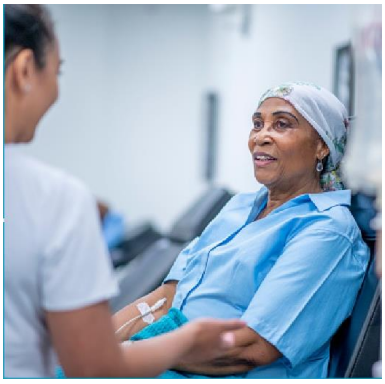
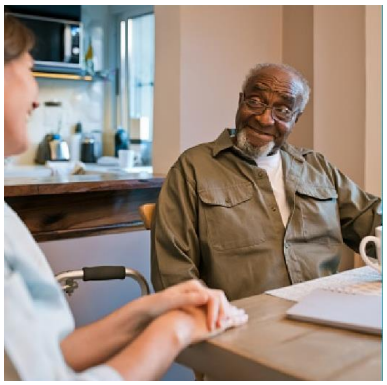
Appendix 2

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

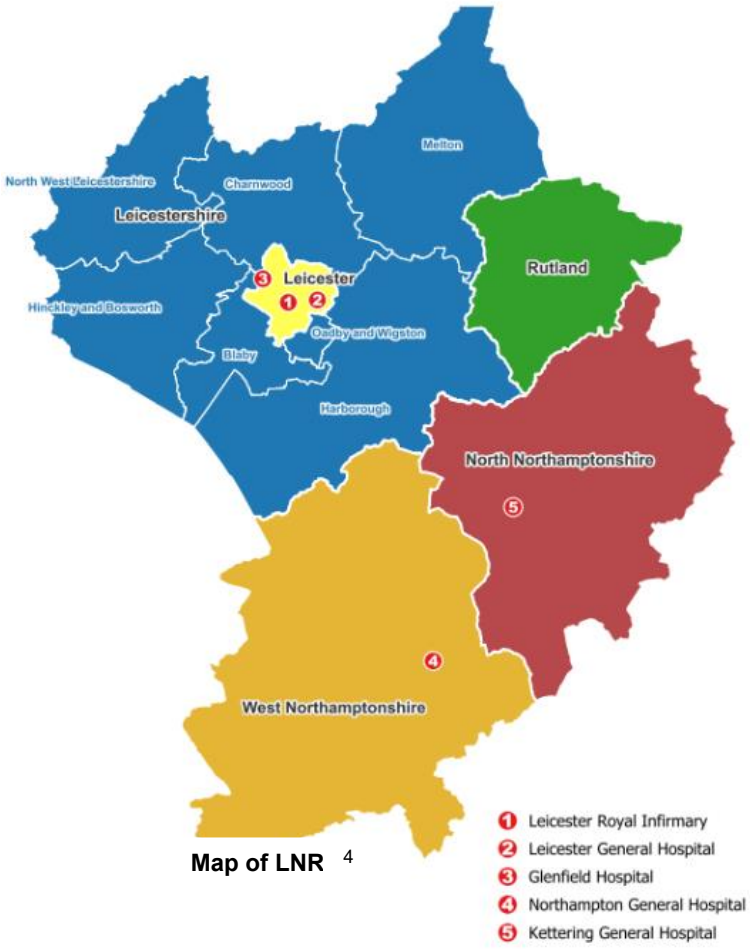
4. ABOUT US

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).

