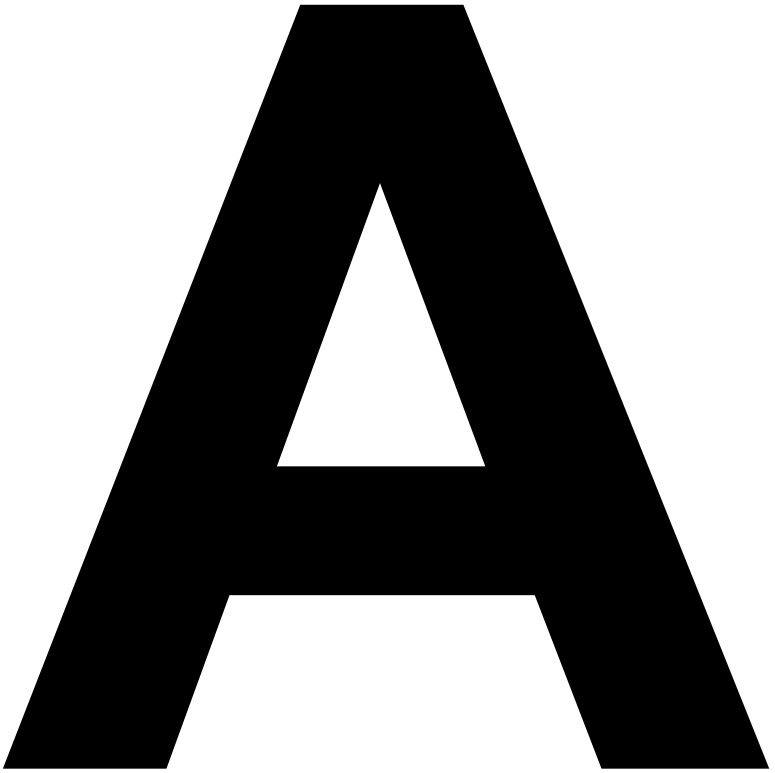
Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 14 July 2022**
Meeting no.	**2**	**Time**	**9:00am – 11:30am**
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/22/10	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/22/11	Apologies for Absence: • Andy Williams (Caroline Trevithick deputising) • Dr Nil Sanganee • Nicci Briggs (Spencer Gay deputising) • Professor Azhar Farooqi • Rachna Vyas (Yasmin Sidyot deputising)	To receive	David Sissling	**Verbal**	9:00am
ICB/22/12	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/22/13	Declarations of Interest	To receive	David Sissling	**Verbal**	9:00am
ICB/22/14	To consider **written questions received in advance** from the Public in relation to items on the agenda	To receive	David Sissling	**Verbal**	9:05am
ICB/22/15	• Minutes of the meeting held on 9 June 2022 • Minutes of the inaugural meeting held on 1 July 2022	To approve	David Sissling	**A** **B**	9:15am
ICB/22/16	Matters arising and actions for the meeting held on 1 July 2022	To receive	David Sissling	**C**	
ICB/22/17	Minutes of the LLR CCGs' Governing Body meetings-in-common held on 28 June 2022 and actions to carry forward *(there are no outstanding actions to carry forward)*	To approve	Caroline Trevithick	**D**	
ICB/22/18	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/22/19	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Caroline Trevithick / Richard Mitchell / Angela Hillery	**Verbal**	9:25am
STRATEGY AND SYSTEM PLANNING					
ICB/22/20	Update on the development of the Health and Wellbeing Partnership	To receive	Sarah Prema	**verbal**	9:35am
ICB/22/21	Specialist Child and Adolescent Mental Health Services and CAMHS Collaborative Progress Update	To receive	Helen Thompson / David Williams	**E**	9:40am

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
OPERATIONAL					
ICB/22/22	LLR System Flow Partnership - briefing	To receive	Jon Melbourne	**F**	10:00am
ICB/22/23	Financial allocations and spend	To receive	Spencer Gay	**G**	10:30am
ICB/22/24	System Finance Report M2	To receive	Spencer Gay	**H**	10:40am
ASSURANCE					
ICB/22/25	Report from the Quality and Safety Committee	To receive	Pauline Tagg	**I**	10:50am
ICB/22/26	System Performance Overview	To receive	Caroline Trevithick	**J**	10:55am
ICB/22/27	Report from the Finance Committee	To receive	Cathy Ellis	**K**	11:10am
GOVERNANCE					
ICB/22/28	Remuneration Committee terms of reference	To approve	Simone Jordan	**L**	11:15am
ICB/22/29	Board Development and Public Engagement Approach	To approve	Alice McGee	**M**	11:20am
ITEMS TO NOTE					
ICB/22/30	Covid briefing and vaccination programme update	To note	Caroline Trevithick	**N**	-
ANY OTHER BUSINESS					
ICB/22/31	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:30am
The inaugural meeting of the LLR ICS NHS Board meeting will take place on **Thursday 11 August 2022, 9:00am to 11:30am, (meeting to be held in public)**, via MSTeams.					



Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Thursday 9 June 2022
9.00am – 11.05am, Via MSTeams

Members present:

Mr David Sissling	Integrated Care Board (ICB) Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, Leicester, Leicestershire and Rutland CCGs and designate ICB Chief Executive
Mr Spencer Gay	Deputy Director of System Finance, LLR CCGs (on behalf of Nicci Briggs)
Dr Nil Sanganee	ICB Medical Director (designate)
Dr Caroline Trevithick	Executive Director of Nursing, Quality and Performance, LLR CCGs and designate ICB Director of Nursing
Ms Sarah Prema	Executive Director of Strategy and Planning, LLR CCGs and designate ICB Director of Strategy
Ms Simone Jordan	Non-Executive Director (designate)
Mr Darren Hickman	Non-Executive Director (designate)
Ms Pauline Tagg	Non-Executive Director (designate)
Mr Richard Mitchell	Chief Executive, University Hospitals of Leicester (UHL)
Ms Angela Hillery	Chief Executive, Leicestershire Partnership Trust
Dr Mike Sandys	Director of Public Health, Leicestershire County Council
Mr Mark Andrews	Chief Executive, Rutland County Council
Mr Martin Samuels	Strategic Director, Social Care and Education, Leicester City Council
Professor Azhar Farooqi	Chair, Leicester City CCG and designate Non-Executive Director
Dr Vivek Varakantam	Chair East Leicestershire and Rutland CCG
Dr Rajiv Wadhwa	Primary Care Sector Representative
Ms Rachna Vyas	Executive Director of Integration and Transformation, LLR CCGs and designate ICB Director of Transformation
Ms Alice McGee	Executive Director of People and Innovation, LLR CCGs and designate ICB Director of People

Participants in attendance:

Mr Richard Henderson	Chief Executive, East Midlands Ambulance Service (EMAS)
Mrs Cathy Ellis	Chair, Leicestershire Partnership Trust (LPT)
Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire

In attendance:

Mr Jon Melbourne	Chief Operating Officer, University Hospitals of Leicester (UHL)
Mr Ian Wakeford	LLR ICS Chief Information Officer (for item 22/107)
Mr Richard Morris	Deputy Director of People and Innovation (for item 22/108)
Ms Chris West	Deputy Director of Nursing, Quality and Performance (for items 22/109- 22/110)
Ms Claire Ellwood	ICS Chief Pharmacist (for item 22/110)
Katherine Packham	Consultant in Public Health, Leicester City Council (for item 22/111)
Mrs Daljit Bains	Head of Corporate Governance
Ms Clare Mair	Corporate Affairs Officer, LLR CCGs (note taker)

Five members of public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
NHSB/22/98	**Welcome and Introductions** Mr David Sissling welcomed everyone to the shadow meeting of the NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB). The meeting was being held in public.	

ITEM		LEAD RESPONSIBLE
	Mr Sissling advised that some attendees were present in a designate ICB capacity whilst others were continuing in their current roles recognising the transition period.	
NHSB/22/99	**Apologies for absence from Members and Participants in attendance:** Apologies for absence were received from the following members: • Ms Nicci Briggs, Executive of Finance, Contracting and Corporate Governance, LLR CCGs and designate ICB Director of Finance (Spencer Gay deputising) • Professor Mayur Lakhani Chair, West Leicestershire and CCG • Dr Anu Rao, Interim ICB Clinical Executive Lead	
NHSB/22/100	**Notifications of Any Other Business** The Chair had not been advised of any other items of business.	
NHSB/22/101	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items.	
NHSB/21/102	**To consider written questions received in advance from the Public in relation to items on the agenda** The following questions had been received in advance from Mr Zuffar Haq. ***Q1) Is the ICB going to responsible for delivering healthcare to the population of Leicestershire?*** The ICB is responsible for planning and funding healthcare for the population alongside our partners who directly deliver services. ***Q2) Will the ICB be the responsible organisation for services provided by UHL, LPT and EMAS as the paymaster.*** The ICB is responsible for working with partners to plan, co-ordinate and fund service provision, however the accountability for service delivery sits with partner organisations who remain statutory organisations. ***Q3) Questions submitted at the last meeting were not answered. Is this because the ICB is not a statutory body?*** The ICB is operating in shadow form until 1 July 2022. It was understood responses had been provided previously via email. *[post meeting note: the responses to questions asked by Mr Haq at the May 2022 meeting of the ICB are appended to these minutes for completeness].* ***Q4) Are the executive team being paid the full ICB salary or at the current CCG role level?*** Salary information is in the public domain and is provided in a structured way within the Annual Reports published on the CCGs' websites. ***Q5) Why are DHU Health CIC allowed to attend ICB meetings as a provider and which other primary care providers will be able to attend? Does DHU attend confidential ICB meetings?*** The ICB was allowed to appoint additional partners to the board from local government, provider trusts and the clinical community through a nomination process. A primary care partner member is currently being sought. Representatives from DHU are not formally part of the ICB but, as the meeting is held in public, they are welcome to attend and observe the meeting. It was clarified that DHU representatives are not in attendance during confidential sessions.	

ITEM		LEAD RESPONSIBLE
	Q6) Does the ICB feel confident that the services currently being provided by LPT and DHU have no quality issues? Reviewing and assuring quality is an ongoing and live process. As issues are identified they are managed and addressed with all providers, LPT and DHU being no different. LPT recently had a follow up visit by the Care Quality Commission (CQC) and showed significant improvements in many areas. The ICB is not aware of any specific concerns with DHU but maintains a continuous process of review. ***Q7) Do any of the ICB members know of any incidents where patients have died in the back of ambulances while outside the Emergency Department?*** It was acknowledged that sadly patients do die in transit or shortly after admission. All deaths in healthcare are subject to a process of review, regardless of circumstance. A response has previously been provided through the FOI process. ***Q8) Which members of the ICB board visited the Emergency Department in the last 6 months, given that patients are waiting hours to be seen?*** Through day-to-day work, colleagues from the ICB visit the Emergency Department and have regular contact with relevant clinical colleagues. UHL are, moreover, represented on the ICB Board. Mr Williams felt it would not be necessary for all ICB members to make such visits although some members had done so over recent months. ***Q9) Organisations are going back to face-to-face meetings. When will ICB meetings be face to face?*** ICB meetings continue to be held on a virtual basis however the arrangements are being reviewed and a blended approach may be adopted. The following questions had been received in advance from Ms Sally Ruane. ***Q1) There are many advantages arising from remote or digital communications when these are used appropriately but I have heard numerous complaints about remote or digital care received in LLR over the past year or two. Some of these concerns:*** • ***difficulties in having remote consultations at home in the context of caring responsibilities (from a patient who is also carer),*** • ***poor use of the consultation by the NHS clinician reflecting a possible lack of training in conducting remote consultations (from a patient),*** • ***poorer quality assessments of patients when assessment is conducted remotely (from a clinician),*** • ***poor quality assessment of patients when assessment is remote leading to short-term and inappropriate solutions which result in longer-term problems and increased expenditure (relative of patient),*** • ***pressure on clinicians to move work to digital delivery (from a different clinician),*** • ***difficulty in hearing and understanding everything that is being said over the 'phone (older patient),*** • ***lack of privacy (patient),***	

ITEM		LEAD RESPONSIBLE
	• ***expected NHS telephone call not being received then, after waiting an hour before trying to call the clinician's office, being reproached by NHS personnel for blocking the line (patient),*** • ***in-person GP appointments being switched at short notice to telephone appointments (friend of patient),*** • ***confusion over which appointment is being referenced in text messages where patient has been given several appointments (friend of patient).*** ***How are these and other problems being addressed in the digital strategy? Furthermore, what principles are being adopted to prevent the inappropriate use of digital/remote care?*** Mr Williams hoped that patients, their carers or advocates would feel empowered to ask for a different type of appointment if digital was not suitable for them and that providers would offer blended options. Some patients found digital appointments to be quicker and more convenient. The digital strategy is much broader than technology and looks at skills, behaviours and cultures of working differently. It also includes support to service users. During the Covid response, a clinically led piece of work was commissioned on the appropriate use of remote care. This took account of relevant guidance such as that produced by the Royal College of General Practice. ***Q2) What is the nature and extent of public engagement and consultation in the development of the digital strategy?*** The digital strategy received active public engagement but there were no requirement to formally to consult on the strategy. Mr Sissling thanked members of the public for their questions.	
NHSB/21/103	**To APPROVE the Minutes of the meeting held on 12 May 2022 (Paper A)** The minutes of the NHS LLR ICB held on 12 May 2022 were received and accepted as an accurate record. It was **RESOLVED** to: • **APPROVE** the minutes.	
NHSB/22/104	**To RECEIVE matters arising and action log (Paper B)** Mr Sissling requested a review of actions to ensure timely attention is given to enable actions to be resolved. It was **RESOLVED** to: • **RECEIVE** the action log.	
NHSB/22/105	**Update from the ICS Independent Chair (verbal)** It was noted that this would be the last ICB meeting in shadow form with the inaugural meeting taking place on 1 July 2022 following legal establishment. Mr Sissling was pleased to confirm that Partner Member nominations had been received from Leicester City Council and Rutland County Council; Professor Mayur Lakhani had been nominated as the representative of the Clinical Executive; and a process was underway to identify a primary care partner member. A visit to University of Leicester, with Professor Lakhani and Mr Williams had provided an opportunity to explore future opportunities for joint research programmes. Similarly, a visit had already taken place with Loughborough University and arrangements had been made to meet with colleagues from De Montfort University.	

ITEM		LEAD RESPONSIBLE
	A quarterly performance review with the NHSEI regional team resulted in some positive feedback on ICB governance and leadership but highlighted concerns on aspects of performance for urgent and elective care waiting times. The ICB was asked to strengthen its plans to address these areas. The role and function of the Health and Wellbeing Partnership (HWP) had been explored with the Chairs of the Health and Wellbeing Boards and Directors of Public Health. The general consensus was that the form should follow function and that the HWP should initially comprise a small foundation membership. A meeting to further consider the proposed HWP arrangements would take place on 30 June. It was **RESOLVED** to: • **RECEIVE** the update.	
NHSB/22/106	**Update from LLR Chief Executives (verbal)** Mr Williams reported on the considerable effort from all parts of the system to address the operational pressures across urgent and emergency care. He expressed his thanks to staff across the CCGs for their work to enable the legal establishment of the ICB on 1 July 2022. Looking ahead, Mr Williams reflected that health equity issues will a priority alongside and as part of the work to improve access performance. Ms Hillery highlighted the ongoing level of pressure due to high demand and occupancy at LPT. There was a concerted effort on re-shaping services enabled by new workforce contributions to enable improvements in delivery. Ms Hillery was pleased to confirm that the partnership approach to learning disabilities services was proving to be successful. This was based on initiatives within LPT and across East Midlands providers. Mr Mitchell acknowledged that experience of care for patients attending ED or waiting for discharge was variable and, in some cases, unsatisfactory. He regretted this position and the impact on patients and staff, both in UHL and EMAS. The trust was continuing to take all appropriate actions, often in partnership, to enable improvements. Mr Mitchell emphasised the need to be attentive to the health and wellbeing of staff during a period of sustained challenge. Mr Sissling thanked the Chief Executives for providing realistic and informative commentaries. It was agreed that a report on staff health and wellbeing activities be commissioned for an early ICB agenda. Also, the item on children's services, led by Mr Samuels, should be planned for the July meeting. It was **RESOLVED** to: • **RECEIVE** the update.	**Alice McGee** **Martin Samuels**
NHSB/22/107	**ICS Digital Strategy (Paper C)** Ms. McGee introduced the item. The Digital Strategy focuses on transformation and has been developed in conjunction with partners and with support from the LLR Digital Strategy Board. The ICB members were previously invited to comment on the draft document. No further comments had been received.	

ITEM		LEAD RESPONSIBLE
	Members acknowledged that digital accessibility could be difficult for some service users due to affordability or technical competence and therefore consideration was required to ensure health inequalities were not increased as digital solutions were implemented. The problems experienced by patients in Rutland who received some of their care from outside LLR were raised. In some cases, system interoperability issues prevented information being shared on a timely basis. The ICB would liaise with neighbour systems to address these issues. Implementation of the Strategy was predicated on the receipt of national funding. It was noted that the allocation of such funding to ICBs was dependant on the delivery of financial balance. This clearly was a source of some risk and should be taken into account as decisions were considered to commit investment. The ICB would be kept appraised of the position. The ICB expressed support for the strategy on basis of receiving funding. If funding was not received to the anticipated level, the ICB would reconsider the plan. It was **RESOLVED** to: • **APPROVE** the LLR ICS Digital Strategy 2022-2025 on the basis that funding would be received.	
NHSB/22/108	**Communications and Engagement update: (Paper D)** • **Draft LLR ICB People and Communities Strategy** • **ICB and ICS Logos** Ms. McGee introduced the item. The national ICB guidance and the design framework set out the principles and expectations of the ICB in engaging with people and communities to inform decision-making and good governance. The regional team had provided positive feedback on the draft strategy. The Board considered the ICB and ICS logos which, if approved would be used from 1 July 2022. The ICB logo was subject to national NHSEI standards on branding. Brand guidelines supported how and where the logos could be used. It was confirmed that communications teams from the local authorities had been involved in the development of the ICS logo. Mr Morris was unable, however, to comment as to how the proposed outcomes had been further cascaded internally within partner organisations. It was agreed the ICS logo was more relevant as an ICP logo and should be shared with the Health and Wellbeing Board members for adoption. In response to a query, Mr Morris suggested that an engagement charter could be developed alongside the strategy if it was felt this was required. It was positive to note that NHSEI and other organisations were keen to learn from LLR's good practice, both in respect of large- scale consultation and very targeted engagement with local communities. The board welcomed the strategy and expressed support for approval.	**Alice McGee / Richard Morris**

ITEM		LEAD RESPONSIBLE
	It was **RESOLVED** to: • **APPROVE** the LLR ICB People and Communities Strategy 2022-2024 for submission to NHS England and NHS Improvement forming part of the evidence to operate as an ICB identifying how we will work with people and communities. • **APPROVE** the ICB logo. • **APPROVE** the ICP logo, subject to support from partner organisations.	
NHSB/22/109	**LLR ICS Quality Strategy (Paper E)** Ms. Trevithick introduced the item. The strategy sets out relevant assurance processes and clarifies an approach to quality improvement. The assurance processes are in line with the requirements of the National Quality Board. They respect and build on the responsibilities of individual providers for the quality of care they provide. The ICB will offer appropriate support to smaller providers. It was acknowledged that the strategy will evolve as the ICB matures. The strategy, however, sets out important key principles for assurance and quality improvement. The Board expressed support for the strategy. A six-month review of the impact of all of the Strategy documents considered was agreed. It was **RESOLVED** to: • **APPROVE** the ICS Quality Strategy.	**Alice McGee / Caroline Trevithick**
NHSB/22/110	**LLR Professional Leadership Strategy (Paper F)** Ms Trevithick introduced the item. The strategy sets out the objectives and key actions for professional leadership development in LLR ICS. The strategy is aligned to the Inclusive Culture and Leadership Strategies and the People Plan. The strategy has been developed as a bottom-up approach with extensive engagement of local clinicians. It has many elements but will, in particular, build productive clinical networks and support the future development of clinical leaders. The impact of this Strategy will be considered in six months. It was **RESOLVED** to: • **APPROVE** the Professional Leadership Strategy.	**Dr Nil Sanganee**
NHSB/22/111	**Cross-cutting themes across the Leicester, Leicestershire and Rutland Joint Health and Wellbeing Strategies (Paper G)** The item on the similarities and differences across the three Joint Health and Wellbeing Strategies (JHWS) was noted. It was noted that the content of the report would form the basis of the discussion taking place on 30 June 2022 and therefore members were invited to comment on the content and forward comments to Mr Sandys, Ms Packham and Ms Robbins. It was **RESOLVED** to: • **RECEIVE** the item.	
NHSB/22/112	**Update on LLR system flow and urgent and emergency care (Paper H)** Ms Rachna Vyas provided an overview of the wide-ranging actions described in more detail in the paper. Four key work programmes to improve flow were	

ITEM		LEAD RESPONSIBLE
	highlighted: non-acute, home first services, acute care and elective care work. These were co-ordinated with an overall aim of improving the alignment between demand and capacity. The board discussed key aspects of the system flow work. There was agreement that many commendable initiatives was being implemented but performance remained disappointing. This was particularly evident in relation to excessive ambulance handovers. A reflection on the arrangements in place during Bank Holidays demonstrated excellent collaboration amongst partners to enable flow and discharge through the system. It was noted that these periods were supported by experienced on-call managers, additional staff and a range of measures to enhance capacity. There was clearly learning in this experience although it would not be possible to fully replicate the arrangements on a continuous basis. The position for 104-week waiters showed improvement but the level of progress was insufficient to provide confidence that the end of June and July targets would be achieved. Mr Mitchell advised the Board on the range of additional measures being considered and activated to enable necessary improvement. These included further use of the independent sector, mutual aid and appropriate validation. The achievement of the milestone targets remained at risk but all options would be pursued by UHL with support from the ICB and the region. Mr Sissling summarised the position. The Board were impressed by much of the collaborative work but concerned about the variable progress in improving performance. These concerns should also be positioned in the certainty that winter would bring further challenge. The Board were keen to secure a greater level of assurance that the plans would deliver a sustainable improvement. An updated urgent care plan should therefore be presented to the Board in July. This should focus on the high impact opportunities and provide clear trajectories for improvement. It was **RESOLVED** to: • **RECEIVE** the update on system flow. • **RECEIVE** an updated urgent care plan at the July 2022 ICB meeting.	**Rachna Vyas / Richard Mitchell**
ITEMS TO NOTE		
NHSB/22/113	• **Assurance Report from the LLR System Finance Committee held in May 2022 (Paper I)** The report was received. The 2022/23 operation / financial plan was due for resubmission on 20 June 2022 with the system aiming to breakeven. Allocations had been received to offset inflation. Significant risks remained in the plan. The Board would be discussing the position in detail in the subsequent session. It was **RESOLVED** to: • **RECEIVE** for assurance.	
NHSB/22/114	**LLR ICS Transition Committee Summary Report (Paper J)** The report was received. It described a wide range of actions relating to the establishment of the ICB and the close down of the CCGs. It was noted	

ITEM		LEAD RESPONSIBLE
	NHSEI were indicating satisfaction with the position. A final submission of key documents would be made to NHSE the following day. It was **RESOLVED** to: • **NOTE** progress of the LLR ICS transition programme. • **NOTE** due diligence activity relating to the closedown of the Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) for assurance. • **NOTE** NHS Leicester, Leicestershire and Rutland Integrated Care Board (NHS LLR ICB) establishment arrangements for assurance.	
NHSB/22/115	**Update on governance arrangements (Paper K)** The report was received, noting the Constitution had been approved and would now be published on the NHSEI website. The nomination processes continued to make good progress in readiness for the 1 July 2022 ICB commencement. Ms Bains had developed a range of governance documents and comments on the drafts were requested ahead of the 20 June 2022 submission date and ICB adoption on 1 July 2022. The Non-Executive Directors had met with Mr Sissling to go through the detail of the governance arrangements. Mr Sissling thanked Ms Bains and others for their work. It was **RESOLVED** to: • **RECEIVE** for assurance the progress made on the governance arrangements. • **APPROVE** the Functions and Decisions Map at Appendix 1. • **APPROVE** the terms of reference for the Audit Committee (Appendix 2), Remuneration Committee (Appendix 3), and the Quality and Safety Committee (Appendix 4).	
ITEMS TO NOTE		
NHSB/22/116	**Covid briefing and vaccination programme update (Paper L)** The item was received for information and noting. It was **RESOLVE** to: • **RECEIVE** the update.	
NHSB/22/117	**Any Other Business and Review of the Meeting** There were no other items of business. The meeting closed at 11:07am.	

Date and Time of next meeting:
The next meeting will be the inaugural meeting of the LLR NHS Integrated Care Board taking place on Friday 1 **July 2022 at 10:00 am via MS Teams.** The meeting will be held in public.

A meeting in confidential session followed for which the Chairman moved that member of the public be excluded from the remainder of the meeting, owing to the confidential nature of the business to be transacted, which is related to the commercial affairs of the ICB.

Appendix 1

Questions from Mr Zuffar Haq as raised in the LLR ICB meeting on 12 May 2022

1. ***How many patients have waited in Ambulances outside A+E longer than 4 hours? Have any patients died while in ambulances outside A and E?***

This question was responded to via the FOI process.

2. ***Has the ICB made any comments or written to Leicester City Council in regard to the proposed workplace parking levy? Have any of the member organisations made submissions to Leicester City Council, I would like copies of all submissions, has any impact assessment been made for staff retention been made?***

The ICB has not made any comments or written to Leicester City Council as the ICB is not a constituted organisation. The CCGs have not written to Leicester City Council and have not undertaken an impact assessment on CCG staff as our consolidated staff base is at County Hall with contractually agreed parking arrangements.

