform the health system by shifting from a predominantly reactive model focused on treating illness, to one which places greater emphasis on prevention, early intervention and addressing the wider determinants of health. The Plan seeks to prevent avoidable long-term illness and reliance on acute hospital-based care, whilst recognising the continued importance of hospitals for specialist and emergency treatment. Central to this vision is the strengthening of primary and community care services and improved integrated working between healthcare partners to enable a 'Neighbourhood Health Service' in which care is delivered closer peoples' homes through multidisciplinary neighbourhood teams and the expansion and increased use of community facilities (such as neighbourhood health centres, diagnostic services, community hospitals and urgent treatment centres).

5. The Plan also aims to catalyse the shift of the NHS from an analogue to a digital-first service – applying digital (including artificial intelligence) to improve access, operational efficiency and productivity as well as enable enhanced patient self-management. In the context of neighbourhood care, digital will perform a key role through expansion of virtual ward or 'hospital at home' services, including the use of wearable remote monitoring devices which send real-time data (e.g., oxygen levels, blood pressure) to clinical teams, which, if necessary, trigger prompt interventions.

6. Alongside these reforms, the NHS is also implementing a programme of organisational and workforce changes intended to improve efficiency, productivity and financial sustainability. This includes significant workforce reductions across NHS England, Integrated Care Boards and provider organisations, alongside consolidation of functions, simplification of governance arrangements and a clearer delineation of responsibilities between national, regional and system levels. These changes are intended to reduce duplication, streamline decision-making and release resources for frontline care, while supporting a shift towards leaner operating models, greater use of digital automation and more consistent productivity improvements across the system.

Local Context

7. University Hospitals of Leicester (UHL) faces many of the same challenges as the wider NHS, including rising demand, workforce pressures, financial constraints and the need to improve productivity while maintaining safe, high-quality services. For example, with rising emergency department attendances, Leicester Royal Infirmary (LRI) is now one of the busiest emergency departments in the country, seeing hundreds of thousands of patients every year.

8. Despite these challenges however, we continue to deliver significant improvements in service access, quality and safety as well as our overall operational efficiency and productivity. For example, the percentage of patients seen in A&E within 4 hours across LLR (a key national metric and NHS constitutional standard) has risen from 59% in December 2024 to 66% in December 2025. Similarly, in planned care, during the same time period we have achieved a significant 57% reduction in over 13 week waits for diagnostics, with our compliance on the NHS 6-week target for diagnostic waits having risen from 74% in December 2024 to 82% in December 2025.

9. We have also achieved significant improvements in the quality, safety and sustainability of key services, such as our maternity services – through a wide range of changes, such as introduction of an enhanced telephone triage service to identify women and birthing people at risk of deterioration, increased safe staffing recruitment, strengthened safeguarding supervision, and enhanced ward environments – our regional maternity heatmap score (through which a lower score indicates better performance) has improved from 57 at the start of the financial year to 24 as of December 2025.

10. We are also continuously improving our operational efficiency and productivity, supporting ongoing financial sustainability. In 2025/26, we have significantly reduced our bank and agency workforce expenditure (surpassing our agency reduction target surpassed and on track to meeting our target for bank usage). We are also on track to deliver non-pay efficiencies in 2025/26 of £26m. Further, we have identified £3.8m additional commercial income (exceeding target of £1.9m).

11. Additionally, in 2025/26 we have made significant progress in our journey towards establishing a fully data- and digital-driven operating system. We have deployed a purpose-built patient administration system from Nervecentre (updating previous 35 year legacy systems) which manages patients' care journeys through recording tests requests, referrals to consultants, outpatient appointments and hospital admissions, while allowing staff to review medical records and manage treatments. Our new Data Academy is upskilling staff and building a data confident workforce and we have achieved a first-of-type milestone exploring the use of Palantir technology for advanced data warehousing through the Federated Data Platform (FDP). We have also signed a pivotal Memorandum of Understanding with Microsoft to formalise our partnership to develop AI healthcare solutions – placing us in a pioneering

position with scope to incorporate AI into how we deliver clinical care, administer care and transform support services across our organisations.

12. UHL also has significant further improvement opportunities, particularly through our emerging Group model with University Hospitals of Northamptonshire (UHN). Since 2023, UHL and UHN have been working together as a formal NHS Group. With a combined annual spend of £2.9 billion and a dedicated workforce of nearly 30,000 colleagues, we are one of the largest NHS Groups - providing more planned care than any other NHS organisation, with 400,000 planned treatment pathways completed last year. Together, we provide high-quality healthcare across five major hospital sites serving the populations of Leicester, Leicestershire and Rutland (LLR), and Northamptonshire. Each of our hospitals delivers essential general services, including three busy Emergency Departments (EDs), supporting some of the region's most pressing acute needs. In addition, we operate from 19 smaller community hospitals, delivering care closer to home. Increasingly, we are embracing virtual care models and delivering services in peoples' homes to prevent unnecessary hospital admissions.

13. Our size and scale bring opportunity: as a Group we will consolidate and standardise services, achieve efficiencies, share learning, attract and retain talent, and build innovative care pathways across the region. By working together, we will deliver more consistent, higher-quality care for the people we serve, better support colleagues and tackle shared challenges – improvements which neither organisation could achieve alone.

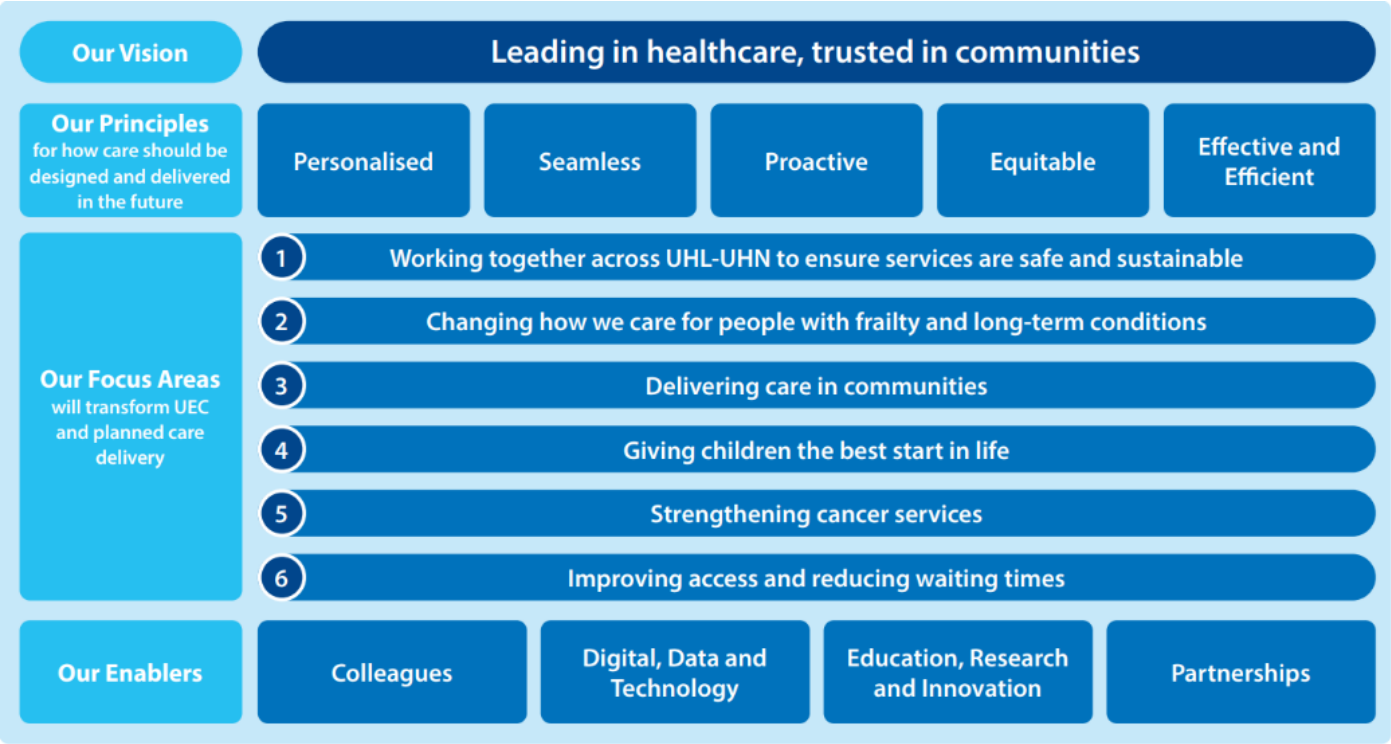
Group Clinical Strategy

14. Our Group Clinical Strategy (2025-30), shaped through extensive co-creation with stakeholders across UHL, UHN and the wider system, sets out how we will apply our collective Group assets and resources to tackle shared challenges - rising demand, workforce shortages, financial pressures, and quality variation. This includes reviewing the configuration of major services, such as our cancer, frailty and maternity, neonatal and paediatric services, to ensure they best meet the needs of local communities and remain safe and sustainable. It also involves bringing together clinical services across the Group to develop joint care models and pathways in order to build consistency, share knowledge/resources, and enhance efficiency such as via economies of scale.

15. In accordance with the 10 Year Plan for Health, our Clinical Strategy also outlines our ambition to perform a key role in shaping and delivering Neighbourhood Health across Leicester, Leicestershire, Rutland and Northamptonshire (LLR&N) – working with our ICB partners to deliver care closer to home, enhancing peoples' access to early and preventative primary and community care services and thereby reducing reliance on hospital services.

16. The Group Clinical Strategy sets out 6 key focus areas which we will tackle through our evolving Group model, as well as 5 principles to guide our approach. These align closely with the life course strategic priorities set out in the Leicestershire Joint Health and Wellbeing Strategy (JLHWS) (2022-32), as they include, for example, enhancing the accessibility, quality and sustainability of clinical services including our maternity, neonatal and children and young people services (supporting the JLHWS 'best start for life' priority), working with partners to improve access to community-based care / prevention through a neighbourhood model (supporting the JLHWS 'staying healthy, safe and well' priority), working with partners to support more joined-up care provision across settings for those living with frailty and/or long-term conditions and strengthening cancer care across the entire pathway from diagnostics and prehabilitation to treatment, rehabilitation, and palliative care (supporting the JLHWS 'living and supported well' and 'dying well' priorities).

Figure 2: Group Clinical Strategy Framework (2025-30)



17. In October 2025, programme governance was mobilised to coordinate and drive the strategy's delivery. Six workstreams, each of which is chaired by an executive leader from across the two trusts, manage the planning and day-to-day delivery of the focus areas - reporting progress, issues and risks to the Operational Group. The Operational Group, comprising colleagues from UHL and UHN Strategy and Partnerships teams, undertakes overall programme management including coordinating, monitoring and supporting the workstreams. The Steering Group, comprising the Group's executive leadership, receives regular highlight reports from the Operational Group, using these to shape strategic decision-making such as around the delivery approach and resources.

18. A brief overview of each key focus area (priorities, progress to-date and next steps) is below:

<u>Safe and Sustainable Services</u>

19. Waiting times, outcomes and patient experience currently vary depending on where people live and where they receive care. Across the Group, the way in which services are currently configured across different hospital sites can lead to duplication and inefficiency. Some our services are 'fragile' (i.e. workforce challenges and sustainability risks - meaning they are highly vulnerable to disruption).

20. Our Group model presents significant opportunities to enhance service sustainability - such as through formation of Group-level service consolidation, integration, or the delivery of care through virtual platforms. This workstream's primary focus is on identifying and addressing areas of clinical service fragility and inefficiency (e.g. duplication), clinical risk, and variation in access and/or outcomes across sites. The workstream aims to support these fragile specialties to capitalise on the Group model through development of specialty-level Group clinical plans, setting out how the specialty will work more collaboratively across UHL and UHN going forward. In identifying specialties to prioritise for this work, there is consideration of whether the specialties already have a partnership clinical strategy in development through East Midlands Acute Providers (EMAP). The review and redesign of specialty care models and

pathways also includes supporting specialties to access the benefits of AI and other emerging technologies.

21. Underpinning this work is a relentless focus on maintaining optimal patient safety, care quality and experiences – this includes ensuring that patients have a consistent experience and receive the same high-quality care, wherever they are treated – supported through exploring initiatives such as single points of access for referrals, single patient tracking lists, shared Electronic Patient Record (EPR), and establishing consistent clinical policies and processes across the Group.

22. Key achievements from October 2025 – present include the development of enhanced Group collaboration arrangements across key specialties such as Plastic Surgery, Haematology, Spinal Surgery and Nuclear Medicine. The workstream is now identifying the next set of specialties to be prioritised for this work, based on clinical engagement and prioritisation analysis – exploring, for each specialty, the potential positive impact of establishing Group-level collaboration arrangements as well as the feasibility of establishing and maintaining them.

Frailty and Long-term Conditions

23. The prevalence of chronic and long-term conditions has increased in recent years and is expected to continue rising as the population ages. The Health Foundation estimates that by 2040, the number of people in England living with major illness will increase by 37% - nine times the projected growth rate of the working-age population. In LLR and Northamptonshire, three in five respondents to the 2024 GP survey reported living with at least one long-term condition.

24. Poorly managed long-term conditions are a major contributor to rising demand for urgent and emergency care, particularly among patients living with frailty. At UHN in 2024/25, for example, patients with frailty accounted for 50% of emergency admissions and 77% of all bed-days - equivalent to 523 hospital beds. Too often, patients living with frailty are admitted to hospital unnecessarily and remain in hospital for extended periods. This reflects a health and care system that is not adequately equipped to meet the needs of these patients. For many frail patients, prolonged hospital stays lead to functional decline and a higher risk of readmission.

25. This workstream's focus is therefore on working with system partners to develop effective primary and secondary prevention programmes, using predictive analytics to target population and individual risk - preventing long-term disease, halting progression, and supporting early diagnosis and treatment. The workstream aims to ensure that patients living with frailty and/or long-term conditions are able to spend more time at home or in their usual place of residence, supported by community-based teams and digital tools (e.g. remote monitoring). The workstream will support joined-up frailty services across settings and frailty-attuned hospital services, as well as design urgent care services and pathways which rapidly assess and treat patients experiencing a deterioration in their condition.

26. From October 2025 to present, the workstream has focused on undertaking a comprehensive review of our current position across both trusts, shaping areas for improvement and developing a clear roadmap to deliver these priorities. An LLR&N Cluster Frailty Workshop has been held with attendance from Clinical & Operational leads from across UHL and UHN. A 5 Year LLR&N Frailty Commissioning Strategy has been established and shared for feedback. Five LLR&N Frailty intervention clusters have been drafted and shared, with a view to these forming delivery plans:

- Intervention 1: Personalised care delivered closer to home

- Intervention 2: Clear access and coordinated response for deterioration and crisis
- Intervention 3: Rapid hospital-based assessment without admission
- Intervention 4: Stronger recovery, step-down and post-hospital support
- Intervention 5: Resilient communities, carers and workforce

Neighbourhoods

27. This workstream aims to ensure residents are cared for in the lowest acuity setting appropriate to their needs, receiving timely, safe and proportionate care – thereby supporting improved population health and reducing demand on urgent and emergency care. As a result, the number of people attending our Emergency Departments will be reduced to a safe and sustainable level, allowing us to focus our emergency care capacity on those who need it most. As part of this, the workstream aims to support enhanced community-based care and establish the 'digital front door' as the primary route of accessing care, with 'digitally enabled care' transforming how care is delivered.

28. The workstream's current focus is on engaging system partners to shape the LLR and Northamptonshire neighbourhood care priorities and approach. In LLR, the workstream is committed to supporting the implementer neighbourhood site in West Leicestershire, focusing on respiratory illness. It has also undertaken analysis of urgent and emergency care (UEC) demand – identifying four neighbourhood 'hotspots' for UEC demand in Leicester, with a view to focusing on these localities with a targeted neighbourhood care approach. A questionnaire has been developed to identify the key factors which drive disproportionate attendance at UEC for low-acuity residents in these areas. In the medium term, the workstream will also aim to define and coordinate the Group's overall approach to supporting population health management.

Maternity, Neonatal and Children and Young People

29. The UHL-UHN Group provides maternity and neonatal services across five maternity units and four neonatal units, supporting around 17,000 births annually. We also operate 10 inpatient paediatric wards and three paediatric emergency departments, serving a population of 1.9 million. Some of these services are fragile, due in part to workforce shortages that may compromise safety, efficiency and quality of care. Children's health issues such as dental decay, obesity and diabetes are rising and expected to worsen without targeted intervention. Demand and complexity in children's services have increased significantly over the past decade.

30. This workstream aims to ensure that our maternity, neonatal and paediatric services are safe, high-quality, and consistently meeting the needs of children and families across LLR&N – with services remaining clinically and financially sustainable, underpinned by a workforce which is skilled, resourced and resilient. A key priority is ensuring that all families have equal access to high-quality perinatal and paediatric care and can expect equitable experiences across all our services.

31. The workstream's focus is on mapping current service positions (strengths, weaknesses, opportunities and threats) and co-producing a shared vision and plans for the future configuration of these services across the Group. An in-depth review of service pressures and workforce gaps is underway, together with outpatient demand and capacity modelling – together these will provide a clear, evidence-based overview of the quality, safety and sustainability of services. Clinicians across the Group are being engaged through an initial

survey, with good response rates so far. Two Group workshops are planned for late March (19 and 26) to co-produce future configuration plans.

Strengthening Cancer Services

32. Cancer is one of the top three causes of death across LLR&N. Incidence is rising and referrals for suspected cancer have increased by nearly 130% since 2009/10. Due to these significant demand pressures, our service sustainability and performance against national standards is challenged. Access to treatment is further constrained by regional shortages of critical resources, including oncologists and radiotherapy equipment. Several cancer services across the Group remain fragile due to workforce shortages. We have seen clear benefits from collaborative working through regional partnerships, including the East Midlands Cancer Alliance, the East Midlands Radiotherapy Network, and the UHL-UHN Cancer Collaborative. These collaborations have supported mutual aid, resource sharing and clinical coordination, both within the Group and across neighbouring providers.

33. We aim to establish the Group as home to an integrated South-East Midlands cancer service, delivering modern, innovative, and comprehensive care across the entire cancer pathway - from diagnostics and prehabilitation to treatment, rehabilitation, and palliative care. Our key focus is on ensuring that anyone with suspected or confirmed cancer has equal access to the same high-quality services, delivered as close to home as possible to support convenience, continuity, and equity. We will meet NHS standards - ensuring patients are seen and treated without unnecessary delay.

34. The workstream has co-produced an action plan for the next three years through the Cancer Collaborative Group (UHN and UHL), which includes:
    - Tackling unwarranted variation in clinical pathways;
    - Streamlining Multi-disciplinary Teams (MDTs);
    - Increased use of AI.

35. Key next steps are to exploring adopting ‘License to Attend’ process to improve cross-site working across the Group, agreeing actions to improve capacity, and organizing a joint cancer strategy conference in April to review progress and shape future plans.

Improving Access

36. The UHL-UHN Group delivers more episodes of elective care than any other organisation or Group in the NHS. We have already made significant capital investments to expand our elective care capacity. Key developments include the Hinckley Community Diagnostic Centre (May 2025), the East Midlands Planned Care Centre (December 2024), and a new endoscopy unit at Leicester General Hospital (August 2025). However, demand for elective care continues to grow, with more patients joining the waiting list every month. This means we must increase delivery volumes just to maintain our current position.

37. This workstream aims to ensure that at least 92% of patients are treated within 18 weeks of referral, meeting the NHS constitutional standard and delivering on the government’s pledge for timely access to elective care. To achieve this, it will ensure that all our sites - including community hospitals - are operating at high levels of utilisation and productivity, giving us more elective capacity than ever before. Where possible, we will aim to ensure that patients travel shorter distances for routine appointments, diagnostics and minor procedures. Where clinically appropriate, patients will benefit from the option to connect with our clinicians virtually, improving convenience and access.

38. The workstream has initially focused on engaging planned care leads across the Group to develop a shared understanding of priorities and existing work programmes in relation to outpatient transformation. It has developed a draft set of focus areas for the workstream covering areas such as enhancing use of digital and AI to enhance outpatient efficiency and productivity, improving information, advice and guidance and referral pathways, and exploring pathway redesign.

Appendix

- UHL-UHN Group Clinical Strategy (2025-35)

Officer to contact

Ashley Epps, Head of Strategy (University Hospitals of Leicester NHS Trust)

Email: ashley.epps@nhs.net

Relevant Impact Assessments

Equality Implications

39. No Equality Impact Assessment (EIA) is required at this time.

Human Rights Implications

40. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

41. Our UHL-UHN Group Clinical Strategy focus areas, priorities and deliverables have been shaped by listening to patients, carers, colleagues, and partner organisations. As we progress their further development and implementation, we remain committed to system-wide co-production and close collaboration with our key Integrated Care System partners – recognising that our Group alone cannot deliver all of the changes required to realise the vision set out in the 10 Year Plan for Health.

APPENDIX

NHS

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UHL-UHN
Group Clinical Strategy

2025 - 2035

University Hospitals of Leicester NHS Trust

University Hospitals of Northamptonshire NHS Group

Kettering General Hospital NHS Foundation Trust

Northampton General Hospital NHS Trust

Contents

Foreword

We are publishing our strategy following the launch of **Fit for the Future: 10 Year Health Plan for England.**

The 10 Year Health Plan seizes the opportunities provided by new technologies, medicines, and innovations to deliver better care for all patients – wherever they live and whatever they earn – and better value for taxpayers.

It makes three big shifts to how the NHS works, moving from:

- hospital to community
- analogue to digital
- sickness to prevention

The NHS is embarking on significant change whilst it manages operational and financial pressures. The aim of the NHS structural reorganisation is to decentralise power and to reduce bureaucracy and duplication. The operating context has become too complex, and the Secretary of State for Health and Social Care has described his ambition *"to lead an NHS where power is moved from the centre to the local and from the local to the citizen."* This means making healthcare services more accountable outwards to the communities we serve, not just upwards to Whitehall.

These themes run through the UHL-UHN Group Clinical Strategy, which has been shaped by listening to patients, carers, colleagues, and partner organisations. We have identified six focus areas and five cross cutting principles for patient care: personalised, seamless, proactive, equitable and effective and efficient.

As well as delivering on the three shifts, our strategy is also focussed on the opportunities of Neighbourhood Health Services and Integrated Health Organisations. We are committed to working together and we recognise our joint accountability to the people and patients we serve and the colleagues we employ.

We hope our strategy gives confidence and optimism to colleagues – we are as well positioned as any NHS organisation to respond to the opportunities in the 10 Year Health Plan. UHL-UHN is a large organisation, and we care for more patients than any other NHS provider. In addition to the benefits of working at scale, we are leading nationally on several digital programmes, including being the primary development partner of Nervecentre and partnering with Microsoft to become the first AI-empowered NHS Group.

Delivering change is dependent on having the right operational and governance structures – and this strategy provides the UHL-UHN framework for clinical change for the next decade and beyond.

We hope you enjoy reading it.

July 2025

Andrew Furlong
Medical Director,
UHL

Julie Hogg
Group Chief Nurse,
UHL-UHN

Hemant Nemade
Medical Director,
UHN

Introduction to the UHL-UHN Group

The University Hospitals of Leicester NHS Trust (UHL) and the University Hospitals Northamptonshire NHS Group (UHN) have come together to form the UHL-UHN Group - an ambitious and forward-looking collaboration designed to enhance patient care, improve population health, and make our Trusts exceptional places to work.

Together, we provide high-quality healthcare across five major hospital sites serving the populations of Leicester, Leicestershire and Rutland (LLR), and Northamptonshire. Each of our hospitals delivers essential general services, including three busy Emergency Departments (EDs), supporting some of the region's most pressing acute needs. In addition, we operate from 19 smaller community hospitals, delivering care closer to home. Increasingly, we are embracing virtual care models and delivering services in people's homes - supporting independence and preventing unnecessary hospital admissions.

With a combined annual spend of approximately £2.9 billion and a dedicated workforce of nearly 30,000 colleagues, we are one of the largest NHS Groups. Our size and scale bring opportunity: we are able to standardise and improve services, share learning, attract and retain talent, and build innovative pathways of care across the region.

The Group also holds an enviable position in the fields of research, education and innovation. Both UHL and UHN have university hospital status and maintain strong academic partnerships with local universities. Our training programmes shape the next generation of NHS clinicians, while our research contributes to advances in diagnosis, treatment, and care on both a national and international stage.

We are proud to be part of a broader ecosystem of care. Our work is deeply connected with our local Integrated Care Systems (ICSs), community and mental health providers, primary care partners, local government, voluntary and charitable organisations, and the East Midlands Acute Provider Collaborative. As a Group, we are committed to collaboration, innovation and transformation - delivering better outcomes for our patients and communities and creating a healthier future for all.

UHL-UHN Group in numbers

Almost 30,000 colleagues
across the Group, putting each of our Trusts amongst the largest employers in the East Midlands

£2.9 billion
in annual spend, amongst the largest of any Trust or provider Group in the NHS

17,000 births annually
in our five maternity units

5 acute hospitals
giving us one of the largest acute estates in the NHS

3,200 beds
across our five acute sites

3 Emergency Departments
across the Group, at the LRI, KGH and NGH

Half a million
annual attendances at our Emergency Departments

19 community sites
across the East Midlands, giving us the ability to treat patients closer to their home

1.9 million
local residents served across Leicester, Leicestershire and Rutland, and North and West Northamptonshire

The population we serve

Together we serve a dynamic and growing population of more than 1.9 million people across LLR and Northamptonshire. In addition to delivering local care, we provide specialist services that extend across the East Midlands and beyond, including nationally recognised expertise in cardio-respiratory, renal and cancer care.

The communities we support are diverse and culturally rich. Leicester stands as a proud symbol of this diversity, recognised as the UK's first plural city, where no single ethnic group forms a majority. This rich cultural landscape brings unique strengths and specific healthcare needs, requiring services that are inclusive, responsive and culturally competent.

