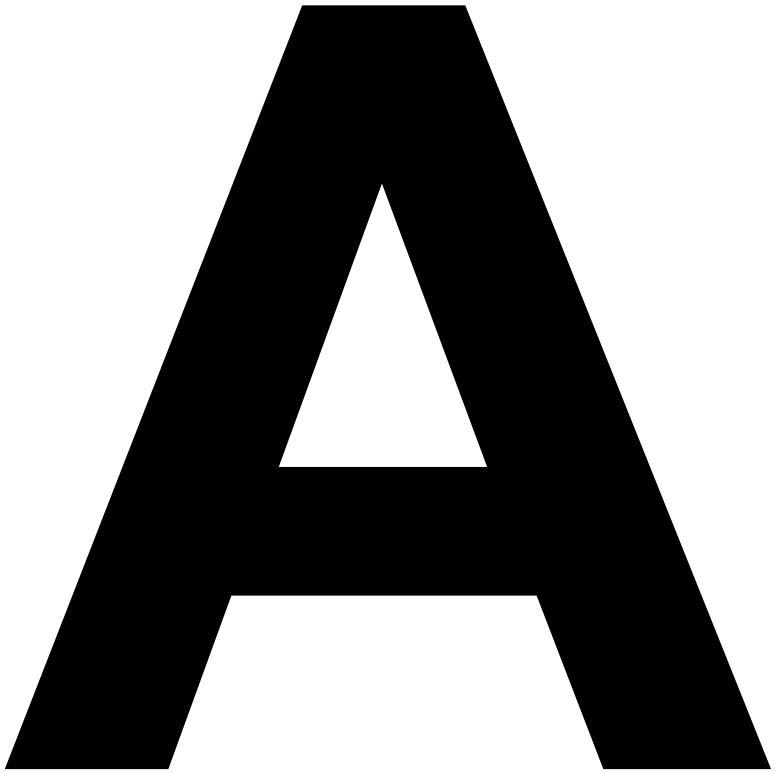
Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 13 October 2022**
Meeting no.	**4**	**Time**	**Meeting in public: 9:00am – 11:00am** Confidential:11:00am – 11:30am
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/22/51	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/22/52	Apologies for Absence: • Simone Jordan • Caroline Trevithick • Richard Henderson (Ben Holdaway deputising)	To receive	David Sissling	**Verbal**	9:00am
ICB/22/53	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/22/54	Declarations of Interest	To receive	David Sissling	**Verbal**	9:00am
ICB/22/55	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/22/56	Minutes of the meeting held on 11 August 2022	To approve	David Sissling	**A**	9:15am
ICB/22/57	Matters arising and actions for the meeting held on 11 August 2022	To receive	David Sissling	**B**	
ICB/22/58	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/22/59	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/22/60	An integrated delivery plan for the second half of 2022/23	To approve	Andy Williams	**C**	9:40am
OPERATIONAL					
ICB/22/61	Leicester, Leicestershire and Rutland Better Care Funds 2022/23	To approve	Rachna Vyas	**D**	10:10am
ICB/22/62	LLR System Finance monthly report (month 5)	To receive	Caroline Gregory	**E**	10:20am
ASSURANCE					

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/22/63	Assurance report from the Finance Committee	To receive	Cathy Ellis	**F**	10:30am
ICB/22/64	Assurance report from the Quality and Safety Committee	To receive	Prof Azhar Farooqi	**G**	
ICB/22/65	Assurance report from the System Executive Committee	To receive	Andy Williams	**H**	
ICB/22/66	Assurance report from the Audit Committee	To receive	Darren Hickman	**I**	
ICB/22/67	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi	**J**	
GOVERNANCE					
ICB/22/68	Mandated amendments to the ICB Constitution	To approve	Sarah Prema	**K**	10:50am
ICB/22/69	Review Board forward planner	To approve	David Sissling	**L**	
ANY OTHER BUSINESS					
ICB/22/70	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:00am

The next meeting of the LLR Integrated Care Board meeting will take place on Thursday 8 December 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 11 August 2022
9:00am – 11:15am, Via MSTeams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Ms Caroline Gregory	Interim Chief Finance Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Dr Caroline Trevithick	Chief Nursing Officer, NHS LLR ICB
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Ms Simone Jordan	Non-Executive Director
Ms Pauline Tagg	Non-Executive Director
Professor Azhar Farooqi	Non-Executive Director
Mr Darren Hickman	Non-Executive Director
Mr Jon Melbourne	Partner Member - acute sector representative (Chief Operating Officer, University Hospitals of Leicester NHS Trust) (deputising for Richard Mitchell)
Ms Angela Hillery	Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust))
Mr Mike Sandys	Partner Member – local authority sectoral representative (Director of Public Health, Leicestershire County Council)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)
Mr Martin Samuels	Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City Council)
Professor Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB

Participants:

Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire
Ms Cathy Ellis	Chair of Leicestershire Partnership Trust (for item ICB/22/45)
Cllr Sam Harvey	Chair, Health and Wellbeing Board, Rutland County Council

In attendance:

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

13 members of public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/22/32	**Welcome and Introductions** Mr David Sissling welcomed everyone to the meeting of the NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB). He particularly welcomed Caroline Gregory, Interim Chief Finance Officer to her first meeting. The meeting was being held in public and was quorate.	
ICB/22/33	**Apologies for absence from Members and Participants:** Apologies for absence were received from the following: <u>Members</u> • Richard Mitchell (Jon Melbourne deputising) <u>Participants</u> • Richard Henderson, East Midlands Ambulance Service (EMAS)	
ICB/22/34	**Notification of any other business**	

ITEM		LEAD RESPONSIBLE
	The Chair had not been notified of any other items of business.	
ICB/22/35	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items. The Register of Interests is published on the ICB website and will continue to be updated.	
ICB/22/36	**To consider written questions received in advance from the Public in relation to items on the agenda** Mr Sissling thanked Mr Haq who submitted questions in advance of the meeting. Mr Williams provided responses as set out below. <u>Questions received from Zuffar Haq</u> *1. What has happened to the winter plan. I thought it was supposed to be coming in August.* Mr Williams explained that intensive preparations for winter were underway. The winter plan would cover a range of areas including vaccinations, demand management, system flow, discharge, capacity and communication. A number of schemes and initiatives were already being progressed. Many of these were outlined in the report from the System Flow Partnership. The detailed winter plan would be completed in September with appropriate discussion at the September and October Board meeting. *2. The GP patient survey has LLR seventh worst out of 42 ICS systems. What are the plans to change this?* In introducing his response, Mr Williams commented that Primary care and General Practice remain under significant pressure in responding to increasing demand. In May 2022 (latest validated data) 581,287 appointments were provided, with 72% of these face to face across LLR. This represented progress against previous activity levels, but challenges remain. Mr Williams explained that the ICB Primary Care Transformation Board has used the results of the survey and those carried out by Healthwatch to design an improvement plan. The plan focusses on improving access, appointment arrangements and service delivery models. Appropriate attention was being given to workforce and public engagement. Whilst seventh in the table referenced, the article does draw a correlation between the number of GPs per capita and the experience of patients. The LLR position of 61.35 GPs per capita is lower than that of the higher performing systems. It should also be noted that many of the results, particularly regarding the quality of care provided by our practices, show a positive position against the national average. Mr Williams welcomed the detailed report on primary care which was on the agenda for discussion later in the meeting.	

ITEM		LEAD RESPONSIBLE
ICB/22/37	**Minutes of the LLR NHS Integrated Care Board meeting held on 14 July 2022 (Paper A)** The minutes of the LLR NHS Integrated Care Board meeting held on 14 July 2022 were approved as an accurate record. Ms Harsha Kotecha advised that she was present at the previous meeting. The minutes will be amended to record this. **It was RESOLVED to:** • **APPROVE** the minutes of the LLR NHS Integrated Care Board held on 14 July 2022.	
ICB/22/38	**Matters arising and actions for the meeting held on 14 July 2022 (Paper B)** The action log was reviewed, and progress noted. **It was RESOLVED to:** • **RECEIVE** the actions from the LLR NHS Integrated Care Board held on 14 July 2022.	
ICB/22/39	**Update from ICB Chair** Mr Sissling confirmed that formal Board meetings will be held on a bi-monthly basis going forward, with Board development sessions held in the intervening months. Mr Sissling outlined plans for the first face-to-face session with members of the public on 8 September 2022. This would offer an opportunity for detailed discussion on a range of subjects with a focus on primary care at the first meeting. Board members confirmed their support for the development sessions. Mr Sissling requested suggestions for future topics. In response Ms. Tagg proposed a review of the risk appetite which exists across the system. It was also suggested that the Board reviews the developing strategic plans towards the end of 2022. Mr Sissling noted the first meeting of the Health Equity Committee would take place on 16 August 2002. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/22/40	**Update from ICB, Acute Sector, Mental Health and Community Sector** Mr. Williams drew attention to the continued challenge of improving elective wait times. He acknowledged the hard work and sustained effort from colleagues in achieving a 96% reduction in the longest waiting patients over the past 12 months. It would be important to maintain this path of improvement into the second half of 2022. Mr. Williams commented on the developing collaborative work to offer responses to the cost-of-living pressures. These were being taken forward through the Health and Wellbeing Partnership and individual organisations. Mr Williams had met representatives of the Local Dental Committee recently. This had provided a helpful opportunity to explore some of the challenges facing dental practices.	

ITEM		LEAD RESPONSIBLE
	Finally, Mr Williams referenced the later Board report regarding the planned delegation of commissioning functions for pharmacy, dentistry and optometry from NHS England. Work was progressing with strong collaboration across the five East Midlands ICBs. Ms Hillery spoke of the unprecedented pressures on mental health services, with high levels of inpatient occupancy. This pressure was common nationally and was, for example, presenting challenges in securing specialist placements. Ms. Hillery emphasised the commitment and many contributions of LPT to the design and mobilisation of the winter plan. The Trust was particularly conscious of the pressures on staff and was taking wide ranging action to offer support. . Ms Hillery also praised the positive work which is evident in relation to Learning Disability services. This work involved Local Authorities and regional partners. Mr Melbourne offered his thanks to staff and colleagues within UHL and to regional partner who had offered peer support to enable the reduction in long waiting patients. Mr Melbourne reported on the proactive work undertaken to support patients to attend outpatients through a patient-initiated follow up (PIFU) pathway. This offered flexibility and would support work to address inequity. Ms Underwood requested that attendances for appointments be maximised by undertaking a number of activities in a single visit as opposed to multiple attendances. Schemes to support staff health and wellbeing continue at UHL including food banks on all sites and the provision of affordable meals. Mr Sissling thanked all for their updates. **It was RESOLVED to:** • **RECEIVE** the report.	
ICB/22/41	**Update on LLR Primary Care – Current position, plan and strategy (Paper C)** Dr Nil Sanganee introduced the discussion, highlighting the critical importance of primary care services at a practice and PCN level. He provided an overview of the pressures and challenges being faced- many associated with increasing demand and patient expectations. He also set out a range of opportunities, some of which were highlighted in the recent Fuller review. These related to prevention, community teams, estates and care delivery models. Dr. Sanganee emphasised some of the workforce challenges which were particularly acute in Leicester City. An effective response would require new workforce contributions and some targeted action.	

