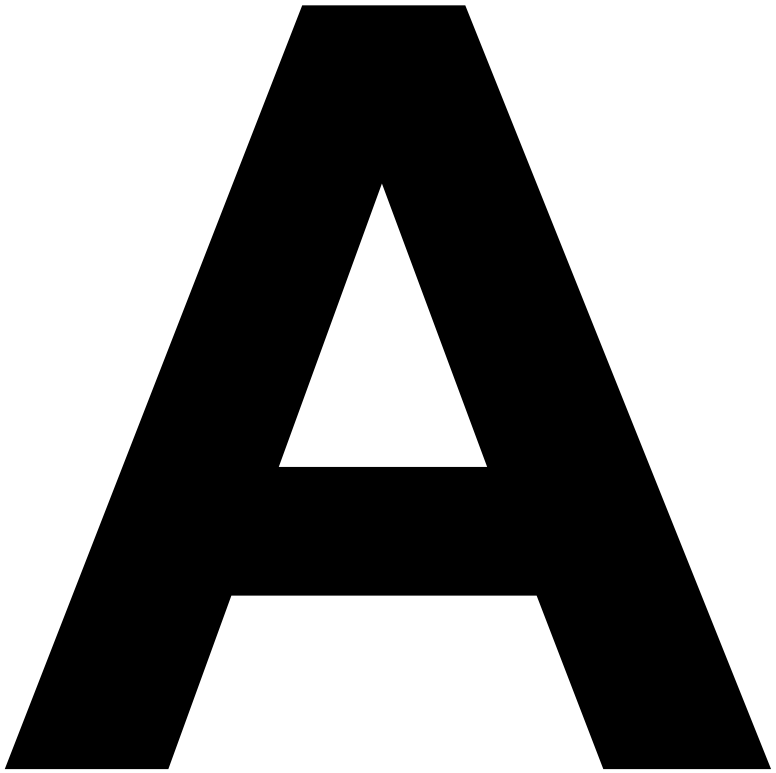
Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 11 August 2022**
Meeting no.	**3**	**Time**	**Meeting in public: 9:00am – 11:10am** **Confidential – 11:15am – 11:30am**
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/22/32	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/22/33	Apologies for Absence: • Richard Mitchell	To receive	David Sissling	**Verbal**	9:00am
ICB/22/34	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/22/35	Declarations of Interest	To receive	David Sissling	**Verbal**	9:00am
ICB/22/36	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/22/37	Minutes of the meeting held on 14 July 2022	To approve	David Sissling	**A to follow**	9:15am
ICB/22/38	Matters arising and actions for the meeting held on 14 July 2022	To receive	David Sissling	**B**	
ICB/22/39	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/22/40	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Andy Williams / Richard Mitchell / Angela Hillery	**Verbal**	9:25am
STRATEGY AND SYSTEM PLANNING					
ICB/22/41	Update on LLR Primary Care – Current Position, Plan and Strategy	To receive	Dr Nil Sanganee	**C**	9:30am
OPERATIONAL					
ICB/22/42	LLR System Flow Partnership – briefing	To receive	Rachna Vyas / Jon Melbourne	**D**	10:00am
ICB/22/43	Elective Care Plan	To approve	Helen Hendley	**E**	10:20am
ICB/22/44	System Finance: • LLR ICS Finance Report M3 • LLR ICB Risk Sharing Approach	To approve	Caroline Gregory	**F1** **F2**	10:35am

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ASSURANCE					
ICB/22/45	Report from the Finance Committee	To receive	Cathy Ellis	**G**	10:45am
ICB/22/46	Assurance report from System Executive	To aprpove	Angela Hillery / Caroline Trevithick	**H**	10:55am
ICB/22/47	Assurance report from the Quality and Safety Committee	To receive	Pauline Tagg	**I**	11:05am
GOVERNANCE					
ICB/22/48	Memorandum of Understanding - Leicester, Leicestershire and Rutland Integrated Care Board and NHS England	To approve	Sarah Prema	**J**	11:10am
ICB/22/49	Pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services	To approve	Sarah Prema	**K**	
ANY OTHER BUSINESS					
ICB/22/50	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:15am

The next meeting of the LLR ICS NHS Board meeting will take place on Thursday 13 October 2022, 9:00am to 11:30am, (meeting to be held in public) via MSTeams.

Motion for private session - the Chairman to move, that members 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.



Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Thursday 14 July 2022
9:00am – 11:30am, Via MSTeams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Dr Caroline Trevithick	Chief Nursing Officer/ Deputy Chief Executive (deputising for Andy Williams), LLR ICB
Mr Spencer Gay	Deputy Director of Finance (deputising for Ms Nicci Briggs), LLR ICB
Prof Michael Steiner	Deputy Chief Medical Officer (deputising for Dr Nil Sanganee), LLR ICB
Ms Sarah Prema	Chief Strategy Officer, LLR ICB
Ms Simone Jordan	Non-Executive Member, LLR ICB
Mr Darren Hickman	Non-Executive Member, LLR ICB
Ms Pauline Tagg	Non-Executive Member (designate), LLR ICB
Mr Richard Mitchell	Chief Executive, University Hospitals of Leicester NHS Trust (UHL) (acute sector representative)
Ms Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust (LPT) (community/mental health sector representative)
Mr Mike Sandys	Director of Public Health, Leicestershire County Council and Rutland County Council (local authority sectoral representative)
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, LLR ICB

Participants:

Mrs Yasmin Sidyot	Deputy Director of Integration and Transformation (deputising for Rachna Vyas), LLR ICB
Ms Alice McGee	Chief People Officer, LLR ICB
Mr Richard Henderson	Chief Executive, East Midlands Ambulance Service (EMAS)
Dr Janet Underwood	Chair, Healthwatch Rutland
Mr David Williams	Director of Strategy and Business Development, Leicestershire Partnership NHS Trust (LPT) (for item ICB/22/21)
Mrs Helen Thompson	Executive Director of Families, Young People and Children's and Learning Disability Services, Leicestershire Partnership NHS Trust (LPT) (for item ICB/22/21)
Mr Jon Melbourne	Chief Operating Officer, University Hospitals of Leicester NHS Trust (UHL) (for item ICB/22/22)
Ms Cathy Ellis	Chair of Leicestershire Partnership NHS Trust (for item ICB/22/27)
Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board

In attendance:

Mrs Daljit Bains	Head of Corporate Governance, LLR ICB
Mr Imran Asif	Corporate Affairs Officer, LLR ICB (note taker)

Seven members of public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/22/10	**Welcome and Introductions** Mr David Sissling welcomed everyone to the Board meeting of NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB). He confirmed that the Chairs of the three Health and Wellbeing Board would be attending and participating in Board meetings at his invitation. The meeting was held in public and was quorate.	
ICB/22/11	**Apologies for absence from Members and Participants:**	

ITEM		LEAD RESPONSIBLE
	Apologies for absence were received from the following: • Andy Williams (Dr Caroline Trevithick deputising) • Dr Nil Sanganee (Prof Michael Steiner deputising) • Nicci Briggs (Spencer Gay deputising) • Professor Azhar Farooqi • Rachna Vyas (Yasmin Sidyot deputising)	
ICB/22/12	**Notification of Any Other Business** There were no additional items of business.	
ICB/22/13	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items. The register of interests was published on the ICB website and will continue to be reviewed and updated.	
ICB/22/14	**Consider written questions received in advance from the Public in relation to items on the agenda** Mr Sissling thanked members of the public for submitting questions in advance of the meeting. <u>Questions received from Mr Geoffrey Smith</u> **"***Paper M on this agenda offers some welcome proposals. However, it does not seem to address the difficulty interested members of the public have in reading through the extensive Board papers in the limited time between their appearance on the ICB web site and the deadline for questions to be submitted. Would the Board consider making the necessary administrative arrangements to enable the Board papers to be published five days before the meeting so as to allow more time for the public to read them and submit questions?"* <u>Question received from Ms Kathy Reynolds</u> *"When did you become aware that the public could not access papers? How did you communicate with the public, explaining the problem and telling them how they could get the papers? Paper M is to be welcomed but your constitution gives the public just 3 days' notice of a meeting, it does not specify if that excludes weekend. When it comes to the agenda and papers it is even less clear as no notice period is specified. Can the Board assure the public that they will be provided with the agenda and papers 5 clear days, excluding weekend, before the meeting, except in the most unusual circumstances when the delay will be explained?"* Mr Sissling observed that questions received from Mr Smith and Ms Reynolds were similar in nature. He offered an apology for the late availability of the Board papers. He explained that the papers had been circulated to members the Friday prior to the meeting. A technical issue with the website prevented the papers being published on the website. The ICB was alerted to this issue on Tuesday (two days prior to the meeting) and the necessary steps were taken to address the situation. The ICB will take action to ensure that the significant majority of papers are circulated and published at least 5 days before the meeting. In addition, it was noted that Paper M provided the opportunity to explore additional options for the Board to engage with members of the public. Dr Caroline Trevithick provided responses to the remaining questions received.	

ITEM		LEAD RESPONSIBLE
	Questions received from Mr Zuffar Haq *"1. The picture on the Web site shows a board meeting taking place, can the board tell me which meeting this is?* *2. Can my questions on the 12th of May now be answered as the ICB is a statutory body.* *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?"* In relation to question 1, Dr Trevithick advised that a generic photo has been uploaded to the website as a placeholder until it is replaced by a photo of the board of the ICB. She advised that responses had previously been made to questions 2 – 9. These was appended to Paper A within the pack of papers for this meeting. They confirmed that the ICB does not hold the requested information and therefore Mr Haq was signposted to the relevant local organisation. For question 10, it was noted that a report on Children's and Adolescent Mental Health Services (CAMHS) was to be considered later in the meeting. As detailed within the report, a number of risks had been identified and mitigations are in place. In relation to performance of A&E, the Board will be receiving an update on this later in the meeting. Mr Sissling invited Mr Haq to comment. Mr Haq had understood that the ICB was responsible for overseeing the system partner organisations and was expecting the response to his questions to be included within the minutes. However, he agreed to contact the respective organisations to obtain a response to his questions. Mr Haq advised that patients and members of the public contact him and raise their concerns and he feels obliged to bring these to the Board's attention. Dr Trevithick thanked Mr Haq and other members of the public for their questions.	

ITEM		LEAD RESPONSIBLE
	Questions received from Mrs Gemma Uddin It was noted that Mrs Uddin had submitted a number of questions. She identified three specific questions for the Board's consideration. The remaining questions, which were sensitive and specific to Mrs Uddin's situation, would be responded to outside of the meeting. 1. *"The change of name i.e., integrated, is similar concept expected from EHCP. However, in practice have failed to observe any improvement with EHCP, as responsibility is passed onto the either LA to Health (CCG) or CCG to LA. How do you seek to improve collaborative work with EHCP? 40 areas of breach were identified in Section F of an EHCP. LA complaint response included an email address to contact CCG for an answer. How does ICB propose the improvements of the services they receive with respect to EHCP?* 2. *Who holds clinical governance for children with complexed health needs with conditions such as severe quadriplegia cerebral palsy and autism?* 3. *What are the total funds allocated for children with SEND for 2020-2021 and for this year 2022-2023 for children with autism and cerebral palsy? How are the funds allocated and how are the needs assessed for individual children? How is the provision monitored and co-ordinated to provide continuity of care?"* Dr Trevithick noted that the responses to questions 1 – 3 required a detailed response and this would be provided subsequently in writing. She did, however, offered an initial overview. In response to question 1, Dr Trevithick advised that the CCG responsibilities have transferred to the ICB and that the ICB will continue to ensure Education and Health Care Plans (EHCP) are in place in collaboration with partner organisations. Dr Trevithick confirmed she is the ICB's Executive Lead for Special Education Needs and Disability (SEND) and will continue to co-ordinate relevant work. In response to question 2, Dr Trevithick confirmed that the clinicians and organisations responsible for individual children's care hold responsibility for clinical governance. In relation to question 3, Dr Trevithick advised that funds are allocated based on a child's needs. Funding requirements are determined through collaborative processes with mechanism in place to determine whether Local Authority or Continuing Health Care funding options should be applied. Decision are based on detailed assessments of the individual circumstances. Mr Sissling expressed his thanks to members of the public for their questions.	
ICB/22/15	**Minutes of the meetings held on 9 June 2022 and 1 July 2022 (Papers A and B)** The minutes were received and accepted as an accurate record, subject to an amendment in Paper A to Mr Mike Sandys' title which should read, "Director of Public Health, Leicestershire County Council and Rutland County Council". It was **RESOLVED** to: • **APPROVE** the NHS LLR ICB minutes subject to the amendment noted.	
ICB/22/16	**Matters Arising and actions for the meeting held on 1 July 2022 (Paper C)**	

ITEM		LEAD RESPONSIBLE
	Mr Sissling advised a number of outstanding actions would be remitted to the relevant Board committee for review and assurance. They would receive detailed scrutiny and challenge through these processes with appropriate reports provided to the full Board. This would provide more time for the Board to focus on strategic matters. Board members supported this approach. It was noted that the Board forward planner is being compiled which will help to focus the business of the Board going forward. It was **RESOLVED** to: • **RECEIVE** the action log and approve the content and proposed delegation of completion of actions to the relevant committee(s) with assurance reports to be received by the Board.	
ICB/22/17	**Minutes of the LLR CCGs' Governing Body meetings in common held on 28 June 2022 (Paper D)** The minutes of the LLR CCGs' Governing Body meetings in common held on 28 June 2022 were received and accepted as an accurate record. It was **RESOLVED** to: • **APPROVE** the minutes.	
ICB/22/18	**Update from ICB Chair** Mr Sissling provided an update on three specific areas. He commented on the announcement made by NHS England & Improvement regarding opportunities to streamline its operating arrangements. There was some prospect of functions and resources being transferred to ICBs. Mr Sissling advised of a recent visit to a general practice in Measham. This provided an opportunity to understand the priorities and challenges faced by primary medical care operating both as individual practices and within the wider system. He had been impressed by the commitment and professionalism of those he met, who were clearly facing significant pressure and challenge. It was noted that a detailed report on primary care was scheduled to be received at the next meeting. Mr Sissling finally reflected on the scale of operational challenge being experienced across the health and care sector. The current heatwave was adding to the pressures. The ICB partnership would clearly need to respond in the immediate term but also ensure strategically sustainable solutions were progressed. This would require transformation and innovation. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/22/19	**Update from ICB, Acute Sector, Mental Health and Community Sector** Dr Trevithick advised that a proactive review was underway in preparation for the second half of the year. This would focus on key priorities including urgent and emergency care, the winter plan, financial recovery and elective care. An underpinning challenge relates to workforce with a need to address both recruitment and retention aspects.	

ITEM		LEAD RESPONSIBLE
	System resilience meetings continue to take place with partner organisations to assess risks and mobilise mitigations ahead of the forthcoming heatwave. The key message for patients and members of the public was to remain safe and vigilant over the coming days. An improvement in primary care performance against access targets was evident, with practices offering a variety of appointments including face-to-face, virtual or telephone. Where practices were not meeting the trajectories, they have been contacted and mitigating actions were in place. Dr Trevithick advised that Ms Nicci Briggs will be leaving the ICB to take up her new role at the end of July. She thanked Ms Briggs for her contributions to the system and in supporting the CCGs transition into the ICB. Board members wished Ms Briggs all the best in her new role in Cambridge and Peterborough. Mr Mitchell framed his reflections against the four goals of the Integrated Care System: improving outcomes, tackling health inequalities, enhancing productivity and socio-economic development. He observed some areas of improvement but acknowledged, in particular, the continued challenges faced by patients and staff in relation to ambulance handover delays and elective care waiting lists. Mr Mitchell had visited some GP Practices which had highlighted the benefit of collective action between primary and secondary care to reduce health inequalities and improve service delivery models. Mr Mitchell recognised the difficulties some staff may be experiencing as a result of the cost-of-living pressures. UHL had opened food banks at the three hospital sites for staff and were offering discounted travel arrangements. Ms Angela Hillery was pleased to advise that the *Step Up to Great Mental Health* programme was enabling an improvement in access to services and an enhancement in health outcomes. Work is continuing to progress positively across the East Midlands mental health collaborative. Ms Hillery also relayed her concerns in relation to the increase in the cost of living and the significant impact this is having on staff. LPT were taking action to offer support to colleagues. Mr Sissling thanked all for their updates. Prof Lakhani enquired whether updated guidance was available regarding patient visiting and the wearing of face coverings in health care settings. Dr Trevithick advised that the guidance in relation to wearing face coverings had recently been issued for clinical staff. **It was RESOLVED to:** • **RECEIVE** the report.	
ICB/22/20	**Update on the development of the Health and Wellbeing Partnership**	

ITEM		LEAD RESPONSIBLE
	Ms Prema reported that the LLR Health and Wellbeing Partnership development session, held on 30 June 2022, had been well received. It had provided an opportunity for colleagues from across health and social to review key priorities across LLR. Three key themes had emerged for further urgent consideration and collective action- the cost-of-living crisis, equitable access to services and the development of an "anchor" system. It was agreed that a formal meeting of the core members of the LLR Health and Wellbeing Partnership would be held in August 2022, supported by a working group of key officers. A further developmental workshop will be scheduled in September inviting members from the Health and Wellbeing Boards and the ICB. It was agreed that updates from the Health and Wellbeing Partnership meetings will be reported to the ICB on a regular basis. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/22/21	**Specialist Child and Adolescent Mental Health Services (CAMHS) and CAMHS Collaborative Progress Update (Paper E)** Ms Helen Thompson and Mr David Williams (LPT) provided a comprehensive overview of the range of preventative, early intervention and specialist services for children and young people (CYP) with emotional and mental health needs. During the Covid pandemic there was an increase in the number of children and young people seeking support, and an increase in urgent and complex referrals. Ms Thompson outlined relevant service changes and highlighted some of the key challenges in providing a timely response to children and young people with mental health needs. A sustained increase in demand and the acuity of presentations was anticipated. There was recognition that the service required transformation and further investment through the Mental Health Investment Standard (MHIS). Where performance was not meeting expected standards and trajectories, improvement plans were in place. Ms Thompson provided an overview of services across Tiers 1 – 3 (lower complexity) and Mr David Williams provided an overview of Tier 4 services which relates to the more complex services, provided through the CAMHS Collaborative across the East Midlands. A summary of the developments in progress and key issues were highlighted. One key challenge relates to work force with action being taken to ensure retention levels were optimised. Mr Sissling thanked Ms Thompson and Mr David Williams for the comprehensive report and invited questions from Board members. Members from local authorities explained that many similar trends were evident in the services they provided to young people and emphasised the impact of COVID. They enquired whether early intervention and investment was making a difference or was more needed. They also highlighted to need to act in a manner which prevented an increase in inequity	

ITEM		LEAD RESPONSIBLE
	Mr Thompson highlighted a concern that some children and young people in the community were not accessing the level of support required. Targeted collaborative was required and a differential service offer may be required across each place depending upon the need identified. For instance, it was noted that some targets were being achieved at system level but not for Leicester City. Mr Sissling thanked all for their contributions and commended the integrated approach to service improvements. It was noted that assurance on future progress will be reported via the System Executive Committee. **It was RESOLVED 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 plans are in place, which are being robustly governed at organisational and system level.	
ICB/22/22	**LLR System Flow Partnership – briefing (Paper F)** Mr Jon Melbourne, Chief Operating Officer (UHL) provided an overview of the work of the system flow partnership to improve patient experience, reduce the risk of harm and to respond to delays in the delivery of patient care. High impact actions had been expedited to enable delivery of the ambulance handover standards in Q2 and to initiate a strategic demand and capacity review for Q3 and Q4. He outlined the position in relation to flow management, in particular noting that flow into the hospitals is overseen by the primary care collaborative, flow in the hospitals is overseen via the acute care collaborative and flow out is overseen by the Home First collaborative. Mr Sissling requested confirmation of when the plans and trajectories would be presented to the Board. Mr Melbourne advised that the metrics for each intervention were due to be reviewed in the next couple of weeks and that the ambition was to have no extended ambulance handover delays by September. He proposed an update to be provided in the report for the next meeting. Mr Mitchell advised that concerted action in a range of areas was required to achieve a reduction in ambulance wait times by September 2022. Concerns in respect of the workforce were identified. It was noted that the System Executive Committee will be reviewing the current challenges and pressures in the system and the impact that this is having on workforce recruitment and retention. An overview will be presented to the Board through the assurance report from the System Executive. Mr Melbourne commented that the risks were now understood in necessary detail. Improvements was both necessary and achievable. Mr Sissling thanked all for their contributions and noted the position is challenging. He emphasised the Boards expectation that the System Executive will co-ordinate and oversee work to enable sustained improvements. A further update will be provided at the next meeting.	

ITEM		LEAD RESPONSIBLE
	It was RESOLVED to: • **NOTE** the ongoing challenge to meet constitutional standards, including ambulance handover targets. • **SUPPORT** the approach to bring forward elements of the strategic plan as outlined in the slides; and • **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.	
ICB/22/23	**Financial allocations and spend (Paper G)** Mr Spencer Gay highlighted that the report detailed the increase, over time, in investment in primary care and across mental health services, with a relative reduction in investment across acute care. The analysis indicated 4-year trends and how the proportion of spend and allocations have changed over that period. ICB members were 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. A long-term financial plan containing details on future spend allocations will be developed and will be presented to the Board for consideration later in the year. When setting the priorities, the Board would need to consider how the allocations and expenditure profiles need to shift to align with the ICB's priorities. Mr Gay confirmed that programme budgeting is used by the ICB in its financial analysis, however this is not reported to the System Executive Committee or the Board and remains an operational activity for the finance team. Mr Sissling thanked Mr Gay for his report and **agreed that a long-term financial plan would be scheduled for a future meeting. The report would set out alignment with strategic objectives and the financial enablement for delivery of a population health approach.** It was noted that the Board will also be interested in understanding how equity and equality will be addressed through our financial approach. **It was RESOLVED to:** • **RECEIVE and NOTE** financial performance information for 2022/23.	**Spencer Gay**
ICB/22/24	**System Finance Report M2 (Paper H)** Mr Gay highlighted that at month 2 it was too early to definitively determine the financial position. The position and scale of risk will be better determined by month 3 and 4. There were however early indications of significant risk and the Board discussions on care delivery and workforce had emphasised the need to manage performance, quality and financial aspects in an integrated manner. The values presented in the report were 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 three organisations submitting a break-even plan for the financial period. From month 3 onwards, a forecast position will be reported against this agreed plan.	

ITEM		LEAD RESPONSIBLE
	Mr Gay confirmed the close work being taken forward between the 3 organisations with an agreed risk share plan being presented to the next Board. Mr Sissling thanked all for their contributions. **It was RESOLVED to:** • **RECEIVE** and **NOTE** the system financial report for month 2.	
ICB/22/25	**Report from the Quality and Safety Committee (Paper I)** Mrs Tagg provided an overview following the inaugural meeting of the Quality and Safety Committee (QSC). The Committee had reviewed a number of areas and had assessed the level of risk in light of mitigating actions. The committee's conclusions were set out in its report to the board. Further assurance was to be sought from the System Executive Committee in relation to ambulance handover delays noting the risk to patients. The Clinical Executive had been asked to support and review actions to reduce patient harm and keep individuals safe. Mr Sissling thanked Mrs Tagg for her report. **It was RESOLVED to:** • **RECEIVE** the Quality and Safety Committee report.	
ICB/22/26	**System Performance Overview (Paper J)** Dr Trevithick introduced the report and highlighted some areas of improvement and deterioration. She particularly emphasised the need for further action in relation to ambulance handovers, 104 week waits and cancer access. In line with the new governance arrangements, assurance reports from the System Executive Committee will include progress on performance standards going forward. Dr Trevithick confirmed that the information and data captured in the report must undergo a process of validation before it is made available and hence the data was not live data. Prof Steiner enquired whether the definition for medically optimised for discharge (MOFD) patients' needs to be reviewed. Dr Trevithick would discuss this point further with the members of the Clinical Executive Group. Mr Henderson suggested that it would be useful to capture the total number of ambulance hours lost to indicate the impact of ambulance handover delays. Dr Trevithick noted this and would ascertain if it was possible to capture the information in future reports. Mr Sissling observed that the report may need further refinements through the System Executive Committee and noted that the vaccination programme updates will be consolidated within this report. Dr Trevithick welcomed the feedback received and advised that the vaccination briefing later on the agenda was for noting and drew attention to recent regional awards for the vaccination programme. The ICB was the winner for the best publicity campaign, and runner up in the following two	

ITEM		LEAD RESPONSIBLE
	categories: innovation (drive thru – community pharmacy partner) and supporting vulnerable people (LPT learning disabilities clinic). **It was RESOLVED to:** • **RECEIVE** the System Performance Overview report.	
ICB/22/27	**Report from the Finance Committee (Paper K)** Ms Ellis provided the key highlights from the report noting that the 2022/2023 financial plan whilst balanced, contained £80m worth of risk. Efforts are underway to drive transformation and deliver efficiency savings to meet financial target. It was noted that the system Project Management Office (PMO) was working on redesigning the reporting for transformation. Delegation of specialised commissioning budget is an emerging risk and Finance Committee will seek assurance in respect of this risk, currently the risk has not been quantified because the budget and workforce have not been determined. Ms Ellis highlighted the proposed risk share agreement which the Board would be asked to approve. Mr Sissling acknowledged the request to approve a risk share agreement however confirmed that the Board had not been sighted on this. It was noted that the risk share agreement was in draft and was being reviewed with partner members. Mr Sissling noted that the transformation work was necessary but risks had been raised by the Finance Committee for a number of months. The transformation programme would be considered by the System Executive Committee recognising that this had not been resolved and a mitigation plan would be developed. **It was RESOLVED to:** • **RECEIVE** the Finance Committee report.	
ICB/22/28	**Remuneration Committee terms of reference (Paper L)** Mrs Simone Jordan confirmed that the Remuneration Committee had held its inaugural meeting. She asked members for approval of the amendments to the terms of reference which related to the scope of the committee's work. The members supported the amendments highlighted in appendix 1. **It was RESOLVED to:** • **APPROVE** the amendments to the Remuneration Committee terms of reference as detailed in Appendix 1.	
ICB/22/29	**Board Development and Public Engagement Approach (Paper M)** Members recognised the importance of holding development sessions over the next few months as the Board. Of the three options presented by Ms Alice McGee, the preference was "Approach 3"; to hold a bi-monthly half day development session of Board members and participants. The report also provided options to improve engagement between the Board and the public. It was proposed that the approach be accessible and inclusive and therefore both face-to-face and virtual meetings with members of the	

ITEM		LEAD RESPONSIBLE
	public was agreed, with the initial face-to-face meeting taking place in late September 2022. Sufficient notice would be given to members of the public. Mr Sissling thanked all for their contributions. He suggested that Board meetings alternate between formal business meetings and development sessions. The Board development sessions would be held face-to-face. For public engagement the schedule was agreed in principle and the blended approach was supported, recognising that the approach needed to remain flexible and adapt accordingly. It was also noted that an invitation would be extended to Ms Ellis, as chair of the finance committee. to attend the development session. **It was RESOLVED to:** • **APPROVE** for Board meetings to be held on a bi-monthly basis. • **APPROVE** bi-monthly Board development sessions for 2022/23; and • **APPROVE** the approach to engaging with the public as per the proposed timetable set out in the report.	
ICB/22/30	**Covid briefing and vaccination programme update** The report was received as noted under item ICB/22/26. **It was RESOLVED to:** • **NOTE** the report.	
ICB/22/31	**Items of any other business and review of the meeting** There were no further items of business. The meeting ended at 11.33am.	
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board will take place on **Thursday 11 August 2022** at 9:00 am via MS Teams. The meeting will be held in public.		

B

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 11 August July 2022	Status
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~~ October 2022	This will be reviewed as part of a development session initially with an update to the subsequent Board meeting.	**Amber**
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 on the agenda at the August 2022 meeting. **ACTION COMPLETE**	**Green**
ICB/22/23	14 July 2022	Financial Allocations and Spend	Spencer Gay	The long-term financial plan to be scheduled for a future meeting. The report to set out alignment with strategic objectives showing financial enablement for delivery and population health approach as opposed to sectoral approach.	October 2022	Work in progress.	**Amber**

C

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	11 August 2022	**Paper:**	**C**
Report title:	**ICB Report on LLR Primary Care – Current Position, Plan and Strategy**		
Presented by:	Dr Nil Sanganee CMO and Yasmin Sidyot (Deputy Chief Operating Officer)		
Report author:	Yasmin Sidyot (Deputy Chief Operating Officer)		
Executive Sponsor:	Dr Nil Sanganee (CMO) & Rachna Vyas (Chief Operating 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:

- **NOTE** the contents of this report that provides a comprehensive overview and plans in relation to Primary Medical Care
- **NOTE** the complexity challenges in in delivering the required transformation in Primary Medical Care including recognising the key improvements and successes delivered
- **RECEIVE** the overview through which the governance and assurance is delivered for Primary Medical Care through the ICB in relation to Transformation & Delivery, Quality & Risk and Performance.
- **AGREE** to receive the Primary Medical Care Strategy for the ICB in 6 months' time at the ICB Board.

Purpose and summary of the report:

The purpose of this report is to provide an overview of Primary Medical Care in Leicester Leicestershire and Rutland. The report will highlight the current priorities and performance outlining the issues, challenges, and opportunities for Primary Care. The report outlines the strategic vision for Primary Care in LLR and Primary Care Plan for 2022/2023 including the ICB response to the Fuller Review and the 15-point action plan.

Appendices:	• Appendix 1 - **List of PCNs in LLR** • Appendix 2 - **Additional Roles Reimbursement Scheme roles** • Appendix 3 - **Investment and Impact Fund (IIF) Indicators** •

	• Appendix 4 – **Fuller Report** • Appendix 5 - **Current 'Extended Access Service Provision across Leicestershire** • Appendix 6 - **Governance Structure charts illustrating how transformation, delivery and risk & Quality is supported through Primary Care**
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	N/A

LLR ICB Report on LLR Primary Medical Care – Current Position, Plan and Strategy

August 2022

Purpose of the Report

The purpose of this report is to provide an overview of Primary Medical Care in Leicester Leicestershire and Rutland. The report will highlight the current priorities and performance outlining the issues, challenges, and opportunities for Primary Care. The report outlines the strategic vision for Primary Care in LLR and Primary Care Plan for 2022/2023 including the ICB response to the Fuller Review and the 15-point action plan.

Background

The last 2 years have seen an unprecedented demand on health and social care services. Primary Care amongst others have had to make significant changes to the way they deliver services in order to adapt and respond to the COVID-19 pandemic. As we come out of the pandemic response, we are now faced with a number of different challenges which includes the increase in the demand for primary medical care.

Despite the challenges in LLR our General Practice in their Primary Care Networks (PCNs) were pivotal to the successful delivery of the mass COVID Vaccination Programme working in partnership with public health, local authority, community pharmacy, local NHS Providers and volunteers. Primary Care colleagues supported changes in the way it which delivered services to ensure essential services were delivered during the height of the pandemic.

Key successes include:

- **Community Pharmacy Consultation Scheme (CPCS) Delivery** – NWL PCN have worked with all 12 of their member GP practices and local pharmacies to develop a positive working relationship in order to support navigating their patients to the most setting of care. They have been able to successfully implement the scheme being the highest user of the scheme in LLR and have been sharing their best practice across the region as well as within LLR. Recently the Chief Pharmaceutical Officer for England visited NWL PCN which gave the PCN the opportunity to highlight the work they have done.

- **Outstanding CQC rating for Responsiveness at Willows Health Pasley Road Practice** - Demonstrating responsiveness and innovative approaches to providing integrated person-centred care.

- **Social prescribing project at Oadby and Wigston PCN** – the PCN has undertaken a proactive approach to addressing wider determinants of health and wellbeing. They have through the use of ARRS funding developed a health and wellbeing team that consists of social prescribers, health and wellbeing coaches and care coordinators who work with local partners and VCS to offer a service that is aimed at supporting patients

with non-clinical needs that impact on an individual's health outcome. For example, the team support patients with issues relating to poor housing, stress, anxiety, loneliness, physical activity, debt etc. they have taken a 'what matters to me' approach to support integration of services at a neighbourhood level.

- **Health Inequalities Work as a collaborative between county PH and Charnwood PCNs** – the Charnwood network have worked with public health to develop a locality-based approach to reducing inequality using the national Core20Plus5 tool. Using the data available across the general practice and public health they identified communities that experience challenges in accessing screening/preventative interventions. Engaging with local communities and working with wider partners has resulted in scoping a outreach model to deliver for example health checks.

- **GP registrations work** – During the Pandemic it was highlighted the number of potentially unregistered patients in Leicester. A project was developed and launched that worked with local communities, practices and statutory partners about how we support people to register with a GP and understand the barriers to this looking at we take those barriers out. The programme was launched in January 2021 with 2 GP registration Officers engaging communities, partners and practices to identify the issues and work out ways in which we addressed those to encourage and facilitate people to register with a GP. The project has enabled over 23,000 patients to register in Leicester City. It has received national recognition from the national GP registration team and the project has now been rolled out across Leicestershire and Rutland since April 2022.

- **Work of PCL and partnership board** – Recognising the changing role and relationship of Primary Care within the system as we have moved from CCGs to ICBs; PCL has worked to develop the Partnership Board. Including 3 elected representatives (clinical and managerial) from each of the former CCG areas, the Partnership Board aims to provide a unified voice for Primary Care and a vehicle for the transformation of services. The Partnership Board has overseen the development of the Commissioning Framework which it is hoped will support this process in future.

As a result of the increase in demand and the need to change the way general practice worked during the pandemic a number of key challenges have been faced since by Primary Care:

- **Access** – the way patients accessed general practice took a radical change especially access to face-to-face appointments due to Infection Control and Prevention (IPC) challenges and the resulting reduced capacity and ability to manage COVID Positive patients. Since the early 2021 as we have been working with Primary Care to reset and restore services the demand for Primary Care saw a rapid increase and change and the ability to respond to that has been variable across General Practice. There remains variation in delivery models across primary

care which impacts on patient's experience of access to their GP Practice.

- **Workforce** – there has been a significant impact on workforce both clinical and administrative in general practice both in terms of day to day staffing due sickness and self-isolation regulations and ability for practices to successfully recruit to vacancies. We have a significant variance in the GP workforce capacity across Place – with City having the most significant deficit compared to Leicestershire and Rutland.
- **Infection Control prevention (IPC)** – Revised IPC guidelines in relation to social distancing, ventilation, Personal Protective Equipment (PPE) restricted the number of patients that could safely be seen in the practice's surgery which has affected appointments availability for face to face in particular. As the guidance has changed over the past year adapting to that has been challenging for Primary Care which is significantly due to estates of primary care.
- **IT and telephony infrastructure** – the rapid change from predominantly seeing patients face to face to delivering more patient appointments via telephone and virtual consultation placed a significant burden on the current telephony and IT infrastructure in GP Practices which meant that we needed to change technology infrastructure that supports online consultations, online appointment making, telephone consultations and video consultations. We still have some practices that struggle with getting the balance right with this in their practice and thus see variance in use and application of online appointments and use of cloud-based telephony in primary care.

General Practice in LLR

In LLR we have 134 GP practices (including branch practices) and 26 Primary Care Networks (PCN) (see **appendix 1** for full list of GP Practices and PCNs for LLR). PCNs are made up of groups of practices that align together to enable greater provision of proactive, personalised and co-ordinated care for people closer to home. They serve registered populations of between 30,000 to 50,000. PCNs are led by Clinical Directors who is likely a GP working in general practice. The main purpose for PCNs is to enable greater integrated working at a population level that enables the delivery of services from a wider workforce in primary care.

In LLR we have practices that vary in list size from smallest being at around 4-5,000 patient list size to largest being around 30,000 patient list size. On average patient list size is around 10-14,000. The premises through which general practice is delivered varies significantly across LLR which also has a significant influence on how services are delivered. The Strategy and Planning directorate has been leading the development and now the implementation of the Primary Care Estates Strategy which looks to address some of the inequity issues and challenges practices face in trying to deliver the changing ways in which primary care is providing services as well as enabling a population-based approach to access.

Each practice is commissioned either on a GMS/APMS contract. Recently in LLR we rolled out our own Primary Care Funding Model which enhances the existing funding

formula at a local level to address inequity, rurality and deprivation. The Model is now being adapted by other Systems and is being considered as a blueprint nationally. In LLR we have been at the forefront of changing the way in which fund Primary Care and address inequity through our funding model.

Primary Care Networks (PCNs) in LLR

PCNs have been in operation since 2018. Therefore, still relatively new concept that remains currently in development. Recently we provided an opportunity for Practices to reconfigure in order to assist in achieving better alignment and member practice relationships. We supported 4 reconfigurations, 2 of which were creation of new PCN configurations. Over the last 4 years PCNs have increasingly become a significant route through which transformation and delivery of key services at a population level is happening.

Within PCNs we have a wide range of workforce that deliver a wider range of appointments at a population level. Currently there are up to 15 different roles (Additional Roles Reimbursement Scheme - ARRS) ranging from clinical pharmacists to care co-ordinators. A full list of the different roles can be found in **appendix 2.**

These roles have been introduced incrementally since 2019 to create multi-disciplinary teams in primary care to enable the delivery of preventative and proactive management of care as per the requirements of the PCN DES (Direct Enhanced Service). Each PCN determines their workforce plan in relation to ARRS and submit their plan to the ICB. The ICB workforce team works with the PCNs to oversee delivery of these plans and ensure that PCNs fully utilise the funding available. In 2022/23 the funding available to the PCN for ARRS is £18m. Detail on the plans for this is outlined below in the LLR Primary Care Plan section.