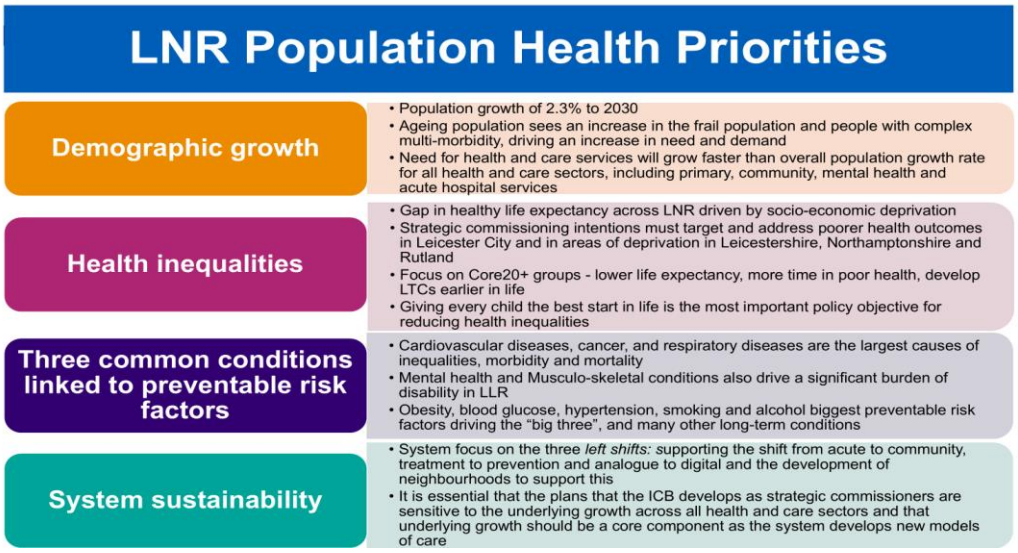


Figure 3 – Our population health priorities.

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

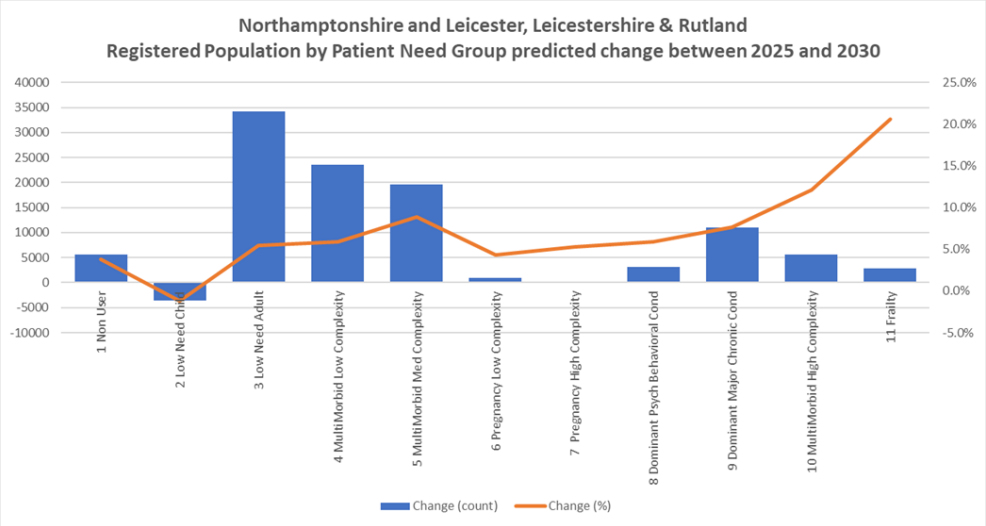


Figure 4 – Our predicted population growth grouped by health need

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.