3. ***How many patients have used the drive in covid centre at Glenfield? What is the cost of the service per month?***

4. ***How many Hospital consultants UHL have taken Early retirement? In the last 12 months.***

5. ***How many Locum consultants are being employed by LPT? Currently, and figures for 2020, 2021 please.***

6. ***DHU is running the Walk in Centres. How many patients are being turned away because of no available appointment slots? What are the totals per year for the last 3 years of people seen in each of the walk in Centres?***

7. ***UHL is currently running a temporary triage tent, how many patients are being seen per day in the last two weeks? What is the level of clinical staff?***

8. ***How many CAMHS staff have transferred over to the school service? How many CAMHS clinical psychologist are working as permanent staff for the Leicestershire?***

9. ***How many of Ambulance crews are able to have a break during their shift in a typical week? Please use first week of May as an example.***

For questions 3 – 9 it was advised that partner organisations would need to be contacted directly as this level of detail is not held by the CCGs or ICB.

10. ***Is this board able to give assurance in regard to the following?***
    a) No risks to young people due to service pressure in CAMHS
    b) Bed waits for A+E patients will improve next month?
    c) 90% of Ambulances will arrive to all category 1 calls within 15 mins?

It was noted that the ICB is currently operating in shadow form and is not at present required to provide assurances on partner organisations so this question would need to be redirected to the respective partner organisations.

B

Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Thursday 1 July 2022
10.00am – 12.00noon, Via MSTeams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Ms Nicci Briggs	Chief Finance Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Ms Chris West	Deputy Director of Nursing, Quality and Performance, NHS LLR ICB (on behalf of Caroline Trevithick)
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Ms Simone Jordan	Non-Executive Director
Ms Pauline Tagg	Non-Executive Director (designate)
Professor Azhar Farooqi	Non-Executive Director
Mr Richard Mitchell	Chief Executive, University Hospitals of Leicester (UHL) (acute sector representative)
Ms Angela Hillery	Chief Executive, Leicestershire Partnership Trust (community/mental health sector representative)
Mr Jon Wilson	Assistant Director of Strategic Commissioning, Leicestershire County Council (local authority sectoral representative on behalf of Mike Sandys)
Mr Mark Andrews	Chief Executive, Rutland County Council (local authority sectoral representative)
Mr Martin Samuels	Strategic Director, Social Care and Education, Leicester City Council (local authority sectoral representative)
Professor Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB

Participants:

Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Mr Richard Morris	Deputy Director of People and Innovation, NHS LLR ICB (on behalf of Alice McGee)
Mr Richard Henderson	Chief Executive, East Midlands Ambulance Service (EMAS)
Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire

In attendance:

Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Clare Mair	Corporate Affairs Officer, NHS LLR ICB (note taker)

Six members of public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/22/1	**Welcome and Introductions** Mr David Sissling welcomed everyone to the inaugural meeting of the NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB). The meeting was being held in public and was quorate. Constitutional matters would be the focus of the meeting to enable legal establishment requirements to be fulfilled. Attention was drawn to the ICB membership list appended to the agenda. Mr Sissling confirmed that designate members had been appointed to their substantive board positions earlier today. He highlighted that Ms Pauline Tagg would continue in her ICB designate role until she relinquishes her position as the Chair of EMAS at the end of July 2022, and similarly Dr Nainesh Chotai would attend as designate primary care sector representative until his appointment is formalised.	

ITEM		LEAD RESPONSIBLE
	Mr Sissling thanked those who had accepted the invitation to join the board of the ICB and he looked forward to the delivery of key priorities over the coming years.	
ICB/22/2	**Apologies for absence from Members and Participants:** Apologies for absence were received from the following members: • Dr Caroline Trevithick (Chris West deputising) • Darren Hickman • Mike Sandys (Jon Wilson deputising) • Alice McGee (Richard Morris deputising)	
ICB/22/3	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items. The register of interest has been published on the ICB website and will be continue to be updated.	
ICB/22/4	**To consider written questions received in advance from the Public in relation to items on the agenda** Mr Sissling thanked members of the public who had submitted questions in advance of the meeting. The ICB would be giving further consideration to options to enable effective engagement with members of the public. Ms Nicci Briggs provided responses to the questions raised. <u>Questions received from Sally Ruane</u> ***1. If I have understood correctly, the F&O Plan can be summarised as taking £33m cost out of the system while increasing productivity. £16.4m of the savings rely on grip, control, waste reduction and efficiencies which have yet to be identified.*** • ***What do you think are your chances of delivering a best endeavours break-even plan?*** • ***Can you assure the public that in delivering your best endeavours break-even plan neither patient care or staff wellbeing will be reduced?*** Our financial plan has a high level of risk given the scale of uncertainty (including COVID and inflation) and the operational pressures in this system (elective backlogs and urgent care capacity). The level of risk is similar to other systems who are all managing the post COVID recovery. We recognise the high risk as teams and continue to develop robust plans to deliver the efficiencies. If we deliver our best endeavours breakeven plan it would mean that we have delivered more elective care, thereby reducing the waiting list and we will have treated patients on the emergency pathway in the right care setting with the appropriate clinician. If the financial plan delivers, we will see improvements in patient care not reductions in service. We are coming out of a very busy time and addressing many challenges so we are conscious of maintaining staff health, wellbeing and fitness through that period. ***2. a) What do you think is the NHS-specific rate of inflation and, in financial terms, what are the additional costs you have identified for the NHS in Leicester, Leicestershire and Rutland that have arisen as***	

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	a result of higher than predicted inflation since the original government spending plan for 2022-23 was announced? ***b) How much extra funding has the government made available to address these inflation-driven additional costs?*** Additional funding has been received for pay and non-pay, however additional pressures beyond this are being seen as a result of increasing fuel and foods costs etc and so far, we have included a further 0.7% into our plan which equates to a much higher non-pay inflation level. Additional funding from the NHS has been received to cover this - £9.4m or 0.7%. The expected level of inflation as set out in the NHSEI planning guidance in December 2021 was for 2022/23 inflation to be at 2.8% and this was fully funded by the NHS. The 2.8% assumes pay inflation of 2% and also covers the cost of employers NI increasing by 1.25% as well as covering non-pay inflation. The organisations across are forecasting for further increases in inflation but these have not yet materialised. We will be closely monitoring inflationary impacts and feeding this back to NHSEI. ***3. At present, it is not possible for the public to find the fact of these meetings and the link for them online. Also, there is no public visibility of the ICB Constitution on the websites of the CCGs, although it is on NHS England's website. When will these ICB meetings, the Constitution and other relevant papers be made easily accessible for the public?*** Details of public ICB meetings, including this one, were contained on the outgoing CCG website, along with details of how to join meetings. A new ICB website has launched today (1 July 2022) and our Constitution is now uploaded to that website. Details of how to join future meetings will also be available on the site. We aim to build on the content of our website over the next few weeks. However, if you are not able to locate the relevant documentation then please do contact us. <u>Questions received from Ramsay Ross</u> ***Observations which have relevance to the questions that follow:*** ***i) The accounts to March 2021 did not provide a true and fair view of the operations of UHL; the information produced for management was, by extension, worthless as a tool to control the functions of UHL. This would also mean that the budgets for 20/21 were not properly prepared on any set of reasonably prudent assumptions. These issues are aside from any underlying system weaknesses or failures that then existed.*** ***ii) It is noted that in the ICB meeting the Directors are confirming that 'appropriate corporate governance systems are in place.....and fit for purpose'*** The observation was noted. ***1. a) Appendix B - 28th April 2022 LLR Operational & Financial Plan and question refers to financial movements, items 3 to 5 inclusive What***	

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	phasing of savings was assumed and do the actual results to end May 2022 confirm the reasonableness of these assumptions The phasing of the savings is 10% in quarter 1, 20% in quarter 2, 32% in quarter 3 and 38% in quarter 4. LLR like many systems highlighted that productivity improvements and efficiencies would be more difficult in quarter 1 for a number of reasons including the stringent COVID related Infection prevention control measures. As they are relaxed and as additional elective capacity becomes available the savings are expected to increase, hence the backloaded profile. Regarding May 2022 YTD position, the system has reported £3.5m delivery against a plan of £4.5m ***2. a) Questions on additional key improvements:*** ***i) does the planning process followed incorporate those changes recommended by the investigatory report (be that interim or final) arising from the 2020/21 accounts of UHL.*** The UHL board, audit committee and finance teams will be expected to incorporate any recommendations from an external audit report in line with organisation good governance. There is an expectation that the 2021/22 accounts will demonstrate progress against that. In line with national planning guidance the system and organisations will be commissioning an audit covering the most recent HFMA publication – Improving NHS financial sustainability. This will be wide ranging and will highlight any areas of weakness in financial governance and prescribing remedial actions. UHL finance team have gained Level 1 accreditation and have demonstrated satisfactory financial governance control to do that, so a positive move. ***ii) do detailed and phased plans underpin each of these savings*** Both organisations and the system have a RAG rated assurance process on their savings and efficiency plans. At the time of plan submission LLR highlighted that there were still some high-risk schemes that did not have the required level of robust plans but it is expected as we move through quarter 1 into quarter 2 that the plans will be strengthened. Efficiencies planning and delivery is closely monitored at organisation and ICB finance committees. ***2 b) Has the Independent Sector been consulted to confirm that this assumption is realistic and what has been actually achieved against the plan in the 2 months to May 2022.*** The independent sector is part of appropriate discussions regarding additional activity and have been working closely with the system and partner organisations to assist us in managing our waiting lists. In activity terms independent sector activity is well in excess of 2019/20 levels which are the drivers of this year's planning assumptions. In terms of finance activity this is paid 3 months in arrears but we are assuming they will be on or slightly above plan. ***3. Other assumptions:*** ***a) Item 1) '...closure of additional emergency capacity through the winter.'***	

ITEM		LEAD RESPONSIBLE
	Is this assumption supported by the actual bed utilisation over the 3 years of 2017/18/19? Our bed modelling across the system is based on the total numbers of bedded and non-bedded solutions available across the health and care system. We have been working towards a 'Home First' model of care, providing care in people's own homes since 2017 and our plans this year have been to grow this capacity outside of hospital based on patient and staff feedback as well as clinical efficacy of the model of care. Additional emergency capacity has been opened through each winter whilst these models of care have grown. This year sees an exponential growth in the virtual ward model across many specialties, ensuring we can treat patients in their own homes rather than in hospital beds. The total numbers of 'beds' using joint modelling with LPT UHL and LAs therefore is greater than in previous years, hence why our modelling has not included additional winter capacity for 22/23. ***b) Item 5) - £40m cash saving. Question: What third party organisational commitments have been achieved to date (June 2022) vs the planned realisation sum of £40m. This information is requested on the basis that cash will typically not be realised for 2 to 3 months from any commitment.*** £40m is the cumulative organisational efficiency requirement which is approximately 2.1% of the overall budget. The majority of these efficiencies are not from third party organisational commitments but from increases in productivity and the elimination of inefficiencies. We should also receive additional funding if we improve elective activity levels. Mr Sissling observed that many of the questions related the management of significant financial resources. Prospects to do this effectively and to improve patient outcome would be best enabled by effective system working. The questions were welcomed. The board would come back with further proposals on how its engagement could be further developed.	
ICB/22/5	**Establishment of NHS Leicester, Leicestershire and Rutland Integrated Care Board (A)** Mr Andy Williams highlighted the importance of the documents being considered by the Board as they would define the ICB's ability to act as a statutory entity and discharge its functions going forward. Ms Nicci Briggs drew attention to the paper, its supporting appendices and the supplementary pack of papers which had been circulated prior to the meeting. It was noted that the Staff and Property Transfer Schemes, which had been received yesterday from NHSEI and circulated separately. Ms Briggs went through each document separately, noting the requirements of approval, adoption and/or endorsement. Ms Briggs provided an opportunity at each point for members to make comment or raise questions before moving to the next document in the pack. With reference to the primary care delegated function, it was confirmed that this would be discharged through the Strategic Commissioning Group, which would be a sub-group of the System Executive. In response to a query, Ms	

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	Briggs explained that the ICB would be responsible for full delegation of primary medical care with effect from 1 July 2022.
	
	Ms Sissling expressed his thanks Ms Daljit Bains and to those who had worked tirelessly on the ICB governance preparation.
	
	Whilst policies and documents were being agreed by the Board, they would be subject to review and further refinement as the ICB evolves and matures. The strategies would be further reviewed to ensure consistency with the governance arrangements.
	
	Mr Sissling welcomed Professor Lakhani's suggestion to have named deputies to attend in the absence of members of the board to enable continuity.
	
	Mr Sissling proposed that various primary care aspects be the key focus of the August meeting and for the item to be led by Dr Sanganee and Mr Williams.
	
	It was **RESOLVED** to:
	
	• **RECEIVE** the Establishment Order to legally establish NHS LLR Integrated Care Board.
	
	• **ENDORSE** and **ADOPT** the NHS LLR ICB Constitution and Standing Orders as approved by NHS England.
	
	• **ENDORSE** and **ADOPT** the NHS LLR Integrated Care Board purpose, principles and priorities.
	
	• **APPROVE** the Scheme of Reservation and Delegation and the Functions and Decisions Map (as contained within the Governance Handbook).
	
	• **APPROVE** the Standing Financial Instructions (as contained within the Governance Handbook).
	
	• **APPROVE** the Operational Scheme of Delegation and the Detailed Financial Policies (as contained within the Governance Handbook) and **NOTE** that the Chief Executive is responsible for its review and approval going forward.
	
	• **APPROVE** the establishment of the following committees as Committees of the board, **APPOINT** the chairs of the committees and **APPROVE** the terms of reference and the membership (details of which are contained within the Governance Handbook):
	  o Audit Committee
	  o Remuneration Committee
	  o System Executive
	  o Health Equity Committee
	  o Finance Committee
	  o Quality and Safety Committee
	
	• **ENDORSE** and **ADOPT** the signed Delegation Agreement for Primary Medical Services.
		N Sanganee / A Williams

ITEM		LEAD RESPONSIBLE
	• **APPROVE** the primary care delegated function to be discharged through the Strategic Commissioning Group which will be a sub-group of and report to the System Executive and onwards to the board. • **APPROVE** the Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy (as contained within Pack A). • **APPROVE** the Risk Management Strategy and Policy and the Board Assurance Framework 2022/23 (as contained in the supplementary Pack A). • **APPROVE** the Governance Handbook (as contained within the supplementary Pack A). • **ENDORSE and ADOPT** the policy frameworks of the legacy CCGs for those staff and registered populations to which they apply, until such a time as consolidation is completed or successor documents are approved, or they are no longer required. • **APPROVE** the appointment of the Conflicts of Interest Guardian and the Freedom to Speak Up Guardian. • **APPROVE** the appointment of the ICB founder members of the Integrated Care Partnership. • **ENDORSE** and **ADOPT** the following strategies as presented to the board whilst in shadow form (all contained within Pack A): a. People and Communities Strategy b. Quality and Performance Strategy c. Digital Strategy d. Professional Leadership Strategy • **RECEIVE for ASSURANCE** the Staff and Property Transfer Schemes.	
ICB/22/6	**Financial and Operational Plan 2022/23 (Paper B)** Ms. Briggs introduced the item. A best endeavours break-even plan had been developed across the LLR system. Significant risks remained. Mitigating actions had been identified to respond to some of these risks but work continue to address other risks. The board will need to consider the deployment of certain mitigating actions if risks materialise. The plan specified improvement trajectories for key service delivery areas. The areas of highest challenge were the elective recovery programme and the improvement in urgent care access. Ms Briggs highlighted that the operational plan for the system had been submitted at the end of April 2022 with a deficit of £49m. Inflationary pressures had been recognised nationally, which resulted in additional allocations at 0.7% which equated to over £9.5m across LLR. Subsequent action had focussed on action to bridge the remaining gap. The plan was taken through the System Executive and shadow ICB in June. It had been considered by the ICB Finance Committee which had concluded that the plan had appropriate elements and the right targeted action had been	

ITEM		LEAD RESPONSIBLE
	taken to bridge the final financial gap. It did however highlight a high level of risk in relation to delivery. The plan specifies 4 specific areas where action will be taken to avoid costs or reduce expenditure. These are; managing continued growth in prescribing and CHC; avoiding the requirement to invest in additional urgent care capacity; enhancing productivity (and securing additional activity related national funding) in the elective pathways; and increasing the overall efficiencies requirement. Delivery of the plan is being monitored through the system PMO. Mr Williams provided an overview of the thorough process by which the plan had been developed. This had been challenging but the outcome were in line with regional and national expectations. Risks will be closely monitored and managed through weekly chief finance officer meetings, the system executive with regular reports to the finance committee and board, and monthly reporting to NHSEI. The plan will be fully observant of the need to prioritise patient safety and will be subject to regular review by the clinical executive. Mr Sissling made requests for further reports: • a detailed summary of the allocation and distribution of relevant funds. • further information on specific areas of workforce growth. • an update on the urgent and emergency care plan including trajectories – July board. Mr Sissling thanked for the report. The level of risk was significant and success would require very careful and rigorous implementation. The board should receive regular report on key matters. It was **RESOLVED** to: • **RECEIVE** the update.	
ICB/22/7	**Reflections / Update from ICB Chair** Mr David Sissling wished to record his thanks and gratitude to the CCGs for all they had done to provide solid foundations for integrating working and to enable a remarkably smooth transition. A meeting of the Health and Wellbeing Partnership (HWP) which is a statutory element of the ICS took place on 30 June 2022 resulting in positive agreement on priorities and collective work programmes. The HWP and ICB will work in supportive and complementary ways.	
ICB/22/8	**Reflections / Update from LLR Chief Executives** Mr Williams was pleased the ICB had now been statutorily established and in good order to commence business. The LLR CCGs had brought forward their Annual General Meeting (AGM) to earlier this week. An inordinate amount of work had taken place to prepare the annual report and accounts amid a range of technical issues. Thanks were expressed to all involved. The questions asked by the public at the AGM had been pertinent and whilst the CCGs reported many positive things the business was grounded in the reality that significant challenges are faced by staff delivering services and the people receiving them.	

ITEM		LEAD RESPONSIBLE
	The CCG staff transferring today had been through a management of change process to get ready for this point, delivering a 20% running cost reduction, responded to the Covid-19 pandemic and adapted to agile working. Mr Mitchell framed his reflections on the four core system goals of the Integrated Care System: • improving outcomes - long waits for elective care had reduced significantly, emergency care remains challenged with radical redesign and transformation needed. • tackling health inequalities – LLR has piloted an 'unable to attend' programme for chronic respiratory disease in response to the 20+5 core standards. The programme offered additional measures and support to encourage attendance by those from challenged communities. • enhancing productivity- with a recognition this relies on motivated and committed staff. UHL were increasing the health and wellbeing support to colleagues. • Social and economic development – UHL is working with Ellesmere college, a large SEND education provider who works with local employers to secure student placements and permanent employment. Ms Hillery expressed her thanks to partners for their support in implementing the Step up to great Mental Health agenda. Operational pressures continued with occupancy levels high across adult acute and CAMHS beds. A CQC urgent and emergency care review of the system had included a review of the psychiatric liaison service and positively confirmed the progress in delivering high quality care. Ms Hillery expressed thanks to all who had organised and supported the excellent Lead, Connect and Care festival sessions. Mr Sissling opened the item for members to comment. Professor Lakhani acknowledged there was more to be done to minimise gaps in service and increase integration. The Covid response and virtual wards were good examples of innovative system delivery. Professor Farooqi supported this and highlighted the importance of the transformation and integration agenda. Dr Underwood had attended yesterday's HWP meeting where it had been acknowledged that the voice of the public and need to communicate with them was pivotal to delivery. Mr Sissling concurred with that as a theme for the ICB to take forward. Mr Sissling concluded that in planning for future meetings he would welcome input from members to inform future agenda content. Further business items would include the HWP future working arrangements, CAMHs, primary care (August meeting), major capital investments and transformation. The statutory ICB establishment was acknowledged and thanks expressed for input to today's meeting.	

ITEM		LEAD RESPONSIBLE
	The meeting closed at 11.28am.	

Date and Time of next meeting:
The next meeting of the NHS LLR Integrated Care Board will take place on **Thursday 14 July 2022** at 9:00 am via MS Teams. The meeting will be held in public.

C

The Leicester, Leicestershire and Rutland (LLR) INTEGRATED CARE SYSTEM (ICS) NHS BOARD

Action Log

Key

Completed	On-Track	No progress made

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at 14 July 2022	Status
NHSB/22/30	10 February 2022	Application of System Headroom Funding	Andy Williams	Update to be provided following year end on the utilisation of the funding and any learning for the ICB/ICP to take account of in the future.	~~May 2022~~ June / July 2022	The report was considered by the Finance Committee. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHSB/22/50 NHSB/22/86	10 March 2022 12 May 2022	Update / briefing on Ockenden Review into maternity services	Caroline Trevithick	Quarterly progress updated on the implementation of the recommendations from the Ockenden Review to be provided.	~~May 2022~~ September 2022	Report received in May 2022, next report due in September 2022. Item captured on the board forward planner. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHSB/22/67	14 April 2022	Research Review	Prof Nigel Brunskill	ICB to receive a further update on research.	August 2022	Item captured on the board forward planner. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHSB/22/68	14 April 2022	Reducing health inequalities across LLR	Sarah Prema	ICB to receive performance dashboards and delivery plans.	~~June 2022~~ July / August 2022	In line with the approved governance arrangements, the board is requested to note that this item is scheduled for discussion at the inaugural meeting of the Health Equity Committee in August 2022. Assurance will be reported to the board by the Committee. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at 14 July 2022	Status
NHSB/22/71	14 April 2022	Assurance Finance Report from the LLR System Finance Committee held 30 March 2022	Nicci Briggs / Rachna Vyas	ICB to receive details of the transformation approach and methodology, how many schemes were being supported and the delivery times.	~~June / July 2022~~ August 2022	In line with the approved governance arrangements, the board is requested to revert to the Finance Committee for review of this action and for the Committee to provide assurance to the board. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHSB/22/85	12 May 2022	LLR Chief Executives' update	Richard Mitchell	To provide an update on reconfiguration plans at a future date.	~~July 2022~~ August/ September 2022	Item to be reported in August / September, exact date to be agreed with the lead officer.	**Amber**
			Alice McGee	ICB to receive a headline paper on LLR health and wellbeing activities.	July 2022	Report to be presented to the System Executive meeting in July 2022 in line with new governance arrangements. Assurance will be provided to the board through the System Executive. **REQUEST FOR ACTION TO BE CLOSED**	**Amber**
NHSB/22/88	12 May 2022	LLR System Flow update	Rachna Vyas	To receive a further stocktake of the system flow plan priority elements and a briefing on MOFD patients.	July 2022	Specific agenda item on plan for urgent and emergency care to be received, covering these areas for ICB on 14 July. **ACTION COMPLETE**	**Green**
NHSB/22/106	9 June 2022	Update from LLR Chief Executives	Alice McGee	ICB to receive a headline paper on LLR health and wellbeing activities.	July 2022	Update provided above under NHSB/22/85. Therefore to close this action.	**Green**
			Martin Samuels	To provide an overview of children and children's services at the July 2022 meeting of the board.	July 2022	Mr Samuels has requested that the item be considered by the LLR Health and Wellbeing Partnership.	**Amber**

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at 14 July 2022	Status
NHSB/22/108	9 June 2022	Comms / Engagement update and Logos	Alice McGee / Richard Morris	The Health and Wellbeing Partnership logo to be presented to the HWP members for support and endorsement from their respective organisations.	End June 2022	**ACTION COMPLETE**	**Green**
NHSB/22/108	9 June 2022	Draft LLR ICB People and Communities Strategy	Alice McGee	The board to receive an update in six months' time on the impact of this strategy.	December 2022	Item captured on the board forward planner. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHSB/22/109	9 June 2022	LLR ICS Quality Strategy	Dr Caroline Trevithick	The board to receive an update in six months' time on the impact of this strategy.	December 2022	Item captured on the board forward planner. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHSB/22/110	9 June 2022	LLR Professional Leadership Strategy	Dr Nil Sanganee	The board to receive an update in six months' time on the impact of this strategy.	December 2022	Item captured on the board forward planner. **REQUEST FOR ACTION TO BE CLOSED.**	**Amber**
NHS/22/112	9 June 2022	System Flow/Urgent & Emergency and Care	Rachna Vyas / Richard Mitchell	Greater level of assurance to be provided that the plans would deliver a sustainable improvement. An updated urgent care plan to be presented to the Board in July, with a focus on the high impact opportunities and provide clear trajectories for improvement.	July 2022	Item on the agenda for July 2022 meeting. **ACTION COMPLETED**	**Green**
ICB/22/5	1 July 2022	Establishment of the ICB – discussion relating to primary care	Dr Nil Sanganee	To provide a report on various elements of primary care as agreed.	August 2022	Report due in August 2022.	**Amber**

D

LEICESTER, LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUPS GOVERNING BODY MEETINGS

Minutes of the LLR CCGs' Governing Body Meetings in common held on Tuesday 28 June 2022 from 10.30am via MS Teams

Present:

Leicester, Leicestershire and Rutland CCGs:

Mr Andy Williams	Chief Executive
Mrs Chris West	Deputy Director of Nursing (deputising on behalf of Dr Caroline Trevithick)
Ms Nicci Briggs	Executive Director of Finance, Contracts and Corporate Governance
Ms Rachna Vyas	Executive Director of Integration and Transformation
Ms Sarah Prema	Executive Director of Strategy and Planning
Ms Alice McGee	Executive Director of People and Innovation

East Leicestershire and Rutland CCG:

Dr Vivek Varakantam	Clinical Chair (Chair of Meeting)
Dr Andrew Ahyow	Member Practice Representative and Clinical Vice Chair
Ms Fiona Barber	Deputy Chair and Independent Lay Member
Mr Clive Wood	Independent Lay Member
Mr Warwick Kendrick	Independent Lay Member
Dr Girish Purohit	Member Practice Representative
Dr Graham Johnson	Member Practice Representative
Dr Nick Glover	Member Practice Representative
Dr Nikhil Mahatma	Member Practice Representative

West Leicestershire CCG:

Prof Mayur Lakhani	Clinical Chair
Dr Nil Sanganee	Clinical Vice Chair
Ms Wendy Kerr	Independent Lay Member
Dr Fahad Rizvi	Locality Lead, North Charnwood
Dr Reema Parwaiz	Locality Lead, Hinckley and Bosworth
Dr Rowan Sil	Locality Lead, North West Leicestershire (joined remotely)

Leicester City CCG:

Prof Azhar Farooqi	Clinical Chair
Dr Avi Prasad	Assistant Clinical Chair (joined remotely)
Mr Nick Carter	Independent Lay Member
Prof Jeffrey Knight	Independent Lay Member
Dr Sulaxni Nainani	South Health Need Neighbourhood Chair
Dr Tony Bentley	North and East Health Need Neighbourhood Chair (joined remotely)
Dr Raj Than	Left Shift / Integration Lead (joined remotely)
Mr Matthew Trotter	Secondary Care Clinician
Prof Ivan Brown	Director in Public Health, Leicester City Council

In Attendance:

Ms Harsha Kotecha	Healthwatch Leicester and Leicestershire Chair (joined remotely)
Ms Clare Mair	Corporate Affairs Officer (taking notes)

Members of the public: No members of public were in attendance.