PCNs are not statutory organisations and therefore commissioning and contracting for PCNs happens through a lead provider model. As per the Fuller Review PCNs will continue to be a key driver through which transformation occurs in Primary Care.

The commissioning route for services via Primary Care Networks is through the PCN Network DES (Direct Enhanced Services) which all member practices within a PCN must sign up to in order to be able to operate as a PCN. Since the introduction of PCNs we now have the following services delivered through a PCN approach:

- Covid Vaccinations
- Structured Medication Review and Medicines Optimisation
- Enhanced Health in Care Homes
- Supporting Early Cancer Diagnosis
- Social Prescribing Service
- Cardiovascular Disease Prevention and Diagnosis
- Tackling Neighbourhood Health Inequalities
- Additional Roles Reimbursement Scheme
- Investment and Impact Fund (IIF)

Over 22/23 -23/24 the following provisions are being moved to be delivered through PCNs:

- Personalised Care – commence delivery of the proactive social prescribing service for the identified cohort from October 2022
- Enhanced Access (previously extended access and hours) – transition and mobilisation from October 2022
- Anticipatory Care – transition and mobilisation from April 2023

In 2020 NHSE introduced the Impact Investment Fund (IIF) for PCNs. The value of this fund has increased over the last 2 years. With the Investment fund in 2022/23 being worth £5m for PCNs should they achieve the indicators required to receive the funding. **Appendix 3** has a full list of the indicators including the weighting and what the achievements need to be to receive the investment. The IIF has been used to incentivise general practice to undertake a population health management approach to how they deliver services that focus on addressing health inequalities and improving key health outcomes. This now forms a core part of the PCN Development Plan and strategically how we drive transformation and change in primary care.

General Practice Access in LLR

Within general practice now there are a wide range of appointments available in terms of the different health professionals and different ways in which these appointments are offered. There is a wide variation in this provision practice by practice and this is dependent on several factors that range from size of the practice to premises and technology infrastructure that exists for that practice.

Appointment types available include on the day, advanced, face to face, telephone, online consultation, video consultation. In the last 2 years with the pandemic general practice have had to make some very rapid and significant changes. Changes that would have been implemented incrementally have had to be implemented very quickly and for some of our practices this has been particularly challenging due to the IT, telephony infrastructure, premises, workforce availability and Infection Prevention and Control (IPC) changes that have had to be considered.

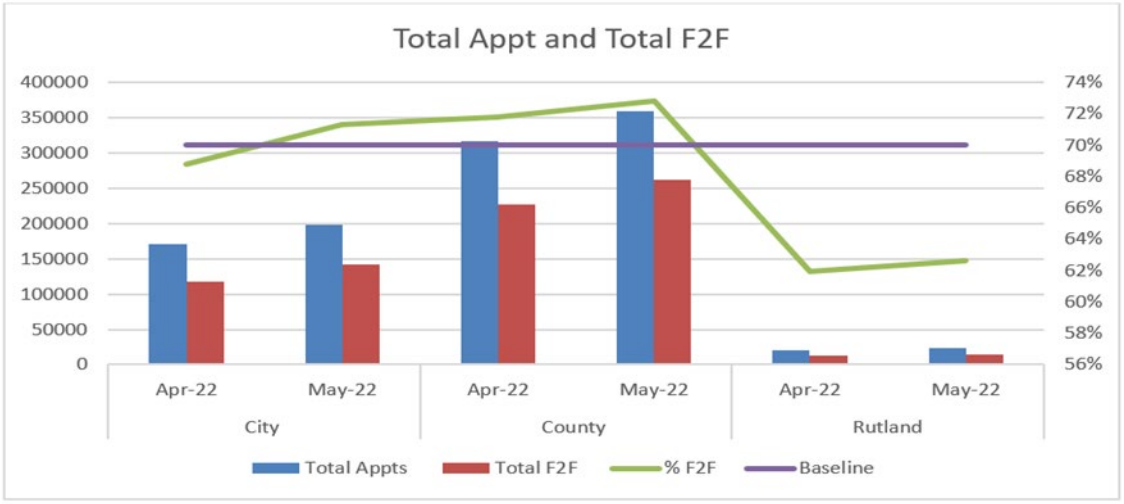
The table below summarises the total number of appointments that were delivered by our practices in LLR in May 2022 (latest data currently available from NHS England) and how this compares with the previous year's activity especially compared to pre-covid. The data shows that overall, the number of appointments delivered has grown. The proportion of face to face have incrementally increased. As at May 2022 we are now at around 70% of the total proportion of appointments delivered are face to face. We know that face to face appointments need to continue to be an integral part of service delivery particularly for our frail and vulnerable patients. A good balance between this needs to be achieved and therefor our access plan is about redressing the balance with maintaining face to face appointments at 70%.

Total appointments delivered, inc. F2F contacts						
	City total	County total	Rutland total	City F2F	County F2F	Rutland F2F
Apr-22	171422	316173	20120	68.80%	71.81%	61.95%
May-22	198053	359739	23495	71.32%	72.80%	62.64%

Although we have delivered more appointments in 22/23 compared to pre-pandemic 2019 levels, we recognise that there is variation in this across our practices. In order to identify where we are seeing variation that needs addressing, we have agreed a benchmark that we utilise to assess the level of that variation that exists. We utilise a benchmark of 75 appointments per 1000 registered patient population. This includes the following appointment types:

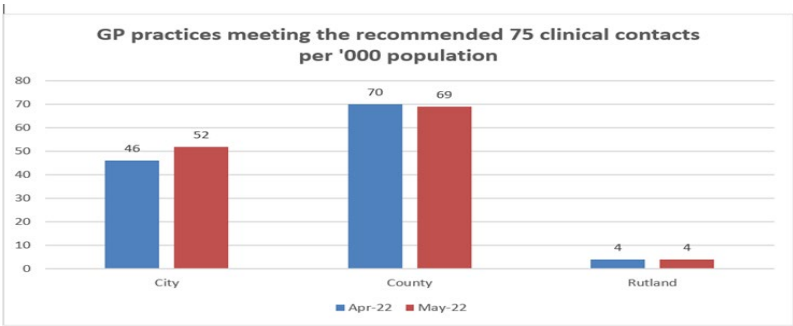
- GP Appointments
- Nurse Appointments
- HCA appointments

These appointments are as a mixture of face to face and virtual (telephone, online and video).

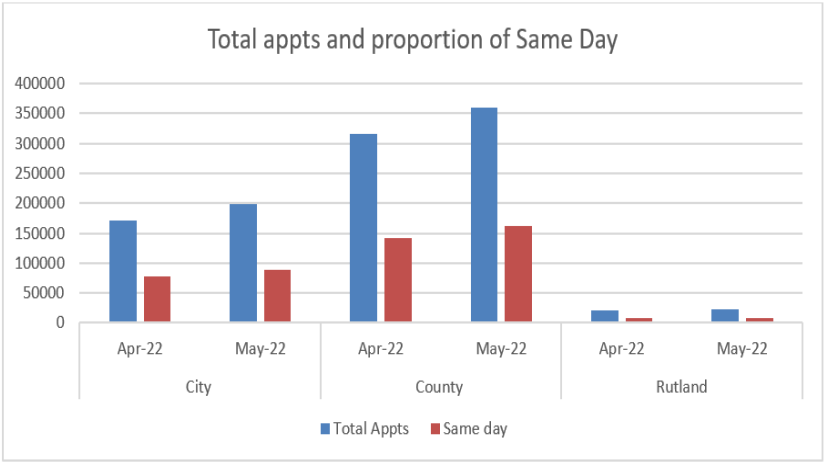


Out of the 130 practices in Leicester we have 5 practices that currently fall below the benchmark. In addition we can see the variation now at practice level for practices in delivering face to face appointments, proportion of same day to booked appointments, DNA rates and ED usage variation using adjusted clinical groups (ACG) risk stratification to benchmark expected variation based on demographic, frailty, deprivation and multi-morbidity.

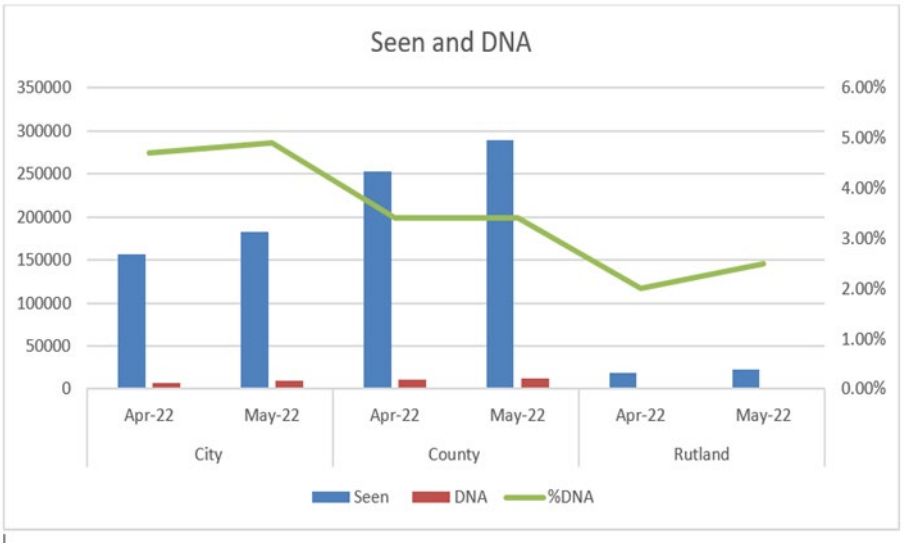
Graph below indicates practices meeting the 75 clinical contacts per 1000 population.



We can see from the data that around half of the appointments delivered are ‘same day’ appointments which does demonstrate a good balance between same day and advanced appointments.



Overall, our practices experience minimal DNA rates for appointments. For LLR DNA rates are around 3.5% in terms of the total appointments offered.



Using this data and the intelligence gathered relating to quality measures and performance we have identified up to 26 practices across LLR where we are seeing this significantly impact on outcomes. Early this year we implemented a programme of work developed with the Royal College of General Practitioners (RCGP) to

implement a quality improvement approach to working with the practices to drive improvements. Phase 1 of the work has commenced with the first 10 practices. The progress of this is being overseen by the Primary Care Transformation Board.

As general practice looks to move forward it is important that we look to restore those elements of provision that we can and work to embed the new ways of service delivery that have been implemented during the pandemic but require programme of transformation that creates sustainability.

Fuller Review and LLR Strategy for Primary Care

In early July we had the publication of the Fuller Review. This was a national review led by Dr Claire Fuller on Primary Medical Care. The summary of the review is in **appendix 4.** The review highlights the following key recommendations:

- Need for retaining continuity of care as the core strength of primary care – offering to those patients that need it most recognising that it is not possible to offer the same level of relationship and continuity for all patients.

- New model of primary care which means designing different service offers that suit the needs of different groups of patients – driven by population health management – PCNs will be central to this.

- Implementing risk stratified approach to care starting with a clear and consistent focus on 'Core20Plus5' populations – supporting MDT delivery approach with redesigned pathways of care.

- Streamlined access for urgent and episodic care with greater use of the whole primary care team, improving co-ordination between primary and secondary care and enhanced access to diagnostics

- Primary care supporting a system-wide focus on preventing ill-health and the wider determinants of health with local authority colleagues, VCS, community leaders supported by national and local public health campaigns and harnessing the potential of anchor institutions.

As a result of these key recommendations the following 3 key priorities for change have been identified in the Fuller Review:

- Step-change in **preventative care** – addressing the wider determinants of health through partnership working particularly at neighbourhood and place to address health inequity. The report talks about addressing lifestyle change – locally this is about how we work as a system with our wider partners, stakeholders and communities to address inequity in opportunity that prevents our people to make those 'lifestyle changes' which is more than just about providing 'advice and guidance'

- Scaled and streamlined offer to deliver **urgent and episodic care** – having a 24/7 single point of co-ordination for urgent and episodic care. Locally we have our Clinical Navigation Hub model and recognise we need

to build upon this to how we incorporate urgent community response for example. We have already started the work with this in the development of the urgent community crisis response hub (UCCR) bringing together the clinical navigation hub, EMAS and Home first currently. There are plans through the Home first workstream to build upon this and expand so that we have co-ordinated system response that ensures consistency and ability to navigate the patients to the most appropriate service and to ensure we have provision in place that best meets the need.

In addition, for general practice getting the balance right on the offer of virtual and face to face consultations. At system level we are currently working on a benchmark of 70% face to face appointments. We recognise that for some of our practice this may differ particularly practices that serve a predominantly student population and our specialist practices such as the homeless, asylum seeker and violent patient scheme practices. For them their offers and models of delivery will be more bespoke to the specific population types they are delivering their services to.

- Person Centred and team-based approach to **Chronic Disease Management** and **Complex Care** – enabling and supporting people to manage their own long-term conditions driven by practice management of chronic disease to prevent deterioration. LLR has been one of the four national pilot sites for the 'proactive care at home' model. Developing the thinking and how we deliver this programme at practice and PCN level.

  Care co-ordination is a major feature of this change programme. Delivering an MDT approach to support case management of more complex patients forms a key part of plan as we work to develop our anticipatory care model for LLR.

A framework of shared action has been developed by the national team at NHSE. This sets out clear actions that the ICB will lead on the delivery of and the key actions NHSE will lead on. The framework is part of the Fuller Report in Appendix 4. We have undertaken a self-assessment as an ICB to map ourselves in terms of where we are at currently and what the gaps/priorities are for us to address as system. Key areas of focus that highlighted for the LLRICB are as follows:

- Enable PCNs to develop into Integrated Neighbourhood Teams – this is a key area of development which requires a place and neighbourhood-based approach strengthening the key partnerships that enable integrated working.

- Development of Primary Care workforce – this is a key workstream in our Primary care plan for LLR and currently the longer-term strategy is in development ensuring it is integral to wider system workforce strategy

- Development of sustainable Primary Care structure enabling integration of services – having a clear commissioning and funding framework through which we can deliver transformation is critical. That's why the work we

have already done enables us to have a strong foundation to work from. The next key step is delivery and measuring outcomes.

We have established a task and finish group that is the subset of the Primary Care Transformation Board to develop our LLR ICB strategy for Primary Care which will address the following:

- LLR Model for Primary Care
- Commissioning Model for Primary Care – service delivery models and commissioning framework
- Approach to engaging and working with our communities and general practice colleagues to drive improvement and change
- Development of PCNs
- Primary care Workforce

We recognise that this transformation requires us to bring our general practice colleagues, system partners and our patients on that journey of change. This strategy will underpin our place and neighbourhood approach ensuring that it links into the Health and Wellbeing Strategies at place and the 2-year place-based delivery plans.

LLR Primary Care Plan 2022/23

We have developed our operational plan for 2022/23. This plan focusses 5 key priorities:

- **Access** – tackling the variation in appointments, how people can make appointments and how they are able to access their practice including times etc.

- **Workforce** – understanding the scale of the challenge in terms of GP Workforce and how we maximise the use of the wider clinical roles available through PCNs

- **Delivering on key Long-Term Conditions (LTC) indicators and reducing the prevalence gap** – closing the gap on long term condition detection and optimisation in primary care.

- **Primary Care Network Development** – developing our PCNs so that they become an effective way of delivering an integrated approach to managing the health of our population at a local level

- **Quality** – reducing variation in quality and experience for our patients. Improving the resilience and sustainability of our practices. Seeing an overall improvement in patient experience.

Access

A strategic review of all same day access points across primary care, urgent & emergency care and unscheduled care services (noting the interdependencies) is underway. This review encompasses

- **Primary Care Enhanced Access**
  The development and mobilisation as per the Network Contract Direct Enhanced Service 2022/23 (detail below)
- **Urgent care pathways across LLR**
  Analysis of the differences in currently commissioned services has been completed together with a multi-stakeholder workshop to discuss future commissioning of consistent care pathways across sites. Engagement, consultation, estate options and project planning is scheduled for completion by 31st March 2023.
- **Unscheduled care services**
  Analysis of the multiple standalone contracts is currently underway. The Access Strategic Review Group supports consideration of consolidation of a number of these services by 2024 to improve patient flow, improve referrer access to additional patient support and generate economies of scale for the system.

The introduction of Enhanced Access services at a local Primary Care Network level amalgamates the current Extended Hours services provided at GP practice level and the Enhanced Access services, currently commissioned at hub-level across LLR. **Appendix 5** provides detail of the current service provision and the locations from which this is delivered from.

Each PCN's development of their Enhanced Access plan must meet the needs of their local population. To support this a number of different data sets have been used to inform the plans and what the expectations are:

- GPAD (General Practice Appointment Data)
- Metrics articulating PCN population use of existing similar services
- Adjusted Clinical Groups and Population Health Management tools (Aristotle)
- PCN Health Inequalities plans
- PCN Development plans
- Joint Strategic Needs Assessments
- Health & Wellbeing Strategies
- Shape Atlas
- Public Health Fingertips data
- General Practice Experience Survey

Enhanced Access services will go live on 1st October 2022 in line with the nationally mandated timetable and will provide enhanced care Monday to Friday 18:30-20:00 and Saturdays 09:00-17:00 as a minimum. The mix of same day care, complex care and prevention support will be informed by the needs of the local population.

The ten sites across LLR which currently support extended access to primary care will continue to run in tandem with PCN-based services until at least 31st March 2023. This arrangement will support PCN-based service provision in its infancy as well as additional resources to manage winter pressures.

Defining standards for safe General Practice Appointment Capacity

A task & finish Group was established to understand the wider ask of general practice and design a way forward to describe and promote safe and quality care. Primary Care providers need to be able to articulate their overall activity demand in the same way that all other LLR providers already have established processes for. This work was the first stage of a phased approach to articulating capacity and demand across the different clinical aspects of the wider primary care offer.

- Articulate safe workload levels to deliver high quality care and access within general practice.
- Describe a set of metrics to regularly capture real time data in general practice aimed to reflect workload – agreed as a minimum of 75 clinical contacts per '000 population per week

The next stage of this review is to:

- Address GP practice variation
- Provide recommendations to effectively communicate demand and capacity to the wider system.

Community Pharmacy Consultation Service

The NHS Community Pharmacist Consultation Service (NHS CPCS) is a community pharmacist led clinical service which is well established in community pharmacy across England and has been managing referrals for minor illness conditions from NHS111 since October 2019. It was expanded to include referrals from LLR GP practices from April 2021.

LLR has 210 community pharmacies who have confirmed participation in this initiative. Referrals into CPCS are increasing month on month, with the latest activity below:

- April 2022 - 673
- May 2022 - 704
- June 2022 – 1,114

The national target is 0.34 referrals per '000 population per annum as a sustainable referral rate. This equates to 3,351 referrals per month for LLR, with a current trajectory of 2,623 per month by June 2023. Community pharmacies are experiencing considerable workforce pressures and are not always able to support CPCS across all working days. LLR recognises this constraint and has therefore not sought to add burden by committing to a March 2023 achievement date for the national target.

Workforce

Workforce is one of the greatest challenges facing general practice, broader primary care services, support services and the NHS. We are in or near approaching a workforce crisis across the country and across LLR. The health sector in its broadest terms continues to be a growth sector, has the largest workforce constituting 13% of all jobs nationally and spends 65% of its operational budget on workforce. However, sitting alongside this we also have unprecedented Vacancies.

In LLR we are committed to addressing workforce shortages, through retaining our existing workforce whilst supporting and optimising new roles.

It is our ambition to make LLR a great place to work, and we will do this by working together to drive our ambitions. We will:

1. Embrace neighbourhood working with an integrated sustainable workforce
2. Make primary care in LLR a great place to work – ensuring staff are well engaged, supporting wellbeing, promoting diversity and career development.
3. Address workforce shortages, attracting new talent and optimising new roles.
4. Establish a new operating model for primary care workforce ensuring the have the capacity and capability to deliver the right care, at the right time, by the right person to our citizens.

This will be achieved through:

- **Rewarding** and **Recognising** staff achievements.
- **Engaging** our staff.
- **Supporting** Resilience
- **Embedding** clinical and non-clinical leadership
- **Enabling** our people and teams to innovate
- **Listening** and **Responding** to the needs of our staff
- **Developing** an approach to talent management

We are beginning to work with providers and Higher Education Institutes to cultivate opportunities and promote the NHS as an exciting and rewarding career of choice. Working with the Deanery locally to engage ST3 and creating opportunities across practices to connect graduates with local recruitment.

We are also embarking on an exciting pathway to work with the regional NHSE team and the LLR Training hub to create a pathway linking career opportunities for international Medical Graduates through the national Tier 2 sponsorship. 2022/23 will be our first pilot year where we have 2 practices already progressing through priority access to create a Visa sponsorships opportunity. This will be supported by clear development and pastoral care. This cohort of graduates are fundamental to a sustainable workforce supply in the future, and we are making every effort to ensure we retain those trainees locally, through an attractive and supportive employment package.

A key workforce priority is developing plans to promote job creation for our local population to support a local thriving economy and the creation of seamless career progression pathways. In doing so we will collaborate with our system partners to widen participation in health and care for local communities, to create education, employment, apprenticeship, and volunteering opportunity. Working through established routes to employment as well as developing a local offer to identify and support hidden tales in communities.

Through the pandemic we know there is a growing population of young unemployed citizens, together with refugees who have a right to work status. Our efforts are in reach into communities, working with charities to engage local communities and create opportunity. Supported through one of LLR's main training provider, UHL, we

have developed a clear apprenticeship pathway to support this. Key will be lining this into primary are to pilot as a future approach.

To support all of this, we will ensure that by removing barriers a variety of flexible approaches are adopted including off the job training, on the job training, career progression, full time and part time opportunities, support packages for those who wish to retrain and creative approaches to recruitment for those who face barriers to work.

GP and Primary Medical Care Workforce Variations

We are beginning to develop and galvanise workforce data, despite there being no established routes to accessing electronic data locally. The Observatory enables regular recording of workforce across primary care sites and PCNs.

In 2021/22 workforce growth across primary Care in LLR was 4.9%, of this ARRS comprised 4.3% of this growth. In contrast GPs and Nurses are indicating a decline in growth however Registrars have increased. To note, Leicester city is experiencing a decline which is disproportionate across LLR. We will continue to use data insights to drive targeted interventions and proactively inform trends and resilience's issues.

ARRS - LLR

- ARRS WTE has grown by 69% from April 21 to March 22 from 164 WTE to 277 WTE.
- Plan to reach 465 WTE before April 23 to maximise the use of budget of £18.6m
- ARRS roles are a monitored through actual finance claims from PCNs, based on roles and WTEs. This provides a level of accuracy on spend and forecast of growth. This also will highlight recruitment challenges and successes across 15 ARRS staff groups. We will also be able to monitor agency use. There are challenges with using finance data as some PCNs lag others in submitting claims.

GPs and Primary Medical Care

Throughout 21/22 our reports indicate a decline of GPs across City and County of 18.2 WTE. This issue is weighted towards City (-11.2 WTE) than County (-7 WTE) with County (County have a higher portion of registered patients). With Plans submitted to NHSEI, LLR plan to recruit 14.6 WTE by April 23. Registrars have increased during 21/22 by 18% (24.2 WTE) with 51% in ST3 training grade.

City proves to be the largest challenge in terms of workforce and continues to decline in Nurses and Direct Patient Care staff (non ARRS) (-28% & -29%)

East **Leicestershire & Rutland seeing the biggest increase in total by 12.9%.**

- Primary Medical Care grew by 4.7%
- ARRS grew by 91% (based on claims)

- EL&R saw the biggest decline in GPs (excluding registrars) which **declined** by 7.4% (13.2 FTE)
- PMC Direct Patient Care grew by 58% and Nurses grew by 26%

West Leicestershire increase in total by 5.0%.

- Primary Medical Care grew by 1.9%
- ARRS grew by 71% (based on claims)
- WL is the only area that showed growth in GPs (excluding registrars) which grew by 3.4% (6.2 FTE)

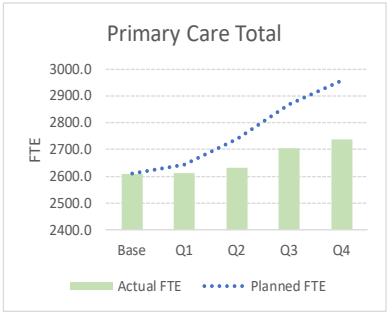
Leicester City declined in total by 2.6% and is the lowest growth area.

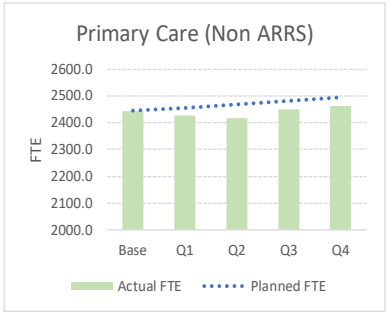
- Primary Medical Care **declined** by 5.5%
- ARRS grew by 46% (based on claims)
- GPs (excluding registrars) **declined** by 6.3% (11.2 FTE)
- PMC Nurses and Direct Patient Care also **declined** by 28% & 29% (29 FTE & 35 FTE)

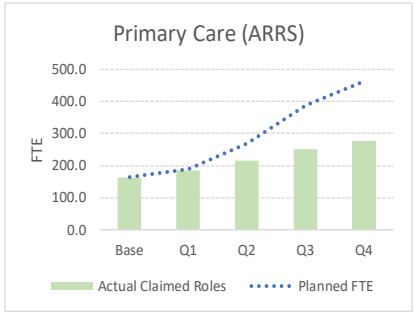
There are clear links between workforce and the health inequalities agenda. As we see a decline in workforce particularly in Leicester City, there is a need to point interventions and initiative's here to support 'place'. Currently considering models of recruitment i.e., via central role for PCN, that works seasonally. We know that a reduction in workforce impacts on the offer and appointments, for example extended appointments are likely to become unavailable which directly impacts health inequalities.
Consideration at place level extend to tier 2 sponsorship routes and ST3 through links to the Deanery. Through partnership working with the LLR Training hub we are also exploring GP fellowships at PCN level to work across member practices.

		Planned FTE				Actual FTE				Variance vs Q4 Planned (FTE)				FYTD Growth	
Position	Base	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	%	FTE
GPs (excluding registrars)	**541.0**	542.0	544.0	546.0	547.0	544.1	527.2	524.7	522.8	-2.9	-19.8	-22.3	-24.2	-3.4%	-18.2
GPs (registrars)	**0.0**	0.0	0.0	0.0	0.0	138.0	172.6	171.4	162.2					0.0%	162.2
Nurses	**291.0**	292.0	295.0	296.0	299.0	280.8	276.1	281.0	279.6	-18.2	-22.9	-18.0	-19.4	-3.9%	-11.4
Direct Patient Care roles (Claimed ARRS)	**164.0**	189.3	269.1	386.2	461.2	185.8	215.2	252.0	276.5	-275.4	-246.0	-209.2	-184.8	68.5%	112.4
Direct Patient Care roles (not ARRS funded)	**289.0**	282.0	284.0	287.0	289.0	281.1	291.7	299.3	306.1	-7.9	2.7	10.3	17.1	5.9%	17.1
Other – admin and non-clinical	**1324.0**	1338.0	1346.0	1353.0	1361.0	1320.1	1323.5	1346.6	1352.9	-40.9	-37.5	-14.4	-8.1	2.2%	28.9
Total	**2609.0**	**2643.3**	**2738.1**	**2868.2**	**2957.2**	**2611.9**	**2633.7**	**2703.5**	**2737.9**	**-345.3**	**-323.6**	**-253.7**	**-219.3**	**4.9%**	**128.9**

		Planned FTE				Actual FTE				Variance vs Q4 Planned (FTE)				FYTD Growth	
CCG		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	%	FTE
NHS East Leicestershire and Rutland CCG	**841.0**	849.7	877.9	906.1	929.4	904.5	901.5	923.7	949.8	-24.9	-27.9	-5.7	20.4	12.9%	108.8
NHS West Leicestershire CCG	**878.4**	890.0	937.6	971.5	1006.0	880.9	890.2	920.6	922.0	-125.0	-115.8	-85.3	-83.9	5.0%	43.6
NHS Leicester City CCG	**889.6**	903.6	922.6	990.6	1021.9	826.5	842.0	859.1	866.1	-195.3	-179.9	-162.7	-155.8	-2.6%	-23.5
Total	**2609.0**	**2643.3**	**2738.1**	**2868.2**	**2957.2**	**2611.9**	**2633.7**	**2703.5**	**2737.9**	**-345.3**	**-323.6**	**-253.7**	**-219.3**	**4.9%**	**128.9**







Workload Pressures

The GP Work life Survey is a national survey of GPs in England. It focuses on GPs experience of their working lives, asking questions such as job satisfaction,

pressures, demands workload and future intentions. The Eleventh GP Work life Survey was published in 2021 and found:

More than eight out of 10 GPs reported experiencing considerable or high pressure from increasing workloads and increased demands from patients.

96.5% stated that they were seeing increasingly more complex patients.

Over a third (33.4%) said there was a considerable or high likelihood of them leaving direct patient care within 5 years for those over 50 the figure was 60.5%.

Our partner organisations are integral to us delivering on our ambitions and are committed to deliver a wide range of national and local initiatives to deliver these goals. Some examples of progress made so far and planned actions:

We are maximising the opportunities offered by the Additional Roles Reimbursement scheme which provide funding for PCNs to recruit new staff to delivery of key services such as enhanced healthcare in care homes, complex care, and enhanced access. A key aspect of this will be supporting patients to understand the range of new roles and how they enhance delivery of high-quality patient care. A framework for ARRS development includes:

- Development of PCN Workforce Plans by August 2022.
- Education sessions aimed at building the potential of ARRS
- An ARRS induction plan for new starters
- A “Toolkit” of support, information, and guidance for PCNs
- An ARRS Recruitment Strategy.

A suite of comprehensive, high-quality programmes of education, training and development have been delivered to all roles within primary care delivered by the LLR ICS Primary Care Training Hub (LLRTH).

2021/22 saw the launch of “Wellbeing Wednesdays” to support staff health and wellbeing, this now includes Community Pharmacy and Community Ophthalmology.

To support supply and resilience in 2021 we set out to develop a local innovation and took brave step to Initiate a Locum Bank to increase supply. This is a proof of concept and in very early stages but we e committed to working with practices over 2022/23 on beyond to make this a reality.

In addition to this Community Pharmacy intelligence from COVID Vaccination work is now feeding into the system wide workforce strategy. We continue to implement ‘Grow Our Own’ programme that supports existing staff to undertake professional training, along with a Recruit to Train programme, allowing and encouraging internal staff to develop and recruitment of external staff on to professional training programmes.

In 2021/22 we expanded a local initiative with one of our LLR practices to Increase Admin roles within PC by an additional 120 across primary care, building on

expansion achieved in 2021/22 through the implementation of an innovative training and development programme.

Through the LLRTH there is a continued focus on designing and implementing programmes of work to support the aspiration to grow, nurture and retain the workforce, including through:

- GP Fellowships – 18 GP fellows confirmed on to the NHSEI programme in LLR,
- Settling into Practice (Supporting Mentors) Scheme – a programme of mentorship for our GP fellows, existing GPs and those who are new to the area
- GP Trailblazer Fellowships - the LLRTH will continue to promote this innovative offer across primary care in accordance with HEE timescales for implementation
- GP Retention Scheme – with a continued commitment to support GPs to explore more flexible working patterns at any point during their career
- New to Practice / Fellowship nurse opportunities, including the GPN Fundamentals Programme, delivered through the DMU Nursing Facility (26 nurses currently on the programme)
- Upskilling/ bespoke training of Admin staff and those aspiring to join PC – the LLRTH will continue to support the delivery of a bespoke training offer

Delivering on key long-term conditions and reducing prevalence gap

The disruption of proactive care, due to COVID, for people living with long-term conditions, such as Type 2 Diabetes, high cholesterol, hypertension, Chronic Obstructive Pulmonary Disease and asthma, results in exacerbation and complications in these conditions.

The pandemic has allowed primary care to rethink and reset how care is delivered to patients and to optimise the management of cardiovascular and other long term health conditions.

In 2020 we became one of the first early national adopters of the Proactive Care @ Home programme which about reducing variation in detection and optimisation of patients by:

a) Creating a sustainable solution to LTC management in Primary Care.
b) Creating capacity to focus on recovery and develop new ways of working.
c) Delivering pathway specific interventions to support the areas of greatest need and complexity

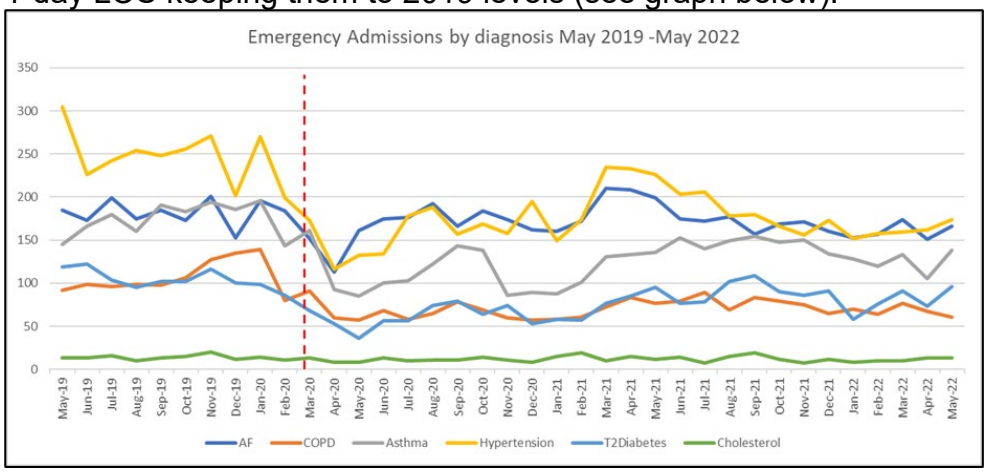
We are supporting primary care teams across LLR to provide this approach through implementing virtual consultations, digital solutions, and optimal use of the wider primary care team. This model of care is helping to restore routine care, post Covid-19, by prioritising patients at highest risk of deterioration, with pathways that mobilise

the wider workforce and digital/tech, to optimise remote care and self-care, while reducing GP workload.

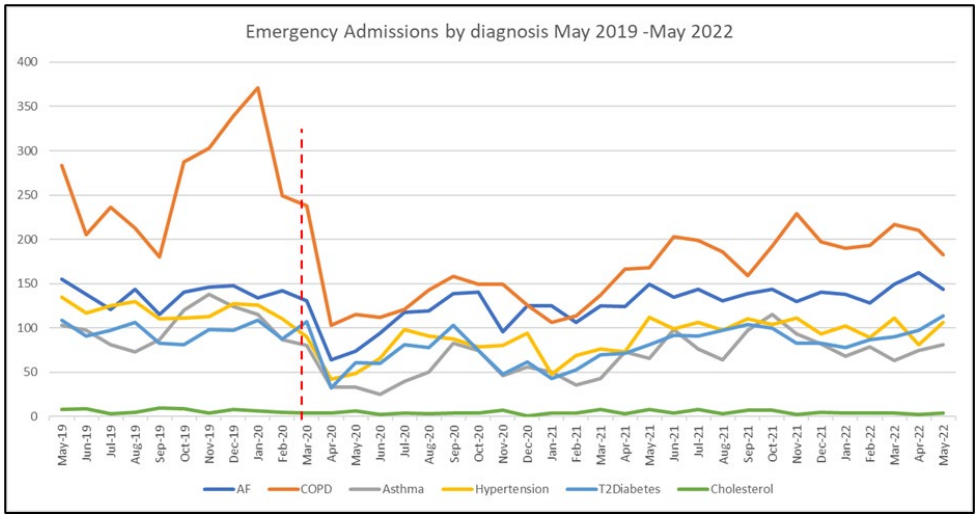
The 4 key principles of the programme are:

- Virtual by default
- Mobilising and supporting the wider workforce (including pharmacists, HCAs, other non-clinical staff)
- Step change in support for self-management
- Digital innovation, including apps for self-management and technology for remote monitoring

What we can see with the work that has been done in Primary Care to optimise patients and early management is a real management of emergency admission in 0–1-day LOS keeping them to 2019 levels (see graph below).



However, a steady increasing trend in 2+ day LOS is noted and the focus of our actions is on that early detection, risk stratification and pro-active management linking into the wider 'home first' agenda.



Our plan for 2022/23 is focussed on delivering the following:

- Reducing the variation in QOF and IIF – working with practices and PCNs to achieve their QOF and IIF by March 2023
- Using risk stratification working with practices and PCNs with the greatest prevalence gap to reduce this in the following key disease group areas:
    - Cardiovascular Disease
    - Respiratory
    - Diabetes

  This incudes hypertension.
- Implement digital resources through the proactive care at home programme to support patient self-management and optimisation of patient outcomes.
- Deliver care planning to ensure that our most complex and vulnerable patients care is co-ordinated.
- Implementation of the anticipatory care DES

We have a clear trajectory for improvement set out for our QOF achievement in LLR (see table below).

Baseline (QOF)	Actual	Plan	Trajectory for Improvements	National Standard/ Expectation
18,113 (No. of pt instances not competed end of March 2020 – 20 QOF indicators)	75,500	57,274	No monthly comparable data to July 2020 or 2021	No monthly comparable data until Dec 2022 – End of March 2020 QOF continues to be the target

PCN Development

We have established a work programme to support our 26 PCNs develop a level of maturity and leadership, to maximise the opportunities within the PCN DES and to play a major role in the ICS. Our objectives for the programme include:

- Interpret, implement and respond to national guidance including the five priorities published in August 2021 (see below) as well as the Fuller Stocktake Report (Framework of Shared Action)
    - Improving prevention and tackling health inequalities
    - Better patient outcomes in the community through proactive primary care
    - Improved patient access to primary care services
    - Better outcomes for patients on medication
    - Create a more sustainable NHS

- Support the identification of PCN risks and escalate to the appropriate risk management group

- Build links with Integrated Neighbourhood Teams

- Join up PCN development programmes to support independencies, avoid duplication and problem solve including the DES service requirement areas.