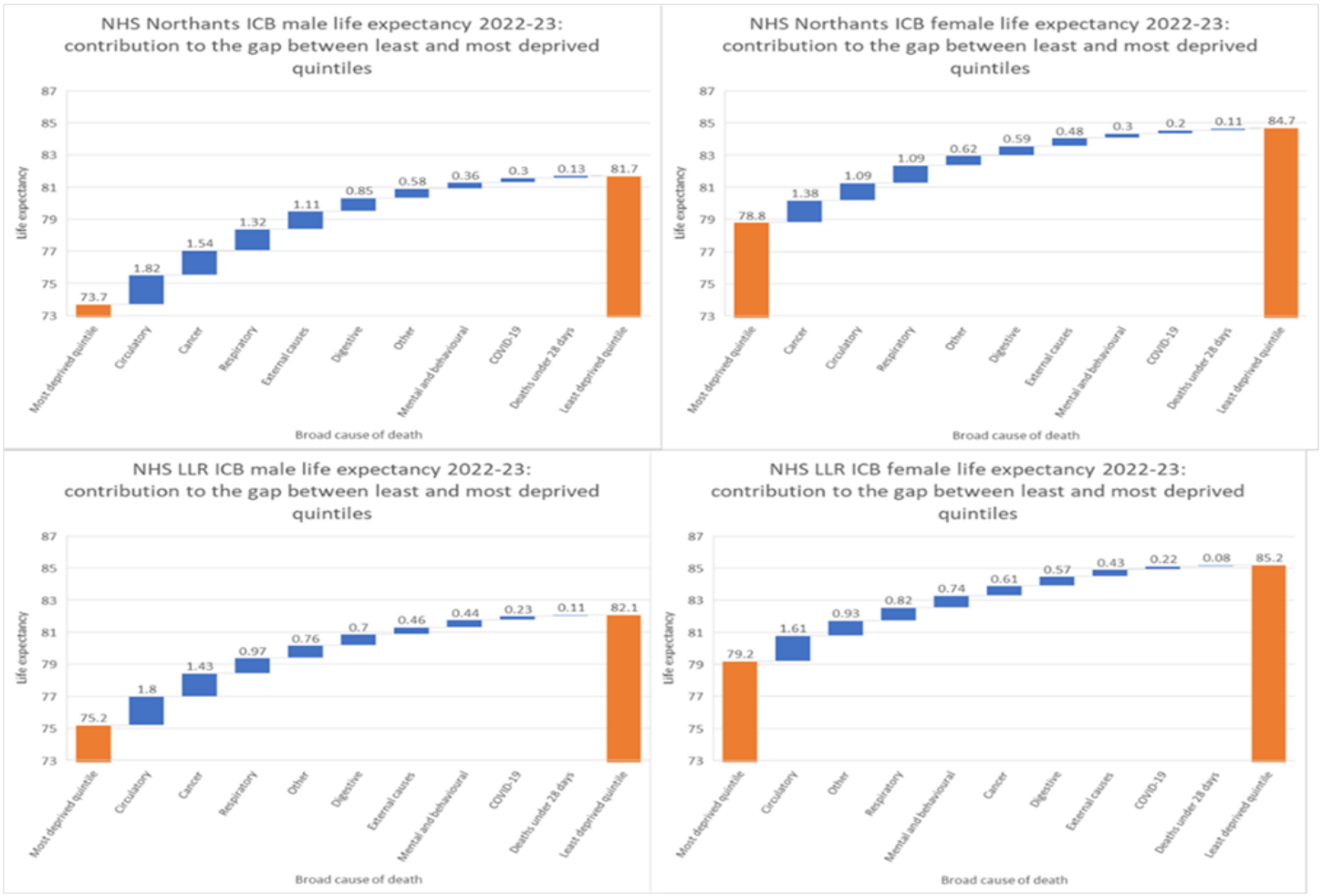


Figure 5 – Inequalities in life expectancy[6]

[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.

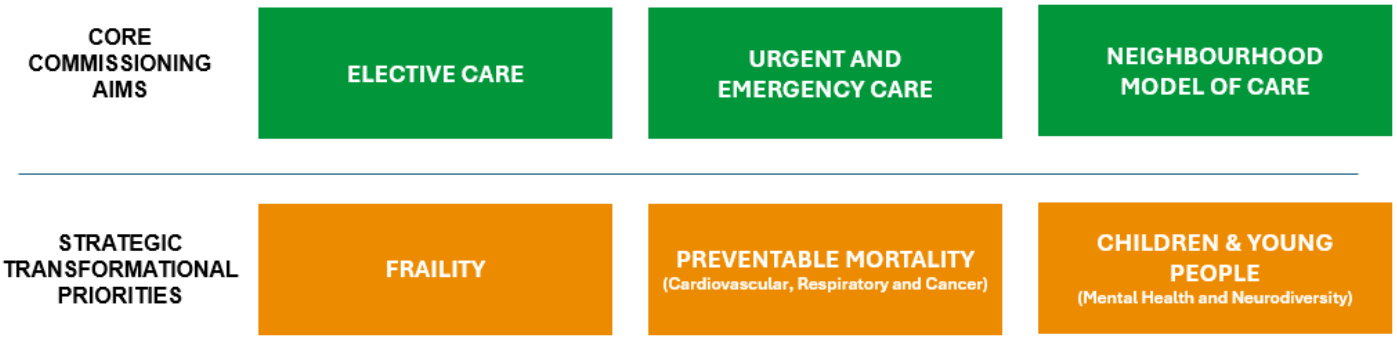


Figure 6 Our Commissioning Intentions

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.