ITEM	DISCUSSION	LEAD RESPONSIBLE
GBs/22/42	**Welcome and Introductions** Dr Vivek Varakantam welcomed members of the Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups (CCGs) to the meeting of the Governing Bodies in common.	
GBs/22/43	**Apologies for Absences** Apologies for absence were received from: **LLR CCGs:** • Dr Caroline Trevithick, Executive Director of Nursing, Quality and Performance (Chris West deputising) **East Leicestershire CCG:** • **West Leicestershire CCG:** • Ms Gillian Adams, Independent Lay Member • Mr Steve Churton, Independent Lay Member **Leicester City CCG:** • **In attendance:** • Dr Janet Underwood, Healthwatch Rutland Chair The meeting was confirmed as quorate for East Leicestershire and Rutland CCG (ELR CCG), Leicester City CCG (LC CCG) and West Leicestershire CCG (WL CCG) Governing Bodies.	
GBs/22/44	**Notification of Any Other Business** Dr Varakantam reported he had not received notification of any other items of business.	
GBs/22/45	**Declarations of Interest on Agenda Topics** It was noted that each CCG maintains a conflicts of interest register available on respective CCG websites and any declarations raised at this meeting would be documented in the minutes of the meeting and action(s) will be taken to manage the conflict(s) at the meeting in line with the conflicts of interest policy. It was **RESOLVED** to: • **NOTE** that actions would be taken as required.	
GBs/22/46	**To receive questions from the Public in relation to items on the agenda only** The Chair had not received questions in advance and no questions were raised at the meeting.	

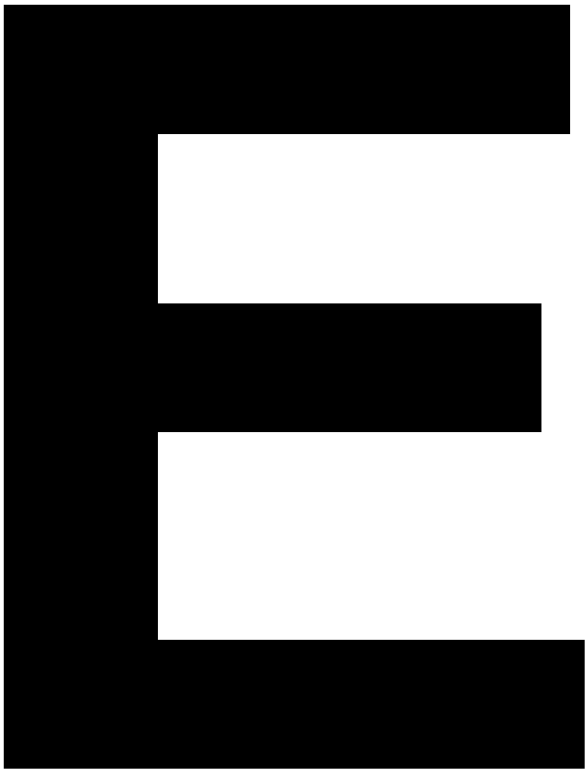
ITEM	DISCUSSION	LEAD RESPONSIBLE
GBs/22/47	**Minutes of the LLR CCG's meetings in common held on 26 April 2022 (Paper A)** The minutes were approved as an accurate record of the meeting. It was **RESOLVED** to: • **APPROVE** the minutes of the LLR CCGs' Governing Bodies held on 26 April 2022.	
GBs/22/48	**Matters arising and actions from the LLR CCGs' Meetings in common held on 26 April 2022 (Paper B)** The action log was received and it was noted that there were no outstanding actions. It was **RESOLVED** to: • **RECEIVE** the updates provided.	
GBs/22/49	**Report from the LLR CCGs' Chairs (Paper C)** The Chairs of East Leicestershire and Rutland CCG, West Leicestershire CCG and Leicester City CCG reflected on the work undertaken to ensure the smooth transition towards becoming an Integrated Care Board on 1 July 2022. Professor Farooqi noted the work of designate Medical Directorate colleagues in taking forward clinical work into the new organisation, including the Clinical Reference Group which Professor Farooqi had now chaired for the last time. It was **RESOLVED** to: • **RECEIVE** the contents of the report.	
GBs/22/50	**Accountable Officer's Corporate Report (Paper D)** Mr Andy Williams expressed his thanks and those of his executive colleagues to the governing bodies for the collaborative work which had supported the seamless transitioning of the CCGs to become an Integrated Care Board. Mr Williams further acknowledged the circa 300 CCG staff who had been through a management of change process which had delivered a 20% running cost reduction, worked through the impact of the Covid-19 pandemic and delivered everything asked of them in that respect and the organisations' statutory duties. Mr Williams spoke of CCGs being uniquely member organisations with considerable primary care engagement having been delivered over the ten years. He thanked clinical leaders and the GP community for these strong links and extraordinary contribution made, whilst acknowledging the challenges facing primary care and welcomed primary care's continued support into the ICB.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	The governing bodies were asked to consider the LeDeR annual report for approval, noting the assurances provided and the successor arrangements. A further change to note for the CCGs had been the adoption of agile working. The Executive Management Team had reviewed the impacts; two of the three physical office bases had closed, the running costs had reduced by a further £750,000, 1.5 million commuting miles had been removed and the carbon footprint of the workforce reduced. Mr Williams thanked the CCG Chairs for their support himself. Dr Nick Glover in response to Mr Williams' comments on primary care challenges acknowledged the tremendous work of the nursing and quality and integration and transformation teams to directly support practices which translated to better support for patients. It was **RESOLVED** to: • **RECEIVE** for assurance the Accountable Officer's report. • **APPROVE** the LeDeR Annual Report (1 April 2021 – 31 March 2022) ahead of its submission to NHS England / Improvement. • **APPROVE** the disestablishment of the LLR CCGs' committees as at 30 June 2022.	
GBs/22/51	**Equality, Diversity and Inclusion (EDI) Annual Report 2021/22 (Paper E)** Ms Alice McGee, Executive Director of People and Innovation presented the Equality, Diversity and Inclusion (EDI) Annual Report 2021/22 demonstrating the LLR CCGs' compliance with the Equality Act 2010 and the Public Sector Equality Duty 2011. The report covered both the local population and workforce compliance and is published annually. For 2021/22 the report included April to June 2022 information. It was **RESOLVED** to: • **APPROVE** the LLR CCGs' combined Equality, Diversity and Inclusion Annual Report 2021/22 prior to its publication on the CCGs websites. • **NOTE** the addendum for the period April to June 2022.	
GBs/22/52	**Summary report from the Audit Committee meetings in common held on 17 May and 20 June 2022 (Paper F)** Professor Jeffrey Knight as Chair of the Audit Committee meetings in common provided a summary of key areas of discussion from the May and June 2022 meetings. The May meeting had considered the ICB transition work and the June meeting the audit process to agree the annual audit	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	submission ahead of the AGM. At the June Audit Committee meeting the auditors advised of a risk that necessary audit work to support the Annual Report and Accounts finalisation before the 22 June 2022 deadline may not be achieved and due to this ongoing work, the Letter of Representation could not yet be provided. The work continued after the Audit Committee and identified a section which had previously been advised as not required, was indeed a necessary part of the audit work. CCG officers worked to provide this information in short time and ensure all was in place and approved in readiness for today's AGM. Professor Knight reported all actions had been completed for areas of significant weakness found by the auditors. Ms Briggs thanked the chairs of the three CCG Audit Committees for their work over the years and particularly for their support to this year's audit process which Ms Briggs recognised as being the most challenging in terms volume of lines of enquiries and the protracted time period to complete the processes. The value for money statement reflects the CCG's compliance against NHSE's instruction to manage finances collectively. The auditor found no material issues. Mr Wood, Mr Kendrick and Professor Knight as Audit Chairs of the three LLR CCGs noted their appreciation to the team who had completed the year end and audit work in challenging and exceptional circumstances. It was RESOLVED to: • **RECEIVE** the report for assurance. • **NOTE** that the Audit Committees approved their respective CCG Annual Report and Accounts 2021/22 in line with the authority delegated to them. This was subject to any final editing.	
GBs/22/53	**Closedown of the Leicester, Leicestershire and Rutland Clinical Commissioning Groups and summary assurance report from the LLR ICS Transition Committee (Paper G)** Ms Sarah Prema provided a final update on progress towards the establishment of a statutory Integrated Care Board on 1 July 2022. The CCGs had entered their last few days of operating prior to ICB establishment. The transition was almost complete with some transfers to take place later in the week. A number of assurance processes, including the Transition Committee had provided assurance to the shadow ICB that	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	processes were well developed. Independent legal advice had been obtained to check due diligence processes. NHSE/I had been involved in processes and gained assurance. The establishment orders were going through national sign off and were expected the following day. Governance and ICB membership was in place for the inaugural meeting on 1 July 2022. Professor Lakhani as co-chair of the Transition Committee with Professor Farooqi expressed their appreciation for the diligent and complex work delivered. Professor Knight acknowledged the detailed legal checklist which again had required considerable work from the transition team. It was **RESOLVED** to: • **APPROVE** the closedown of the three LLR CCGs and associated due diligence activity. • **NOTE** progress of the LLR ICS Transition Programme	
GBs/22/54	**Summary report from the LLR CCGs' Primary Care Commissioning Committee meetings in common – 3 May and 7 June 2022 (Paper H)** The report was taken as read. It was noted that a decision had been escalated to the LC CCG Governing Body due to the PCCC meeting on 7 June 2022 not being quorate. Work was underway with the national teams on practical matters for Spectrum Health whilst they were not part of a PCN, such as DES payments. PCN changes were allowable once a year by NHSE/I and the matter could not be fully resolved until April 2023. Nick Glover expressed his thanks to the PCCC chairs and other lay members for the support provided to primary care commissioning and contract matters. It was **RESOLVED** to: • **RECEIVE** the highlight report from the Primary Care Commissioning Committee. • **NOTE** the approval provided by members of LC CCG Governing Body via email for the Future Alternative Provider of Medical Services (APMS) Procurements 2022/23 contract lengths.	
GBs/22/55	**Summary Report from the Clinical Reference Group – January to June 2022 (Paper I)**	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Professor Farooqi took the report as read acknowledging the breadth of work and clinical input to support the decision-making process of the commissioners. Dr Sanganee was in support of CRG evolving to a multi-professional, system-based membership. The design groups and provider collaboratives would further mature to reflect wider representation. It was **RESOLVED** to: • **RECEIVE** the LLR Clinical Reference Group Highlight Report.	
GBs/22/56	**Closing remarks from the LLR CCGs' Chairs** Professor Farooqi reflected on ten years of valuable work and whilst the CCGs were drawing to a close the ICB was primed to take forward the system challenges. Professor Lakhani gave thanks to Mr Williams as Accountable Officer and the executive team in their delivery of the transition. The fantastic achievements across LLR health and social care were to be celebrated but caveated with a pause for reflection around the tasks ahead and the challenge of waiting times for urgent and emergency care. Dr Varakantam felt privileged to have worked in the LLR CCGs and with his colleague chairs and recognised the dedication of clinicians, lay members and managers in striving to improve healthcare for patients.	
GBs/22/57	**Items of any other business** Professor Varakantam confirmed there were no items of other business to discuss.	
	Date of next meeting There will be no further meetings of the LLR CCGs Governing Bodies. The LLR CCGs will be transitioning into the NHS LLR Integrated Care Board on 1 July 2022. **The meeting concluded at 11:30am**	



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	14 July 2022	**Paper:**	**E**
Report title:	**Specialist Child and Adolescent Mental Health Services and CAMHS Collaborative Progress Update**		
Presented by:	Helen Thompson and David Williams		
Report author:	Paul Williams, Helen Thompson and David Williams		
Executive Sponsor:	Angela Hillery		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE for information.**
- **RECEIVE for assurance**

Purpose and summary of the report:

This report and presentation summarise the range of preventative, early intervention and specialist services for children and young people (CYP) with emotional and mental health needs, detailed in the Future in Mind Plan 2021 – 2022.

The Covid pandemic has resulted in more CYP seeking support, with an increase in urgent and complex referrals. This has required transformation and the development and expansion of services through the Mental Health Investment Standard.

This report sets out the service changes and challenges in providing a timely response to CYP with mental health needs and the sustained increase in acuity and demand. Where performance is not meeting expected standards, improvement plans are in place to mitigate the risks set out in directorate level risks and Organisational Risk Register risk 75. Delivery against improvement trajectories and plans is governed through Directorate, Executive and Board committees within Leicestershire Partnership NHS Trust (LPT). The Mental Health Design group provides direction to the CYP Emotional and Mental Health Delivery group, where detailed performance is scrutinised and reviewed.

Appendices:	• Appendix 1 – Presentation
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Leicestershire Partnership NHS Trust Board – 31 May 2022

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		

e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	

Specialist Child and Adolescent Mental Health Services and CAMHS Collaborative Progress Update

14 July 2022

Introduction

1. One in ten children and young people (CYP) report having a mental health problem; many more say they are stressed or overwhelmed. This has been compounded by the Covid pandemic and an integrated multi-agency response, detailed in the refreshed Future in Mind Plan http://3xmatc1p0cnc3crfv93ovogp-wpengine.netdna-ssl.com/wp-content/uploads/2021/09/Collaborative-CYP-FIM-Plan-Refresh-2021.pdf is being enabled through the Mental Health Investment Standard (MHIS) and service transformation.

Prevention and Early Intervention

2. Schools and Local Authority Early Help services are available for CYP and self-help tools and advice has been developed by Leicestershire Partnership NHS Trust and is available at: https://www.healthforkids.co.uk/ and https://www.healthforteens.co.uk/
3. Kooth and Relate provide early intervention services for CYP with emotional and mental health difficulties, all referrals are triaged by DHU and routed to the most appropriate service.
4. Leicestershire Partnership Trust are expanding the early intervention offer in LLR through the establishment of CYP Wellbeing Practitioners working within primary care settings and the recruitment of a further twelve trainee Education Mental Health Practitioners to expand the number of Mental Health Support teams in schools to eight in total.

Specialist CAMHS

5. Specialist CAMHS services have experienced a sustained increase in demand since the onset of the pandemic. The specialist teams have transformed clinical pathways and skill mix to respond to this demand and benefited from increased investment through the MHIS.
6. CAMHS out-patient services are responding within the four week contractual targets to urgent cases. Routine performance is significantly challenged, with less than half the CYP referred being seen within 13 weeks. An improvement plan is in place, which is rate limited by workforce supply and issues within DHU affecting the processing of referrals. A risk stratification and duty system is in place to keep CYP safe whilst waiting.
7. Neurodevelopmental (ND) referrals for CYP over eleven years old, who require assessment for Autism or Attention Deficit Hyperactivity Disorder (ADHD), progress along the CAMHS ND pathway. CYP under the age of eleven are diagnosed by the multidisciplinary team within the Community Paediatric service. A timely response to the year on year rise in ND referrals requires system-wide transformation and this programme is being led by LPT and overseen by the CYP and Learning Disability and Autism Design groups. Significant additional investment will be required in 2023/24 to address this area of growing need.
8. Specialist Learning Disability services and the Young Peoples Team are consistently meeting the referral to treatment time expectations.
9. CAMHS Eating Disorders have received additional funding to expand the service in order to respond to the increased number of young people requiring specialist support. An improvement plan and trajectory are in place for routine cases, as the service is prioritising urgent referrals that require assessment and treatment within one week. Workforce supply is again proving to be challenging; however the service is now able to signpost to First Steps

voluntary sector provider for routine cases, whilst they are waiting and provide home intervention to support young people who need more intensive support.

10. CAMHS Crisis and Home Treatment service have an enhanced offer and slides 8-9 describe the range of access routes and support available. Strengthened relationships with UHL and integrated clinical pathways have reduced the number of hand-offs and escalation calls, with further initiatives planned.
11. The Beacon is our local 15 bedded inpatient unit for CYP with acute mental health needs. Due to the acuity and complexity of cases in recent months, workforce supply challenges and lack of availability of Psychiatric Intensive Care and Low Secure beds for CYP, the number of beds 'open' to admissions has been limited. Currently 7 beds are open and a plan is in place to increase this number as vacancies are filled and current complex cases are able to access the right package of support.

Recommendations:
The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE** the report and **NOTE** the sustained increased demand for specialist CAMHS resulting from the Covid pandemic.
- The report provides **ASSURANCE** that MHIS funding has enabled expansion of early intervention and specialist services and improvement trajectories and plans are in place, which are being robustly governed at organisational and system level.

NHS
Leicestershire Partnership
NHS Trust

Child and Adolescent Mental Health Services Presentation

ICB 14 July 2022

www.leicspart.nhs.uk

Inpatient Care

Workforce challenges

COVID

Increasing numbers of complex referrals

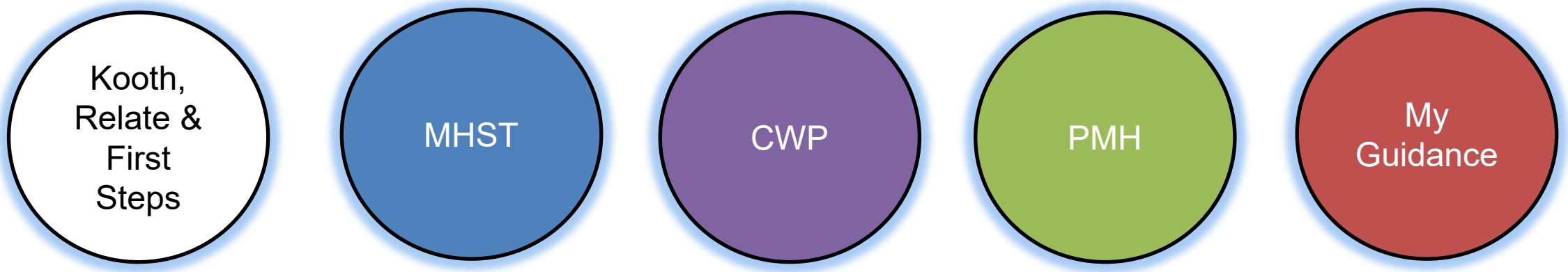
Crisis and Paediatric acute liaison, Urgent Care Hub, Home Intervention Team, Intensive Community Support

Outpatient and Specialist Teams

Increased investment

Early Intervention – Children's Wellbeing Practitioners, Mental Health Support Teams, Primary MH

Early Intervention



Improving access to early intervention and support

Improving access for CYP in Leicester City in line with the Future in Mind strategy

Strengthening the emotional and mental health offer at neighbourhood level; aligning with the Step up to Great Mental Health transformation

Co-production is at the centre of reducing inequality and improving access

CAMHS Outpatients

Nationally a record high for referrals to child and adolescent mental health services in March 2021. At 65,533, it is more than double the number in March 2020 and 68% higher than March 2019.

Locally within this, we are seeing an increase in urgent and complex referrals

Consequences

Prioritisation of urgent and acute cases
Waiting times for routine assessment appointments exceeding 13 weeks
Lengthy internal waits for treatment

Actions

Redesigned ND pathway – waits reducing
Increased investment – MHIS Improvement plan – initial assessment waits
Restoring Group work
Improved digital offer
Improved care navigation
Weekly PTL meetings

WeAreLPT
compassion respect integrity trust

Specialist Teams

CAMHS LD

Eating Disorders

Paediatric Psychology

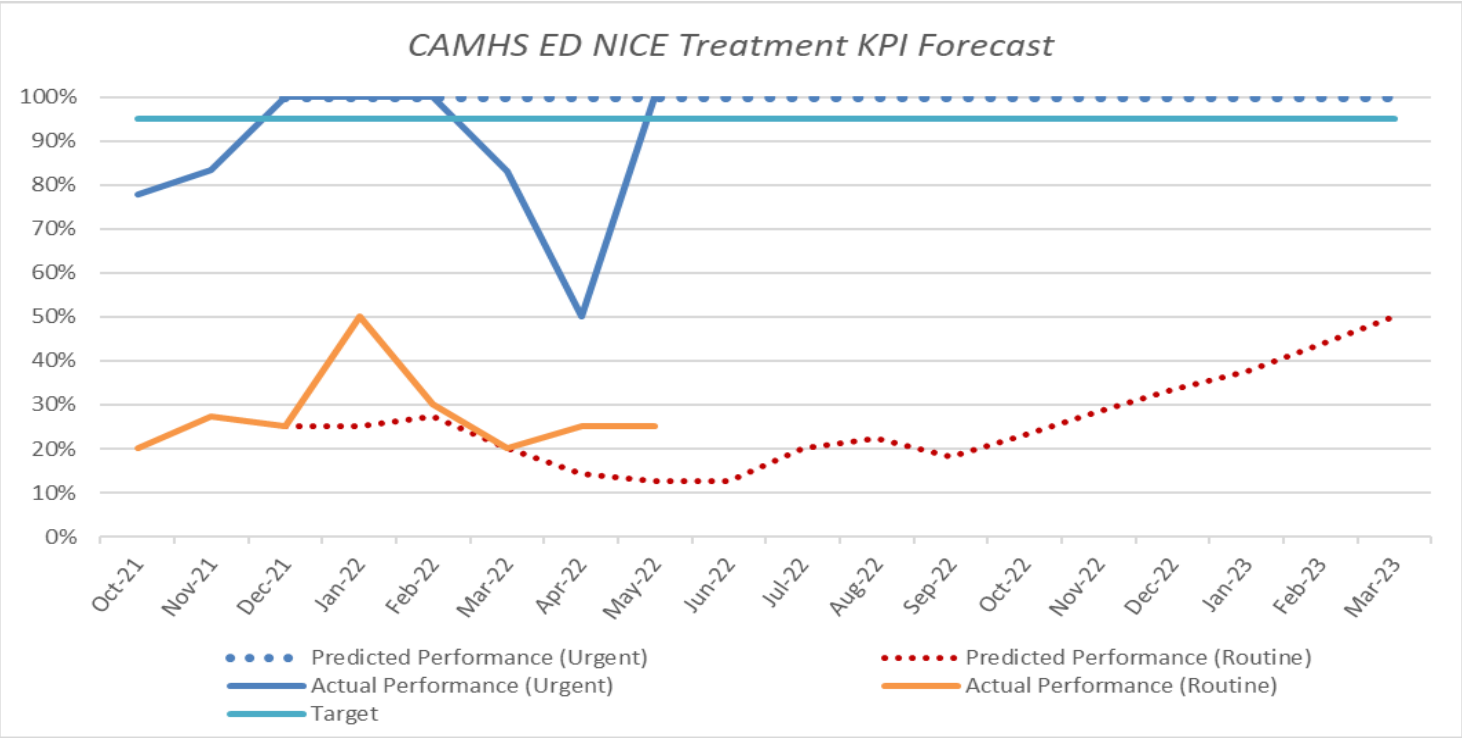
Young People's Team

Increasing number of complex referrals in CAMHS LD stretching the capacity of the team – new investment allocated through MHIS

CAMHS ED increase in referrals 31% (2020/21) and further 26% (2021/22) – investment in HIT team and core team – partnership working with VCS

CAMHS ED Performance

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
4 Week National NICE Treatment	42.9%	22.2%	30.0%	42.9%	20.0%	30.8%	25%	50%	30%	20%	25%	25%
1 Week National NICE Treatment	30.0%	50.0%	100.0%	85.7%	77.8%	83.3%	100%	100%	100%	83.3%	50%	100%



- CAMHS ED has experienced increasing numbers of referrals since 2020
- Priority given to urgent referrals which adversely affects waits for routine referrals.
- Service provides information via its website for support whilst waiting.
- Links with primary care enable monitoring whilst waiting
- Families contacted at regular intervals prior to treatment commencing to ensure any change to risk is identified and actioned.
- Capacity and demand model has been further updated to reflect the increase in referrals.
- Recruitment underway for additional staff. The forecasted recovery is slower than anticipated due to difficulty recruiting to core roles

Crisis and urgent Care

Previous model was based on assessment, home treatment and 7 day follow up from A&E attendance

The service saw a 17% increase (2020/21) and a further 13% increase (2021/22) in referrals

New Model

Improved System working

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University Hospitals of Leicester NHS
NHS Trust

Caring at its best

NHS
Leicestershire Partnership
NHS Trust

CYP Mental Health Pathway Work

Progress update…

- **Identified system challenges in LLR-** Delayed interventions, LOS increased, confidence in services reduced, quality of care and safety potentially impacted. Escalations to MHA's.
- **Solutions and joint working**
  - Dedicated and identifiable support from CAMHS (in addition to the all age mental health offer), which is integrating into the LRI.
  - Escalation process and working relationships between LPT/UHL are improved.
  - UHL CYP is included in the CAMHS daily acuity meeting.
  - Developing a joint UHL/LPT SOP,
  - Scoping meetings with system providers and commissioners to improve CYP MH pathway
- **Outcomes observed now**
  - Access to support is clearer, with advice and guidance from LPT to support UHL colleagues
  - Discharge is safer with the Crisis team assessing when medically fit on wards.
  - UHL has been supported by LPT's H&S team regarding a ligature risk assessment
  - More timely reviews to assess medically fit CYP
  - Number of children being seen by CAMHS has increased at the LRI, there is a reduction in 7 day follow ups, improving the patient experience.