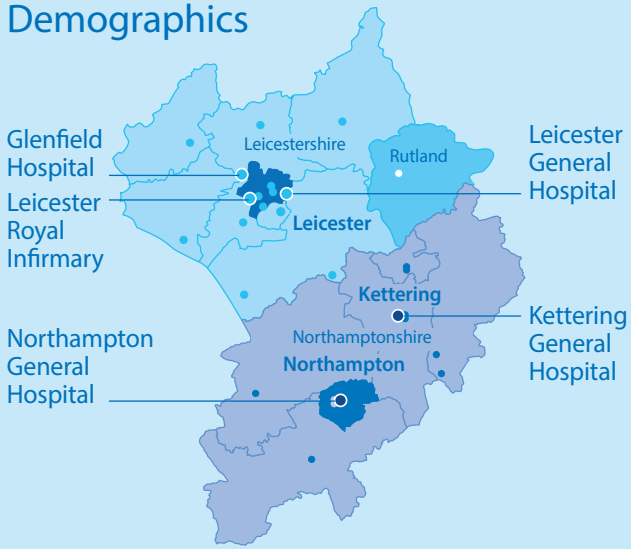
Our population is also ageing. The number of residents aged over 65 is expected to rise by nearly 25% by 2035 - outstripping national averages and placing growing pressure on services that support frailty and multiple long-term conditions. Meeting the needs of this expanding cohort will require innovation in integrated care, prevention, and community-based support.

At the same time, we face stark health inequalities driven by socioeconomic deprivation. While one in eight residents across LLR and Northamptonshire live in areas ranked among the most deprived in the country, this figure rises to around one in three in parts of Leicester and Corby. Evidence shows these communities using health services differently – with a disproportionate reliance on emergency care and lower uptake of preventative services such as vaccinations and chronic disease management.

The impact is profound. People living in the most deprived areas of our region face worse health outcomes than their more affluent neighbours. In Northamptonshire, for example, men living in the least deprived areas can expect to live up to nine years longer than those in the most deprived communities.

Addressing these challenges is central to our mission. As a Group, we are committed to tackling the deep-rooted causes of inequality, investing in tailored local solutions, and designing care that truly meets the needs of every community we serve.

Demographics



6%
do not speak English as their main language

19%
aged 65 and over, with increased and specific health needs

23% by 2035
growth in the number aged 65 and over, larger than the growth in any other age group

Three in five
self-report a long-term health condition, including: 4% chronic kidney disease, 2% COPD, 8% diabetes, 15% hypertension

13%
living in areas classified as amongst the most deprived areas in the country

14.8%
smoking prevalence, higher than the national average

21%
from non-white ethnic groups, including 59% of Leicester residents, making it the first non-white majority city

12.2%
obesity amongst adults, lower than the national average

Our challenges

Our four biggest challenges are demand for urgent and emergency care, the number of people waiting for planned care, our financial position and fragmentation within the health and care system.

Ensuring patient safety

Maintaining consistently safe care is one of the most pressing challenges facing the NHS, both nationally and locally. Across the country, increasing service demand, persistent workforce shortages, and financial constraints are placing sustained pressure on healthcare providers. At the same time, rising staff fatigue, burnout, and moral injury are threatening the ability of teams to consistently deliver high-quality care.

While national initiatives such as the NHS Patient Safety Strategy and the implementation of PSIRF (Patient Safety Incident Response Framework) have provided important foundations, pressures and variation in care remain. In this environment, maintaining safety requires more than vigilance - it demands focused investment in the workforce, strengthened leadership, and a commitment to continuous improvement.

Tackling this challenge locally means making difficult but necessary decisions to ensure care is delivered in the safest way possible within the resources we have. It also means listening to staff, prioritising psychological safety, and embedding a culture where learning is valued and actioned.

Urgent and emergency care demand

The number of attendances at our Emergency Departments has grown by 13% since 2022, and demand now far exceeds what our facilities were designed to cater for. Across our three Emergency Departments, we see 500, 000 people every year and Leicester Royal Infirmary is home to the busiest Emergency Department anywhere in the NHS - both in terms of ambulance and walk-in attendances. Growth in paediatric attendances is even higher than for adults.

The drivers of demand include an ageing population with multiple long-term conditions, and insufficient capacity in primary care and urgent treatment centres to cater for minor conditions.

For many people, attending the Emergency Department is a poor experience and could have been avoided if other services more readily available in the community. Demand for our Emergency Departments also represents a significant operational challenge for our hospitals and is increasingly leading to burn-out for colleagues working tirelessly to meet an ever-increasing workload. We must address these issues by enabling the hospital to community shift.

Elective waiting list

UHL-UHN provide more planned care than any other NHS organisation, and last year we completed 400,000 planned treatment pathways. Over the last three years we have focused significant effort and resources on reducing our elective waiting times and this has led to significant improvements in our performance against national standards.

Despite these efforts, we still have a significant number of people waiting for elective care and the number of people joining the waiting list continues to grow year on year.

The government has pledged that the NHS will meet the national standard of treating 92% of patients within 18 weeks of referral by March 2029. Meeting this target will require us to diagnose and treat many more patients per year than we currently do, and to work with partners across the system to curb the rise in demand and embed neighbourhood models of care.

Financial position

The financial position of the NHS is more challenging than it has ever been. The government has been clear that this cannot continue, and that NHS overspending must be addressed.

At UHL-UHN, we receive a financial allocation of around £2.7bn, but in 2025/26 we are likely to spend closer to £2.9bn. The cost of providing care has increased faster than our funding allocation, meaning that many of our services are unaffordable. As well as ensuring that our services are safe and high-quality, this strategy must also target the ways in which our services can be provided at a lower cost.

Fragmentation in the health and care system

The health and social care system is fragmented, and organisations are often incentivised to prioritise organisational outcomes over working with partners to improve the integration of services. Patient and public engagement highlights this, with people regularly telling us that they have to tell their story multiple times to different professionals and agencies.

The fragmentation is worsened by a multitude of different digital systems, which do not support effective care co-ordination between settings.

National policy drivers

Our strategy is grounded in the national direction set by the 10 Year Plan for Health - a landmark policy that reimagines the future of health and care in England. It calls for a radical transformation of the NHS, driven by three strategic shifts: analogue to digital, sickness to prevention, and hospital to community. These shifts demand a whole-system redesign in how care is planned, delivered and experienced.

1 Hospital to community

The first shift is a move away from the traditional, centralised model of hospital care towards a neighbourhood-based model of delivery. The 10 Year Plan for Health envisions a system in which care is increasingly delivered in the places people live, work and age - making access easier, personalising support, and reducing unnecessary reliance on hospital services.

This shift places neighbourhoods at the heart of the health system. Multidisciplinary teams - spanning primary care, community health, social care, mental health and the voluntary sector - will work together to proactively support people with long-term conditions, frailty and complex needs. The focus will be on early intervention, continuity of care, and seamless coordination across organisational boundaries.

2 Sickness to prevention

The second shift will change the NHS from being a service that predominantly treats illness, to one that actively promotes prevention and wellbeing. This requires efforts to tackle the root causes of ill health - such as obesity, smoking, poor housing and social isolation - and invest in proactive, community-based services that keep people well for longer.

This reinforces our role as an anchor institution with the reach and responsibility to influence health beyond the hospital walls. Through our partnerships across local government, public health, education, and the voluntary sector, we are positioned to design services that support early intervention, reduce health inequalities, and address the wider determinants of health.

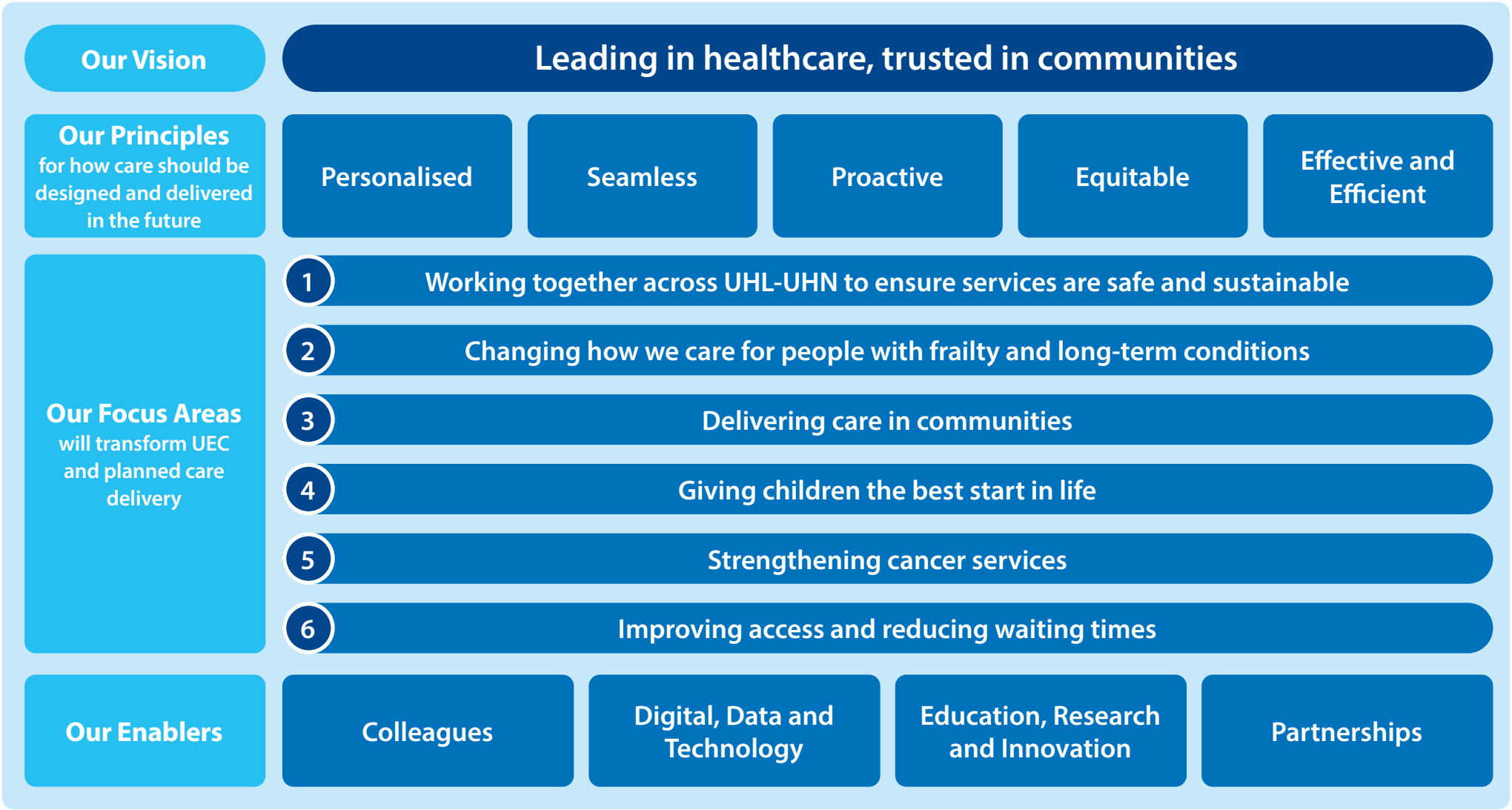
3 Analogue to digital

The third shift is to a fully digital NHS. This includes modernising infrastructure, integrating data, and enabling patients to interact with services in ways that are convenient, personalised, and transparent.

One of the most transformative components is the planned end to outpatients as we know it. The traditional model of routine, time-based follow-up is being replaced by patient-initiated care, remote monitoring, digital triage and virtual consultations. These changes are central to a new model of care that puts power in the hands of patients, enabling them to make informed choices and have greater control over their health.

The 10 Year Plan for Health challenges the NHS to become more digitally enabled, prevention-focused, and community-anchored - all while giving power to patients. Our clinical strategy is a response to these shifts, as well as an enabler. The UHL-UHN Group is committed to leading this transformation for the benefit of the people and communities we serve.

Our Group Clinical Strategy



Principles

Personalised, seamless, proactive, equitable, effective and efficient – these are the principles that will guide how we design and deliver care.

Personalised

We will give people greater choice and control over decisions about their health, based on what matters most to them

This means:

- Providing patients and carers with the information they need to understand and manage their conditions, including outside of a hospital setting - such as through self-care, exercises or medicine routines
- Working with patients and carers to make decisions about care that account for psychological, social and cultural needs, as well as medical and caring needs
- Empowering patients to make choices about their care according to what matters to them, with an expectation that care is tailored to individuals
- Leveraging advances in precision medicine, genomics and artificial intelligence to enable personalisation of diagnostics and treatment options
- Using advances in health technology, such as app-based care and remote monitoring systems, to deliver out-of-hospital care that is truly person-centred

Seamless

We will ensure patient pathways are seamless, integrated and easy to navigate

This means:

- Ensuring services and pathways are co-designed with patients and organised around patient needs - care will be coordinated and continuous across settings, professionals and time
- Working closely with general practice and providers of community-based services to create end-to-end pathways that are integrated, seamless and digitally enabled
- Where patients have multiple or complex needs, working with partners to coordinate care across different services
- Facilitating the seamless transfer of patient information
- Using the power of digital and data to connect people and integrate care

Proactive

We will embed proactive care, identifying risk early and designing services that support people to stay well for longer

This means:

- Creating new pathways that support patients with long-term conditions to get the specialist care they need earlier, in the best setting for their needs
- Collaborating with partners on population health management tools that predict and target the prevention and early detection of disease across local populations
- Ensuring lifestyle medicine advice and signposting is incorporated into every patient and community contact, including digitally
- Being proactive in sharing information that could be used to prevent future deterioration and admissions for patients with long-term conditions

Principles (continued)

Equitable

We will tackle inequalities in access, experience and outcomes so that all patients receive the same high-quality care

This means:

- Designing standardised and evidence-based pathways that are consistently implemented across all hospitals
- Ensuring our resources are deployed where they are needed most, addressing known gaps in care and experience
- Addressing health inequalities early in life, recognising that inequalities follow people through their whole life course and start pre-conception
- Promoting equitable access to information and supporting improvements in health literacy
- Using data, digital solutions and patient feedback intelligently to tackle inequalities in access and experience
- Embedding equity in digital transformation to ensure solutions benefit everyone, for example through improved access to medical records and correspondence via patient portals
- Ensuring digital healthcare services are accessible to all

Effective and Efficient

We will ensure that we are effective and efficient, using evidence and innovation to deliver sustainable services

This means:

- Ensuring we are clinically effective, so that care and pathways are safe, evidence-based and responsive
- Working with system partners to eliminate duplication, inefficiency and delays
- Streamlining processes and using technology to free-up clinical time for patient care
- Ensuring responsible financial management of our resources, for example by focusing on productivity – meaning we can care for more patients within our existing resource
- Using our Group scale to purchase consumables and devices at lower unit cost, so that resources can be reinvested in patient care
- Tackling health inequalities as a cause of inefficiency and waste (for example, in relation to high 'did not attend' (DNA) rates amongst inclusion health groups)

Focus area 1: Working together across UHL-UHN to ensure services are safe and sustainable

Where we are now

- Waiting times, outcomes and patient experience currently vary depending on where people live and where they receive care. We believe this is unacceptable.
- Across the Group, a number of our services are fragile, which means they are highly vulnerable to disruption that directly impacts patient care. This is often due to workforce shortages that cannot be resolved through recruitment alone.
- Within the Group - particularly between NGH and KGH - we have services that are duplicated across a small geographical area. This spreads our resources more thinly than necessary, affecting both the quality and safety of care, and representing a cost we can no longer justify.
- In some cases, the way services are configured across different hospital sites leads to duplication, inefficiency, poor patient experience and clinical risk. For example, Leicester Royal Infirmary does not currently have emergency cardiovascular and respiratory services on-site to support its Emergency Department.
- As a Group, we operate at significant scale - with nearly 30,000 colleagues and an annual expenditure of around £2.9 billion. Yet we are not making full use of our collective size. We continue to operate largely as separate organisations, with incompatible processes, limited digital integration, and minimal collaboration between clinical teams. Many clinicians lack strong working relationships with peers at other sites, which is a missed opportunity for learning and improvement.

Where we want to get to

- All patients receive the same high-quality care and experience, regardless of where they live or where they are treated.
- Our services are optimally configured across our five acute hospitals and community facilities - striking the right balance between local access to routine care and the consolidation of specialist expertise and equipment. As a result, all our services are clinically and financially sustainable.
- Digital tools and data systems enable our clinical teams to collaborate effectively across hospital sites - supporting more coordinated, efficient and joined-up care.

How we will get there

- We will work with partners and patients to develop a multi-stage reconfiguration plan. This plan will balance the need to provide routine services as close to communities as possible (see Focus Area 3), with the need to consolidate highly specialist expertise and equipment on fewer sites - improving patient outcomes, strengthening fragile services, and ensuring long-term financial sustainability.
- We will bring clinical teams together across the Group to form virtual networks that learn, innovate and share knowledge. We will ask teams to design evidence-based pathways and shared clinical policies, so that patients have a consistent experience and receive the same high-quality care, wherever they are treated. Digital integration, including a shared Electronic Patient Record (EPR) across the Group, will be a key enabler.
- By working more closely together and becoming digitally connected across the Group, clinical teams will unlock opportunities to improve access to and from specialist services, align on product selection to reduce costs, and identify opportunities for mutual aid and cross-site support.
- Where services are fragile or unsustainable at one or more of our hospitals, we will collaborate to explore alternative models of care - including service consolidation, integration, or the delivery of care through virtual platforms.
- Where clinically appropriate, we will create single points of access for referrals and implement a single Patient Tracking List (PTL) across the Group to ensure fair and consistent access for all patients (see Focus Area 6).
- We will embrace AI and other emerging technologies - particularly in diagnostic areas like radiology and pathology - to support our services to become more resilient and effective.
- We will actively pursue opportunities to provide clinical enabling services - such as pathology and decontamination - at scale, maximising the impact of our shared resources and any future investments in technology.

Focus area 2: Changing how we care for people with frailty and long-term conditions

Where we are now

- The prevalence of chronic and long-term conditions has increased in recent years and is expected to continue rising as the population ages. The Health Foundation estimates that by 2040, the number of people in England living with major illness will increase by 37% - nine times the projected growth rate of the working-age population. In LLR and Northamptonshire, three in five respondents to the 2024 GP survey reported living with at least one long-term condition.
- Poorly managed long-term conditions are a major contributor to rising demand for urgent and emergency care, particularly among patients living with frailty. At UHN in 2024/25, for example, patients with frailty accounted for 50% of emergency admissions and 77% of all bed-days - equivalent to 523 hospital beds.
- Incompatible digital systems continue to undermine efforts to deliver coordinated care. For instance, although many patients seen by the East Midlands Ambulance Service (EMAS) are already known to healthcare providers within the system, our digital infrastructure does not yet provide EMAS with timely access to the information that could prevent them from conveying a patient to hospital.
- Too often, patients living with frailty are admitted to hospital unnecessarily and remain in hospital for extended periods. This reflects a health and care system that is not adequately equipped to meet the needs of these patients. For many frail patients, prolonged hospital stays lead to functional decline and a higher risk of readmission.
- Patients attending Emergency Departments or admitted to hospital frequently undergo multiple investigations, some of which may be unnecessary or misaligned with their goals. This is especially common among patients who are frail or have multiple long-term conditions.
- The clinical expertise needed to manage long-term conditions is often concentrated within acute hospital trusts. Many patients must therefore travel frequently to hospital - despite growing evidence that delivering specialist care in community settings is both more effective and offers a better experience.
- The prevalence of long-term conditions is closely tied to health inequalities. National data shows that people in the most deprived areas typically develop multiple health conditions a decade earlier than those living in the least deprived areas.

Where we want to get to

- Patients form long-term partnerships with us as their care providers - enabled and empowered with choice, control, and the tools they need to manage their conditions. This includes proactive care planning across the full trajectory of illness, from diagnosis to recovery or personalised end-of-life care.
- We are part of an integrated and prevention-focused health and care system that works together to reduce the risk of chronic disease across our population. Working with partners, and leveraging data and intelligence, we diagnose conditions sooner, and deliver personalised interventions to slow disease progression and prevent avoidable admissions.
- Patients living with frailty and/or long-term conditions spend more time at home or in their usual place of residence, supported by community-based teams. We work with partners to predict, detect and treat deteriorations early- before they escalate into crises. Where hospital admission is needed, we focus on ensuring that patients can return home as quickly and safely as possible.
- Urgent care services and pathways are designed to rapidly assess and treat patients experiencing a deterioration in their condition - without unnecessary delay. This reduces pressure on Emergency Departments, ensuring that emergency care remains timely, safe, and available for those who need it most.
- Our approach to partnership with patients living with long-term conditions is transformed by digital tools and real-time data - enabling responsive care and more meaningful day-to-day support.

How we will get there

- We will work with system partners to develop effective primary and secondary prevention programmes, using predictive analytics to target population and individual risk - preventing disease, halting progression, and supporting early diagnosis and treatment.
- We will use digital tools, including apps, patient portals and wearables, to support remote monitoring and help patients manage their long-term conditions with confidence, outside of hospital settings.
- We will provide specialist expertise into neighbourhood health services, supporting patients with complex needs and helping to manage care closer to home.
- We will work with system partners to ensure frailty services are joined up end-to-end across all care settings, including frailty-attuned hospital services.
- We will deliver same-day emergency care tailored to specific patient groups - treating deteriorations quickly and effectively before they become crises.
- We will explore ways to expand discharge support in patients' homes, helping to enable earlier discharge from hospital.
- We will reduce unnecessary and unwanted investigations and treatments for patients attending or admitted to hospital.
- We will work with patients to develop personalised care plans, shared across providers, that reflect their preferences including end of life care.
- We will work with partners to improve interoperability of digital systems, ensuring effective data sharing across primary, community and secondary care.

Focus area 3: Delivering care in communities and neighbourhoods

Where we are now

- Too much care is still delivered in acute hospitals - including patients occupying hospital beds who would be better cared for in the community, patients with minor conditions attending the Emergency Department due to a lack of alternatives, and patients with social care needs being managed in clinical settings.
- Many patients continue to travel to hospital for care that could be more appropriately delivered in a community setting or via virtual contact with our clinicians.
- With a growing proportion of the population being older, retired, or less able or willing to travel, the current model is not sustainable. We must rethink how and where care is delivered to meet future needs.
- Evidence shows that integrated, community-based care improves quality, and over time reduces mortality, emergency attendances, hospital admissions, bed days and complications.
- The 10 Year Plan for Health calls for a fundamental shift from hospital to community care - embedding neighbourhood-based services as the default, and ensuring care is closer to home, more proactive, and better integrated across settings.

Where we want to get to

- Patients are cared for in the lowest acuity setting appropriate to their needs, receiving timely, safe and proportionate care. As a result, the number of people attending our Emergency Departments is reduced to a safe and sustainable level, allowing us to focus our emergency care capacity on those who need it most.
- Increasingly, care across LLR and Northamptonshire is delivered in or near patients' homes. People only travel to hospital when absolutely necessary, and only for treatments that require specialist expertise, equipment, or facilities that cannot be provided closer to home.
- The NHS 'digital front door' becomes the primary route of access to care. Patients are supported to view their records, book appointments, receive personalised health advice, and manage their own care with confidence through the platform.
- We are at the forefront of adopting digitally enabled care, transforming how and where services are delivered. From virtual consultations and remote monitoring to digital discharge planning, technology helps us to reduce avoidable hospital visits, shorten lengths of stay, and support safe and timely transitions back home - improving outcomes and experience.

How we will get there

- We will work with partners to expand capacity in community services, with a focus on increasing the availability of step-up and step-down community beds. This will help to keep high-acuity inpatient beds for those with the most complex needs.
- We will increase Urgent Treatment Centre (UTC) capacity across the region to provide a safe, timely and more appropriate alternative to Emergency Departments for patients with minor injuries and non-life-threatening conditions.
- We will make full use of community hospital facilities by delivering clinics, diagnostics and minor procedures, where this is clinically appropriate and cost-effective.
- We will establish 'one-stop-shop' diagnostic clinics, enabling patients to receive all investigations for a condition in a single visit, reducing delays and improving experience.
- As part of the Neighbourhood Health Service outlined in the 10 Year Plan, we will support outreach into primary care settings - including GP practices, community pharmacies and local venues - targeting areas with high health needs and inequalities.
- We will implement alternative workforce models, such as GPs with Extended Roles (GPwERs), to bring specialist expertise into primary care and support the growing number of patients with multi-morbidity and complex care needs.
- We will better integrate primary and secondary care by agreeing clear referral criteria, supporting digital interoperability, standardising data-sharing protocols, and investing in trusted relationships between hospital clinicians and general practice.
- We will increase the use of pre-referral advice and guidance schemes, making it easier for GPs to consult with hospital specialists to determine whether a referral is necessary. This helps to reduce unnecessary appointments and improve care navigation.
- We will identify services and care pathways that no longer need to be delivered in acute hospital settings, developing digital, community or neighbourhood-based models to replace them. We will eliminate the use of traditional outpatient appointments as outlined in the 10 Year Health Plan.
- We will harness technology to expand virtual models of care, including wearable monitoring devices, virtual wards, and patient-initiated follow-up - supporting more people at home and reducing unnecessary hospital visits.
- We will support cross-sector initiatives that address the wider social determinants of health, recognising that factors such as housing, employment, education and social support have a profound impact on health outcomes.

Focus area 4: Giving children the best start in life

Where we are now

- The first few years of a child's life have a profound and lasting impact on long-term health outcomes. Health inequalities experienced before or at birth can shape a child's wellbeing across their entire life course.
- Perinatal services across the NHS remain inconsistent in delivering care that is safe, high-quality and equitable for mothers and babies. National reports such as MBRRACE-UK have highlighted the particular disadvantages faced by non-white women and inclusion health groups in accessing high-standard care.
- Across the UK, progress in reducing infant mortality has stalled, leaving national rates significantly higher than many peer nations. This challenge is especially stark in Leicester, where infant mortality rates are almost double the national average. Contributing factors include high rates of maternal obesity, low levels of breastfeeding, poverty, poor education, and maternal ethnicity.
- The UHL-UHN Group provides maternity and neonatal services across five maternity units and four neonatal units, supporting around 17,000 births annually. We also operate 10 inpatient paediatric wards and three paediatric emergency departments, serving a population of 1.9 million. Some of these services are fragile, due to workforce shortages that may compromise safety, efficiency and quality of care.
- Children's health issues such as dental decay, obesity and diabetes are rising and expected to worsen without targeted intervention. In Leicester, nearly twice as many five-year-olds experience dental decay compared to the national average. In North Northamptonshire, around 25% of children aged 4–5 are overweight or obese, contributing to childhood diabetes admission rates more than 10% above the national average. Without action, one in three of the most disadvantaged boys in England is projected to be obese by 2030.
- Demand and complexity in children's services have increased significantly over the past decade. UHL's paediatric Emergency Department is now the busiest in the NHS, reflecting both rising need and growing pressure on paediatric care pathways.
- Unlike most regions in England, specialist paediatric services in the East Midlands are split across two centres - Leicester and Nottingham. This presents ongoing challenges for workforce planning, service integration and innovation.