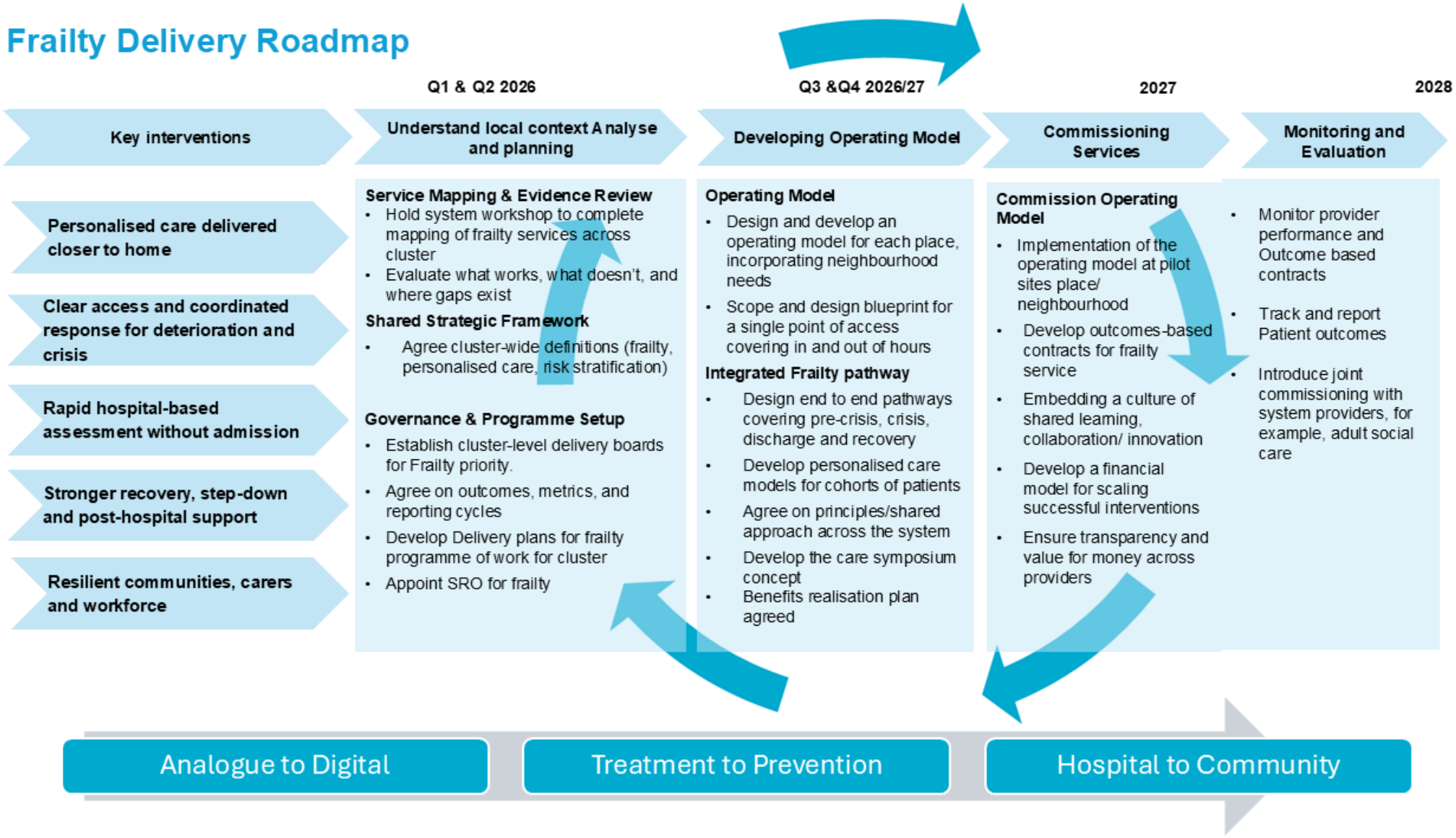


Figure 7 – Delivery road map for frailty care commissioning

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.