Our local areas of focus, to support PCNs deliver these national priorities are:

PCN Reconfiguration – Targeted support to PCNs who reconfigured from April 2022 to ensure NHSE requirements for new/ amended PCNs are met, as well as organisational development to support high functioning teams.

Vision / Engagement – We have commissioned NHS South, Central and West CSU to run a programme of development workshops for our PCNs which have been well attended by CDs and PCN Managers. The workshops have provided much needed headspace to reflect on the achievements realised over the last two years, and how the learning through the covid vaccination programme will be carried through to 2022/23, including strong engagement with member practices and a voice within the ICS/B. Our third workshop focussed on workforce and how the ARRS workforce programme can be strengthened this year, including optimisation of roles and efficiencies working at scale and what is best delivered at system/ place/ neighbourhood to reduce duplication of resources. The learning will help to shape the LLR Workforce Strategy. The themes for each session are being designed based on feedback from each session. Our fourth workshop will explore requirements around embedding a PHM approach to support delivery of the Tackling Health Inequality Neighbourhood plans and Personalised Care plans.

Our PCN Development Steering Group is now established in its role to lead PCN Development and coordinate activity and engagement both across the ICB, as well as with relevant partners. The Steering Group forms a sub-group to our Primary Care Transformation Board, as it plays a key role in supporting the transformation of primary care.
The I&T team are working with the Medical Directorate to deliver a 'PCN Listening Exercise' to enable engagement with our 26 PCNs to understand local successes and support challenges, as we transition to an ICB. Themes will be collated and shared for implementation.

Service Delivery Grip – An IIF Task and Finish Group has been established to lead the development of a local dashboard for the 35 IIF indicators and develop a support offer for PCNs to achieve the requirements which includes searches, templates, options for patients to access the services in non-traditional ways, and a series of webinars.

The dashboard will be used to understand trends, identify gaps and support requirements to reduce variation. The dashboard is now being published monthly with five indicators showing a nil return and 11 indicators still red. The CSU will develop guidance to support practices and PCNs to invite patients for reviews, LHIS will provide guidance and information for PCNs to identify the appropriate patient cohorts and through the webinars, encourage PCNs/ practices to spread the work over the coming months and advertise support.

Through the service requirements of the DES, we have used the opportunity to work collaboratively with our ICB Leads across Directorates and with external partners. This has helped identify synergies across work programmes, offer broader support to PCNs from a range of experts and show how areas link together. This has included support from many partners including Public Health Leads, PHM Lead, MH Lead, Personalised Care Lead and our Social Prescribing Lead which has ranged from individual practice/ PCN support to a LLR approach through our system workshops. PCN DES interdependencies have been identified, as well as system support offers which we will share with PCNs to better understand our ICB offer.

As part of the PCN Standard Contract DES requirements, PCNs were required to identify a population within their PCN experiencing inequality in health provision and/or outcomes and develop a plan to tackle the unmet needs of that population. All LLR PCNs submitted a plan in February 2022, based on a range of data sources and intelligence on health inequalities, working in partnership with system partner organisations, and engagement with local populations to understand any gaps/barriers to their care and maintain ongoing engagement to deliver and measure their intervention.

Themes from the plans submitted, related to addressing the following health inequalities:

- Improving access to Primary Care with a focus on patients with long term conditions, CVD or people who struggle to attend the practice.
- Interventions for individuals experiencing:
- overweight or with obesity or support for people are not physically active
- social isolation
- poorly controlled diabetes
- cardio/respiratory conditions
- heart failure
- dementia
- Mental health or on the Severe Mental Illness (SMI) Register
- Screening for cancer (cervical, bowel and breast) and early cancer diagnosis amongst the 20% most deprived
- Housebound / co-morbidity / frailty

We will be working in partnership with Public Health and our PHM lead to understand how the qualitative and quantitative work undertaken at PCN level is addressing health inequalities needs. This will inform how we embed this way of working with our PCNs and make it an integral part of the Primary Care Model.

We have mapped the overlap between IIF and QOF requirements and further work will be progressed to understand the potential health inequalities in areas if PCNs/practices do not meet the required thresholds. Work has commenced with the LTC@Home programme on ways to reduce further inequity.

Funding – We are working with PCNs to maximise funding opportunities to support development, such as the PCN Development Fund once guidance has been released for 22/23.

Risks – We have established a forum to consider and review PCN risks, working with our colleagues in Quality, Finance, Contracts and Workforce, as well as our Integration and Transformation Managers to triangulate hard and soft intelligence. This will enable us to identify potential risks and issues to PCN resilience and sustainability and escalate as appropriate to our Risks Operational Group, as we do with general practice risks.

Best Practice – we have changed the format of forums and developed a programme of workshops to champion initiatives, share good practice and learning. MS Teams is also being maximised as a collaboration platform for PCNs and a PCN Tracker developed to pull together intelligence for each of our PCNs.

Quality – Reducing Variation

Despite the differing demography of patients and variance in size of practices across LLR, we have found that the key challenges they face are very similar: -

- Capacity for development - alongside unprecedented demands e.g., resilience, back-log/recovery pressures, covid/flu vaccinations
- Increasing number of practices requiring support for resilience – largely citing workforce challenges, staff sickness and recruitment issues
- Operational demands limiting the capacity to work proactively on some of the wider determinants of health issues
- Operational demands also taking focus away from future planning and transformation in line with national vision.
- Mixed engagement from primary care stakeholders limiting ability to offer consistent support

Despite these, our ambition is to develop and implement a strategic approach to resilience to offer at-scale solutions and support, and to develop and implement a Primary Care Engagement policy including thresholds for support and intervention.

Progress and Actions to Date:

1. Care Quality Commission (CQC) Notifications
   If/when a Leicestershire practice receives prior notice of an impending CQC inspection, or a provisional or final inspection outcome report, officers of the Clinical Commissioning Group's (CCG) Primary Care, Quality and Contracting teams, supported by Clinical Leads, work together to develop a bespoke improvement/recovery plan for that practice, and work with the practice to implement and make the required improvements.

2. General Practice Quality and Operations Group/Risk Share Group – Primary Care Quality Dashboard
   These committees, (again with membership from Primary Care, Quality and Contracting teams, and Clinical Leads), meet regularly to identify LLR practices "at risk". This "risk" maybe due to a specific quality, performance, or contractual issue, it maybe because of an impending or realised CQC inspection, or it may

be because a practice has reached out to the Clinical Commissioning Group with endemic resilience and sustainability issues.
Numerous sources of data and information in respect of primary care and general practice quality, sustainability, and resilience are pulled together in our Primary Care Quality Dashboard, which both committees review to also identify practices at, or potentially at, risk so appropriate support and improvement plans can be developed and implemented with the practices.
Currently there are 7 County GP practices with active CQC and or Risk improvement plans in place and a number of others being supported with "lower level" challenges through the Quality Operational Group.

3. Primary Care Operational Pressures Escalation Level Reporting

At the end of March '22 we implemented our revised LLR wide Primary Care Operational Pressures Escalation Level (OPEL) reporting process to bring LLR primary care into line with our other System provider partners – UHL, East Midlands Ambulance Service, Leicestershire Partnership Trust etc., - who use OPEL to inform of operational pressures that may impact on overall patient care and or that require support from other parts of the LLR Care System.
As well as giving us a robust and consistent view of the pressures on and issues impacting on primary care in the County and LLR, it is also the mechanism through which practices can, daily, Monday – Friday, flag individual operational and resilience issues and reach out to the CCG for advice and support.
The Primary Care Team, the relevant managers, and the LLR Workforce Team now work with on average 5 practices per week who have flagged issues through the OPEL report and have been able to support them through their difficulties whilst continuing to provide services in a safe way.
Most of these issues were in relation to workforce shortage and the impact of Covid-19, but we have also been able to agree a range of actions including: -

- Allowing practices to close for a half day, with cover provided by Derbyshire Healthcare United and Willows Health Care, where it has not been clinically safe to open
- Allowing practices additional Protected Learning Time session to enable the training of new staff.
- Allowing a short series of lunchtime closures to enable practice staff to catch up on a backlog of tasks

Most of the challenges raised are short term but some unfortunately are longer standing and the team has worked with 10 practices over the last 12 months offering advice and support to minimise impact on patient services.

4. Royal College of General Practitioners Support Programme

The LLR CCGs have commissioned a support programme for all LLR Practices from the Royal College of General Practitioners (RCGP).
This programme will provide a two staged offer for practices in the County and across LLR:

I. CQC Preparation - for all LLR practices, delivered at Primary Care Network level

II. Bespoke Practice Support - for individual practices identified via a holistic prioritisation and “Expression of Interest” process – comprising a scoping discussion, a diagnostic visit, development of bespoke action/improvement plan, and direst support to deliver that plan

The RCGP support is focused on resilience and sustainability and achieving and embedding long term change and improvement through developing leadership and an improvement culture within the practice, rather than specific or critical quality, safety, or performance issues.
Recruitment of practices for the bespoke support – prioritised and motivated to participate – is under way, and the CQC Preparation element is expected to commence early summer.

5. NHSE/I “Time 4 Care - Accelerate Access” Programme 22/23
This is a recent initiative/opportunity being offered “to nominated” LLR practices from NHSE/I, aimed at supporting practices to improve all aspects of access, from how they manage/smooth demand and realise/optimise capacity, increase appointments, reduce waiting times, improving signposting etc., through to increasing staff resilience and improving the experience of their patients.
We are in the process of reviewing practice data and intelligence relevant to the aims and objectives of this programme, for example, located in an area of high deprivation, experiencing a high level of complaints, where Healthwatch have concerns, where our access data and benchmarking shows significant variation etc., to identify practices we will engage with to support and encourage them to take up our nomination and this support offer.

Engaging and communicating with our people

In July the latest outputs from the national GP Patient Experience Survey (GP PES) have been published at PCN level. This is an annual survey that goes out to a proportion of registered patients at a practice. The questions focus in the main on access, overall experience, confidence in the clinician and care delivered. This year the results have been published at PCN level and is accessible through the following link (add link here). The key themes picked up from the survey is as follows:

- Response rate
- Access – ease of contacting the practice by telephone, ease of being able to make an appointment
- Overall experience
- Confidence in the clinician/healthcare professional that has dealt with the presenting problem for the patient

There is a distinct variation and disparity in response rates when you compare County and Rutland to City PCNs. Response rates in the City average around 24% whereas County and Rutland average around 40%. There is likely to be a number of reasons for this and what it absolutely demonstrates that the way we engage with our communities to increase that participation to get that feedback needs to change and how we locally influence that given that the survey is set nationally. Our engagement plan working with our PCNs needs to reflect this so that we can increase that participation that then enables us to have a real understanding of what

the experience of patients are in accessing and receiving care and treatment from General Practice.

There were 2 key areas in terms of access where a variation in experience is noted:

- Ease of contacting the practice by telephone – the national average for this was 53% where patients reported a good experience. 50% of our PCNs were at the national average and above in their patients reporting a good experience in contacting their practice.
- Ease of being able to make an appointment – the national average for this was 56% where patients reported a good experience. 58% of our PCNs were at the national average and above in their patients reporting a good experience of making an appointment.

This highlights what we already know in terms of that variation in experience and links into the work we outlined in our plan and work to work with our practices and population in promoting better relationships and improve this overall experience moving forwards.

There is a real variation in overall patient experience at PCN level. The national average of good experience reported is at 72%. In LLR 54% of our PCNs survey results were at the national average and above where their patients reported good experience. The insights work that has been carried out by our engagement team needs to be overlayed on this to then understand the key issues to which we can then work with PCNs to address through their development plans.

The final key theme was about the overall confidence in the clinician/health care professional in their delivery of care treatment. This is in the main about the patient's experience of their contact with the clinician and whether they felt that they received the most appropriate care and treatment. Overall, there is high levels of confidence reported. The national average was 93% of high levels of confidence reported. 70% of our PCNs were at and above the national average of their patients reporting high levels of confidence. There are 2 PCNs that were outliers to this identified and considering the response levels we will be picking up in particular this theme as part of the targeted RCGP quality improvement work with those 2 PCNs.

Engagement and Communication Plan and key activities

We are in the process of rolling out a campaign under the theme of *You and your GP practice*. This campaign will promote better relationships between patients and practices and support patients to access the most appropriate care and understand how practices are changing and transitioning:

- **Routes of access**: this will highlight the options patients have for contacting their GP. It highlights the online booking process in practices as an alternative to phoning. Patients able to use this method can benefit from a convenient, secure and time saving way to seek help from their practice;

- **Awareness of alternatives to a GP – the Multi-disciplinary team**: Some patients are unaware of the extent of the GP practice team available to provide care. In some circumstances patients may benefit from care

provided by another health professional able to provide specific care. Examples of other members of the practice team includes Clinical Pharmacists, Physiotherapists, Dieticians, Podiatrists, Occupational Therapists, Care Coordinators, Health and Wellbeing Coaches.

- **Promoting the use of self – referral services:** These are services patients can access directly without needing a GP referral. Examples are 'Talking Therapies', Podiatry and Musculoskeletal self-care through a locally developed App.

- **Community Pharmacy Consultation Scheme (CPCS):** The (CPCS) allows our practices to use the expertise of our community pharmacists to support delivery of care. If a patient's symptoms can be resolved by a booked consultation with the pharmacist instead of the GP, patients will be given a same-day referral to a pharmacy of your choice. In some circumstances the pharmacist can prescribe. This service was recently highlighted on BBC East Midland.

- **Active signposting/care navigators:** Aim is to connect patients with the most appropriate alternative source of advice and support when a GP or health service may not be the best response to meet someone's needs. Where it works effectively, active signposting has been shown to significantly reduce unnecessary appointments. This is a very popular service with practice staff and patients and has enabled effective integration across health, care services and the voluntary sector, learning from the model of care piloted with our 'Local Area Coordinator' service across Leicestershire.

- **NHS App:** We are continuing to promote the use of the NHS App by patents comfortable using digital applications. The App provides access for patients to a range of NHS services including heath advice, ordering a prescription and manage appointments.

The campaign focuses on self – care. Using data to ensure we adopt an evidence – based approach highlighting the most common minor conditions/ailments that have led to unnecessary attendance at ED or GP practices. The campaign will highlight the self-care options, the role of the pharmacist and NHS111 online.

We are also working with GP practices to develop capability to improve communications with patients. We will ensure they are benefiting from the national support available on digital tools such as social media and websites. For example, the recent website review highlights good practice on core information available to patients and we will work with practices to use this to improve websites locally.

To support the campaign, we are already working with practices to reduce demand and support patients to self-care through hyperlocal engagement at a practice, PCN or neighbourhood level. We are bringing practices together with community, Voluntary, Community and Social Enterprise organisations and patients and patient

groups. Practices being supported are being prioritised based on the health inequalities of their population.

Work will also commence with PCNs and practices to develop a Primary Care Engagement Framework including reinvigoration of PPGs which for some practices has significantly declined during the pandemic. This Framework, which is a key priority within the Integrated Care Board (ICB) People and Communities Strategy, will work at practice, PCN, place and system level to ensure that communities are engaged with in a way that fits their needs, and their voices are heard and their impacts influence service design and delivery.

Joint work with patients, carers, practices and Primary Care Networks is vital to develop the primary care engagement framework. The framework would ensure that PPGs are revitalised and linked into their GP practice, their Primary Care Network and the ICB:

- Support PCNs and health system to engage and consult on enhanced access and gaps that emerge from national ask.

- Support practices to reduce demand and support patients to self-care through hyperlocal engagement bringing practice together with community, VCSE sector, patient. Practices prioritised and links established with use of A&E.

- Working with Quality Team support practices to enhance their collection of lived experiences from patients and carers to enhance quality of care

- Support practices with contractual changes, or improvements requiring statutory public consultation (Forest House/Lubbesthorpe, Wymondham, Barwell, Husbands Bosworth, Cossington Park, LLR Violent patient scheme)

- Support practices with Care Quality Commission and quality visits through pre and post activities
-
- Work with PCNs and practices to develop a primary care engagement framework including reinvigoration of PPGs and engagement activities

Leadership and Governance

Over the last year to support the transition from CCGs to ICB for primary care we have worked with GP colleagues, partners and the LMC to establish a clinical leadership and engagement model that supports the ICB governance.

This has involved the establishment of a portfolio and transformation led development of clinical leadership working in partnership with PCL to establish a team of clinical leads across all the key transformation areas.

In addition, recognitions that delivery of functioning and performing PCNs including establishing of integrated neighbourhood teams requires place-based focus that creates clinical leadership at place and neighbourhood. Five place based clinical leads are now in place who are key to the delivery of the primary care plan at place.

We have also recently worked with the LLR LMC to develop a collaborative framework through which we work with the LMC and ensure that engagement happens where it is most impactful.

The Primary Care Transformation Board will be the key transformation delivery vehicle for Primary Care Transformation. Overseeing the design and development of the ICB Primary Care Strategy and the delivery of the key workstream plans as set out in this paper. The Board has responsibility in assuring the performance and identifying issues and risks that impact on the delivery of the key metrics in relation to access, quality, workforce, PCN delivery and chronic disease management.

Commissioning related decisions pertaining to primary care such as:

- Funding
- Procurement
- Estates
- Formal sign-off of delegated budgets

will be done through the LLR Strategic Commissioning Group which has a delegated function that supports decision making and sign off from the ICB Board (Daljit is this right).

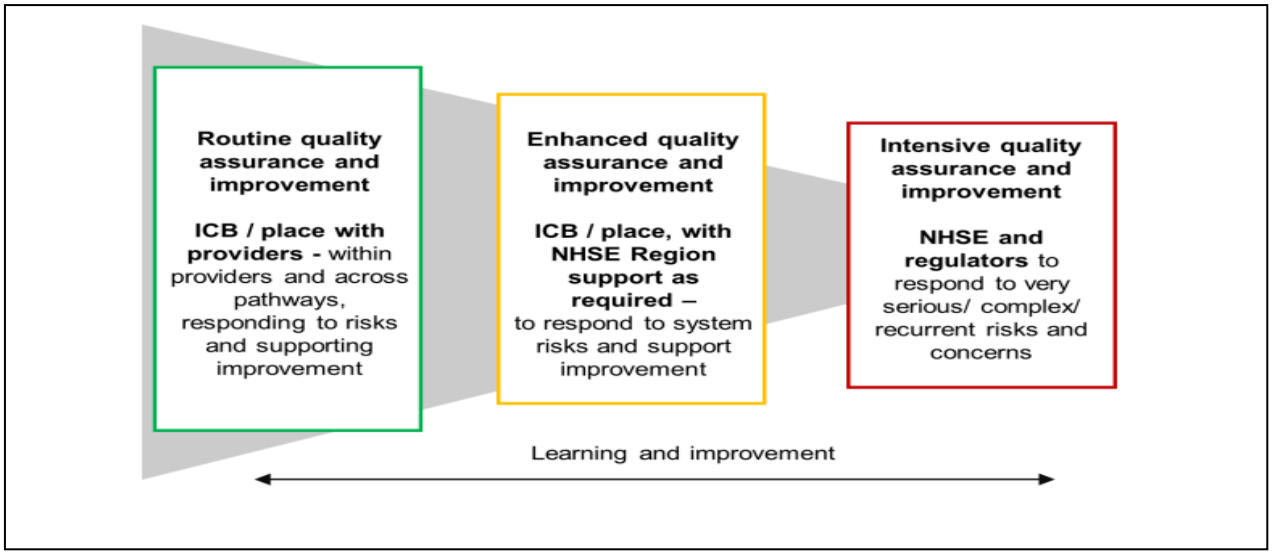
The Primary Care Partnership Board led by PCL provides a provider-led delivery framework supporting the development and delivery of a commissioning framework through which Primary Care transformation and delivery can be supported at scale where this is appropriate and relevant.

Appendix 6 provides the reporting structure for the LLR Primary Care Transformation Board and the reporting structure for the Primary Care Partnership Board

Management of Risk and Quality in Primary Care

The LLR ICB Primary Care quality assurance and improvement processes have recently been reviewed against the National Quality Boards updated guidance on ‘Quality Risk Response and Escalation in Integrated Care Systems’.

This national guidance defines the refreshed approach to quality risk management which is focuses on three main levels of assurance:



This guidance has been mapped to the current LLR structures for the management and escalation of quality assurance and improvement within Primary Care, as shown below:

Level of Assurance	Detail	LLR ICB Forum currently aligned to:
Routine quality assurance and improvement	Led by ICB - Business as usual activity and reporting within Primary Care providers / PCNs for service delivery	Primary Care Quality Operational Group
Enhanced quality assurance and improvement	Implemented when concerns/ risks are identified that require more frequent and intensive oversight to gain confidence that care is of sufficient and consistent quality, that action/ improvement plans are leading to the desired outcome and that the improvements in care are sustained. May include regulatory action, including enforcement action and contractual actions (e.g. service development and improvement plans, suspension of service, termination of contract).	LLR Risk Share Group
Intensive quality assurance and improvement	Implemented as a last resort, when there are very significant, complex, or recurrent risks, which require mandated or immediate support from NHSE for recovery and improvement, including support through the Recovery Support Programme, or from wider regulators. The intensive approach must be agreed based on the risk profile and support needs within the ICB. This assurance level covers previous NHSE Risk Summits	Oversight Panel Quality Summit

In light of the new national guidance and the changes from CCG to ICB Terms of reference of each of the groups that oversee and manage risk and quality are being reviewed and revised to ensure alignment and continued robust governance and effectiveness.

The ICB System Quality Committee will oversee the finalisation and sign-off of this revised structure to ensure robust management and oversight of risk and quality in Primary Medical Care.

Recommendations

The LLR ICB Board are asked to:

- **NOTE** the contents of this report that provides a comprehensive overview and plans in relation to Primary Medical Care
- **NOTE** the complexity challenges in in delivering the required transformation in Primary Medical Care including recognising the key improvements and successes delivered
- **RECEIVE** the overview through which the governance and assurance is delivered for Primary Medical Care through the ICB in relation to Transformation & Delivery, Quality & Risk and Performance.
- **AGREE** to receive the Primary Medical Care Strategy for the ICB in 6 months' time at the ICB Board.

Appendix 1 List of PCNs in LLR

Leicester (415,849)	Leicestershire (362,317)		Rutland (41,609)
Aegis PCN (36,612) Belgrave & Spinney PCN (47,020) City Care Alliance PCN (39,788) Leicester Central PCN (47,613) Leicester City & Uni PCN (42,898) Leicester South (31,084) Millennium PCN (37,076) Orion PCN (46,980) Salutem PCN 50,792 (5) Foxes PCN 35,986	Cross Counties PCN (41,087) Market Harborough PCN (39,898) MSV PCN (71,745) (5) North Blaby PCN (47,178) O&W PCN (45,754) South BL&L PCN (47,593) G3 PCN (27,952) Beacon PCN (34,747)	Bosworth PCN (35,208) Carillon PCN (55,942) Fosseway PCN (45,485) Hinckley Central PCN (38,112) NWL PCN 111,539 (12) Soar Valley PCN (50,378) Watermead PCN (33,122)	Rutland PCN (41,609)

Appendix 2 Additional Roles Reimbursement Scheme roles

Clinical Pharmacists	**Care Coordinators**	**Physician Associate**	**Dieticians**	**Training Nurse Associate**
Paramedic	**Podiatrist**	**First Contact Physio**	**Nurse Associate**	**Advanced Practitioner**
Mental Health Practitioner	**Health and Wellbeing Coach**	**Social Prescribing Link workers**	**Pharmacy Technician**	**Advanced Practitioner**

Appendix 3 Investment and Impact Fund (IIF) Indicators
IIF indicators and thresholds to receive PCN investment.

Domain 1 : Prevention and tackling health inequalities		
Indicator	**Threshold**	**Value**
HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	**60% (LT), 80% (UT)**	**£8.1m /36 pts**
HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	**81% (LT), 95% (UT)**	**45 pts**
VI-01: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**80% (LT), 86% (UT)**	**£9.0m /40 pts**
VI-02: Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**57% (LT), 90% (UT)**	**£19.8m /88 pts**
VI-03: Percentage of children aged two or three years on 31 August 2022 who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**45% (LT), 82% (UT)**	**£3.2m/ 14 pts**

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	**25% (LT), 50% (UT)**	**£16.0m /71 pts**
CVD-02: Percentage of registered patients on the QOF Hypertension Register	**Increase 0.6pp (LT), Increase 1.2pp (UT)**	**£7.9m /35 pts**
CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	**48% (LT), 58% (UT)**	**£7.0m /31 pts**

CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	**20% (LT), 48% (UT)**	**£4.1m /18 pts**
CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	**UT: 95% LT: 70%**	**£14.8m / 66 points**

CVD-06: Number of patients who are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC).	**UT: 60% LT: 40%**	**£14.8m / 66 points**
Domain 2 : Providing high quality care		
PC-01: Percentage of registered patients referred to a social prescribing service	**1.2% (LT), 1.6% (UT)**	**£4.5m /20 pts**
EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	**30% (LT), 85% (UT)**	**18 pts**

EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	**80% (LT), 98% (UT)**	**£4.1m /18 pts**
EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	**Mean of 6 patient contacts per care home resident (LT),**	**£2.9m /13 pts**

EHCH-06: Standardised number of emergency admissions per 100 care home residents aged 18 years or over	**Mean of 8 patient contacts per care home resident (UT)**	**£6.1m /27 pts**
AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per 1000 registered patients	**Improvement: Reduction: 0 (LT), 0.001 (UT) Absolute: 0.01 (LT), 0.008 (UT)**	**£25.0m /111 ots**
CAN-01: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	**UT: 80% LT:40% (22/23), 65% (23/24)**	**£5.0m/ 22 points**

ACC-02: Number of online consultation submissions received by the PCN per 1000 registered patients	**0.26 (single threshold) 5 per 1000 per week**	**£4.1m / 18 points**
ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	**35th (LT),65th (UT) percentile of performance from piloting**	**£25.0m /111pts**

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	**0.066 (LT), 0.19 (UT)**	**£9.9m /44 pts**
ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	**90% (LT), 98% (UT)**	**£16.0m /71 pts**
ACC-09: Number of referrals to the Community Pharmacist Consultation Service per 1000 registered patients	**34 (single threshold)**	**£6.1m /27 pts**

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	**44% (LT); 62% (UT)**	**Points 26**
SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review	**44% (LT); 62% (UT)**	**9**

Appendix 4 – Fuller Report

Link to the report inserted

https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

Appendix 5 - Current 'Extended Access Service Provision across Leicestershire

Service	Operating Hours	
	Mon-Fri	**Sat-Sun**
Oadby Urgent Treatment Centre ("UTC")	0800-2100	0800-2000
Enderby UTC (Extended Primary Care)	1830-2100	0900-1900
Lutterworth UTC (Extended Primary Care)	n/a	0900-1900
Market Harborough UTC (Extended Primary Care)	1830-2100	0900-1900
Melton Mowbray UTC (Extended Primary Care)	1830-2100	0900-1900
Oakham UTC (Extended Primary Care)	1830-2100	0900-1900
Market Harborough Minor Injuries Unit	0830-1800	n/a
Melton Mowbray Minor Injuries Unit	0830-1800	n/a
Oakham Minor Injuries Unit	0830-1800	n/a
Loughborough Urgent Treatment Centre	24/7	24/7
Hinckley Urgent Treatment Centre	1900-2200	0800-2000
Coalville Urgent Treatment Centre	n/a	0900-1200 / Sundays closed
Merlyn Vaz Urgent Treatment Centre	0800-2000	0800-2000
Belgrave H.C Extended Primary Care	1830-2200	1200-2000 (incl. BH)
Saffron Lane Extended Primary Care	1830-2200	1200-2000 (incl. BH)
Westcotes Extended Primary Care	0800-2000	0800-2000 (incl. BH)

Appendix 6 – Governance Structure charts illustrating how transformation, delivery and risk & Quality is supported through Primary Care

Diagram 1 PCTB Governance

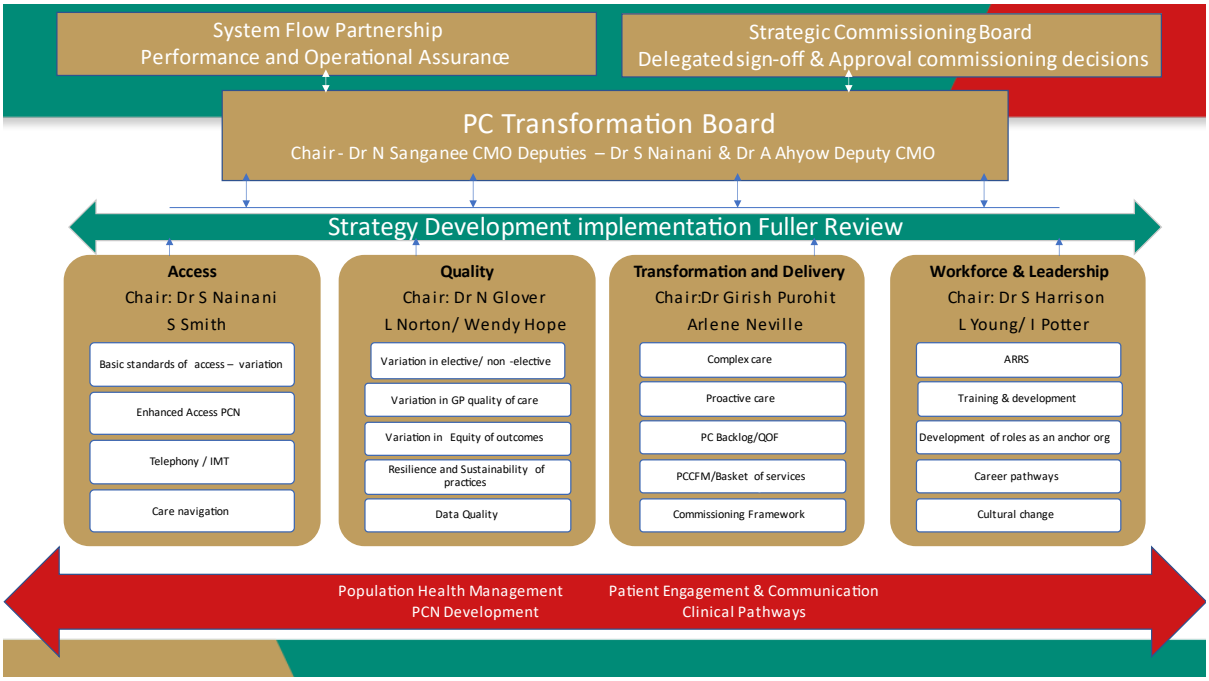
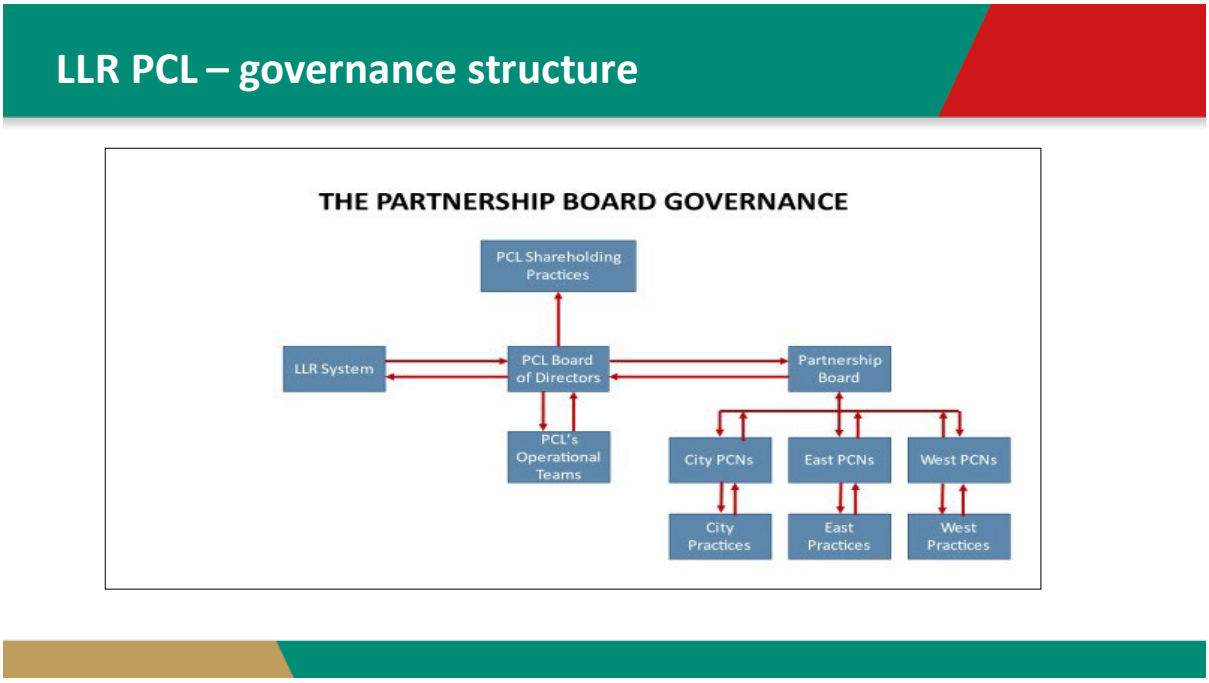


Diagram 2 PCL Primary Care Partnership Board Governance



D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 August 2022**	**Paper:**	**D**
Report title:	**LLR System Flow Partnership – briefing**		
Presented by:	Rachna Vyas, Chief Operating Officer, NHS LLR		
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
- **RECEIVE and SUPPORT** the summary of the System Flow Partnership Improvement Plan
- **NOTE** the ongoing work to balance demand and capacity across the system in readiness for surge

Purpose and summary of the report:

This report provides the ICB with:

- A summary of the System Flow Partnership Improvement Plan & associated performance
- A summary of the demand and capacity planning currently being undertaken across health and care

Appendices:	
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.	Awaiting confirmation of additional funding from national team
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

System Flow Partnership – briefing paper
August 2022

System Flow Partnership – Delivery plan

1. The System Flow Partnership remains a collaborative, Chief Executive led forum where health and care partners assess the performance of the wider urgent and emergency care system. The priority action for the Partnership is to deliver zero ambulance handover delays over 30 mins. This is done through assessment of delivery against three interdependent improvement plans across three multi-agency and multi-professional groups:

Collaborative	SRO/lead	Key objectives
Primary Care Transformation Board	Rachna Vyas / Yasmin Sidyot	• Ensure 80% of all frail and multi-morbid patients reviewed with a refreshed care plan linked to use of community crisis services by Oct 22, enabling complex admissions to acute care to be maintained at 19/20 levels in 22/23 • General practice to maintain minimum access standard of 75/1000 to enable access to services as needed, with variation addressed by Sept 2022 • Strategic review of urgent care access completed by Oct 22, ensuring needs-based access in readiness for winter 22 • Consistent and ongoing communication and engagement with our patients on new models of access, care and treatments
Home First Collaborative	Sam Leak / Fay Bayliss	• Implement the unscheduled care hub, managing appropriate EMAS / ED / DHU presentations by Oct 22 enabling complex admissions to acute care to be maintained at 19/20 levels in 22/23 and the EMAS call standards to be met safely • Maintain 70% of all 2-hour urgent community responses across health and care, decreasing the need for hospital attendance • Implement 200 virtual ward ‘beds’ in key specialty areas enabling admissions to acute care to be maintained at 19/20 levels in 22/23 • Implement an ICS health and care integrated discharge function enabling safe and timely discharge within 24 hours of MOFD for P1 & 48 hr for P2 by October 22
Acute Care Collaborative	Jon Melbourne / Rachel Dewar	• Design and test the UHL-led care home capacity, creating an additional 24 beds by August 22 • Create & implement a pre-transfer unit to support flow of patients out of ED • Create additional capacity within UHL to support flow out of ED • Embed additional rehab and reablement support Implement and embed SDEC, consistent board round processes, criteria led admission and criteria led

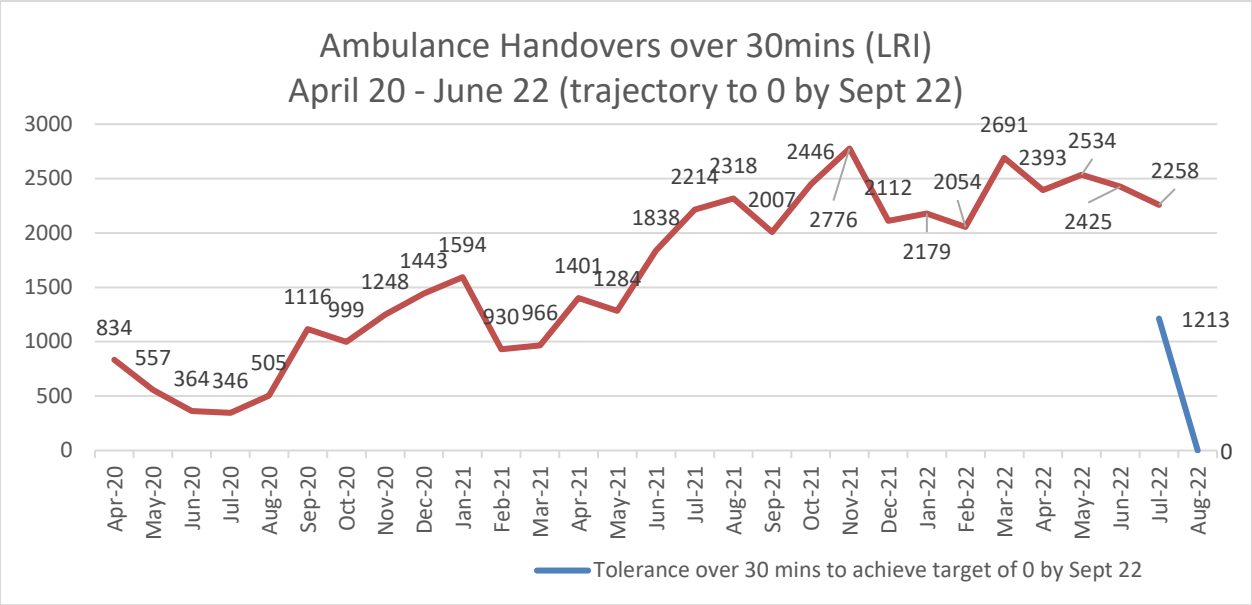
		discharge as priorities in key specialties such as medicine and RRCV by Oct 22, including 66% of simple discharges by 5pm

2. The full plan, combining plans and trajectories from each collaborative, is assessed by the System Flow Partnership on a bi-monthly basis; all actions contained within this plan are geared towards delivery of the objectives in the table above.