ITEM		LEAD RESPONSIBLE
	Dr Sanganee also highlighted the importance of the primary care estate. A review had been undertaken which indicated significant need for improvement-both in relation to the capacity and the quality of practice premises. A primary care estates strategy has been developed. Dr Sanganee confirmed that work on a comprehensive primary care strategy was progressing and would be submitted to the Board within the next 6 months. Mr Sissling thanked Mr Sanganee and colleagues for an excellent report. He invited comments and questions. Board members raised a number of points: • Almost half the population of Rutland are registered with a GP Practice outside of the county due to the proximity and accessibility of practices. This would need specific consideration in the strategy. • In light of the very significant workforce pressures in Leicester city there would be a requirement for targeted action. This would need to cover both recruitment and retention aspects. • The neighbourhood model as proposed in the Fuller report needs to fine tuned for LLR localities and progressed with pace. • Digital solutions need to be pursued but require appropriate funding and should be preceded by effective engagement with Primary care teams. • Plans to improve access need to be sensitive to the experience of patients and in particular the ease or difficulty of making appointments. • Effective metrics and impact indicators need to be in place focussing as far as possible on outcomes. Mr Sissling thanked everyone for a detailed discussion on this item. It was agreed that the draft Primary Care Strategy would be received by the Board in November 2022. The final version of the Primary Care Strategy to be presented in February 2023. **It was RESOLVED to:** • **NOTE** the contents of the report that provided a comprehensive overview of Primary Medical Care • **NOTE** the complexity challenges which exist in relation to achieving necessary improvement. • **ACKNOWLEDGE the commitment of all those working in Primary care and the many areas of good practice.** • **AGREE** to receive the final version of the Primary Medical Care Strategy for the ICB in 6 months' time at the ICB Board.	**Nil** **Sanganee**
ICB/22/42	**LLR System Flow Partnership – briefing (Paper D)** Mr Jon Melbourne and Ms Rachna Vyas 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. It was noted that four external reviews had been undertaken over recent months. These provided opportunities to learn and make improvements. In addition, opportunities to share best practice from within LLR and the wider region are being explored.	

ITEM		LEAD RESPONSIBLE
	Attention is being given to all key aspects of patient flow and in particular; preadmission, EMAS to UHL interactions, flow within hospital and discharge. Detailed analysis has confirmed the need for additional capacity. This will be a blend of beds in acute and non-acute stings. There will also be an expansion of virtual beds. Options to enable associated investment are being progressed. The winter plan was in the process of being finalised and would be presented to the September and October Board meetings. Mr Sissling gave his thanks for the report and for all that was being done to address the significant challenges. **It was RESOLVED 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 finalise the winter plan and commend the strong underlying collaboration across the NHS and with Local Government.	**Rachna Vyas / Jon Melbourne**
ICB/22/43	**Elective Care Plan (Paper E)** Mr Melbourne reported the 104-week wait target for the end of July had been achieved. There were no capacity breaches. This was a very positive achievement. Work is now needed to address relevant complex cases and those delayed because of patient choice. Plans to eliminate long waits over 78 weeks were being implemented. Mr Melbourne described the position in relation to cancer diagnosis and treatment. This was challenging but there were positive indications of improvement in respect of the 62-day standard. Mr. Melbourne emphasised the importance of the LLR elective care strategy. This needed to be aligned with the winter strategy with work in progress to enable this. Mr Sissling expressed his thanks for the work undertaken to deliver 104-week wait milestone target. This provided confidence that future targets could be achieved although there was now a requirement for further operational and strategic planning. The Board looked forward to receiving the finalised elective care strategy. **It was RESOLVE to:** • **NOTE**: – And acknowledge the progress made on 104+ week RTT waits – The further work to develop an elective care strategy enabling sustained progress in elective waiting times.	
ICB/22/44	**System Finance:** **LLR System Finance Report – Month 3 (Paper F1)** Ms Gregory reported a £2.1m year to date surplus. This was a favourable variance against plan. However, caution needed to be exercised as significant risks remain and pressures on resource expenditure was anticipated to increase in the later months of the year.	

ITEM		LEAD RESPONSIBLE
	A thorough and systematic review of relevant risks was being undertaken by the ICB and Trust finance teams. These focussed on a range of issues including, realisation of CIPs, continuing health care, prescribing costs, operational pressures and spend on agency staff. Ms. Gregory reflected positively on the risk sharing agreement which had been developed. Ms Hillery emphasised the pressure on mental health services which was leading to increased expenditure to ensure appropriate provision. Enhanced agency and bank expenditure was being incurred. Mr Sissling summarised. The surplus position was positive but there were clear indications of underlying risk. Appropriate early responsive action is required. This would feature strongly in the Board development session in September. **It was RESOLVED to:** • **RECEIVE and NOTE** the attached report which is a summary of the month 3 system financial position. **LLR ICB Risk Sharing Approach (Paper F2)** Ms Gregory advised the risk share approach had been through constituent Boards for approval and had been embedded into contracts. The approach is in line with the commitment to system working and encouraged the sharing of benefits and risks. The arrangements will be monitored through the LLR ICB Finance Committee. **It was RESOLVED to:** • **APPROVE** the Risk sharing agreement in place for 2022/23.	
ICB/22/45	**Report from the Finance Committee (Paper G)** Ms Ellis introduced the report which offered an assessment of risk against key priorities. The revenue position was satisfactory in respect of year-to-date performance, but the Committee supported the work to take stock and strengthen the plans for the second half of the year. Ms Ellis advised the board that capital spend was behind schedule. The Committee would continue to monitor this issue and the mobilisation of plans to expedite or re-prioritise capital expenditure. Ms. Ellis explained that the Committee noted the extent of transformational work but remained concerned that this was not translating consistently into quantifiable outcomes. Finally, Ms. Ellis commented on the positive progress being made by UHL towards a position where it could exit from the recovery support programme. Mr Sissling thanked the Committee for its work. He proposed a longer discussion and assessment of the transformation programmes take place. **It was RESOLVED to:** • **RECEIVE** for assurance the LLR ICS Finance Committee Highlight Report.	

ITEM		LEAD RESPONSIBLE
ICB/22/46	**Assurance Report from the System Executive (Paper H)** Ms Hillery advised that she had chaired the meeting in Mr Williams' absence; future arrangements would see Dr Trevithick take the chair in his absence. The performance reporting approach was being refreshed. An integrated approach was proposed covering performance, finance, quality and workforce. The System Executive would receive the revised report in late August. Ms Hillery highlighted key developments and initiative set out in the report. These covered a range of areas including contractual matters, service developments and the vaccination programme. The Board supported the recommendations and noted the recommendation to proceed to procurement for the Non-Emergency Patient Transport Service. **It was RESOLVED to**: • **RECEIVE and NOTE** – the approval of the LLR ICB Mental Health Commissioning Plan for 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 o Improving Access to Psychological Therapies (IAPT) contract to achieve national targets o LLR Pulmonary Rehabilitation o Community Diagnostic Centre Business Case (Hinckley District Hospital) and o PCN Cardiorespiratory Diagnostics • **RECEIVE for assurance** the actions pertaining to the Performance Report • **NOTE** the recommendation to proceed to procurement for the Non-Emergency Patient Transport Service.	
ICB/22/47	**Report from the ICB Quality and Safety Committee (Paper I)** Ms Tagg introduced the report which covered a range of identified risk areas. In general terms the Committee would encourage a clinically led review of risk management and risk appetite considerations. Such a review should be taken forward on a system wide basis. Ms Tagg highlighted specific risks considered by the Committee. These generally related to areas which had been covered by previous reports and discussions. An example relates to ambulance handover with a significant risk in the community with ambulances unable to respond on a timely basis. The Committee was encouraged by the responsive action including an urgent and emergency care summit on 13 September. Mr Samuels responded to an issue raised by the Committee relating an unexpected cessation in local government commissioned care arrangements for children. These consequences could include a period in a hospital setting as a new placement was identified. Mr Samuels described the complex	

ITEM		LEAD RESPONSIBLE
	contractual and regulatory considerations which sometime existed. This subject would be reviewed by relevant partners to develop improved arrangements. **It was RESOLVED to:** • **RECEIVE** for assurance the LLR ICB Quality and Safety Committee Highlight Report.	
ICB/22/48	**Memorandum of Understanding - Leicester, Leicestershire and Rutland Integrated Care Board and NHS England (Paper J)** Ms Prema explained the MOU was similar to that signed by the ICB in shadow form last year. It set out how ICB would work with NHSE going forward. Whilst the MOU had standard, national elements there was scope to customise to reflect local priorities and circumstances. The MOU was supported in readiness for submission to NHSE. **It was RESOLVED to:** • **APPROVE** the Memorandum of Understanding between NHS Leicester, Leicestershire and Rutland Integrated Care Board and NHS England.	
ICB/22/49	**Pre-delegation assessment framework for 2023 delegations: Pharmaceutical Services, General Ophthalmic Services and Dental (primary, secondary and community) Services (Paper K)** Formal documentation is being prepared to provide assurance to NHSE regarding the ICB's readiness to assume delegation for Pharmacy, Optometry and Dentistry (PODs) and specialised services. Appropriate sub- regional hosting arrangements were envisaged. Ms Prema advised it was likely relevant committees would be in place for both East and West Midlands. Ms Prema sought support for the System Executive to sign off the Pre-delegation assessment framework in September. The Board provided support for the System Executive to approve the submission to NHSE. Mr Sissling reflected that the Board needed further information and insight into the relevant service areas and the associated commissioning challenges. Appropriate opportunities for Board discussion should be planned during the period prior to the delegation. **It was RESOLVED to:** • **SUPPORT** 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) • **SUPPORT** the proposed governance route for approval.	
ICB/22/50	**Any other business and review of business** The Chair was not notified of any other items of business. The meeting closed at 11.25am	

Date and Time of next meeting:
The next meeting of the NHS LLR Integrated Care Board will take place on **Thursday 13 October 2022** at 9:00 am via MS Teams. The meeting will be held in public.