CAMHS Collaborative

East Midlands Alliance
for Mental Health and Learning Disabilities

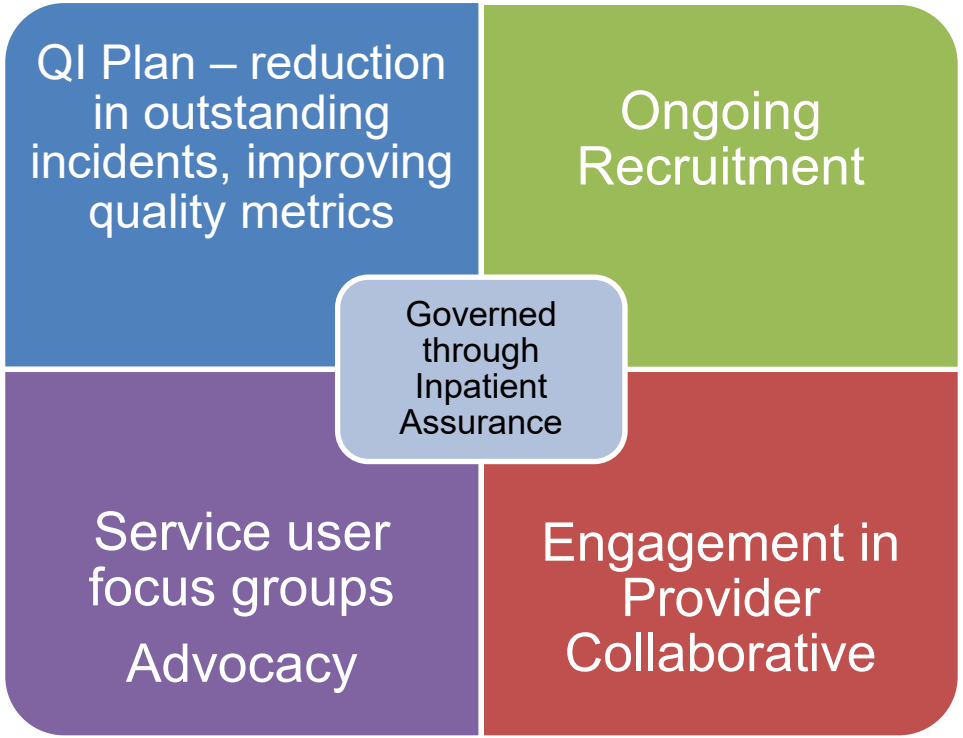
- Inpatient Collaborative operates across the East Midlands (linked to NHS E specialised collaboratives)
- Lead provider is NHFT, with in-patient units provided by LPT, NHFT, Notts & St Andrews' Healthcare.
- Improving care and resolving challenges through:
- Single system and ways of working
- Shared risk discussions between CAMHS and others
- Improvement plans to open beds and build workforce
- Additional Workforce leadership across the East Midlands
- Investment in Community Services (Tier 3.5 up to £2.2m over 3 years in LLR).

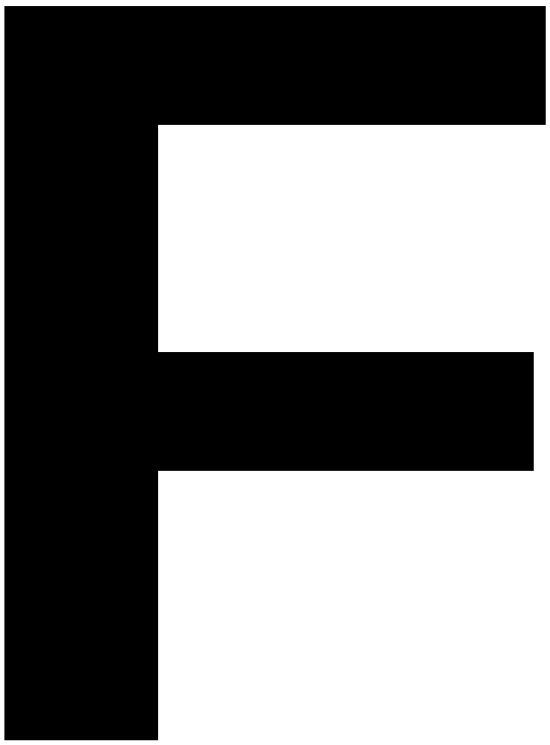
Beacon

Challenges include:

- Acuity of CYP
- Availability of suitable beds e.g. PICU and LSU
- Workforce supply

Improvement Actions





Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**July 2022**	**Paper:**	**F**
Report title:	**LLR System Flow Partnership – briefing**		
Presented by:	Jon Melbourne, Chief Operating Officer, UHL		
Report author:	Rachna Vyas, Chief Operating Officer, NHS LLR		
Executive Sponsor:	Andy Williams, Chief Executive, NHS LLR		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **NOTE** the ongoing challenge to meet constitutional standards, including ambulance standards
- **SUPPORT** the approach to bring forward elements of the strategic plan as outlined in the slides
- **NOTE** that the August ICB will receive a briefing against the trajectory for ambulance handover delays and a strategic demand and capacity plan for the system

Purpose and summary of the report:

1. The purpose of this paper is to provide a precis of the ongoing work of the System Flow Partnership to improve patient experience, reduce the risk of harm and to reduce delay to patient care.
2. The paper outlines the analysis undertaken to understand the thematic issues across the system and the high impact actions being expedited to tackle both operational delivery of the ambulance handover standards in Q2 and a strategic demand and capacity review for Q3 and Q4

Appendices:	Slide pack
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒

4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Achievement of constitutional standards remains a risk on all Trust / provider Board assurance frameworks as well as the LLR CCG's
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	System pressures across every part of the health and care system are discussed throughout the paper.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	The programme plan for each workstream has been formulated using intelligence from various patient and public involvement exercises; this includes Healthwatch audits and reports, feedback from local patients via their local councillors and formal engagement processes e.g. ageing well.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	A full equality analysis will be undertaken as part of any service change presented

NHS
Leicester, Leicestershire and Rutland

Key actions to support the UEC pathway

LLR System Flow Partnership

NHS Leicester, Leicestershire and Rutland is the operating name of
Leicester, Leicestershire and Rutland Integrated Care Board

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Objective

- To update the Board on:
  - Thematic analysis of flow, benchmarked against the region
  - Key high impact actions being taken to support flow across the UEC pathway
  - Governance and oversight
  - Next steps

Benchmarking analysis

Benchmarking exercise, comparing LLR ICS to regional counterparts:

- EMAS call volumes have increased at a similar rate for all 5 East Midlands (EM) ICSs. For LLR, this is on average c3600 more calls per month when comparing Mar-May 2022 vs Mar-May 2021
- EMAS calls for LLR are in the middle for the 5 EM ICSs and conveyances are lower in LLR than anywhere else (774 per 100,000; next lowest ICS is 933)
- LLR has relatively high numbers of people accessing primary care appointments (all appts, same day and F2F) compared to 5 EM ICSs – 1 other ICS has a higher rate per 1000 population in 2022
- Hospital capacity – activity levels are lower than the majority of the 5 EM ICSs (per 100,000 population)
- LLR is in the middle of the 5 EM ICSs for A&E Attendances, although the lowest for those arriving by ambulance (11.6% compared to next highest of 14.3% and 24.8% in Northants.) LLR have had the highest ED attendance growth compared to the 5 EM ICSs.
- LLR are second lowest in total admissions as a rate per 100,000.
- LLR had 13,000 fewer admissions comparing 20/21 with 19/20. Excluding COVID-19 period, this was a 9,619 reduction
- Bed occupancy is broadly similar in ICSs across the region (92.%% for LLR and 93.6% for region) although this does not consider bed availability across different sites/service. Given the nature of secondary and tertiary services, Notts ICS is the most comparable around occupancy.
- LLR is below the East Midlands 5 ICS average for LOS (for 7+, 14+ and 21+ day LOS) but our local trend shows increase month on month
- ED 4-hour wait performance relative to peers has recently been improving

Key actions

Primary Care Collaborative – led by Rachna Vyas

- Managing access to primary care
  - Working in partnership with PCN's to implement innovative models of care across LLR, addressing the '8am' surge. Pilots underway in 3 PCN's.
  - Matching demand with capacity – example: for use of alternatives roles such as community pharmacy, LLR has the highest rate of referral nationally with over 8000 patients seen, treated and discharged by community pharmacy. Service in place, with plans to significantly grow for winter 2022
- Stack management in EMAS and DHU
  - Patient calls to EMAS have increased and often require alternatives to conveyance. The management of the EMAS stack and a single referral route into all pre-hospital / step up services will yield a minimum of 20 less medical presentations a day. Pilot underway, full service ready for winter 2022

Key actions

Home First Collaborative – led by Sam Leak

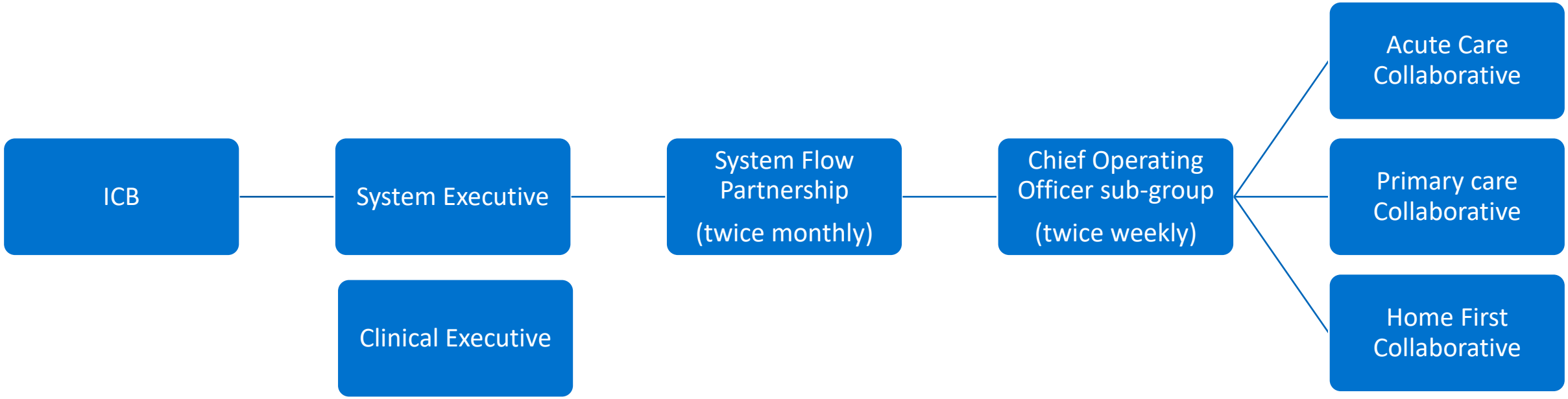
- Decrease the time taken to assess and broker care for all complex patients to within timeframes
  - Process review complete
  - Plans being developed to increase capacity
  - Revised process in place, showing that on average in June 22, UHL patients waited for 3.09 days for discharge via P2, compared to 5.42 days in May 22 (43% improvement)
- Implement full virtual ward model, with 223 beds live by the end of the year
- Complete demand and capacity review for a full rehabilitation and recover service across LLR – pilots underway, full service plan for April 23

Key actions

Acute Care Collaborative – led by Jon Melbourne

- Pilot underway with Integrated Discharge Team now onsite at the LRI, full model in place for winter 22
- Other initiatives under review include:
  - Pre-transfer unit
  - UHL capacity review
  - Improved transport/portering/pharmacy provision
  - Rapid Discharge Team to support flow
  - Enhanced therapy and reablement
- Urgent treatment centres review
- Embedding of internal professional standards, ensuring speciality ownership of patients across UHL. Significantly increased medical in-reach implemented
- Implement additional capacity at local Care Home (24-30 beds) in August 2022, with full case management to ensure flow

Delivery oversight



Winter planning 22/23

1. The System Flow Partnership is in the process of refreshing the demand and capacity modelling to support the winter plan for Q3 and Q4 2022/23. This plan will identify expected levels of demand with a range of scenarios. This is building on the demand and capacity model which UHL has completed.
2. The plan will then determine the number of acute beds, community beds, virtual beds and social care beds and placements needed to meet these different demand levels. It will indicate how much of this response can be achieved through improved flow and how much will need to be met through increased capacity.
3. The plan will be designed to support the accelerated achievement of ambulance handover targets, the continued delivery of elective activity through the winter period in line with the elective recovery plan and the achievement of the revised financial assumptions in the operational plan.
4. Alongside this, Dr Ian Sturgess is currently undertaking a system flow review which will report back to System Flow Partnership at the end of July 2022, which will inform the system's plans

Next steps

- Important to note that the analysis has not changed our strategic direction of travel

- Expedited plans are being led by each collaborative lead:
  - Clinical model of care / support required
  - Feasibility of workforce requirements
  - Funding required

- The winter plan is being collaboratively agreed, with mitigations modelled, with high level plan to August 2022 and the full plan in September 2022

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	**14 July 2022**	**Paper:**	**G**
Report title:	**ICB Allocations and Spend**		
Presented by:	Spencer Gay (Deputy Director of Finance (System)		
Report author:	Nicci Briggs (ICB Chief Finance Officer)		
Executive Sponsor:	Nicci Briggs (ICB Chief Finance Officer)		

To approve ☐	**For assurance** ☐	**To receive and note** ☐	**For information** ☒
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE for information a briefing on the ICB allocations and expenditure**

Purpose and summary of the report:

This report sets out how the £1.9bn allocations the ICB receives is allocated to each programme/ provider and it will clearly set out the spend with other ICBs and specialised services for which any change in allocations could have an impact on the finances of the system.

The report shows a 4 year trend and how the proportion of spend and allocations have changed over that period.

Readers are asked to note that 2020/21 and 2021/22 saw a change in financial framework with a central process with COVID funding and top ups to ensure systems and organisations were able to achieve a break-even

Appendices:	• None
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☐

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	

Financial Allocations

Introduction

1. The LLR ICB has an allocation of £1.9bn but as a collection of organisations we have a spend of £2.6bn this is largely due to the specialised commission spend in UHL and the patients treated from outside of LLR.

2. At the start of 2020/21 the system made a conscious decision to try to align spend to the strategic priorities of care closer to home and right care right setting. This saw the introduction of the LLR primary care funding model and other service harmonisation initiatives that increased spend by between £5m-£10m. During this time there has been significant investment in mental health through the mental health investment standard. In addition, innovation initiatives and the use of headroom to invest in social care has seen significant investments in the voluntary sector and local authorities (other programme costs). These investments meant as a proportion of spend acute sector spend has reduced despite actual expenditure increasing each year.

3. 2020/21 and 2021/22 saw an increase above normal levels of allocation because of COVID and national top ups to manage the financial burden to prioritise COVID response, vaccinations, hospital discharge programme and reset and recovery of elective care.

4. 2022/23 has seen the return to tariff and contracting process with incentives such as ERF to ensure additional funding targets the elective backlog as well as continued increases in Mental Health and BCF and development/ transformation funds to support primary care.

Allocations

5. LLR received £1.9bn of allocations in 2022/23 and this is split out by programmes of spend in Figure 1 below. Please note that 2020/21 and 2021/22 included a level of COVID and top up spend.

Figure 1: LLR ICB Allocations

						% of Total Expenditure				
	19/20 Actual	20/21 Actual	21/22 Actual	22/23 Plan	Comments	19/20	20/21	21/22	22/23	3-Year Growth
Acute	184,660	158,077	188,262	221,233	Drop in 20/21 attributed to NHSE COVID regime around acute contracts (IS, OOC and NCAs paid by NHSE)	12.01%	9.15%	9.88%	11.38%	19.81%
Acute - UHL	561,202	667,978	743,111	782,985		36.49%	38.65%	38.99%	40.29%	39.52%
Mental Health	37,667	41,342	53,551	58,184	Rise in 21/22 as a result of MHIS/SDF payments to local authority	2.45%	2.39%	2.81%	2.99%	54.47%
Mental Health - LPT	118,695	126,189	140,306	144,731		7.72%	7.30%	7.36%	7.45%	21.94%
Community Health	5,991	8,343	12,129	10,675		0.39%	0.48%	0.64%	0.55%	78.20%
Community Health - LPT	104,219	119,370	137,244	137,150		6.78%	6.91%	7.20%	7.06%	31.60%
Continuing Care	84,577	115,739	104,338	97,788		5.50%	6.70%	5.47%	5.03%	15.62%
Primary Care and Co-Commissionin	183,863	214,924	228,602	228,269	Rise in 20/21 due to Primary Care Covid costs	11.96%	12.43%	11.99%	11.75%	24.15%
Prescribing	163,455	170,509	173,478	177,970		10.63%	9.87%	9.10%	9.16%	8.88%
Other Programme	72,027	86,527	105,944	64,007	Rise in 21/22 as a result of mitigating headroom schemes	4.68%	5.01%	5.56%	3.29%	-11.13%
Running Costs	21,467	19,388	18,864	20,385		1.40%	1.12%	0.99%	1.05%	-5.04%
	1,537,821	**1,728,385**	**1,905,828**	**1,943,377**		**100.00%**	**100.00%**	**100.00%**	**100.00%**	

ICB Expenditure

6. The ICB in 2022/23 plans to spend £2.6bn including UHL and LPTs specialised expenditure and expenditure on out of area patients (Figure 2). 2022/23 sees the proportion of spend

changing dynamics with acute sector and UHL making up 61% of spend compared to 58/59% previously.

7. The national investments in mental health through the mental health investment standards has seen a 3-year growth of over 54% with mental health spend with local authorities/ voluntary sector and the 19% growth in LPT expenditure.

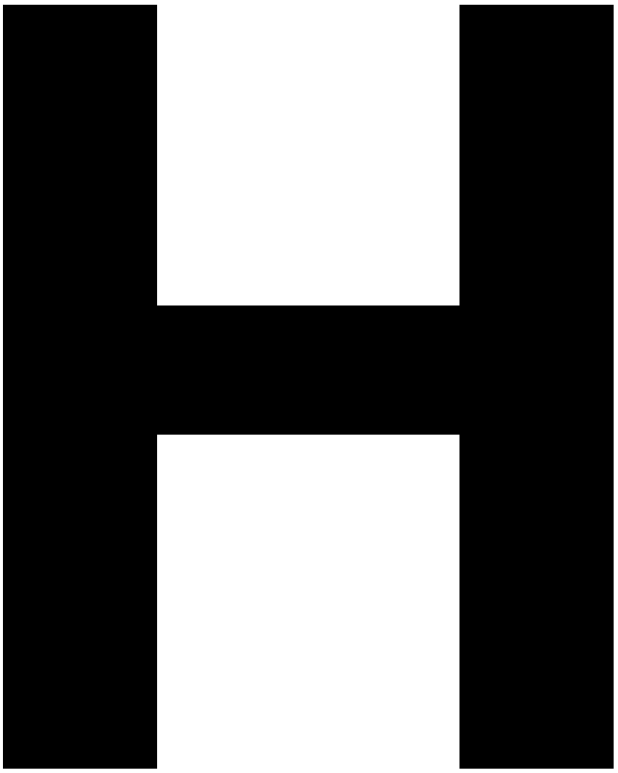
8. In line with expectations running costs across the ICB have reduced in real terms and after removing inflationary increases the reduction is more aligned to 20% over a 3-year period.

Figure 2: LLR ICB Expenditure

						% of Total Expenditure				
	19/20 Actual	**20/21 Actual**	**21/22 M11 FOT**	**22/23 Plan**	**Comments**	**19/20**	**20/21**	**21/22**	**22/23**	**3-Year Growth**
Acute	184,660	158,077	190,762	221,233	Drop in 20/21 attributed to NHSE COVID regime around acute contracts (IS, OOC and NCAs paid by NHSE)	8.10%	6.54%	7.60%	8.61%	19.81%
UHL Expenditure	1,235,392	1,274,507	1,275,998	1,343,356		54.18%	52.76%	50.87%	52.30%	8.74%
Mental Health	37,667	41,342	51,190	58,184	Rise in 21/22 as a result of MHIS/SDF payments to local authority	1.65%	1.71%	2.04%	2.27%	54.47%
Community Health	5,991	8,343	12,689	10,675		0.26%	0.35%	0.51%	0.42%	78.20%
LPT Expenditure	291,022	326,165	345,707	346,450		12.76%	13.50%	13.78%	13.49%	19.05%
Continuing Care	84,577	115,739	103,893	97,788		3.71%	4.79%	4.14%	3.81%	15.62%
Primary Care and Co-Commissionin	183,863	214,924	230,281	228,269	Rise in 20/21 due to Primary Care Covid costs	8.06%	8.90%	9.18%	8.89%	24.15%
Prescribing	163,455	170,509	173,127	177,970		7.17%	7.06%	6.90%	6.93%	8.88%
Other Programme	72,027	86,527	105,394	64,007	Rise in 21/22 as a result of mitigating headroom schemes	3.16%	3.58%	4.20%	2.49%	-11.13%
Running Costs	21,467	19,388	19,432	20,385		0.94%	0.80%	0.77%	0.79%	-5.04%
	2,280,120	**2,415,520**	**2,508,472**	**2,568,317**		**100.00%**	**100.00%**	**100.00%**	**100.00%**	

Considerations

9. It is likely that ICBs will be required to set a medium-term financial plan in Q3 2022/23. When setting the priorities, the board should consider how the allocations and expenditure profiles need to shift to align with the ICB priorities.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	14 July 2022	**Paper:**	**H**
Report title:	**Finance Report Month 2**		
Presented by:	Nicci Briggs, Chief Finance Officer		
Report author:	Spencer Gay, Deputy Director of Finance (System)		
Executive Sponsor:	Nicci Briggs, Chief Finance Officer		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** financial performance information for 22/23.

Purpose and summary of the report:

To provide an update on financial performance against plans during 22/23.

Appendices:	• None
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Longer form report taken to ICB Finance Committee on 29.06.2022

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	

		☐
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☐

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☐	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	BAF 13 - Financial viability over next 5 years
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	All pages – this is the finance report
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	N/A
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	N/A
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	N/A

ICB FINANCE REPORT – MONTH 2

Executive Summary

- UHL and LPT have reported an year-to-date deficit of £7.2m and £0.9m respectively. This equates to a £0.6m underspend against the current plan for UHL and break-even for LPT. CCGs are reporting £4.2m YTD deficit; £0.9m worse than planned.
- The values presented in this report are against the plans submitted in April due to the monthly accounts process preceding the final plan submission.
- Financial plans have since been finalised with all 3 organisations submitting a break-even plan for the financial period. From M3 onwards, we will report a forecast position against this agreed plan.
- There is a significant level of risk assumed in this plan which has been offset with planned mitigations to ensure delivery of a balanced financial plan.

M2 System Position

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
UHL Outside System Income	91,561	91,538	(23)
LPT Outside System Income	10,529	11,858	1,329
Provider Income Outside of System	**102,090**	**103,396**	**1,306**
CCG Allocation	**312,025**	**312,342**	**317**
Total System Allocation	**414,115**	**415,738**	**1,623**
UHL Expenditure	(227,852)	(227,304)	548
LPT Expenditure	(56,422)	(57,751)	(1,329)
Provider Expenditure	**(284,274)**	**(285,055)**	**(781)**
CCG Expenditure Outside of System	**(146,694)**	**(147,853)**	**(1,159)**
Total System Expenditure	**(430,968)**	**(432,908)**	**(1,940)**
Intra-System Misalignment	4,856	4,856	0
System Surplus/(Deficit)	**(11,997)**	**(12,314)**	**(318)**

The reported YTD position is based on the deficit plans submitted in April; UHL £46.1m), LPT (£1.4m) and CCGs (£1.8m).

UHL have reported a year-to-date deficit of £7.2m; £0.6m better than planned largely due to staffing vacancies. LPT have reported a £0.9m YTD deficit which is break-even against plan.

CCGs are reporting £4.2m YTD deficit; £0.9m worse than plan as a result of cost pressures relating to acute variable activity and S117.

Following the submission of a revised plan in June, the profiling of those plans showed a planned system deficit of £8.7m as at M2. Although making the current position appear to be worse, it is important to note that the final plan included additional allocations of £29.7m.

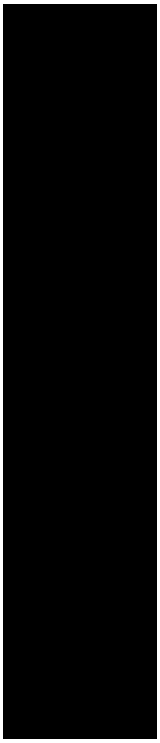
A straight-line extrapolation of the YTD position would result in a projected £73.9m system deficit for the financial year.

The intra-system misalignment relates to a difference in the phasing of the UHL contract which we will aim to resolve ahead of next months reporting.

Risks and Planned Mitigations

The system has several other assumptions and risks that are being mitigated. These will be monitored through the year to ensure delivery of the financial plan.

- Virtual ward funding and other emergency pathway improvements have a significant impact on activity levels and capacity pressures from Q2 enabling closure of additional emergency capacity and maintaining that position through winter (£10m)
- Opportunities across mutual aid, Independent Sector, GIRFT and other productivity measures are maximised to increase the ERF funds. Alternatively, the system will need to implement serious cost control measures to support an £11.4m financial improvement.
- SDF funding is not subject to any claw backs and the system can maximise the use of digital and other transformation funds to support cost reduction (£5m)
- Clinical improvements or developments such as Children and Young Peoples Learning Disability Services are not supported until additional funding or improvements in the in-year positions materialise
- All organisations deliver the £40m cash releasing efficiencies required
- Workforce recruitment, retention and utilisation are managed to planned levels and don't have an impact on elective recovery
- CHC and prescribing growth is managed to 21/22 levels to mitigate a £10m cost pressure
- Other contractors, provider organisations can provide services at levels of inflation set out in the planning guidance without impact on services levels (£6.8m)



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**14 July 2022**	**Paper:**	**I**
Report title:	Summary of the Leicester, Leicestershire and Rutland Integrated Care Board Quality and Safety Committee		
Presented by:	Pauline Tagg – Non-Executive Director for Quality and Safety		
Report author:	Hannah Hutchinson – Assistant Director Quality and Performance Improvement		
Executive Sponsor:	Caroline Trevithick – Chief Nursing Officer		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE for assurance.**

Purpose and summary of the report:

To provide the Integrated Care Board with a summary of the Leicester, Leicestershire and Rutland Integrated Care Board Quality and Safety Committee with took place on 7th July 2022 meeting for the first time.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☐

6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☐
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☐	No conflict identified.	
☒	Conflict noted, conflicted party can participate in discussion and decision	Designate Chair is currently the Chairman of EMAS.
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	

Summary of the Leicester, Leicestershire and Rutland Integrated Care Board Quality and Safety Committee

July 2022

Introduction
The purpose of the report is to provide assurance to the Integrated Care Board in terms of Patient Safety and Quality of care across the system and to Alert the board to Patient safety and Quality Risks where they exist considered by the Quality Safety Committee on July 7th 2022.