3. A confirm and challenge of the full plan has also been undertaken with the LLR Clinical Executive over a series of months, with no further actions being added to the plan.

Performance summary – July 22

4. In July 22, all systems were asked to model the requirements to deliver against constitutional ambulance standards. To meet the standard of zero 30 min handovers by Sept 1st, the LLR system was required to deliver a trajectory of 1,213 handovers > 30 mins in July '22. The actual position was 2,258 handovers over 30 mins.



5. Whilst this is an improvement against the monthly actuals for March, April, May and Jun 22, the risk position as a system remains critically high, with all actions focussed on creating flow across the system.

6. Despite this pressure, the system was able to fulfil the requirement of zero capacity breaches for long waiting elective patients in July 22 and within tolerance of the July trajectory for the 104 week wait patients (plan 351, actual 379).

7. Other notable metrics from the SFP plan in July against the actions outlined in point :

   Primary Care Collaborative:
   - 64% of vulnerable patients have had a care plan review in the last 12 months against a target of 80%
   - 72% of 581,287 appts in primary care were face to face in May 22 (up from 70% of 507,715 in April 22)

   Home First Collaborative:

- 130 patients were safely diverted away from acute services in June 22 via the unscheduled care hub (up from baseline of 120)
- 8,500 patients were admitted to UHL in June 22 compared to 9,100 in June 19 (baseline year)
- Urgent community response standards were met in June 22 (baseline 80%)
- 44% of P1 patients were discharged within 24 hours against a target of 95% and 36% of P2 patients were discharged within 48 hours against a target of 85%

Acute Care Collaborative

- 53% of UHL patients were discharged before 5pm against a target of 66%
- An average of 48 patients were waiting for beds at 8am in ED against a target of 5 patients
- An average of 139 ambulance conveyances occurred against a target of 140

8. To enable consistent reporting against key metrics across the system, a full suite of metrics has been produced across health and care and is shared on a bi-weekly basis across the system. Each action has an agreed trajectory for improvement against either a national or locally set standard.

Further iterations of the plan in readiness for winter / surge

9. Through June and July 2022, the LLR system has participated in in-depth reviews of the UEC pathway, both to confirm and challenge current assumptions / plans and to assess whether any further actions are required to deliver improvements. Findings & recommendations are now being finalised for each report, if not already received:

    - Missed opportunities audit (NHS E, June 22)
    - UEC system review (CQC, July 22)
    - Regional benchmarking exercise (ML CSU, July 22)
    - Acute pathway review (Ian Sturgess, due to report August 5th '22)

10. Each collaborative will review its plan in light of these recommendations following the System Flow partnership session on August 12th 2022. However, noting the continued pressure on the pathway and the risk carried across the system, many recommendations have already been enacted / planned for launch:

Actions for the Acute Care Collaborative:

Title	Summary	Impact	Timescale
Care Home Capacity	UHL plan to open 30 additional beds in Ashton Care Home to support flow. These will be supported with appropriate staffing to ensure good flow from the unit	30 beds	August 2022 (pending CQC approvals)
Enhanced rehab and reablement	Additional rehab and reablement support	Improved discharge (impact TBC)	Sep-22
Extended hours MIAMI	Extend hours of the new UHL minor injuries and minor illness unit (9am-midnight, currently 10am-10pm).	Increased duration of streaming from ED	Sep-22
Additional UHL capacity	Initiatives being explored including: - 8 spaces in ED for patients awaiting admission - ward 15 surgery to medical switch (6-8 beds) - discharge lounge at Glenfield hospital	8 spaces freed up in majors, 8 medicine beds, 8 respiratory/ cardiology beds	Sep-22
Pre-transfer unit	A pre-transfer unit for patients awaiting transfer from ED which will free up space in ED. Model approved by region and EMAS. Could be expanded for other patients awaiting transfer at UHL.	~20 spaces	Oct-22
Patient flows	Review of patient flow, for example increasing fit to sit in ED/wards and numbers through GPAU (GP assessment unit) – will include additional support to embed change	TBC	Sept-22

Actions for the Home First Collaborative:

Title	Summary	Impact	Timescale
Pathway 1 and discharge to assess capacity increase	Commission an increase in pathway 1/DTA capacity	20-30 beds (might be more opportunity)	Sep-22
Step-Down Ward	Leicestershire Partnership Trust step-down ward	18-24 beds	Sep-22
Unscheduled Care Coordination Hub (UCCH) expansion	Stack Management in EMAS, ED - Unscheduled Care Coordination hub (UCCH) expansion to manage the 'stack' in EMAS and ED, with the aim of preventing admissions and attendances	Up to 20 admissions prevented a day	Sep-22
Support service increases	Initiatives include: - Increased transport provision and coordination in and out of hours - Mutual aid for pharmacy provision given significant UHL challenges	5 discharges + 5 beds (possibly more)	TBC
UTC expansion	Expansion of UTC models being explored	TBC	TBC
Clinical Bed Bureau expansion	Enhanced streaming of non-elective presentations onto elective pathways	TBC	Sep-22

11. These further schemes have been through a confirm and challenge process with regional and national teams and supported. Early indications are that system costs will be funded, with confirmation expected w/c 8th August.

12. From reading the four draft reports, it is clear that the objectives outlined in the table above remain the highest priorities for this system; we must manage inflow, optimise flow and amplify discharge across seven days In fact, many of the recommendations recommend 'optimising' pathways, suggesting that the basic infrastructure and improvement intervention is in place but requires delivery consistently or differently. At the session on the 12th, the system will come together to assess the recommendations in full and assign to relevant officers to take forward, where not already completed in the tables above.

Planning for additional surge through winter – demand and capacity analysis

13. In addition to delivery of the system plan, the System Flow Partnership has continued to build on local intelligence to inform the LLR surge plan for winter 22/23. This plan will support the 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.

14. The end product will identify expected levels of demand with a range including best, worst and most likely cases built in. The plan will then determine the number of acute beds, community & virtual beds and social care beds & placements needed to meet these different demand levels. It will indicate how much of the required response can be achieved through improved flow and how much will need to be met through increased capacity. Once completed, this is be subject to a confirm and challenge process through both System Flow Partnership and the Clinical Executive and then onto the ICB.

15. This aligns with the national ask on demand and capacity planning and the System Flow Partnership plan and will also be triangulated with workforce and financial requirements.

16. In addition, each ICB will be asked to complete a suite of assurance documents around winter planning; these have yet to be released and will be bought to ICB once completed.

Conclusions

17. We are now much clearer in terms of the differences between LLR and peer systems and that in fact, LLR continues to out-perform peers in many benchmarked areas on the UEC pathway:

    a. The improvements made against access to services are clearly impacting, with LLR showing comparatively good access to primary care compared to peers. There is absolutely a recognition that more work is required, particularly focused on gaining public confidence and this work is being taken forward by the Primary Care Collaborative, led by Rachna Vyas. Equally, the conveyance rates and admission rates into the acute Trust remain significantly lower than peers.
    b. In terms of flow through hospitals, again, good progress has been made with our 7, 14 and 21 length of stay patients, now showing below the average for the East Midlands region. Discharge improvements are being taken forward by the Acute Care Collaborative, led by Jon Melbourne.
    c. Finally, the work on flow out of hospitals (including pre-hospital) has shown has showed an improving position, particularly for complex patients. Again, much more to do to reach a sustainable position with key actions led via the Home First Collaborative, chaired by Sam Leak.

18. Reviews of the system have shown that our plans are broadly focussed on the right interventions; the challenge for the system in readiness for further surge will be to consistently and relentlessly optimise demand and capacity interventions to enable constitutional standards to be met sustainably.

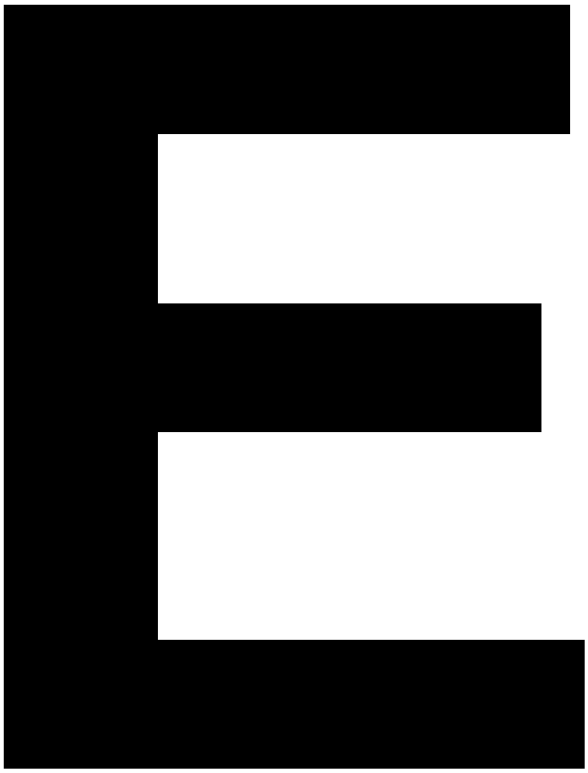
19. Despite this, the system remains incredibly challenged in its emergency care pathways, with process, capacity and flow issues leading to ambulance handover delays. Our

interventions are focussed upon ensuring capacity in the right areas and improving flow to improve performance.

Recommendation

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

- **NOTE** the ongoing challenge to meet constitutional standards, including ambulance standards
- **RECEIVE and SUPPORT** the summary of the System Flow Partnership Improvement Plan
- **NOTE** the ongoing work to balance demand and capacity across the system in readiness for surge



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 August 2022**	**Paper:**	**E**
Report title:	**Elective Care Plan paper**		
Presented by:	Helen Hendley System Director of Planned Care (LLR)		
Report author:	Helen Hendley System Director of Planned Care (LLR)		
Executive Sponsor:	Richard Mitchell, Chief Executive of UHL and Planned Care SRO		

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**:

- Progress made on 104+ week RTT waits
- The National Tier 1 support programme
- Establishing an interventions-based approach to recovery
- Early development of a 3-year elective strategy

Purpose and summary of the report:

To provide an update on the long wait RTT position within LLR; to outline the next steps on Interventions to support elective recovery and development of a 3-year elective strategy.

Appendices:	• Appendix 1 – Supporting Information.
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Aspects of this report notably performance have been discussed at the Executive Management Team 01/08/2022 and UHL's Operational and Performance Committee 27/07/2022.

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.*	Yes. BAF 1 Quality of care delivered by acute provider and BAF 11 – failure to deliver core standards in relation to the cancer standards
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Yes. Page 4 references membership of the Elective Recovery Board including patient representation.
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.	Yes. A full equality analysis will be undertaken as part of any service change presented.

Elective Care Plan paper

11 August 2022

Introduction

LLR have one of the largest and longest waiting lists in the country and a significant backlog of cancer patients. Good progress is being made but it has been on a specific cohort of patients. UHL continue to experience the significant effects of emergency pressures reducing available bed capacity, notably medical patients outlying into surgical beds and a growing number of queries and complaints about elective waits. There is a vast number of programmes and projects in place to support elective recovery that need to be brought together to ensure that the basics are as sound as they can be, that the rationale and impact is robust, and that delivery is affordable and achievable both now and for future years.

Main Report

As at the end of July 2022 the LLR system are reporting an unvalidated position of 379 patients waiting 104+ weeks for treatment with zero capacity breaches. This represents a 96% reduction from the cohort at the start of October 21 of 8,555. UHL and System partners continue to work together to reduce the volume of patients waiting with the next key milestone being the end of August where the trajectory is set at 203 however the most likely position will between 249-289. The aim is to get to zero patients waiting as quickly as possible, there will be a small number of patients beyond September that will have chosen to wait.

The position in terms of 78+ week waits has also been improving (see table 2), the cohort of patients who are at risk up until the end of March 2023 is c.29,000. The LLR system remain in the "Tier 1" National support programme which offers access to subject matter experts to support rapid recovery.

The risk to the system currently is the rising 52+ week wait position. This is not unique to LLR and is mirrored across the country. Whilst the focus has been on the very long wait patients it is equally as important that lower waits are addressed to prevent unnecessary delays.

Four letters have been received from NHS England between the 25th July and 29th July 2022. The key themes centre on increasing activity above pre-pandemic levels, eliminating 78+ week RTT waits by April 2023 and returning the number of 62 days waits for suspected cancer back to pre-pandemic levels by March 2023.

The risks associated with delivering this are well documented locally, regionally and nationally and centre on maintaining low levels of COVID-19, a return to normalised operating conditions and staffing availability .

Several key actions, with system and regional level management of long waits are referenced throughout the documents and align to the eight interventions that are proposed to be at the centre of the LLR Elective Recovery Programme. The interventions include:

1. Productivity and releasing constraints (Increasing activity)
2. OP Transformation (PIFU and Advice and Guidance)
3. Additional capacity (Community diagnostic hub / Elective hub)
4. Pathway changes

5. Validation of the waiting list (Clinical and technical)
6. Mutual aid
7. Use of the Independent Sector
8. Elective Recovery Fund (ERF) to return to better than pre-pandemic levels of activity

The proposed management of the key Interventions will be via an engine room approach led by the Associate Director of Planned care. The engine room will report into an Elective Recovery Board chaired by the System Planned Care Director with membership from UHL, ICS, Primary Care, Voluntary sector, patient representatives and other Partners. It is expected this will develop into the Elective Collaborative in the future.

In terms of an elective strategy over the next 3 years the draft proposal for discussion and debate is currently:

Year 1 – 2022/23

- Exit Tier 1 regime
- Stabilise waiting list
- Deliver zero 104+ and reduce 78+ week waits
- Reduce 62-day cancer waits

The "how" in year 1 is by maximising the opportunity of the interventions whilst underpinning decisions for future years with good demand and capacity modelling. This includes a review of all existing capacity aligned to the strategy for community settings.

Year 2 – 2023/24

- Channel long term conditions out of the acute setting
- Agree longer term contracts with IS providers to support expansion of the case mix offered
- Community Diagnostic Centre's – (2 & 3)

Year 3 – 2024/25

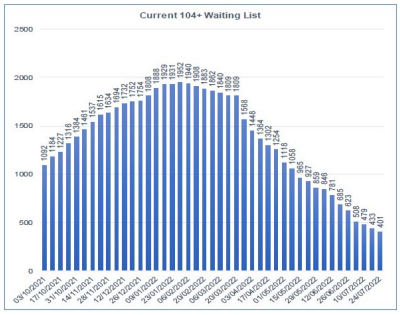
- Elective hub fully operational
- Net importer of activity into capacity
- Intelligent scheduling – Upper Quartile Productivity
- Digital Leader

The next steps are to:

- Establish the first Elective Recovery Board in September 2022
- Align a 3-year elective strategy to other UHL and ICB strategies including estates, health inequalities and reconfiguration.

Supporting Information

Table 1 – July 104+ cohort and weekly reported position.



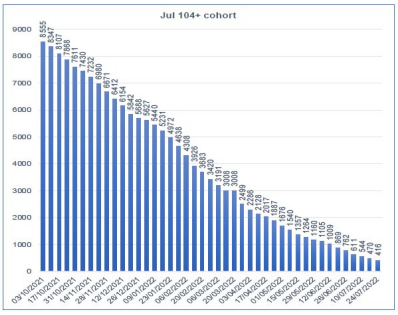


Table 2 – 78+ cohort and weekly reported position

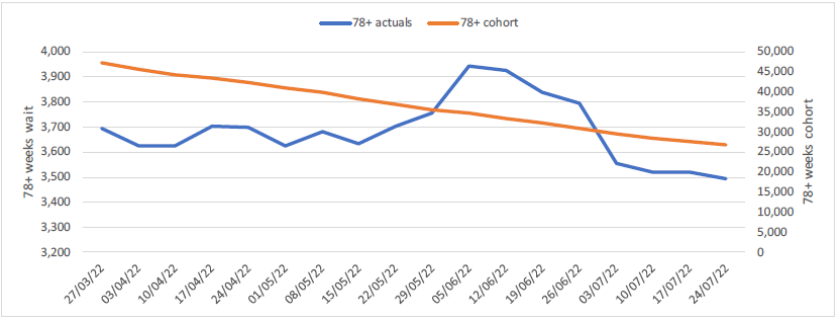
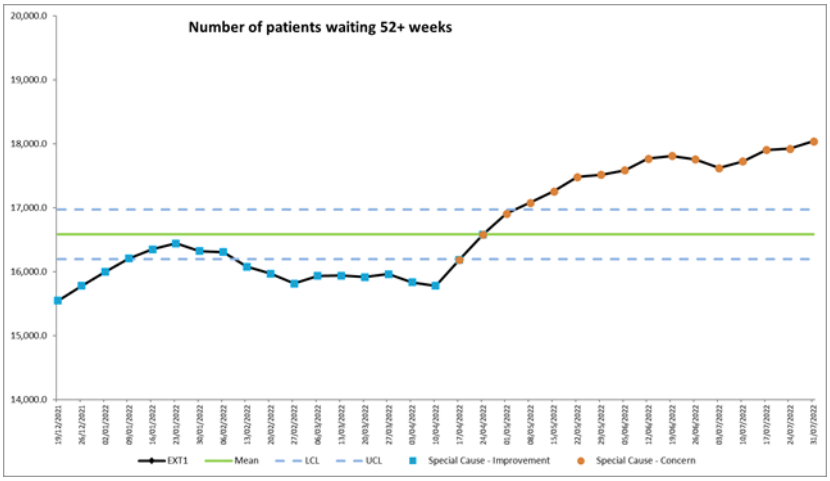


Table 3 – 52+ weekly reported position



Recommendations:

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

- Progress made on 104+ week waits
- The LLR system remain in the National Tier 1 support programme
- Establishing an interventions-based approach to recovery
- Support the development of 3-year elective strategy


F1

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 August 2022**	**Paper:**	**F1**
Report title:	**LLR ICS Finance report Month 3**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Gill Killbery, Head of System Finance Jo Mckenna, Assistant Director of Contracts and Procurement		
Executive Sponsor:	Caroline Gregory, 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 LLR ICB Finance Committee is asked to:

- **RECEIVE and NOTE** the attached report which is a summary of the month 3 system financial position.

Purpose and summary of the report:

The purpose of this report is to inform the board with regards to the system financial position as at month 3 and highlight a specific risk in relation to the ICB contract with EMAS.

Appendices:	ICS Finance Report – M3 (ICB Board)
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	The financial position has been discussed at the ICB Finance Committee (27/7/22).

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	
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☐	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.*	Slide 4 discusses the risks to delivery of a balanced plan.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Slide 5 additional cost, slide 8 potential funding
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Slide 7 Ambulance handover improvement trajectory
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

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

LLR ICB FINANCE REPORT

MONTH 3

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Executive Summary

- The overall YTD system position is a surplus of £2.1m.
- Although a continuation of the YTD position would indicate that the system will be in surplus by the end of the year, it is worth noting that there are significant NR benefits driving the year to date position for all organisations which are not set to continue. As such there remains a risk that the ICB will not be able to deliver financial balance.
- UHL and LPT have reported a year-to-date deficit of £0.7m and £1.2m respectively. This equates to a £2.4m underspend against the current plan for UHL and is in line with profiled plan for LPT. The CCG are reporting a £4.1m YTD surplus against a break-even plan.
- UHL and LPT have formally forecasted break-even positions for the year to NHSE while the CCG have not been required to do so at this stage (although the ICB would currently predict a break even position for the year also).
- There was a significant level of risk in the financial plan which was offset with planned mitigations to ensure delivery of a balanced financial plan. A risks and mitigations tracker has been created with details collated across the system, a summary is included within this report and more detail will be shared with the finance committee from month 4 onwards.
- The system has planned efficiencies of £70.7m of which we are currently forecasting £69.7m delivery. A separate piece of work is being undertaken by the PMO team to reflect a more up to date and detailed position in terms of efficiency delivery across the system
- No risk share has been applied at Month 3 due to the complications of CCG close down and lack of a formal system forecast. It is intended to report the impact of risk sharing from month 4 onwards.

M3 System Position

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
UHL Outside System Income	137,554	138,032	478
LPT Outside System Income	15,878	18,342	2,464
Provider Income Outside of System	**153,432**	**156,374**	**2,942**
CCG Allocation	**486,984**	**487,411**	**427**
Total System Allocation	**640,416**	**643,785**	**3,369**
UHL Expenditure	(336,991)	(335,110)	1,881
LPT Expenditure	(84,432)	(86,896)	(2,464)
Provider Expenditure	**(421,423)**	**(422,006)**	**(583)**
CCG Expenditure Outside of System	**(220,234)**	**(216,599)**	**3,634**
Total System Expenditure	**(641,657)**	**(638,605)**	**3,051**
Intra-System Misalignment	(3,070)	(3,070)	0
System Surplus/(Deficit)	**(4,311)**	**2,110**	**6,421**

The intra-system misalignment relates to a mismatch between UHL and LPT which we will aim to resolve ahead of next months reporting.

UHL have reported a year-to-date deficit of £0.7m against a YTD plan of £3.1m deficit; a favourable variance to plan of £2.4m. Several factors have contributed to this position such as ERF spend being significantly lower than planned, greater levels of income generated from private sources and marginal costs activity levels being less than planned. These favourable movements have been offset by inflationary pressures not funded in the plan and increased drug costs.

LPT have reported a £1.2m YTD deficit which is in line with their profiled plan. This position holds risk of underlying pressures materialising in year, such as agency, as the monthly spend profile shifts from deficit to surplus.

CCGs have reported a £4.1m YTD surplus against a break-even YTD plan. Cost pressures in prescribing and S117 have been offset by significant SDF slippage along with prior year benefits and continued vacancy levels in the running costs budget. The surplus allocation from the first quarter will be transferred into the ICB allocation for the remaining part of the year.

It is worth noting that the system YTD surplus is largely as a result of non-recurrent benefits being incurred by each organisation. A closer look at the operational positions for each organisation indicate risks that the system could be heading towards a deficit.

UHL and LPT have both forecasted a break-even position at this stage with further work needed ahead of month 4 to provide an initial outlook on best/worst/likely scenarios for the year. The ICB will begin to formally report a forecast outturn position from month 4 onwards.

Risks and Mitigations

Given the level of risk to achievement of financial balance this year; we are developing a new approach to review risks and mitigations across the system on a monthly basis….
At month 3, a refreshed view of **the gross level of risk in the system is £127.2m** (based on information shared by finance colleagues from each organisation). This level of risk was then adjusted to take into consideration the likelihood of materialising which resulted in an adjusted net risk value of £74.4m. When considered against mitigations (also adjusted to take into consideration likelihood of materialising) of £25.6m, the system is left with a **net risk after mitigations of £48.8m.**

The most significant risks presently include the following;

- Emergency Flow and pressure
- CHC & S117 Growth
- Elective Recovery Fund (loss of allocation)
- Delivery of efficiencies,
- Agency Staff Costs and adhering to the 10% cap
- National funding of the pay award

In addition to the risk of over spending revenue allocations, the ICS is currently forecasting to overspend its capital resource limit. Increasing costs and the potential reallocation of central funding, (to cover AfC pay award), is putting pressure on current plans. A review of planned schemes will take place over the next two months with the intention of bringing forecasts back within available resource.

Further work is required to ensure appropriate understanding of all risks and mitigations ahead of Month 4 reporting to allow us to share more widely the more comprehensive tracker which monitors risks and mitigations against consistent categories.

EMAS Ambulance Contract

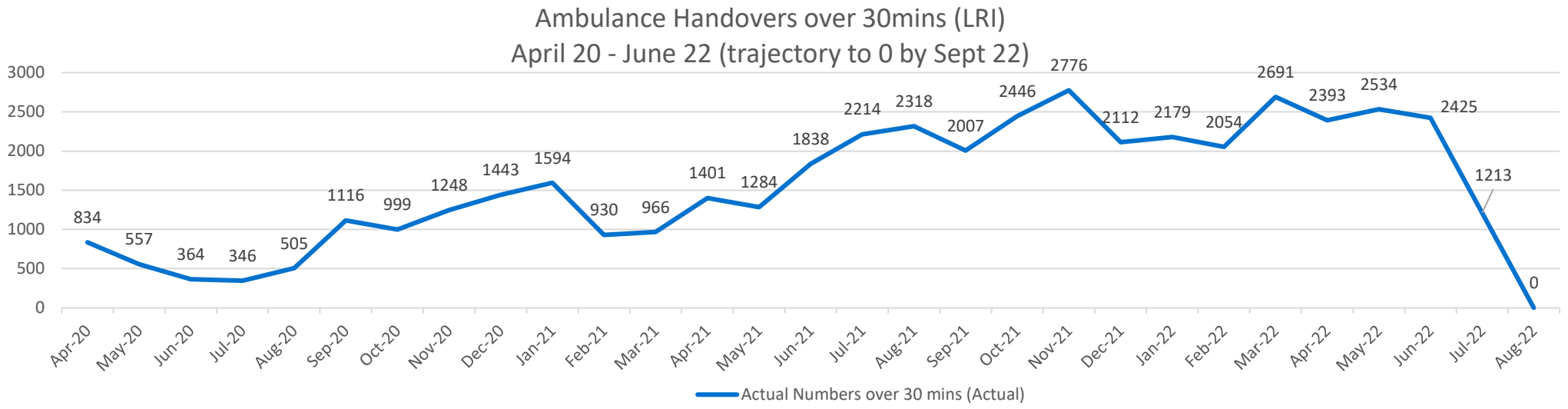
- There are financial risks associated with the current EMAS contract for 2022/23 which have not yet been agreed
- These risks have not been built into the 22/23 ICB plan
- LLR handover performance is a significant outlier, regionally and nationally
- Based on Q1 handovers >30 mins, LLR exposure for 2022/23 could be c£3m (on crude “cost per hours lost” calculation)
- EMAS M3 FOT for 2022/23 (all commissioners) = £6m adverse to plan
- EMAS and Derbyshire (host Commissioner) seeking proportionate risk sharing agreement outside of contract in the event that ambulance handover delays cause financial over-performance

EMAS Risk Share - Principles

- Risk share principles agreed by EMAS and System AOs:
  - EMAS need to demonstrate how any deficit has been driven by additional costs associated with handover delays
  - Risk share should be proportionate to systems where additional costs have been incurred
  - Risk share approach should be fair and simple (“good enough” rather than perfect or complex)
  - Performance and risk share to be monitored and reviewed over the year (rather than fixed now for the year)

Performance improvement trajectory

- Other 4 ICBs have developed trajectories to eliminate >2 hour and >1 hour handover delays
- Due to outlier status, LLR has been instructed by NHSE to eliminate handovers >30 mins by September 2022 – local trajectory:



LLR Improvement Support and Actions

- LLR likely to secure £12m additional external funding to support delivery, actions include:
  - Managing access to primary care
  - Improved / integrated call stack management in EMAS and DHU
  - Process improvements to assess and broker care for all complex discharges
  - Implement full virtual ward model (223 beds this year)
  - Demand and capacity review and piloting rehab and recovery services across LLR
  - Integrated discharge team pilot, full model in place for Winter 2022
  - Embedding internal professional standards and clinical culture change in UHL
  - Additional MOFD capacity (24-30 beds) at local care home from Aug 2022

EMAS Risk Share – Next Steps

Action	Lead	Deadline
EMAS to assess the “costs of failure” – quantify increased costs for service provision as a result of inefficiency in use of commissioned resource – to be shared with DoFs	Mike Naylor (EMAS DOF)	12 Aug 2022
Develop a proportionate approach to risk share in terms of the different challenges and impacts of individual systems in line with the principles	East Mids ICBs’ DOFs and EMAS DoFs	19 Aug 2022
Work through LLR approach to the ambulance handover performance – linking the specific improvement actions to the £12m of external resource and improvement trajectory, with expectation that resource will be clawed back for slippage or non-delivery and may be used to offset LLR liability for risk share	LLR UEC and Contract Leads	19 Aug 2022
Agree monitoring approach in LLR for actions and trajectory – via the System Flow Partnership	LLR UEC and Contract Leads	19 Aug 2022

F2

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board**		
Date:	**11 August 2022**	**Paper:**	**F2**
Report title:	**LLR ICB Risk Sharing Approach**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Spencer Gay, Deputy Director of System Finance		
Executive Sponsor:	Caroline Gregory, 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:

- **APPROVE** the Risk sharing agreement in place for 2022/23.

Purpose and summary of the report:

This paper is presented to approve the risk sharing agreement currently in place for 2022/23.

The risk share was developed by finance and contracting colleagues with oversight and approval from the three CFO's/DoFs. It aligns to agreements reached by system executive during the planning process regarding how organisations will work collectively to manage financial resources during 2022/23.

Appendices:	• Appendix 1 – LLR ICB Risk Share
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• ICB Finance Committee 20.06.22, 27.07.22 • System Executive 22.07.22

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.	The whole report is regarding financial risk share arrangements
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not applicable
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 applicable

LLR ICB Risk Sharing Approach

11.08.22

Introduction

1. This paper is presented for approval of the risk sharing agreement currently in place for 2022/23.

2. The risk share was developed by finance and contracting colleagues with oversight and approval from the three CFOs/DoFs.

3. It aligns to agreements reached by system executive during the planning process regarding how organisations will work collectively to manage financial resources during 2022/23.

4. The risk and gain share agreement attached has been included within the following contracts;
    a. ICB and LPT and
    b. ICB and UHL.

The case of need

5. There are several reasons why the LLR ICB needed to adopt a risk and gain share arrangement which is very different to historical financial arrangements, namely:
    a. The national (NHSE) move to a system first approach to financial management and assurance.
    b. Changes to the financial regime E.g. a significant reduction in "COVID funding", significant funding available through the Elective Recovery Fund (with a risk of removal of funding).
    c. The significant efficiency challenge required in order to deliver our financial plans.
    d. The sense that we need to work together with the best intentions for the LLR NHS pound (rather than organisational sovereignty taking precedent).
    e. The level of risk embedded within financial plans in the system and the fact that risks may not be equally weighted at the outset.
    f. We have invested all funding available to give all organisations an opportunity to deliver a break even position. Therefore we were unable to create a financial contingency to manage risk (which is the method we have used in recent years to manage risks across the system).
    g. As such we need a different approach to mitigate, manage and ultimately share risk.

Key elements

6. It is expected that the majority of financial risks will be managed/mitigated at an organisational level and will only be escalated to system level if mitigation cannot be identified or is unsuccessful.

7. The intention is for each organisation to minimise expenditure whilst maintaining plan commitments (noting that financial implications will only form part of any internal decision making process).

8. Any freed up resources (organisational underspends) to be invested jointly by the system on priorities (i.e. not simply reinvested by the organisation that generates the surplus of funds) – to be clinically driven through the System Clinical Executive to ensure Value for Money (VFM) in investments being made or the funds could be used to reduce the system deficit. i.e. Underspends in one organisation may be required to offset overspend in other organisations.

9. If risks can't be managed or mitigated:
    a. System alternatives analysed
    b. Examine what else needs to be stopped (the system have found this difficult in the past, and is unlikely to release savings quickly from existing services)
    c. Share burden between organisations pro rata to planned expenditure (CCG expenditure excluding UHL & LPT elements)

10. Resultant financial risks (after mitigations) will be shared between all organisations within the system proportionate to planned expenditure (UHL 50%, LPT 13%, ICB/CCGs 37%).

Principles and Approach

11. The success of the approach agreed is reliant upon:
    a. Accurate and transparent financial reporting across the system, and
    b. Clear management and mitigation of risks at organisation and system level from the outset.

12. This will be implemented and overseen by CFOs (who meet weekly, to review significant risks etc) and reported monthly to the ICB Finance Committee.

13. Escalation to System Executive and the ICB Board will occur as required, in addition to the standard monthly financial reporting which will also clearly articulate risk.

14. Risk share reporting will begin from month 4.

Recommendations:
The Leicester, Leicestershire and Rutland ICB Board are asked to:

- **APPROVE** the Risk sharing agreement in place for 2022/23.

NHS
Leicester, Leicestershire and Rutland

Risk and Gain sharing in LLR

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Key Foundations / Principles

- Openness and transparency
- Early warning system
  - Accurate, timely financial reporting of the overall financial positions for each organisation to an agreed level of detail
  - Individual organisational and/or interface issues to be managed via risk registers and where necessary managed via system finance meetings.
  - Run rate reporting and forecasting needs to be realistic with transparency of reporting on levels of risk and assumptions being made in specified areas
  - Other measures of early warning – performance / outcomes / activity / workforce to be considered alongside financial analysis
- High level reporting on key financial elements
  - ERF by scheme – report template in development; income expectations by Elective Collaborative
  - Demand to be reported by organisation and how will we use this to support risk share
  - Financial run rate reporting by organisation clarifying recurrent and non recurrent impacts
  - Efficiency delivery by organisation (eventually to be part of collaborative reporting when sufficiently mature to do this)
  - Workforce/Recruitment delivery against plan via system workforce group
- Need to be clear on contractual arrangements and accountability
  - Collaboration is key - contract is last resort
  - Risk/gain share is last resort when individual organisations or the system cannot jointly manage or mitigate risks
  - The risk and gain share agreement to be included in each organisations contracts

Risk / Gain Share

- Organisations to maintain 2022/23 plan commitments whilst minimising spend where possible (given underlying system financial pressure). Whilst spend is minimised, organisational statutory duties will need to be met, and finance would only be one part of the decision making process
- Any freed up resources (organisational underspends) to be invested jointly by the system on priorities (not simply reinvested by the organisation who generates the surplus of funds) – clinically driven through the System Clinical Executive to ensure Value for Money (VFM) on investments being made or the funds could be used to reduce the underlying system deficit
- Underspends in one organisation may need to be used to offset overspends in another
- Resultant financial risks (after mitigations) will be shared between all organisations within the system proportionate to planned expenditure (UHL 50%, LPT 13%, ICB/CCGs 37%)

Escalation of Risks

- Majority of risks managed at organisational level
- Escalation where system level management is required
- Organisations need to be clear on what management or mitigation has been attempted/considered when risks are escalated to system level
- If risks cannot be managed or mitigated:
    1. System alternatives analysed
    2. Examine what else needs to be stopped (the system have found this difficult in the past, and is unlikely to release savings quickly from existing services)
    3. Share burden between organisations pro rata to planned expenditure (CCG expenditure excluding UHL & LPT elements)
- The risk share arrangements to be managed collectively by CFO's (who meet on a weekly basis) and assurance provided to the ICS Finance Committee on a monthly basis.

Key Risks

- Demand beyond plan assumptions
- Cost of delivering Elective to meet ERF targets
- ERF central funding
- Delivery of efficiencies and transformation (EL, NEL, CHC, Prescribing, SDF)
- Inflation beyond plan assumptions
- Workforce Recruitment (& Agency use)
- COVID waves/Winter
- Discharge/Social Care/Ceasing Hospital Discharge Programme
- Staff Absence
- Ensure monitoring in place for planning risks – ensure learning is built into future planning processes
- Investment not made in key areas

Details

- UHL will explicitly monitor throughout the year expenditure against some of the developments included in the plan including reconfiguration – any slippage to be passed back to the system through the risk/gain share arrangements (i.e. if slippage is £1m then a surplus of £1m would be expected to be delivered by UHL in order to support/mitigate other risks within the system).
- The overarching risk share will be applied to organisations bottom line financial performance against breakeven/plans regardless of the cause of the variation from plan (noting that the expectation is that organisations will make every attempt to mitigate their own risks before system mitigation and ultimately risk sharing).
    - The following exceptions will apply to the above (point 2)
        - Organisational efficiency targets will not be subject to risk share (i.e. Organisations will be responsible for their own CIP delivery up to the following amounts, any deficit declared as a result of non delivery of this organisational efficiency will not be shared between parties but will stay with the organisation responsible for non delivery. Cash Releasing Efficiency amounts required in plans are as follows UHL £21.1m, LPT £5.6m, CCGs £13.2m. Non Cash releasing and additional system gap closure schemes will be included in the risk share.
        - The following will be subject to the risk share but it may be more appropriate to apply different percentage shares to any non delivery linked to actions taken/ where organisational responsibility lies (although in the absence of a more appropriate % being agreed the default % will apply). A revised risk share will need agreement from all 3 CFOs.
            - Non Elective Gap Closure £10m
            - Unidentified/Elective Gap Closure £10m
            - SDF gap closure £5m

Details

- The £10m risk which was intended to be covered by elective productivity or cost reduction is to be held as an unidentified savings target at system level initially whilst we continue to search for opportunities to ensure balance – this will include continuing with the elective work which has not completed in time for us to include explicitly in the plan.
- Monthly position statements of agreed risk sharing should be produced including an agreed forecast from Month 4. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation by agreement of all CFOs.
- This agreement is intended to be used for the 22/23 financial year, it can be adapted/varied by consensus agreement between the CFOs if (and only if) all 3 CFO's are in agreement to do so.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 August 2022**	**Paper:**	**G**
Report title:	**LLR ICS Finance Committee Highlight Report – 27 July 2022**		
Presented by:	Cathy Ellis Chair of ICS Finance Committee		
Report author:	Cathy Ellis Chair of ICS Finance Committee		
Executive Sponsor:	Nicci Briggs Executive Director of Finance, Contracting and Corporate Governance		

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 the LLR ICS Finance Committee Highlight Report.