B

NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care 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 13 October 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 / November 2022	This will be reviewed as part of a development session initially with an update to the subsequent Board meeting.	**Amber**
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**
ICB/22/41	11 August 2022	Primary Care update	Dr Nil Sanganee	Draft Primary Care Strategy to be presented to the Board in November 2022.	November / December 2022	Work in progress. Item on the forward planner.	**Amber**
				Final version of the Primary Care Strategy to be presented for approval in February / March 2022.	February / March 2023	Work in progress. Item on the forward planner.	**Amber**
ICB/22/42	11 August 2022	System Flow update	Jon Melbourne / Rachna Vyas	To provide an update at the next Board development session on progress and implementation of the actions following the four reviews into urgent and emergency care.	September 2022	**ACTION COMPLETE**	**Green**

C

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board - Public**		
Date:	13 October 2022	**Paper:**	**C**
Report title:	**An integrated delivery plan for the second half of 2022/23**		
Presented by:	Andy Williams, Chief Executive Officer, Integrated Care Board		
Report author:	Executive partners across NHS organisations		
Executive Sponsor:	Andy Williams, Chief Executive Officer, Integrated Care Board Richard Mitchell, Chief Executive Officer, University Hospitals of Leicester Angela Hillery, Chief Executive Officer, Leicestershire Partnership Trust		

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 approach to a successful 2022/23 delivery**

- **APPROVE the LLR Winter Plan specifically;**
  - Delegate the approval of the Winter Board Assurance Framework to the System Executive
  - Support engagement with a range of partners and our population about the Winter Plan

- **APPROVE and NOTE the LLR Elective Recovery Position specifically;**
  - Note the current position of elective recovery
  - Approve the responsibility of the Elective Recovery Board to manage the £39m funding allocation
  - Approve the underspend of £4.8m of Elective Recovery Fund to go against the financial deficit

- **RECEIVE and APPROVE the financial plan for the remainder of 2022/23 of which the Board is asked to:**
  - Endorse and agree to breaking even at the end of the current financial year
  - Endorse a review of £17m of investment funds to close some of the financial gap
  - Enact the Risk Share Agreement to address the remaining financial gap of £31m

Purpose and summary of the report:

This report provides the LLR Integrated Care Board with the operational proposals regarding the management of identified financial risk in the second half of the year, the continued work on elective recovery and the Winter Plan . These proposals have been developed between the ICB, UHL and LPT. They recognise the paramount importance of patient safety and the requirement to

maintain progress with elective recovery whilst implementing a comprehensive plan for the forthcoming winter months.	
Appendices:	Appendix 1 - Winter Plan
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.*	
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.	

CONTEXT

1. At the start of the financial year, NHS England asked all systems to develop operational plans that would deliver a number of key priorities for systems to deliver elective recovery, improve non elective care standards and achieve financial balance. Nationally a number of planning assumptions were provided to enable systems to build robust plans. NHS England also asked systems to consider any additional financial risks that might materialise outside of the national planning assumptions and to consider these separately.

2. At the half year stage, it is clear that many of the additional risks identified are materialising and some of the cost reduction areas are proving difficult to achieve. Consequently, a reset is required to develop further appropriate mitigations and/or to defer planned expenditure in other areas to achieve a break-even position.

3. This paper summarises three areas of work:

   - The Winter Plan
   - The Elective Recovery Plan
   - The Financial Plan

   These areas or work are inter-related with the delivery of a safe winter plan being a pre-requisite for the elective recovery plan and the financial plan flowing from this.

THE WINTER PLAN

4. The Winter plan is constructed on the basis for a whole-system demand and capacity model needed for a safe winter, ensuring that capacity is added to the right part of the system to ensure the best impact for our patients during winter.

5. The twenty key actions which make up the plan, which are included in Appendix 1 have been developed considering a range of national and local documents such as the recommendations from the Sturgess report, Missed Opportunities review, 100 day discharge challenge and the CQC urgent care pathway review.

6. The national directive for securing a safe and successful winter sets out 8 areas of national focus. These 8 areas of focus are included within the LLR Winter Plan.

7. Each ICB has also been asked to complete a further 'Board Assurance Framework' (BAF). This consists of the following components:

   a. A demand and capacity plan, outlining how the system will increase bedded and non-bedded capacity
   b. A self-assessment checklist against best practice
   c. A detailed improvement framework, covering every part of the health and social care system

This is expected to be submitted every four weeks. The Winter Board has scrutinised this BAF ensuring that any gaps within the improvement framework are addressed either directly by the Winter Plan actions or through other means, such as contracting mechanisms. Given the frequency of submission, it is recommended that the LLR System Executive will approve this prior to submission each month.

8. The LLR winter plan makes the following assumptions about demand and capacity:

    a. Predicted demand assumes a worst-case scenario, likely scenario and best-case scenario based on peak winter levels of activity and predicted patients waiting in the emergency department for a bed.

    b. The model includes potential ward closures due to Infection Prevention and Control measures of between 56 and 84 beds. These estimates are based on experience in previous years.

    c. A range of mitigations have been agreed through the winter plan including additional bedded capacity at UHL, LPT and across care home providers, additional non-bedded capacity in Home First services, including virtual wards, and additional capacity in primary care and mental health services. In the bed model, the impact of these mitigations has been cautiously approached to assume between a 50% and 75% impact of the total bed base.

    d. A model using the same assumptions has been built for LPT

9. In the best-case scenario the model shows that with mitigations we will have sufficient capacity to meet demand. In both the most likely scenario and the worst-case scenario the model shows a bed deficit, even with mitigations in place. Further work will be undertaken to review this bed gap and add further mitigations to enable the system to cope through winter.

10. A Winter SAGE group has been established to assess actual demand and make recommendations about levels of escalation. It will use the latest available data from the Australian flu season and our local and regional public health led predictive models, ensuring that the Winter Board has access to intelligence which can be used to support changes to service delivery.

11. The implementation of the Winter Plan will also require wider partner engagement such as Healthwatch, social care and our regulatory partners such as CQC. It is anticipated that subject to approval from the Board on the proposals wider engagement will commence in mid-October, along with a plan to communicate with our staff and population using lessons learnt from previous Winters and the COVID response.

ELECTIVE RECOVERY

12. The elective recovery is set over three years with key milestones, performance indicators and strategic intent.

13. LLR has made significant progress in 2022 to reduce 104 week waits, stabilise overall waiting lists and make significant improvements in cancer wait times. However, there are still substantial waiting lists for elective treatment. The plan sets out an approach to address this across 8 domains:

    a) Productivity improvements and constraints
    b) Outpatient transformation
    c) Pathway changes
    d) Validating waiting lists
    e) Increasing physical and staffing capacity
    f) Working with neighbouring areas (mutual aid)
    g) Maximising the value of the independent sector
    h) Use of the Elective Recovery Fund

14. The table below sets out the 22/23 LLR operational planning trajectories for key referral to treatment (RTT) standards and actuals to date. These trajectories were set at the beginning of 2022/23 and are currently under review to ensure these are adjusted according to actual delivery and the ambition to continue to improve the elective recovery.

Key Metrics	April	May	June	July	August	September	October	November	December	January	February	March
52+ Plan	14,491	14,218	13,341	12,431	11,975	11,722	11,518	11,311	10,822	10,269	9,980	9,555
Actuals	16,936	17,187	17,556	18,218	18,422							
78+ Plan	3,661	3,734	3,238	2,671	2,498	2,440	2,361	2,324	2,141	1,789	1,383	945
Actuals	3,625	3,754	3,438	3,483	3,400							
104+ Plan	847	655	482	351	203	0	0	0	0	0	0	0
Actuals	1,138	841	508	363	265							
Incomplete RTT PTL Plan	114,089	116,184	115,086	116,625	115,913	116,331	118,529	116,621	116,827	118,160	117,204	116,540
Actuals	122,516	122,999	123,196	124,467	127,608							

15. Since April 2022 a series of programmes of work have been implemented to improve the current performance against the referral to treatment metrics, including a strengthened approach to mutual aid, the use of the independent sector and implementation of Getting it right first time (GIRFT) principles.

16. The Elective Recovery Fund (ERF) is designed to support the NHS to move back to and beyond pre-pandemic levels of activity, eliminate long waits, improve access to diagnostics and deliver cancer standards. Almost £39m of non-recurrent revenue spend was planned for 22/23 on schemes to deliver the 8 interventions listed above. Value for money assessment and investment or disinvestment decisions are taken via the Elective Recovery Fund (ERF) Board and ratified by UHL and system executives.

17. Based on the current trajectory and realistic assessments of capacity, the view of the ERF Board is that the ERF plan will unavoidably underspend by £4.8m. This funding could be used to offset financial pressures.

FINANCIAL POSITION

18. During 2021/22 the system delivered a surplus of £15m split between UHL and the CCGs (LPT delivered breakeven) against an overall system budget of approximately £1.9 billion. This position masked the underlying (recurrent) financial challenge faced by the system for a number of reasons, most significantly:

    a) a substantial amount of COVID funding was received
    b) UHL were operating at below historic levels of elective activity
    c) System Top Up funding was received non recurrently

19. The financial and operational plan for 2022/23 assumed a number of investments and cost improvement programmes. So far in 2022/23 a number of investment programmes have already commenced:

    a. The System Development Fund has committed £33m to deliver improved patient care and transform the way this care is delivered across a range of services.
    b. The Elective Recovery Fund has committed over £30m to support the achievement of elective care targets through improved efficiency, increased capacity and sustainable delivery of elective care
    c. £45m has been invested across a number of priority areas such as Mental Health, hospital reconfiguration, substantive recruitment and reducing clinical risk
    d. £32m has been provided to support out of hospital capacity, community resilience over winter, increase in primary care activity and primary care funding to support addressing health inequalities.

20. In August 2022 ICB Board members were made aware of the review which had taken place to determine the level of financial risk facing the LLR system during the remainder of 2022/23 and potential mitigations to address this.

21. Further work has concluded that LLR ICS has financial risks of £88m of which the table below shows the mitigating position against this potential deficit.

£31m	Confident of delivery to achieve
£9m	Plans and some confidence of delivery against plan
£17m	Proposals for paused investment or underspend
£11m	Initially had limited mitigations in place but now deemed as not achievable
£20m	No mitigations in place

22. Adjusting for those schemes that have been rag rated as ‘green’ reduces the systems financial risk from £88m to £48m.

23. The £17m comprises a number of system wide programmes of work that we anticipate will have an underspend. This includes funding streams for elective recovery, system

development and partnership funding. It is proposed to use these opportunities to support cost pressures including those arising from the winter plan.

24. This leaves a £31m financial challenge. It is proposed to enact the System Risk Share Agreement to address this with each of the three statutory NHS bodies in Leicester, Leicestershire and Rutland taking a pre agreed share of this risk and developing plans within the organisations to achieve a break-even position.

25. The risk sharing arrangement distributes risk against the three NHS organisations on agreed percentages (based on turnover). If this is applied to the remaining gap of £31m, then the resultant shares would be: UHL £15.5m (50%), LPT £4.03m (13%) and ICB £11.47m (37%).