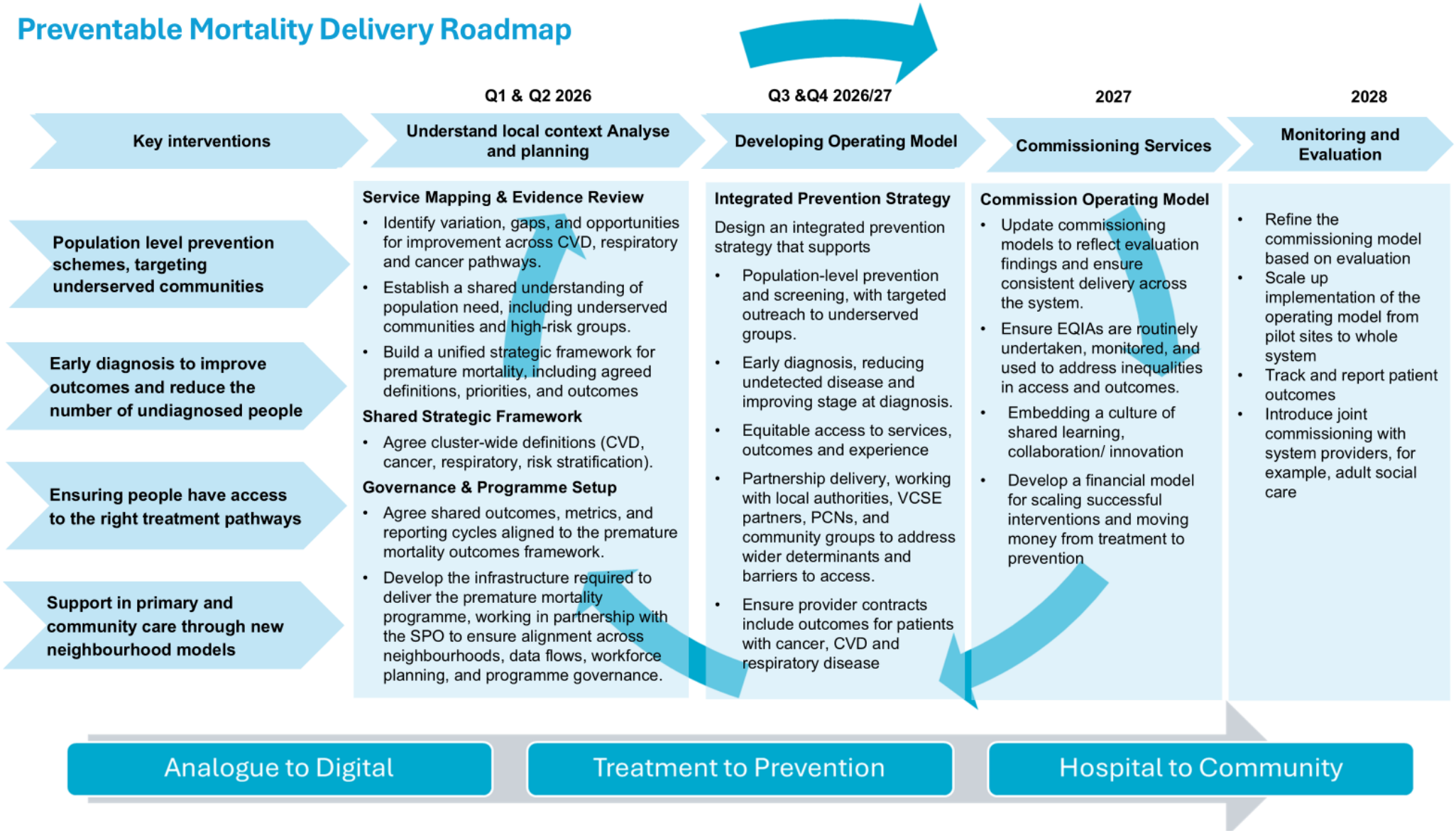


Figure 8 – Delivery roadmap for commissioning preventable mortality interventions

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.