Where we want to get to

- All our maternity, neonatal and paediatric services are safe, high-quality, and consistently meeting the needs of children and families across LLR and Northamptonshire. Services are clinically and financially sustainable, underpinned by a workforce that is skilled, resourced and resilient.
- All families - regardless of race, ethnicity, or socio-economic background - have equal access to high-quality perinatal and paediatric care and can expect equitable experiences across all our services.

How we will get there

- We will review the configuration of maternity, neonatal and paediatric services across the Group to ensure they meet the needs of our populations. The review will take health inequalities, workforce availability, and resource constraints into account.
- We will maintain a relentless focus on safety and quality across all maternity and neonatal services, ensuring full compliance with national standards and recommendations, including those from the Ockenden Review and any that may emerge from the National Maternity and Neonatal Investigation.
- We will raise awareness among colleagues about the health inequalities experienced by pregnant women from inclusion health groups and promote culturally competent care.
- We will ensure 'every contact counts' in our interactions with pregnant women, focusing on the prevention of smoking and obesity during pregnancy as key risk factors.
- We will work with system partners, including Local Authority public health teams, to expand prevention and early intervention services for children under five - targeting Core20PLUS5 disease groups such as asthma, diabetes, epilepsy, oral health, and mental health.
- We will collaborate with general practice to improve communication between clinicians across settings ahead of referral decisions for paediatric patients, supporting better care planning.
- We will work with regional partners to develop a strategy for specialist paediatric services across the East Midlands, supporting innovation, workforce planning and equitable access.

Focus area 5: Strengthening cancer services

Where we are now

- Cancer is one of the top three causes of death across LLR and Northamptonshire. Incidence is rising and referrals for suspected cancer have increased by nearly 130% since 2009/10.
- Patients continue to face significant inequalities in accessing cancer care, both at the screening and referral stages. Patients from inclusion health groups are more likely to experience delays in diagnosis and late-stage presentation.
- Our cancer services are under pressure from rising demand and performance against national standards is challenged. We are struggling to meet key targets consistently, including the requirement to treat 96% of patients within 31 days of a decision to treat.
- Access to treatment is further constrained by regional shortages of critical resources, including oncologists and radiotherapy equipment, limiting capacity across the East Midlands.
- Several cancer services across the Group remain fragile due to workforce shortages, making them vulnerable to disruption that can negatively affect patient experience and outcomes.
- We have seen clear benefits from collaborative working through regional partnerships, including the East Midlands Cancer Alliance, the East Midlands Radiotherapy Network, and the UHL-UHN Cancer Collaborative. These collaborations have supported mutual aid, resource sharing and clinical coordination, both within the Group and across neighbouring providers.

Where we want to get to

- The UHL-UHN Group is home to an integrated South-East Midlands cancer service, delivering modern, innovative, and comprehensive care across the entire cancer pathway - from diagnostics and prehabilitation to treatment, rehabilitation, and palliative care.
- Everyone with suspected or confirmed cancer has equal access to the same high-quality services, delivered as close to home as possible to support convenience, continuity, and equity.
- We are consistently meeting or exceed national standards for the timeliness of cancer diagnostics and treatment - ensuring patients are seen and treated without unnecessary delay.
- As an active partner in the East Midlands Cancer Alliance, we contribute to a collaborative regional network that supports equitable access to highly specialist cancer services across the East Midlands.

Focus area 5: Strengthening cancer services

How we will get there

- We will work with partners to expand lifestyle medicine initiatives - such as smoking cessation and behaviour change programmes - to help reduce preventable cancers across our population.
- We will partner with local communities and stakeholders to address inequalities in cancer care, with a particular focus on increasing screening uptake and promoting earlier-stage presentation in under-represented groups.
- We will collaborate with general practice to co-design improved diagnostic pathways, including greater GP access to diagnosis services for suspected cancer.
- We will increase our use of 'one-stop-shop' diagnostic clinics and enhance the role of Community Diagnostic Centres (CDCs) to improve diagnostic speed and accuracy. We will strengthen multidisciplinary working to support earlier detection, with a focus on diagnosing more cancers at stages 1 and 2.
- We will expand access to evidence-based prehabilitation, digital support tools, and rehabilitation including exercise therapy, to help patients prepare for treatment and recover more effectively.
- We will plan for sustainable capital investment in critical equipment and infrastructure - including linear accelerators (LINACs), brachytherapy units, aseptic labs and surgical robots. We will also maximise the use of existing assets to increase capacity across the Group.
- We will deliver more cancer care in patients' homes, including systemic anti-cancer treatments (SACT) and the use of virtual wards. We will use digital platforms to support communication and empower patients as active partners in their care.
- We will work with the East Midlands Cancer Alliance to develop and expand our regional and super-regional specialist cancer services, including complex and rare cancer surgery.
- We will improve the management of cancer treatment-related complications by embedding same-day emergency care (SDEC) and ambulatory care models, developing pathways with geriatricians, cardiologists and other key specialties.
- We will become early adopters of pioneering diagnostics and treatments, especially AI-enabled diagnostic tools, digital clinical pathways, robotics, genomics and precision medicine.
- We will strengthen palliative and end-of-life care by addressing service gaps and ensuring equitable access to support across all settings, from hospital to home.

Focus area 6: Improving access and reducing waiting times

Where we are now

- The UHL-UHN Group delivers more episodes of elective care than any other organisation or Group in the NHS. We provide elective care across five main acute hospitals and nearly 20 community sites, offering minor procedures, outpatient appointments, and diagnostics closer to home. Achieving the 18-week Referral to Treatment (RTT) target is a national, regional, and local priority.
- Demand for elective care continues to grow, with more patients joining the waiting list every month. This means we must increase delivery volumes just to maintain our current position.
- We have already made significant capital investments to expand our elective care capacity. Key developments include the Hinckley Community Diagnostic Centre (May 2025), the East Midlands Planned Care Centre (December 2024), and a new endoscopy unit at Leicester General Hospital (August 2025).
- Patients often face long waits and uncertainty due to last-minute cancellations. In 2024, the Group cancelled around 3,300 elective procedures at a late stage, impacting on patient experience and operational efficiency.
- The NHS spends millions of pounds annually on commissioning elective care from non-NHS providers. While this has added much-needed capacity and enabled more patients to be treated, it represents money lost to the NHS system. Bringing more of this care back into the NHS would improve financial sustainability.

Where we want to get to

- At least 92% of patients are treated within 18 weeks of referral, meeting the NHS constitutional standard and delivering on the government's pledge for timely access to elective care.
- All our sites - including community hospitals - are operating at high levels of utilisation and productivity, giving us more elective capacity than ever before.
- Patients waiting for treatment feel confident and reassured that their procedure will go ahead as planned. Last-minute cancellations due to bed shortages or failed pre-operative assessments are significantly reduced.
- By using our hospital estate effectively, patients travel shorter distances for routine appointments, diagnostics and minor procedures. Wherever clinically appropriate, patients also benefit from the option to connect with our clinicians virtually, improving convenience and access.

How we will get there

- We will develop community hospitals into high-volume, low-complexity elective hubs, helping to free up capacity in our acute hospitals for patients with complex or urgent needs.
- We will provide proactive support to people waiting for treatment, helping them to 'wait well' by exploring alternative therapies or interventions such as physiotherapy.
- We will implement shared waiting lists across the Group (see Focus Area 1), reducing unwarranted variation in waiting times and supporting patients to access the earliest available appointment, regardless of location.
- As part of a site configuration plan (see Focus Area 1), we will identify opportunities to separate elective and emergency care pathways, protecting theatre availability, intensive care capacity, and inpatient beds for planned procedures.
- We will bid for national capital funding to invest in new elective care facilities and technologies that enhance productivity and throughput.
- We will adopt proven innovations and best practice from across the NHS and beyond, making better use of data, digital tools and AI to improve productivity. This includes digitally enabled waitlist management systems, AI-powered planning tools and exploring opportunities for seven-day elective working across disciplines.
- We will invest in digital pre-operative assessment models to help identify risks earlier- reducing late cancellations and improving overall efficiency.

Our journey to becoming an Integrated Health Organisation (IHO)

The 10 Year Plan for Health signals a shift towards a more localised, integrated model of care, placing emphasis on the development of neighbourhood health and the potential creation of Integrated Health Organisations (IHOs).

UHL-UHN is committed to transforming the way care is delivered across our communities. We recognise that high-quality, sustainable health outcomes must be rooted in the places where people live, work and age.

As anchor institutions with deep connections across LLR and Northamptonshire, we are uniquely positioned to take a leading role in hosting and supporting neighbourhood-based teams and services. We see this as a vital evolution in our role - extending our reach into communities to address health needs earlier, reduce health inequalities, and promote proactive, person-centred care.

Neighbourhood models of care are evolving rapidly. We need to develop a model that enables greater alignment of our services with primary care providers, community health providers, social care and the voluntary sector. This includes exploring opportunities to co-locate services, share workforce and digital infrastructure, and embed our clinical expertise more deeply into neighbourhood teams. Through neighbourhoods, we aim to support the development of multidisciplinary teams that wrap around patients and deliver seamless care across organisational boundaries.

Our long-term ambition is to become a fully-fledged Integrated Health Organisation (IHO) - one that is not only capable of delivering outstanding hospital care, but which also plays a central role in the planning, coordination and delivery of integrated and proactive neighbourhood services. This ambition aligns with the broader strategic goals of our Integrated Care Systems and reflects a growing consensus that traditional hospital-centric models must give way to more distributed, community-anchored approaches.

By investing in neighbourhood health delivery and embracing the IHO model, we will deliver more anticipatory, equitable, and sustainable care. This will require cultural change, new capabilities, and strong partnerships - it we get it right, it offers one of the greatest opportunities to transform health for our populations.

The enablers of our strategy

Colleagues

Developing as a great place to work is one of the four key priorities in our organisational strategy. We know that when colleagues feel valued, supported and included, they are empowered to perform at their best.

Our people strategies and workforce plans will support in the following ways:

- **Culture, inclusion and wellbeing**
  Our greatest strength is our people. By focusing on getting the basics right, creating an inclusive culture, supporting health and wellbeing, and ensuring equitable access to development and career progression, we will continue to make UHL-UHN exceptional places to work and grow.
- **Recruiting and retaining talent**
  As our population grows older, disease burden rises, and treatments become more advanced, demand for care will continue to increase. We need robust, forward-looking workforce plans to attract and retain people with the right values and capabilities, across all disciplines and services.
- **Evolving our skill-mix**
  The future of healthcare will be shaped by technology, data and innovation. We must equip our people with the skills and confidence to adapt to change - embracing new roles, new tools and new ways of delivering care, particularly in digitally enabled and integrated settings.
- **Unlocking opportunity across the Group**
  The scale of the UHL-UHN Group offers a unique platform to support mobility, progression and development. We will ensure that all colleagues - regardless of role, location or background - have access to meaningful opportunities to broaden their experience and take on new challenges.

The enablers of our strategy

Digital, Data and Technology

The future of sustainable healthcare is digitally enabled and data driven. Getting it right will mean better care and outcomes for patients, as well as an improved experience for colleagues. Our scale as a Group gives us the opportunity to attract commercial partners, negotiate better contracts and create centres of excellence. Our aim as a Group is that by April 2027 no time should be spent on a task where a digital or AI solution could do it better, faster or to the same standard.

Digital and data will support in the following ways:

- **Getting the basics right**
  We will standardise digital tools and systems, modernise network infrastructure, and ensure devices work reliably. When colleagues log in, things will work.
- **Putting user needs first**
  We will integrate with the NHS App as it develops new features, ensuring our patients can book appointments, access results, and manage their care digitally. The 10 Year Plan's vision of the NHS App as the digital front door aligns with our user-first approach.
- **Using digital as a tool for transformation**
  Our shared Electronic Patient Record programme positions us well for the national single patient record ambition by 2028. As Nervecentre's primary development partner, we are actively shaping how integrated records will work across the NHS.
- **Embracing emerging technology**
  We will take managed risks with innovative solutions, from AI to data process mining. Ambient AI scribes, automated coding, and our Microsoft partnership are already delivering results.
- **Bringing our data together**
  We will transform care through unified data and use of the NHS Federated Data Platform (FDP). We will use predictive analytics to support the shift from sickness to prevention, identifying at-risk patients early and enabling proactive care.
- **Harnessing strategic partnerships**
  Our partnerships with Nervecentre, Microsoft and Palantir bring investment and expertise. These relationships position us to support national initiatives whilst addressing our local needs. We are building solutions that can scale across the NHS.
- **Creating and embedding one digital**
  We will deliver a unified approach across the Group with shared governance and collaborative teams. This positions us to rapidly adopt national solutions like the single patient record whilst maintaining our ability to innovate locally.

The enablers of our strategy

Education, Research and Innovation

We believe in the transformative power of education, research and innovation to shape the future of healthcare. By working closely with our academic partners, we can reimagine how care is delivered, accelerate the adoption of new discoveries, and evaluate what works.

Both UHL and UHN hold university hospital status. Together, we provide education and clinical placements for hundreds of medical students, nursing students and other healthcare professionals each year. We are already recognised as a leading centre for clinical research, with many of our academic clinicians conducting globally significant studies and shaping the international research agenda.

Education, research and innovation will support in the following ways:

- **Putting UHL-UHN at the forefront of discovery**
  Healthcare systems worldwide need bold and transformational change. By embedding research and innovation into our core mission, we can become a testbed for new models of care and lead the rapid adoption of solutions that improve outcomes and efficiency.
- **Developing the workforce of the future**
  The students we are training today will be providing care for decades to come. We must ensure they are prepared for the technological, clinical and societal changes that lie ahead. Working with our academic partners, we will shape education that builds a workforce equipped to lead in an evolving health and care landscape.
- **Improving outcomes for patients**
  Research-active organisations consistently deliver better clinical outcomes - even for patients not directly involved in trials. By embedding research in clinical practice, we improve quality, drive evidence-based care, and increase our responsiveness to new challenges.
- **Attracting the brightest minds**
  A strong reputation for education, research and innovation helps us recruit and retain high-calibre clinicians, researchers and leaders.
- **Strengthening collaboration and partnership**
  Through Leicestershire and Northamptonshire Academic Health Partners, we are building deep, cross-sector relationships between the NHS and academic institutions - delivering our shared mission to improve population health through education, discovery and implementation.
- **Creating opportunity for our communities**
  Education, research and innovation bring opportunities for our organisations, staff and the communities we serve. This includes access to grant funding, commercial research income, new technologies, and career pathways.

The enablers of our strategy

Partnerships

Our clinical strategy is ambitious and cannot be delivered in isolation. Too often, organisational boundaries act as barriers to progress. We are committed to breaking down these silos by working with a wide range of local partners who share a common goal: to improve the health and wellbeing of people across LLR and Northamptonshire.

Partnerships and collaboration will support in the following ways:

- **Patients**
  We will collaborate with patient groups to ensure that patient and public insight informs all levels of decision-making. We will embed co-production in service improvement efforts and co-design care models that genuinely reflect the needs, values and experiences of patients.
- **Communities**
  We will act as an anchor institution, working with communities and local partners to address the physical, social and environmental drivers of poor health. We will continue to integrate prevention into service delivery and engage proactively with underserved groups to tackle health inequalities.
- **Health and care partners**
  We will work closely with ICBs, general practice, community and mental health providers, local authorities and the voluntary sector to deliver joined-up care. Together, we will develop integrated teams that deliver the right care, in the right place, at the right time.
- **Academic partners**
  We will build on our strong relationships with universities and research institutions, continuing to contribute to national and international research networks. Our ambition is to keep UHL-UHN at the forefront of discovery, learning and innovation.
- **Digital and commercial partners**
  We will strengthen our long-standing relationships with strategic digital partners including Nervecentre, while developing innovative new commercial collaborations that enhance our ability to deliver digital care.
- **Organisational and clinical networks**
  We will participate in our regional and national networks, including the East Midlands Acute Provider Collaborative and specialty-specific clinical networks. Through these platforms, we will share best practice, collaborate on service development, and, where appropriate, co-create regional strategies for specialist care.

Strategy development process

Our strategy has been developed through a programme of engagement with colleagues, system partners and representatives from patient and carer communities across LLR and Northamptonshire.

A Clinical Advisory Group, formed of senior clinical colleagues from across UHL-UHN and general practice, developed the framework and content of the strategy and all colleagues were invited to provide written input.

We would like to thank everyone who took the time and energy to contribute.

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Agenda Item 11

Leicester, Leicestershire and Rutland
Integrated Care Board

HEALTH AND WELLBEING BOARD: 26 FEBRUARY 2026

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND ICB

5 YEAR STRATEGIC COMMISSIONING STRATEGY

Purpose of report

1. The purpose of the report is to inform the Board of the contents of the ICB 5 Year Strategic Commissioning Strategy.

Recommendation

2. The Health and Wellbeing Board is asked to:

   (a) Note the contents of this report;

   (b) Note the 5 Year Strategic Commissioning Strategy.

Background

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

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

5. We face significant and growing challenges:

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

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

Policy Framework

Alignment with the NHS 10-Year Plan

7. This Five-Year Commissioning Strategy aligns with the direction set out in the NHS 10-Year Plan, supporting the shift from short-term recovery to long-term transformation.

8. It reflects the national focus on:

- Prevention and early intervention;
- Neighbourhood-based, integrated models of care;
- Reducing health inequalities;
- Improving productivity and value for money;
- Financial sustainability.

9. Our priorities — including strengthening Integrated Neighbourhood Teams, reducing preventable mortality (Cardiovascular disease, cancer and respiratory disease), improving frailty care, reforming urgent and emergency care, and improving access to elective and primary care — directly support delivery of these national ambitions.

10. This Plan therefore provides the local strategic commissioning framework to deliver the NHS 10-Year vision for our population over the next five years.

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

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

Background

Cluster-integrated needs assessment

13. The foundation of the 5 Year Strategic Commissioning Strategy is the Cluster Integrated Needs Assessment 2026/27 - 2030/31. This report is a system-wide needs assessment that brings together health, care and wider population data to understand current and future health needs across the population. This

needs assessment has provided us with the evidence base to support our understanding of what the population needs now and over the next 10 years, and how services must change to meet these needs.

14. The Cluster Integrated Needs Assessment is supported by a wider evidence base – LLR and Northamptonshire have both developed health profiles for the ICBs and have published health inequalities annual reports. The five places across LLR and Northamptonshire have developed Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. The ICBs are also developing neighbourhood health intelligence data and resources to support the development of neighbourhood health approaches. The Cluster Integrated Needs Assessment has considered the breadth and depth of these reports to identify the key health and wellbeing challenges that we need to address through the 5 Year Strategic Commissioning Strategy.

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

Demographic growth

16. The population is projected to increase by 2.3% by 2030. However, the growth in population is distributed towards older people. The ageing population will drive increases in people with frailty and people with complex multi-morbidity which will drive an increase in the need and demand for services.

17. The need for health and care services will grow faster than overall population growth rate for all health and care sectors, including primary, community, mental health and acute hospital services.

Health inequalities

18. The needs assessment sets out the inequalities in life expectancy and healthy life expectancy across LLR and Northamptonshire, particularly in Leicester City and North Northamptonshire, and illustrates that that the most significant causes of the gap in life expectancy for the cluster are attributable to cancer, cardiovascular disease and respiratory disease.

19. There is a need to focus on Core20+ groups, including people living in areas of deprivation and people living with conditions where there are known health inequalities, where there is clear evidence of lower life expectancy, people develop long term conditions earlier in life and spend more time living in poor health.

20. The strategic commissioning intentions must target and address poorer health outcomes in Leicester City and in areas of deprivation in LNR.

Children and young people

21. Giving every child the best start in life is the most important policy objective for reducing health inequalities.

22. The needs assessment identifies a need to strengthen support for children and young people (CYP) and families, with an initial focus on mental health and neurodiversity.

Three common conditions linked to preventable risk factors

23. Cardiovascular diseases, cancer, and respiratory diseases are the largest causes of inequalities, morbidity and mortality for the cluster.

24. It is also noted that mental health and Musculo-skeletal conditions drive a significant burden of disability in LLR.

25. Obesity, blood glucose, hypertension, smoking and alcohol are identified as the biggest preventable risk factors driving the “big three”, and many other long-term conditions.

System sustainability

26. The drivers of current and future health needs for the cluster mean that we need to do things differently to manage the growing health needs in our population.

27. There is a need for a system focus on the three left shifts, supporting the shift from acute to community, treatment to prevention and analogue to digital and the development of neighbourhoods to support this is important.

28. It is essential that the plans that the ICB develops as strategic commissioners are sensitive to the underlying growth across all health and care sectors and that this should be a core component as the system develops new models of care.

29. Transforming services for people with frailty will be essential for future sustainability.

Development of the Commissioning Strategy

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

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

32. Pre-Christmas workshops brought together providers, local authorities, commissioning leaders and GPs to review the evidence base and identify the

three strategic priorities:

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

33. These sessions also generated initial interventions for each area.

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

35. A collaborative, engagement-led approach to strategic commissioning has shaped how interventions should be designed and delivered, considering the financial, workforce, digital and estates implications. Partners also highlighted key delivery risks and the importance of aligning commissioning intentions with local authority, provider and neighbourhood plans. This collective effort ensures the emerging 5-Year Strategic Commissioning Strategy is grounded in clinical insight, operational reality and shared system ambition.

Summary of the Commissioning Strategy

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

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

What will change

37. Neighbourhoods will become the core delivery unit, with Integrated Neighbourhood Teams bringing together general practice, community services, mental health, social care and the Voluntary, Community and Social Enterprise (VCSE) sector to provide coordinated, person-centred support. This will improve access, reduce fragmentation, and help people receive the right support earlier, reducing pressure on emergency departments and enabling hospitals to focus on planned care recovery. Investment will gradually rebalance from hospital settings towards neighbourhood, primary and

community services, while maintaining high quality acute care for those who need it.

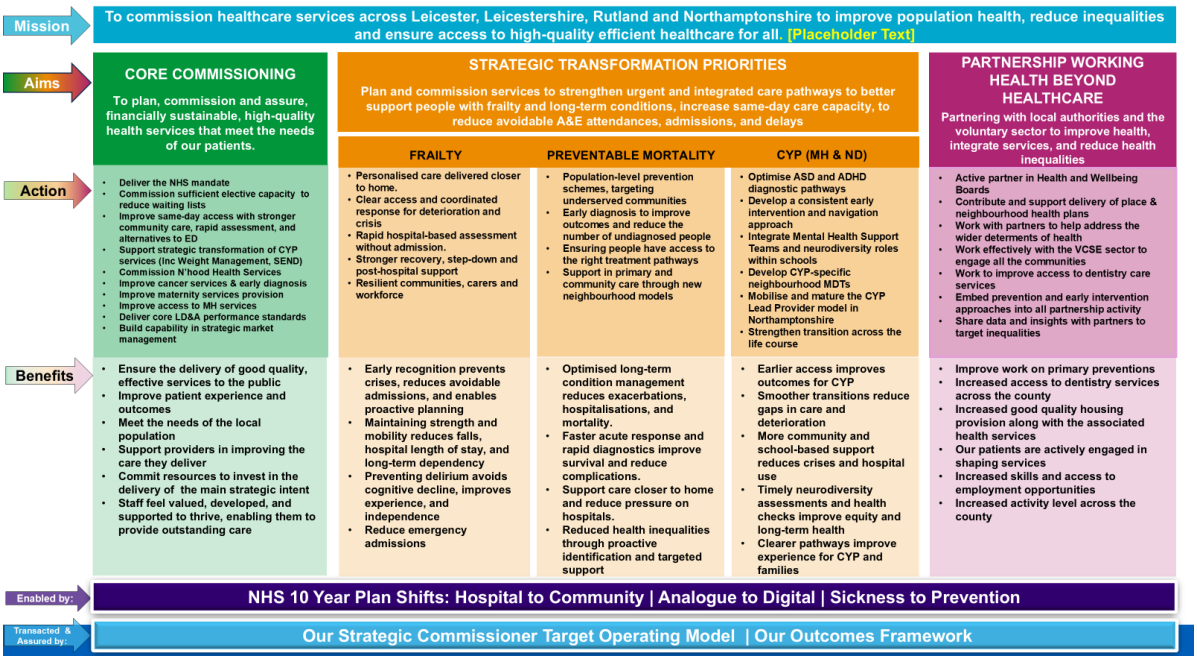
38. **Commissioning priorities:** The Plan focuses on a small number of areas where strategic commissioning can have the greatest impact:

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

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

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

Figure 1: Commissioning Strategy (on a page)



Delivering the Strategy

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

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

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

Appendices

Appendix 1 - LNR Cluster Integrated Care Needs Assessment

Appendix 2 - LNR ICB Five Year Strategic Commissioning Strategy

Officer to contact

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Relevant Impact Assessments

Equality Implications

43. The implications will be assessed as delivery plans are developed and provided in future updates for the Board's consideration.

Human Rights Implications

44. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

45. The implications for partners will be assessed as delivery plans are developed and provided in future updates for the Board's consideration.