26. If the risk sharing agreement is enacted the organisational Boards (UHL, LPT and ICB) will be responsible for agreeing plans to achieve a break-even position

RECOMMENDATIONS

- **RECEIVE AND NOTE approach to a successful 2022/23 delivery**

- **APPROVE the LLR Winter Plan specifically;**
    - Delegate the approval of the Winter Board Assurance Framework to the System Executive
    - Support engagement with a range of partners and our population about the Winter Plan

- **APPROVE and NOTE the LLR Elective Recovery Position specifically;**
    - Note the current position of elective recovery
    - Approve the responsibility of the Elective Recovery Board to manage the £39m funding allocation
    - Approve the underspend of £4.8m of Elective Recovery Fund to go against the financial deficit

- **RECEIVE and APPROVE the financial plan for the remainder of 2022/23 of which the Board is asked to:**
    - Endorse and agree to breaking even at the end of the current financial year
    - Endorse a review of £17m of investment funds to close some of the financial gap
    - Enact the Risk Share Agreement to address the remaining financial gap of £31m

Appendix 1

NHS
Leicester, Leicestershire and Rutland

Planning for a resilient winter across the LLR health and care system

October 2022

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

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

NHS
Leicester, Leicestershire and Rutland

Planning for a resilient winter across the LLR health and care system

Introduction

This plan introduces the approach adopted by the Leicester, Leicestershire and Rutland Integrated Care System (LLR ICS) to plan for resilience across our health and care services through winter 2022/23. This plan is set in the context of what is predicted to be a difficult winter; all health and care services are expecting the negative impact of the cost-of-living crisis, fuel shortages, national industrial action and sustained surges in demand to impact on the resilience of services and therefore the patient and staff experience of receiving and delivering care across Leicester, Leicestershire and Rutland.

The LLR ICS has continued to work together to plan for this winter, using intelligence from patient and staff feedback, our own data modelling and that of public health, and best practice from other areas to implement as efficient and effective a system across health and care as possible within this context.

Objectives

To deliver the objectives set out in this Winter plan in a person-centred approach, the Winter Board has adopted a 'we' statement within the *Making it Real* framework. Our 'we' statement is:

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services"

This 'we' statement forms the fundamental ethos of the LLR Winter Board and each constituent collaborative.

The primary objective of the LLR Winter Board is to work in partnership to ensure people receive the right level of care in the right location this winter, enabling an improved quality of experience & outcomes and improved flow across departments, organisations, sectors and the LLR system.

The national requirements for a safe winter require every Integrated Care System to focus on eight areas:

1. Prepare for variants of **COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
2. Increase **capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3. Increase **resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.

4. Target **Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5. Reduce **crowding in A&E departments** and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6. Reduce **hospital occupancy,** through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7. Ensure **timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100-day challenge'.
8. Provide **better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

The Winter Board will meet its primary objective and these eight national objectives through delivery of this plan and the twenty priority actions detailed within it.

Delivery of these will ensure performance is as per trajectories for the six metrics outlined by the national winter directive:

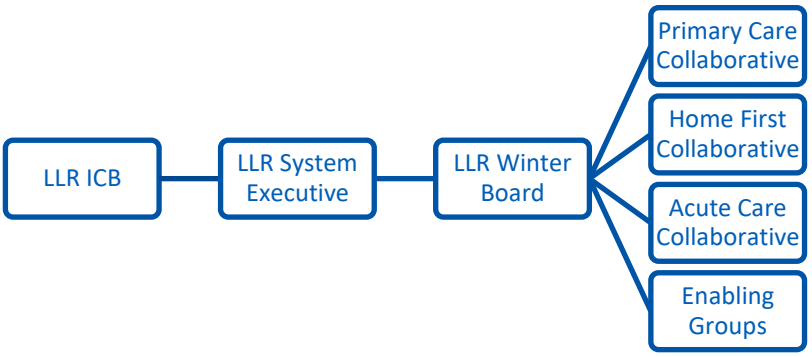
1. 111 call abandonment rates
2. Mean 999 call answering times
3. Category 2 ambulance response times
4. Average hours lost to ambulance handover delays per day
5. Adult general and acute type 1 bed occupancy (adjusted for void beds)
6. Percentage of beds occupied by patients who no longer meet the criteria to reside

Local trajectories for each of these are being agreed with NHS England as part of the winter planning process and will be finalised by the end of October

Delivery against these will also support the elective delivery plan for LLR, covering both elective care and urgent cancer care.

Governance & leadership

Effective leadership, agility of action and robust governance processes are essential components of this plan. This plan will be led by a weekly LLR Winter Board, under the leadership of Richard Mitchell, Chief Executive of Leicester Hospitals and will report on a monthly basis into the Leicester, Leicestershire & Rutland Integrated Care Board through the System Executive.



The Winter Board and the plan will be managed by the executive lead for winter, Rachna Vyas, Chief Operating Officer of the Integrated Care Board, in partnership with the leadership team for winter, comprising of the following:

Jon Melbourne, Chief Operating Officer, Leicester Hospitals
Sam Leak, Director of Community Health Services, Leicestershire Partnership Trust
Dr Nil Sanganee, Chief Medical Officer, LLR Integrated Care Board
Caroline Trevithick, Chief Nursing Officer, LLR Integrated Care Board
Ruth Lake, Director of Adult Social Care, Leicester City Council
Jon Wilson, Director of Adult Social Care, Leicestershire County Council
John Morley, Director of Adult Social Care, Rutland County Council
Ben Holdaway, East Midlands Ambulance Service
Stephen Bateman, Derbyshire Health United
Derek Laird, HTG (Transport Services)

The plan itself is set out in four areas, covering pre-hospital services, in-hospital services, post-hospital services and enabling services.

Pre-hospital actions will be led and delivered by the Primary Care Collaborative, led by Rachna Vyas	In-hospital actions will be led and delivered by the Acute Care Collaborative, led by Jon Melbourne	Post-hospital actions will be led and delivered by the Home First Collaborative, led by Sam Leak and Ruth Lake	Enabling actions will be led and delivered by various groups and overseen by Rachna Vyas

Each collaborative will report in the LLR Winter Board on a weekly basis, reporting on both actions taken to deliver 'inputs' and against the impact against the outcome originally modelled in the Winter Plan. This will enable the leadership team to assess and augment plans in an agile manner and will also consider the impact of as yet unknown scenarios such as industrial action.

Operating model for the Winter Board

The leads for each collaborative will meet weekly with Richard on **Wednesday** to confirm and challenge progress and agree reporting / any escalations to the Winter Board every **Friday**. The Clinical Executive will meet every **Tuesday** as needed to ensure decisions made through the LLR Winter Board are clinically safe and within appropriate governance.

A short set of papers will be circulated every Thursday, comprising of the following:

1. Key intelligence from national and regional departments
2. Performance against metrics
3. Escalations / actions required from partners to improve performance / achieve objectives of the 20 key actions
4. Support required from the LLR Clinical Executive

The full metrics / performance pack will be circulated as an appendix, for information only and a project management function will be in place.

Our approach to the Winter Plan

Our approach to winter planning this year has been data driven, using both historic and more recent trends to understand and model predicted demand through winter 22/23. Whilst this happens annually at UHL, this year we have taken the opportunity to demand model both LPT and social care so as to understand any clear capacity gaps and therefore align actions to mitigate against these. The process undertaken is outlined below.

1. Understand the whole-system **demand model and capacity needed** for 'safe winter', modelled on southern hemisphere flu experience and local pre-COVID / summer '22 demand

This has been modelled in a similar manner to the SAGE approach taken through COVID. System alert levels 0-4 have been built, with assumptions made on a range of occupancy levels, predicted demand, delivery of mitigations etc. Each scenario has then been tested at organisation level and at system levels, showing a fuller picture of where resulting gaps may be.

2. Cross reference the current urgent and emergency care plan with recommendations from other reports (such as the 100-day discharge challenge / CQC etc) and **agree priority evidence-based interventions**, mitigating gaps using monies allocated to system, whilst meeting the eight national requirements

Alongside this work, each ICB received a letter on August 12th *(Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter)* outlining eight actions for each system and six key metrics for measurement. The ICS has also recently received the CQC, Sturgess and Missed Opportunities' reviews and has been systematically working through delivery of each action; given this, our plans have considered most of the eight actions in the winter letter already. To enable a deliverable plan, the LLR Winter Board has prioritised actions from these and chosen to focus on those which fit local need.

3. Understand and define **triggers / actions for 'critical' scenarios** such as elective take down and actions to spread risk across the system

The Clinical Executive led a System risk summit on September 13th with the aim of ensuring the clinical leadership across the system were both clear on and have support to deliver the actions outlined in order to reduce the risk within the system. The Clinical Executive agreed that the actions in this plan are the correct actions and identified further support that the

clinical community would welcome to deliver fully – actions such as patient, resident and staff communications for example.

Each of these three components comprises the LLR winter plan.

The Winter Plan

Part One: Understanding demand and capacity

Detailed demand and capacity modelling has been undertaken, looking at various drivers of demand, including inflow into the Emergency department, length of stay in acute and community hospitals, variation by day of the week and time of the year and occupancy levels in both community and acute bed bases.

Summary of findings:

- Emergency Department and short stay admissions do not show seasonality in their activity demand
- Activity for emergency admissions for 3 days+ do show seasonality, especially 14+ days which showed a marked increase in winter 19/20 and a sustained increase throughout this year
- Weekday demand is higher than weekend demand
- Admission demand is predictable and regular between days of the week
- Emergency Department demand varies greatly and would be more difficult to predict
- Overall community bed demand is similar to 2019 with a growth in general medicine and reduction in other areas but average length of stay has increased
- Use of temporary care home beds (Pathway 2) has increased greatly since pandemic with average LOS doubled from 3 weeks to 6 weeks
- Longer lengths of stay have increased significantly; for example, patients with a length of stay of 32 days+ have increased by 34% in UHL and 53% in LPT compared to 2019, indicating a much higher acuity level
- Lack of capacity across the system is main driver of ambulance handover delays
- At snapshot date, 20 patients waiting 14+ days for pathways 1-3 (av. 3.6 day wait for pathway 1 and 3.1 day wait for pathway 2) suggests waiting for packages of care or care home placements is not the main driver of long lengths of stay

Following this local demand and capacity analysis, the learning from the Australian flu season was also analysed. UK winter bed demand has historically followed the Australian demand between four and five months later. 2022 has seen high admissions and an early flu season across the Southern Hemisphere; if 2022 follows previous trends, we'd expect peak impact in November to levels seen in 19/20 and therefore the November peak would likely be the peak of demand for LLR.

Based on this analysis, a range of bed bridges have been modelled, ranging from best case to likely case to worst case. In summary:

1. Predicted demand assumes a worst-case scenario based on peak winter levels of activity and predicted patients waiting in the emergency department for a bed. This provides a total predicted demand model of between 1984, 2007 and 2085 beds, with the particular pressure in Emergency Medicine and Cardio-respiratory.

2. The model includes potential ward closures due to Infection Prevention and Control measures of between 28, 56 and 84 beds. These estimates are based on experience in previous years

3. A range of mitigations have been agreed through the winter plan including additional bedded capacity at UHL, LPT and across care home providers, additional non-bedded capacity in Home First services, including virtual wards, and additional capacity in primary care and mental health services. In the bed model, impact has been modelled between 50% and 75% of the total impact which could be seen, ranging from 163 beds to 236 beds. 100% delivery would release 317 beds.