Purpose and summary of the report:

To provide a highlight report from the LLR ICS Finance Committee.

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.	However if occurred 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.
☐	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.*		Individual reports to the ICB are aligned to risks within the Board Assurance Framework
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		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.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None
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 undertaken in respect of this report, however, would be undertaken in relation to the reports presented to the Transformation group.

LLR ICS FINANCE COMMITTEE –27 July 2022 meetings

HIGHLIGHT REPORT

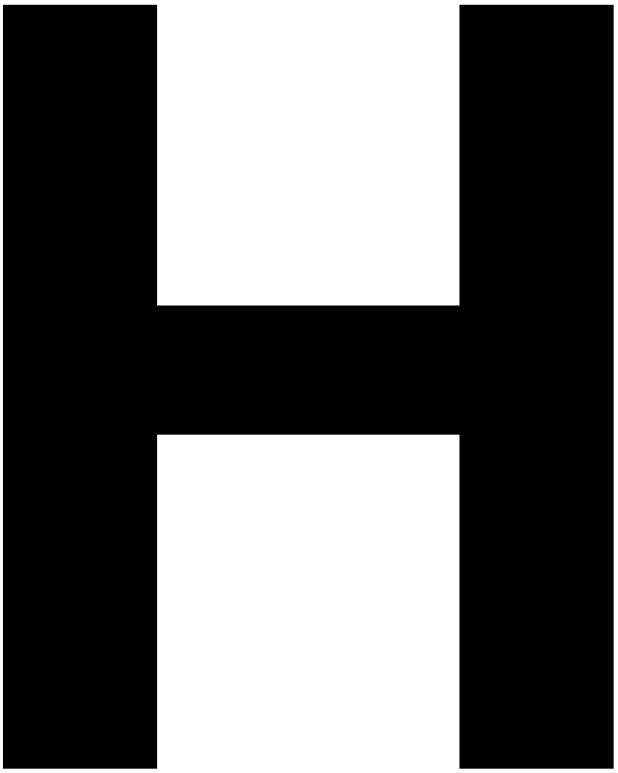
The key headlines/issues and levels of assurance are set out below, and are graded as follows:

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
System Revenue position at Month 3	**Medium**	At month 3 the system reported a surplus of £2.1m (£0.7m deficit in UHL, £1.2m deficit in LPT and £4.1m surplus CCGs). The committee requested monthly reporting of forecast underlying run-rates and efficiency schemes, with a focus on agency spend against the system cap of £43m. Together this will enable early escalation of gaps which will be reviewed in a risk and mitigations schedule in month 4 to forecast the year end position.	Both providers have phased the majority of the efficiency savings in Q3/Q4. The net system risk after mitigations is estimated at £49m.
ICB risk/gain share agreement for 2022/23	**High**	The risk/gain share agreement has been presented to the System Executive for support. This has been embedded into contracts with UHL and LPT and will be presented to UHL and LPT governance committees for awareness.	
Capital Report month 3	**Medium**	At month 3 the system capital is £4.5m underspent compared to plan. LLR have spent 13% of our capital limit versus 25% of time expired. There is a risk of inflation, so the Committee requested that the estates teams keep on track with capital projects. As a control measure there will be a review of schemes at month 6 with an opportunity to reprioritise unspent capital to other projects.	Funding not confirmed for £10m of IFRS16 lease costs (change in accounting treatment) Risk that national digital capital may be reduced to fund staff pay award.

Report	Assurance level	Matters for Committee escalation to Integrated Care Board	Risks to escalate
Transformation	**Low**	The reporting is evolving to show greater granularity of efficiency / transformation schemes for the £90m+ savings which are planned. The Committee have asked for reporting to give higher assurance 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.
UHL exit from Recovery Support Programme (RSP)	**Medium**	The Committee reviewed the UHL risk profile and action tracker that is regularly shared with the National team to monitor progress on exit from the RSP. There is a medium assurance due to the level of risk.	Key risks for UHL RSP are the medium-term financial plan and the 2022/23 delivery.
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 6 high risks: • Risk 6 Workforce recruitment and retention **(rated 16)** ** • Risk 10 Elective care backlog **(rated 20)** * • Risk 11 Delivery of the medium-term financial strategy **(rated 16)** • Risk 12 Transformation & efficiency schemes **(rated 20)** • Risk 14 2022/23 financial plan delivery **(rated 16)** • Risk 15 management of the unmitigated financial risk in 2022/23 **(rated 20)** The Committee requested a review of the Urgent Care financial pressure risk currently scored at 12. The risks marked * will be jointly held with the ICS Quality & Performance Committee and ** with the LLR People & Culture Board	There is £127m of gross risk to manage in the 2022/23 plan, this reduces to a net risk of £49m after mitigations.
AOB		Thanks were given by the committee to Nicci Briggs for her leadership of finance in the CCGs and ICS	

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:	11 August 2022	**Paper:**	**H**
Report title:	**Assurance report from the LLR ICB System Executive - 22 July 2022**		
Presented by:	Angela Hillery, Chief Executive, Leicestershire Partnership Trust		
Report author:	Caroline Trevithick, Chief Nursing Officer/Deputy CEO, LLR ICB		
Executive Sponsor:	Andy Williams, Chief Executive, 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 Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE**
  - the approval of the LLR ICB Mental Health Commissioning Plan 2022/23
  - the approval of the LLR ICB finance risk sharing approach
  - the outcome of the East Midlands Locked Rehabilitation Framework – contract award
  - the development of the LLR Covid-19 Vaccination Programme: Autumn Campaign 2022/23
  - the approval of additional investment for
    - Improving Access to Psychological Therapies (IAPT) contract to achieve national targets
    - LLR Pulmonary Rehabilitation
    - Community Diagnostic Centre 2nd Year Business Case (Hinckley District Hospital) and
    - PCN Cardiorespiratory Diagnostics

- **RECEIVE for assurance** the actions pertaining to the Performance Report

- To **NOTE** the recommendation to proceed to procurement for the Non-Emergency Patient Transport Service will be considered in the confidential session.

Purpose and summary of the report:

The LLR ICB System Executive Committee has been established to
• provide the ICB with assurance that it is delivering LLR System Operational Plan and
• provide assurance to the ICB that there is an effective and sustainable system of operational planning, resilience and robust performance monitoring, and internal control that supports it to effectively deliver its strategic objectives and provide sustainable and transformational, high-quality care.

The following report provides a summary of each of the decisions made at the LLR ICB System Executive Committee on 22 July 2022 in order to provide assurance to the ICB.

Appendices:	• Appendix 1 – Performance Report

Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• All items were discussed at the LLR ICB System Executive 22 July 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.	

Report from the LLR ICB System Executive meeting 22 July 2022

11 August 2022

Introduction

The LLR ICB System Executive Committee has been established to

- provide the ICB with assurance that it is delivering LLR System Operational Plan and
- provide assurance to the ICB that there is an effective and sustainable system of operational planning, resilience and robust performance monitoring, and internal control that supports it to effectively deliver its strategic objectives and provide sustainable and transformational, high-quality care.

The following report provides a summary of each of the decisions made at the LLR ICB System Executive Committee on 22 July 2022 in order to provide assurance to the ICB.

Items to receive and note:

1. LLR ICB Mental Health Commissioning Plan 2022/23

   The NHS Long Term Plan set out an ambitious vision for mental health supported by a multiple year investment programme that goes up and inclusive of 2023/24. NHSEI also instituted a financial control target, the Mental Health Investment standard, to monitor and ensure that each system is increasing the total level of spend in mental health each year. In 2022/23 Leicester, Leicestershire and Rutland have been allocated £14.5m, with over £10m in SDF funding and close to £4.5m in baseline growth.

   The 2022/23 plan represents a continuation of the transformation and investment programme that has been underway for a few years, developed in conjunction with health and care partners across LLR and focusses on the following national themes:

   - Perinatal services
   - CYP & CYP ED
   - Adult SMI
   - Adult crisis, liaison and ambulance
   - IAPT
   - Therapeutic Inpatient

   The System Executive endorsed the Mental Health Commissioning Plan focussing on and supported the use of non-recurrent monies to support the strengthening of aspects of the programme structure including workforce planning, delivery and OD.

2. LLR ICB Finance Risk Sharing Approach

The System Executive supported the development of a financial risk and gain share agreement developed by the 3 CFOs/DoFs and has been included within the following contracts;

a. ICB and LPT and
b. ICB and UHL.

There are several reasons why the LLR ICB needed to adopt a risk and gain share arrangement which is very different to historical financial arrangements, namely:

a. The national (NHSE) move to a system first approach to financial management and assurance.
b. Changes to the financial regime e.g. a significant reduction in "COVID funding", significant funding available through the Elective Recovery Fund (with a risk of removal of funding).
c. The significant efficiency challenge required in order to deliver our financial plans.
d. The sense that we need to work together with the best intentions for the LLR NHS pound (rather than organisational sovereignty taking precedent).
e. The level of risk embedded within financial plans in the system and the fact that risks may not be equally weighted at the outset.
f. We have invested all funding available to give all organisations an opportunity to deliver a break even position. Therefore we were unable to create a financial contingency to manage risk (which is the method we have used in recent years to manage risks across the system).
g. As such we need a different approach to mitigate, manage and ultimately share risk.

The framework places an onus on each organisation to:

1) Identify if there were any issues that would result in a financial surplus or deficit and aim to mitigate these internally first.
2) Where a deficit was identified that could not be mitigated internally to raise at system level.
3) The expectation the system would work together to mitigate the risk, and if all else failed to have a risk share agreement.
4) If there are any surpluses, it is not for the individual organisations to make a decision on how to use these as there are some clinical priorities to address across the system.
5) The first port of call about where any surpluses should be used would be through the CFOs and then escalated up to System Executive if required.

3. East Midlands Locked Rehabilitation Framework – contract award

System Executive approved the outcome of the procurement for the East Midlands Locked Rehabilitation Framework that provides services for High Dependency (Lockable) Rehabilitation and Complex Care Rehabilitation for Patients with Learning Disabilities, Mental Health Issues and Brain Injuries. The outcome of this will be shared with the ICB following the completion of the standstill period of 10 days for challenges.

4. LLR Covid-19 Vaccination Programme: Autumn Campaign 2022/23.

System Executive reviewed the plans for the Autumn Vaccination Campaign in the context of a new financial and contractual framework. The requirements are to ensure:

- Co-delivery of Covid, Flu & Pneumococcal
- Delivery of other routine immunisations through vaccine estate if appropriate
- All vaccination sites to deliver Making Every Contact Count
- Continued emphasis on addressing inequalities via an accessible, convenient service and a focus on community engagement
- Surge planning that limits the impact on business-as-usual primary care, acute elective care and other immunisation programmes.

To deliver the autumn campaign requirements within the £5.8m financial envelope, the delivery model will need to be significantly scaled back with an expectation that the approach will be more similar to the flu vaccination programme i.e. delivered at practice and high street pharmacy locations. Work is now underway to establish which PCNs and CPs intend to opt into the autumn

campaign and how much capacity this will deliver. Extensive modelling work has been undertaken to identify the optimum delivery model that balances the priority of affordability with successful vaccination performance. System Executive are working through the implications of the new framework to ensure delivery of the vaccination programme through core activity, an inequalities programmes and surge capacity planning.

5. Approval of additional investment

5.1 Improving Access to Psychological Therapies funding to achieve national targets

The original procurement of the IAPT contract fell short of the required activity to deliver the national targets. Partners across the system have explored different options to mitigate the challenge and worked with the current provider to form a viable and costed expansion and delivery plan. This plan is within the financial investment available and within 50% of the current contract (and therefore in the limits of the regulation 72).

System Executive agreed to apply procurement legislation PCR15 - Regulation 72 to use a contract variation with VITA Mind to increase the VITA Mind contract by £791,832 in 22/23 and a further £2,174,321 in 23/24 (to lead to a £2,966,153) with corresponding increase in access targets in line with national targets.

5.2 LLR Pulmonary Rehabilitation Funding Allocation

In April 2022, the National Respiratory Programme released Pulmonary Rehabilitation Five Year Vision which takes into account the challenges that have been further compounded as a result of the pandemic and aligning the vision for PR to national strategic context of the NHS in reducing inequalities, aligning to Integrated Care Systems (ICSs) and recovery of services that meet the needs of local populations. The impact from the Covid pandemic has resulted in long waiting lists and backlogs due to demand exceeding capacity within the current service. This has a further adverse impact on system plans to target resources to areas most in need and ensure increased PR capacity meet the needs of the populations served. In order to address this challenge locally, LLR have been awarded £242,000 recurrent funding by NHSE/I to expand PR services to meet local population needs by offering a personalised approach, increasing uptake and targeting specific populations to address health inequalities.

System Executive approved the plan to commence the recruitment to expand the service to meet the needs of our population.

5.3 Community Diagnostic Centre (CDC) phase 2 (Hinckley District Hospital)

System Executive supported the CDC business case requesting £14.6m Capital and £15.3m revenue funding covering 22/23, 23/24 and 24/25 for the development of the new CDC build noting that all will be externally funded through NHSE/I.

The Hinckley CDC builds on LLR's year 1 scheme which is based at the Leicester General Hospital and will

- Increase diagnostic provision within LLR
- Renovate existing NHS estates which are not fit for purpose
- Increase staff satisfaction
- Improve accessibility of healthcare for deprived communities and reduce health inequalities
- Support recovery plans as a result of Covid-19
- Apply national best practice to maximising diagnostic productivity

- Improve access to cancer diagnostics, enhancing earlier diagnosis by providing additional diagnostic capacity and by improving clinical pathways. The plan will also ensure that the programme fits into the wider strategic approach for the system i.e. reducing inequalities, the impact of the vaccination approach on our acute trusts, the implications for the Workforce Bureau's wider strategic role to support the system workforce approach and the use of estate to support Making Every Contact Count.

5.4 Community Diagnostic Centre PCN Cardiorespiratory Diagnostics (CDC)

System Executive supported the business case for the PCN Cardiorespiratory Diagnostics, requesting £1.77m recurrent revenue funding, noting that there is NHSE/I funding until 24/25.

Community Diagnostic Centres are proposed to be set up across LLR to deliver diagnostic tests (such as MR, CT, x-ray, endoscopy and cardiorespiratory diagnostics). The PCN diagnostic spokes will support the main hub CDCs in LLR. The CCG purchased diagnostic equipment to support the roll-out of the programme in 21/22 utilising community diagnostic funding

Items to RECEIVE for assurance

6. LLR Performance Report

The committee reviewed the areas which are most under scrutiny by our regulators, including Primary care access, learning disabilities, Urgent Care including Ambulance Handovers, elective long waiters, Priority 2 patients, cancer and the uptake of covid vaccinations in LLR. The full report is attached as Appendix 1. Please note that due to the timing of the meetings, the performance report was also reviewed at the July ICB.

System Executive noted that a Cancer Summit to review all tumour sites is planned to take place in July to ensure that all appropriate actions are taking place to improve cancer performance in UHL and were assured that all organisations were focussing on the improvements required for improving ambulance handover waits. The actions relating to the Urgent and Emergency Care Pathway are subject to a separate report to the ICB.

To enable System Executive to provide assurance to the ICB regarding performance, they supported the development of a single framework to report finance, activity, performance, quality and workforce that will be reviewed by the Committee on a monthly basis. Issues will be escalated from Collaboratives, Design Groups and organisations to ensure that the system was focussed on the appropriate actions to improve performance across the framework. To enable the ICB to maintain it's strategic focus, System Executive would then give consideration to any items to be escalated to ICB for further discussion, debate or approval.

Items to note

7. Non-Emergency Patient Transport Procurement

System Executive reviewed the proposal to reprocure the LLR Non-Emergency Patient Transport Service. Due to the financial delegation limits for the System Executive, the ICB is required to confirm the decision to move to a procurement. The report will be considered in the confidential session.

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

- **RECEIVE and NOTE**
    - the approval of the LLR ICB Mental Health Commissioning Plan 2022/23
    - the approval of the LLR ICB finance risk sharing approach
    - the outcome of the East Midlands Locked Rehabilitation Framework – contract award and
    - the proposals for the LLR Covid-19 Vaccination Programme: Autumn Campaign 2022/23
    - the approval of additional investment for
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        - PCN Cardiorespiratory Diagnostics

- **RECEIVE for assurance** the actions pertaining to the Performance Report

- To **NOTE** the recommendation to proceed to procurement for the Non-Emergency Patient Transport Service will be considered in the confidential session.

LLR ICS INTEGRATED CARE BOARD

Leicester, Leicestershire and Rutland

Performance Overview

11th August 2022

Hannah Hutchinson - Assistant Director of Performance & Quality Improvement

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 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 elective waiters (+104 weeks)

Cancer 2 week wait for an urgent referral for breast symptoms

Areas of Deterioration

A&E 4hour wait

Long elective waiters (+52 weeks)

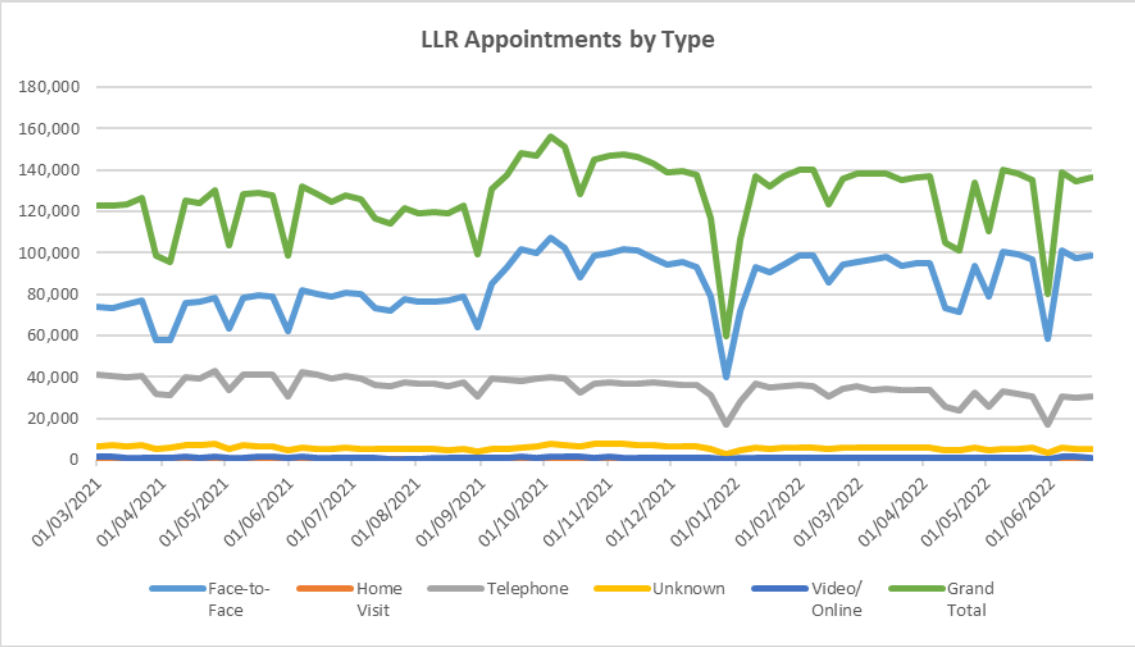
Priority 2 patient numbers

Cancer 62day wait from GP referral to first treatment

Primary Care – General Practice Appointments

Weekly LLR Appointments by Appointment Type

Mar 2021 – June 2022



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-20	357,677
May-21	489,783
May-22	578,737

The data is now received weekly as well as monthly. The total appointment types are showing an increase of 1.3% from the previous week (total appointments w/c 13-June - 134,504 w/c 20-June - 136,211).

The number of face-to face appointments has also increased by 1.1% for the same time period.

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**

22/23 ACTUALS ADULTS				
	Q1	Q2	Q3	Q4
CCG Commissioned	17			
NHSE Commissioned - ADULTS only	14			
TOTAL Commissioned	**31**			

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

Inpatient (adult)- Two long-stay inpatients in secure settings were due to move to a purpose built 4-bedded deaf service but unfortunately the service was not able to proceed. Alternative placements are now being sought but both discharges have been delayed.

There has also been an increase in referrals from eating disorder wards for individuals with Autism Spectrum Disorder (ASD).

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

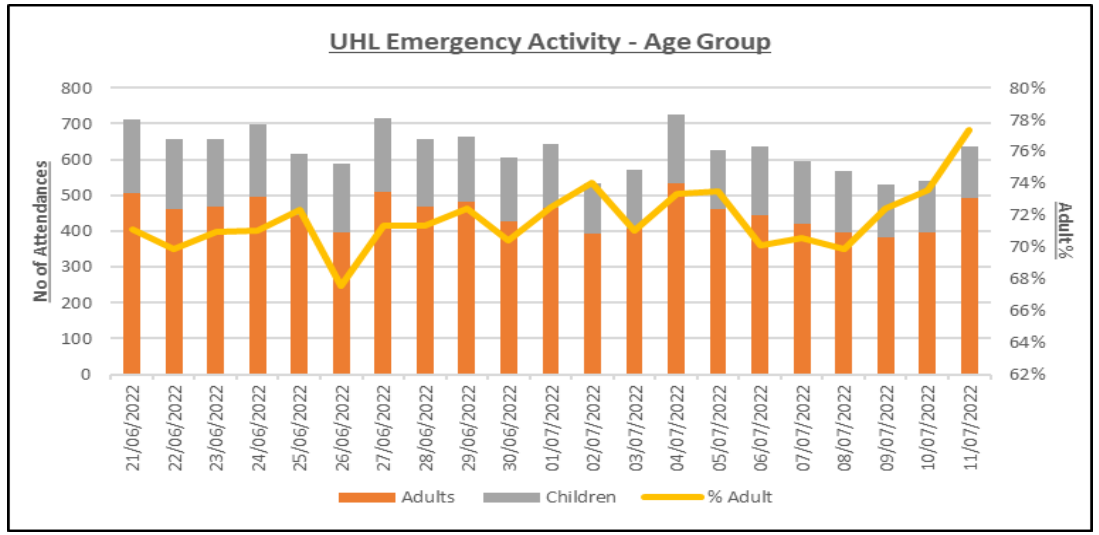
CCG Name	Monthly count of patients aged 14+, on the practice's LD register who have received a learning disability health check by the GP practice		22/23 HC's Year to date	Q1 22/23 Plan
	Apr-22	May-22		
East Leicestershire and Rutland CCG	22	30	52	
Leicester City CCG	33	38	71	
West Leicestershire CCG	22	37	59	
LLR	**77**	**105**	**182**	**202**

Annual Health Checks (AHCs)

LLR had 182 completed AHC's at the end of May 22, so on track to achieve 202 by the end of June 22.

By the end of last year we had reduced the percentage of completed AHCs from 26% to 7.8% resulting in no Health Action Plan, however we aim to improve this going forward

Urgent Care

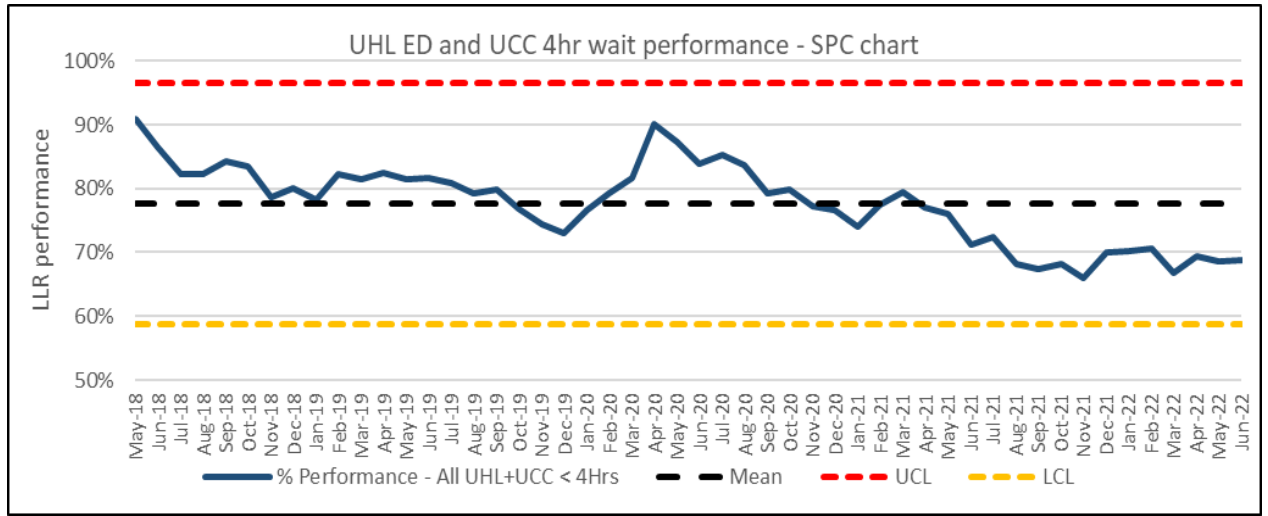


There has been a reduction in ED activity compared to the previous 7 days. Overall children's has seen a reduction (7.3%) and adults have reduced (5.5%) attending ED compared to the previous 7 days.

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

UHL ED Activity - Age Group		
Period	**Adults**	**Children**
Latest 7 Days (5th Jul-11th Jul)	2,997	1,135
Previous 7 Days (28th Jun-4th Jul)	3,173	1,224
Variance	**-176**	**-89**
% Variance	**-5.5%**	**-7.3%**

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).



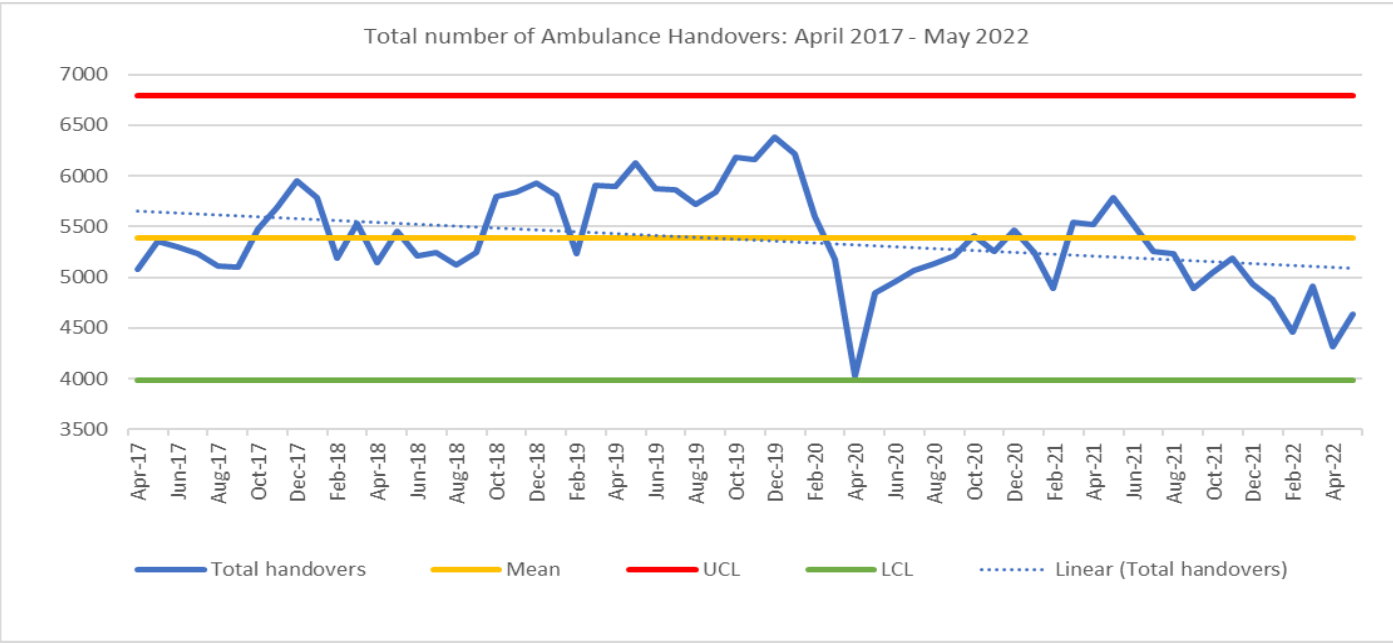
Out of County Provider A&E Performance				
Provider (All Patients)	Apr-22	May-22	22_23 YTD	
UH Derby & Burton FT	62.0%	64.2%	63.1%	↗
Nottingham University Hospital	**CRS Trial Site**			
George Eliot Hospital	72.3%	76.5%	74.5%	↗
UH Coventry & Warwick	67.0%	70.3%	68.7%	↗
Kettering	**CRS Trial Site**			
Northampton	64.4%	66.0%	65.2%	↗
NW Anglia FT	56.5%	53.2%	54.8%	↘
UHL	56.0%	56.0%	56.0%	↗

Ambulance Handovers

Urgent Care	19-June	26-June	3-Jul	10-Jul	Variation from prev wk (n)	% change from previous wk	% change from 4wks ago
EMAS UHL Handover: Cases	989	936	939	854	-85	-9.1%	-13.7%
EMAS UHL Handover: Queueing >2hr	196	280	143	166	23	16.1%	-15.3%
EMAS UHL Handover: Queueing >60mins	320	400	307	284	-23	-7.5%	-11.3%
EMAS UHL Handover: Queueing 30-59mins	201	142	202	214	12	5.9%	6.5%

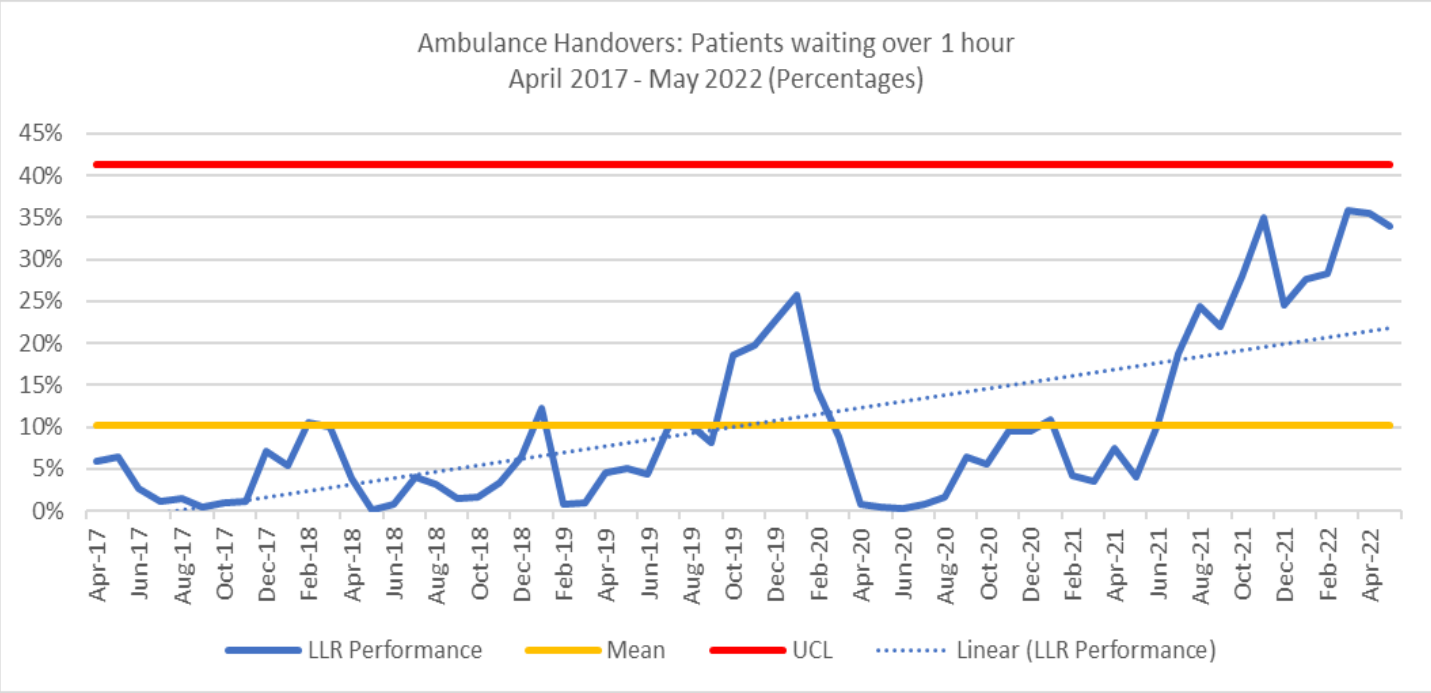
The table shows the weekly number of Ambulance Handovers at UHL, the numbers waiting over 2hrs, over 1hr and between 30-60min. There has been some improvement in the most recent reporting week.

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



Ambulance waits continue to be a concern. Poor outflow across the emergency care pathway and a high inflow of walk-in patients competing with ambulance patients for trolley space. Sick patients walking in due to the inability to get an ambulance.

Percentage of patients waiting over 1 hour

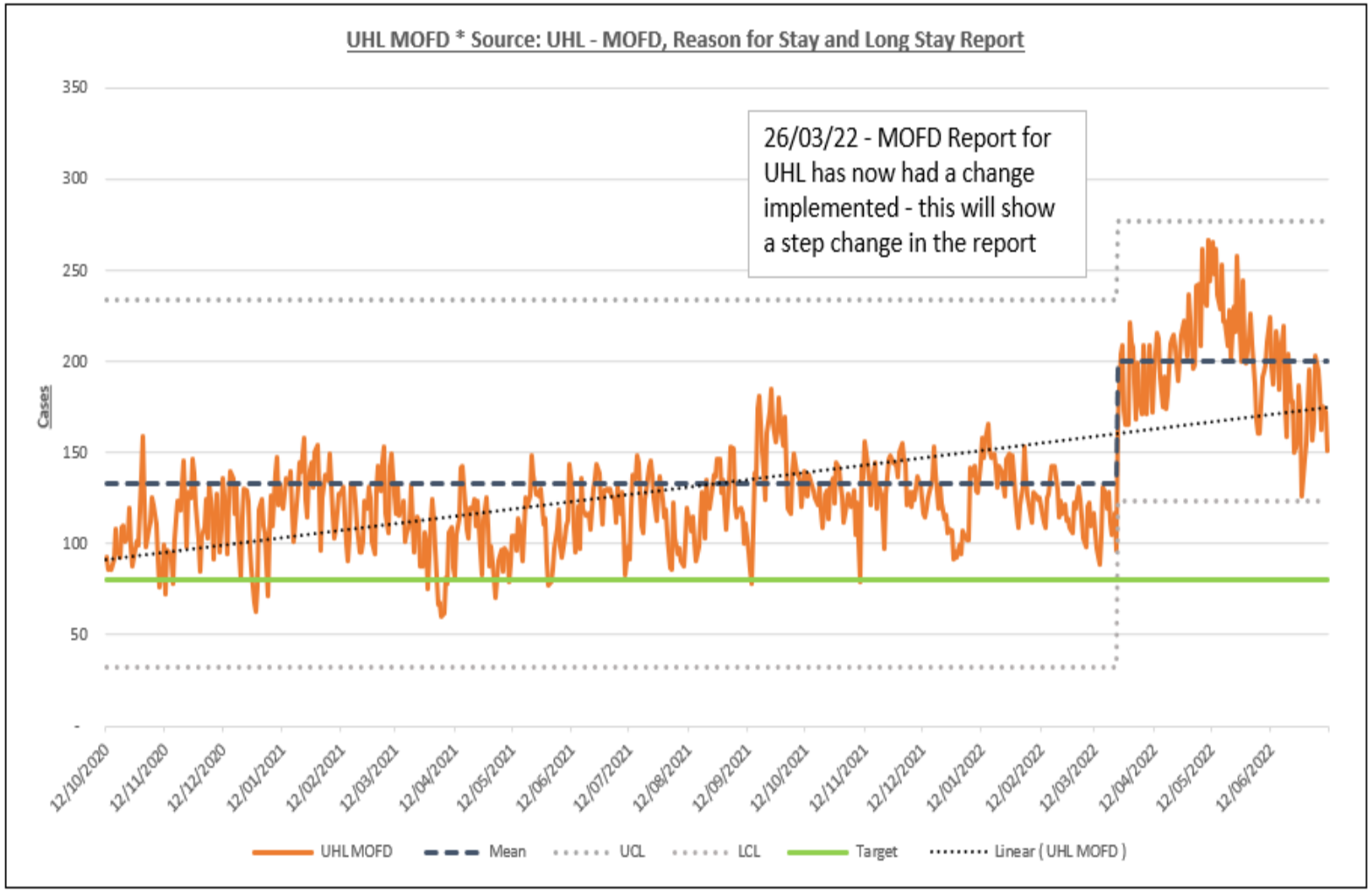


The target is zero for Ambulance Handovers over 1 hour - the graphs shows the historical performance for the percentage of patients waiting over one hour.