Summary
Performance will be considered through the quality lens within the Quality and Safety Committee with a full performance overview taking place through the System Executive Committee.

The Committee will allow space for issues which are high profile and causing concern e.g., Quality Risk Summit but also have a workplan to ensure that all issues and topics are covered from a quality perspective throughout the course of the year and all quality actions being agreed need to be viewed through an equality lens going forward

The Committee is working through how it needs to be assured that there are mitigating actions in place to reduce patient harm to the LLR system in areas of challenge, as the committee presents an opportunity for learning across the system in terms of patient experience and thematic risks and opportunities. The following report identifies areas for escalation that the Committee wishes to alert the ICB, and areas confirming assurance and information

Item for Escalation

- Ambulance Handovers
- Cancer waits
- GP practice with concerns
- Monkeypox

Alert	**Ambulance Handover** Ambulance handover numbers are increasing and this is presenting quality and patient safety challenges to the System including the risk of deaths in the community. The committee discussed the assurances in place around ambulance handover delays and were reassured that there are processes in place to address risks with impact in some areas of the Urgent and Emergency Care Pathway. It was noted that an Urgent and Emergency Care Risk Summit is being held in September to focus on quality and patient safety improvements. However, further assurance was requested to ensure that all patient safety risks are understood, captured and mitigated.
Alert	**Cancer** The committee acknowledged the risks associated with Cancer delays and have requested an in-depth discussion following the Cancer Summit in July to ensure that patient harm relating to delays in treatment are appropriately mitigated until this has taken place there is a lack of assurance in the system around levels of improvement in key areas.

Alert	**GP Practice with concerns** The CNO and CMO reported the ongoing concerns relating to a GP practice in LLR and a number of quality and patient safety issues have been triangulated from a range of different sources to inform potential risk issues relating to patient safety, culture and increases in list size. Assurance was received that the ICB is working in partnership with stakeholder to understand the risk and offer support to the practice to address the concerns. A quality risk summit has been undertaken with the practice and further work is ongoing to work to mitigate patient risk due to the level of engagement by the practice.
Alert	**Monkeypox** Monkeypox is increasing in number but this is not an issue locally for us currently. There is a programme of work around vaccinations for high risk clinical staff and individuals. A system group is being set up with the lead from the Chief Medical Officer working with partners including sexual health services and UHL.
Assure	A report from the Chief Nursing and Chief Medical Officers was presented for assurance around risk in care homes, never events in UHL, CQC warning notice, quality and safety risk management in the ICB and development of the professional nurse advocacy processes.
Assure	The ICB partner quality meetings presented for assurance demonstrated how quality is dealt with in the system. There is membership from the ICB management team within UHL and LPT's quality meetings to address any concerns at an organisational level. For EMAS this is undertaken through Derbyshire as the lead commissioner.
Assure	The Committee was assured around the work taking place within the Patient and Public Involvement Assurance Group and who was involved within this.
Advise / Actions	Future papers will outline the scope and the purpose of groups feeding into the Committee and also ensure that papers have cover sheets to bring out the key elements of alert, assure and advise.
	The Chief Nursing Officer agreed to present the purpose and aims of the Quality and Safety Committee to the Patient and Public Involvement Assurance Group to ensure that the subgroup can work to effectively advise the committee.
	A process is required to review all system quality risks scoring highly and the assurance around the plans, timescales and mitigating actions.
	Further assurance from the patient engagement and inclusion team was requested around the work they are undertaking in LLR for improved patient outcomes.
	The quality and safety risk register needs to capture the quality and patient safety risks for the LLR system. This needs to be based around the ICB strategic objectives and a development session will take place around bringing together the draft risk register; health inequalities and test the system risks. The Q&S Committee will recommend the risk appetite for the ICB to approve.

The key headlines/issues and levels of assurance are graded as follows:

Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Low	**Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls**
Medium	**Amber - there is reasonable level of assurance but some issues identified to be addressed.**
High	**Green – there are no gaps in assurance and there are adequate action plans/controls**

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE for assurance.**

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care System NHS Board**		
Date:	14 July 2022		**J**
Report title:	System Performance Summary Overview		
Presented by:	Caroline Trevithick Chief Nursing Officer, LLR ICB		
Report author:	Hannah Hutchinson Assistant Director of Performance Improvement		
Executive Sponsor:	Caroline Trevithick Chief Nursing Officer, LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE for assurance.**

Purpose and summary of the report:

This report provides an update with key performance indicators which are currently the critical areas of focus for Leicester, Leicestershire and Rutland (LLR). Full assurance of these areas will be monitored through the System Executive Group under the new governance arrangements.

The performance slides cover the full cohort of the performance indicators including:

- P2s
- Long Waiters - 104 and 52 weeks
- Cancer
- Urgent Care
- Mental Health & Learning Disabilities
- Covid Vaccinations
- ICS upper and lower quartile comparisons

Appendices:	Appendix 1 – Performance Slides June 2022
Report history and prior review and date:	System Quality Group – June 2022

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒

6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☐
7. Integration	Deliver integrated health and social care.	☐

Conflicts of interest		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s)? *If so, state which risk and also detail if any new risks are identified.*	Assurance at pathway and provider level supporting improvements and input against LLR BAF 01 and LLR BAF 02. This Committee will review risks associated with quality at design group / collaborative level on a monthly basis.
b) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	N/A
c) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Quality and patient safety are key areas which of assurance and included in the template which all presenters will be asked to report against. Quality and patient safety is at the centre of the assurance and improvement work coming to the Quality Performance Improvement and Assurance Committee.
d) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The Committee in accordance with the requirements of the National Quality Board will have members of Healthwatch as part of the group. Design groups reporting to the committee are also asked to demonstrate their improvement work based on patient and public feedback and there is an item on the workplan with specific focus on this from a quality perspective.

e) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	
f) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	

LLR ICS INTEGRATED CARE BOARD

PERFORMANCE OVERVIEW

July 2022

Hannah Hutchinson – Assistant Director Quality and Performance Improvement (LLR ICB)

Kate Allardyce– Senior Performance Manager (M&LCSU)

PERFORMANCE OVERVIEW

KEY NUMBERS

PERFORMANCE AGAINST PLAN

RECOVERY TIMES FOR LLR

The aim of this PowerPoint is to provide a high-level overview around the areas which are most under scrutiny by our regulators. It focuses on Primary care, learning disabilities, Urgent Care including Ambulance Handovers, elective long waiters, Priority 2 patients, cancer and the uptake of covid vaccinations in LLR.

Within this presentation, we have included an Out of County performance snapshot on key metrics for six Out of County Acute Providers, a brief summary of the NHS System Oversight Framework Segmentation and where LLR ICS are performing in the highest and lowest ICS's in England.

Areas of Improvement

Primary Care - GP appointments & face- to-face appointments

Long waiters (+104 weeks) at UHL

Cancer 2 week wait breast symptoms

Areas of Deterioration

Ambulance Handovers 30-59 minutes

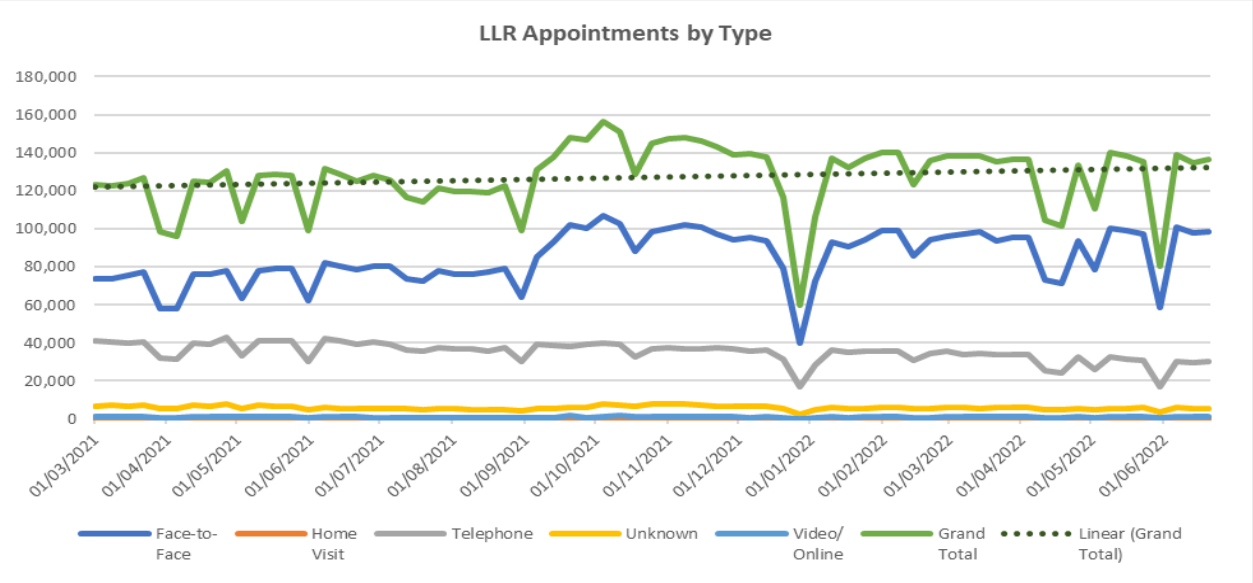
Priority 2 patient numbers

Primary Care – General Practice Appointments

Monthly data The table below shows the monthly number of all general practice appointments in May 22, which was higher than in May 20 and May 21.

All Appointments	Total
May-19	522,137
May-20	357,677
May-21	489,783
May-22	578,737

Weekly LLR Appointments by Appointment Type Mar 2021 – June 2022



Weekly data The data is now received weekly as well as monthly. Total appointment types show an increase compared to the previous published 7 days. The number of face-to face appointments has also increased compared to the previous published 7 days.

The % of appointments seen on the same day as booked has reduced slightly to 44.4% of all appointments.

Learning Disabilities

Adults and Children who are autistic, have a learning disability or both and who are in inpatient care for treatment of a mental disorder

22/23 PLAN ADULTS	Q1	Q2	Q3	Q4
CCG Commissioned	17	16	15	15
NHSE Commissioned	13	13	13	13
TOTAL Commissioned	**30**	**29**	**28**	**28**
ONS Resident Population of CCG (18+ only)	856,089	856,089	856,089	856,089
LD Inpatient Rate per Million	35.04	33.87	32.71	32.71

22/23 ACTUALS ADULTS	Q1	Q2	Q3	Q4
CCG Commissioned	17			
NHSE Commissioned - ADULTS only	14			
TOTAL Commissioned	**31**			
ONS Resident Population of CCG (18+ only)	856,089			
Inpatients per million population	36.21			

	Q1	Q2	Q3	Q4
CHILDREN Inpatients 22/23 PLAN	5	4	4	4
NHSE Commissioned - CHILDRENS only ACTUAL	5			

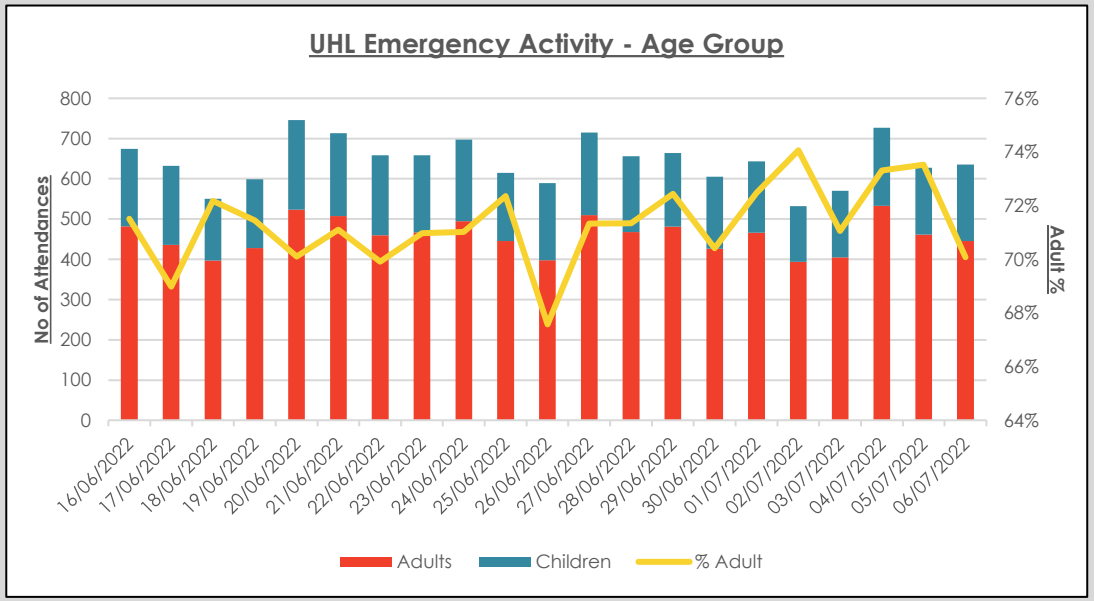
Inpatient (adult)- Some discharges have been delayed due to losing staff, as a result of the double covid vaccination requirements. Appointing new staff is taking time as there are shortages of staff in the care market. CCG commissioned Adult and Child inpatients are on target.

Annual Health Checks (AHCs) Due to the impact of Covid the target for health checks was not achieved. The Q1 22/23 data is not yet available.

Number of Annual Health Checks carried out for persons aged 14+ on GP Learning Disability Register

CCG Name	Monthly count of patients aged 14+, on the practice's LD register who have received a learning disability health check by the GP practice												21/22 HC's Year to date	Q1-Q4 21/22 Plan
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22		
East Leicestershire and Rutland CCG	0	25	52	45	29	47	54	142	59	89	210	167	919	922
Leicester City CCG	35	72	90	70	125	107	167	130	127	171	178	283	1555	1703
West Leicestershire CCG	24	34	51	40	34	58	67	103	130	134	154	279	1108	1188
LLR	**59**	**131**	**193**	**155**	**188**	**212**	**288**	**375**	**316**	**394**	**542**	**729**	**3582**	**3813**

Urgent Care



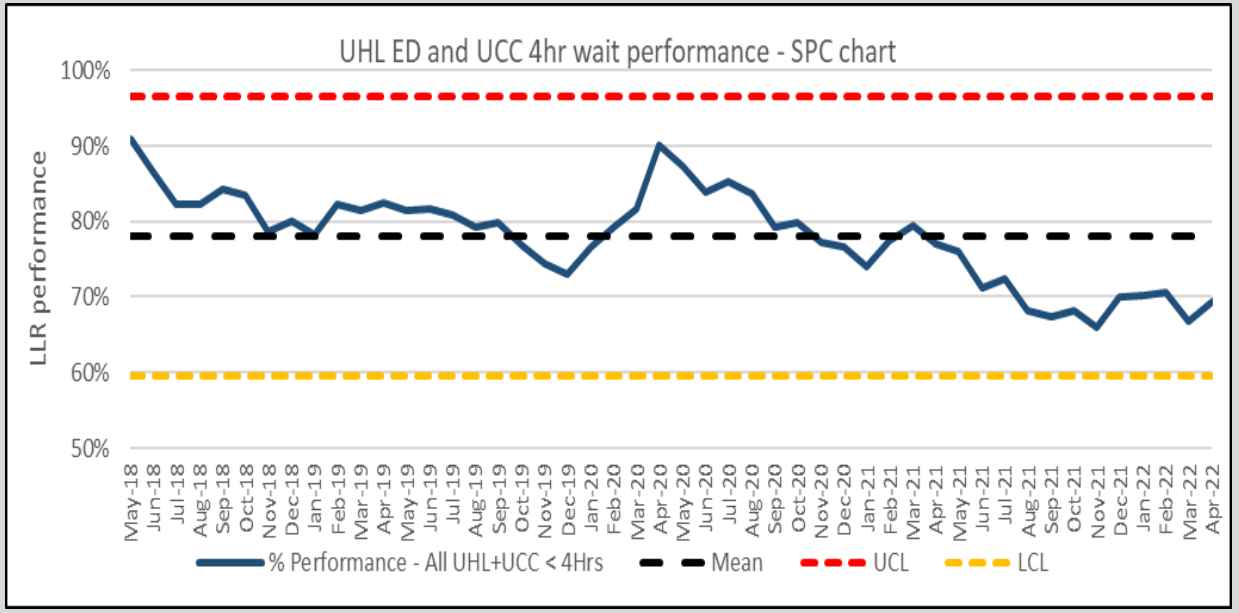
A&E activity for LLR residents is around 80% at the Leicester Royal Infirmary Emergency Department. The remaining 20% will access A&E hospital services outside of Leicestershire (Coventry & Warwick, Derby & Burton, Nottingham, Peterborough etc etc).

April's 4hr A&E wait performance continues to be below the required standards across all local providers.

*** Source: UHL - *Accident & Emergency Report***

UHL ED Activity - Age Group

Period	Adults	Children	% Adult
Latest 7 Days	3,130	1,209	72%
Previous 7 Days	3,264	1,330	71%
Variance	**-134**	**-121**	**1%**
% Variance	**-4.1%**	**-9.1%**	
6 week average	**3,359**	**1,300**	**72%**

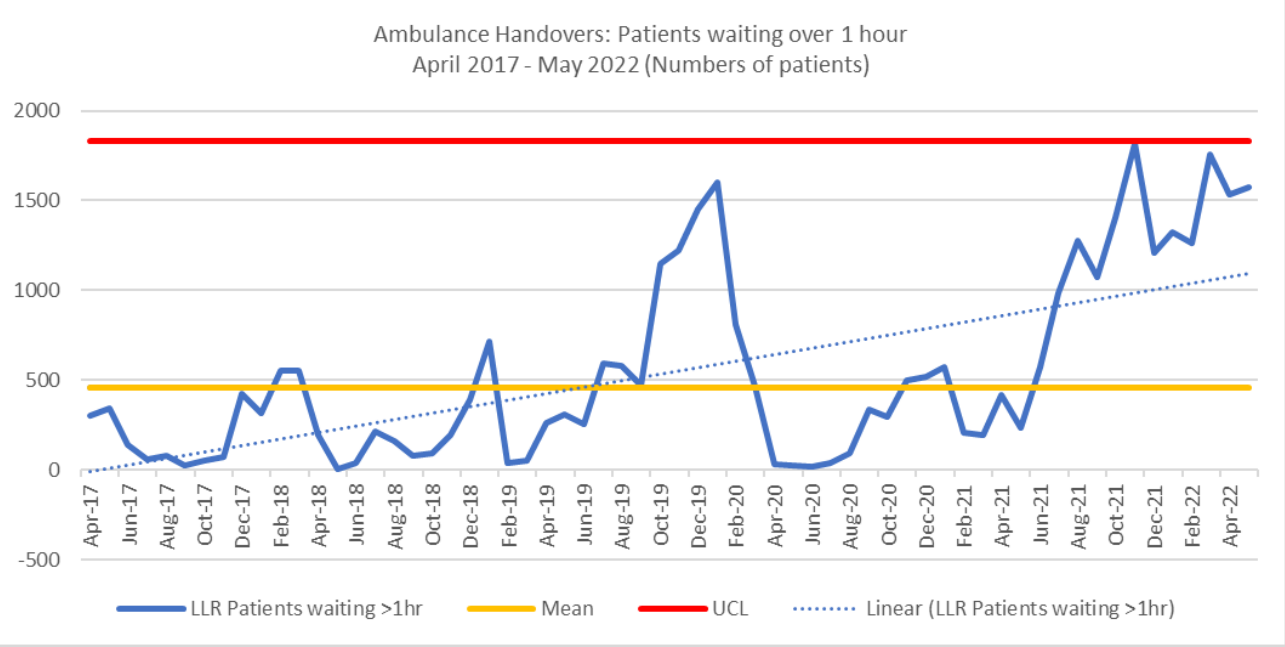


Ambulance Handovers

Urgent Care	12-Jun	19-June	26-June	3-Jul	Variation from prev wk (n)	% change from previous wk	% change from 4wks ago
EMAS UHL Handover: Cases	962	989	936	939	3	0.3%	-2.4%
EMAS UHL Handover: Queueing >2hr	276	196	280	143	-137	-48.9%	-48.2%
EMAS UHL Handover: Queueing >60mins	424	320	400	307	-93	-23.3%	-27.6%
EMAS UHL Handover: Queueing 30-59mins	150	201	142	202	60	42.3%	34.7%
<4hr wait performance - UHL ED & UCC*	66.8%	67.5%	67.8%	70.3%	2.6%	3.8%	5.3%

The table shows the weekly number of Ambulance Handovers at UHL, the numbers waiting over 2hrs, over 1hr and between 30-60min.

Monthly number of Ambulance Handovers- The graph shows the monthly number of Handovers at UHL.

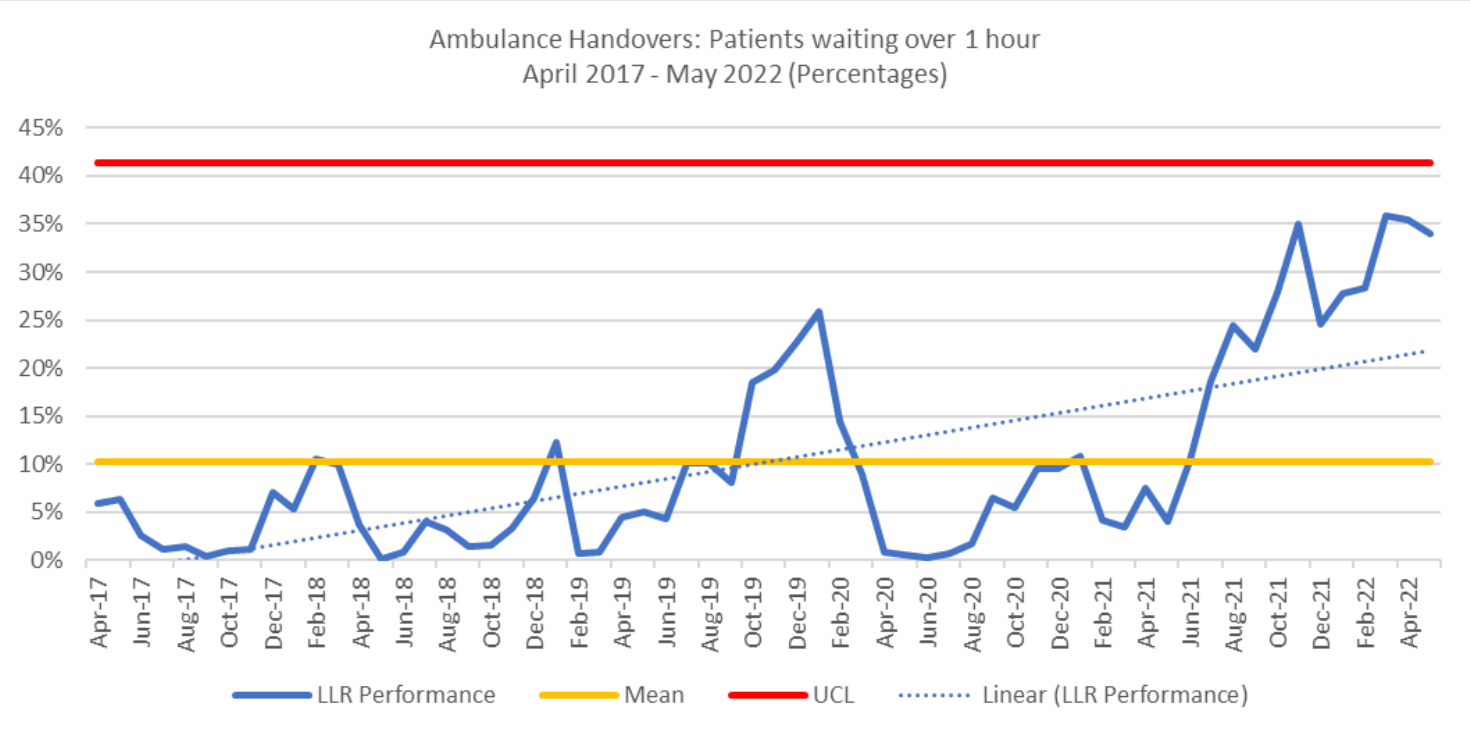


Whilst performance has improved, ambulance waits continue to be a concern. Pressures within our local system are also replicated regionally, though LLR continue to be worse performing system.

The current position puts a significant risk into the system and we need all partners to be focussed on tackling this issue collectively.

Ambulance Handovers

Percentage of patients waiting over 1 hour



The target is zero for Ambulance Handovers over 1 hour - the graphs shows the historical performance for the percentage of patients waiting over one hour.