The scenarios modelled are summarised in Appendix A with the assumptions for each detailed alongside.

Testing the model

The model has then been tested against actual bed demand using the same methodology and assumptions in the UHL bed model.

- For April 22, the overall demand was 59 beds fewer (c.3%) than predicted, mainly in Emergency beds
- For May 22, the variance was less at only 4 beds higher (>1% variance) with Emergency demand lower than predicted and Elective demand being higher
- June 22 saw a much lower demand for beds than predicted (104 lower) with Emergency demand the driver (104 lower)
- July 22 also saw a lower demand than predicted, c. 5% lower again driven by lower emergency demand (-61) but also a lower Day Case demand (-17)

If this trend continues, then the winter forecast **may** be up to 5% lower than currently forecast. If we take into account, the 5% variance between the predicted demand and actual YTD then the bed gap outlined above is **likely** to narrow.

Regardless of the accuracy of the model, the Winter Board accepts that the current plan will not mitigate the full bed gap at the peak of demand without full delivery of the actions agreed, with further work needed to strengthen resilience against all scenarios.

Part Two: Actions agreed to mitigate the bed gap

The system has been working to improve the urgent and emergency care pathway for many years, with historic and systemic quality issues across the entire pathway. Improvements have been evidenced over the last two years, summarised below.

- The LLR system has one of the lowest ED attendance rates per 100,000 population, the lowest ambulance conveyance rate by a significant margin and one of the second lowest admission rates per 100,000 in the region. Importantly, the LLR system also

has the second highest number of available appointments in primary care, per 1,000 population, behind Lincolnshire in 2022. Almost 70% of these are now face to face appointments, an increase from 40% as the system emerged from the pandemic.
- The system also benchmarks well against 7-day, 14 day and 21-day length of stay patients; although this have grown significantly when compared to pre-pandemic levels.

However, 'criteria to reside' metrics show that whilst LLR is not an outlier in terms of numbers of patients awaiting care outside of provider trusts, reviews of the LLR system show that we have a mismatch in capacity and demand, impacting on optimal flow and outcomes for patients.

The actions prioritised therefore focus on four areas:

Primary care Collaborative

1. Increase uptake of flu and COVID vaccinations to > 70%, with a targeted focus on equity and high-risk groups
2. Risk stratify, identify and case manage respiratory patients most at risk of acute admission, linking to community RSV clinic and virtual ward pathway
3. Implement GP to consultant telephone discussions for all but immediate life-threatening referrals as per Sturgess recommendations
4. Assess and implement increase in UTC walk in capacity at Merlyn Vaz and Westcotes / assess impact of increasing Loughborough

Home First Collaborative

5. Open additional ward at LPT and assess potential of further opportunities
6. Understand gap in workforce, identify funding & agree recruitment timescales to increase Pathway 1 capacity
7. Assess utilisation and unblock usage of spot purchasing for pathway 2 capacity
8. Expand Unscheduled Care Hub to encompass all admission avoidance for non-life-threatening cat 2+ calls
9. Mobilise and increase utilisation of > 200 virtual ward beds in key specialties

Acute Care Collaborative

10. Design and implement pathway and model of care for UHL@Ashton, open additional capacity at LGH, and the discharge lounge at GGH
11. Design and implement model of care for the pre-transfer unit at the LRI
12. Assess and implement the North Bristol Model of care across UHL LRI and CDU
13. Implement ED/SDEC improvement plan
14. Extend MIAMI opening hours to midnight and increase utilisation to 125-150
15. Implement an efficient and effective discharge process within providers to enable simple discharges by 5pm and 85% of complex discharges same day

Other enabling actions

16. Design and implement an IPC risk management strategy across health and care to enable the spread of risk across the system whilst maintaining safety for patients
17. Implement fuel poverty plan in areas of high deprivation

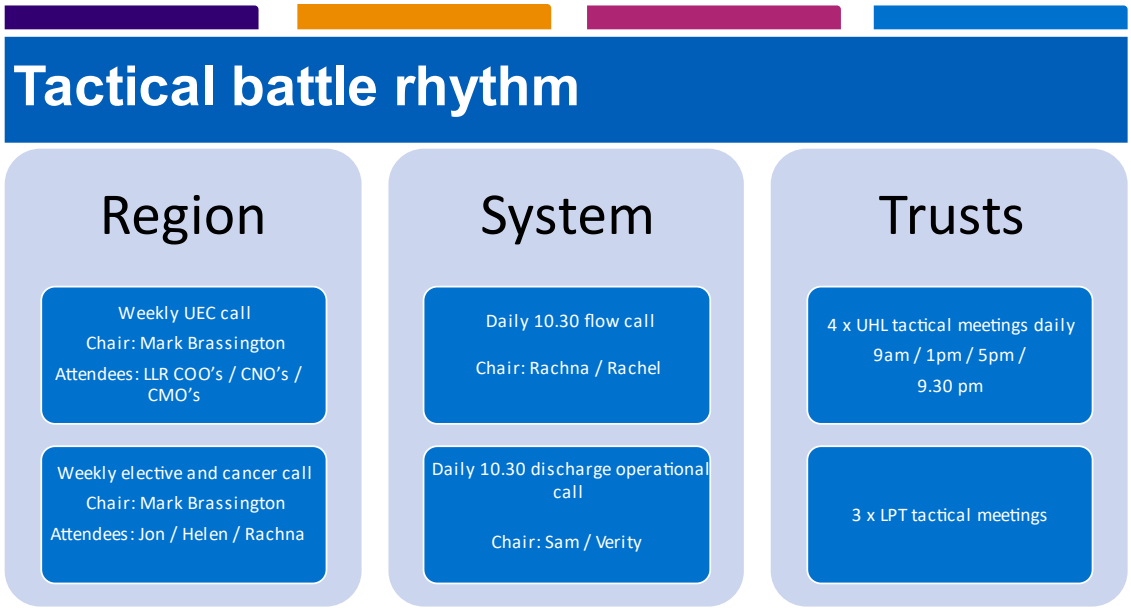
18. Increased 999 call handling establishment by 70 WTE, increasing to establishment of 210
19. Increased 111 call handling establishment by XX WTE, increasing to establishment of XXX (*numbers of WTE being quantified by lead commissioner)*
20. Implement mental health winter plan, focussed on preventative, pre- and post-acute mental health services

Each action has a management lead and a clinical accountable lead to ensure actions are not just delivered from an 'input' perspective but that the impact is evidenced and embedded. The full action plan is outlined in Appendix 2.

Part Three: The escalation plan

During peak demand, it is likely that the system will have to make tactical decisions to ensure patient safety. To enable this proactively, a set of system triggers for escalation have been developed and work is ongoing to agree this. Expected to be agreed by Clinical Executive in October.

The daily tactical operating rhythm remains in place across seven days a week, with all partners joining the system flow call daily at 10.30am. The current rhythm is as follows:



This has been strengthened with Executive oversight in place as needed, and with clear links to NHS England tactical arrangements.

Conclusion

This plan represents the actions this system knows will make a difference this winter; however, given the model laid out, it is clear that we will need to strengthen the plan further, together as a health and care system. Some of our metrics are improving as is our joint working as a single team. Despite this, this winter is likely to be exceptionally tough and we need to be actively aware of and managing the risks as they arise across the system.

The implementation of the Winter Plan will also require wider partner engagement such as Healthwatch and our regulatory partners such as the CQC. It is anticipated that wider engagement will commence in mid-October, along with a plan to communicate with our staff and population using lessons learnt from previous Winters and the COVID response.

The impact of the cost-of-living crisis and fuel / food poverty are largely unknown as yet - where possible using data from public health these have been modelled in but the full scale of impact is difficult to model accurately. The agility and ability to react therefore, at every level of the ICS, will be significant and the system will be reliant on partnership working at a scale seen only through the pandemic.

Appendix One – Winter Scenarios

	Level One	Level Two	Level Three
Predicted Bed demand	1934	1952	2024
Patients waiting a bed in ED	50	55	61
TOTAL DEMAND	1984	2007	2085
TOTAL CAPACITY	1765	1737	1709
Unmitigated Bed gap	-219	-270	-376
Mitigations	+317	+236	+163
Residual bed gap	**+98**	**-34**	**-213**
Assumptions	▪ 28 beds closed for IPC ▪ 5% lower emergency demand ▪ 90% elective occupancy ▪ 88% emergency occupancy	▪ 56 beds closed for IPC ▪ Emergency demand as per model ▪ 90% elective occupancy ▪ 90% emergency occupancy	▪ 84 beds closed for IPC ▪ 5% higher emergency demand + 5% higher LOS ▪ 90% elective occupancy ▪ 92% emergency occupancy

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Winter priority actions by collaborative

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Primary Care Collaborative

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Managerial / Clinical accountable lead	Timescale
W1	Targeted COVID and Flu vaccination programme	Increase uptake of flu and COVID vaccinations to > 70%, with a targeted focus on equity and high risk groups	(0 to prevent double count with admission avoidance)	LLR Vaccination Board / Primary Care Collaborative	Kay Darby / Caroline Trevithick	Jan 31st 2023
W2	Robust risk management of high risk respiratory patients	Risk stratify, identify and case manage respiratory patients most at risk of acute admission, linking to community RSV clinic and virtual ward pathway	(0 to prevent double count with admission avoidance)	Primary Care Collaborative	Arlene Neville / Dr Louise Ryan	Dec 31st 2023
W14	Efficient and effective GP > acute referral pathway	Implement GP to consultant telephone discussions for all but immediate life threatening referrals as per Sturgess recommendations	10 beds	Primary Care Collaborative	Sarah Smith / Dr Sulaxni Nainani	Dec 31st 2022
W15	Right size UTC walk in capacity	Assess and implement increase in UTC walk in capacity at Merlyn Vaz and Westcotes / assess impact of increasing Loughborough	volume of appts and walk-in % tbc	Primary Care Collaborative	Sarah Smith / Dr Nick Glover	Oct 31st 2022

Home First Collaborative

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W6	LPT step down capacity	Open one ward at LPT	18-24 beds	Home First Collaborative	Nikki Beacher / Dr Sudip Ghosh	Sept 9th 2022
W7	Pathway 1 capacity increase	Understand gap in workforce, identify funding & agree recruitment timescales	24-50 beds	Home First Collaborative	Fay Bayliss / Dr Ricky Inamdar	100% of staff in post by Dec 31st 2022
W8	Utilise all Pathway 2 capacity	Assess utilisation and unblock usage of spot purchasing	10 - 30 beds	Home First Collaborative	Fay Bayliss / Dr Ricky Inamdar	Sept 30th 2022
W17	Efficient and effective admission avoidance service	Expand Unscheduled Care Hub to encompass all admission avoidance for non -life threatening cat 2+ calls	20 beds	Home First Collaborative	Kerry Kaur / Dr Nicky Dosanjh	
W20	Efficient and effective admission avoidance service	Mobilise and increase utilisation of > 200 virtual ward beds in key specialties	68-95 beds	Home First Collaborative	Kerry Kaur / Dr Nicky Dosanjh	Specialty specific plans through 2022/23