Local actions include:

- Focused work on flow through the hospital to include board rounds, criteria led discharge
- Avoid using discharge lounge overnight for additional capacity
- Plan for Urgent Care Co-ordination hub test pilot in July

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.

MOFD activity for UHL has seen an increase (10.8%) over the last 7 days.

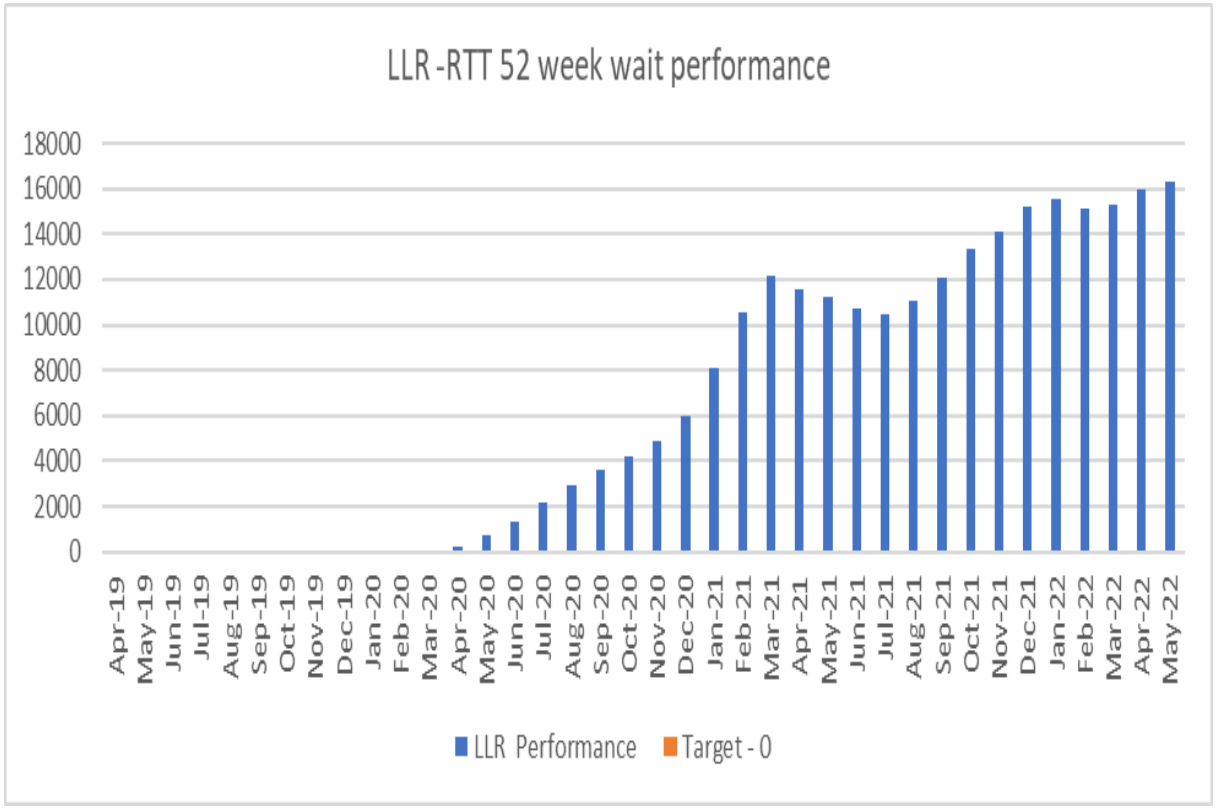
*** Source: UHL - MOFD, Reason for Stay and Long Stay Report**

UHL Medically Optimised for Discharge - Reason to Reside	
Period	Medically Optimised for Discharge
Latest 7 Days (5th Jul-11th Jul)	1,243
Previous 7 Days (28th Jun-4th Jul)	1,121
Variance	122
% Variance	10.8%

Elective +52 week waits (LLR patients at all LLR providers)

The total LLR waiting list size at the end of May was 132,455, a reduction of just over 800 LLR patients from April which stood at 133,268.

52-week waiters stands at **16,277** at the end of May 22, an increase of 288 patients between April 22 and May 22. ***This is for LLR patients at all LLR providers.***

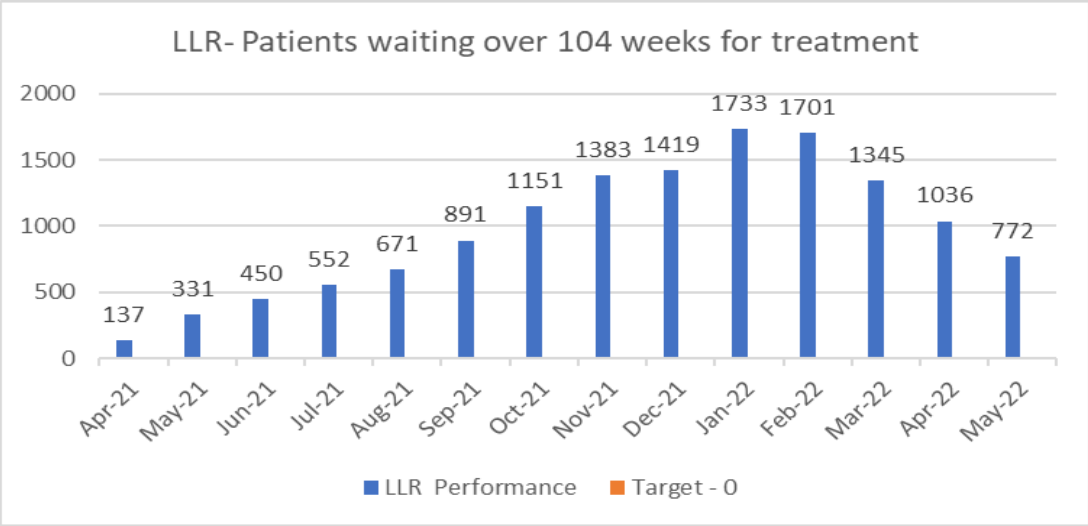


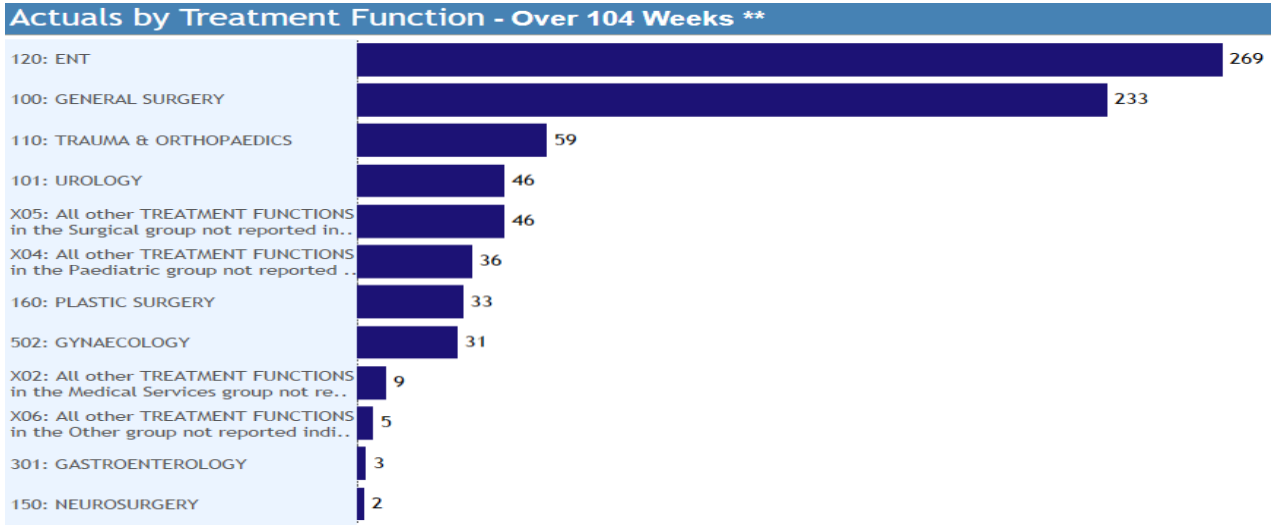
Waiters by Time Period and Provider - 2) Incomplete pathways for all patients (unadjusted)

	Within 18 weeks	Over 18 weeks	Over 28 weeks	Over 36 weeks	Over 40 weeks	Over 52 weeks	Over 104 weeks
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST : (RWE)	55,466	54,604	38,973	29,074	25,190	15,014	722
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST : (RTG)	2,705	1,856	1,201	797	636	271	4
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST : (..	1,315	1,268	841	578	449	166	
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST : (RX1)	1,038	702	465	321	275	158	4
WOODTHORPE HOSPITAL : (NVC40)	810	960	692	440	341	147	1
NUFFIELD HEALTH, LEICESTER HOSPITAL : (NT226)	91	217	164	138	131	107	18
MERIDEN HOSPITAL : (NT424)	277	389	289	222	196	102	
NORTH WEST ANGLIA NHS FOUNDATION TRUST : (RGN)	1,103	632	375	234	193	83	

Elective +104 week waits (LLR patients at all LLR providers)

In May 22 there were **772** 104+ week breaches within LLR, a reduction of 264 patients from April 22. *This is for LLR patients at all LLR providers*





Elective capacity is showing signs of recovery, however, the requirement to increase ITU Capacity has led to a reduction in theatre capacity.

Local actions in place:

- Identify a suitable cohort of patients awaiting above 52+ weeks for mutual aid, this is to be shared with the GIRFT team to contact patients. Also to contact patients who breach 104+ weeks to ask if they are willing to travel to an alternate Out of County Provider.
- Submit final trajectory for system planning

Elective Long Waiters – Weekly UHL position, all patients

The following table provides the latest weekly position on the total number of patients waiting at UHL only, those waiting over 18weeks, over 52weeks and over 104 weeks for elective treatment.

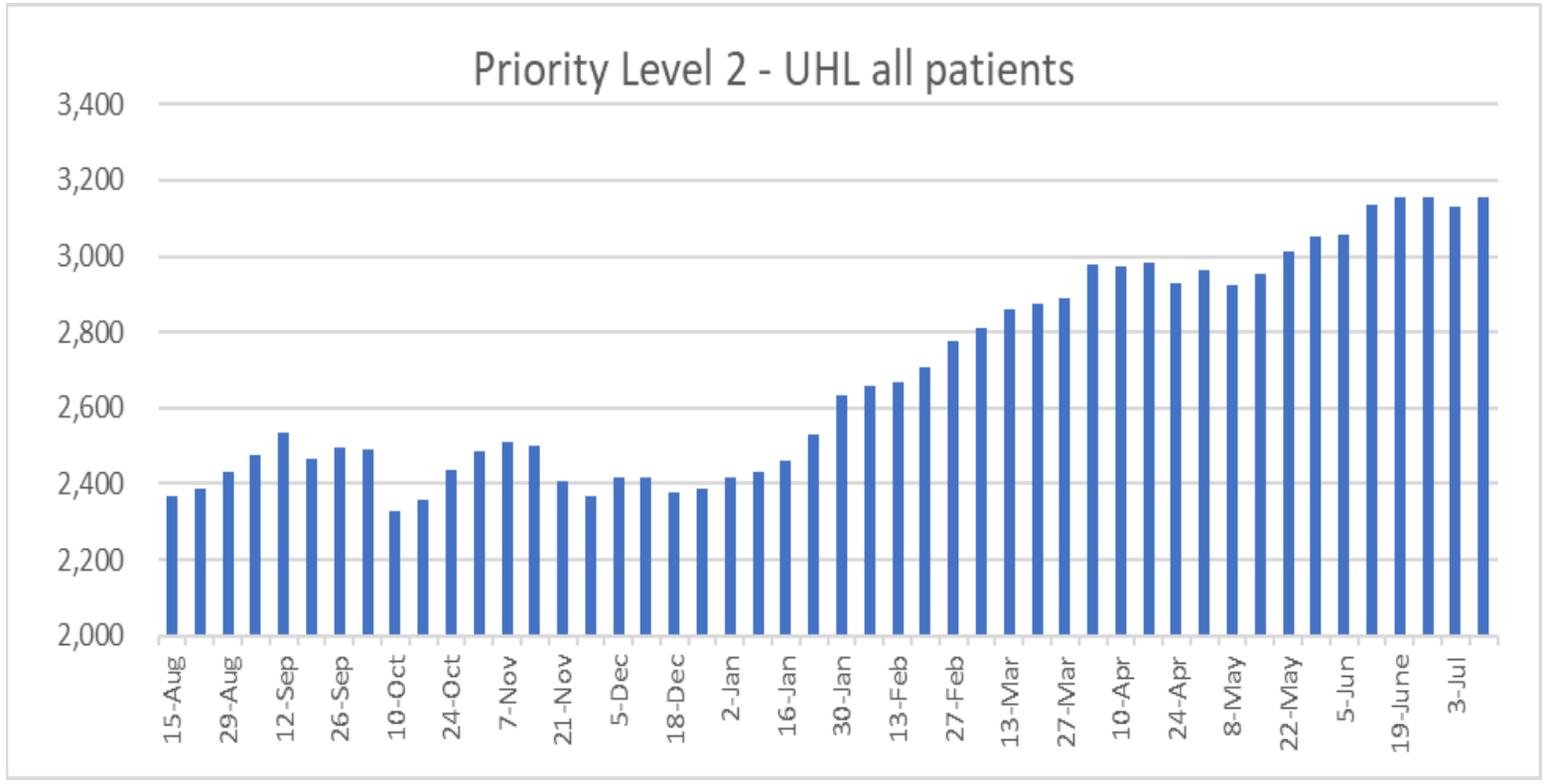
There has been an improvement in the number of +104wk waiters from a peak at the end of January 22. This is mainly due to the Vanguard being on site from February 22 and new agreements with IS providers have been put in place to support the 104+ positions and GIRFT have supported on successfully agreeing further mutual aid which is contributing to reduction in 104+ waiters.

	week ending (2022)						
UHL - Elective care	19-June	26-June	3-Jul	10-Jul	Variation from prev wk	% change from previous wk	% change from 4wks ago
18+ wks	62,960	62,818	62,406	63,234	828	1.3%	0.4%
52+ wks	17,823	17,772	17,622	17,737	115	0.7%	-0.5%
104+ weeks	688	630	511	482	-29	-5.7%	-29.9%
Total Count (Incomplete Pathways)	122,074	122,531	121,710	121,509	-201	-0.2%	-0.5%

Priority 2 Patients at UHL only

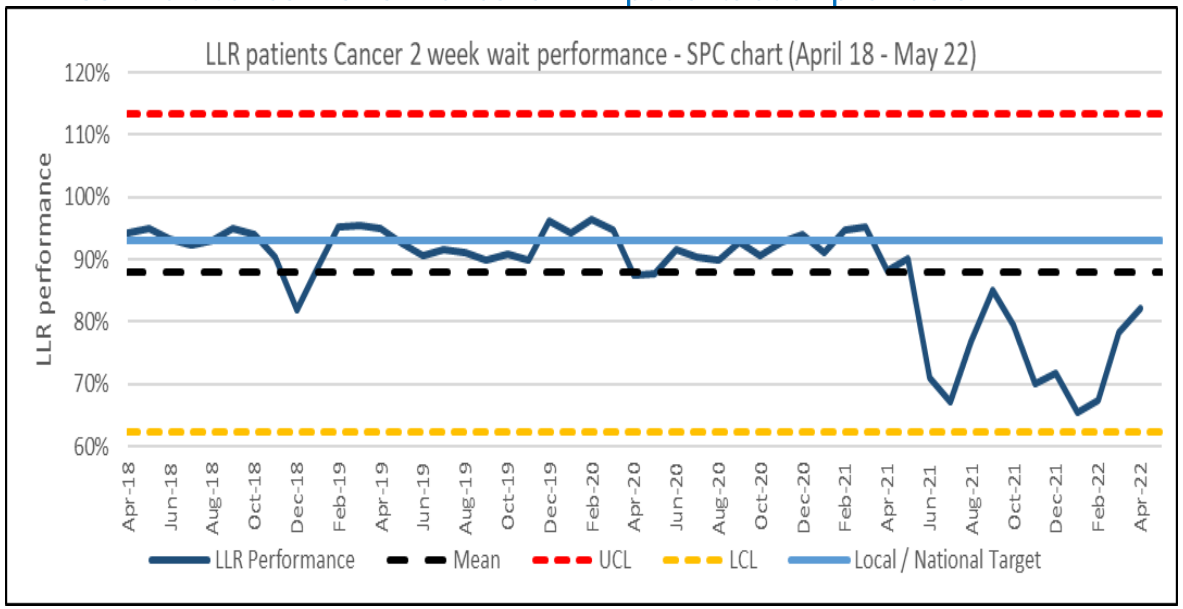
Definition of Priority Level 2: Surgery that can be deferred for up to 4 weeks.

The number of P2 patients has continued to increase from mid-December 2021.

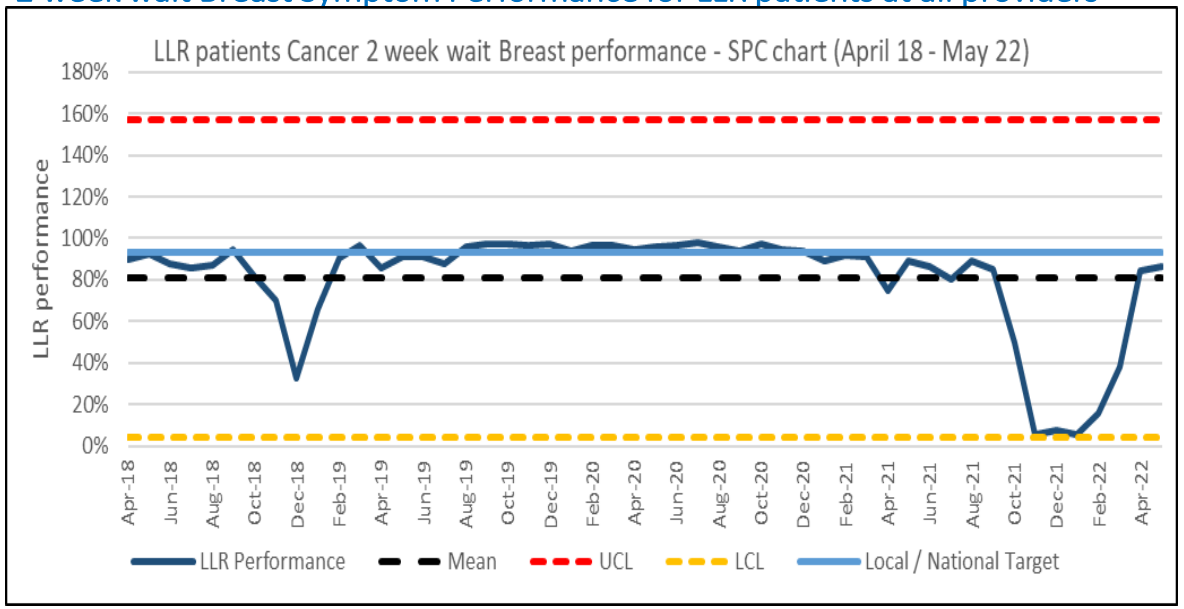


Cancer

2 week wait Cancer Performance for LLR patients at all providers



2 week wait Breast Symptom Performance for LLR patients at all providers



Despite the pathway improvements the 2WW standard remains at risk due to the sustained increase in demand, outpatient and diagnostic capacity issues and workforce challenges in both admin and clinical.

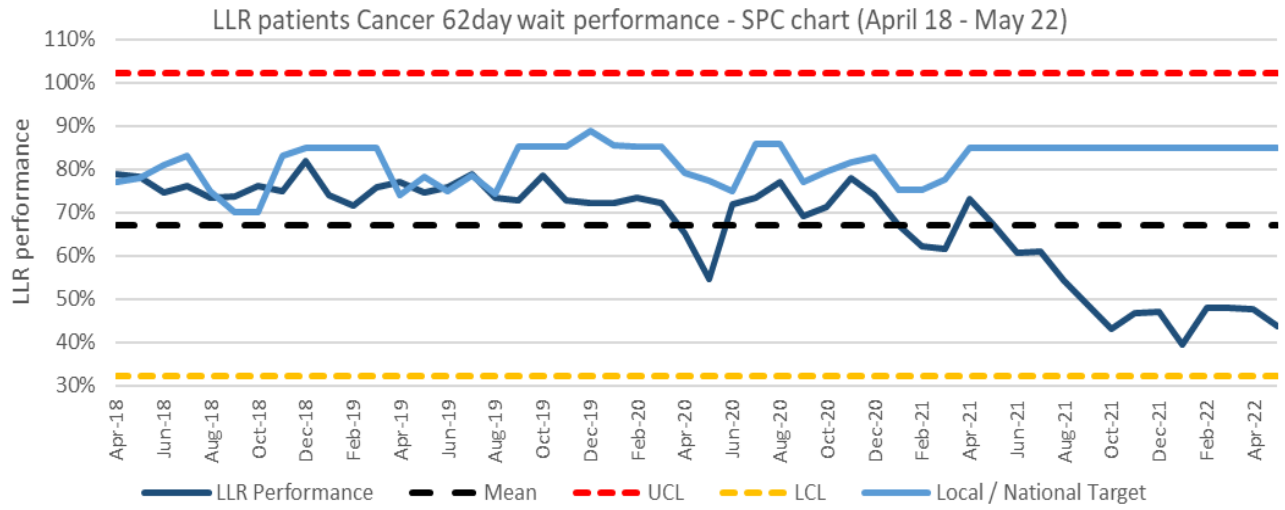
Monthly Clinical Management Group (CMG)/tumour site recovery action plan meetings held with all tumour sites with clear actions on 2WW recovery identified for:

Breast- Breast pain and outsourcing under 35s. Insourcing for weekend activity. Additional WLI and USS rooms at GGH

ENT- Mandatory face to face assessment prior to referral. Task and Finish group for national timed pathway implementation setup. Increase clinic capacity following removal of social distancing

Haematology- Demand and capacity gap- service clinically triaging each referral and appropriately booking. 2WW triage pilot planned for August

Cancer 62 day wait



62-day wait from referral to treatment (incl rare carncers).
Data Source: https://future.nhs.uk/OIforC/view?objectId=137156261

Benchmarking against LLR STP Peers:	Standard	Apr-22 Perfomance	21-22 Q1 Perfomance
Kent and Medway STP	85%	76.0%	79.6%
Cambridgeshire and Peterborough STP		68.8%	75.1%
Northamptonshire STP		68.3%	78.4%
Bedfordshire, Luton and Milton Keynes STP		61.7%	72.0%
Nottingham and Nottinghamshire Health and Care STP		61.4%	73.6%
Bristol, North Somerset and South Gloucestershire STP		60.7%	75.5%
Joined up Care Derbyshire STP		60.6%	69.0%
Staffordshire and Stoke on Trent STP		51.6%	70.0%
Coventry and Warwickshire STP		51.2%	71.2%
Mid and South Essex STP		49.3%	62.5%
Leicester, Leicestershire and Rutland STP		**47.0%**	**67.2%**

Waiting list volumes for 62 day remain high as a result of ongoing demand. Urology remains the key area of concern. Capacity constraints include Diagnostic capacity particularly Endoscopy and theatre capacity remains challenged due to staffing and capacity where HDU beds are required.

Local actions:

- Continue to clinically prioritise all patients on a cancer pathway with ongoing focus on ensuring cancer theatre sessions are protected where possible.
- Work with East Midlands Cancer Alliance (EMCA) and regional providers to seek mutual aid where possible to support equitable access for all patients
- Skin AI programme (Pilot in progress at Loughborough, Melton and Hinckley) to release capacity and improve pathway delays
- Weekly tumour site PTL/CAB review meetings with the Cancer Centre as well as deep dives into all backlog patients

The 62 day standard remains challenged and LLR is ranked at the bottom,11th out of 11 against STP Peers.

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.

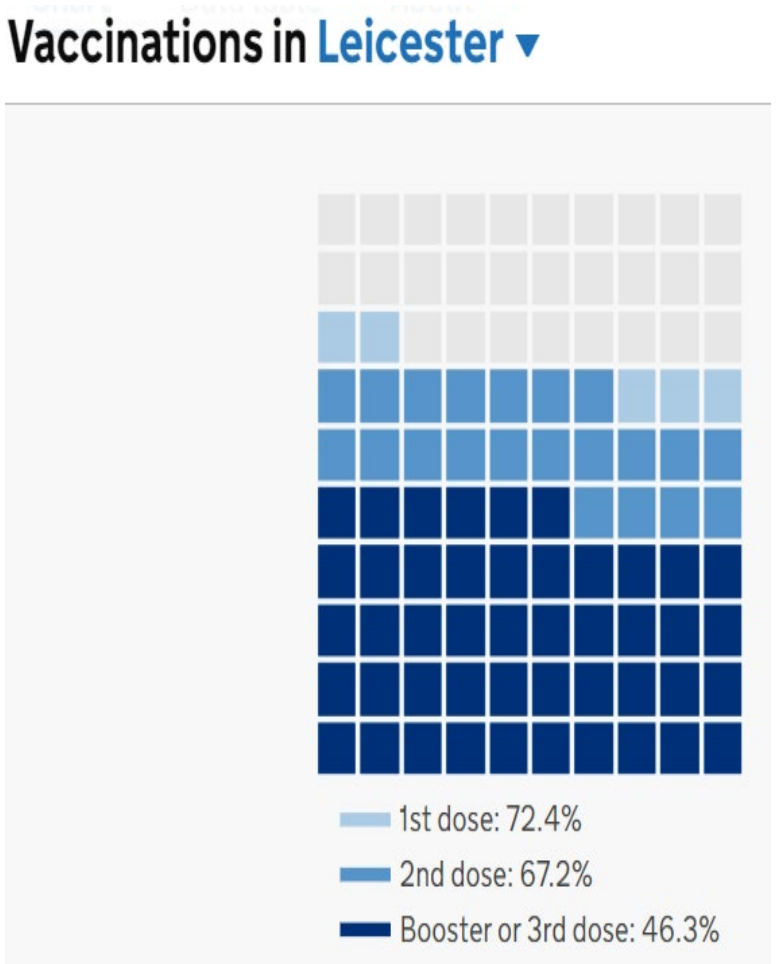
Note:

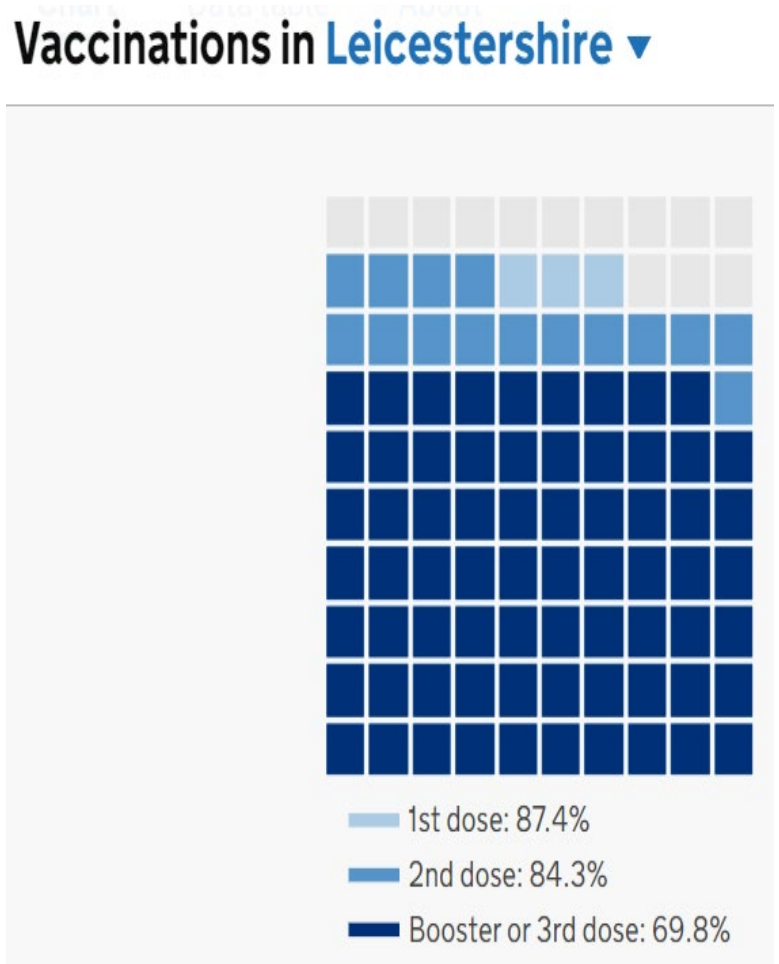
- A&E 4 hour wait remains at Provider level only
- For RTT, Diagnostic tests and Cancer metrics, data is shown for LLR patients only at these providers.
- Metrics have been RAG rated for LLR patients. In some circumstances a metric may be rated red for LLR patients but green as a whole provider position.

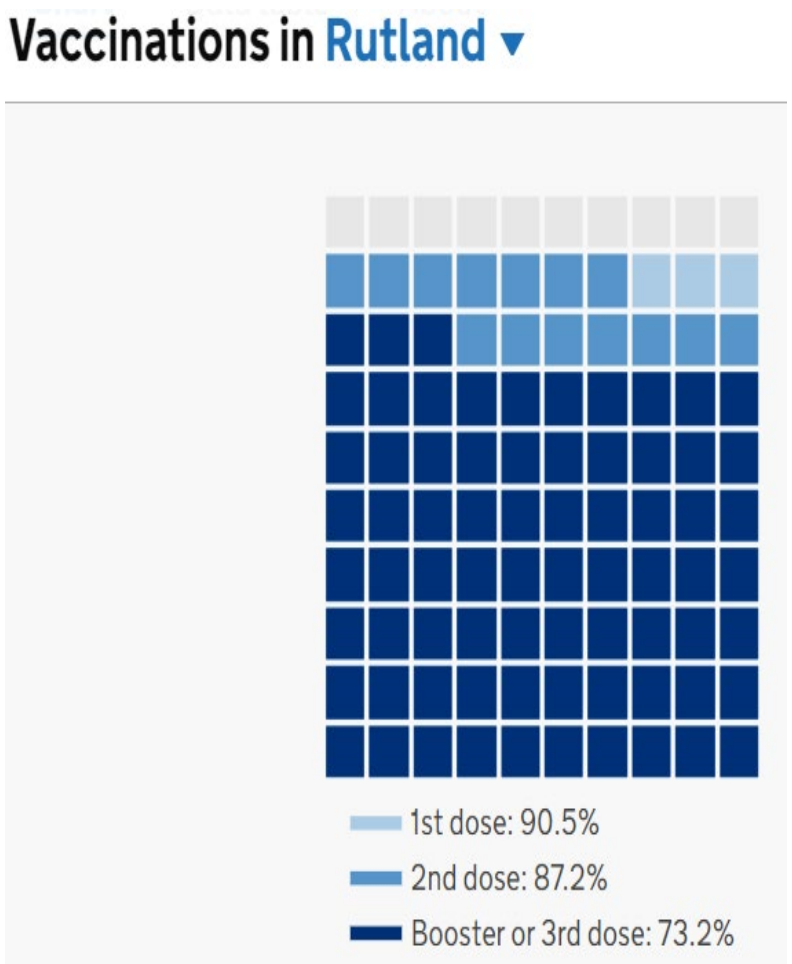
Covid Vaccinations – Published Data

COVID Vaccinations Position, 06-July-22:

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







Performance against other ICS's

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

Next Steps…

Changes in reporting & governance

As LLR formed their Integrated Care Board on 1st July 2022 the **governance** around performance reporting changed. Performance Improvement moved from having quality oversight to System Executive Group.

Rather than performance being viewed in several forums there was an ask to have "**one version of the truth**" which System Executive Group could review.

A group of ICB colleagues met in July to discuss this ask and then face to face on 15th July to **progress** what the report could look like.

Future reporting will collate **finance, activity, performance and quality** into one reporting framework.

Pilot Framework

- **What?** The group agreed that the focus would initially be around
  - Elective Care
  - Emergency Care – including ambulance handovers, bed occupancy, discharge and length of stay
- **Why?** These are areas of local and regional concern.
- **When?** A draft format will hopefully be presented in August to the Group.
- **Next Steps:** The third area to pilot will be either learning disabilities (the first collaborative) or mental health.

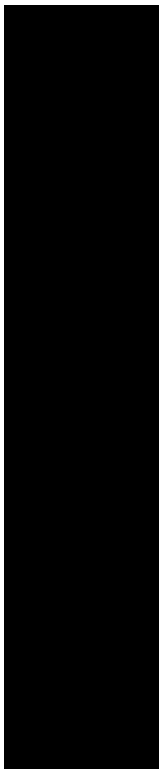
Caveats

UHL data will primarily be used for timeliness.

UHL provides care for 80% of the LLR population.

Quarterly there can be a wider pack for the LLR population receiving care by all providers.

There will be other reports looking specifically at place, health inequalities and workforce. There will be a plan to add these into the framework over time.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 August 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:	Imran Asif – Corporate Affairs Officer, LLR ICB		
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 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 4 August 2022.

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.	x

		☐

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 Assurance Framework: LLR BAF 11 – Cancer targets LLR BAF 18 – Ambulance handover delays LLR BAF 19 – 104 week waits Quality & Safety Committee Risk Register: 004 – Quality of care UHL 005 – Quality of care EMAS 006 – Primary Care quality 007 – Workforce
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	NO
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	YES
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	YES
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

4 August 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 4 August 2022.

Summary

The QSC received updates on the recent cancer summit which took place on the 26 July 2022. Significant concerns were raised on the performance against national targets. QSC members were informed that an action to review the demand and capacity of cancer services was planned for completion in August 2022 which is of critical importance for future planning of services The committee took limited assurance from the action plan presented

The CNO and CMO presented a quality and safety report. Conversations focused upon the pharmacy workforce risks, current safeguarding arrangements within the LLR system and an update on Practice X following the quality risk summit in July 2022.

LPT, UHL and EMAS presented system quality reports for assurance to the QSC. EMAS reported 23 serious
s incidents (SI) to date and projected if the trajectory continued it could result in 102 SI at the end of the year. LPT reported that they had low assurance for gathering and reporting data on the Mental Health Act Census. The LPT Medical Director has been tasked to provide solutions via the legislative committee.

A general theme emerged during the discussions concerned with the importance of Risk appetite across the system and the requirement for this to be reviewed if Patient Safety risks are too to be mitigated.

Item for Escalation

- Pharmacy workforce
- GP practice with concerns
- UEC - system risk appetite
- Abandoned children in emergency department

Alert	**Pharmacy Workforce** Concerns were raised on pharmacy workforce in relation to the additional roles reimbursement scheme (ARRS) funding for primary care networks (PCNs). Due to ongoing absences, there is a risk of de-stabilisation which can have an adverse effect on service delivery, quality of patient care, flow, elective recovery and delivery of the transformation agenda due to insufficient capacity. Mitigation includes ongoing workforce development planning through the MODG workforce group and dialogue with the system workforce group, including scoping specific models for workforce delivery across the different sectors.
Alert	**GP Practice with concerns** The CNO and CMO reported the ongoing concerns relating to a GP practice in LLR. The ICB is continuing to support the GP practice in conjunction with CQC to work towards an improvement in patient safety and quality of care.

	Assurances were provided that the ICB is taking the appropriate action to ensure patient safety and taking legal advice in relation to the contract.
Alert	**UEC – System risk share** The QSC members acknowledged that risk share was a common trend across the discussions they held on multiple items on the agenda. The consensus was that colleagues within the LLR system would need to be better supported to move away from individual organisational risks and seek opportunities for increasing risk appetite to reduce the overall level of risk faced by the ICB.
Alert	**Abandoned Children in Emergency Department** QSC noted that there were significant concerns in the processes related to the management of abandoned children in Emergency Department (ED) due to a breakdown in care arrangements in the community. An escalation process has been developed across health and care partners, but a specific example was cited of a child who had been in ED for 11 days and no resolution had been reached to date. Further work is needed to review the escalation processes and ensure that there is a shared approach across health and care to resolving these cases.
Alert	PPIAG was not assured of the improving of access to general practices outside of usual opening times (Enhanced Access to Services). The CMO committed to bringing the GP patient experience report and action plan to the October 2022 meeting to enable a discussion regarding the plans in place.
Assure	**Cancer Summit** An update was provided to the QSC on the recently held cancer summit in July 2022. The cancer summit aimed to discuss concerns, best practice, solutions to improve quality, experience and waiting times for patients across LLR. An overview was provided of the cancer performance, cross cutting tumour site themes for imaging, radiotherapy, pathology, oncology, and theatres pathways. There are significant concerns around the 2ww, 31 days, 62 days, 62+ backlog and 104+ backlog national targets for cancer and the impact on patient safety. A demand and capacity review is expected to be completed in August 2022 to identify specific requirements by tumour sites. Work is underway to address health inequalities across the cancer pathway. QSC to engage with Chair of ICB Health Equalities committee to seek assurance on coordination of health inequalities work.
Assure	Risk register to be updated to include the following three risks: 1) Risk share – leading to patient harm and lack of quality of service 2) Abandonment of children at Emergency Department – lack of assurance on processes in place 3) Ambulance handovers – explicit risk detailing the prolonged waiting times for patients in the community waiting for an ambulance response
	The CMO to present the GP patient experience report and action plan at the October 2022 meeting.
Assure	The QSC received assurances from the CNO regarding arrangements for safeguarding across the ICB, including the new ICB Safeguarding Strategy.
Assure	System Quality Group have identified two patient safety risks which will benefit from a system wide approach Preventing Falls and Pressure Ulcers.