Appendix 1

Our Cluster Integrated Needs Assessment

2026/27 – 2030/31

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

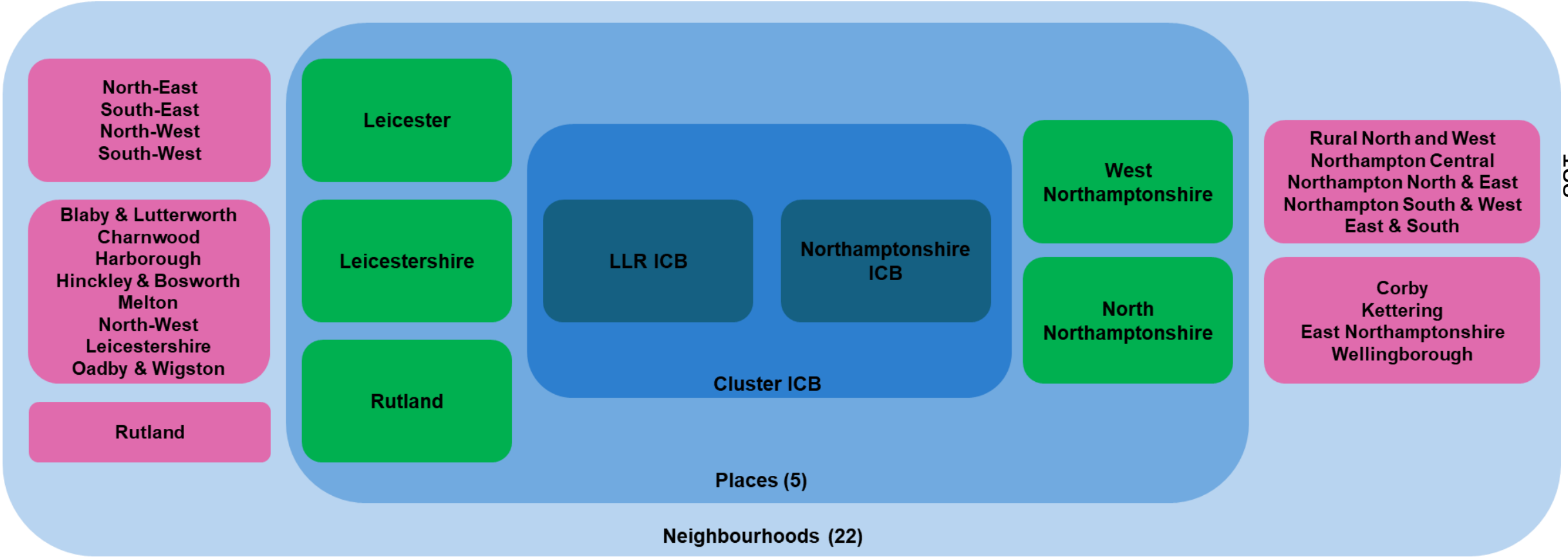
Contents

1. Purpose and Scope

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

2. Our Landscape

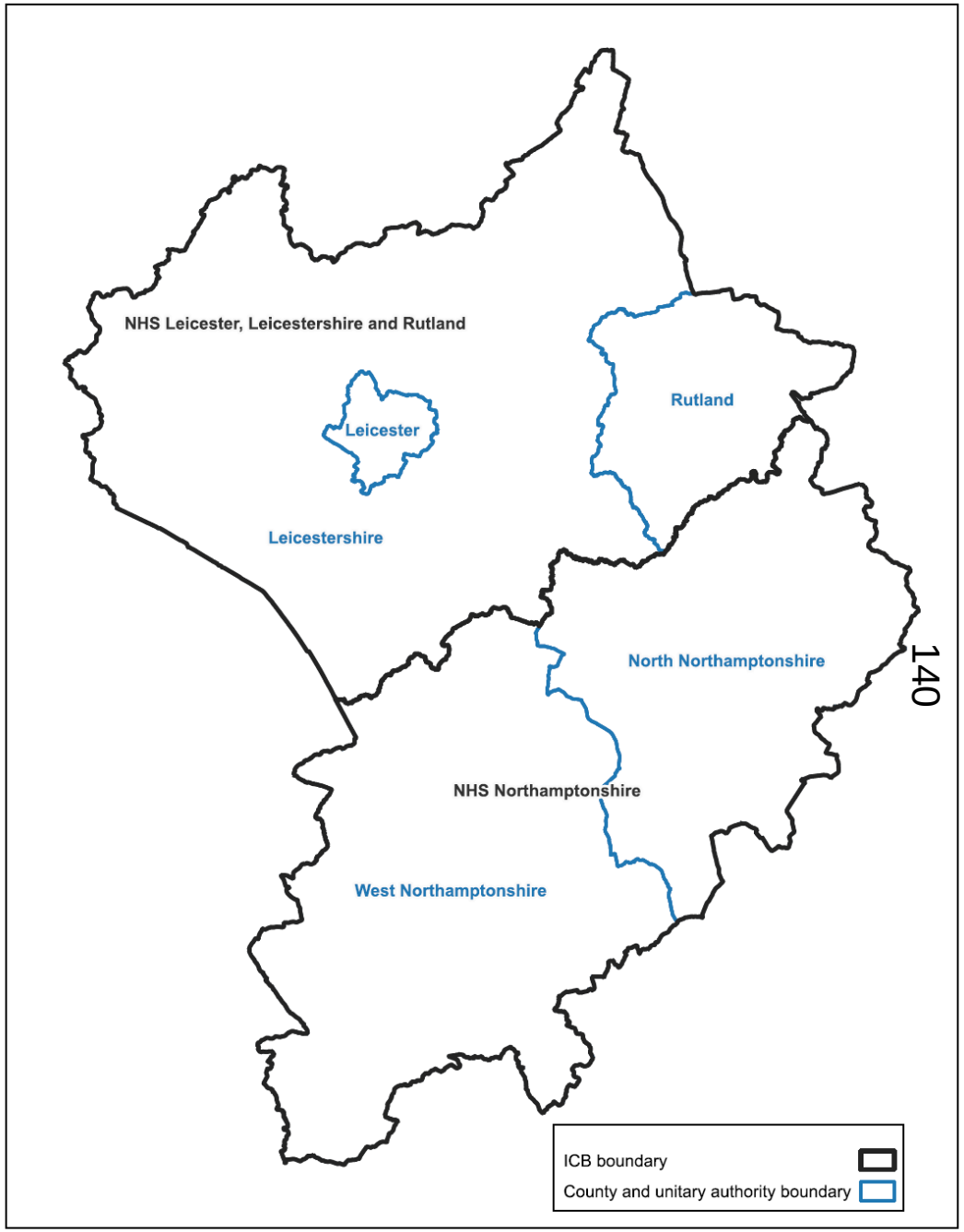
Whilst operating as individual statutory organisations, in line with national directives, NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board and NHS Northamptonshire Integrated Care Board are working under a cluster arrangement. This means between our two organisations, we have single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



3. Our Integrated Needs Assessment: Key messages

Northamptonshire, Leicester, Leicestershire and Rutland

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



Population and Demographic Growth in LNR

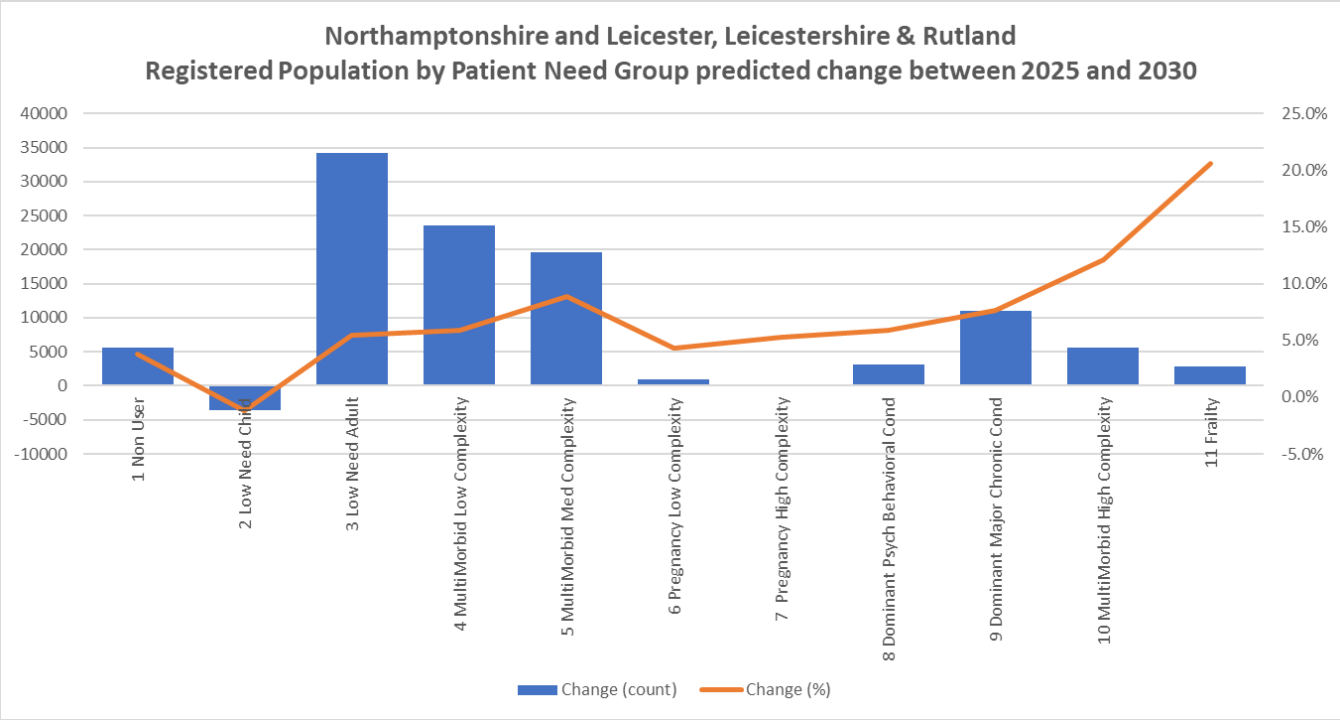
- In 2024, for the ICB cluster
  - Resident population of 1.989 million
  - 19,205 live births
  - 17,082 deaths
- In the next 5 years (2026-2030), the population is projected to rise to 2.059 million, an increase of 2.3%
- The population aged 80 and older is expected to grow the fastest, increasing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

Population Estimates and Projections

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

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

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



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

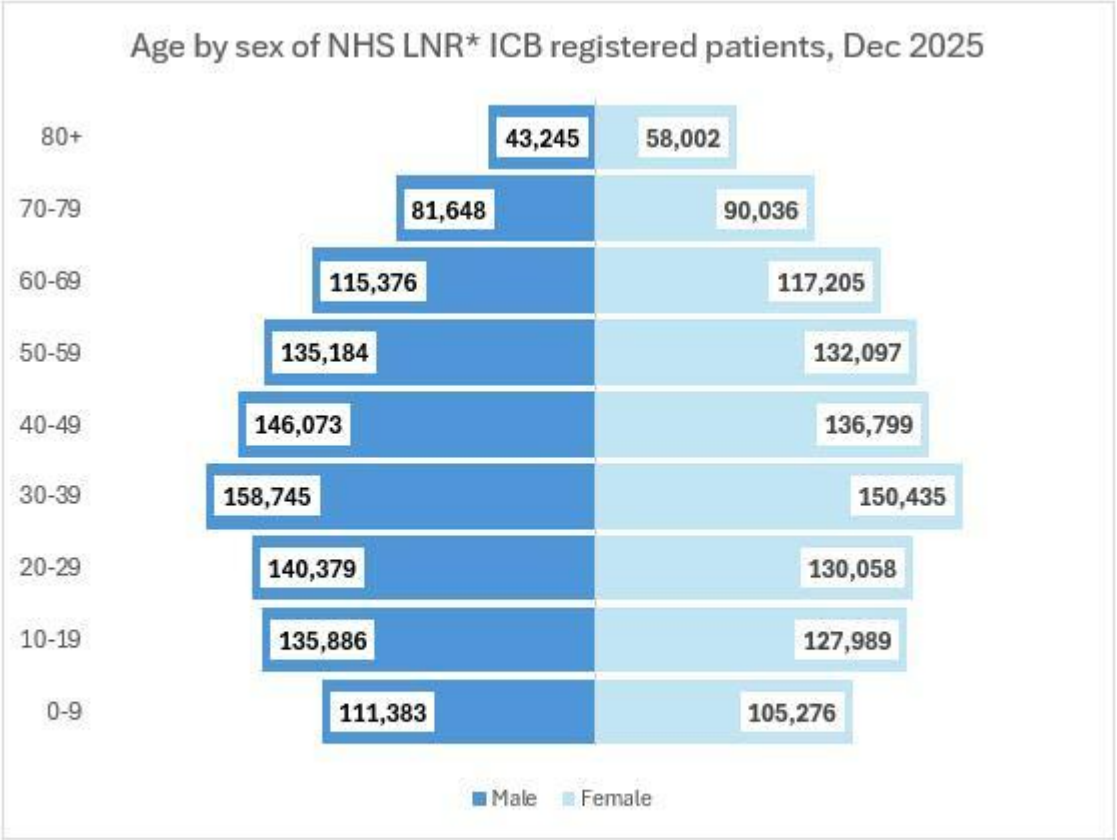
Data is sourced from LLRs PHM data in Aristotle and Northamptonshires NARP data

In the chart

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

LNR registered population

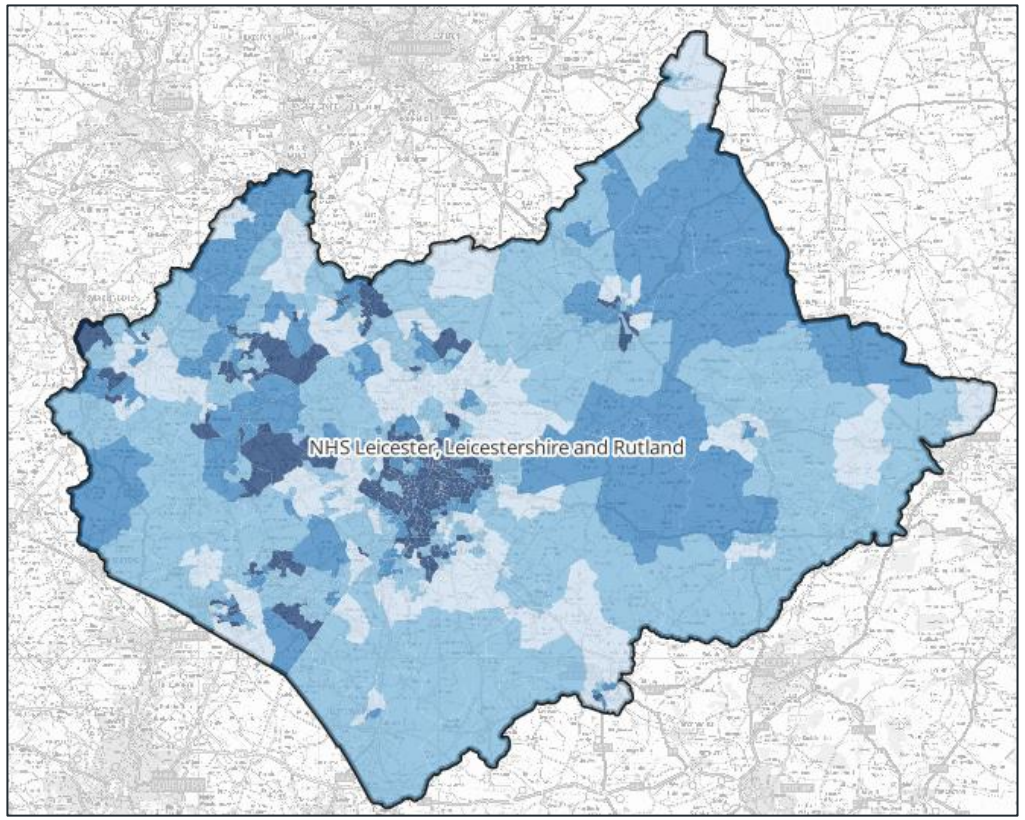
- Nearly half of the population consists of working-age adults between 30 and 59 years old (41%)
- Children and young people under the age of 20 make up nearly a quarter of the total population (23%)
- Young adults aged 20-29 years account for roughly one in eight people (13%)
- Adults aged 70 years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



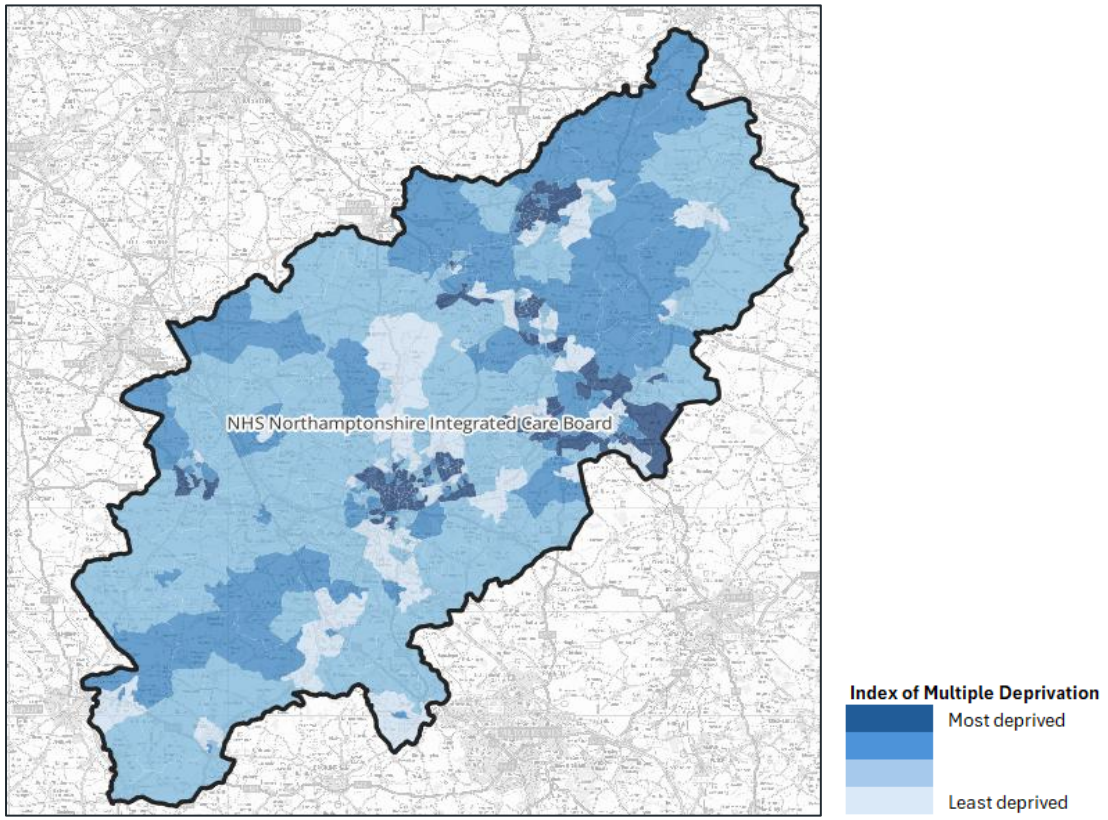
* LNR: Leicester, Leicestershire, Rutland, and Northamptonshire
Source: NHS Digital, 2025

Deprivation

Levels of deprivation in LLR at Lower Super Output Area level



Levels of deprivation in Northamptonshire at Lower Super Output Area level



Source: Index of Multiple Deprivation, ONS, 2025

Deprivation

For the LNR Cluster

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

In Northamptonshire

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

Within Leicester, Leicestershire and Rutland (LLR)

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

Overall 2025 Index of Multiple Deprivation - % of registered population

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

Source: English Indices of Deprivation 2025, DCLG

Ethnicity (2021 Census)

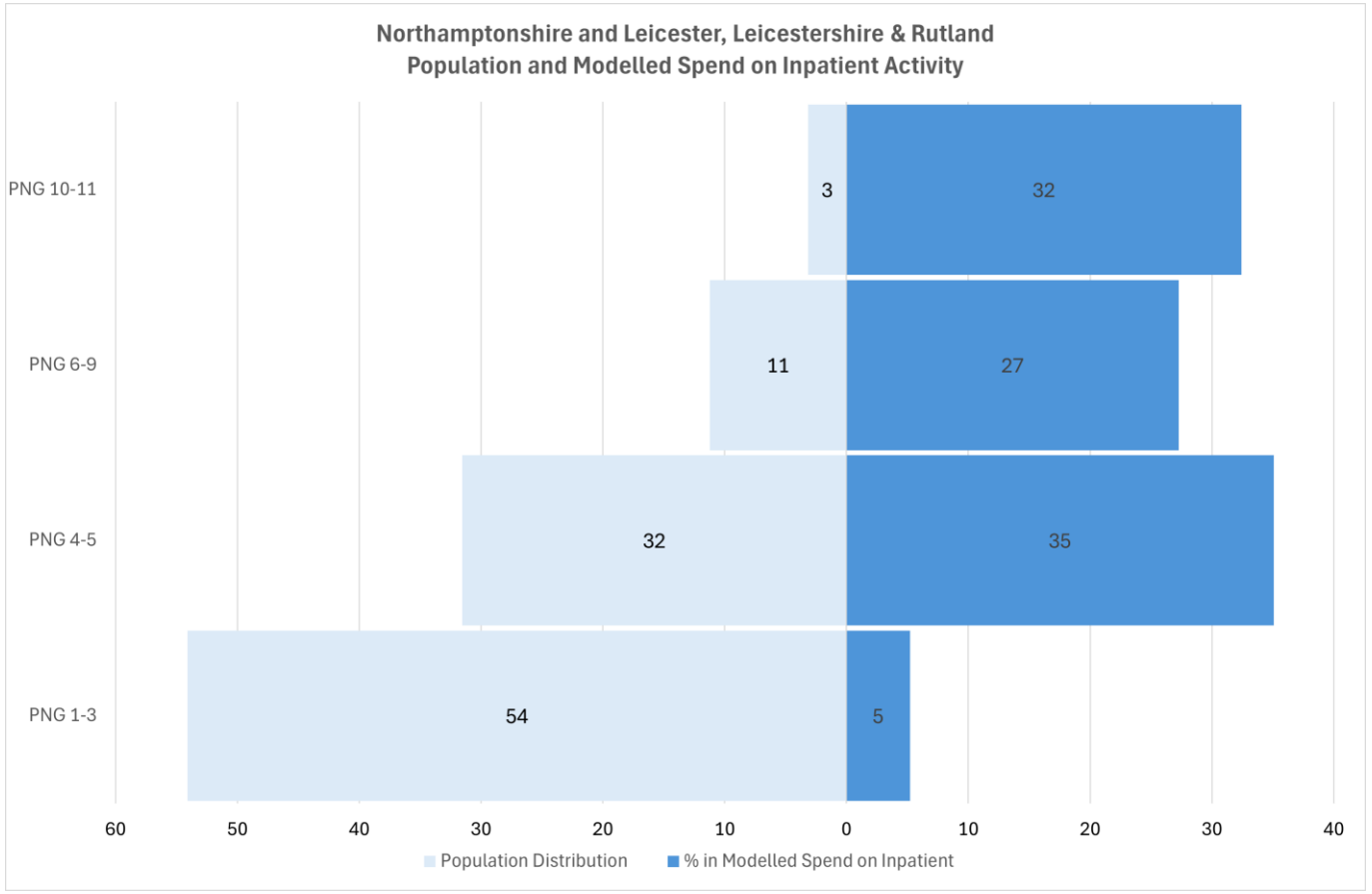
Ethnic group	Leicester	Leicestershire	North Northamptonshire	Rutland	West Northamptonshire	LNR
Total: All usual residents	368,571	712,366	359,523	41,050	425,723	1,907,233
Asian, Asian British or Asian Welsh	159977 (43%)	58066 (8%)	12726 (4%)	634 (2%)	22463 (5%)	253866 (13%)
Black, Black British, Black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

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

Note: Other White is included in the White category

Source: 2021 Census, Office of National Statistics

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



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

The population is living longer but not always in good health

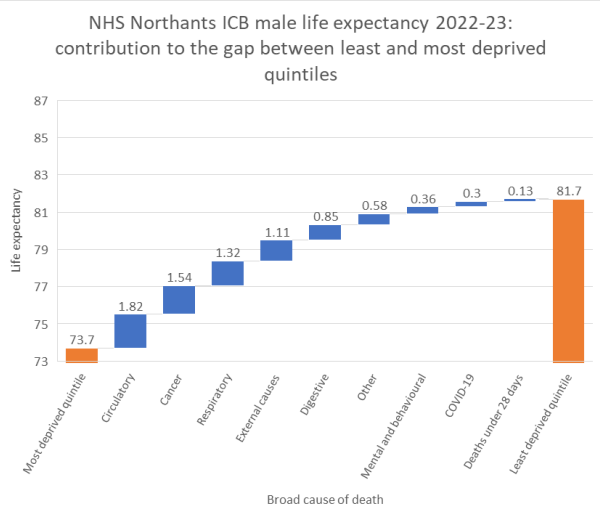
Area	Life Expectancy at birth		Healthy life expectancy at birth		Number of years in poor health		Proportion of life in poor health	
	Male	Female	Male	Female	Male	Female	Male	Female
Leicester	76.5	80.6	56.7	56.3	19.8	24.3	25.9%	30.1%
Leicestershire	80.2	83.7	62.7	62.6	17.5	21.1	21.8%	25.2%
Rutland	81.6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

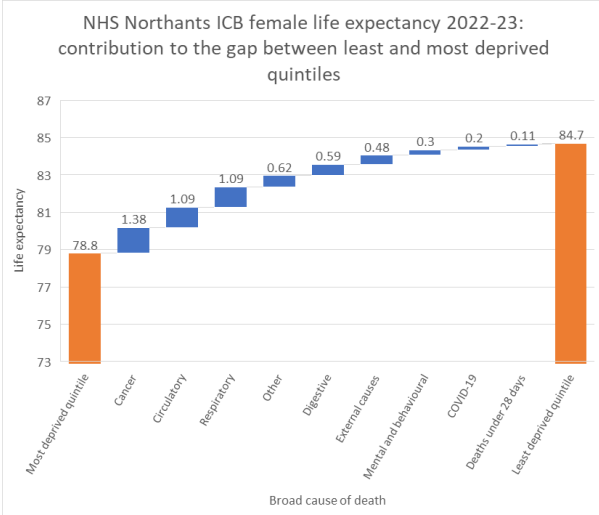
Source: OHID, Fingertips, Life expectancy 2021-2023

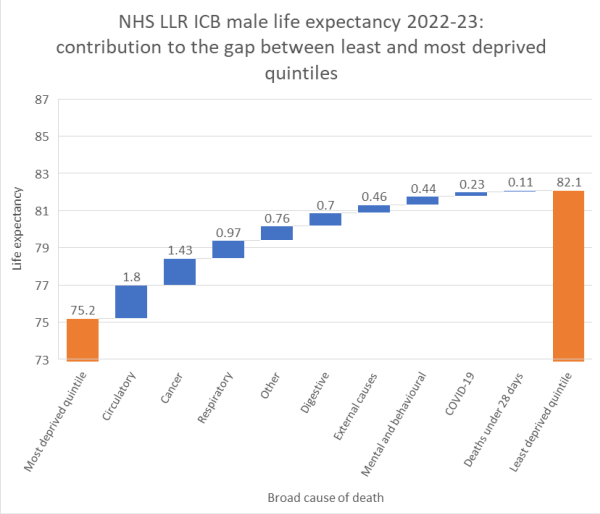
Significantly lower than England
Statistically similar to England
Significantly higher than England