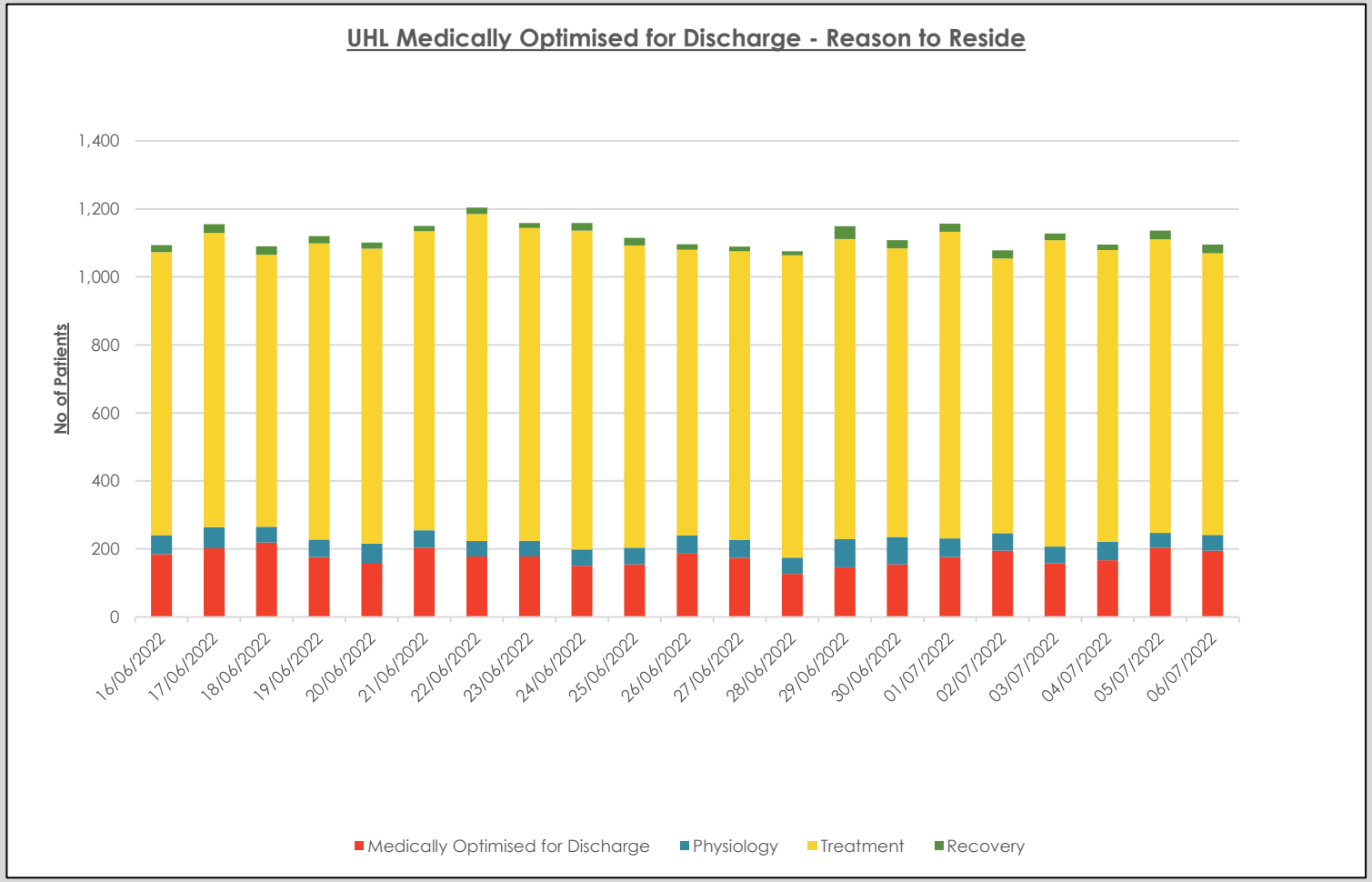
Local actions include:

- Further work with EMAS to implement referrals to GP Assessments Unit (GPAU)

- Action plan being developed with EMAS for trial of mandating calls to pre-admission clinical assessment service (PTCDA) before conveyance to acute site.

- Plans in place to re-establish medical wards at LGH as part of Trust reconfiguration

Medically Optimised for Discharge (MOFD) at UHL



The clinical decision, that a patient is medically optimised, is the point at which care and assessment could be continued at home or in a non-acute setting or the patient is ready to go home.

* Source: UHL - MOFD, Reason for Stay and Long Stay Report

UHL Medically Optimised for Discharge - Reason to Reside

Period	Medically Optimised for Discharge	Physiology	Treatment	Recovery
Latest 7 Days	1,247	381	6,012	158
Previous 7 Days	1,115	379	6,211	139
Variance	132	2	-200	19
% Variance	11.9%	0.5%	-3.2%	
6 week average	1,321	350	6,017	118

UHL Medically Optimised for Discharge - Reason to Reside

Elective – Long Waiters (July 2022 – UHL only data)

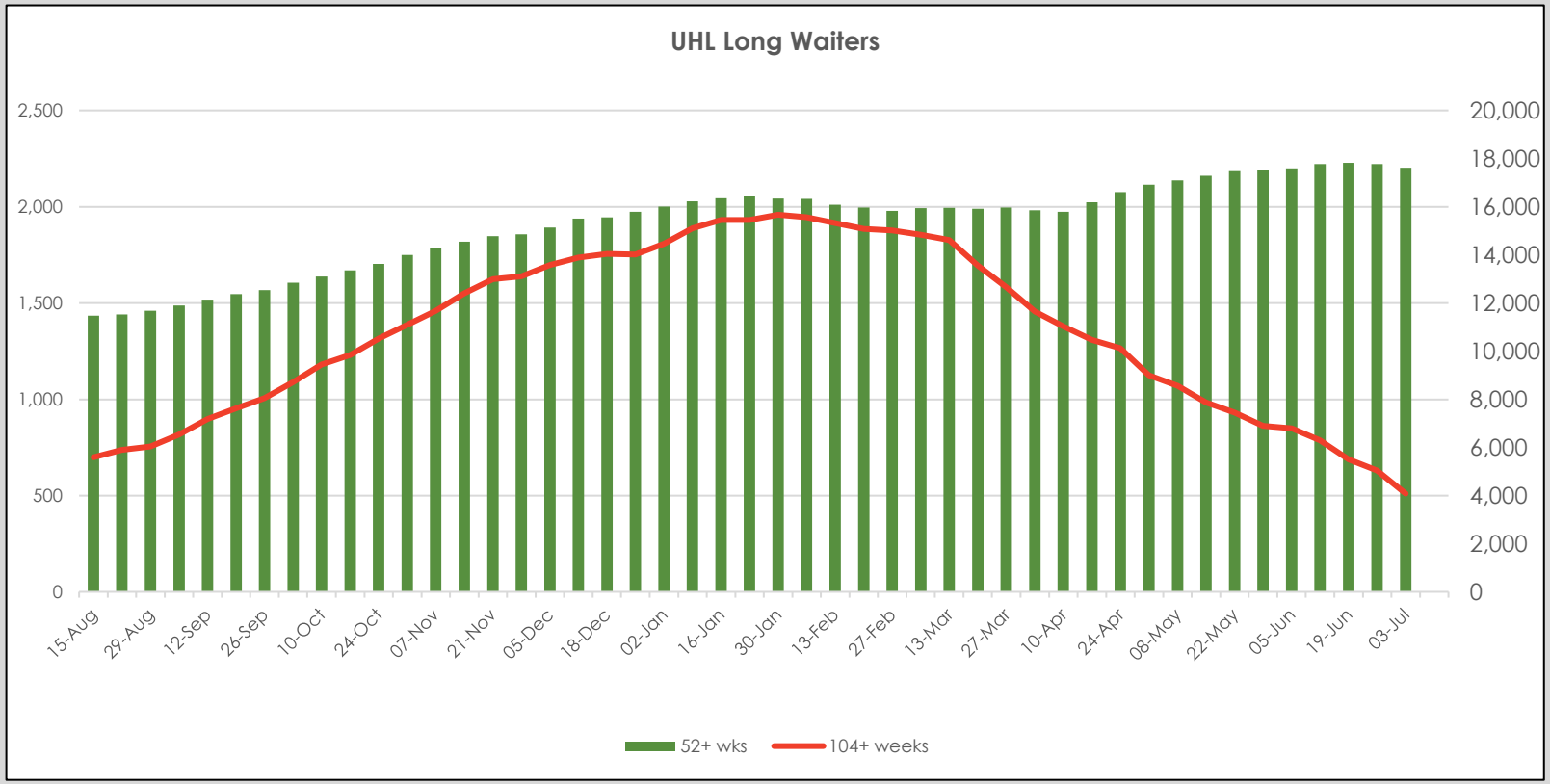
The UHL total waiting list on the 3rd July was **121,716**

52-week waiters stands at **17,622** on 3rd July

104 week waiters stands at **511** on 3rd July which is a significant decrease as per the graph below.

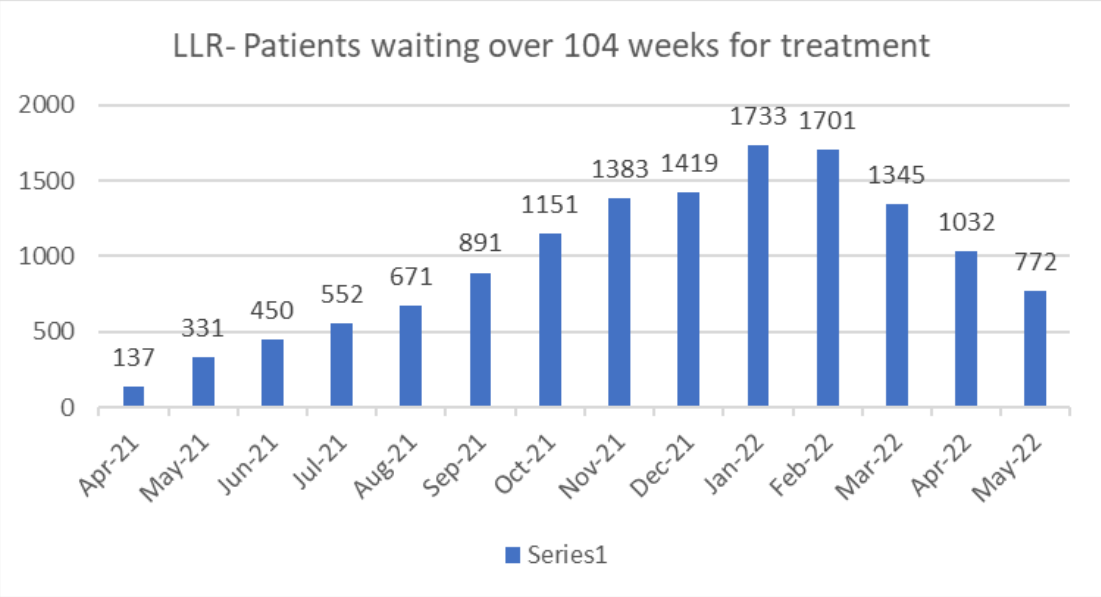
The top 5 specialties with the highest number of 104 plus week waiters are :

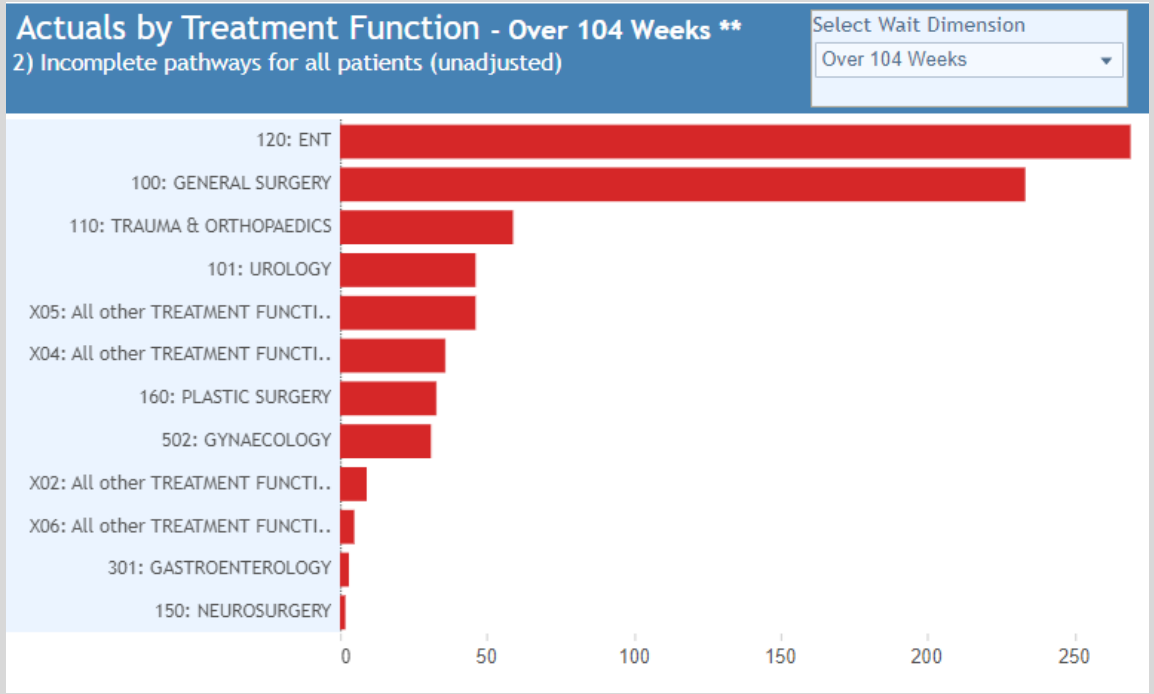
- General Surgery 192
- ENT 149
- Urology 27
- Plastic Surgery 23
- Bariatric Surgery 23
- All other combined specialties 103 (makes up the remaining 20%)



Elective - Long Waiters (LLR patients at all LLR Providers)

In May 22 there were 772 104+ week breaches within LLR, a reduction of 260 patients from April 22. *This is for LLR patients at all LLR providers*



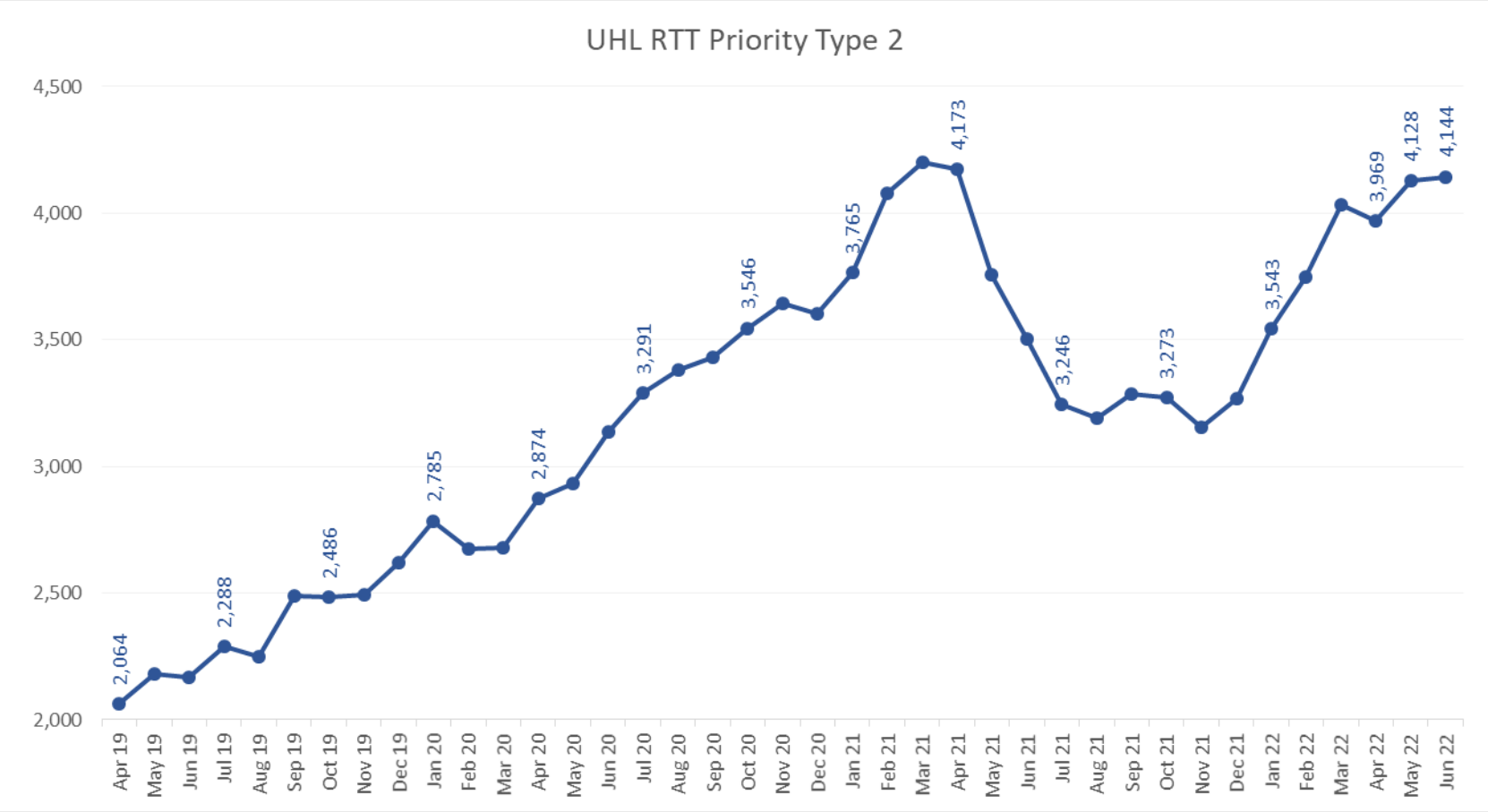


Elective

- During June 224 patients were contacted to firstly to check if patient still wants surgery and secondly to offer option of attending another provider. 50 patients are moving to an alternative provider.
- Insourcing, use of IS capacity and Mutual Aid continues to be sourced to support recovery and discussions are ongoing to maximise opportunity
- MSK Transformation session arranged with NHSE/I for August to focus on areas for improvement

UHL RTT Weekly Summary for Priority Type 2 Patients - (Un-validated)

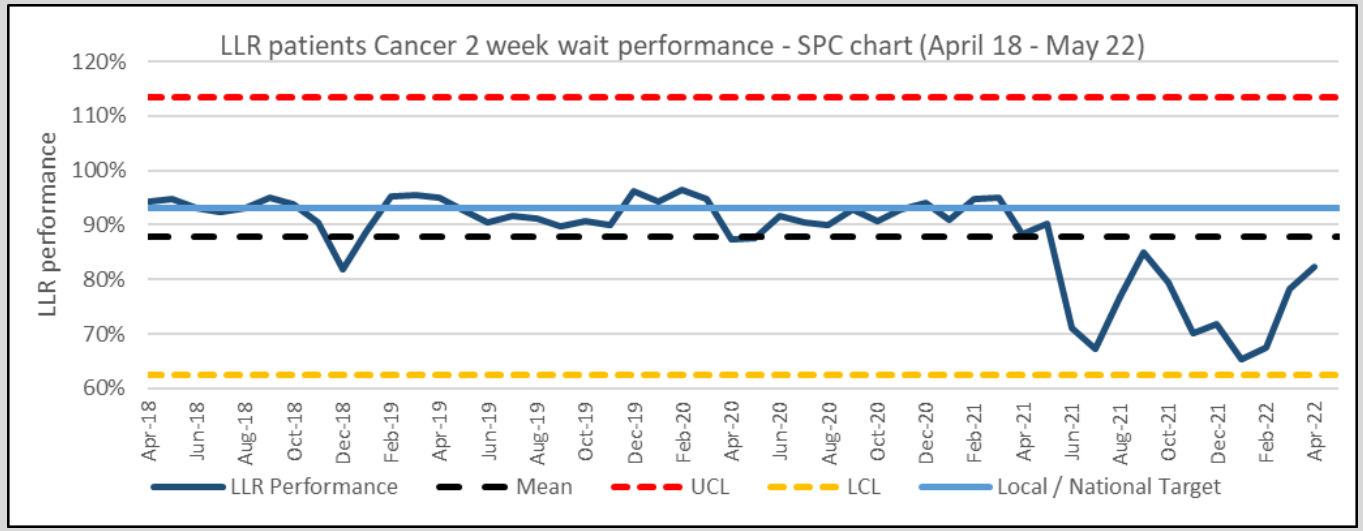
- As at 30th June 2022 there were 4,144 patients waiting for treatment.
- An increase of 0.4% compared to the previous month where there was 4,128 patients waiting for treatment.
- The top 5 specialties make up 47% of the total incompletes.
- The top 5 specialties are:
  - Gastro, 1,332
  - Urology 437
  - Cardiology 363
  - General Surgery 244
  - Gynaecology 201
  - All other combined specialties 1,567 (makes up the remaining 38%)



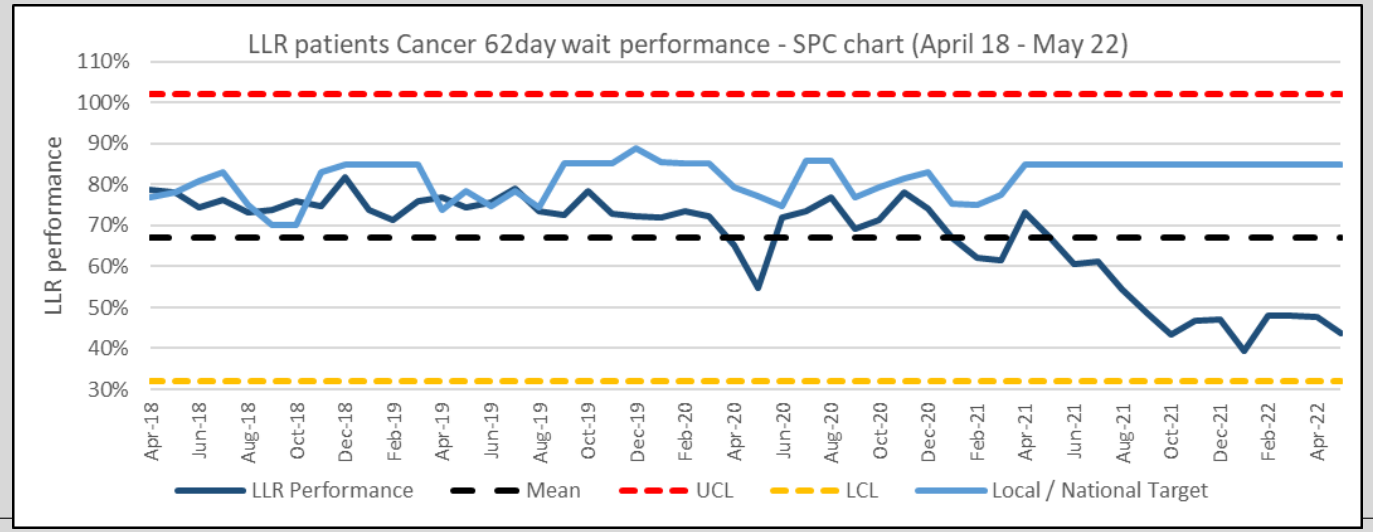
EMT / EDG RTT SUMMARY: Helen Mather/Alpesh Patel

Cancer

2 week wait Cancer Performance for LLR patients at all providers



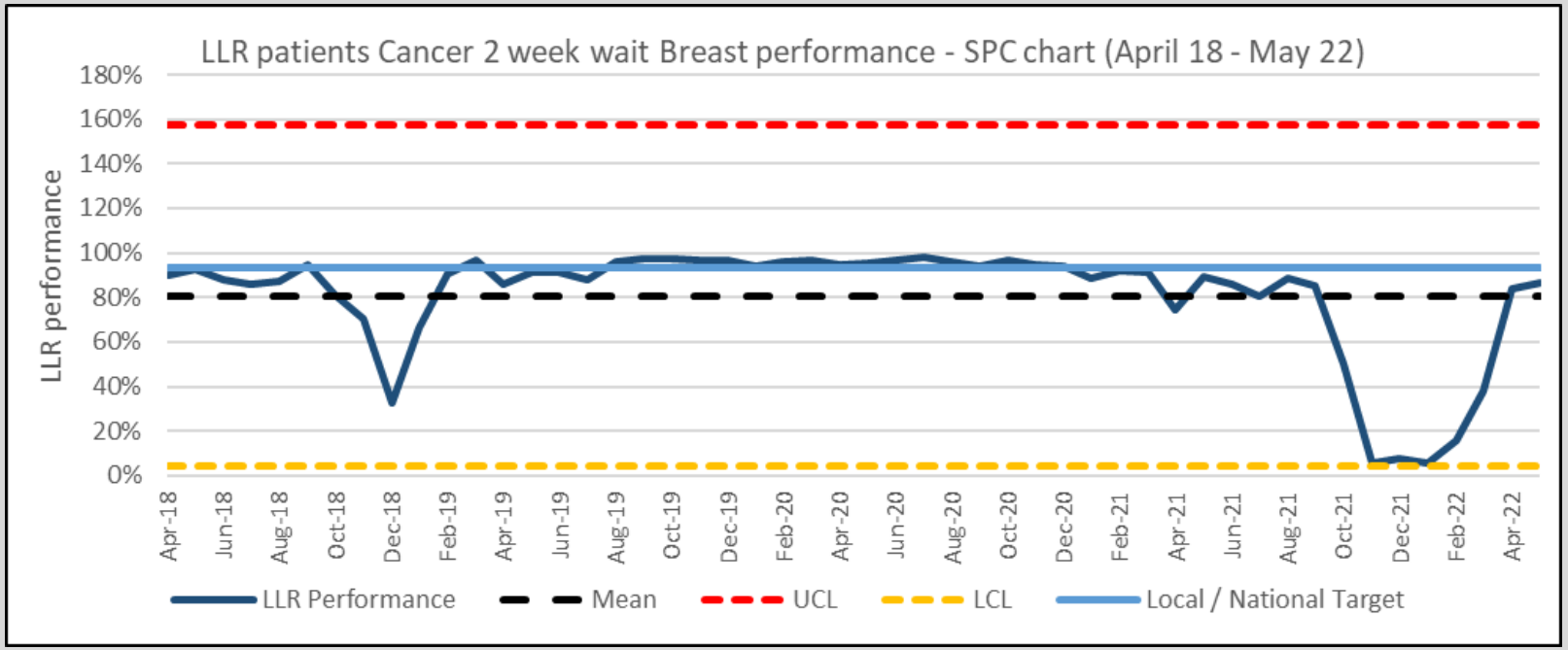
62day wait Cancer Performance for LLR patients at all providers



Haematology, Head & Neck and Urology performance continues to put the 2WW standard at risk of delivery. There are a high level of patients waiting on 62day pathway. Although breast are now booking within 14 days, performance remains poor against the 14 day target.