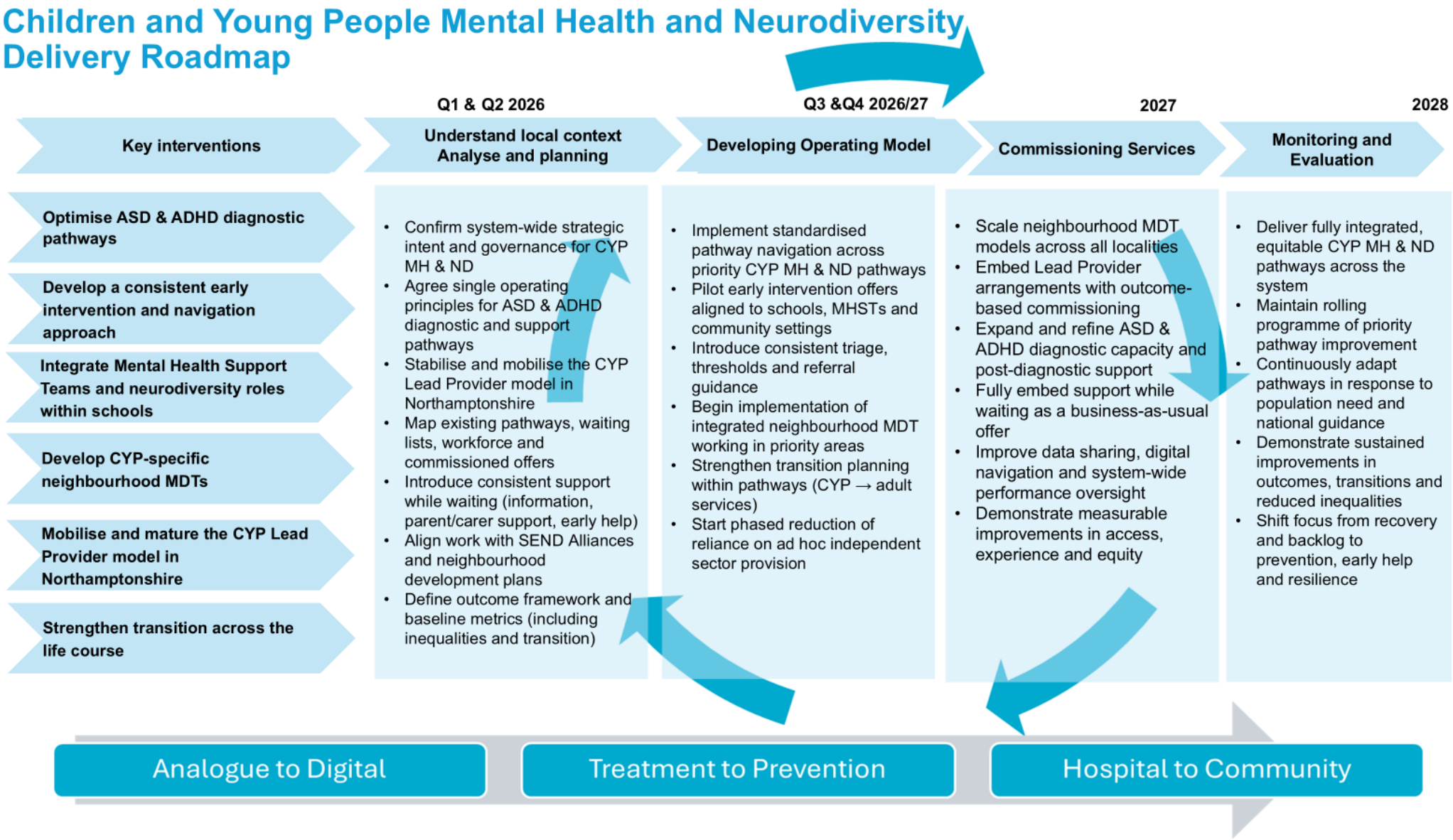


Figure 9 – Delivery roadmap for CYP mental health and neurodiversity care commissioning

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