Acute Care Collaborative

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W5	UHL capacity	Design and implement pathway and model of care for UHL@Ashton Open additional capacity at LGH Discharge lounge at GGH	24 beds + 16 beds + discharge lounge spaces	Acute Care Collaborative	Rachel Marsh	Ashton – complete Aug 22 LGH – complete 14/09
W11	Pre-transfer Unit	Design and implement model of care for the pre - transfer unit at the LRI	12 beds in ED	Acute Care Collaborative	Vivek Pillai	Expected December 22 (12 week lead time)
W12	Implement rapid push model from ED	Assess and implement the North Bristol Model of care across UHL LRI and CDU	---	Acute Care Collaborative	Vivek Pillai	Late Sept 22 (parts implemented early September)
W13	Efficient and effective ED/SDEC pathways	Implement ED/SDEC improvement plan	~10 beds	Acute Care Collaborative	Julie Dixon	Dec 31st 2022
W16	Right size UTC walk in capacity	Extend MIAMI opening hours to midnight and increase utilisation to 125 -150	---	Acute Care Collaborative	Sarah Taylor	Oct 31st 2022
W18	100 day discharge challenge	Implement an efficient and effective discharge process within providers to enable simple discharges by 5pm and 85% of complex discharges same day	5-10 beds	Acute Care Collaborative	Robin Binks	Oct 31st 2022

Other

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W3	Robust IPC / risk management across the system	Design and implement an IPC risk management strategy across health and care to enable the spread of risk across the system whilst maintaining safety for patients	---	Chief Nurse Forum / HETCG	Caroline Trevithick	31st Oct 2023
W4	Safeguard high risk patients from respiratory exacerbation due to fuel poverty	Implement fuel poverty plan in areas of high deprivation	(0 to prevent double count with admission avoidance)	Health Inequalities Board / Primary Care Collaborative	Mark Pierce / Dr Louise Ryan	Dec 31st 2023
W9	Increase in 999 call handling capacity	Increased call handling establishment by 70 WTE, increasing to establishment of 210	+70WTE	EMAS lead commissioner	---	210 WTE by Dec 31st 2022
W10	Increase in 111 call handling capacity	Increased call handling establishment by XX WTE, increasing to establishment of XXX	+XXWTE	DHU lead commissioner	---	XXX WTE by Dec 31st 2022
W19	Efficient and effective discharge process for mental health pathway	TBC		Mental Health Collaborative	Justin Hammond / Dr Graham Johnson	Oct 31st 2022

D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**13th October 2022**	**Paper:**	**D**
Report title:	**BCF Framework 2022/23**		
Presented by:	Rachna Vyas, Chief Operating Officer, LLR ICB		
Report author:	Mayur Patel, Head of Integration and Transformation, LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating 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:

- **REVIEW** and **APPROVE** the 3 BCF DRAFT Plans submitted on 26th September
- **NOTE** the approach taken, including the engagement & governance is as per annual arrangements and national requirements

Purpose and summary of the report:

1. BCF Planning Requirements and subsequent documents for the financial year 2022-2023 were released on July 19th, with a submission deadline of September 26th 2022.

2. For LLR, there were be 3 x BCF submissions – one for each of our Places (Leicester City, Leicestershire and Rutland).

3. Each submission had the following components:

   • A narrative plan
   • A completed BCF planning template, including:
   - planned expenditure from BCF sources
   - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
   - ambitions and plans for performance against BCF national metrics
   - any additional contributions to BCF section 75 agreements.
   • A demand and Capacity plan

4. Each set of documents has been agreed by each place governance structure, including engagement with lead councillors.

5. The Integrated Care Board members are asked to acknowledge engagement and governance process to date, and approve plans for all three Places.

Appendices:	• Appendix A – Leicester City BCF 2022/23 summary • Appendix B – Leicestershire BCF 2022/23 summary • Appendix C – Rutland BCF 2022/23 summary

Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• City ISOC – March 22/May 22/July 22/Sep 22 • City JICB – Sep 2022 • Leicestershire IDG – July 22/August 22/Sep 22 • Leicestershire JCG – Sep 22 • Rutland IDG – July 22/August 22/ Sep 22 • EMT – 26th September • ODG – 28th September

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.*	The BCF investments are aligned to BAF 01,02,03, 05, 10 and 14
b) Does the report highlight any resource and financial implications? If so, provide which	NHS LLR Minimum CCG contributions to the 2022-23 Better Care Fund and allocated uplift as identified in the NHS BCF guidance and framework issued on 19.07.2022

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.	The range of BCF investments across LLR are aimed at improving the quality of health and care services accessed by the residents of the system and at supporting the delivery of safe care. Quality Impact Assessments for individual services are undertaken by those services as part of the commissioning or service redesign process
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Public and Patient representation at the Integrated Systems of Care (ISOC), Integration Delivery Groups (Leicestershire and Rutland) Groups which oversees development of the BCF investment plans each year is through the Health Watch representative who sits on these groups. Periodically, a representative of the ICB Communications and Engagement team also attends these groups and reports on outcomes of the numerous patient and public consultations and engagements undertaken by members of the Integrated Care Partnership. Individual services or pathways are expected to include the views of those with lived experience as part of re-design or commissioning processes.
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.	Equality Impact Assessments for Individual services are undertaken by each service as part of the commissioning or service re-design services. It is anticipated that a refreshed BCF EIA will be undertaken as part of the BCF planning for 2023-25 which is due in November 2022.

Briefing Paper - BCF Framework 2022/23

Context

1. BCF Planning Requirements and subsequent documents for the financial year 2022-2023 were released on July 19th, with a submission deadline of September 26th 2022. Each plan has already been, or shortly will be approved by the relevant HWB (or its chair), CEO of Council and Accountable Officer of ICB prior to submission as per previous years, and as per the national governance requirements.

2. As we were already in M4 of H1 of 22/23, teams had already been mobilised to enable these deadlines to be met across each place, with a clear understanding that narrative will be written once where system programmes are referenced, with localisation for each section of the plan where required.

3. Our three Place submissions had the following components:

   • A narrative plan – this is mandatory and has been completed for each Place

   • A completed BCF planning template, including:

   - planned expenditure from BCF sources
   - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
   - ambitions and plans for performance against BCF national metrics
   - any additional contributions to BCF section 75 agreements.

   • A Demand and Capacity plan for those patients receiving intermediate care

4. For LLR, there were three BCF submissions – one for each of our places (Leicester City, Leicestershire and Rutland).

BCF income

	Leicester	**Leicestershire**	**Rutland**
ICB minimum NHS contribution	£28,134,913	£46,137,029	£2,655,018
Improved BCF grant	£17,556,473	£17,690,614	£218,818
Disabled Facilities Grant	£2,714,004	£4,447,227	£270,255
Total	**£48,405,390**	**£68,274,870**	**£3,189,091**

5. All three BCF templates, that detail the breakdown for the above allocations, were reviewed by the EMT members and EMT recommend the approval of the submission to the Board. A summary for each is appended to this report (see Appendices A – C).

Requirements

6. Each year, each BCF plan and template must demonstrate compliance against a set of national conditions. The BCF Policy Framework sets out the four national conditions that all BCF plans must meet to be approved. These are:

   a) A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board

b) NHS contribution to adult social care to be maintained in line with the uplift to CCG/ICB minimum contribution (5.66% for each of the 3 Places)
c) Invest in NHS commissioned out-of-hospital services
d) Implementing the BCF Policy objectives

7. Specifically for point (d) above, this national condition requires areas to agree a joint plan to deliver health and social care services that support improvement in outcomes against the fund's two policy objectives:
    - enable people to stay well, safe and independent at home for longer
    - provide the right care in the right place at the right time

8. In meeting the first objective, plans should describe how HWB partners should continue to focus on taking steps to promote independence, and address health, social care and housing needs of people who are at risk of reduced independence, including admission to residential care or hospital.

9. In meeting the second objective, HWB partners should continue to focus on making sure that people are supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes. This includes continued implementation of the High Impact Change Model for Transfers of Care, which is integral to meeting BCF requirements around supporting discharge.

10. In addition to the above, this year's submission also requires each Place to agree and submit a plan showing expected demand for intermediate care services in the second half of the financial year and the capacity across the HWB area to meet this expected demand. These capacity and demand plans require submission at the same time as main BCF plans (26th Sep).

11. This is the first time that capacity and demand plans have been required through BCF. As far as possible, we have used existing data and plans to ensure alignment. To model the H2 demand and capacity plans, work has been undertaken in partnership with the CSU (and other system partners) to bring together existing system metrics and trajectories to support the H2 planning. Trajectories for Q3 and Q4 have been agreed between partners.

Approach across health and care

12. Given the strength of our BCF submissions in previous years, our approach remains largely the same – where possible, system level narrative through each programme lead will be provided, with localisation where required. This year, once again, the system had the opportunity to learn from each of the 3 place based BCF programmes, taking the strength of each to continuously improve.

13. Each plan has described the alignment of BCF delivery plans with its Joint Health and Wellbeing Strategy and it priorities. This includes:
    - The life course approach
    - Action to reduce health inequalities
    - Actions to deliver improvements in the areas described in the CORE20Plus5 framework

14. Each plan has been localised and augmented by each place completing locally driven detail, including confirmation of compliance against the four national conditions.

15. For the data template, we have used metrics and trajectories associated with the relevant programmes which have been agreed by system partners (i.e. Discharge and Home First)

Governance process to date

16. Each place is still operating under slightly different governance arrangements; where possible, we have standardised the engagement with stakeholders such as our PCN Clinical Directors and Clinical Leads and elected members in each place, as well formal approval routes.