Specific actions are in place, these include new pathways in the community, utilisation of the independent sector, insourcing, face to face GP appointments, recruitment to locums and waiting list initiatives.

Cancer 2 week wait Breast Symptoms



Monthly stakeholder recovery action plan meetings held with all tumour sites with clear actions on 2WW recovery. Actions in place at UHL:

Breast:

- Breast pain and outsourcing U35s
- Additional WLI and USS rooms at GGH
- Insourcing for weekend activity

ENT:

- Mandatory F2F assessment prior to referral
- Task & Finish group for national timed pathway implementation set-up
- WLI activity and review of i/P for clinic capacity

Haematology:

- Demand and capacity gap-service clinically triaging each referral and appropriately booking
- Service to consider clinical triage telephone consultations

Out of County Performance

The table below provides an overview of the most recent performance data available at UHL and 6 Out of County Acute Providers (Kettering, Nottingham University Hospital, North West Anglia NHS Foundation Trust, University Hospital Derby & Burton, George Eliot and University Hospitals Coventry & Warwickshire)

Indicator	Target	Date of data	UHL	Kettering	Nottingham University Hospitals	North West Anglia NHS Foundation Trust	University Hospitals of Derby and Burton	George Eliot	University Hospital Coventry and Warwickshire	Spire Leicester	Nuffield Leicester	Newmedica Community Ophthalmology, Leicester
A&E Four Hour Wait (excl UCCs)	>95%	May-22	56.0%	CRS Trial Site	CRS Trial Site	53.2%	64.2%	76.5%	70.3%			
Cancer 2 Week Wait from GP referral	>93%	May-22	84.63% 3375/3988	94.23% 49/52	63.64% 14/22	63.89% 69/108	70.97% 110/155	85.71% 30/35	84.45% 44/55			
Cancer 31 day first definitive treatment	>96%	May-22	83.15% 301/362	88.89% 8/9	55.56% 5/9	100% 9/9	87.50% 14/16	100% 8/8	75.00% 3/4			
Cancer 62 day GP referral to first definitive treatment	>85%	May-22	41.88% 98/234	60.00% 3/5	0.00% 0/5	71.43% 5/7	100% 5/5	66.67% 4/6	50.00% 1/2			
Cancer- 28 Day FDS two week referral	>75%	May-22	73.84% 2695/3650	79.55% 35/44	66.67% 16/24	69.15% 65/94	56.74% 80/141	70.97% 22/31	77.27% 34/44			
RTT-18 Weeks Incompletes	>92%	May-22	50.4%	62.6%	59.7%	63.6%	59.3%	67.1%	50.9%	39.6%	29.6%	62.4%
RTT-Overall size of the waiting list		May-22	110,070	936	1,740	1,735	4,561	1,330	2,583	1,030	308	1,139
RTT -Patients waiting over 52 weeks for treatment	0	May-22	15,014	13	158	83	271	16	166	20	107	2
RTT -Patients waiting over 104 weeks for treatment	0	May-22	722	8	4	0	4	0	0	2	18	0
Patients waiting six weeks or more for a diagnostic test	<=1%	May-22	46.87% 16,027/34,192	28.73% 129/449	44.35% 153/345	32.88% 171/520	31.39% 285/908	3.43% 6/175	9.58% 34/355	14.55% 8/55	0.00% 0/13	

Data source- Aristotle

***Note for RTT, Diagnostic tests & Cancer metrics, the data relates to LLR patients only.**

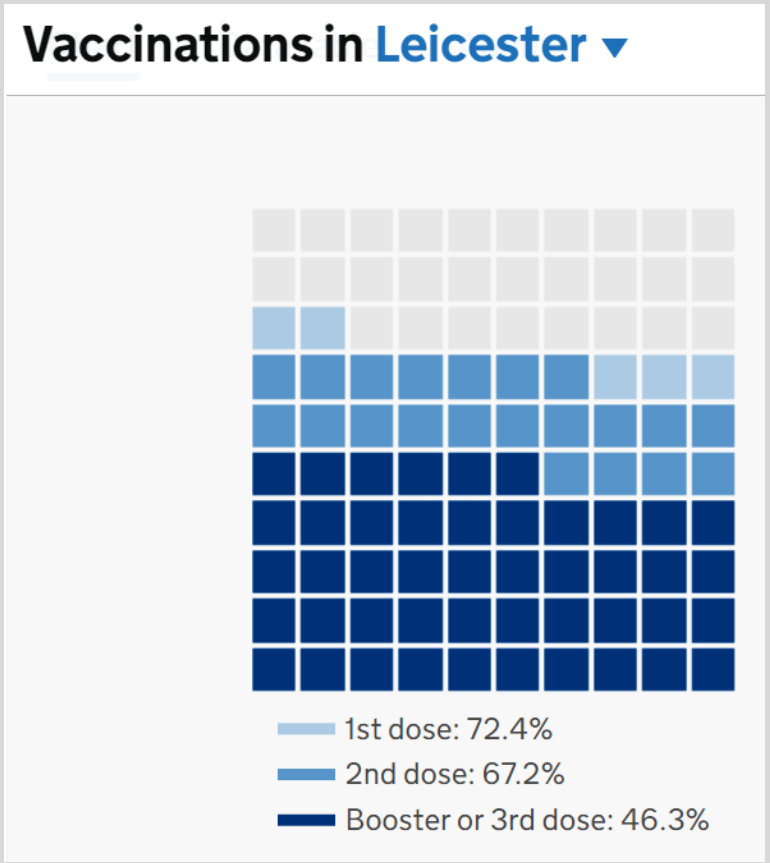
Note:

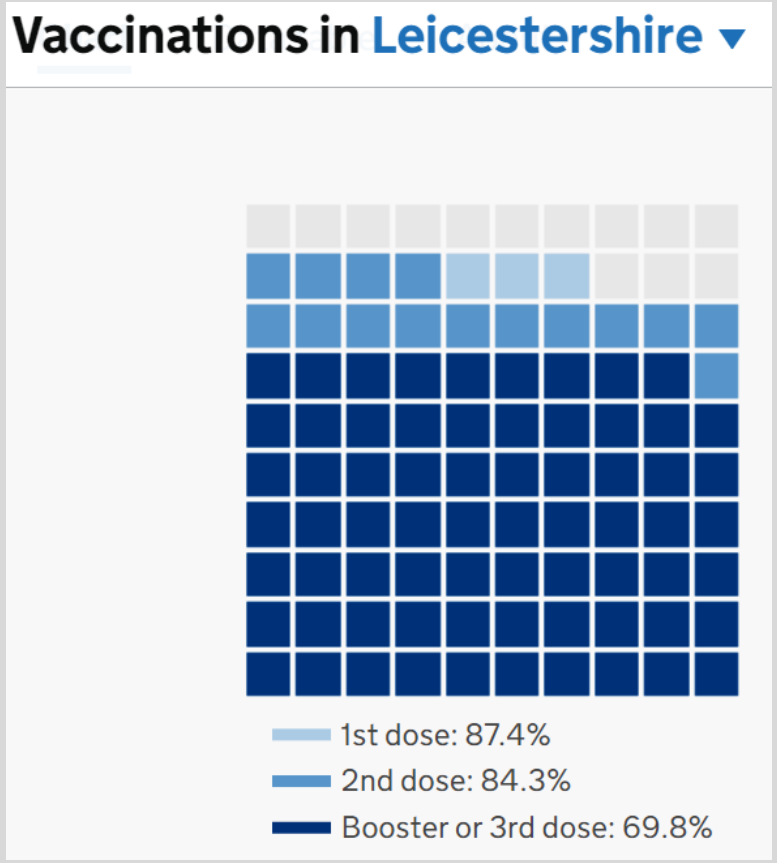
- A&E 4 hour wait remains at Provider level only
- For RTT, Diagnostic tests and Cancer metrics, data is shown for LLR patients only at these providers.
- Metrics have been RAG rated for LLR patients. In some circumstances a metric may be rated red for LLR patients but green as a whole provider position.

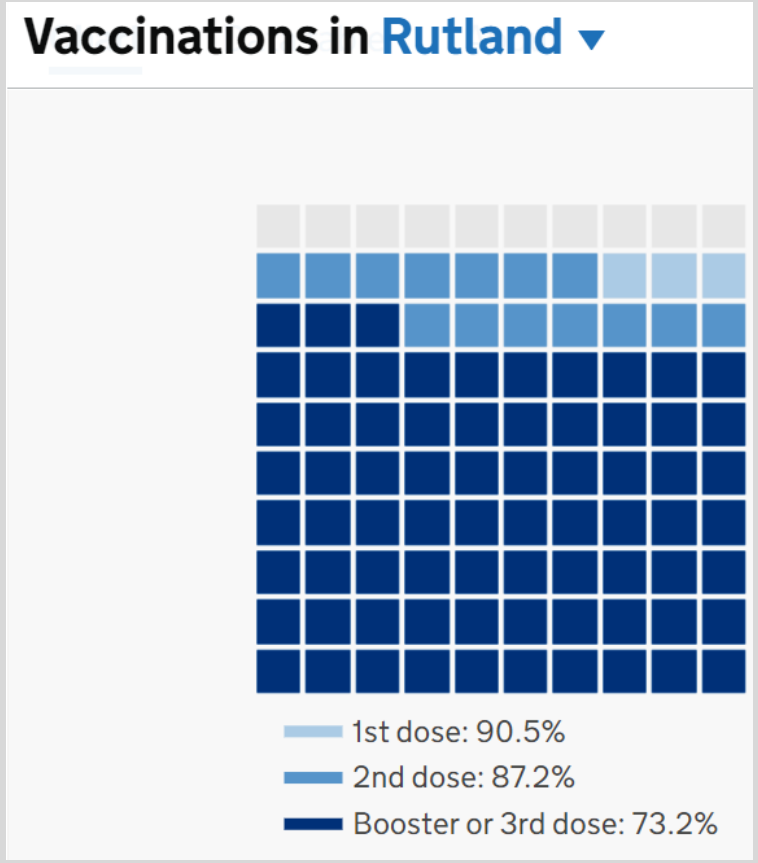
Covid Vaccinations – Published Data

COVID Vaccinations Position, 06-July-22:

Latest total percentage of people aged 12 and over who have received a COVID-19 vaccination, by dose.







NHS System Oversight Framework Segmentation

https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

NHS/I released their latest document outlining the segmentation decisions for all NHS trusts on 16th May 22.

Trusts have been allocated to one of four segments. A segmentation decision indicates the scale and general nature of support needed, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). The table right gives a description for each segment.

The table below shows which segment EMAS, LPT and UHL have been categorised.

14 of the 211 Providers (7%) were classified within segment 4.

Table 3: Support segments: description and nature of support needs

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective, self-standing ICS Plans that have the support of system partners in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

NHS System Oversight Framework 2021/22

NHS Provider Segmentation - May 22

Trust	Segment
East Midlands Ambulance Service NHS Trust	2
Leicestershire Partnership NHS Trust	3
University Hospitals of Leicester NHS Trust	4

The table below shows which segment LLR ICS were categorised in November 2021. 17/42 (40%) ICSs were at segment 3

NHS ICS Segmentation - November 21

ICS	SOF Segmentation
Leicester, Leicestershire and Rutland	3

In June 22 NHSE/I provided an update on performance data for a number of key metrics from the System Oversight Framework (SOF).

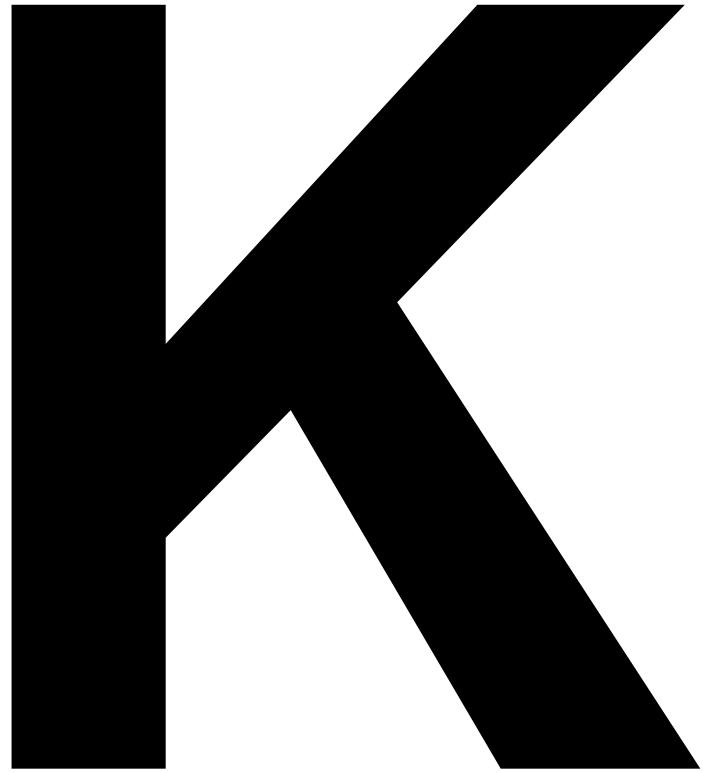
The following table provides details of those metrics where LLR ICS are in the highest performing quartile (top 25%), and their rank against all reporting ICS's, according to the nationally produced dataset.

Jun-22		
NHS Oversight Framework Metric	**Period**	**Rank**
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2022 03	1
S026a: Proportion of ED patients who turn up unheralded	2022 05	1
S039a: National Patient Safety Alerts not completed by deadline	2022 04	1
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2022 04	1
S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	Jan 2022 - Mar 2022	1
S051a: Number of people supported through the NHS Diabetes Prevention programme	21-22 Q4	6
S041a: Clostridium difficile infections	2022 04	7
S052a: Diabetes patients that have achieved all the NICE recommended treatment targets (adults and children)	2020-21	9
S012a: Cancer - % meeting faster diagnosis standard	2022 04	9
S041a: Clostridium difficile infections	2022 04	11
S068a: Sickness absence (working days lost to sickness)	2022 01	11
S022a: Maternity - number of stillbirths per 1,000 total births	2019	11

The following table provides details of those metrics where LLR ICS are in the lowest performing quartile (bottom 25%), and their rank against all reporting ICS's, according to the nationally produced dataset.

It should be noted that metrics vary in their frequency and timeliness of publication.

Jun-22		
NHS Oversight Framework Metric	**Period**	**Rank**
S021a: Maternity - % women on continuity of care pathway	2022 02	41
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2022 04	39
S087b: Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2022 03	39
S044b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Apr 2021 - Mar 2022	38
S073a: Nursing vacancy rate	2021 12	37
S089b: Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Apr 2021 - Mar 2022	37
S016a: Outpatient - Specialist Advice (including A&G) activity levels	2022 03	36
S088a: Number of women accessing specialist community perinatal mental health services	Apr 2021 - Mar 2022	36
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019	36
S014a: Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018	35
S013b: Diagnostic activity levels - Physiological measurement	2022 04	34
S037a: Patient experience of GP services	2021	34
S013a: Diagnostic activity levels - Imaging	2022 04	32
S031a: Number of personalised care interventions	21-22 Q3	32
S070a: Number of people working in the NHS who have had a flu vaccination	2022 02	31



Name of meeting:	LLR CCGs' ICS NHS Board Public / Confidential		**Date:**	14 July 2022	**Paper:**	**K**
Report title:	**LLR ICS Finance Committee Highlight Report – 20 and 29 June 2022**					
Presented by:	Cathy Ellis Chair of ICS Finance Committee					
Report author:	Cathy Ellis Chair of ICS Finance Committee					
Executive lead:	Nicci Briggs Executive Director of Finance, Contracting and Corporate Governance (LLR CCGs)					
Action required:	**Receive for information only:**	✓	**Progress update:**			
	For assurance:	✓	**For approval / decision:**			
Executive summary:	1. The LLR ICS NHS Board is asked to: • **RECEIVE** for assurance the LLR ICS Finance Committee Highlight Report.					
Appendices:	• N/A					
Recommendations:	The LLR CCGs' ICS NHS Board are asked to: • **RECEIVE** for assurance.					
Report history and prior review:	• N/A					

Aligned to Strategic Objectives		
Leicester City CCG	**West Leicestershire CCG**	**East Leicestershire and Rutland CCG**
✓	✓	✓

Implications	
a) Conflicts of interest:	These would be managed during the meeting and appropriate actions would be taken to mitigate conflicts should there be conflicts at any point during the meeting.
b) Alignment to Board Assurance Framework	Individual reports to the Governing Body are aligned to risks within the Board Assurance Frameworks.
c) Resource and financial implications	The report highlights the risks associated with revenue and capital expenditure in 2022/ 23. There is a requirement for delivery of significant transformation in LLR.
d) Quality and patient safety implications	None.

e) Patient and public involvement	None.
f) Equality analysis and due regard	Not undertaken in respect of this report, however, would be undertaken in relation to the reports presented to the Transformation group.

LLR ICS FINANCE COMMITTEE – 20 June and 29 June 2022 meetings

HIGHLIGHT REPORT

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Low	Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls
Medium	Amber - there is reasonable level of assurance but some issues identified to be addressed.
High	Green – there are no gaps in assurance and there are adequate action plans/controls

Report	Assurance level	Matters for Committee escalation to Integrated Care Board	Risks to escalate
2022/23 plan (approved at 20 June meeting)	**Low**	The governance route taken to date for the approval of the system plan was outlined for the ICB, UHL and LPT. The break even plan reflects national guidance. There are 4 priority areas to change the cost base of the system to enable it to break-even: • Emergency pathways £10m • Elective productivity £10m • Prescribing and CHC £5m • Grip, control, reduce waste £5m The Committee noted the clear accountability for each priority and requested that metrics and trajectories were developed to track performance. In addition to the 4 priorities, LLR organisations need to deliver efficiency schemes of £40m. The plan was supported by the Committee, noting that there were significant risks to delivery. Real-time reporting was requested for mitigating actions to be taken early. A risk share agreement has been proposed and is supported by the Committee. This will be approved by respective Boards.	If the revenue plan is not delivered this will impact LLR's reputation and could restrict capital & digital funding, both of which are essential for system transformation.

Report	Assurance level	Matters for Committee escalation to Integrated Care Board	Risks to escalate
System Revenue position at Month 2	**Medium**	At month 2 the system reported a deficit of £12.3m (£7.2m in UHL, £0.9m LPT and £4.2m CCG). The committee requested monthly reporting of forecast run-rates, efficiency schemes and progress against the 4 priority areas in the 2022/23 plan. Together this will enable early escalation of gaps which will be reviewed in a risk and mitigations schedule to forecast the year end position.	Both providers have phased the majority of the efficiency savings in Q3/Q4
Transformation	**Low**	The system Project Management Office (PMO) will be used to drive transformation in the 4 priority areas outlined above. £15m has been identified with further work to do. The committee have asked for reporting that is focused on actual delivery with trajectories of projected savings and quality outcomes for patients.	Significant transformation needs to be delivered in LLR to offset demand growth and close the financial gap.
Headroom expenditure 2021/22 lessons learned	**High**	A total of £58.6m was spent in the second half of 2021/22 on headroom schemes which were approved by the system executive or system flow board. The committee commissioned this one-off report to understand the benefits delivered and whether there were any learnings for future investment schemes. Key lessons relate to: • Accuracy of forecasting • Timing of expenditure • Conducting value for money assessments and benchmarking • Development of metrics and tracking systems • Opportunity to pilot new ideas These lessons have informed the PMO approach to monitoring the 4 priorities.	
Delegation of commissioning budgets from NHSEI in 2023/24	**Medium**	A presentation was shared on the proposals relating to the delegation of commissioning to ICS for pharmacy, optometry, dentistry and specialised services (high value /complex procedures).	Risk relates to the (as yet unknown) allocation of budget and workforce to LLR.

Report	Assurance level	Matters for Committee escalation to Integrated Care Board	Risks to escalate
Risk register Month 2	**Risks rated as indicated**	The ICS Finance Committee risk register is dynamic with updates every month to risk scores and mitigations. New risks have been developed for 2022/23. There are now 5 high risks: • Risk 10 Elective care backlog **(rated 20)** * • Risk 12 Transformation & efficiency schemes **(rated 20)** • Risk 15 management of the unmitigated financial risk in 2022/23 **(rated 20)** • Risk 6 Workforce recruitment and retention **(rated 16)** ** • Risk 11 Delivery of the medium-term financial strategy **(rated 16)** The risks marked * will be jointly held with the ICS Quality & Performance Committee and ** with the LLR People & Culture Board	There is circa £80m of risk to manage in the 2022/23 plan
Terms of Reference	**High**	The draft terms of reference were reviewed and some changes to the membership were agreed.	
AOB		Thanks were given by the committee to CCG lay members, Warwick Kendrick and Wendy Kerr, for their contribution to the committee over the last year and for their many years of service to the NHS.	

Authors:	**Cathy Ellis (Chair of Committee) and Nicci Briggs (LLR CCGs Executive Director of Finance, Contracting and Governance)**

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	14 July 2022	**Paper:**	**L**
Report title:	**Remuneration Committee terms of reference**		
Presented by:	Simone Jordan, Non-Executive Member – Remuneration		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Executive Sponsor:	Andy Williams, Chief Executive		

To approve ☒	**For assurance** ☐	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **APPROVE** the amendments to the Remuneration Committee terms of reference as detailed in Appendix 1.

Purpose and summary of the report:

1. The Remuneration Committee held its inaugural meeting on 1 July 2022. In line with the Constitution and Standing Orders, assurance and outcomes from the meeting will be reported to the confidential meeting of the board.

2. An element of the Committee's business that is being brought to the public session of the board relates to the Committee's terms of reference. The **terms of reference** were received by the Committee and some minor amendments were proposed for the board's consideration and approval. The amendments are tracked within Appendix 1. In the main the amendments relate to determining the remuneration of office holders and employees on frameworks other than the Very Senior Manager framework and Agenda for Change.

3. The board is asked to support and approve the amendments to the Committee's terms of reference.

Appendices:	• Appendix 1 – Remuneration Committee terms of reference
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐

3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☐
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No decision is required in relation to individual remuneration rates and therefore no conflicts noted.
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance arrangements could result in non-compliance with legal and statutory requirements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are adhered to with the Constitution and governance arrangements.

Leicester, Leicestershire and Rutland Integrated Care Board
Remuneration Committee
Terms of Reference

1. Constitution

The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors excluding the Chair.

As the Committee will consist of Non-Executive Directors, the remuneration for the non-executive members will therefore be determined by the Chair and the Chief Executive, and approved by the Chair in line with the Constitution.

The Board has also delegated the following functions to the Committee:
This might include functions such as:

- Elements of the nominations and appointments process for Board members;
- Oversight of executive board member performance.

3. Authority

The Remuneration Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership and attendance

Membership
The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint four non-executive members of the Board as members of the Committee. Other members of the Committee need not be members of the board, but they may be.

The Chair of the Audit Committee may not be a member of the Remuneration Committee.

The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

Members of the Committee shall be the Non-Executive Directors of the ICB:

- Non-Executive Director – Remuneration (Chair of Committee)
- Non-Executive Director – Health Inequalities, Public Engagement, Third Sector and Carers
- Non-Executive Director – Quality, Safety, Performance and Transformation (vice Chair of the Committee)
- Chair of the ICB

Chair and Vice Chair
In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy
- The Head of Corporate Governance
- Chief Executive

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

No individual should be present during any discussion relating to:

- Any aspect of their own pay;
- Any aspect of the pay of others when it has an impact on them.

5. Meetings Quoracy and Decisions

The Committee will meet in private.

The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

For a meeting to be quorate a minimum of two of the non-executive members is required, including the Chair or Vice Chair.

If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Responsibilities of the Committee

The Committee's duties are as follows:

For the Chief Executive, Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);
- Oversee contractual arrangements;
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For office holders and individuals not on either Very Senior Managers framework or Agenda for Change:

- Determine all aspects of remuneration including but limited to salary, (including performance-related elements),
- Determine arrangements for termination of appointment or employment and other contractual terms and non-contractual terms.

Additional functions of the Committee include:

- Functions in relation to nomination and appointment of (some or all) Board members;
- Functions in relation to performance review/ oversight for directors/senior managers (i.e. for the Chief Executive, Directors and other Very Senior Managers);
- Succession planning via a skills review / audit for the Board;
- Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR).

7. Accountability and reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary.

The Remuneration Committee will submit a report to the Board following each of its meetings. Where reports identify individuals, they will not be made public and will be presented at part B of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Behaviours and Conduct

Benchmarking and guidance

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality diversity and inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

9. Declarations of interest

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. Secretariat and Administration

The Committee shall be supported with a secretariat function provided by the Head of Corporate Governance, which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

11. Review

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: ~~1 July 2022 by the board of the LLR ICB~~

Date of review: July 2023

M

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care System NHS Board**		
Date:	14th July 2022	**Paper:**	**M**
Report title:	**Integrated Care Board Development and Public Engagement Approach**		
Presented by:	Alice McGee, Chief People Officer		
Report author:	Alice McGee, Chief People Officer Richard Morris, Deputy Director of People and Innovation		
Executive Sponsor:	Andy Williams, Chief Executive Officer		

To approve ☒	**For assurance** ☐	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Integrated Care Board is asked to:

1. **APPROVE** its approach to Board meetings being virtual or face to face
2. **APPROVE** its approach to ICB development for 2022/23
3. **APPROVE** its approach to engaging with the public

Purpose of the report:

This paper has been prepared to set out the proposal for ICB Board Development as a Unitary Board corporate function, recognising the corporate development and the strategic development of a new board.

The report considers a number of ways of approaching board development and the links with the Health and Care Partnership ensuring our approach to development allows for flexibility and integrated working.