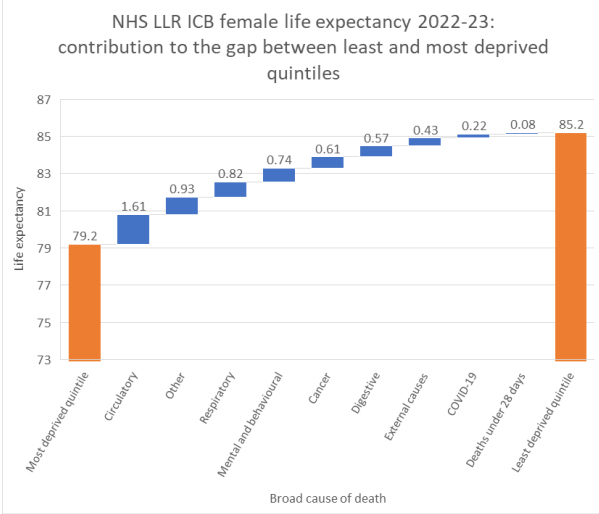
- Life expectancy is the average number of years a person is expected to live for, healthy life expectancy is the average number of years that a person can expect to live with good health
- On average, males born in LNR can expect to live for 79.3 years (17 years in poor health) and females 83 years,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

Inequalities in Life Expectancy









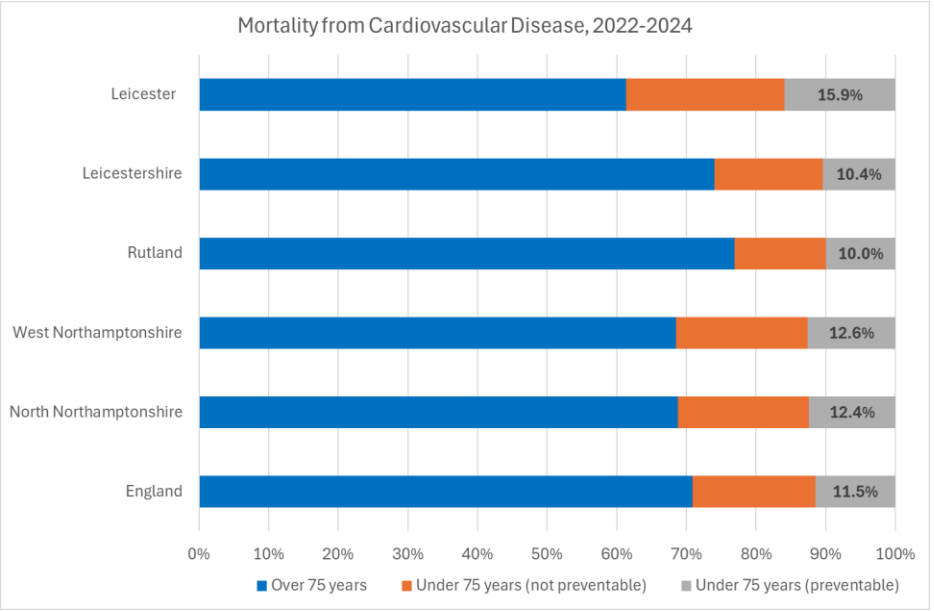
- In 2023, for LNR residents
  - aged under 75 years - the leading cause of death is neoplasms (36%), followed by cardiovascular diseases (22%) and respiratory disease (9%)
  - all ages - the leading cause of death is neoplasms (27%), followed by cardiovascular diseases (23%) and respiratory diseases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

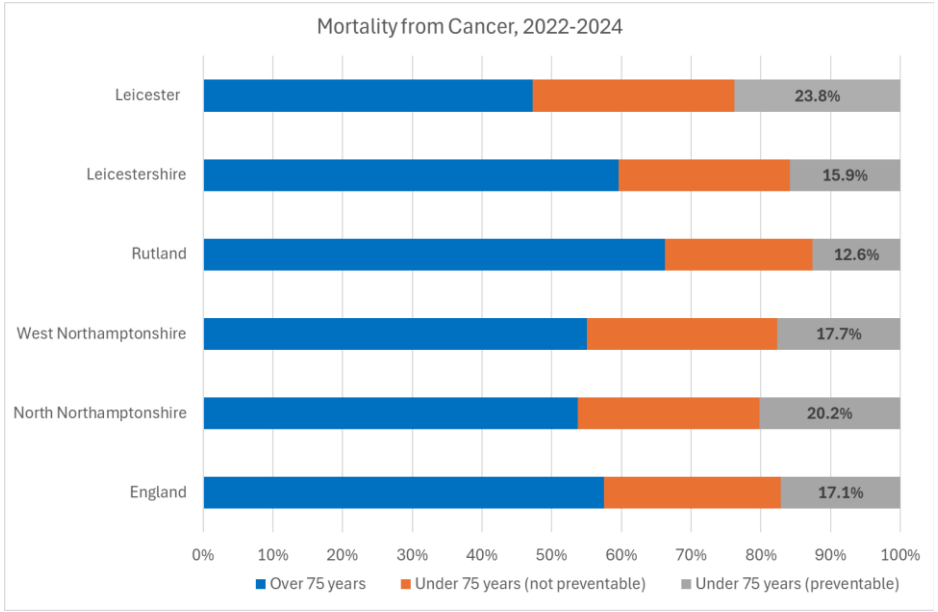
Mortality in LNR 2022-24

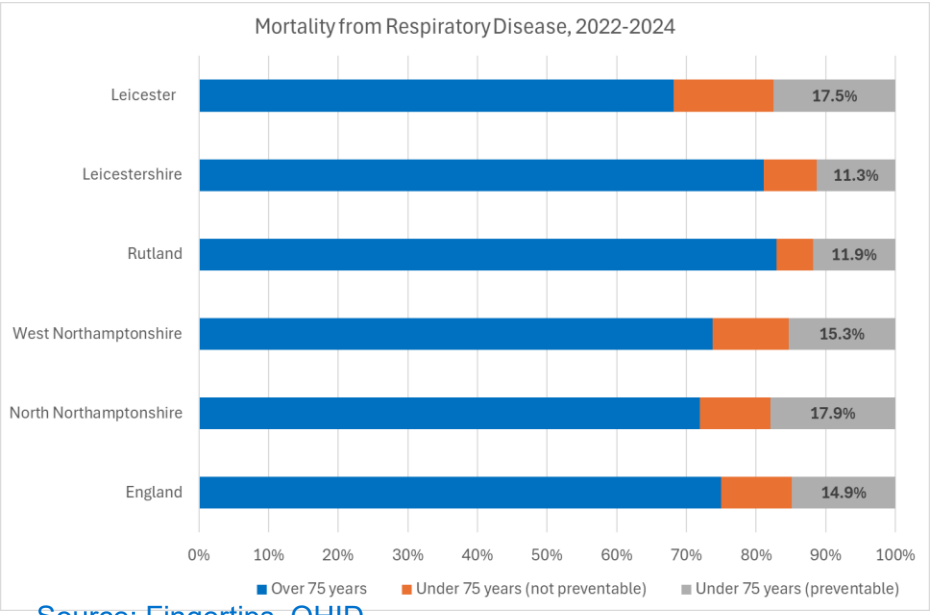
14% of mortality LNR is estimated to be preventable through healthcare treatment or public health interventions

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

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







Source: Fingertips, OHID

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

- Years of life lived with disability will drive the health and care needs of the LNR population
- The Global Burden of Disease enables us to explore the risk factors that drive ill-health and death locally

- The primary risk factors highlighted for LNR are
  - Obesity
  - Tobacco
  - Blood glucose
  - Alcohol
  - High Blood Pressure

- The causes of ill-health that are hidden in the mortality data but drive a significant proportion of the health and care needs in LNR – particularly
  - Musculoskeletal conditions
  - Mental health
  - Diabetes

Children and Young People

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

Health outcomes for children and young people

LLR

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

Northamptonshire

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

Health Inequalities

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

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

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

Health Inequalities

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

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

Source: Performance Overview Dashboard, NHS England

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

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

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

LLR outlier for
- pre-term births
- stroke admissions
- flu vaccinations
- LDA health checks*

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

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

How much will our activity change in 15 years

Today → 2040

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

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

Notes:

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

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

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

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

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

Frailty

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

Potentially mitigable activity

Redirection 792k bed days

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

Prevention 242k bed days

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

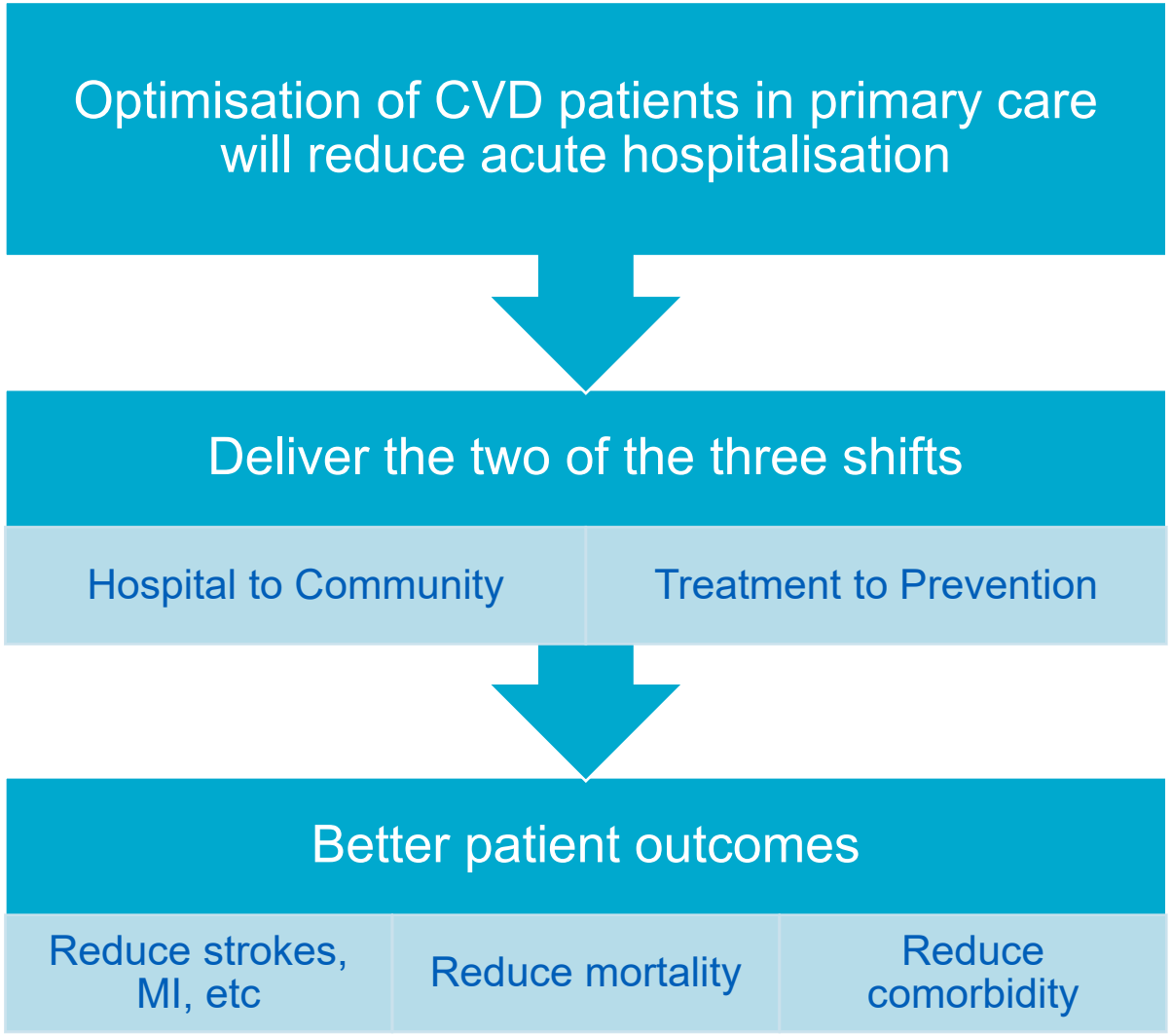
Relocation 142k bed days

- Virtual Wards

Efficiencies – LoS Reductions 800k bed days

- Stroke
- MH comorbidity
- Older people

Cardiovascular Disease



- If LLR and Northamptonshire were to meet NICE ambitions for **hypertension, lipids, CKD and diabetes optimisation**
- In 3 years
  - Prevent 2,145 health events
  - Cost of £21 million
  - System benefits of £87 million
- In 5 years
  - Prevent 3,442 health events
  - Cost of £33 million
  - System benefits of £174 million

- Closing the diagnosis gap by identifying and adding patients to GP QOF registers will significantly increase potential opportunities for better health outcomes for patients with CVD

Respiratory Disease

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

Early diagnosis

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

ED

- Model Hospital 27,590 attendances above benchmark

Non Elective Admissions

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

* indicative cost estimate of £2,500 per admission

Cancer

Early diagnosis

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

Improved survival

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

Performance standards

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

Inequalities

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

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

Community Insights

Prioritise local and accessible services

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

Build trust through communication

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

Deliver integrated, person-centred care

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

Support prevention and self-care

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

Strengthen support for CYP and families

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

Population Health priorities on a page

Demographic growth	•Population growth of 2.3% to 2030 •Ageing population = increases in frail population and people with complex multi-morbidity =increase in the need and demand •Need for health and care services will grow faster than overall population growth rate for all health and care sectors, including primary, community, mental health and acute hospital services
Health inequalities	•Gap in healthy life expectancy across LNR driven by socio-economic deprivation •Strategic commissioning intentions must target and address poorer health outcomes in Leicester City and in areas of deprivation in LNR •Focus on Core20+ groups - lower life expectancy. more time in poor health, develop LTCs earlier in life •Giving every child the best start in life is the most important policy objective for reducing health inequalities
Three common conditions linked to preventable risk factors	•Cardiovascular diseases, cancer, and respiratory diseases largest causes of inequalities, morbidity and mortality •Mental health and Musculo-skeletal conditions also drive a significant burden of disability in LLR •Obesity, blood glucose, hypertension, smoking and alcohol biggest preventable risk factors driving the “big three”, and many other long term conditions
System sustainability	•System focus on the three left shifts and supporting the shift from acute to community, treatment to prevention and analogue to digital and the development of neighbourhoods to support this •It is essential that the plans that the ICB develops as strategic commissioners are sensitive to the underlying growth across all health and care sectors and that underlying growth should be a core component as the system develops new models of care •Transforming services for people with frailty will be essential for future sustainability

Translating health priorities to commissioning intentions

Elective demand	UEC	Neighbourhoods	Commissioning for Value
Managing demographic growth in elective	Managing demographic growth in UEC	Opportunity to develop local innovations to support the system	Addressing health inequalities
Reducing variation and understanding system opportunities through benchmarking	Growth is outstripping capacity	Health inequalities	System sustainability and demographic growth
Pathway changes	Focus on frail and multi-morbid and hospital avoidance	Understanding local needs and drivers of disability	Reducing variation and understanding system opportunities through benchmarking
Addressing health inequalities	Inequalities drive higher rates of UEC demand	Build prevention into the design	Opportunity to build the three shifts into our strategic commissioning plans

4. Alignment to System Strategies

- Based on our analysis we have determined that our Strategic Transformational Priorities will centre on Frailty, Premature Mortality (Cardiovascular, Respiratory and Cancer) and CYP (Mental Health and Neurodiversity).

- The following section demonstrates synergy and alignment to synch with existing system-wide strategies.

Integrated Care Strategies

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

Key Areas of Focus:

Focus 1
Improving health equity

Focus 2
Preventing illness and helping people to stay well

Focus 3
Championing integration

Focus 4
Fulfilling our role as ‘Anchor’ organisations

Our Priorities:

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

Integrated Care Strategies

Integrated Care Strategy Northamptonshire
Live your best life, a ten-year strategy 2023-2033

Our Ten Ambition Areas:

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

Health and Wellbeing Board Strategies

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

Themes for Action

Healthy Places

Healthy Minds

Healthy Start

Healthy Lives

Healthy Ageing

Leicestershire Joint Health and Wellbeing Strategy 2022-2032

Life Course Approach

Best start for life

Staying healthy, safe and well

Living and supported well

Dying well

Rutland Health and Wellbeing Strategy 2022-2027

Priority Themes

The best start for life

Staying healthy and independent: Prevention

Healthy ageing and living well with long term conditions

Ensuring equitable access to services for all Rutland residents

Preparing for significant population growth and change

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

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

Health and Wellbeing Board Strategies

West Northamptonshire Joint Health and Wellbeing Strategy 2023-2028

Ambition

(Placeholder as being updated/reviewed)

The best start in life

Access to the best available education & learning

Opportunities to be fit well and independent

Employment that keeps you and your family out of poverty

Good housing in places which are clean and green

Safe in your homes and when out and about

Connected to friends and family

The chance for a fresh start when things go wrong

Access to health and social care

Accepted and valued for who you are

North Northamptonshire Health and Wellbeing Strategy 2024-2029

Five Key Priorities

Smoking and Vaping

Keeping Active

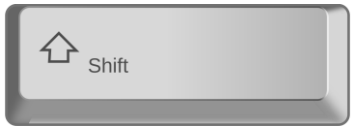
Mental Health and Wellbeing

Children and Young People

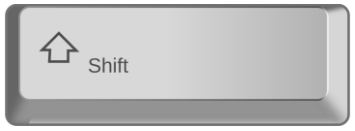
Financial Resilience

The 10-Year Health Plan for England

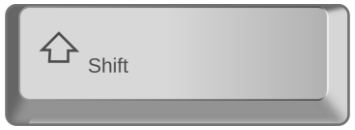
The Three Fundamental Shifts



Hospital to Community



Analogue to Digital



Sickness to Prevention

Frailty

Population Impact	Frailty is a major driver of UEC activity, longer lengths of stay, and social care demand. Modelling across the cluster shows a significant increase in an older and frailer cohort with greater pressure on services.
Commissioning Framework Alignment	Guidance commands the use of population segmentation and risk stratification; frailty is a high-risk cohort where proactive, integrated care can reduce demand and improve outcomes.
LLR ICS Strategy	**Aligns with priorities and key focus areas:** Staying healthy and well Living and supported well Preventing illness and helping people to stay well
Northamptonshire ICS Strategy	**Aligns with ambitions:** Opportunity to be fit, well and independent To feel safe in their homes and when out and about Access to health and social care when they need it
Leicester JHWS	**Aligns with themes:** Healthy Lives Healthy Ageing
Leicestershire JHWS	**Aligns with life course approach:** Staying healthy, safe and well Living and supported well
Rutland JHWS	**Aligns with priority themes:** Staying healthy and independent Healthy ageing and living well with long term conditions
West Northamptonshire JHWS	**Aligns with ambitions:** Opportunity to be fit, well and independent To feel safe in their homes and when out and about Access to health and social care when they need it
North Northamptonshire JHWS	**Aligns with key priority:** Keeping Active
10-Year Plan Shifts	Investing in frailty pathways supports the shift from **hospital to community** care, harnesses neighbourhood models of care and can reduces avoidable admissions, improving independence and quality of life.

Premature Mortality (Respiratory, CVD, Cancer)

Population Impact	These three disease areas are leading cause of early death across the cluster. They drive inequalities, demand and mortality.
Commissioning Framework Alignment	The guidance explicitly highlights the need to assess the impact of poor health on children and young people's life chances
LLR ICS Strategy	**Aligns with priorities and key focus area:** Preventing illness and helping people to stay well Staying healthy and well Living and supported well
Northamptonshire ICS Strategy	**Aligns with ambition:** Opportunities to be fit, well and independent
Leicester JHWS	**Aligns with theme:** Healthy Lives
Leicestershire JHWS	**Aligns with life course approach:** Staying healthy, safe and well
Rutland JHWS	**Aligns with priority theme:** Staying healthy and independent: Prevention
West Northamptonshire JHWS	**Aligns with ambition:** Opportunities to be fit, well and independent
North Northamptonshire JHWS	**Aligns with key priorities:** Smoking and Vaping Keeping Active
10-Year Plan Shifts	Clear alignment with one of the three shifts within the 10YP – **Sickness to Prevention.**

Children and Young People

Population Impact	Giving every child the best start in life is the most important long-term objective for reducing health inequalities.
Commissioning Framework Alignment	Guidance emphasises tackling drivers of risk and demand and reducing unwarranted variation. Respiratory disease, cardiovascular disease, and cancer all show significant inequalities in incidence, access, and outcomes.
LLR ICS Strategy	**Aligns with priorities and key focus areas:** Best start in life Preventing illness and helping people to stay well
Northamptonshire ICS Strategy	**Aligns with ambition:** The best start in life
Leicester JHWS	**Aligns with theme:** Healthy Start
Leicestershire JHWS	**Aligns with life course approach:** Best start for life
Rutland JHWS	**Aligns with priority theme:** The best start for life
West Northamptonshire JHWS	**Aligns with ambition:** The best start in life
North Northamptonshire JHWS	**Aligns with key priorities:** Children and Young People
10-Year Plan Shifts	Care closer to home, greater opportunities for joint commissioning with partners and preventing escalation to hospital care. CYP cohort ideal beneficiaries of digital by default approach. Todays CYP are tomorrows adults - childhood is the most critical stage for prevention — tackling obesity, smoking, poor diet, and mental health early has lifelong benefits.

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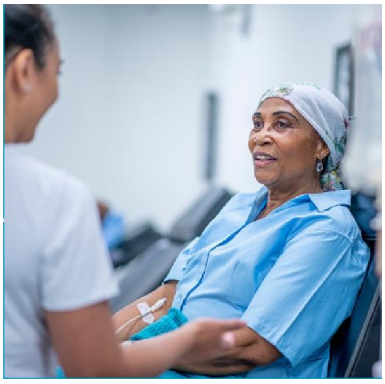
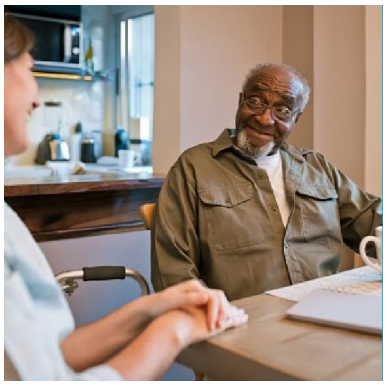
Appendix 2

FIVE-YEAR STRATEGIC COMMISSIONING PLAN

2026-27 to 2030-31

Version 1.0



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

CONTENTS

EXECUTIVE SUMMARY

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

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

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

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

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

What will change

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

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

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

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

Our commissioning ambitions and priorities

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

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

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

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

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

Delivering this plan

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

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

1. OUR PLAN ON A PAGE

Mission

To commission healthcare services across Leicester, Leicestershire, Rutland and Northamptonshire to improve population health, reduce inequalities and ensure access to high-quality efficient healthcare for all. [Placeholder Text]

	CORE COMMISSIONING	STRATEGIC TRANSFORMATION PRIORITIES			PARTNERSHIP WORKING HEALTH BEYOND HEALTHCARE
Aims	To plan, commission and assure, financially sustainable, high-quality health services that meet the needs of our patients.	Plan and commission services to strengthen urgent and integrated care pathways to better support people with frailty and long-term conditions, increase same-day care capacity, to reduce avoidable A&E attendances, admissions, and delays			Partnering with local authorities and the voluntary sector to improve health, integrate services, and reduce health inequalities
		FRAILTY	**PREVENTABLE MORTALITY**	**CYP (MH & ND)**	
Action	• Deliver the NHS mandate • Commission sufficient elective capacity to reduce waiting lists • Improve same-day access with stronger community care, rapid assessment, and alternatives to ED • Support strategic transformation of CYP services (Inc Weight Management, SEND) • Commission N'hood Health Services • Improve cancer services & early diagnosis • Improve maternity services provision • Improve access to MH services • Deliver core LD&A performance standards • Build capability in strategic market management	• Personalised care delivered closer to home. • Clear access and coordinated response for deterioration and crisis • Rapid hospital-based assessment without admission. • Stronger recovery, step-down and post-hospital support • Resilient communities, carers and workforce	• Population-level prevention schemes, targeting underserved communities • Early diagnosis to improve outcomes and reduce the number of undiagnosed people • Ensuring people have access to the right treatment pathways • Support in primary and community care through new neighbourhood models	• Optimise ASD and ADHD diagnostic pathways • Develop a consistent early intervention and navigation approach • Integrate Mental Health Support Teams and neurodiversity roles within schools • Develop CYP-specific neighbourhood MDTs • Mobilise and mature the CYP Lead Provider model in Northamptonshire • Strengthen transition across the life course	• Active partner in Health and Wellbeing Boards • Contribute and support delivery of place & neighbourhood health plans • Work with partners to help address the wider determents of health • Work effectively with the VCSE sector to engage all the communities • Work to improve access to dentistry care services • Embed prevention and early intervention approaches into all partnership activity • Share data and insights with partners to target inequalities
Benefits	• Ensure the delivery of good quality, effective services to the public • Improve patient experience and outcomes • Meet the needs of the local population • Support providers in improving the care they deliver • Commit resources to invest in the delivery of the main strategic intent • Staff feel valued, developed, and supported to thrive, enabling them to provide outstanding care	• Early recognition prevents crises, reduces avoidable admissions, and enables proactive planning • Maintaining strength and mobility reduces falls, hospital length of stay, and long-term dependency • Preventing delirium avoids cognitive decline, improves experience, and independence • Reduce emergency admissions	• Optimised long-term condition management reduces exacerbations, hospitalisations, and mortality. • Faster acute response and rapid diagnostics improve survival and reduce complications. • Support care closer to home and reduce pressure on hospitals. • Reduced health inequalities through proactive identification and targeted support	• Earlier access improves outcomes for CYP • Smoother transitions reduce gaps in care and deterioration • More community and school-based support reduces crises and hospital use • Timely neurodiversity assessments and health checks improve equity and long-term health • Clearer pathways improve experience for CYP and families	• Improve work on primary preventions • Increased access to dentistry services across the county • Increased good quality housing provision along with the associated health services • Our patients are actively engaged in shaping services • Increased skills and access to employment opportunities • Increased activity level across the county

Enabled by: NHS 10 Year Plan Shifts: Hospital to Community | Analogue to Digital | Sickness to Prevention

Transacted & Assured by: Our Strategic Commissioner Target Operating Model | Our Outcomes Framework

2. WHAT WILL BE DIFFERENT WHEN THIS PLAN IS DELIVERED

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

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

3. OUR NEW ROLE AS A STRATEGIC COMMISSIONER

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

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

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

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

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

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

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

Figure 1 – Our core functions as a strategic commissioner

[1] Independent Investigation of the National Health Service in England NHS England. 2024