Governance arrangements	**Leicester City**	**Leicestershire**	**Rutland**
Draft plan sent to regional BCF team for preliminary review by Sep 1st	✓	✓	✓
Placed based Groups to receive for information	ISOC/JICB - ✓	IDG/JCG - ✓	IDG - ✓
HWBB approval (retrospective where applicable)	13th Oct 22:	22nd Sep 22: ✓	11th Oct 22:
Exec/Lead notifications	Rachna Vyas: ✓ Ruth Lake: ✓ Cllr Vi Dempster: ✓	Rachna Vyas: ✓ Jon Wilson: ✓ John Sinnott: ✓ Tracey Ward: ✓	Rachna Vyas: ✓ John Morley: ✓ Cllr Harvey: ✓

ICB arrangements	• 3 x Place leads to receive plans	✓
	• EMT to receive 1 Paper covering all 3 BCF Plans and financial templates on Monday 26th Sep	✓
	• Andy Williams to approve, following EMT paper on Monday 26th Sep (retrospective if applicable)	
	• Submit to ICB for retrospective sign off post submissions	

Recommendation

- **REVIEW** and **APPROVE** the three BCF Plans submitted on 26th September
- **NOTE** the approach taken, including the engagement & governance as per annual arrangements and national requirements

Appendix A

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Leicester

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,714,004	£2,714,004	£0
Minimum NHS Contribution	£28,134,913	£28,134,913	£0
iBCF	£17,556,473	£17,556,473	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£48,405,390**	**£48,405,390**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£7,995,144
Planned spend	£8,018,149

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£18,114,380
Planned spend	£18,265,488

Scheme Types

Assistive Technologies and Equipment	£365,545	(0.8%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£764,025	(1.6%)
Community Based Schemes	£3,262,386	(6.7%)
DFG Related Schemes	£2,714,004	(5.6%)
Enablers for Integration	£134,388	(0.3%)
High Impact Change Model for Managing Transfer of	£3,561,127	(7.4%)
Home Care or Domiciliary Care	£31,362,865	(64.8%)
Housing Related Schemes	£225,606	(0.5%)
Integrated Care Planning and Navigation	£1,138,306	(2.4%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£4,352,983	(9.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£93,679	(0.2%)
Prevention / Early Intervention	£373,761	(0.8%)
Residential Placements	£0	(0.0%)
Other	£56,714	(0.1%)
Total	**£48,405,389**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.3%	93.7%	93.0%	93.2%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	433	569

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.3%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Appendix B

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Leicestershire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£4,447,227	£4,447,227	£0
Minimum NHS Contribution	£46,137,029	£46,137,029	£0
iBCF	£17,690,614	£17,690,614	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£68,274,870**	**£68,274,870**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£13,107,300
Planned spend	£18,519,199

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£27,565,566
Planned spend	£28,124,346

Scheme Types

Assistive Technologies and Equipment	£714,000	(1.0%)
Care Act Implementation Related Duties	£858,150	(1.3%)
Carers Services	£1,803,388	(2.6%)
Community Based Schemes	£7,794,197	(11.4%)
DFG Related Schemes	£4,447,227	(6.5%)
Enablers for Integration	£1,133,699	(1.7%)
High Impact Change Model for Managing Transfer of	£3,570,389	(5.2%)
Home Care or Domiciliary Care	£28,185,741	(41.3%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£3,372,319	(4.9%)
Bed based intermediate Care Services	£859,158	(1.3%)
Reablement in a persons own home	£1,296,604	(1.9%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£9,204,193	(13.5%)
Prevention / Early Intervention	£175,065	(0.3%)
Residential Placements	£4,860,741	(7.1%)
Other	£0	(0.0%)
Total	**£68,274,871**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.2%	92.7%	92.7%	93.9%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	309	860

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Appendix C

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Rutland

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£270,255	£270,255	£0
Minimum NHS Contribution	£2,634,018	£2,634,018	£0
iBCF	£218,818	£218,818	£0
Additional LA Contribution	£45,000	£45,000	£0
Additional ICB Contribution	£21,000	£21,000	£0
Total	**£3,189,091**	**£3,189,091**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£752,021
Planned spend	£847,577

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£1,456,747
Planned spend	£1,683,705

Scheme Types

Assistive Technologies and Equipment	£65,000	(2.0%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£222,500	(7.0%)
Community Based Schemes	£837,367	(26.3%)
DFG Related Schemes	£270,255	(8.5%)
Enablers for Integration	£131,326	(4.1%)
High Impact Change Model for Managing Transfer of	£988,079	(31.0%)
Home Care or Domiciliary Care	£123,929	(3.9%)
Housing Related Schemes	£35,000	(1.1%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£74,150	(2.3%)
Reablement in a persons own home	£106,717	(3.3%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£276,768	(8.7%)
Residential Placements	£29,000	(0.9%)
Other	£29,000	(0.9%)
Total	**£3,189,091**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.4%	90.4%	90.4%	90.4%

Residential Admissions

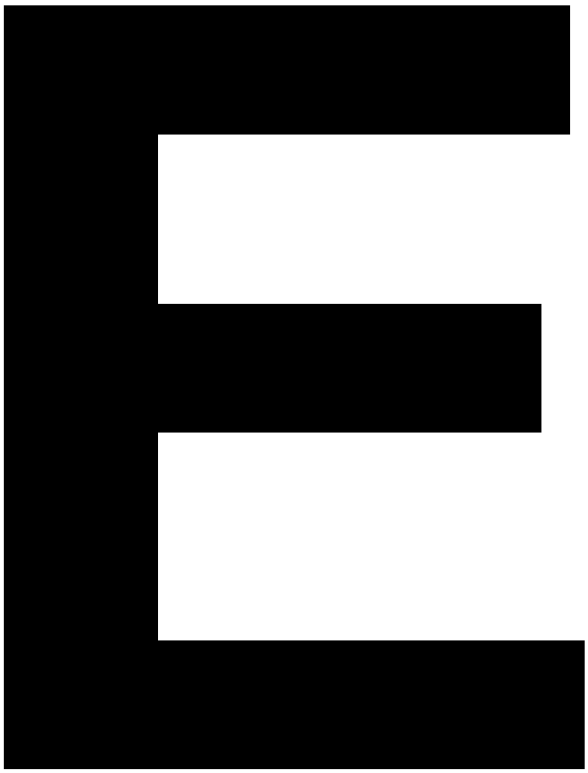
		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	503	281

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes



Name of meeting:	**Leicester, Leicestershire and Rutland ICB**		
Date:	13 October 2022	**Paper:**	**E**
Report title:	**Month 5 ICS Finance Report**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Liban Abdi/Spencer Gay		
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 5 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 5.

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

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

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

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	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.*	The whole report is regarding finance and the risk to delivery of a balanced financial plan.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	N/A
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	N/A
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	N/A
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	N/A

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

LLR ICS FINANCE REPORT

MONTH 5

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Executive Summary

- The overall year-to-date (YTD) system position is a deficit of £7.4m.
- UHL have reported a YTD deficit of £4.3m which is a £1.5m favourable position against the current plan whilst LPT have reported a YTD deficit of £2.6m, a £1m adverse position against their YTD plan.
- The ICB have formally reported a £2.1m YTD deficit against a break-even plan although this comes down to a £0.5m deficit after the reimbursement for primary care additional roles.
- All organisations have formally forecasted break-even positions for the year to NHSE.
- 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 summary of the net risks within the system position highlights the risk of the system heading towards a deficit position.
- Mitigations are being determined to aim to deliver a breakeven position.
- The system has planned efficiencies of £70.7m of which we are currently forecasting £65.7m delivery. A further £26m of system-wide cost avoidance and income generation plans were identified at the planning stage but not included in organisational plans as efficiencies. More detailed analysis of the system efficiency position is provided in the PMO report.

M5 System Position

	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Annual Budget £'000	Annual FOT £'000	FOT Variance £'000
UHL Outside System Income	230,573	235,392	4,819	557,085	557,085	0
LPT Outside System Income	27,863	30,422	2,559	65,470	71,475	6,005
Provider Income Outside of System	**258,436**	**265,814**	**7,378**	**622,555**	**628,560**	**6,005**
ICB Allocation	**811,530**	**813,935**	**2,405**	**1,940,952**	**1,941,757**	**805**
Total System Allocation	**1,069,966**	**1,079,749**	**9,783**	**2,563,507**	**2,570,317**	**6,810**
UHL Expenditure	(564,309)	(567,657)	(3,348)	(1,343,356)	(1,343,356)	0
LPT Expenditure	(146,796)	(150,338)	(3,542)	(346,450)	(352,456)	(6,006)
Provider Expenditure	**(711,105)**	**(717,995)**	**(6,890)**	**(1,689,806)**	**(1,695,812)**	**(6,006)**
ICB Expenditure Outside of System	**(367,570)**	**(370,487)**	**(2,918)**	**(873,948)**	**(874,752)**	**(805)**
Total System Expenditure	**(1,078,675)**	**(1,088,483)**	**(9,808)**	**(2,563,754)**	**(2,570,564)**	**(6,810)**
Intra-System Misalignment	1,360	1,360	0	247	247	0
System Surplus/(Deficit)	**(7,349)**	**(7,374)**	**(25)**	**(0)**	**0**	**0**

UHL have reported a year-to-date deficit of £4.3m against a YTD plan of £5.8m deficit; a favourable variance to plan of £1.5m. Several factors have contributed to this position such as ERF spend being lower than planned along with greater levels of income generated from private sources.

LPT have reported a £2.6m YTD deficit against a YTD planned deficit of £1.6m. This adverse variance of £1m continues to be driven by higher levels of acuity leading to higher agency staffing requirements. A comprehensive programme to reduce reliance on agency staff is underway and initial signs of improvement are visible in the month 5 agency run-rate.

The ICB has reported a £2.1m YTD deficit against a break-even YTD plan. Additional roles reimbursement of £1.6m is expected to bring this deficit down to £0.5m. The movement from a surplus position in M4 to a deficit in M5 is as a result of updated out of county acute contract values and acceleration of SDF schemes.

All organisations have at M5 reported a break-even forecast position. Work is being undertaken to establish the level of risk in the reported position that needs mitigating in order to deliver break-even position.

There is a slight intra-system misalignment at M5. Work will be undertaken as part of the M6 agreements of balance exercise to resolve this.

Run-Rate

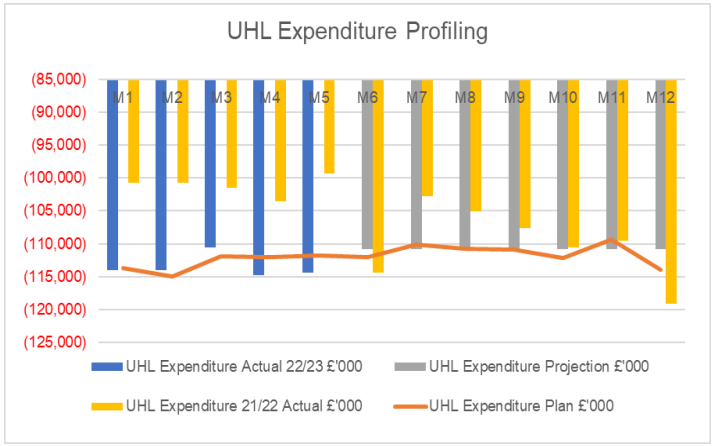
	Annual Position		Straight Line Run-Rate	
	YTD Actual £'000	FOT £'000	Run-Rate FOT £'000	Variance £'000
UHL - Income	563,352	1,343,356	1,352,045	8,689
UHL - Pay	(340,120)	(810,354)	(816,289)	(5,935)
UHL - Non-Pay	(227,537)	(533,002)	(546,089)	(13,087)
UHL - Net Position	**(4,305)**	**0**	**(10,333)**	**(10,333)**
LPT - Income	147,782	352,455	354,677	2,222
LPT - Pay	(114,978)	(265,349)	(275,947)	(10,599)
LPT - Non-Pay	(35,360)	(87,107)	(84,864)	2,243
LPT - Net Position	**(2,556)**	**(0)**	**(6,134)**	**(6,134)**
ICB - Allocation	813,935	1,941,757	1,941,757	0
ICB - Expenditure	(814,447)	(1,941,757)	(1,954,673)	(12,916)
ICB - Net Position	**(513)**	**0**	**(12,916)**	**(12,916)**
System Net Position	**(7,374)**	**0**	**(29,383)**	**(29,383)**