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:	**NHS Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	11 August 2022	**Paper:**	**J**
Report title:	**Memorandum of Understanding Leicester, Leicestershire and Rutland Integrated Care Board and NHS England**		
Presented by:	Sarah Prema, Executive Director Strategy and Planning		
Report author:	Jo Grizzell, Transition Project Manager		
Executive Sponsor:	Sarah Prema, Executive Director Strategy and Planning		

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 Memorandum of Understanding between NHS Leicester, Leicestershire and Rutland Integrated Care Board and NHS England

Purpose of the report:

Appendices:	Appendix 1: Memorandum Of Understanding Leicester, Leicestershire and Rutland Integrated Care Board and NHS England
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	1 August 2022 – Executive Management Team

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.*	Not applicable
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not within the context of this paper.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not applicable
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not within the context of this paper
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 required within the context of this paper

Memorandum of Understanding between NHS Leicester, Leicestershire and Rutland Integrated Care Board and NHS England

1. Following the establishment of the NHS Leicester, Leicestershire and Rutland Integrated Care Board on 1 July 2022, a memorandum of understanding with NHS England is required that sets out how both parties will work together.

2. NHS England provided all systems with a template for this purpose. Some of the content has been mandated ie the introduction and purpose of the agreement. However, the majority has been developed collaboratively with the Midlands region and through working with members of the ICB Executive Management Team and other ICB colleagues. This ensures that arrangements are tailored to local requirements.

3. A draft of the memorandum of understanding was shared with the ICB Executive Management Team at their meeting on 1 August 2022 and additional feedback was received which has been incorporated into the appended version.

4. The key to the text within the various sections is as follows. This will be removed and standardised once approved:

Item	**Where from?**	**Treatment in tailored MOU?**
This font	Standard national text	Leave in place
Red font	Regional additions or replacements to the standard template	Can be revised as appropriate but material changes should be recorded and agreed.
Purple font	Content agreed between ICB and NHSI	Remove in final version once content agreed

5. Members are asked to note the following:

   - System priorities and deliverables – we have included those that were approved by the Health and Wellbeing Partnership Board (shadow) at its meeting in November 2021. In addition, three NHSE regional key priority areas are contained.
   - Key focus areas have also been identified: elective care, cancer, activity, UEC ambulance handover delays, primary care and finance.
   - Locally determined place, partnership arrangements (collaboratives) and governance and oversight arrangements have been included.
   - The oversight arrangements with NHSE, roles responsibilities in performance improvement, ICS development and reviewing, amending and monitoring of the memorandum of understanding have been developed in conjunction with NHSE.
   - It is proposed that the memorandum of understanding is reviewed every three months to ensure that it continues to reflect arrangements.
   - There are four annexes but those to note in particular are B and C as they set out key factors in NHSE escalation and intervention decision and the NHSE escalation approach respectively.

6. Once approved, the final version will be signed by Andy Williams, Chief Executive and Oli Newbould, NHSE Director of Intensive Support and Director of Strategic Transformation.

Recommendations

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

- **APPROVE** the memorandum of understanding with NHS England (appendix 1). If unable to approve at the meeting, delegated authority is sought to enable Andy Williams, Chief Executive and David Sissling, Chair of the ICB to make any amendments required prior to submission to NHSE England.

Classification: Official

Publications approval reference: xxxxxx

Memorandum of Understanding Leicester, Leicestershire & Rutland Integrated Care Board and NHS England

July 2022

Contents

Appendix:

Key to Midlands region template MOU: please remove in final version

Item	Where from?	Treatment in tailored MOU?
This font	Standard national text	Leave in place
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Executive Summary

The purpose of this draft Memorandum of Understanding (MOU) is to describe the **principles and collaborative ways of working** that underpin how NHS Leicester, Leicestershire & Rutland (LLR) Integrated Care Board (ICB) and NHS England (NHSE) will work together to achieve high quality, equitable health and care services. This will be managed through the LLR **Delivery, Transformation and Oversight** approach (Appendix B) **which signals a new way of working.** As partners, we are committed to deliver the best for our people and our patients. The journey from Clinical Commissioning Groups to ICBs means **ICBs have new statutory responsibilities and accountabilities**. To deliver during this **transition year**, the ICB will lead the ICS, working with NHSE in its regulatory and supporting capacity, to drive delivery, transformation and performance.

The ICB recognises this is a once-in-a-generation opportunity, which is reflected in the **Inception Framework** through its **'system first' approach**. Post-COVID, there are a number of **critical performance challenges** which need immediate attention in 2022/23, such as urgent and emergency care, elective recovery and cancer plus key developments such as the primary care oversight framework. There will be a dedicated focus on improvement in line with the **NHS Oversight Framework and planning trajectories** for 2022/23. Whilst there is a focus on improving performance, quality and safety, the ICB expects to **sustain areas of good delivery** and work towards and improved NHS Oversight Framework rating. The MOU describes **governance and delivery arrangements** which includes **place-based arrangements** that are developing at pace. This will enable the Integrated Care System (ICS) to realise its ambition of **subsidiarity** with decisions taken as locally as possible.

To guide us through we are adopting a set of **leadership behaviours and are changing the way we work.** As highlighted earlier, ICBs will lead the system, working alongside NHSE in this transition. This is because under transitional arrangements, NHSE will need to be confident that in-system governance and assurance mechanisms are mature, which may require some continued presence at meetings and forums initially, to ensure regional and national teams are sighted on progress. This will be managed through the Birmingham and Solihull **Delivery, Transformation and Oversight approach** (Appendix A) which **signals this new way of working.** This has been agreed between the ICB and its system providers including Trusts, Local Authorities and Primary Care and will streamline communications and enable **providers to focus on recovery, transformation and delivery** as far as possible. It also recognises the joint approach and supportive working arrangements between the NHSE, the ICB and its providers.

This MOU signals **a new and collaborative way of working** that will provide effective support and challenge to the ICB, underpinned by **joint values.** The ICB, its partners and NHSE are fully committed to making this work. As such, this remains the foundation for the future ways of working and will be a **live document** that will be refreshed regularly.

Introduction

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

The four key aims of an ICS are to:

- improve quality of services and outcomes in population health and healthcare

- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

ICSs are led by both an LLR Health and Wellbeing Partnership and an Integrated Care Board (ICB). The ICP is a statutory committee bringing together all system partners to produce the ICSs integrated care strategy. The focus of this MOU is with the ICB as the statutory body with responsibility for NHS functions and budgets.

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Purpose of this agreement

This MOU is between the NHS Leicester, Leicestershire & Rutland (LLR) Integrated Care Board, and NHS England- Midlands region, on behalf of NHS England. It is effective as of July 2022. It sets out:

- the principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services
- the delivery and governance arrangements across the ICB and its partner organisations
- how NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks and support needs
- how the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

This MOU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either party. NHSE will continue to exercise its statutory role and powers in relation to regulatory action under legislation, including to address individual organisational issues in line with the principles set out in this MOU. The accountabilities of individual NHS organisations also remain unchanged.

In particular, it is noted that:

- this MoU does not delegate functions from NHSE to the ICB or vice versa
- NHSE's oversight delegated functions will take place in accordance with the delegation agreement.
- the MoU does not mean that functions are being exercised jointly by NHSE and the ICB within the meaning of section 65Z5 of the NHS Act 2006 (joint working and delegation arrangements) and
- references to meetings held jointly do not mean that a joint committee has been set up between NHSE and the ICB.

It is acknowledged that the MOU represents a new way of working and there will be a period of transition and bedding in required, and an associated regular review process.

Ways of working

Midlands Leadership Behaviours to support 'Whole System' Working in the Midlands

To deliver the best for our people and our patients, we are committed to the following leadership behaviours across the Midlands.

Figure 1: Leadership behaviours

Rules of engagement to support 'Whole System' Working in the Midlands

The following principles will inform how the ICB and NHSE will work together:

1. **First among equals whilst respecting the respective responsibilities and accountabilities.** Ways of working will be non-hierarchical and jointly owned whilst respecting that statutory roles and responsibilities of different parts of the system will still need to be carried out. Despite respective NHSE/ICB roles there are common challenges that affect us all which will require collaborative leadership to resolve.

2. **No decision about me without me.** Structures for regional decisions relating to development and improvement will include systems as part of a whole system approach. This is to ensure that decisions around regional support are informed by the knowledge, skills and experience of those leading and delivering the strategic change/operational improvement.

3. **No surprises.** Arrangements will be transitional and will need to evolve as together we build confidence and trust. Early notice of information and concerns, be open and willing to share intelligence using agreed data sources to avoid different views.

4. **No bypassing.** There will be agreed, channels of communication between the organisations, the ICB and NHSE ensuing that duplication is minimised and that the region and system role is not undermined. There should be no bypassing system or regional leadership. NHSE's primary relationship will be with national directorates and ICBs whereas ICB primary relationships will be with place, organisations and local government.

5. **ICB oversight will be NHSE led with oversight of NHS organisations led by the ICB - where we need to deviate from this it will be with ICB involvement.** ICBs are accountable for the oversight of NHS performance whilst NHSE remains statutorily responsible. NHSE will work with and through ICBs to discharge this function. However, where there is a need to respond quickly to unexpected issues or where formal regulatory action is required this will be responsibility of NHSE. In all cases NHSE decisions will include the involvement of the ICB and good relationships and communication should ensure that NHSE is sighted on local issues.

6. **Midlands and NHSE ways of working will be clearly outlined to clarify responsibilities and to avoid undermining or duplicating the role of an ICB.** Jointly agreed arrangements will be set out for Midlands System Leadership. Individual ICB/NHSE ways of working will be outlined in this MOU which are to confirm roles and responsibilities for any NHSE functions discharged or delegated by NHSE and reviewed/updated regularly as arrangements evolve. These will articulate the 'step in rights for NHSE' where required.

7. **Continue to address unwarranted variation whilst upholding the principle of subsidiarity and local flexibility.** Some things will need to be done once for consistency and or where there are benefits to economies of scale. The overriding principle however should be one of decisions being taken as locally as possible to ensure we are meeting the need of populations served.

8. **Together we will strive for excellence and harness the talent we have to improve health and care outcomes, quality and access to care and reduce health inequalities.** Where things go well we will lock in the learning and strive to do better. When things go wrong, we will seek to understand why and learn, to inform future ways of working.

9. **Collaboration.** All ICBs are expected to work together and with NHSE to support effective and timely delivery of care to patients and communities, and performance improvement against regional priorities. We recognise that collaborating and supporting beyond system or organisational boundaries can create additional

challenges and risks locally and we will work together to quickly resolve any barriers and ensure that the positive impact of effective collaborative behaviour is duly recognised and celebrated.

System priorities and deliverables

The Leicester, Leicestershire and Rutland Health and Wellbeing Partnership has developed its Purpose, Principles and Priorities through a series of workshops. As such, the following transformation and operational priorities have been agreed.

TRANSFORMATION PRIORITIES

Transformational Priorities we will transform the following areas ensuring we take steps to improve the equity of access and outcomes	
Best Start in Life We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances	**Staying Healthy and Well** We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities
Living and Supported Well We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently	**Dying Well** We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families

OPERATIONAL PRIORITIES

Operational Priorities – We will:	
Work together across health and local authorities to deliver the COVID vaccination programme and winter Flu programme ensuring maximum uptake	Recover services across all sectors of our partnership that have been affected during the pandemic improving our communication with our residents as we do this
Deliver changes to UHL hospitals and transform our mental health services ensuring appropriate local delivery	Work together across health and care to transform access to the health and care services we provide, with a focus on primary care, urgent care, chronic conditions and mental health services

Note: these priorities will be the focus of the LLR ICS NHS Board to deliver working with partners as necessary

NHSE Regional key priority areas and commitment for 2022/23

1. **Delivering a Greener NHS:**

As a Midlands team we are committed to addressing the climate emergency, which is also a health emergency. Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.

All ICS's and Providers have Green Plans in place, and NHSE will provide appropriate expertise, investment and focus to enable us to deliver as a region. Sustainability should be implicit in all considerations and decisions made and geared towards delivery of the NHS's net zero targets.

2. **Reducing health inequalities:**

We will work together to support tackling Health Inequalities in outcomes, experience and access.

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individual that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

There are unfair and avoidable differences in access to and experience of NHS services by different population groups. Additionally, there are healthcare inequities that could be addressed through the provision of needs based, person centred services and systems.

The Health and Care Act 2022 introduces a range of obligations on NHS bodies in relation to action on health inequalities. These new obligations are summarised in Annex A.

3. **Supporting our People**:

Staff are at the centre of our collective ambition for greater integration and better care and ICBs have a central role to play in delivering the vision for our 'one workforce'.

As NHS leaders and organisations we will work together to deliver 10 outcomes-based functions with our partners in the ICB to make the local area a better place to live and work for their people and we will work together and through the local People Board to meet the following core objectives:

i. Supporting the health and wellbeing of all staff
ii. Growing the workforce for the future and enabling adequate workforce supply
iii. Supporting inclusion and belonging for all, and creating a great experience for staff
iv. Valuing and supporting leadership at all levels, and lifelong learning
v. Leading workforce transformation and new ways of working
vi. Educating, training and developing people, and managing talent
vii. Driving and supporting broader social and economic development

viii. Transforming people services and supporting the people profession
ix. Leading coordinated workforce planning using analysis and intelligence
x. Supporting system design and development.

Key focus areas

It is identified that there are some key areas of work that need to be considered a priority to working together:

- **Elective care:**
  - **Eradication of elective 104 week waits & 78 weeks, reducing 52-week backlogs**
  - With an aim to eradicate 104 weeks, LLR has work to do to achieve this. Ongoing work is underway jointly between LLR and NHSE to identify actions and support wider mutual aid to deliver.
  - System is in tier 1 support for electives, providing national and regional support
  - In line with the principles set out on pages 26-28, this is considered a high-risk area at this point in time, so will retain NHSE support, alongside the system leadership in monitoring and delivering.

- **Cancer**:
  - **Improvement of overall performance position**
  - System is not expecting to meet the 2ww urgent cancer referral backlog ambition reduction. Therefore, the operational plan is currently not compliant. The system has plans in place to look for opportunities to address backlogs to achieve a better predicted trajectory, with the support of NHS England through the tier 1 programme.
  - In line with the principles set out on pages 26-28, this is considered a high-risk area at this point in time, so will retain NHSE support, alongside the system leadership in monitoring and delivering.

- **Activity - Deliver significantly more activity than 19-20 (104%)**
  - The current position for LLR falls below the level required to return to levels above that of 19-20. Against the 104%, LLR sits below 100%.
  - As such, this is considered to be a significant area of concern. Therefore, as per principles held on pages 26-28, would require ongoing support from NHSE, but this is to assist in identifying solutions to data issues (1) recording of activity and(2) aligning reporting metrics to allow benchmarked comparison of data))

- **UEC ambulance handover delays**
  - Key focus areas are handover delays, flow and discharge.
  - There are risks to delivery of the Operating Plan which the system is prioritising in order to provide mitigation in readiness for what is expected to be a challenging Winter period. Planning for Winter is clearly a priority, and the system is fully engaged with NHSE in Winter planning events to ensure the system is focused on the key priority areas. This will continue over the coming year.
  - With ongoing pressures in UEC leading to significant challenge in ambulance handover delays and flow, alongside active work to address issues raised by the CQC- there is a requirement for NHSE to continue with support in an active manner, aligned to principles on pages 26-28.

- **Primary Care – creating a sustainable model of care across Primary Care as outlined in the Fuller review**
    - Enabling better access to urgent primary care services for patients – ensuring people who need it can be assessed on the same day and offering more choices to those who do not regularly use health services.
    - Enabling improved support to patients who need ongoing care by combining primary care and community teams and ensuring they see the same clinicians on a regular basis.
    - Help to make people live well for longer by working at PCN level with local government and the voluntary sector to seek out people who need more support before their health problems escalate.
    - Growing our wider primary care workforce to enable delivery of better access, improved quality and improved outcomes for the population of LLR.
    - Ensure arrangements are in place to enable the safe and legal delegation on pharmacy, optometry and dental services (PODs).

- **Finance**
    - Delivering system-level financial balance remains a key requirement for all ICBs.
    - The additional funding made available to LLR during the planning round was provided on the basis that the following ongoing conditions be adhered to:
    - The principles commit to recurrent delivery of efficiency schemes from quarter 3 to achieve a full year effect in 2023/24 to compensate for any non-recurrent measures required to achieve 22/23 plans.
    - Fully engage in national pay and non-pay savings initiatives which we plan to launch in the coming months, in particular around national agreements for medicines and other non-pay purchasing.
    - Monitoring of agency usage by providers, and compliance with usage and rate limits.
    - Compliance with a similar set of conditions in relation to bank staff
    - Any consultancy spend above £50,000 and any non-clinical agency usage require prior approval from the NHSE regional team.
    - Internal audit to be commissioned to produce a report covering the HFMA publication - Improving NHS financial sustainability: are you getting the basics right? Further details for this review will be issued shortly.
    - Systematically review excess Inflation figures in plans. Further details of this process will be issued in due course.

We would aim to work collaboratively in line with the performance oversight as set out on page 26 (ICS Development).

Place arrangements

At the ‘place’ level, care alliances, including hospitals, local authorities (Health and Wellbeing Boards), urgent care, mental health and community services, transport providers and the newly formed primary care networks, plan the delivery of healthcare in response to local need.

Leicester, Leicestershire, and Rutland have a background of collaborative working across health and social care. We are committed to working together for everyone in Leicester, Leicestershire, and Rutland to have healthy and fulfilling lives now, and for generations to come. This has been formalised under the ICS statutory body from 1 July 2022.

LLR's aim is to deliver a health and care system in Leicester, Leicestershire and Rutland that tackles inequalities in health and delivers improves the health and wellbeing and experiences of local people and provide value for money.

The Integrated Care System is a collaboration between the NHS and local government, working together with partners in the voluntary, community and independent sectors to find the most effective ways to manage the health and care needs of the population within the available resources – providing high quality and sustainable care for the future.

The LLR partnership brings together NHS and council partners with the voluntary, community and social enterprise sectors, to plan services and provide funds to address the needs of our population.

Local Authorities: The current ICS boundary aligns directly with three upper tier local authorities: Leicester City Council, Leicestershire County Council and Rutland County Council.

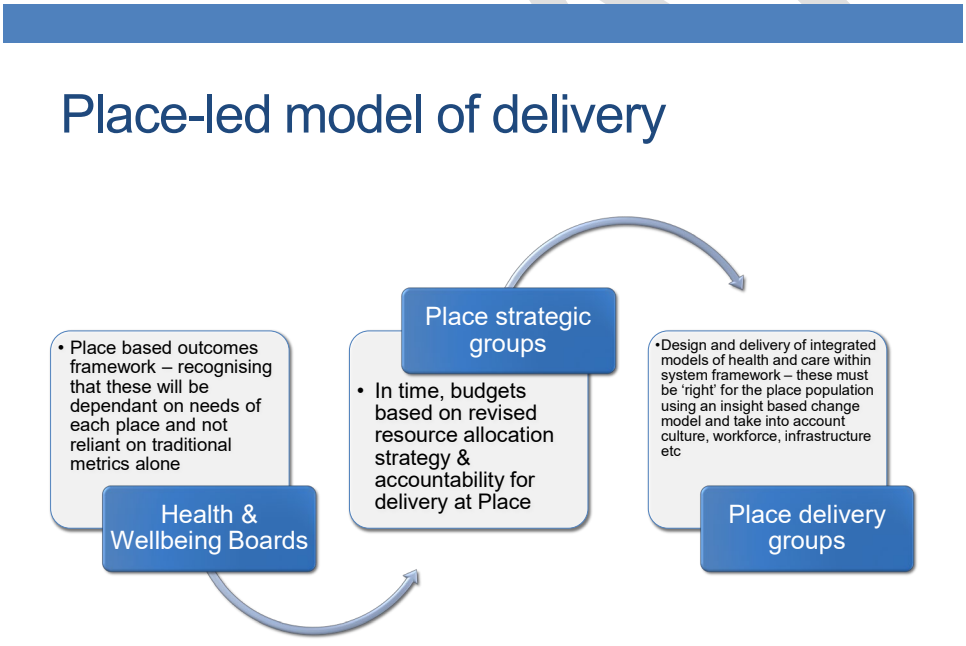
Wider Partners and Stakeholders: General practice, NHS providers, local government and the third sector are the foundation of our ICS.

As a key delivery partner, the general practices, of which there are more than 130 across 25 Primary Care Networks, will have a key role for locality and place-based working that will integrate services and ensure they meet the needs of our diverse communities. Representatives of the voluntary and community sector are also actively engaged with ICS partners in shaping and supporting local services, along with Healthwatch.

LLR have three established places: Leicester, Leicestershire, and Rutland. These link with each of the three Health and Wellbeing Boards to translate the priorities of the LLR Health and Wellbeing Partnership integrated care strategy into local action to reduce health inequalities. While retaining the cohesive integration of the System, reporting may be done at Place or Neighbourhood levels to provide greater clarity and aid decision-making

Place-led model of delivery

The visual below sets out the place-led model of delivery that has been applied across Leicester, Leicestershire and Rutland.

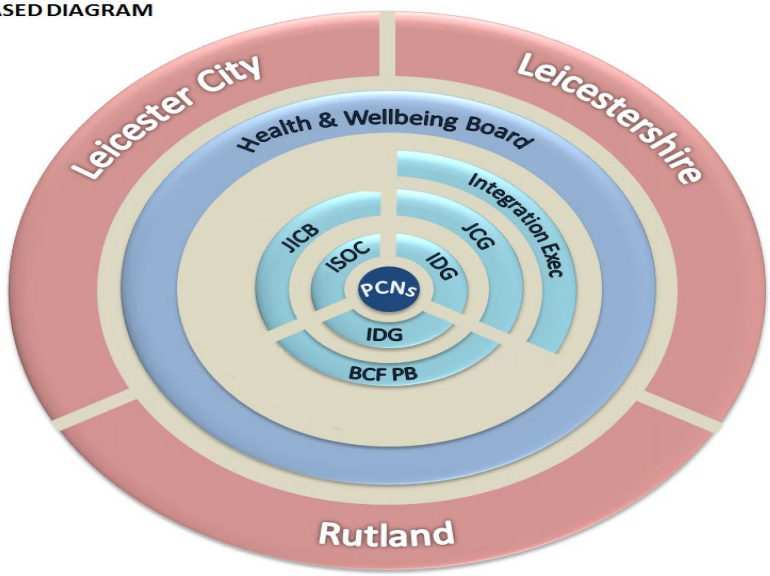


Local Architecture

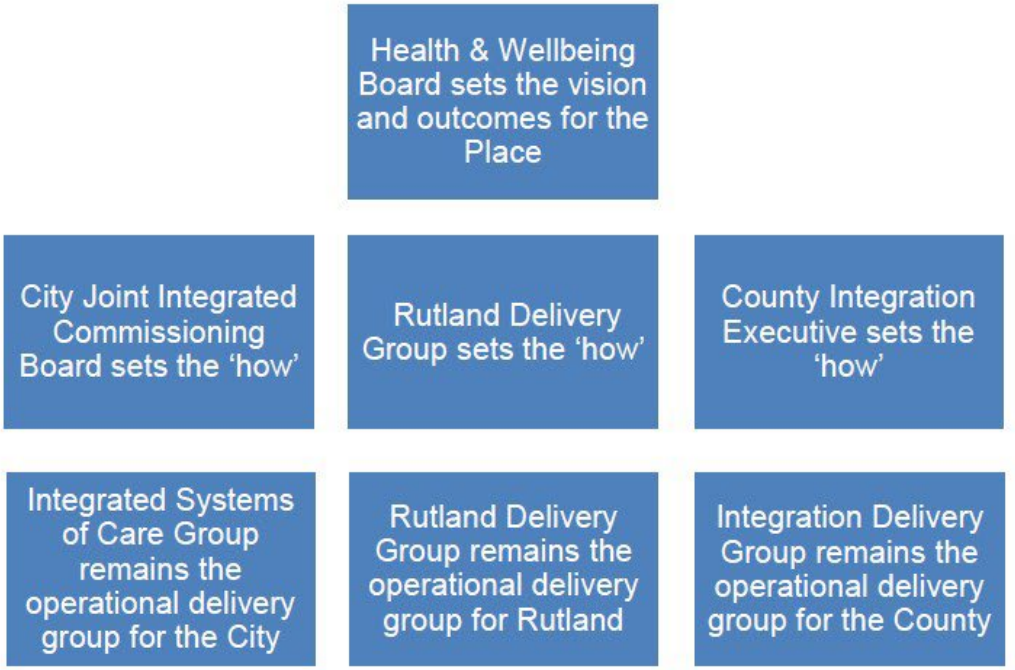
The three visuals below provide an outline of the decision-making within each of the three places and the approach to the development of place-led plans.

Local Architecture

LLR PLACE-BASED DIAGRAM



Architecture (2)



Approach to development of Plans

Place	Approach
Rutland	One Plan
Leicester City	Develop a 'Leicester City Health, Care & Wellbeing Delivery Plan' supporting a refreshed Joint Health & Wellbeing Strategy (2022-27).
Leicestershire	One overarching County Place Plan and more local 'Health, care & Wellbeing Plans' in particular to address areas with significant housing growth.

Partnership arrangements

LLR are developing collaborative arrangements in active consultation with providers. The purpose of the collaboratives is to:

• Build partnerships involving NHS providers working at scale across multiple places with a shared purpose.
• Build broader coalitions with community partners to promote health and wellbeing and reduce unwarranted variation and inequality in health outcomes, access to services and Residents and local population experience.

LLR collaboratives each have a primary focus. These are:

- Elective Care
- Mental Health
- Learning Disabilities and Autism

[Suggested regional text to add after ICB has outlined its internal arrangements]

Collaboration across ICBs:

- In order for an ICB to effectively discharge its functions it will need to collaborate with other ICBs both within the region and across regional boundaries.
- NHSE/ICB ways of working will need to evolve to take account of collaborations and agreed governance including the emerging offices of the East/West Midland ICBs. This MOU will be updated to take account of those arrangements when they are clear both in terms of the governance and the activity.
- For some commissioning activity, the preference is to collaborate across an East and West Midlands footprint. During 2022/23 we plan to develop the existing East and West Collaborative Commissioning Boards into formal committees / decision-making bodies. This work is being led by NHSE Commissioning Directorate and the Chief Executives from the eleven Midlands ICBs.
- Some commissioning functions will be retained by NHSE and these responsibilities will also be recognised within the developing collaborative arrangements noted above.
- The ICBs have formally been delegated responsibility for Primary Medical services. NHSE will operate the support services GMAST under a separate MOU arrangement until all the other Primary Care Services - Pharmacy, Optometry and Dental are formally delegated in April 23.
- NHSE will need to engage directly with providers on specialised and directly commissioned contract arrangements and procurements, but the ICB(s) will be involved as appropriate.
- NHSE Specialised Commissioners have a relationship with mental health provider collaboratives through the NHS Standard form contract, retaining strategic commissioning and oversight and assurance functions. Multi-ICB involvement and oversight will be on an East/West Midlands basis through collaboration and agreed governance as above.

- Responsibility for complaints will be delegated to ICBs at the same time as functions are delegated but the regional complaints functions will continue to transact pending confirmation of national policy and local implementation.
- Mutual aid arrangements to support the region to meet its elective recovery plans will continue during 2022/23. Where mutual aid is provided between providers and systems NHSE will recognise and support where an ICB has provided this capacity, including taking into account any consequential impact on the local delivery of financial and operational performance targets.

Single point of contact:

- The Regional Operations Centre (ROC) will become the single source of access in and out of the NHSE Midlands region for formal and / or routine communications, cascades, commissions and data requests from Regional and National teams.
- The ROC will also assume a point of regional escalation and de-escalation, ensuring the appropriate records management and governance are in place for events such as critical incidents. The ROC will hold a position which considers data at a holistic pan regional level, drawing conclusions and raising alerts where links to delivery are recognised.
- SPOC address: LLRICB-LLR.imt@nhs.net

Governance and oversight

Corporate governance is the means by which the Board of the ICB lead and direct the organisation, to enable effective decision-making.

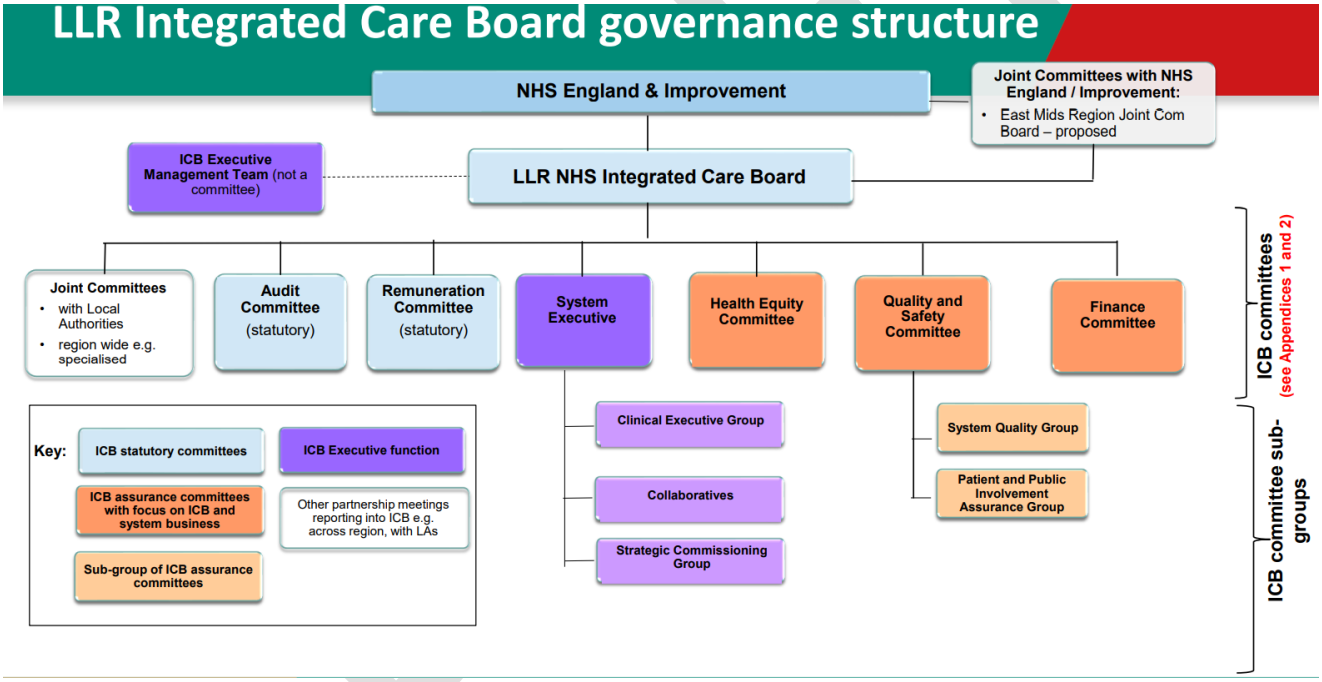
The Board will ensure that it complies with the full range of regulations and legislation to ensure the ICB is governed appropriately. Whether it is statutory requirements or NHS guidance, the ICB is legally accountable for meeting these obligations acting in the best interests of the organisation, patients, their carers and the wider community.

The ICB advocates adherence with the Good Governance Standard for Public Services as the guidance for best practice. It builds on the Nolan Principles for the conduct of individuals in public life, by setting out six core principles of good governance for public service organisations as illustrated below.

The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

a) Selflessness – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

b) Integrity – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
c) Objectivity – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
d) Accountability – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
e) Openness – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
f) Honesty – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
g) Leadership – Holders of public office should promote and support these principles by leadership and example.



Role of the ICB

The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

The LLR ICB is a statutory body responsible for the commissioning of healthcare services across the Leicester, Leicestershire and Rutland Integrated Care System area, bringing the

NHS together locally to improve population health and care. It replaces NHS East Leicestershire and Rutland Clinical Commissioning Group, NHS Leicester City Clinical Commissioning Group and NHS West Leicestershire Clinical Commissioning Group. The statutory functions of these organisations have transferred to the ICB.

The LLR ICB is part of the LLR Integrated Care System, a partnership involving the local NHS, Local Government organisations, the third sector and other relevant bodies with an active interest in the health, care and wellbeing of the residents of Leicester, Leicestershire and Rutland. Together they will collaborate to address health and care inequalities, enhance integrated working, ensure optimal use of available resources and contribute to broader societal priorities.

The LLR ICB is specifically responsible for a range of planning, commissioning, financial and oversight functions which will be discharged with the aims of improving the health of the local population and ensuring the efficient and effective delivery of NHS services.

- Finance and Activity committee:

  The Committee has been established to provide the ICB with assurance that it is delivering its statutory functions in relation to financial planning and management. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of financial planning and management and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

- The Quality and Safety Committee:

  The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

- The System Quality Group (SQG) has been established in line with the guidance from the National Quality Board and reports to the Quality and Safety Committee. The System Quality Group provides a forum to facilitate engagement, intelligence-sharing, learning and quality improvement across the integrated care system. Members of the SQG are accountable to their own statutory body and the SQG will help to ensure that

quality as a statutory function is supported and delivered in an integrated way. As a consequence of the insight shared within meetings, SQG members are expected to take forward a range of actions, reflecting their individual statutory responsibilities (e.g. improvement support, performance management, contractual action, regulatory/enforcement action).

The ICB's Chief Operating Officer has responsibility from the ICB' Chief Executive for the development of primary and community integration (partnership at place and neighbourhood, place based planning). This includes primary care development and oversight of service transformation and redesign (Emergency Preparedness Resilience and Response).

Place-based governance remains within existing arrangements through the respective Health and Wellbeing Boards for Leicester, Leicestershire and Rutland. The Chairs of the respective three Health and Wellbeing Boards form part of the membership of the ICP.

Oversight Arrangements with NHSE

NHS Oversight Framework (previously SOF)

The NHS Oversight Framework has 6 themes:

Theme 1: Quality of care, access and outcomes
Theme 2: Preventing ill-health and reducing inequalities
Theme 3: People
Theme 4: Finance and use of resources
Theme 5: Leadership and capability
Theme 6: Local strategic priorities

The oversight model should ensure that effective system governance and oversight arrangements should underpin regional oversight and assurance processes of the NHS Oversight Framework. Oversight arrangements should reflect a balanced approach across the six oversight themes, including leadership and culture at organisation and system level.

NHSE will ensure there are system-level oversight arrangements in place to regulate the ICB's performance that reflect both the performance and relative development of an ICS.

The ICB will take a leading role in oversight both at a local level and in the contribution and mutual accountability arrangements for Midlands wide performance, supported as necessary by NHSE, with a commitment to proportionality and minimising administrative burden. This will follow an ongoing cycle of monitoring performance and capability against the Oversight Framework and it will identify the scale and nature of support needs; coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

Business intelligence and data-led approaches will be used to support collective effective decision making, in a dynamic and responsive manner.

Core objectives

- The Midlands oversight model recognises that effective system governance and oversight arrangements should underpin regional oversight and assurance processes.
- Systems will take a joint and leading role in oversight both at a local level and in the contribution and mutual accountability arrangements for Midlands wide performance, supported as necessary by NHSE, with a commitment to proportionality and minimising administrative burden.
- Oversight arrangements should reflect a balanced approach across the six oversight themes in the NHS oversight framework, including leadership and culture at organisation and system level.
- NHS Midlands role in system-level oversight arrangements will reflect both the performance and relative development of an ICS.
- The oversight process for providers will be led by the ICB and follow an ongoing cycle of monitoring performance and capability against the six themes; identifying the scale and nature of support needs; and coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.
- Business intelligence and data-led approaches will be used to support collective effective decision making, in a dynamic and responsive manner.

All systems

- ***Quarterly System Review Meeting*** led by NHS Midlands RD.

  Purpose: formal accountability mechanism for region to assess and assure system performance, what support is required and gather evidence for any change to provider or system segmentation.

- ***Regional and sub-regional boards*** include system SROs / professional leads.

  Purpose: mutual oversight and accountability for regional position and agreement of specific support and intervention to address underperformance.

  N.B. specific pan-regional oversight arrangements will be discussed and agreed where oversight is required for services which across ICS boundaries. For example, for ambulance providers.

Most systems

- ***System oversight and assurance structures to include specific system: NHSE: provider oversight and assurance meetings.***

Purpose: to discharge respective responsibilities for enhanced or intensive oversight and support. For example, to oversee elective and cancer recovery, quality and financial improvement actions or monitoring progress against provider undertakings.

These should be agreed on a case-by-case basis between NHSE and the system and arranged to minimise the administrative and regulatory burden on challenged organisations.

Where NHSE is part of system governance meetings, it should be clear in what capacity this is i.e. a critical friend support and / or to support mutual accountability.

Where NHSE is not part of system governance meetings, the ICB will be responsible for notifying NHSE on any new issues or concerns relevant to statutory duties on a timely basis.

- ***System review / oversight and assurance meeting***

Purpose: review performance challenges within the system (which are driving the SOF ratings for the system and organisations), progress made and the effectiveness of interventions and support. Frequency and approach according to table below.

Segmentation level	Led by?	Frequency
SOF 1	n/a	Quarterly formal oversight sufficient unless new concerns emerge
SOF 2	System	Agreed on basis of frequency required given scale of system challenges and support required (at least quarterly)
SOF 3	System or NHSE	Monthly
SOF 4	NHSE	Monthly, more frequently as required

SOF rating:

The LLR system is currently in SOF (now NOF) 3 and as such, will be subject to monthly system review meetings led by NHSE. (The format and content of which has yet to be agreed).