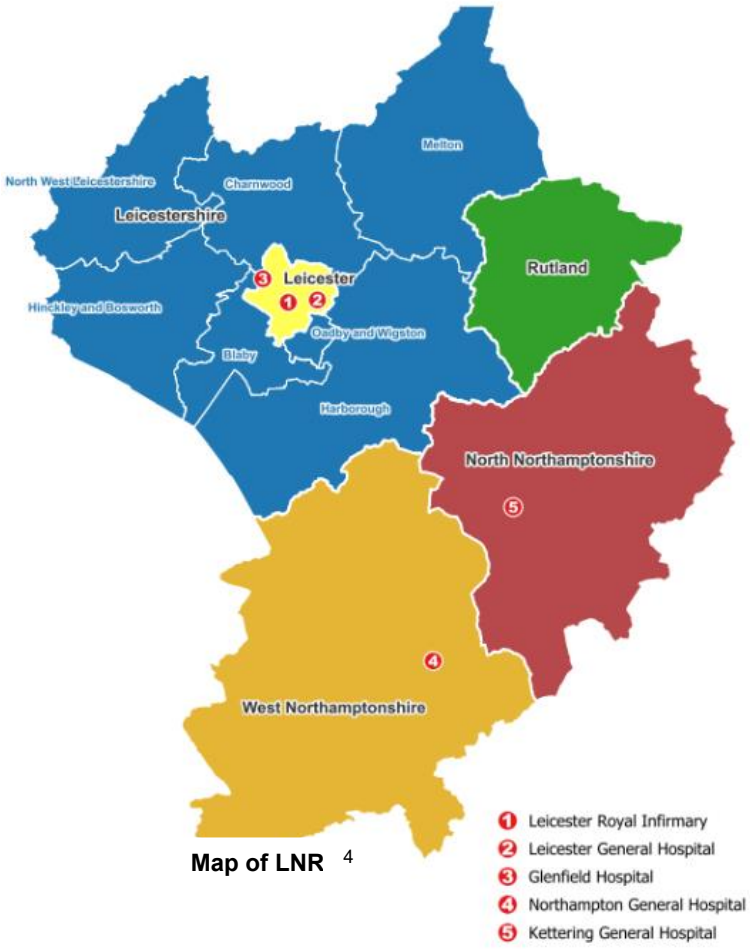
4. ABOUT US

4.1 OUR HEALTH AND CARE LANDSCAPE

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

Health and care provision – A summary[3]

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



Map of LNR [4]

Operating at different levels

Neighbourhoods

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

Places

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

[2] Population source: Registered patient with GP Practices – September 2025
[3] Data accurate as at January 2026
[4] Source: ONS. 2026. Created by Population Health, NHS Northamptonshire

Systems

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

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

4.2 ABOUT OUR POPULATION

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

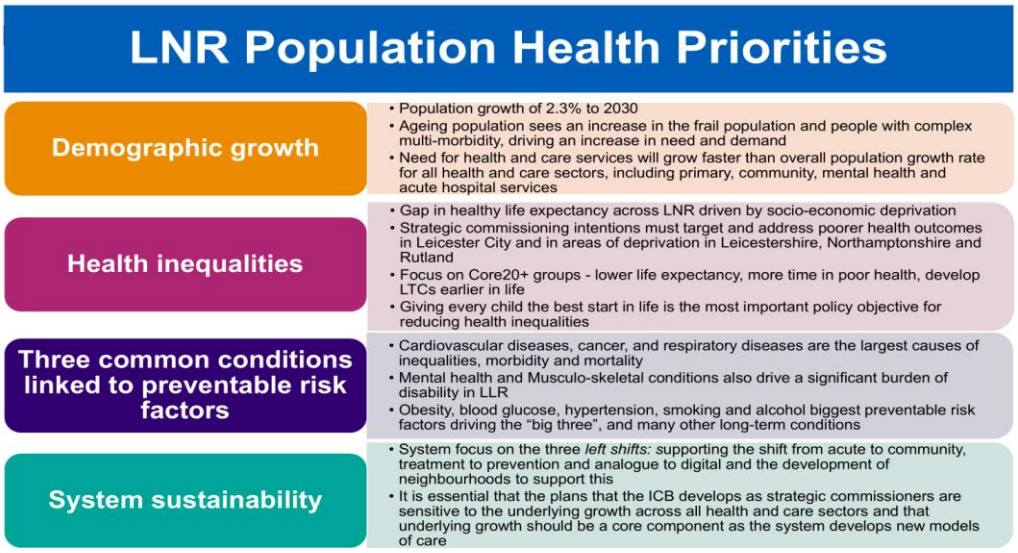


Figure 3 – Our population health priorities.

Demographic growth and increasing frailty needs

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

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

[5] LNR. Cluster Integrated Needs Assessment. 2026

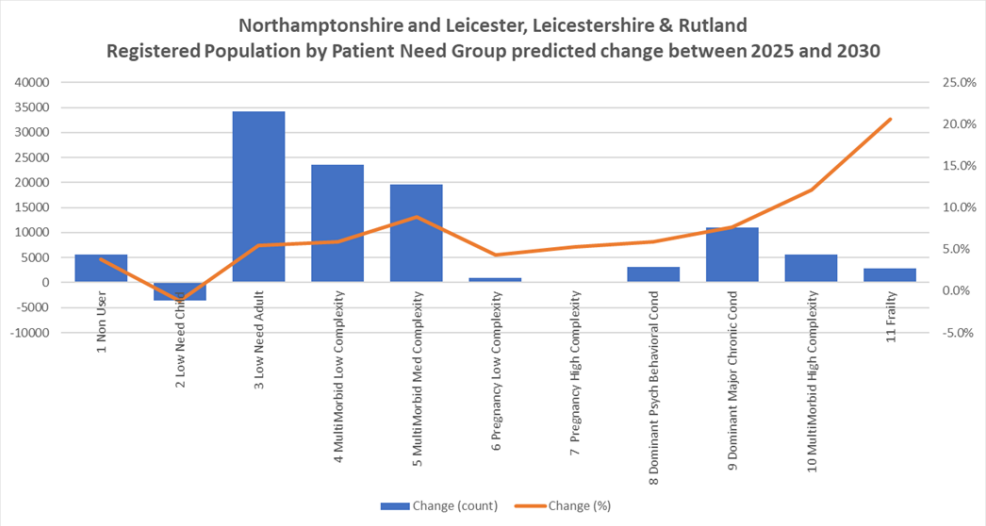


Figure 4 – Our predicted population growth grouped by health need

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

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

Health Inequalities

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

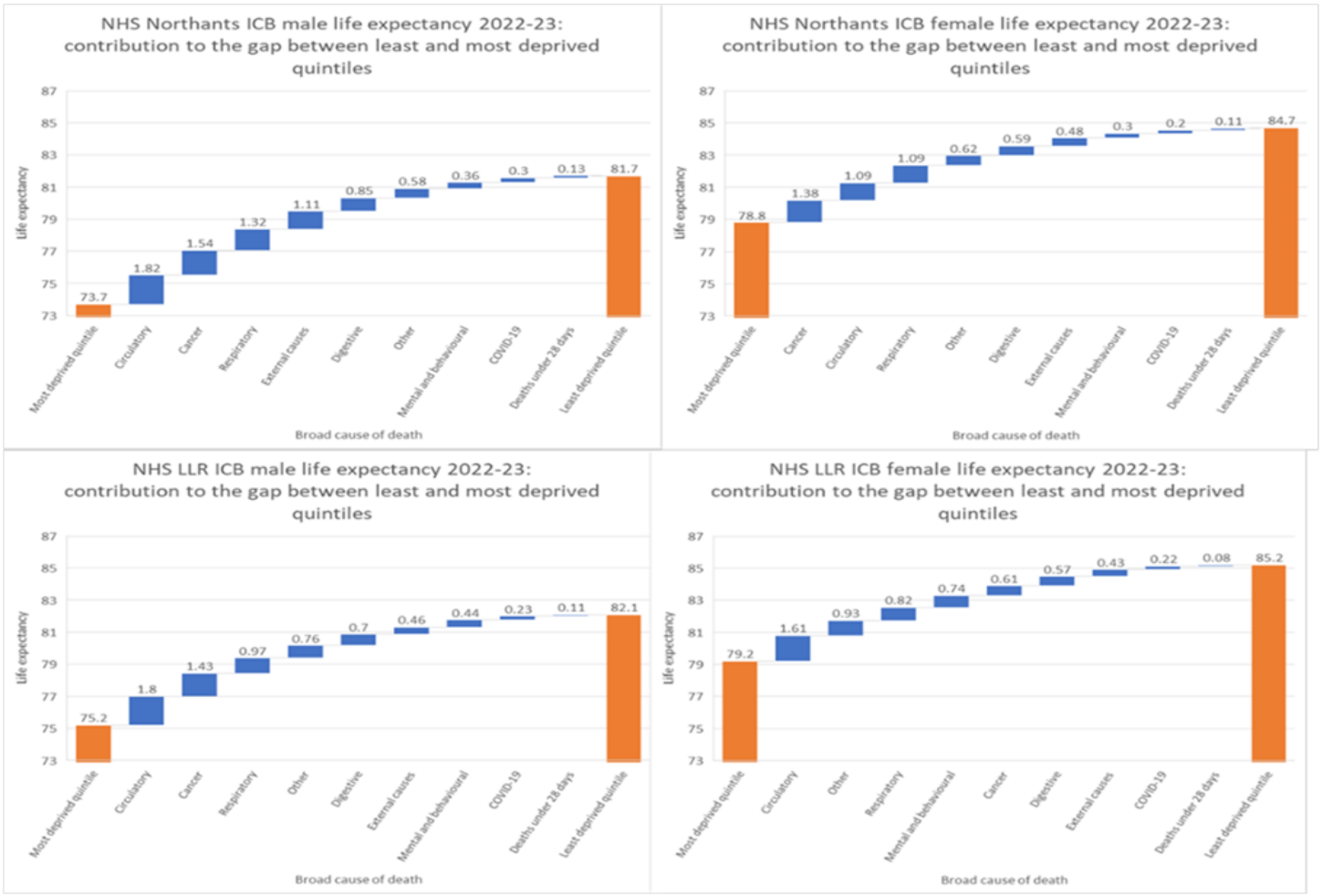


Figure 5 – Inequalities in life expectancy[6]

[6] Source: OHID Segment Tool. 2022-23

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

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

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

Overall 2025 Index of Multiple Deprivation - % of registered population

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

Table 1 – Our population by quintiles of deprivation[7]

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

Three common conditions linked to preventable risk factors

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

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

Children and Young People's mental health

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

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

[7] Source: English Indices of Deprivation. 2025. DCLG

[8] Source: LLR and Northants. Council's JSNA

[9] National Study of Health and Wellbeing: Children and Young People. NHS England. 2025

4.3 SERVICE QUALITY

What is working well

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

A shared commitment to quality

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

Patient Safety

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

Better use of insight and population health data

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

The major quality challenges

Pressures on access and flow

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

Variation in quality and outcomes

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

Workforce pressures

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

Workforce culture and safety

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

The impact of financial and productivity challenges on quality

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

Opportunities to improve quality across LNR

Tackling inequalities with focus and intention

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

Improving access, timeliness and flow

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

Reducing unwarranted variation and strengthening pathways

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

Supporting our workforce and building improvement capability.

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

Delivering quality, productivity and value together

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

Quality in strategic commissioning

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

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

4.4 SERVICE PERFORMANCE

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

Urgent and Emergency Care (UEC)

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

Elective Care (including cancer treatment)

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

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

[10] Source: LLR UEC Strategy/Northamptonshire UEC Strategy. 2025

Mental Health

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

General Practice

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

Opportunities to improve performance across LNR

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

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

5. OUR COMMISSIONING INTENTIONS FOR THE NEXT FIVE YEARS

5.1 KEY DRIVERS OF OUR COMMISSIONING INTENTIONS

Our strategic commissioning role

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

Alignment to national policy and direction

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

Alignment to wider system partner's ambitions

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

Financial sustainability

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

5.2 HOW WE DEVELOPED OUR COMMISSIONING INTENTIONS

Evidence-led

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

Targeted and Manageable

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

Clinical co-production

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

Iterative and Collaborative

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

Local people's insights

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

OUR COMMISSIONING INTENTIONS

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

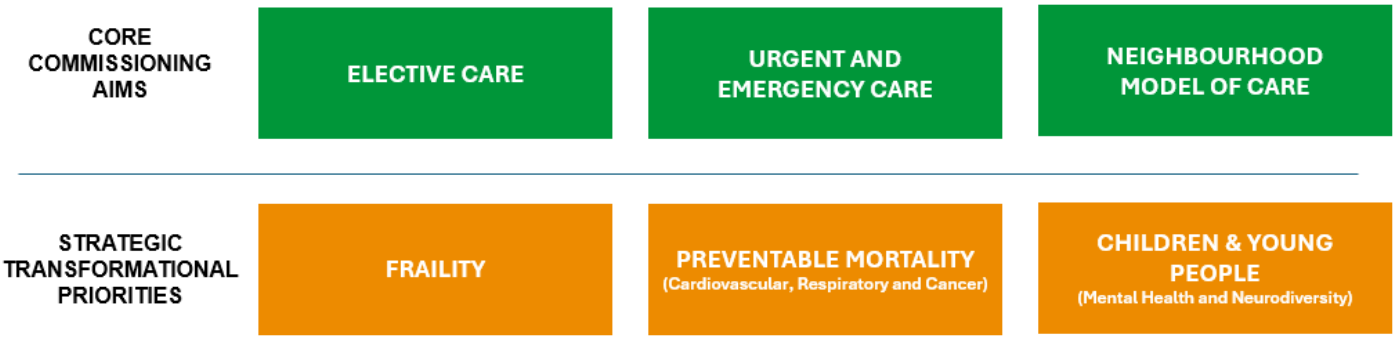


Figure 6 Our Commissioning Intentions

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

5.3 OUR CORE COMMISSIONING AIMS

5.3.1 ELECTIVE CARE

Our ambition for Elective Care

We will:

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

Background and Strategic Context

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

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

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

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

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

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

The Key Interventions we will focus on

Intervention 1 – Reduce elective waiting times and protect planned activity

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

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

Intervention 2 - Transform Outpatient care

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

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

Intervention 3 – Strengthen cancer and diagnostic pathways

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

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

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

Intervention 4 – Develop community surgery models

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

Intervention 5 – Address inequalities and improve outcomes

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

How we will get there

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

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

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

5.3.2 URGENT & EMERGENCY CARE

Our ambition for Urgent and Emergency Care

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

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

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

Background and Strategic Context

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

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

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

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

[11] Source: NHS Data Dashboard. 2025

Key Interventions we plan to make

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

Intervention 1 - Empowered self-care and active prevention	**How we will get there**
• Support people at risk of escalation due to their Long-term condition • Holistic Care Plans for people, to include crisis planning • Keyworker support in the person’s community • Remote monitoring to support those at risk • Long-term condition groups to improve outcomes • Advanced Care Planning for those at the end of life • Enhanced healthcare in care homes	We will embed prevention and proactive care at neighbourhood level by aligning UEC delivery with Local Area Partnerships, neighbourhood models and place-based governance across LNR. This will support early identification, proactive care planning and coordinated support for people most at risk of deterioration.
Intervention 2 - Same day urgent care and rapid access to primary and community services	**How we will get there**
Delivering same day access at scale through: • A consolidated Urgent Treatment Centre model • Neighbourhood-based same day urgent care hubs • A trusted single point of contact (SPOC) for triage and navigation • Expanded community pharmacy and primary care same day access • Increased use of Same Day Emergency Care across acute sites	We will ensure people can access the right same-day care by scaling effective neighbourhood and place-based care, reducing reliance on emergency departments and minimising unwarranted variation between areas.
Intervention 3 - Coordinated urgent care and crisis response	**How we will get there**
Strengthened integrated responses across physical and mental health through: • Urgent Community Response (UCR) and integrated triage models • Mental health crisis assessment and response pathways • Trusted assessor models to reduce duplication and delays • Integrated pathways for CYP, frailty, LDA and end of life care • Improved data flows between teams to support joined up care	We will strengthen and align Urgent Community Response across both systems, enabling rapid assessment and treatment in people’s usual place of residence, avoiding unnecessary conveyance and admission, and ensuring consistent access regardless of location.

Intervention 4 - Expanded sub-acute and same day diagnostic provision	How we will get there
Providing timely assessment and treatment outside acute settings, reducing avoidable ED attendances and admissions.	We will expand and standardise sub-acute and Same Day Emergency Care pathways, including integrated frailty and children and young people pathways, supporting timely assessment, diagnostics and treatment without defaulting to inpatient admission.
Intervention 5 - Improved acute emergency care pathways	**How we will get there**
Ensuring that people with time critical needs receive rapid, high quality care through: • Improved Emergency Department flow • Enhanced Same Day Emergency Care and acute frailty services • Integrated mental health support within the Emergency Department • Expanded Urgent Treatment Centre service • Reduced length of stay in the acute sector	We will protect acute and emergency services for those with time-critical or complex needs by ensuring effective front-door models, consistent triage and clear pathways into community, sub-acute and recovery services.
Intervention 6 - Recovering independence and improving discharge pathways	**How we will get there**
Enabling timely discharge and recovery through: • A fully embedded Intermediate Care model • Rehabilitation and reablement pathways improvement to support reablement • Stronger links to Voluntary and Community Sector and community support • Reduced length of stay and improved patient experience	We will prioritise timely discharge and recovery by strengthening integrated reablement, rehabilitation and discharge pathways across Leicestershire and Northamptonshire, enabling people to return home or move to the most appropriate setting without delay.

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

5.3.3 NEIGHBOURHOOD MODEL OF CARE

Our ambition for Neighbourhoods

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

Background and Strategic Context

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

The Neighbourhood model

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

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

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

Key interventions we plan to make

Intervention1 - Design services around population need and inequality

Neighbourhoods will use data and insights to:

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

Intervention 2 - Shift care to proactive neighbourhood delivery

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

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

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

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

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

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

Intervention 4 - Enable integration through infrastructure and enablers

Neighbourhoods will be supported by:

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

Intervention 5 - Build sustainable neighbourhood systems

Neighbourhoods will embed:

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

How we will get there

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

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

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

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

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

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

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

Scale Integrated Neighbourhood Teams

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

Establish NHCs

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

Redesign Community and Elective Pathways Around Neighbourhoods

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

Strengthen Urgent Community Pathways

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

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

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

Enable Integration Through Digital and Data

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

Align Governance, Contracting and Workforce to Neighbourhood Delivery

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

5.4 OUR STRATEGIC TRANSFORMATION PRIORITIES

5.4.1 FRAILTY

Our ambition for frailty care

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

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

Background and strategic context

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

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

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

Key interventions we plan to make

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

Intervention 1 - Personalised care delivered closer to home:
Strengthen neighbourhood-based models to identify people living with frailty earlier and provide personalised, proactive support through shared, comprehensive care plans. Care will focus on what matters to individuals, maintaining independence, preventing deterioration, and reducing avoidable escalation or crisis.

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

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

Intervention 3 - Rapid hospital-based assessment without admission

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

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

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

Intervention 5 - Resilient communities, carers and workforce

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

How we will know we've succeeded

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

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

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

How we will get there

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

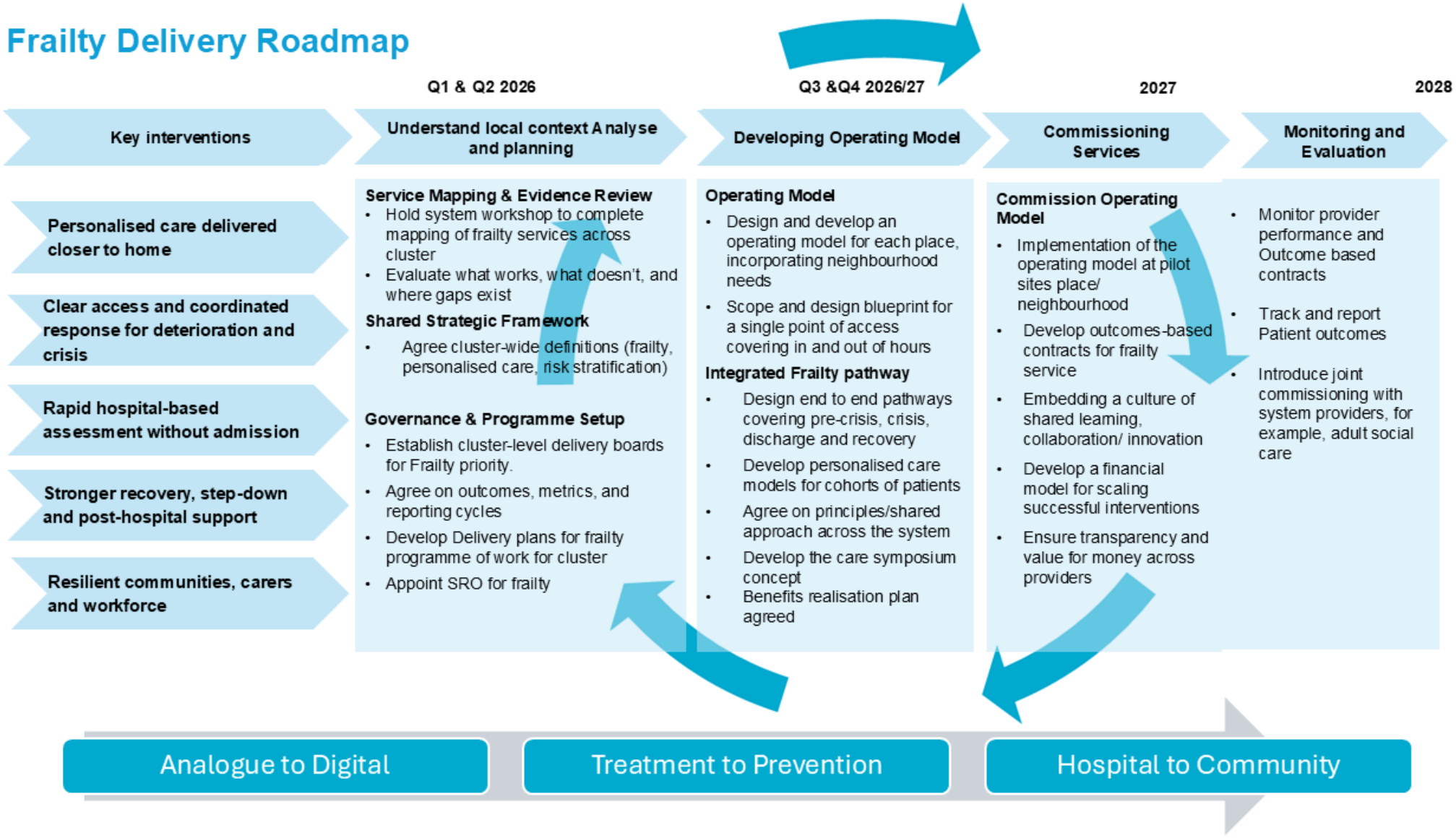


Figure 7 – Delivery road map for frailty care commissioning

5.4.2 PREVENTABLE MORTALITY

Our ambition for preventable mortality

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

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

Background and strategic context

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

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

Key interventions we plan to make

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

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

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

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

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

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

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

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

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

How we will know we've succeeded

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

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

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

How we will get there

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

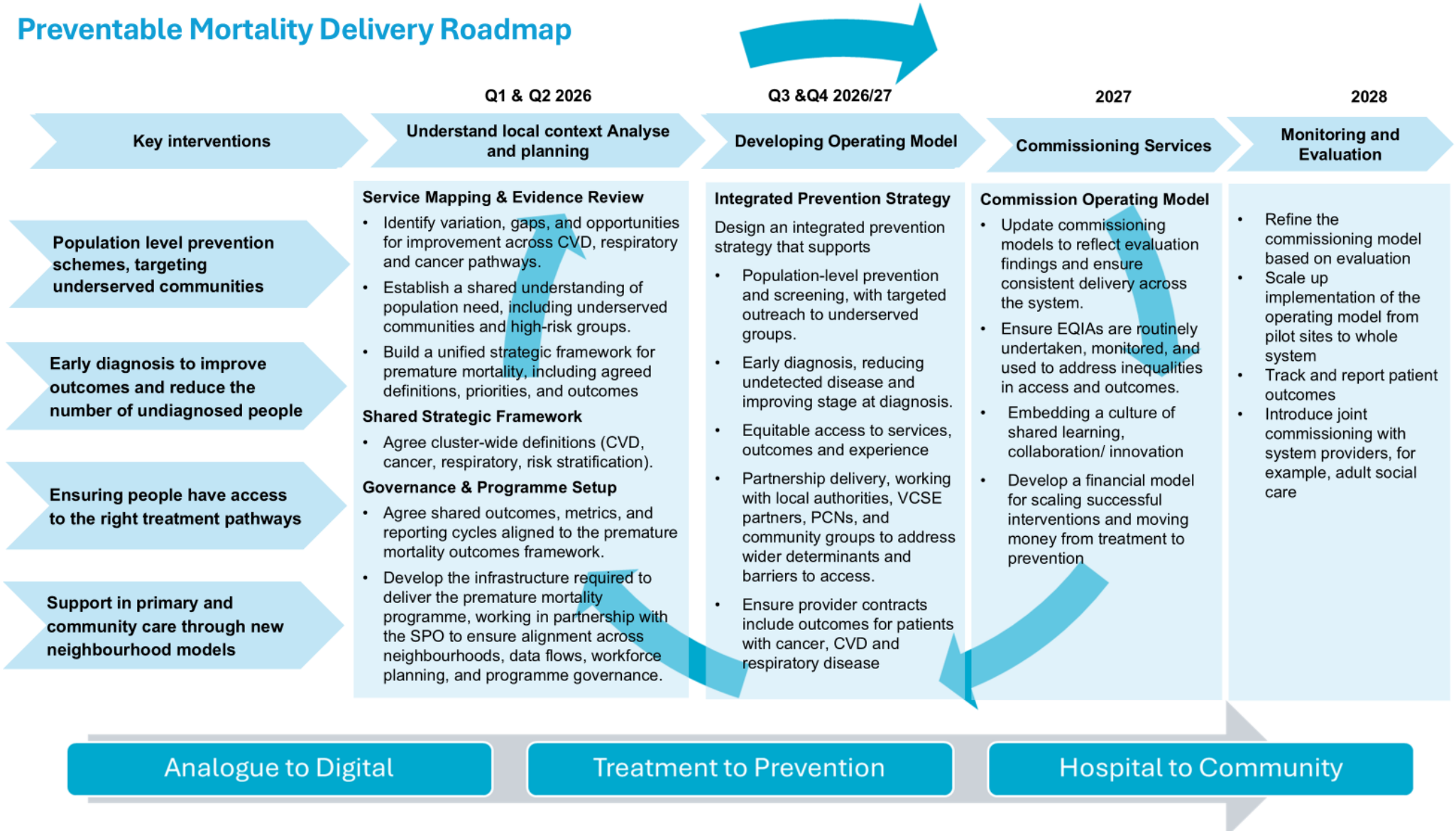


Figure 8 – Delivery roadmap for commissioning preventable mortality interventions

5.4.3 CHILDREN & YOUNG PEOPLE – Mental Health and Neurodiversity

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

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

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

Background and Strategic Context

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

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

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

Key interventions we plan to make

Intervention 1 – Optimise ASD and ADHD diagnostic pathways

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

Intervention 2 – Develop a consistent early intervention and navigation approach

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

Intervention 3 – Integrate Mental Health Support Teams and neurodiversity roles within schools
Supporting earlier identification, timely intervention and wrap-around support for children, young people and families.