The report also considers, in the context of its approach to development and formal meetings, how it could consider working with the population differently to consider a way of connecting with the public and receiving questions, comments and challenges

Appendices:	
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• 2022/23 Quarter 1 sessions were approved at Board in March 2022

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐

4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☐
7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Board development sessions will include time to consider the BAF and the ICB approach to risk
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	There will be venue costs associated with Board development that will be funded through a corporate budget and will be mindful of the public spend
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Board development sessions will include time to consider the approach to quality assurance and improvement
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Board development sessions will include time to consider the approach to engaging and involving the public, communities and patient groups, allowing time to strategically consider the impacts The approach to engaging with the public in an open and transparent way will ensure that the public have an ability to meet directly with the Board on a regular basis
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	n/a

Integrated Care Board 14th July 2022

Integrated Care Board
Development Sessions

Introduction

1. This paper has been prepared for the Leicester, Leicestershire and Rutland Integrated Care Board following three development sessions in April, May and June 2022 with shadow members and full members of the board

Background

2. The development time spent together as a shadow board and had two focusses; time to strategically consider the opportunities, challenges and progress; and how members will operate, behave and work moving forward.

3. Through the development sessions the feedback was overwhelmingly positive in regards to the importance of spending time together, face to face, to continue our journey to becoming a high performing integrated care team at board level.

4. During the period of shadow running the board has begun receiving questions from the public on matters related to its work and responsibilities, and recognised that the public has limited time on the formal agenda to ask questions or raise appropriate issues.

Membership

5. The board membership is listed below. However, there are a number of regular attendees that whilst not voting members of the board consideration should be given as to their attendance at the development sessions.

Chair	David Sissling
CEO	Andy Williams
Chief Finance Officer	Nicci Briggs
Chief Strategy Officer	Sarah Prema
Chief Operating Officer (attendee)	Rachna Vyas
Chief Medical Officer	Nil Sanganee
Chief Nurse	Caroline Trevithick
Chief People Officer (attendee)	Alice McGee
NED - Audit	Darren Hickman
NED – Equalities and Communities	Prof Azhar Farooqi
NED - Quality	Pauline Tagg
NED – Remuneration and People	Simone Jordan
Clinical Executive Partner	Prof Mayur Lakhani
Partner member – Secondary Care	Richard Mitchell

Partner member – Community and Mental Health	Angela Hilary
Partner member – Leicester City Council	Martin Samuels
Partner member – Leicester County Council	Mike Sandys
Partner member- Rutland Council	Mark Andrews
Partner member – Primary Care	Dr Nainesh Chotai
Healthwatch – Leicester, Leicestershire and Rutland (attendee)	Janet Underwood Harsha Kotecha
East Midlands Ambulance (attendee)	Richard Henderson

Approach to Development

6. Given the need for the board to develop as a corporate body, as well as its need to lead on the development of a strategic and operational plan for the system, areas for potential development subjects may include

    - The board constitution and governance
    - Board/team development (values, behaviours, criteria for success, cohesion, corporate responsibility)
    - The development of collaboratives
    - Place and integration
    - Addressing health inequity
    - Transformation and service development
    - People and communities
    - Board Assurance Framework and the board's approach to risk
    - Quality improvement
    - Digital
    - Capital and estates
    - People plan

7. The approach to board development would be to enable discussion that facilitates focus and consideration to exploring the long-term implications, expectations, and success criteria linked to the themes set out above. These proposed topics would not be aimed at approval of business matters in a committee setting, rather ensuring that the direction, strategic intent and the success factors are thoroughly discussed and recognised at Board level. In turn this will help to support formal decision making.

Meeting Schedule

8. There are a number of ways of approaching board development and many of the constituent partner organisations will be used to working at this level as either corporate directors or elected members. The table below suggests three possible approaches to board development alongside the formal schedule of ICB board meetings to conduct business as set out in legislation. These are set out in Table 1.

9. The relationship with the Health and Wellbeing Partnership, including the inter and co dependencies, will be particularly important in our board development. In preparation for the development session on 30th June 2022 it was agreed that there should be ongoing opportunities for the ICB Board and the Health and Wellbeing Partnership to connect together in a developmental way in addition to the formal ICB unitary board development.

10. Depending on the preferred approach to board development, the board may consider it appropriate to re-commence formal public board meetings in person. The Board may consider it appropriate, at least during 2022/23 to connect with the public in person to conduct its formal business.

Table 1:

Approach 1 Twice a year, full day	Meeting will be in person twice a year to cover a mixture of strategic and behaviour development.
Approach 2 Monthly extended formal board	The formal board will be extended to cover business agenda in public for the first part and a second part of the meeting will be for development, focussing on strategic issues and behaviour development. It is recommended that at least the board development is in person and this may lend itself to meeting physically as a formal board in public too.
Approach 3 Bi-monthly half day development	In this approach the monthly meeting schedule would alternate between bi-monthly formal meetings of the board in public to conduct its business, and private development sessions during the intervening months. This means there would be six formal public board meetings per year and a further six private development sessions per year. It is recommended that at least the development sessions are conducted face to face.

Engagement with the Public

11. Since April 2022 the ICB Unitary Board (in shadow form) has invited members of the public to attend its board meetings. To this point each Board meeting has had an agenda item of 10 minutes to consider any questions from the public relating to items on the agenda.

12. It is universally recognised that the ICB Unitary Board should be accessible and willing to hear from the public on a regular basis, including being open to questions, challenge, ideas and comments on the work of the ICB and wider partnership.

13. A possible way forward in engaging the public in the work of the board could be to hold a number open public meetings. This may allow more free-flowing conversations with the public on a regular basis.

14. However, it should be noted that “in person” public events of this nature can have an attendance which can be relatively limited in numbers and diversity. As a result, using our learning from large-scale engagement programmes of work, a mixture of face-to-face and virtual meetings gives the most opportunity for the public to engage with the Board and take part in a discussion in way that is accessible and inclusive.

15. Our experience suggests that, typically, a Facebook Live event can reach a minimum of 500 people in real time with up to ten times as many people watching back the discussion afterwards. The generally high prevalence of Facebook means, whilst not accessible for all, they tend to attract a much more diverse audience.

16. To further extend the Boards public engagement, existing physical engagement events such as Voluntary and Community Sector (VCS) Forum, Patient and Participation Group (PPG) Forum could be attended periodically by members of the Board. By attending these, the Board members would gain insight into a much more diverse cross section of our population including people from often overlooked/seldom heard communities

17. Table 2 suggests a timetable of meetings that would allow for the public to ask questions, either pre-prepared and shared with the Board, or asked on the day. These meetings would be scheduled for 1-1.5 hours and the members of the board will be provided with an annual summary of key lines of enquiry, responses and engagement to understand whether this mechanism of meeting the board works for the public.

18. It is anticipated that these meetings will not replace the formal agenda item on the ICB Unitary Board agenda but would enhance and provide a better space for hearing from the public about what concerns them.

Table 2

Meeting proposal	Details
Late September 2022	1-1.5 hours in person meeting with the public at an appropriate LLR location
December 2022	Facebook/You Tube live stream event to allow for questions to be posted and responded to, also allowing for recording to be published and watched at a later date
March 2023	Facebook/You Tube live stream event to allow for questions to be posted and responded to, also allowing for recording to be published and watched at a later date
June 2023	Formal Annual General Meeting with sufficient time for a full face to face question session from the public

Recommendations

The Integrated Care Board Unitary Board are asked to:

1. **APPROVE** its approach to Board meetings being virtual or face to face
2. **APPROVE** its approach to ICB development for 2022/23
3. **APPROVE** its approach to engaging with the public

N

Coronavirus (COVID-19) latest national insights

Increase in positive COVID tests continues

1 July 2022

The percentage of people testing positive for coronavirus (COVID-19) continued to increase across the UK in the week ending 24 June 2022.

The increases are likely to be caused by increases in infections compatible with Omicron variants BA.4 and BA.5.

The estimated number of people in the community population testing positive was:

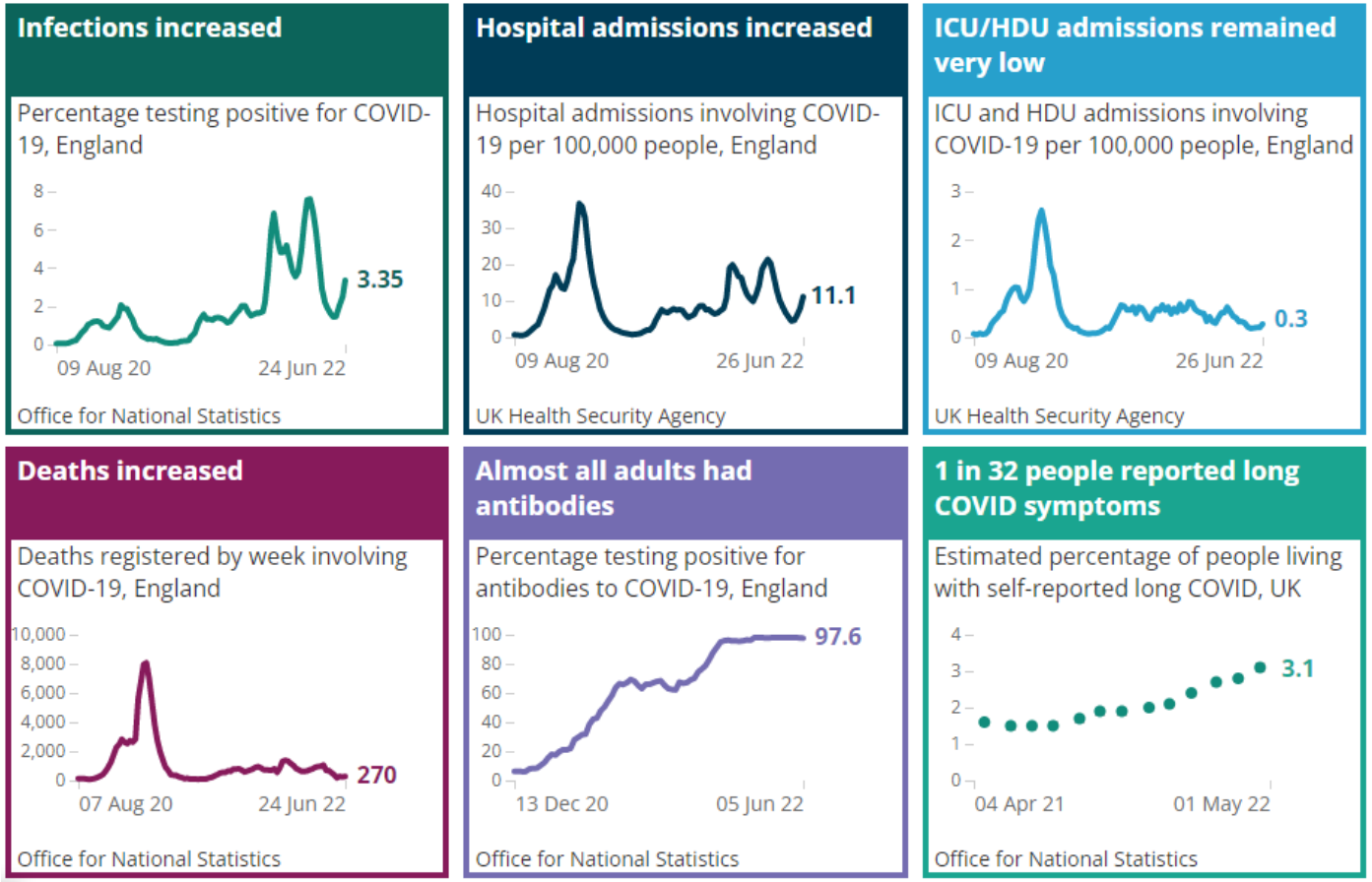
- 1,829,100 (1 in 30 people) in England
- 106,000 (1 in 30 people) in Wales
- 71,000 (1 in 25 people) in Northern Ireland
- 288,200 (1 in 18 people) in Scotland

Deaths involving COVID-19 increased in the UK

5 July 2022

In the UK, there were 346 deaths involving COVID-19 registered in the week ending 24 June 2022, an increase from 309 in the previous week. This accounted for 2.8% of all deaths in the latest week; an increase from 2.5% in the previous week.

There were 12,278 total deaths registered in the UK in the latest week, which is 15.9% above the five-year average.



(Source: ONS)

UK-wide Vaccination Summary

Vaccinations

People vaccinated in England

NATION

Up to and including 30 June 2022

Last 7 days – first dose
26,347

Last 7 days – second dose
42,472

Last 7 days – booster or third dose
50,335

Total – first dose
45,077,701

Total – second dose
42,170,260

Total – booster or third dose
33,210,898

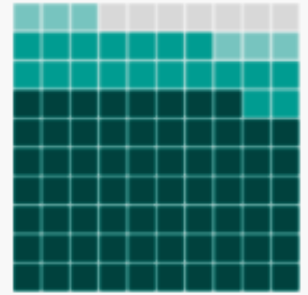
All vaccinations data in England

Percentage of population aged 12+

93.2% First dose

87.2% Second dose

68.7% Booster or third dose



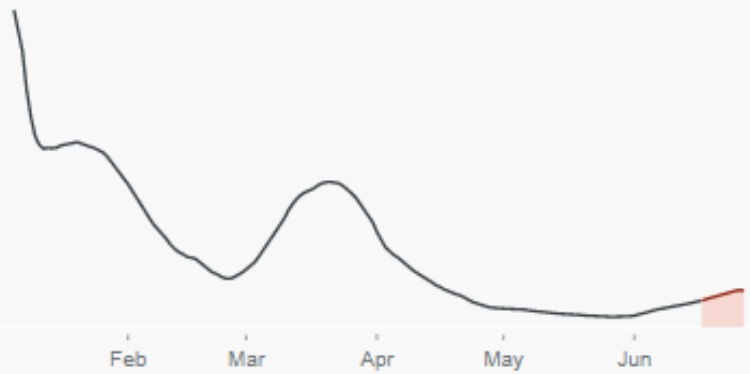
Cases

People tested positive in England

NATION

Latest data provided on 26 June 2022

Last 7 days
116,312 ↑ 29,069 (33.3%)



Deaths

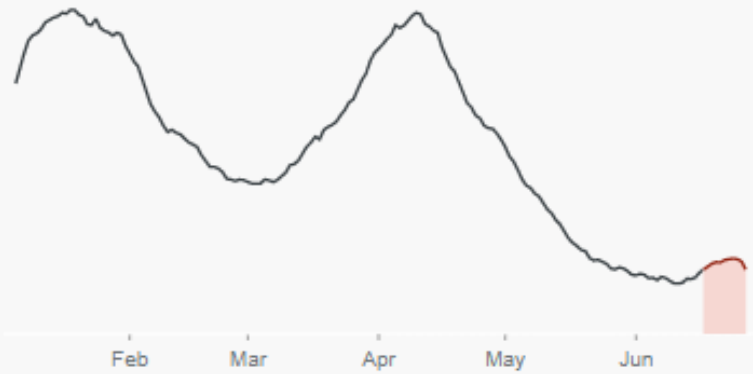
Deaths within 28 days of positive test in England

NATION

Latest data provided on 26 June 2022

Last 7 days
407 ↑ 74 (22.2%)

▶ Rate per 100,000 people: 0.7



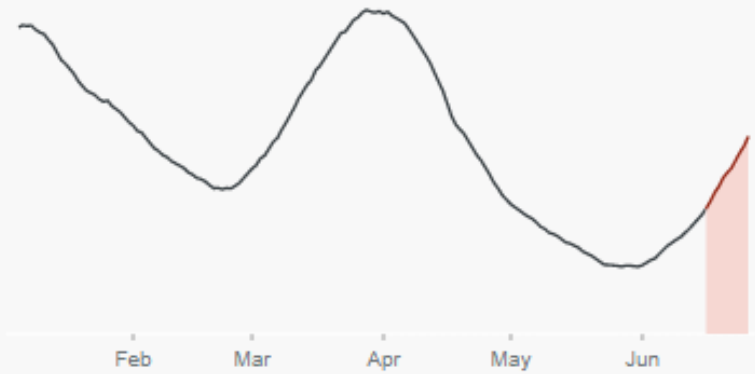
Healthcare

Patients admitted in England

NATION

Latest data provided on 29 June 2022

Last 7 days
9,033 ↑ 2,300 (34.2%)



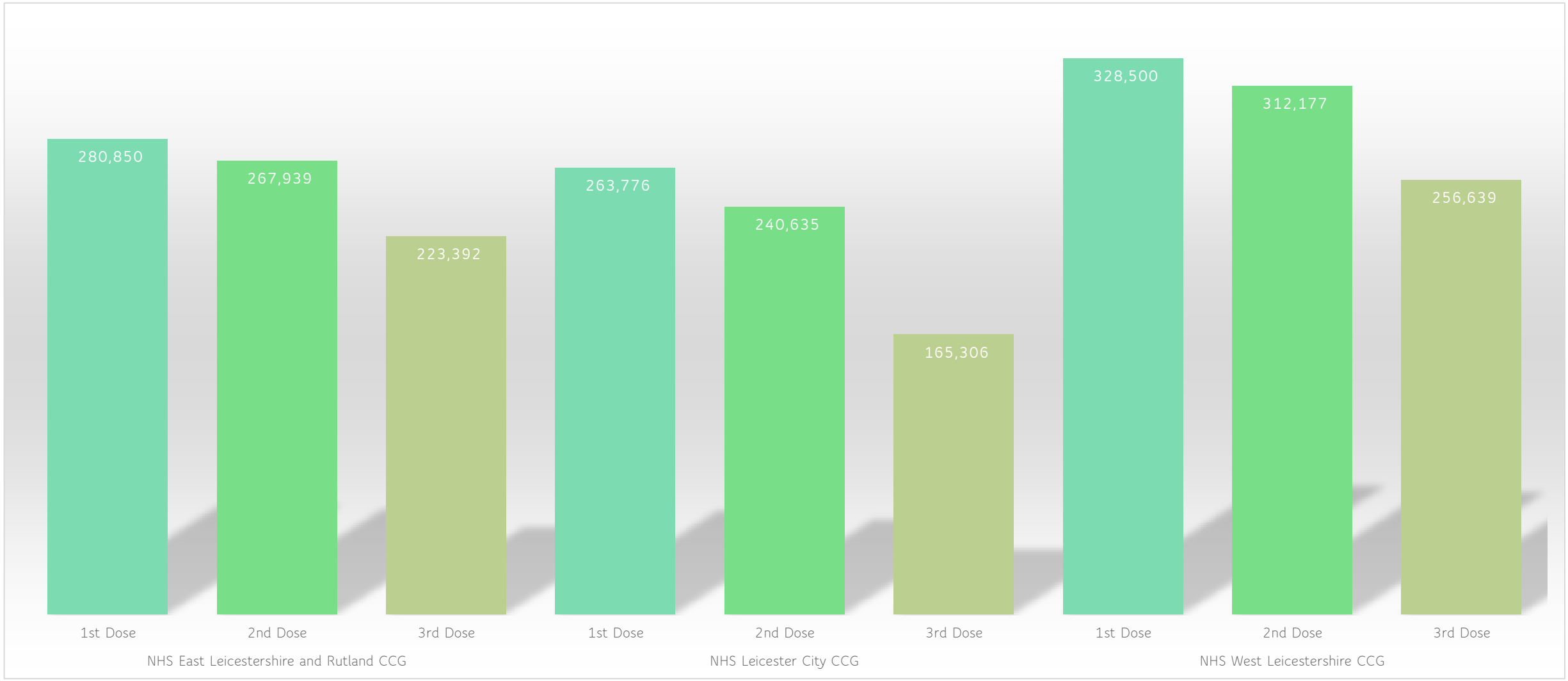
(Source: Gov dashboard)

LLR COVID-19 Published Vaccination Total Uptake Data by Dose and CCG

Between 8th December 2020 to 30th June 2022

2,339,214 Total doses delivered across LLR

Latest available published data



(Source: NHSE Statistics >> COVID-19 Vaccinations

National COVID-19 response: Living with COVID-19

- **Living with COVID-19**: removing domestic restrictions while encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses;
- **Protecting people most vulnerable to COVID-19**: vaccination guided by Joint Committee on Vaccination and Immunisation (JCVI) advice, and deploying targeted testing;
- **Maintaining resilience**: ongoing surveillance, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergency; and
- **Securing innovations and opportunities** from the COVID-19 response, including investment in life sciences.

Objective

To manage COVID-19 like other respiratory illnesses, while minimising mortality & retaining the ability to respond to new variant, or during periods of waning immunity, that could place the NHS under unsustainable pressure.

Planning for year ahead is structured around 3 key priorities:

1. Continued access to COVID-19 vaccination
2. Delivery of a spring and autumn COVID-19 vaccination campaign
3. Development of detailed contingency plans to rapidly increase capacity, if required.

Cross-cutting themes:

- Increase uptake in all communities & address unwarranted variation
- Deliver a spring dose to those most at risk
- Offer vaccination to 5 to 11-year-olds from 4th April.

Living with COVID-19:

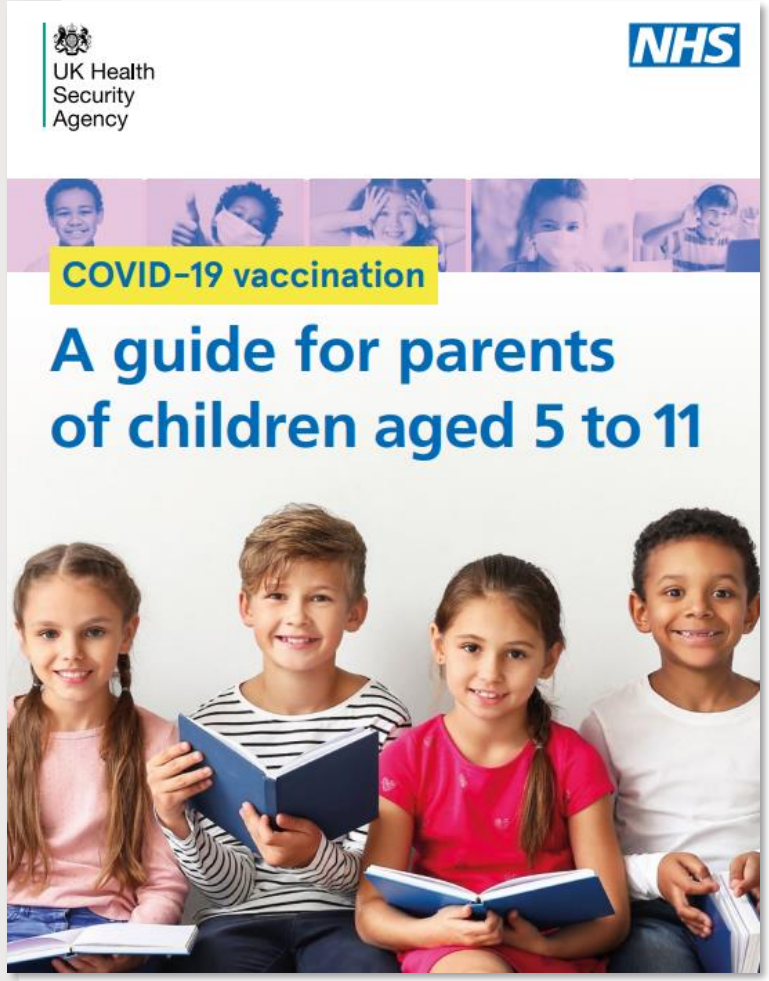
https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19

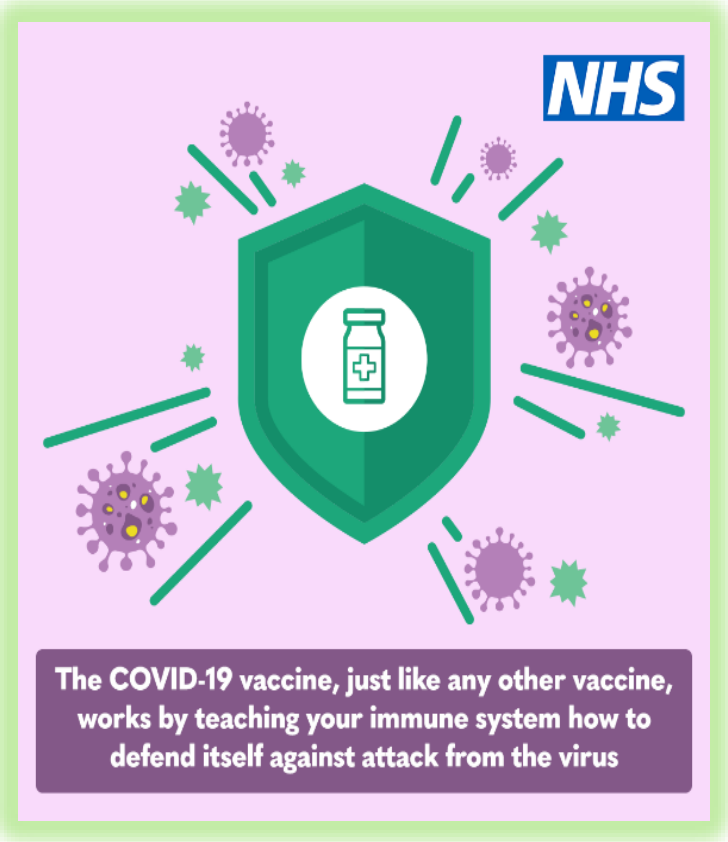
Vaccination offers across LLR

- A wide range of vaccination clinics continue to operate throughout LLR, which include some new approaches:
  - Drive-through vaccination clinic at County Hall, Glenfield (refer to following slide for opening times & more details)
  - Mobile vaccination vehicles taking vaccinations into the heart of communities by targeting specific streets & areas known for low up-take
  - Pop-up clinics located in areas that have low-uptake.
  - Pop-up clinics in areas of high footfall, e.g., Highcross Retail Centre

- The Covid-19 vaccination will reduce the chance of your child suffering from Covid-19 disease. It may take a few weeks for their body to build up some protection from the vaccine.

- Two doses of the vaccine should give your child long lasting protection against serious complications of infection – including any future waves due to new variants.





You can see the leaflet for parents here

LLR Vaccination Status w/c 4th July 2022

Thank you