The communication and engagement processes associated with NHSE and LLR working together, will follow the support and guidance for systems at SOF 3, which are set out throughout this MOU.

UHL is in (N) SOF 4 as a result of financial and operational challenges.
The exit criteria for (N) SOF 4 are:

- To demonstrate that UHL are meeting all of the criteria set out in the undertakings in relation to action plans and delivery ambitions for finance, UEC, elective and cancer.

- Meeting the criteria for the FSM/RSP exit measures, which focus around an agreed financial recovery plan, robust financial controls and processes, shared understanding of risk associated with the plan, oversight and support mechanisms and agreeing the post-exit support package.

The approach to supporting the above is set out on pages 24-28 in relation roles and responsibilities for performance monitoring and a structure which is linked to the levels of escalation based on the key priority areas.

In addition, the meeting structure set out in appendix D, aims to clarify the oversight arrangements and support offer between NHSE and ICB, by reflecting the attendance at the specific meetings according to the required level of support/oversight etc.

These will be in addition to any regional/national (N) SOF 4 escalation meetings (For example tier 1 elective and cancer escalation calls, RSP and financial recovery meetings).

Roles and responsibilities in performance improvement

NHSE and the ICB are committed to working together effectively to support performance improvement locally and across the region, and in accordance with the respective roles and responsibilities outlined below.

System

- ICBs will take a leadership role in driving improvement across the system, including ensuring that a quality improvement methodology underpins the approach within the ICS.
- ICBs will co-ordinate NHS support interventions within their system, where appropriate, working in partnership with NHSE, including to jointly review the impact of interventions.
- Systems are responsible for ensuring that the system develops, monitors and oversees plans to meet the agreed 'exit criteria' for systems and organisations receiving mandated support.
- Common exit criteria:
    - Realistic and ambitious recovery/improvement plan developed
    - Key trajectories being delivered
    - The system has the capacity and capability to deliver the key requirements agreed with NHSE
    - The system is proactively taking relevant actions to ensure that deliverables are maintained.

Region

- Regional support will focus on learning and improvement by:
    - Working with the local system to develop capability and capacity

    - Bringing systems together and/or with experts/peers to share learning and facilitate the adoption of best practice and innovation
    - Embedding colleagues within the system to provide solution focused support, that supports problem solving and sharing of best practice
    - Supporting peer review e.g. of service quality, the model of care, the governance or the approach to quality assurance or improvement etc.
  - Regional support will be tailored according to SOF segmentation level.
  - Clinical Professional Leadership (CPL) to be a critical element of leadership to quality and clinical transformation agenda, working with regional leads on system quality groups, supported by quality leads meetings to review progress against improvement plans/quality metrics/SI thematic reviews/learning.
  - Support will also be provided via Clinical Network Infrastructure and we will agree the approach and interfaces with system leadership.
  - Support and facilitation to mediate or intervene where there is conflict or a difference of opinion within the ICB or between ICBs.
  - Manage the interface and accountability of the region with the national team.
- Conduct the annual performance assessment of the ICB in each financial year and publish a summary of its findings.

<u>System & Region</u>

- Regular engagement between NHS Midlands SMEs / professional leads and system counterparts to:
    - Support individuals in their respective roles
    - Understand the current position
    - Assess what support and input would be helpful
    - Contribute to the development and implementation of improvement actions.
- NHSE will work with systems to identify quality, financial and operational improvement and transformation actions; and design bespoke support as and when mandated, required or requested. This will be linked to SOF and for all domains as necessary.
- NHSE relationship leads will work with systems on oversight infrastructure to provide support/critical friend input into forums such as boards for UEC, elective and cancer.
- NHSE and systems will collaborate through regional forum, such as the finance leadership group.
- Where new concerns are identified, rapid risk and review (or escalation) meetings will be used as a consistent approach to understand issues, agree actions and outcomes required. To include what further support is required, future monitoring and co-ordination arrangements.

<u>Overarching approach to risks and escalation</u>

The approach to the escalation of issues within the ICB or by NHSE with the ICB or provider is dependent on the segmentation of the ICB, current levels of oversight, as well as the specific metrics and qualitative factors.

The 2022/23 NHS Oversight Framework outlines the segmentation approach and key metrics which will be considered by NHSE to assess performance of the system and providers against six key themes or domains. Included in Annex B are some key qualitative indicators, which will influence NHSE's judgement regarding escalation levels and interventions, however, the new framework should be referred to in full for guidance on segmentation and metrics.
For individual providers, NHSE and the ICB will together discuss segmentation and any support required. However, NHSE will be responsible for making the final segmentation decision and taking any necessary formal enforcement action. Where there is a deterioration in segment NHSE and the ICB will agree exit criteria which will need to be met to exit mandated support and move to a lower segment.

ICS development

- Systems will continue to produce a system development plan (SDP) which will evolve in response to system priorities and national policy development.
- NHSE will provide an allocation of funding (figure TBC) for system development and system participation in the co-design of policy related to the long-term ambition and vision for ICSs.
- NHSE will continue to broker regional and national support in relation to needs identified in system development plans.
- NHSE will work collaboratively with systems to support the interpretation and implementation of national policy and share learning and good practice in relation to ICS development.

There are two core functions when considering ICS development:

1) Regulatory and governance oversight which is linked to National operating framework (NOF) set out above and

2) Operational and functional support.

It is considered that operational and functional support aligns to the key priority areas requiring support (as set out on pages 10-11) and the support offer determined as to which group the priority falls into as set out below.

Triggers & escalation:

Regulatory/governance:

Linked to SOF.

- SOF 1- no interventions- provider/system manages independently
- SOF 2- system intervention & oversight- No formal NHSE intervention but will be aware through governance reporting routes of issues. May be asked to support.
- SOF 3- joint system and NHSE intervention. Agreed areas of support, NHSE offering advice and guidance, resource and expertise, areas of best practise etc.
- SOF 4- Regional and/or national NHSE intervention with intensive support

Escalation is via governance reporting structures/boards and via the QSRM

Operational/functional :

Linked to local involvement and agreed triggers & escalation. Linked to the escalation (RAG) in the MOU.

For example, if NHSE have a seat on the elective board:

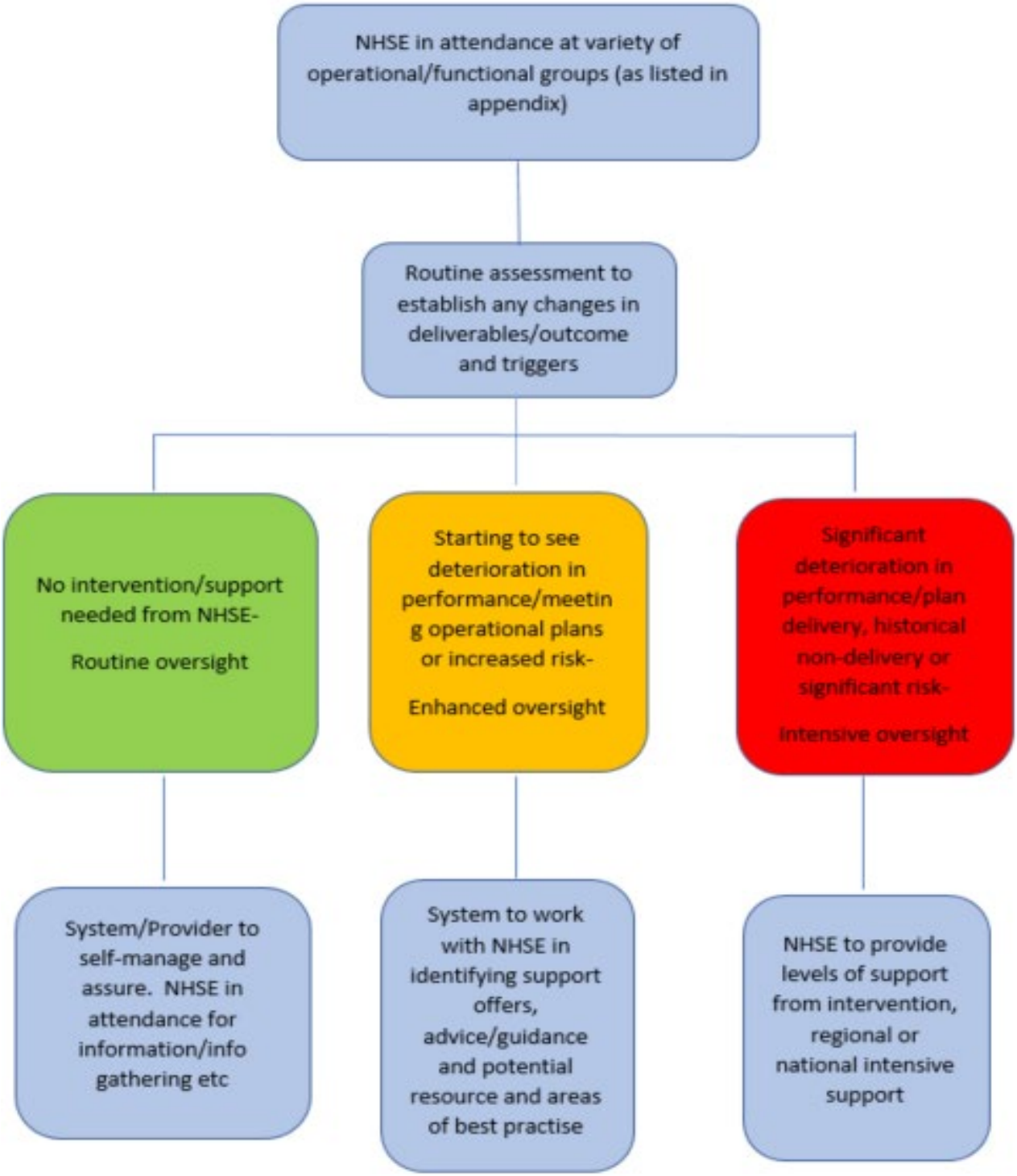
1) GREEN- there are no issues- they would be classed as green, with no intervention required. NHSE will be aware of the work, progress and performance for reporting purposes, but no formal assurance processes needed (similar to SOF1).

2) AMBER- If an area in electives begins to identify risk through the local risk stratification models or sees a dip in performance with either known reasons or through another areas of concern, NHSE will be able to offer support/advice etc. (as per SOF 2/3 process). Will involve potential support/advice/guidance/resource and or further intervention as required

3) RED- If an area has significant performance or risk issues as a result of long standing/historical performance or a significant event leading to high risk, not meeting operational plans or poor patient experience/outcomes etc., (similar to SOF 4), NHSE will support through intervention with the system, identifying actions/support offers and potential escalation into tier meetings/quality summits etc. as required.

The structure for triggers and escalation principles set out in the MOU will be the skeleton above and functional areas will be able to develop local triggers and escalation as required. System to lead the triggers with NHSE supporting and identifying support offers.

Flow diagram for operational functional process



Reviewing, amending, and monitoring of the MOU

This MOU relates to an ongoing relationship between the ICB and NHSE and will be formally reviewed and renewed on an annual basis. The ICB and NHSE agree to review the agreement every 3 months to assess whether it is still accurate and fit for purpose, as an output of the Quarterly System Review Meeting and taking account of any changes in SOF segmentation.

Changes to the MOU required outside of the proposed review period can occur at any time, if agreed by both parties.

Signatures

The ICB and NHSE, as represented by the below officers, agree to honour the aspirations and commitments made in this MOU.

[Andy Williams]

[Oliver Newbould]

[insert effective date]

Annex A: Obligations on Health Inequalities

New ICB obligations on health inequalities

- A new duty on health inequalities for ICBs: 'Each integrated care board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between persons with respect to their **ability to access health services**, and (b) reduce inequalities between patients with respect to the **outcomes achieved for them by the provision of health services**.'
- A new **quality of service** duty on ICBs which includes addressing health inequalities.
- A duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved.
- Duties on ICBs in relation to several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting**, publishing certain reports and plans, **annual reports and forward planning.**
- In addition, each ICB will be subject to an **annual assessment** of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

New requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

- NHS England must publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised.
- NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed

Annex B: Key factors in NHSE escalation and intervention decisions

System Oversight Framework

The 2022/23 System Oversight Framework outlines the key metrics which will be considered by NHSE to assess performance of the system and providers against 6 key domains.

Key qualitative factors

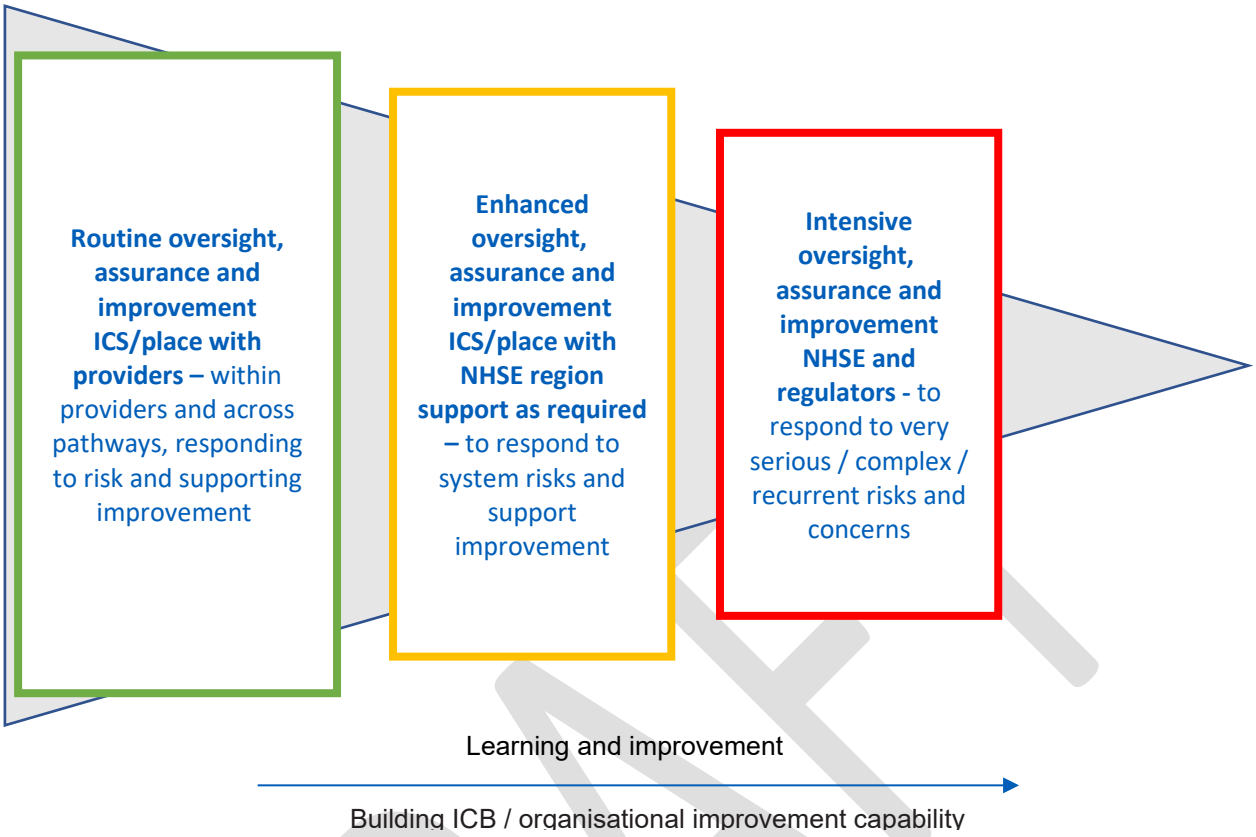
which will influence NHSE's judgement regarding segmentation decisions and if regulatory intervention is required (as a last resort):

- Lack of assurance that the issue/ concern is being addressed or managed in a timely and effective manner by the ICB
- System tensions or conflicts of interest, e.g. a whistleblowing report about an ICB exec lead
- Poor engagement with regional teams
- Lack of effective system collaboration to drive improvements
- Lack of robust governance and oversight arrangements within the ICS or within a provider
- Material concerns regarding the structure, leadership, and culture of an ICB
- Evidence that the ICB or a provider lacks the capacity and capability to effectively address the issue

Instances where NHSE might by-pass the system

- Evidence of a conflict of interest
- A need to act rapidly to protect patients or staff (but we would notify the ICB at the earliest opportunity).
- Whistleblowing issues raised with NHSE

Annex C: Escalation approach

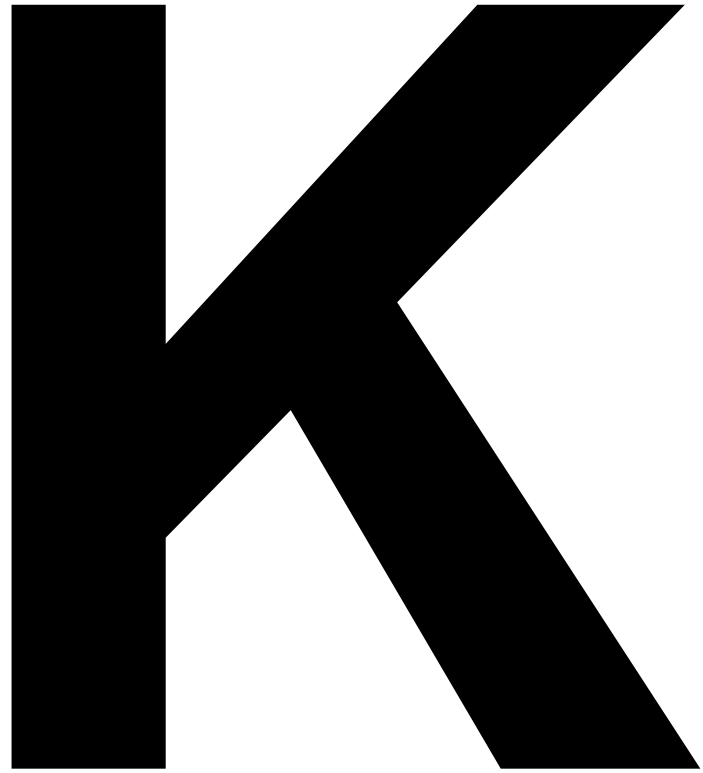


The different escalation levels are as follows:

- Routine oversight, assurance and improvement:
  - Day-to-day activity when there are no risks or minor risks which are being addressed effectively
  - Includes standard monitoring and reporting, due diligence and contract management.
- Enhanced oversight, assurance and improvement:
  - Undertaken when there are system risks that are serious, complex and/ or recurrent and require action/ improvement plans and support.
- Intensive oversight, assurance and improvement:
  - When there are very serious, complex or recurrent risks, which require intensive support, including mandated support from NHS England for recovery and improvement.

Annex D- NHSE/LLR Meeting structure

Name of meeting	Frequency	Lead	NHSE attendance	Purpose of NHSE involvement*
Statutory meetings				
QSRM	Quarterly	Regional Director-NHSE	ESM's	Regulatory/Statutory
LLR ICB	Monthly		x	
HWBB x 3	Quarterly	Chair LA	S&T	
HWBP	Monthly		S&T	Regulatory/Statutory
Joint committee	Monthly		x	
System Executive Group	Monthly		S&T	Assurance/Oversight
Audit committee	Monthly		x	
Remuneration committee	Monthly		x	
Finance Committee	Monthly		NHSE Finance	Assurance/Oversight
Health inequalities committee	Monthly		x	
Q&S Committee	Monthly		x	
System Quality Group	Bi monthly	Clin Chair of ICB	S&T, N&Q	Assurance/Oversight
Functional meetings				
Cancer Board	Monthly	LLR Cancer lead	S&T, Cancer Alliance	Info gathering/Support
Elective Board	Monthly	LLR elective lead	El transformation team	Info gathering/Support
System Flow Partnership	Fortnightly	LLR Chief Executive	(Being agreed)	Assurance/oversight/ support
Acute care collaborative	Weekly	LLR UEC Lead	S&T	Oversight/support/info
Planning review	Weekly	Joint LLR & NHSE	S&T	Assurance/oversight/ support
LLR Performance support call	Fortnightly	Joint LLR & S&T	S&T	Support/oversight
104 week escalation meeting	Weekly	NHSE	P&I	Escalation/ regulatory
System escalation calls UEC	Daily (+ x2)	LLR UEC Lead	S&T/UEC	Operational oversight & support
Strategic Command Group	Ad hoc	ICP	S&T	Incident management
LHRP/LRF	Quarterly	ICP	S&T	*Currently being reconfigured



Name of meeting:	**NHS Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	11 August 2022	**Paper:**	**K**
Report title:	**Pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services**		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Jo Grizzell, Transition Project Manager		
Executive Sponsor:	Sarah Prema, Chief Strategy 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:

- **NOTE** the approach to the completion of the Pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services (PDAF)
- **NOTE** the proposed governance route for approval.

Purpose of the report:

Appendices:	Appendix 1: Pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services (PDAF)
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Not applicable

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.*	Not applicable
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not within the context of this paper.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not applicable
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not within the context of this paper
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 required within the context of this paper

Pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services

Introduction

1. Members will be aware that in May 2022 NHS England set out its intention to delegate responsibility to all ICBs for all pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) (known collectively as 'POD services') in April 2023. This paper sets out arrangements that are in place to ensure the safe and legal delegations and in particular the submission of the pre-delegation assessment framework.

2. To support the process a pre-delegation assessment framework (PDAF) has been published (appendix 1). This is due to be submitted to NHS England on 15 September 2022. It is broken down into four sections:

    - Transformation and quality
    - Governance and leadership
    - Finance
    - Workforce, capacity and capability

3. The attached template is currently blank due to the fact that NHS England will be providing us with standard narrative for each of the sections that we can then build on. This is expected by 13 August 2022.

4. In addition, a workshop with LLR workstream leads has been arranged for 17 August 2022 to further develop the PDAF.

5. We are not required to provide any evidence to NHS England in support of our assessment.

Governance Arrangements

6. An East Midlands Working Group has been established with representation from the five East Midlands systems. The LLR Head of Transition (Sarah Shuttlewood) and Transition Project Manager (Jo Grizzell) are members of this group. It meets every other week with NHS England.

7. Internally, we are taking the same approach as for the ICB transition. As such, LLR has established a Direct Commissioning Core Team that meets weekly which is also attended by Sarah Prema (SRO), LLR Chief Strategy Officer.

8. It is also proposed that a Direct Commissioning Delivery Team with workstream leads that mirror the four domains of the pre-delegation assessment framework as outlined above is established. A paper will be presented to the Executive Management Team on 15 August 2022 outlining an LLR governance proposal, approach to risk management etc.

9. A Governance Working Group has also been established which is being led by Toby Sanders, Chief Executive, Northamptonshire Integrated Care Board with representation from across the patch. (Attended by Andy Williams from LLR).

10. The primary planning footprint for the NHS above individual ICBs is the five East Midlands ICBs and the six West Midlands ICBs. The governance framework for the East and West

Midlands needs to ensure there is the ability for Midlands wide joint working and in turn with NHS England.

11. The eleven Midlands ICBs jointly share the responsibility for commissioning of the service(s) so no individual ICB has primacy over the others. To achieve this the ICBs would develop a formal Joint Committee, where each ICB would have equal authority and standing.

12. Underpinning the Joint Committee there would be jointly established sub-committee arrangements (such as joint quality assurance and joint financial management processes) which reports into the Joint Committee.

13. The ICBs would manage the specific functional business, the appropriate commissioning model for these (Lead commissioner, network commissioner and joint commissioning models) would be applied as best fit. An assessment of different commissioning models has been undertaken by the working group. These groups would have delegated authority from the joint committee laid out in scheme of financial delegation.

14. Their key areas of focus and next steps are as follows:
    - To develop a paper on 'Establishing Multi-ICS Governance - A Framework for effective governance from April 2023'.
    - To work to develop a 'Double Delegation' agreement working with national policy team.
    - To develop a scheme of financial delegation.
    - To develop a SORD (scheme of reservation and delegation).
    - To develop a multi ICB Joint Commissioning Agreement that will underpin the principles and ways of joint operating.
    - To develop terms of reference for the Joint Committee.

15. To enable us to submit the PDAF on 15 September we are proposing that following the LLR ICB meeting on 11 August 2022, the draft PDAF is presented to the Strategic Commissioning Group on **16 August 2022** where it will be considered further, and any comments/amendments incorporated. This will be followed by the workshop on **17 August 2022** as mentioned above.

16. We are also seeking delegated authority from the LLR ICB to the System Executive to approve the final PDAF at its meeting on **9 September 2022.**

17. In addition, a safe delegation checklist is under development. This mirrors the due diligence checklist used for the closedown of the LLR CCGs. The LLR Transition Project Manager will be leading on the completion of this on behalf of the five East Midlands systems. It will be brought back to the LLR ICB in due course.

Workforce

18. NHS England is currently developing a paper for the proposed workforce model. Until the announcement of **"Creating a New NHS England",** the general view was that the safest place for the Primary care MDT was likely to be NHS England. Clarity is still being sought on the impact of this change. However, this may mean that a hosted ICB arrangement may be the best solution.

19. A meeting of the East Midlands Working Group is taking place on Tuesday 9 August where the paper will be presented and comments/input sought. An updated proposal will then be presented at the CEOs time out session on 7 September 2022 for agreement in principle. If the preferred option of transfer is agreed NHSE England will with ICBs on the process for expressions of interest.

Risk Management

20. In terms of risks, the relevant section within each of the domains of the template will be completed once we have received the narrative from NHSE England. In addition, we have also requested sight of NHSE England's risk register/s associated with these services.

21. We will also be developing a programme risk register in conjunction with the Direct Commissioning Delivery Team

Recommendations

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

- **NOTE** the approach to the completion of the pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services (PDAF).
- **NOTE** the proposed governance route for approval and to grant delegated authority to the System Executive to approve the final PDAF at its meeting on **9 September 2022.**

Classification: Official

Publication reference:

Pre-Delegation Assessment Framework for 2023 Delegations: Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services

21 July 2022, Version 1

Pre-Delegation Assessment Proforma for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services

The questions below are aligned to the domains and criteria set out within the pre-delegation assessment framework for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services (see Annex 1) and should be completed and signed-off by each ICB, and the relevant NHS England Regional Director of Commissioning. The responses should be verified by the relevant Regional Director, and the completed proforma sent to england.directcommissioning@nhs.net by **Monday 3 October 2022**.

As part of this assessment process, regional teams will need to approve the accuracy of each response and to provide confirmation of whether they support the ICB's assessment of risk for each question. No additional attachments should be provided as part of the submission.

Completing the assessment

- Responses should be inputted into the template below.
- Examples of supporting activities can be found in the response column in grey italics. These should be deleted prior to submission.
- Responses should be concise and focus on key existing and planned activities that demonstrates capability to assume responsibility for these functions from April 2023.
- Alongside the PDAF, ICBs will also work through a Safe Delegation Checklist which sets out key actions to be completed to support a safe and smooth transition to new delivery arrangements.
- Further resources will be made available on NHS Futures to support completion of PDAF submission and preparations for delegation. If you require any further support, please contact england.directcommissioning@nhs.net.

Name of ICB	[INSERT ICB NAME]
For completion of the Safe Delegation Checklist, please confirm that: ➢ A senior responsible officer and workstream leads have been identified ➢ A delivery plan, including key milestones has been agreed	 Yes / No [DELETE AS APPROPRIATE] Yes / No [DELETE AS APPROPRIATE]

Domain 1: Transformation and Quality				
Question	**Response**	**Current RAG[1] rating at [insert date]**	**Projected RAG[2] rating at March 2023**	**Regional commentary**
Will the ICB have a (shared) understanding of how the functions could be used to deliver additional benefit for people who use services, and could be integrated with current processes and pathways to do so?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Are there current or expected mechanisms through which people who use services and the public could be actively engaged and involved in shaping the functions to be delegated?	Yes / No			
Please provide further details of the key actions that are planned /have	*ICB response*			

[1] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[2] R: Readiness by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for readiness by Mar 2023; C: Completed

been undertaken in support of this domain *(400 words max).*	*Examples of supporting activities include: POD functions reflected in ICB forward plan; ICB strategies for engaging with people and communities include the delegated POD functions; Communications plans for POD delegations; Mapping of delegated functions and the benefits these will bring for the local population; POD functions reflected in overall ICB quality arrangements; Embedding POD within existing ICB quality and associated improvement priorities; Plan to ensure that quality in POD is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.*			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Domain 2: Governance and Leadership				
Question	**Response**	**Current RAG[3] rating at [insert date]**	**Projected RAG[4] rating at March 2023**	**Regional commentary**
Will the ICB have sufficient general governance capability (mature structures, appropriate expertise) to oversee the functions at every appropriate tier of their commissioning and delivery?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Will the ICB have sufficient clinical governance capability and leadership to oversee the functions?	Yes / No			
Will the ICB have mechanisms in place which allow for the identification and monitoring of emerging risks, impacts, and unanticipated dependencies in the immediate post-delegation period?	Yes / No			
Will the ICB have broad agreement amongst the parties[5] relevant to delivering the functions on the approach to monitoring and governance?	Yes / No			
Please provide further details of the key actions that are planned /have been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting activities include: Identified board level leadership and expertise in relation to the POD functions; Integration of primary care into*			

[3] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed
[4] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed
[5] *For example, all parties (e.g. other ICBs) where joint arrangements for the delivery of the delegated functions are being developed.*

	system wide commissioning and development arrangements; Plans to ensure that quality and risk issues relating to POD are linked into existing ICB governance and accountability structures; description of clinical governance arrangements; proposed governance and accountability structure for POD and how this integrates into wider ICB governance and accountability structure and relationship with place based partnerships; robust governance arrangements for risk identification, management and escalation for the POD functions; plans to monitor performance and quality.			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Domain 3: Finance				
Question	**Response**	**Current RAG[6] rating at [insert date]**	**Projected RAG[7] rating at March 2023**	**Regional commentary**
Does the ICB have an understanding of allocated ICB budgets and expenditure on other primary care services?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Has the ICB undertaken a financial risk assessment and developed a plan to mitigate any financial risks identified?	Yes / No			
Please provide further details of the key actions that are planned /have been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting actions include: Financial plans and risk assessments*			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

[6] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[7] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed

Domain 4: Workforce, Capability and Capacity				
Question	**Response**	**Current RAG[8] rating at [insert date]**	**Projected RAG[9] rating at March 2023**	**Regional commentary**
Will the ICB understand the capacity, capabilities and skills it needs to deploy to exercise the function upon assuming responsibility?	Yes / No			
Could the ICB confirm that the capacity, capabilities and skills needed to exercise the function upon assuming responsibility can be made available in due course?	Yes / No			
Please briefly provide further details of the key actions that are planned /have been undertaken in support of this domain (*400 words max).*	*ICB response* *Examples of supporting actions/information include: Agreed workforce model for POD; People Impact Assessment (or similar) which takes into account the impact of change on all affected staff (including POD, Complaints and supporting functions); Evidence of mapping of external support mechanisms (e.g. CSU, shared services etc); Staff transition plans; Staff OD plans including capabilities for the delegated functions.*	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Please describe any known issues/risks associated with this	*ICB response*			

[8] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[9] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed

domain. What mitigation plans does the ICB have to address these issues/risks?		
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*	

Signatories
This document should be signed by the ICB and the relevant NHS England Regional Director of Commissioning. It should also be verified and signed by the relevant NHS England Regional Director.
For completion by the ICB Chief Executive (and, where different, the duly authorised signatory of the delegation agreement as defined by the ICB Scheme of Reservation and Delegation): I confirm that the information provided is accurate and complete. This submission indicates our willingness to proceed with delegation and sign the Delegation Agreement. **Signed by** NHS [Insert name] Integrated Care Board [Name] [Title] Signature (insert scanned image of handwritten signature) Date: Click or tap to enter a date. [Name] [Title] Signature (insert scanned image of handwritten signature) Date: Click or tap to enter a date.
For completion by the NHS England Regional Director of Commissioning: I confirm that the information provided is accurate and complete. **Signed by** [Name] NHS England Regional Director of Commissioning Signature (insert scanned image of handwritten signature)

Date: Click or tap to enter a date.

For completion by the relevant NHS England Regional Director:

Based on the information provided, I am satisfied that the ICB will be ready to proceed to delegation in April 2023.

Please check box as appropriate.

Yes ☐
No ☐

Please provide any further comments below if 'No' has been selected and summarise the rationale behind this decision:

Signed by

[Name]

Regional Director

Signature (insert scanned image of handwritten signature)

Date: Click or tap to enter a date.

Annex 1: Pre-Delegation Assessment Framework: Pharmaceutical services, General Ophthalmic services and Dental services (primary, secondary and community)

Introduction and Context

In May 2022, NHS England set out its intention to delegate responsibility to all ICBs for all pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) (known collectively as 'POD services') in April 2023. Details of this have been set out here.

The pre-delegation assessment framework (PDAF) has been developed to support ICBs to prepare to take on POD services from April 2023. A separate PDAF for specialised services has been developed. This has been aligned to the POD PDAF but has been tailored specifically for specialised services commissioning.

The POD PDAF for the 2023 delegations is based on the Framework that was used to assess ICSs that wished to take on these functions in 2022. The Framework is structured around four domains with underpinning criteria that set out the minimum standards which should be met by ICBs prior to delegation in April 2023. The PDAF should be viewed alongside the Safe Delegation Checklist that has been developed to provide further details on the specific tasks and activities that will be required to support delegation against the four domains.

Each ICB will be required to complete the assessment proforma above with the support of their NHS England regional team. Regional teams will need to approve each ICB's submission and assessment of risk before the completed proforma is submitted nationally. These submissions will be reviewed by a National Moderation Panel in October 2022 which will provide a recommendation to the NHS England Board for formal approval on 1 December 2022.

Principles of Pre-Delegation Assessment Framework

Domain	Principle
Transformation and Quality	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes, deliver improved care quality, reduce health inequalities, improve preventative capacity, and increase efficient use of resources.
	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and Leadership	Governance enables safe, high quality delivery.

	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	There is an understanding of budgets and expenditure for other primary care services and an agreed plan for managing financial risks identified.
Workforce and Capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.

Domains and criteria

The principles detailed above have informed the development of underpinning criteria across the four domains. These criteria describe the plans, governance and activities that ICBs will need in place or to have undertaken prior to assuming responsibility for the functions in April 2023.

1. Transformation and Quality	
Domain description	**Criteria**
ICBs will have clear, feasible plans to improve population health outcomes which are compatible with the use of the delegated functions. These plans will be underpinned by realistic and sustainable financial assumptions, integrated with existing ICB plans and reflect patient priorities and engagement.	The ICB has plans which demonstrate how it could use the functions to improve population health, deliver improved care quality, reduce health inequalities, improve preventative capability, co-produce services with patients, and increase efficient use of resources.
	The ICB has demonstrated an understanding of how the functions could be integrated into wider pathways, including interfaces with provider collaboratives, for patient benefit. It will also demonstrate how this transformation aligns with national policy where appropriate.

2. Governance and Leadership	
Domain description	**Criteria**
ICBs will have a clear governance structure in place. This must involve the expertise necessary to scrutinise individual functions, and to oversee integrated planning and service development encompassing multiple functions. ICBs will determine whether the	The ICB will have clear governance and accountability structures covering every stage of the planning cycle.
	The ICB will have developed governance and accountability structures to make

decisions made on particular functions should be at system or place level, and develop governance accordingly. Clinical leadership should be robust and embedded throughout. Engagement mechanisms should enable people who use services to influence commissioning decisions.	decisions at the appropriate level for each function.
	The ICB will have sufficient expertise (clinical, operational, and financial and strategic) embedded in its governance and accountability structures to ensure that each function can be adequately overseen, including having robust impact assessment processes.
	The ICB will have robust governance processes that allow for the effective identification, evaluation, escalation, recording and monitoring of risk.
	The ICB will have cross-functional governance and accountability structures which can oversee integrated pathways, and which align with other stakeholders to support integration and co-commissioning.

3. Finance	
Domain description	**Criteria**
The ICB will have a plan to deliver financial objectives for the delegated POD functions	The ICB will have an understanding of allocated budgets and expenditure on other primary care services for 2022/23 and 2023/24.
	The ICB will have undertaken a financial risk assessment.
	The ICB will have developed a plan to mitigate financial risks identified.
	Additional criteria placeholder

4. Workforce, Capability and Capacity	
Domain description	**Criteria**
The ICB will assess the capability development and capacity needed to deliver the function, and to ensure a smooth transition for staff (in alignment with the applicable regional workforce model). The workforce model enables population health benefits. Evidence of consideration of the wider needs of staff – for example,	The ICB has assessed its current workforce capabilities through a People Impact Assessment (or similar) and future needs, demonstrating that it has, will possess, or will have access to sufficient resource, capability, and capacity to commission the delegated functions. This may incorporate assumptions on the number of staff already supporting the delegated functions required

OD and cultural integration – will be necessary.	now and in the future, and the mechanism for deploying them to align with the benefits identified.
	The ICB will map (where appropriate) where external support will be needed, and how this is expected to evolve over time. This may imply CSU support, shared services between ICSs, or interfacing with NHSEI regions to provide assurance in relation to their workforce capability to deliver delegated functions.
	The ICB will have developed an understanding of how transitioned staff will integrate into existing teams; the ICB's application for delegation will be based on utilising an employment model(s) from the HR Framework.
	The ICB will have aligned the development of new staffing capabilities and the integration of staff with broader OD and change management processes, connecting with any initiatives and stakeholders which will enable integration including where appropriate with wider stakeholders.
	The ICB will have demonstrated that its senior leadership has appropriate capability, capacity, and information. Robust clinical leadership should be demonstrably established.