Intervention 4 - Develop CYP specific neighbourhood MDTs
Building on learning from ageing well programmes, but tailored to the needs of children, young people and their families.

Intervention 5 – Mobilise and mature the CYP Lead Provider model in Northamptonshire
Commissioning towards outcome-based contracts, strengthened accountability and meaningful VCSE involvement.

Intervention 6 - Strengthen transition across the life course
Ensuring planned, supported and seamless transitions between early years, school, adolescence and adult services, with a specific focus on vulnerable groups and reducing drop-out at points of transition.

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

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

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

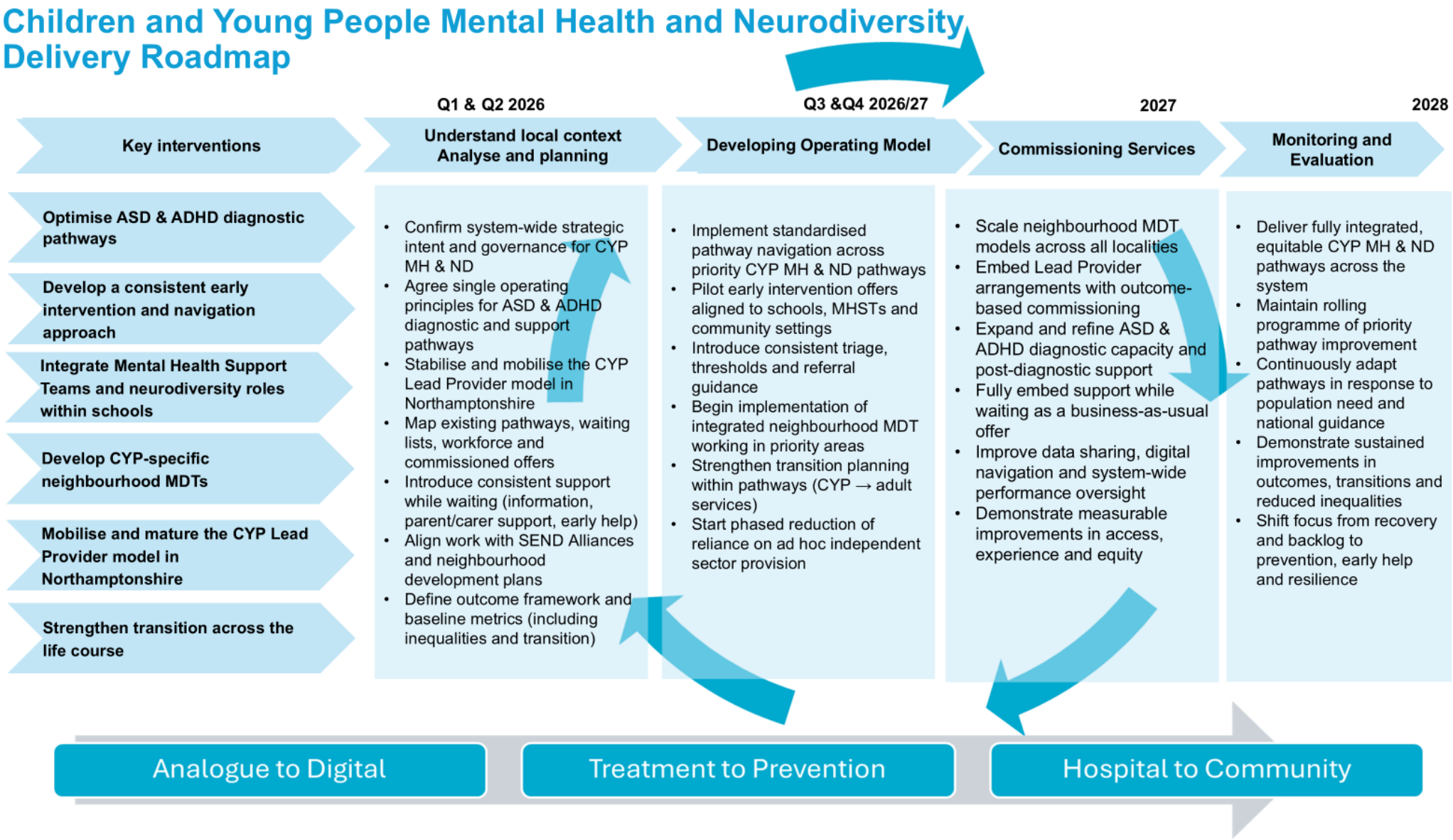


Figure 9 – Delivery roadmap for CYP mental health and neurodiversity care commissioning

6. TRANSFORMATION AND NEW CARE MODELS

Our approach to transformation

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

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

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

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

Community capacity transformation

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

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

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

Embracing new system architecture

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

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

Ensure Value for our Population

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

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

7. FINANCE

Background and Strategic Context

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

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

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

Across both ICBs, the system is experiencing:

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

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

How we are getting there

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

introduction changes the nature of service delivery. With a clear vision of how service provision will need to change, and mindful of the constraints of the resources available to us, we will set out on a journey to develop and implement a long-term population health strategy
The finance directorate will use insights predictive modelling and take a lead in developing strategic purchasing and market shaping functions, providing clear incentives to providers to change their service delivery models and evolve market capacity and capability from where it is today to where it needs to be to provide long term financial sustainability. This will require progressive change over a multi-year timeframe, driven by testing innovative approaches and assessing benefit in a rapid and controlled cycle.

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

A Shared Financial and Strategic Framework

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

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

Transforming Key Patient Pathways

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

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

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

Redesigning Financial Flows to Support Transformation

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

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

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

Enabling Conditions for Delivery

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

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

Our Trajectory

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

Our Route to Sustainability

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

8. DIGITAL

Background and strategic context

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

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

Digital as part of strategic commissioning

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

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

Population health management and use of data

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

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

Digital inclusion and equity

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

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

Workforce enablement and capacity

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

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

Investment and funding approach

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

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

Governance, leadership and alignment

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

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

9. WORKFORCE

Our revised workforce role

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

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

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

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

Our workforce: Strategic commissioning capacity, capability and development

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

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

10. ESTATE & FACILITIES

Background and strategic context

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

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

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

Where we want to be

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

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

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

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

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

11. RISKS TO DELIVERY

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

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

Glossary of terms used

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

NHS
Northamptonshire
Integrated Care Board

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

HEALTH AND WELLBEING BOARD: 26 FEBRUARY 2026

REPORT OF NORTHAMPTONSHIRE AND LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARDS

NHS TRANSFORMATION AND TRANSITION

Purpose of report

1. The purpose of the report is to provide an update and overview on the NHS transformation and transition for Integrated Care Boards.

2. The Health and Wellbeing Board is an important stakeholder in NHS policy and therefore this information provides an update for members to be aware.

Recommendation

3. The Board is asked to note the position of the NHS transformation and change agenda.

Policy Framework and Previous Decision

4. The NHS changes are in response to a national policy decision to reduce the burden of bureaucracy and its spend on management infrastructure.

5. The reductions required are in the context of changing the remit and responsibilities of ICBs to enable:
    - ICBs to become strategic commissioners, and a national policy document called ‘model ICB’ and ‘strategic commissioning framework’ has been published to support design of the new ICB;
    - Commission services to enable the three national shifts (hospital to home; analogue to digital; cure to prevention).

Update

6. In January 2026, a major milestone has been reached in the ongoing development of the new ICB cluster covering Leicester, Leicestershire, Rutland and Northamptonshire.

7. The new cluster was approved last year as part of a national move to transform the roles of ICBs into Strategic Commissioners and aligning with a new national Model ICB Blueprint which outlines core roles and functions while also significantly reducing the running cost budgets – a 33 percent for LLR and 29 per cent for Northamptonshire.

8. In our new Cluster, while both organisations have continued to exist as statutory bodies, we are increasingly working as one and this week marked the start of a staff consultation as we start moving towards a unified staffing structure for both organisations.

9. This Management Of Change (MOC) for staff follows the recruitment and appointments to the Joint Executive Team carried out last year and involves all staff across both organisations with teams and functions being brought together to serve across the LLR and Northamptonshire areas and fulfil the organisations' refreshed role.

10. The consultation will run until March 5 during which there will be full engagement with staff to get views on proposed functions, structures and how they will fulfil the purpose of the organisation.

11. The MOC follows the first round of Voluntary Redundancy while a second round will commence shortly. It is anticipated ultimately there will be a reduction of 30% in the new cluster structure.

12. A full support package has been developed to assist staff during this process including face to face drop in sessions, access to health and wellbeing support, support in CV development and financial support and advice.

13. The enclosed Appendix details the changes the ICB is progressing with, whilst setting out the new geography, population and impact for the citizens of LLR and Northamptonshire.

Consultation/Patient and Public Involvement

14. The infrastructure of the ICB does not require public consultation, however all staff affected are being formally consulted with.

15. Through engagement with established community groups, updates are being provided, as appropriate, with our communities on the programme of change recognising the sensitivity and the impact on those employed by the ICB

Appendices

Appendix – Presentation slides containing summary of ICB changes

Officer to contact

Matt Gaunt, ICB Chief Finance Officer

Email: m.gaunt@nhs.net

Relevant Impact Assessments

Equality Implications

16. A Equality Impact Assessment has been completed for those affected by the change directly and has been developed in partnership with Union representatives. This is not a public document and includes information regarding employed staff

17. A national and local review of the Equality and Quality impacts of the national policy is on going and will become a public document when appropriately completed

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Transformation of ICBs

Building a cluster for Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB

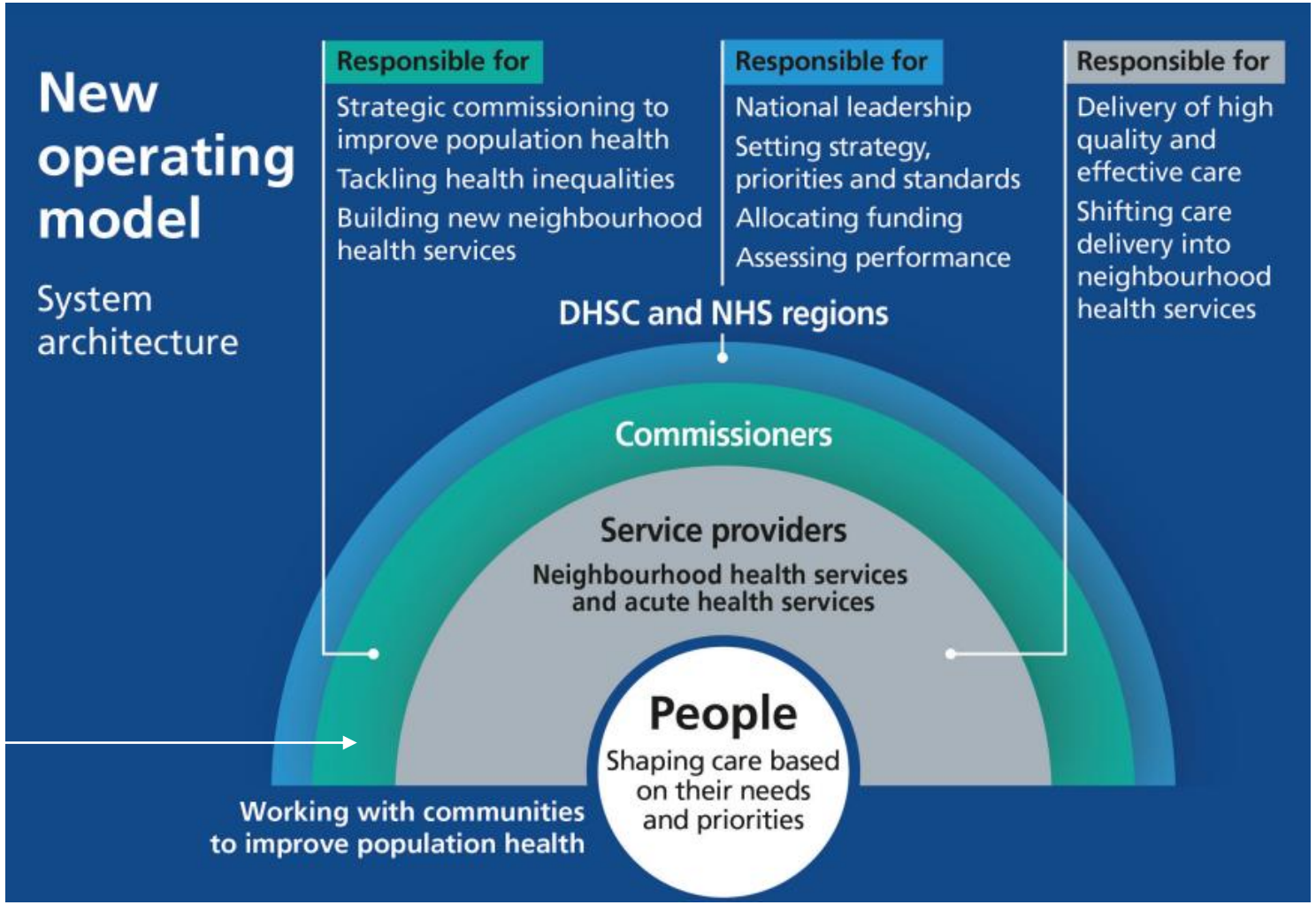
Purpose of this pack

Provides details on the development of new ICB Cluster serving Leicester, Leicestershire, Rutland and Northamptonshire

Shows how our cluster aligns with new national expectations and while focusing on local priorities

Outlines proposed new governance arrangements to drive forward our new operating model and ways of working while further strengthen partnership working

ICBs' refreshed role in new national operating model



Why is change required

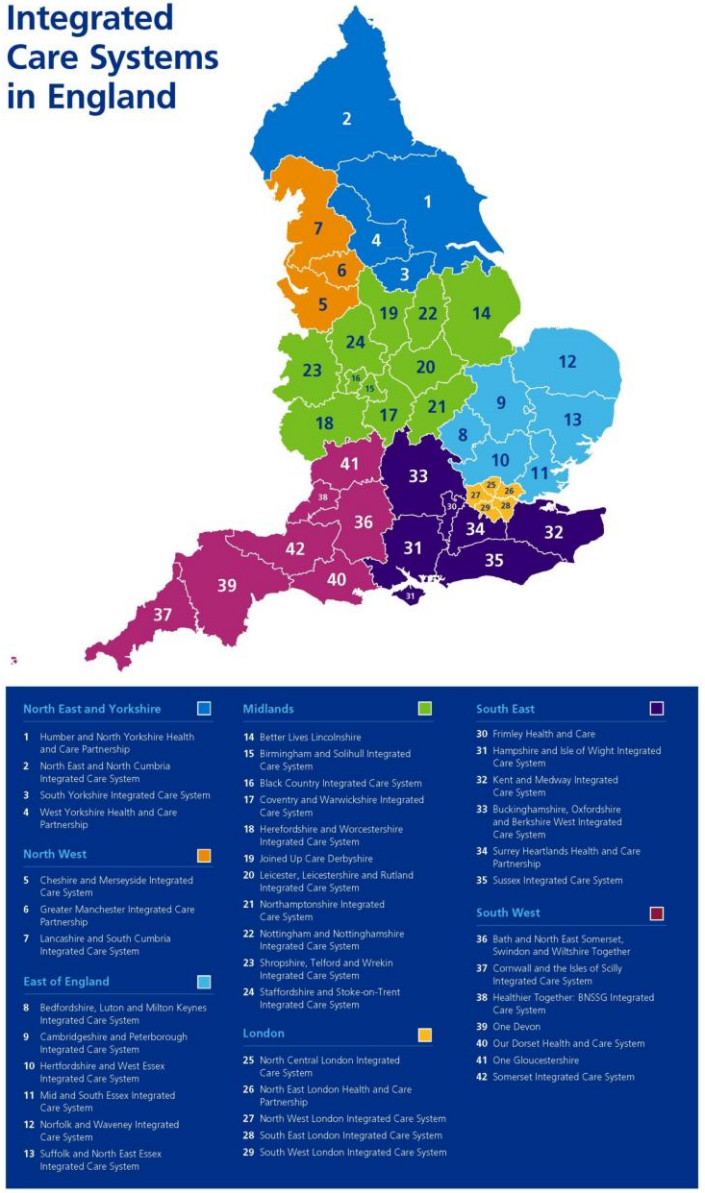
A refreshed and refocused role to ICBs. The national Model ICB Blueprint outlines the crucial function of ICBs in the delivery of the NHS 10 Year Health Plan in acting as **strategic commissioners**, improving population health outcomes, reducing inequalities, setting strategy and ensuring effective use of NHS resources to deliver maximum benefit for their population

Revised resourcing envelop for ICBs to operate within. ICBs across the country have been tasked with reducing costs by an average of 50% nationally to meet the expectation of costing £19.40 per head of population. In LLR this represents a revenue reduction of 33 % and in Northamptonshire 29%

Increased focus on collaboration across regional footprints. The Model ICB Blueprint outlines functions and activities where ICBs could come together to deliver at a larger scale. The blueprint also points to areas which can be delivered by local organisations other than ICBs and those areas which should be delivered by different regional or national structures.

National Response

- There are 42 ICBs in England
- The vast majority of these are now entering clustering arrangements to help them rise to the outlined challenges
- In the Midlands NHS England has agreed that the 11 ICBs will form five clusters
- These are:
  - **Leicester, Leicestershire and Rutland with Northamptonshire**
  - Derbyshire with Nottinghamshire and Lincolnshire
  - Birmingham and Solihull with Black Country
  - Staffordshire and Stoke-on-Trent with Shropshire, Telford and Wrekin
  - Coventry and Warwickshire with Herefordshire and Worcestershire



What our clustering means

- Both LLR and Northamptonshire ICBs will remain as separate statutory bodies working in partnership

- The organisations will have:
  - Single Board Governance
  - A unified leadership team
  - Shared staffing structure

- Building a transformational cluster between NICB and LLR ICBs provides us the opportunity to drive forward the Ten-year-Plan within our communities and neighbourhoods, continue to improve health outcomes, while at the same time rise to the very real financial challenges we face.

- We are still at the early stages of building this cluster and there are still many details yet to be finalised including how individual functions will operate within it

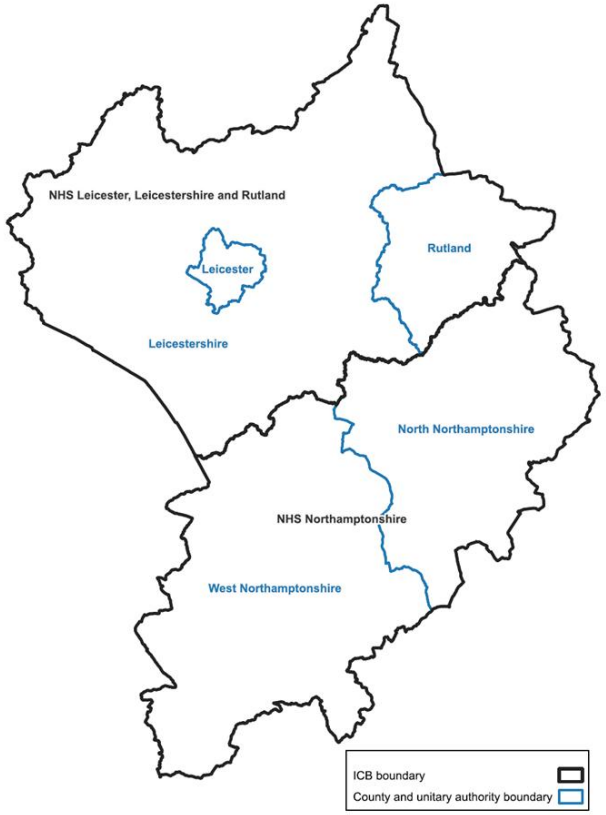
Our geography

£5bn
total budget

5 Provider Trusts

42 Primary Care Networks

5 Upper-Tier Local Authorities



Population:
2m

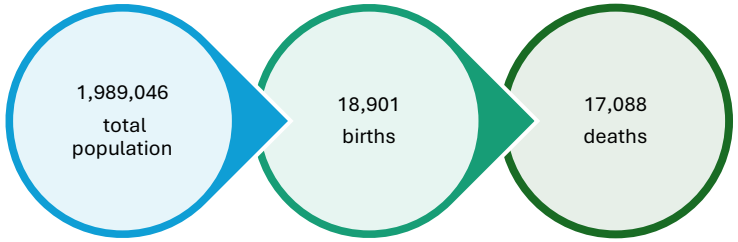
5 Places

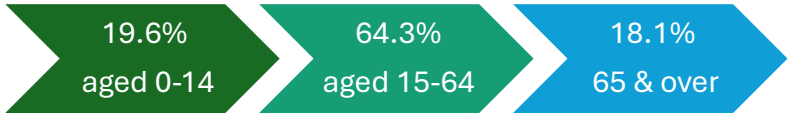
20
neighbourhoods

5 Health Overview Scrutiny Committees

Our population

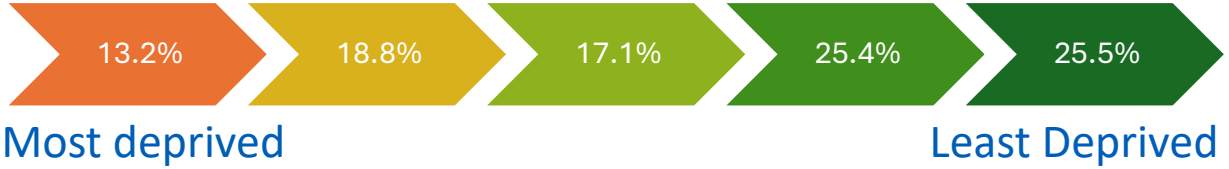
In 2024





Deprivation

13% of the LNR population live in Core 20 areas



In the 2021 Census

- Ethnicity:
  - 78.8% White
  - 13.3% Asian, Asian British or Asian Welsh
  - 3.6% Black, Black British, Black Welsh, Caribbean or African
  - 2.6% Mixed or Multiple ethnic groups
  - 1.6% Other ethnic group
- Health Status
  - 83% Good or very good health
  - 12.4% Fair health
  - 4.5% Bad or very bad health
- Disability
  - 16.2% Disabled under the Equality Act
  - Provision of unpaid care
  - 8.4% of population age 5 and over provide unpaid care with 1.2% providing 20 or more hours per week
- Sexual Orientation
  - 1.2% of over 16 year olds are Gay or Lesbian
  - 1.2% are Bisexual
  - 0.3% are Other Sexual Orientation
  - 7.6% chose not to answer

Our population

Outpatients

- 610,622 1st Outpatients
- 1,127,166 Follow Up Outpatients
- 1,737,788 Total Outpatients

Inpatients

- 251,257 Day Cases
- 34,939 Ordinary Elective Spells
- 286,196 Total Elective Spells; 85,408 Elective Bed Days
- 227,041 Total Non-Elective Spells; 1,073,675 Non-Elective Bed Days

A&E Attendances

- 597,416 A& E Attendances (Type 1 and 2)
- 879,524 Total A&E Attendances

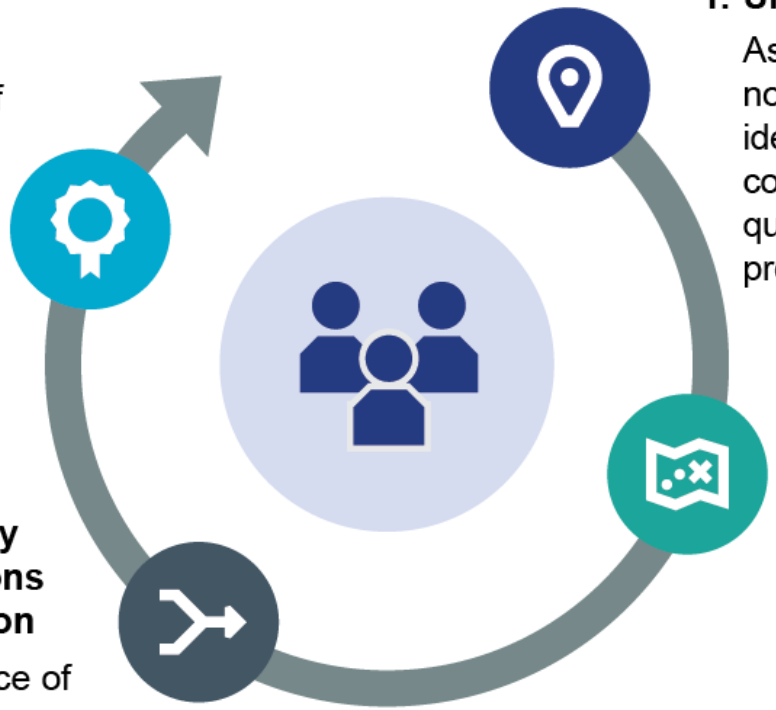
Our focus – The Strategic Commissioning Approach

1. **Understanding local context**
   Assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision

2. **Developing long-term population health strategy**
   Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence

3. **Delivering the strategy through payer functions and resource allocation**
   Oversight and assurance of what is purchased and whether it delivers outcomes required

4. **Evaluating impact**
   Day-to-day oversight of healthcare usage, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes



Our focus – underpinning strategic commissioning

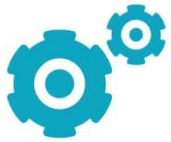
Improve population health and ensure access to consistently high-quality services

Commission, invest in and evaluate services to improve outcomes and reduce inequalities

Accountable for health budgets – ensuring best value now and in the future

Align resources strategically with long-term health objectives

Lead population health strategy – evidence-based and long-term focus



Manage clinical and financial risks across the system

Our leadership

Toby Sanders
Chief Executive
Northamptonshire ICB
Interim Chief Executive
LLR ICB

Anu Singh
Joint Chair
LLR and Northamptonshire ICBs

Northamptonshire non-executive team

Simone Jordan, Non-Executive Member

Liz Gaulton, Non-Executive Member

Andrew Hammond, Non-Executive Member

Afzal Ismail, Non-Executive Member

Partner Members

Anna Earnshaw	**- Local Authorities**
Adele Wylie	**- Local Authorities**
Angela Hillery	**- NHS and Foundation Trusts**
Richard Mitchell	**- NHS and Foundation Trusts**
Dr Jonathan Cox	**- Primary Medical Services**

LLR non-executive team

Simone Jordan, Non-Executive Member	Liz Gaulton, Non-Executive Member	Andrew Hammond, Non-Executive Member	Afzal Ismail, Non-Executive Member

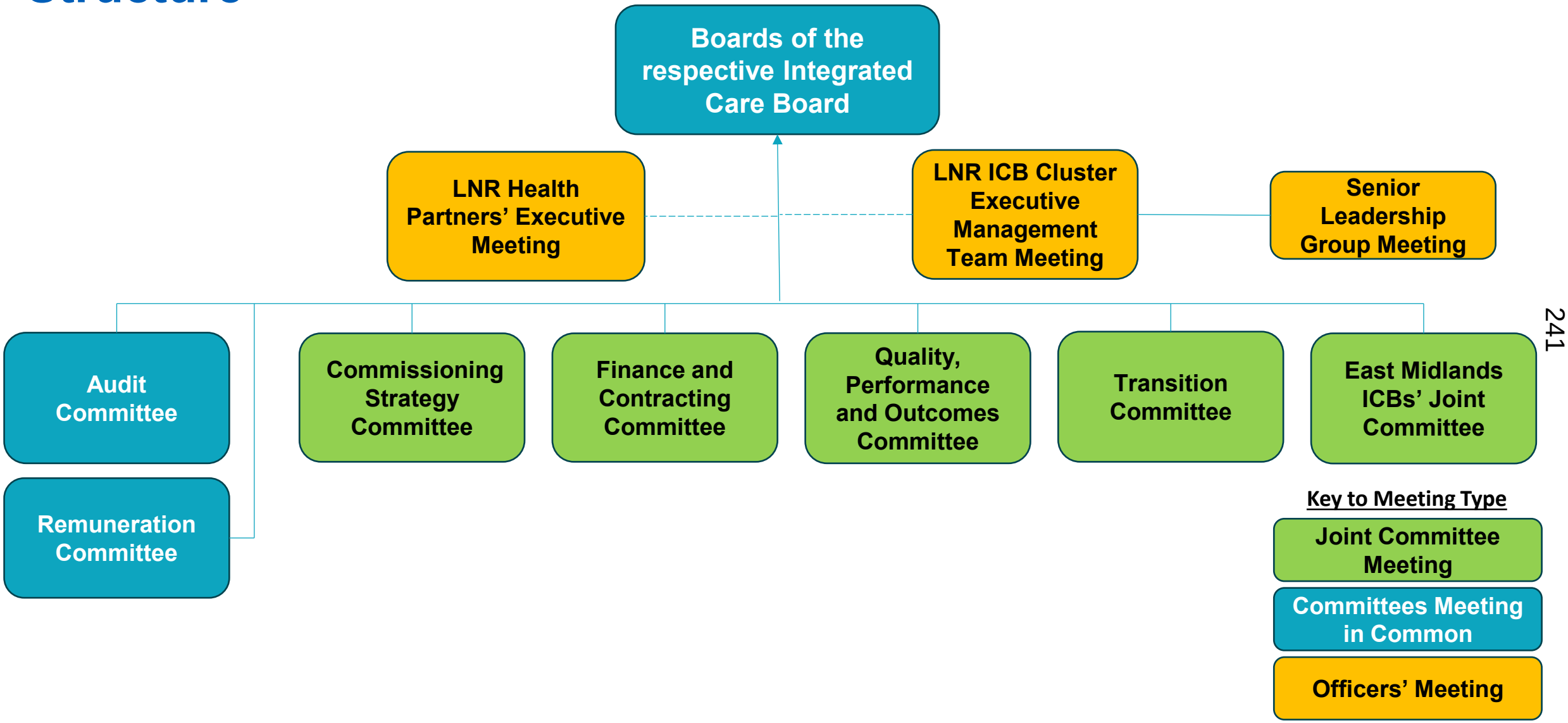
Sector representatives

- Richard Mitchell, Partner Member, Acute sector representative
- Angela Hillery, Partner Member, Community/Mental Health sector representative
- Laurence Jones, Partner Member, Local authority sectoral representative
- Mike Sandys, Partner Member, Local authority sectoral representative
- Mark Andrews, Partner Member, Local authority sectoral representative
- Dr James Ogle, Partner Member, Primary Medical Services

Participants

- Richard Henderson, Chief Executive, East Midlands Ambulance Service
- Harsha Kotecha, Chair, Healthwatch Leicester and Leicestershire
- Dr Janet Underwood, Chair, Healthwatch Rutland

Proposed respective ICB Board and Committee Structure



What next?

- A full management of change process has now commenced with all staff being consulted on proposals to move the organisations into a single staff structure refocused on the new role of the ICB and within the new reduced financial envelope.

- In addition to this a first round of Voluntary Redundancy applications has taken place with a total of 92 applications having been approved. A second round of VR will take place in the coming weeks.

- This consultation will finish on March 5. Following this all representations will be considered and proposed structures revisited before final decisions are taken.

- Extensive staff support programme and resources have been put in place to give advice and guidance to staff groups in what remains a very difficult time

- This includes face to face drop-in sessions, access to health and wellbeing support, support in CV development and financial support and advice.

What next?

There are a number of other workstreams which are part of this transformation of the form and function of the ICB which have reached significant milestones. These include:

- **At scale**
  - Work with regional colleagues looked at a range of functions which could be delivered at a greater scale.
  - The majority of these will not come to fruition and the programme to explore options have been stopped. Those continuing and therefore likely to be delivered at a wider scale rather than within the cluster are data and at scale analytics which may feature at a national level depending on national decisions, and Pharmacy, Ophthalmic, Dental (POD) which will continue to be delivered at scale

- **Transfer to provider or partner organisation**
  - Some areas of ICB activity were identified nationally as being better placed within provider or partner organisations.
  - As a result some functions and responsibilities will be transferring to partners over the next few months.
  - These areas include Workforce Development, System Coordination Centres, Strategic Digital, Personalisation Section 117s, GP IT,

- **Functions transitioning to region**
  - Provider oversight
  - Operational workforce planning

- **Functions now being retained within the cluster**
  - Medicines optimisation; primary care estates and infrastructure, Emergency Preparedness and Response, Research, Strategic workforce planning, CHC, SEND, Safeguarding and Infection, prevention and control

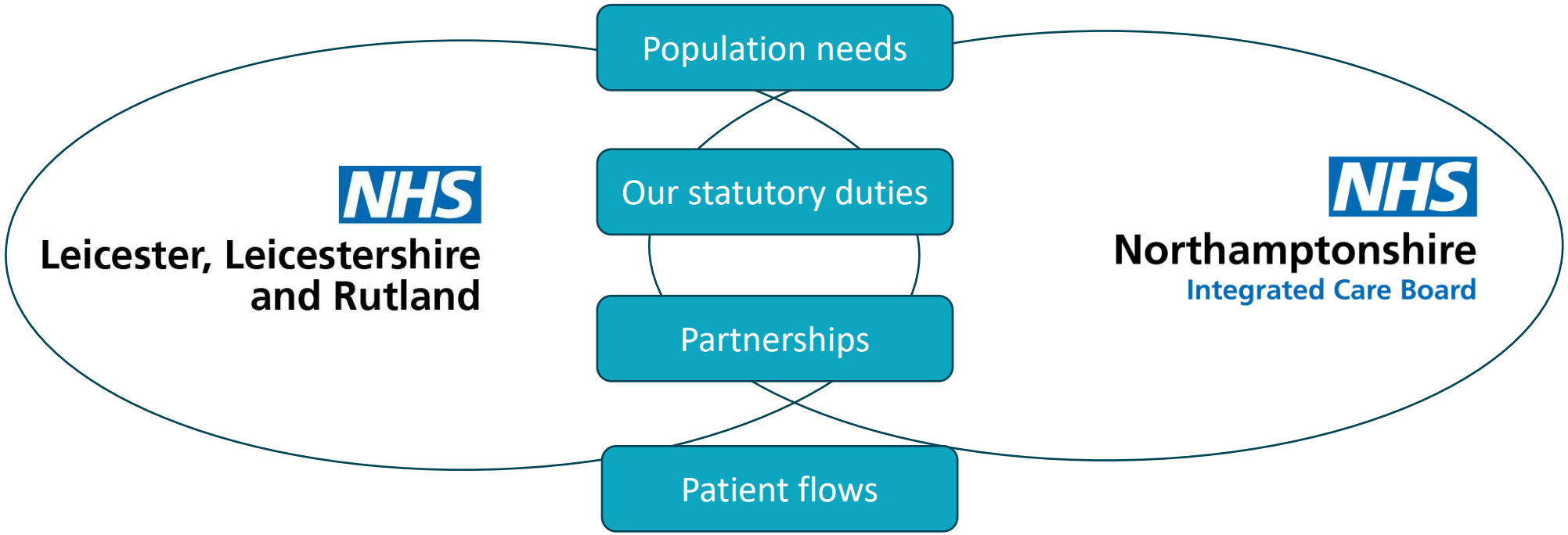
- **Function still being explored into the next financial year**
  - There are a small number of very important areas of work which require further work to understand future roles and responsibilities, whilst also considering national guidance documents
  - These include neighbourhood and place-based partnerships, primary care operations and transformation, pathway and service development

Our design process

Designing the new cluster for LLR and Northamptonshire ICBs will need to meet population needs while reducing running costs

Functions of each ICBs are under review to ensure they align with the Model ICB Blueprint; what to keep, grow, reduce, transfer or stop

Underlying all decisions are:



Agenda Item 13

HEALTH AND WELLBEING BOARD

26 FEBRUARY 2026

REPORT OF THE DIRECTOR OF PUBLIC HEALTH, LAW AND GOVERNANCE

HEALTH AND WELLBEING BOARD GOVERNANCE

Purpose of Report

1. The purpose of this report is to seek the Health and Wellbeing Board's approval for revised Terms of Reference for the Board.

Recommendation

2. It is recommended that the revised Terms of Reference for the Health and Wellbeing Board be approved, including the addition of the following new Operational Delivery Groups:
    - CYP Place Based Group;
    - County Place Based Team.

Policy Framework and Previous Decisions

3. The Terms of Reference of the Health and Wellbeing Board were last updated on 31 October 2023.

Background

4. Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

5. Following the Health and Care Act 2022, clinical commissioning groups (CCGs) were abolished with effect from 1 July 2022 and Integrated Care Boards took on their commissioning functions. The Health and Care Act 2022 did not change the statutory duties of Health and Wellbeing Boards as set out by the 2012 Act though it did replace references to clinical commissioning groups in the 2012 Act with reference to Integrated Care Boards.

6. Chapter 2 Section 194 (2) (f) of the Health and Social Care Act 2012 now states:

"The Health and Wellbeing Board is to consist of—

(a) subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),

(b) the director of adult social services for the local authority,

(c) the director of children's services for the local authority,

(d) the director of public health for the local authority,

(e) a representative of the Local Healthwatch organisation for the area of the local authority,

(f) a representative of each relevant [integrated care board], and

(g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.

7. The Leicester, Leicestershire and Rutland ICB replaced the Leicester City, East Leicestershire and Rutland and West Leicestershire clinical commissioning groups. The ICB manages the budget for the provision of NHS services in LLR.

Current Health and Wellbeing Board membership

8. The current membership of the Leicestershire Health and Wellbeing Board is as follows:
   - Leicestershire County Council Lead Member for Health
   - Leicestershire County Council Lead Member for Adult Social Care
   - Leicestershire County Council Lead Member for Children & Young People
   - Leicestershire County Council Chief Executive
   - Leicestershire County Council Director of Public Health
   - Leicestershire County Council Director of Adults & Communities
   - Leicestershire County Council Director of Children & Family Services
   - Two Clinical representatives of the Clinical Commissioning Groups or health equivalent in the new Integrated Care System including Primary Care Networks.
   - Three non- clinical representatives of the CCGs and or health equivalent in the new Integrated Care System
   - Two representatives of the Local Healthwatch
   - Two elected representatives of the District Councils
   - The Lead District Officer for Health and Housing
   - One representative from Regional NHSEI
   - One representative of the Leicestershire Police
   - One representative of the Office of the Police and Crime Commissioner
   - One representative of the Leicestershire Partnership NHS Trust
   - One representative of the University Hospitals of Leicester NHS Trust

- One representative from the Office of Health Improvement and Disparities
- One representative from Voluntary Action Leicester Shire

9. The Terms of Reference state the quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the CCGs and/or health equivalent in the new Integrated Care System.

Integrated Care Board changes

10. All ICBs in England are being asked to significantly reduce running costs and shift to a more strategic role with different responsibilities for them and other parts of the health and care system.

11. This involves some ICBs working more closely with other ICBs in a 'cluster.' 'Clustering' means that, although individual ICBs will continue to exist, they will work as one – with a single Board, leadership team and staffing structure.

12. NHS England and government ministers approved a new 'cluster' for Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB. This is one of 26 clusters across England. It is anticipated that there will be a workforce reduction of 30% in the new cluster structure.

13. A first round of Voluntary Redundancy applications has taken place with a total of 92 applications having been approved. A second round of Voluntary Redundancies will take place in the coming weeks.

14. Given the reduced workforce at the Leicester, Leicestershire and Rutland ICB, and the need for ICB staff to cover a wider area, the ICB is unable to send as many representatives to Health and Wellbeing Board meetings as it did previously. The ICB has therefore asked to reduce their number of members on the Board.

15. The ICB is unable to allocate any clinical staff to be permanent members of the Health and Wellbeing Board. However, they are able to send clinical staff to Board meetings for specific agenda items where relevant.

16. The ICB will send at least one non-clinical representative to every meeting of the Board.

Proposed amendments to Terms of Reference

17. It is proposed that the formal membership of the Health and Wellbeing Board no longer includes any clinical representatives of the Integrated Care Board. However, clinical representatives will be invited to meetings for specific agenda items.

18. It is suggested that the number of Integrated Care Board non-clinical representatives on the Health and Wellbeing Board be reduced to two.

19. It is proposed that the quorum for the Health and Wellbeing Board should be a quarter of the membership including at least one elected member from the County Council and one representative of the Integrated Care Board or health equivalent in the Integrated Care System.

Vice Chairman

20. Currently the Terms of Reference make no reference to how a Vice Chairman is appointed. It is proposed that this be added into the Terms of Reference stating that the Vice Chairman should be elected at the first meeting each year following the Annual Council meeting. All Board members are entitled to vote on the Vice Chairman.

Healthwatch

21. The Government has announced that Healthwatch functions related to healthcare will in the future be combined with the functions of Integrated Care Boards, and the Healthwatch functions to social care will transfer to local authorities. However, no timescales for these changes have been published and primary legislation will be required to enact them. In the meantime, Healthwatch Leicester and Leicestershire continue to operate business as usual.

22. Healthwatch Leicestershire usually send one representative to Health and Wellbeing Board meetings. It is proposed to reduce the number of Healthwatch representatives on the Health and Wellbeing Board from two to one. This will make it easier for Board meetings to be quorate.

Other members

23. The current Terms of Reference state that the Health and Wellbeing Board membership includes one representative from Regional NHSEI and one representative from the Office of Health Improvement and Disparities. The Board has not had attendance from either of these organisations for some time and therefore it is proposed to remove them from the membership list.

24. The Director Public Health at Leicestershire County Council is now known as the Director of Public Health, Law and Governance to reflect additional responsibilities that have been taken on by that role. The title will need amending in the Health and Wellbeing Board Terms of Reference.

Operational Delivery Groups

25. The Health and Wellbeing Board has four Operational Delivery Groups with the following names:

- Integration Executive;
- Staying Healthy Partnership;
- Children and Families Partnership;
- Mental Health.

26. These groups have their own Terms of Reference but currently they are not listed in the Health and Wellbeing Board Terms of Reference. It is proposed that the names of the Operational Delivery Groups be added to the Health and Wellbeing Board Terms of Reference in order to help increase awareness amongst partners.

CYP Place Based Group

27. Earlier on the agenda for this meeting a report is to be considered proposing that a new Operational Delivery Group named the "CYP Place Based Group" be set up, and the Children and Families Partnership becomes independent of the Health and Wellbeing Board. If that proposal is approved by the Board then the Health and Wellbeing Board Terms of Reference will need to be amended accordingly.

County Place Based Team

28. It is proposed that an additional operational delivery group of the Health and Wellbeing Board is created. This new group (provisionally named the "County Place Based Team") would take on responsibility for oversight of Health and Wellbeing Board activity and integration of neighbourhood models of care work.

29. It is suggested that the newly formed County Place Based Team will:

    - Be chaired jointly by representatives from Leicestershire County Council, and the ICB.
    - Consist of a broad range of partners from teams that include (but are not limited to) Public Health, Children & Family Services, Adults & Communities, the Integrated Care Board, Voluntary sector, University Hospitals of Leicester, Leicestershire Partnership trust, Primary care providers and representatives from each HWB operational working group.

30. Over the past year, The County Place Based Team has operated informally yet effectively supporting the HWB agenda setting process, helping to shape the approach to the JLHWS strategy review, unpicking strategic and operational challenges, reducing duplication of effort and improving communication, engagement and information sharing across system, place and neighbourhood organisations.

Benefits of the Proposed Change

31. The proposed governance arrangements will add value to the work of the HW Board by providing a clearer more joined up approach to system, place and

neighbourhood priorities by aligning the work of both the Neighbourhood agenda and the Health and Wellbeing Board and its subgroups.

32. The group will:

- Create an open forum and dedicated space to celebrate and share good practice and impact, resolve issues and unblock challenges;
- Support HWB agenda setting, future strategy reviews and coordination of the annual report;
- Strengthen the oversight of the JSNA programme of work;
- Identify and address cross-cutting issues affecting population health, the wider system and community wellbeing;
- Coordinate the implementation of neighbourhood working across Leicestershire ensuring consistency while recognising local variation;
- Support the development of proposed neighbourhood models of care and implementation plans;
- Develop a neighbourhood addendum to Leicestershire's Joint Local Health and Wellbeing Strategy.

32. Terms of Reference for the County Place Based Team will be drafted if the Health and Wellbeing Board gives approval for the Team to be set up.

Background papers

Report considered by Health and Wellbeing Board 31 October 2023

https://democracy.leics.gov.uk/documents/s179214/HWB%2024th%20February%20HWB%20Governance%20paper%20v1.pdf

Circulation under the Local Issues Alert Procedure

None

Appendices

Appendix A – Revised HWB Terms of Reference

Officers to contact

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APPENDIX

Leicestershire Health and Wellbeing Board

Terms of Reference

Introduction

The Health and Wellbeing Board has been appointed by the County Council as a subcommittee of the Executive to: -

- Discharge directly the functions conferred on the County Council by Section 194 of the Health and Social Care Act 2012, or such other legislation as may be in force for the time being
- Carry out such other functions as the County Council's Executive may permit.

[Note: The County Council's executive function of approving the Better Care Fund and Plans arising from its use has been delegated to the Health and Wellbeing Board.]

Terms of Reference

The Health and Wellbeing Board shall have the following general role and function: -

To lead and direct work to improve the health and wellbeing of the population of Leicestershire through the development of improved and integrated health and social care services. The Board is responsible for:-

- Preparing and publishing the Leicestershire Joint Strategic Needs Assessment in order to identify the needs and priorities across Leicestershire so that future commissioning/policy decisions and priorities are based on evidence.

- Preparing and publishing a Joint Local Health and Wellbeing Strategy (JLHWS) and associated Plan on behalf of the County Council and its partners.

- Approving the Better Care Fund Plan.

- Publishing and refreshing the Pharmaceutical Needs Assessment to assess the need for pharmaceutical services in Leicestershire and providing an evidence base for future policy and commissioning decisions.

- In conjunction with all partners, communicating and engaging with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing.

- Having oversight of the use of relevant public sector resources to identify opportunities for the further integration of health and social care services.

The Work of the Board

<u>Identifying Needs and Priorities</u>

The Health and Wellbeing Board will take a key role in identifying future needs and priorities in Leicestershire to ensure that its work is based on evidence of needs. The Board will: -

- Ensure that the JSNA and Pharmaceutical Needs Assessment are refreshed, using a variety of tools, evidence and data, including user experience, to support this process.

- Reach a shared understanding of the health needs, inequalities and risk factors in local populations, based on the JSNA and other evidence, and demonstrate how this evidence has been applied to the Board's decisions and strategic priorities.

- Reach a shared understanding of how improvements in outcomes will be monitored and measured, including the benefits of improving integration.

- Ensure that all partners collaborate to use the JSNA and embed a population health management approach across the system to support the delivery of improved outcomes.

- Provide high-level guidance on the development and achievement of Leicestershire's strategic health and wellbeing priorities and outcomes across the Place.

- Adopt a proactive, collaborative approach to the JHWS priorities and delivery plan, setting the agenda around key integration and partnership priority areas, whilst allowing partners to continue to deliver and drive change through the Board's subgroups and partner organisations.

- Consider how wider Leicester, Leicestershire and Rutland (LLR) ICS system health and care priorities are translated and implemented at Leicestershire place and neighbourhood level.

<u>Strategy</u>

The Health and Wellbeing Board will develop, publish and review a Joint Health and Wellbeing Strategy which is developed and owned by all Integrated Care System (ICS) partners. The Strategy will set out key priorities and health and wellbeing outcomes for the Place. The JHWS will act as the Place led plan as required by the ICS to enable one clear vision and create alignment across Place.

The Board will:

- Proactively seek assurance on delivery of the priorities and outcomes set out in the Strategy, including via the Health and Wellbeing Board's sub-groups.

- Monitor the impact of the Strategy through the delivery plan, collectively supporting and constructively challenging progress and performance, taking action as necessary.

- Take account of the recommendations of the Director of Public Health's Annual Report, considering how recommendations are implemented across place.

- Focus collective efforts and resources on the agreed set of strategic priorities for health and wellbeing, as determined from the JHWS recognising the contributions of the wider determinants of health.

- Ensure the work of the Board develops in tandem with other local and national policy developments, dependencies and legislation.

- Establish strong links with the Integrated Care Board and Partnership to ensure both have regard to the Leicestershire JSNA and JHWS.

Integrated Working

The Health and Wellbeing Board will approve and implement plans aligned with the JHWS which will set out how wider determinants of health, care, housing services and prevention will be transformed to provide the people of Leicestershire with better integrated care and support. In addition the Board will:-

- Ensure the Board's work is aligned across the ICS, between system, place and neighbourhood.

- Ensure the Better Care Fund pooled budget and associated Plan is developed in accordance with national guidelines and local priorities.

- Ensure that appropriate partnership agreements, financial protocols, monitoring and risk management arrangements are in place to facilitate the use of the Better Care Fund and other areas of integrated commissioning.

- Ensure that an integrated approach is taken to improving health and wellbeing, including through the wider determinants of health, preventative services and developing asset-based approaches.

- Identify other service areas where place-based and/or pooled budgets would support improvement in outcomes and financial sustainability.

- Make recommendations on the priority of projects and allocation of resources to service providers and/or localities including implementing a preventative approach and reducing health inequalities as appropriate, in order to achieve jointly agreed objectives, noting where appropriate that organisational resource allocation and formal decision making will need to be agreed via the appropriate governance processes.

- Advise on a place based response to service redesign and transformation and operational delivery at system and neighbourhood level which may involve services across Leicester, Leicestershire and Rutland.

Communication and Engagement

The Health and Wellbeing Board will, in conjunction with partners, communicate and engage with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. In support of this, the Board will:-

- Develop and implement a Communications and Engagement Strategy which will focus on how the work of the Board will be influenced by partners and the public, including seldom heard groups, and how the Board will support the specific duties with respect to consultation and engagement on service changes. The Communications and Engagement Strategy will align with and support the delivery of the Joint Local Health and Wellbeing Strategy.

Standing Orders

The Access to Information Procedure Rules and Meeting Procedure Rules (Standing Orders) laid down by the County Council will apply with any necessary modifications including the following:-

The Chairman will be an elected member of Leicestershire County Council's Cabinet.

The Vice Chairman will will be elected at the first meeting each year following the Annual Council meeting

The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the Integrated Care Board~~CCGs~~ and/or health equivalent in the ~~new~~ Integrated Care System.

Membership

The Board will keep its membership under review and make such changes as it feels necessary in accordance with Regulations:

County Council Lead Member for Health

County Council Lead Member for Adult Social Care

County Council Lead Member for Children & Young People

Count Council Chief Executive

County Council Director of Public Health, Law and Governance

County Council Director of Adults & Communities

County Council Director of Children & Family Services

~~Two Clinical representatives of the Clinical Commissioning Groups or health equivalent in the new Integrated Care System including Primary Care Networks.~~

Two~~Three~~ non- clinical representative~~s~~ of the Integrated Care Board~~CCGs~~ and or health equivalent in the new Integrated Care System

One~~Two~~ representatives ~~-~~of the Local Healthwatch

Two elected representatives of the District Councils

The Lead District Officer for Health and Housing

~~One representative from Regional NHSEI~~

One representative of the Leicestershire Police

One representative of the Office of the Police and Crime Commissioner

One representative of the Leicestershire Partnership NHS Trust

One representative of the University Hospitals of Leicester NHS Trust

~~One representative from the Office of Health Improvement and Disparities~~

One representative from Voluntary Action Leicester Shire

Operational Delivery Groups

The Health and Wellbeing Board will have 5 Operational Delivery Groups with the following names:

- Integration Executive;
- Staying Healthy Partnership;
- CYP Place Based Group
- Mental Health.
- County Place Based Team

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