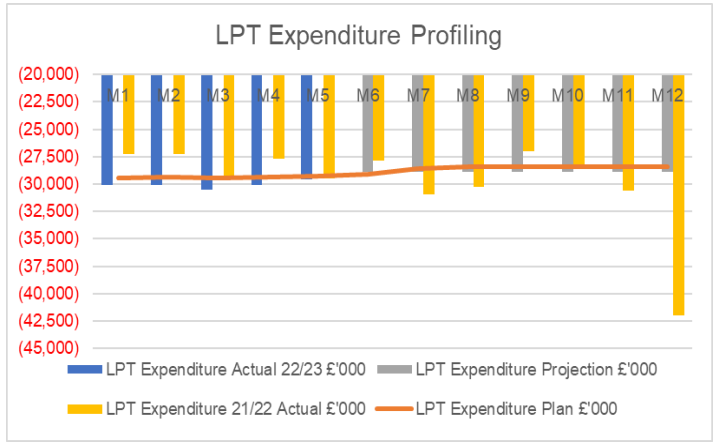
The run-rate forecast outturn (FOT) projects what an organisations FOT will be in the event that the year-to-date position continues as it is for the rest of the reporting period.

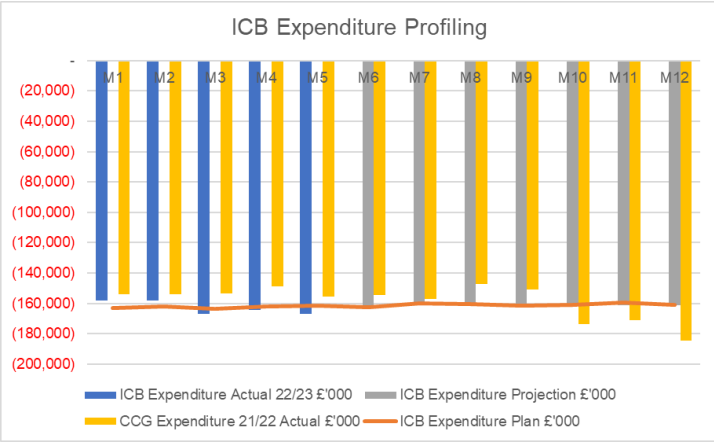
A straight line run-rate of the YTD positions projects a forecasted overspend for all 3 organisations.

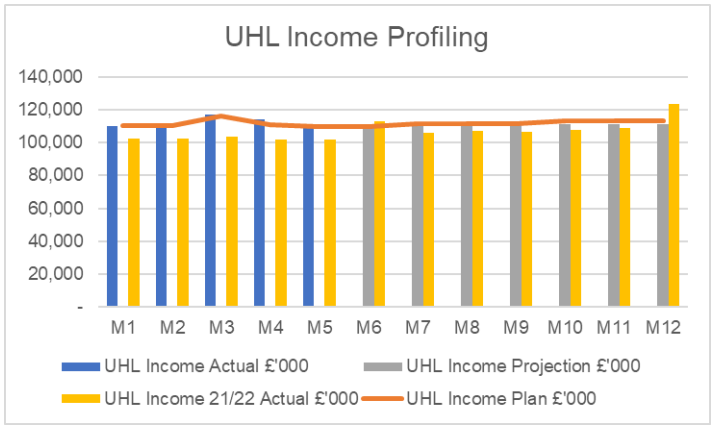
It is worth noting however that the ICB position for M1-5 includes a number of non-recurrent financial benefits, (E.g. £4.4m prior year benefits and over £6m of slippage on investments). This is also true to a lesser extent in both UHL and LPT where the recurrent operational deficit for M1-5 is larger than the headline figures shown (due to non-recurrent benefits).

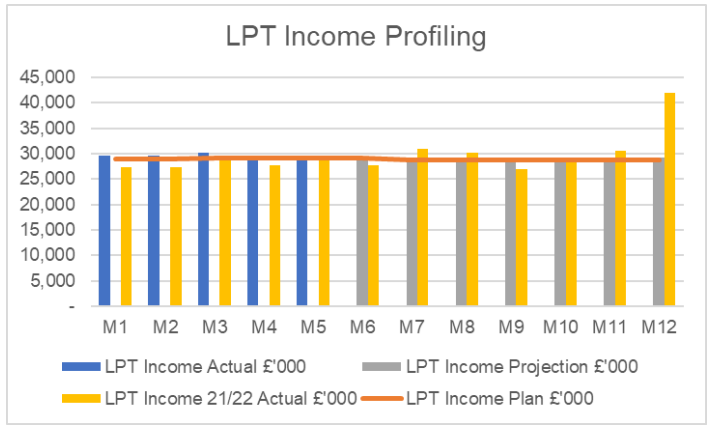
Plan vs Actual Profiling

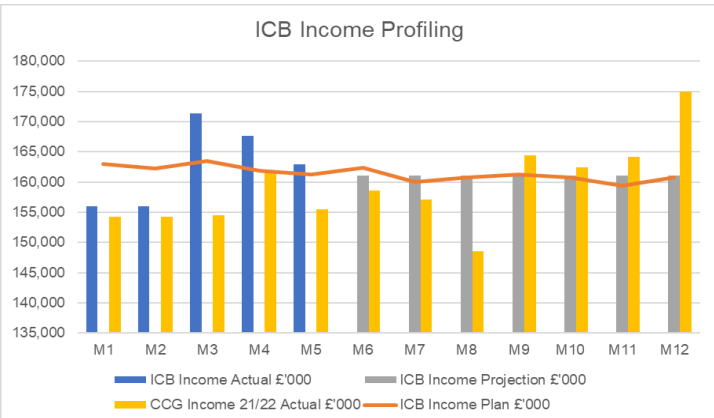












The above charts illustrate how the in-year performance of the organisations compares to the profiling of income and expenditure in the 22/23 plan as well as the actual position from 21/22. The projection shown in the graphs equates to the required spend to achieve the current break-even forecast spread evenly throughout the remainder of the year. The 21/22 year-end spike in expenditure for LPT relates to the additional employers pension costs that are transferred over from the central (national NHSE) team to the providers with accompanying income to match.

Forecast Outturn Scenarios

	Forecast Risk Scenarios			
	Current Reported FOT £m	Worst Case Risk Position £m	Current Likely Risk Position £m	Net Risks after Mitigation £m
UHL Net Risk	0	(46.60)	(25.04)	(13.36)
LPT Net Risk	0	(19.70)	(14.77)	(6.55)
LLR ICB Net Risk	0	(65.31)	(47.48)	0.04
System Net Risk	0	(131.61)	(87.29)	(19.86)

The following table outlines the different forecast risk scenarios depending on the risks calculated by each organisation.

The adjusted risk position factors in the percentage likelihood of the gross risk materialising.

The net risks is calculated by netting off the adjusted risk position with any estimated mitigations.

Organisations are continuing to implement mitigations and pursue further opportunities in order to reduce risk to delivery of financial break even.

Efficiencies

System Efficiencies	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Annual Plan £'000	FOT £'000	FOT Variance £'000
Recurrent	3,429	2,645	(784)	15,572	15,572	0
Non-Recurrent	1,548	3,675	2,127	5,428	5,428	0
Total Cash Releasing	4,977	6,320	1,343	21,000	21,000	**0**
Recurrent	1,763	4,965	3,202	10,578	10,578	0
Non-recurrent	693	34	(659)	3,422	3,422	0
Total Non-Cash Releasing	2,456	4,999	2,543	14,000	14,000	**0**
UHL Total	**7,433**	**11,319**	**3,886**	**35,000**	**35,000**	**0**
Recurrent	1,053	1,195	142	4,722	4,350	(372)
Non-Recurrent	372	230	(142)	878	1,069	191
Total Cash Releasing	1,425	1,425	0	5,600	5,419	**(181)**
Recurrent	0	0	0	0	0	0
Non-recurrent	0	0	0	0	0	0
Total Non-Cash Releasing	0	0	0	0	0	**0**
LPT Total	**1,425**	**1,425**	**0**	**5,600**	**5,419**	**(181)**
Recurrent	6,903	5,067	(1,835)	30,130	22,484	(7,646)
Non-Recurrent		1,235	1,235		2,781	2,781
Total Cash Releasing	6,903	6,302	(600)	30,130	25,265	**(4,865)**
Recurrent			0			0
Non-recurrent			0			0
Total Non-Cash Releasing	0	0	0	0	0	**0**
LLR ICB	**6,903**	**6,302**	**(600)**	**30,130**	**25,265**	**(4,865)**
Total System Efficiencies	**15,761**	**19,046**	**3,286**	**70,730**	**65,684**	**(5,046)**

System Efficiencies	Annual Plan £'000	FOT £'000	FOT Variance £'000
Cash Releasing	56,730	51,684	(5,046)
Non-Cash Releasing	14,000	14,000	0
Total Efficiencies	**70,730**	**65,684**	**(5,046)**

System Efficiencies	Annual Plan £'000	FOT £'000	FOT Variance £'000
Recurrent	61,002	52,984	(8,018)
Non-Recurrent	9,728	12,700	2,972
Total Efficiencies	**70,730**	**65,684**	**(5,046)**

The system has a planned level of efficiencies totalling £70.7m. UHL continue to forecast a break-even position whereas LPT are forecasting a slight underperformance against plan. The ICB is forecasting under-delivery against their efficiency plan of £4.9m.

YTD performance currently shows a £2.1m overperformance by UHL whilst the ICB is under-delivering against their YTD plan.

The System PMO team will provide more detailed analysis on the systems performance in regard to efficiencies.

Capital

Capital Expenditure	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Initial Plan £'000	FOT £'000	FOT Variance £'000
Non central programme	(21,527)	(15,020)	6,507	(52,175)	(52,327)	(152)
New Hospital Programme	0	0	0	(1,128)	(1,128)	0
UHL Total	**(21,527)**	**(15,020)**	**6,507**	**(53,303)**	**(53,455)**	**(152)**
Non central programme	(3,943)	(5,096)	(1,153)	(19,678)	(19,678)	0
Mental Health	0	0	0	0	(795)	(795)
Mental Health Dormitories	(1,160)	(1,160)	0	(4,000)	(4,000)	0
LPT Total	**(5,103)**	**(6,256)**	**(1,153)**	**(23,678)**	**(24,473)**	**(795)**
Total System Capital Expenditure	**(26,630)**	**(21,276)**	**5,354**	**(76,981)**	**(77,928)**	**(947)**

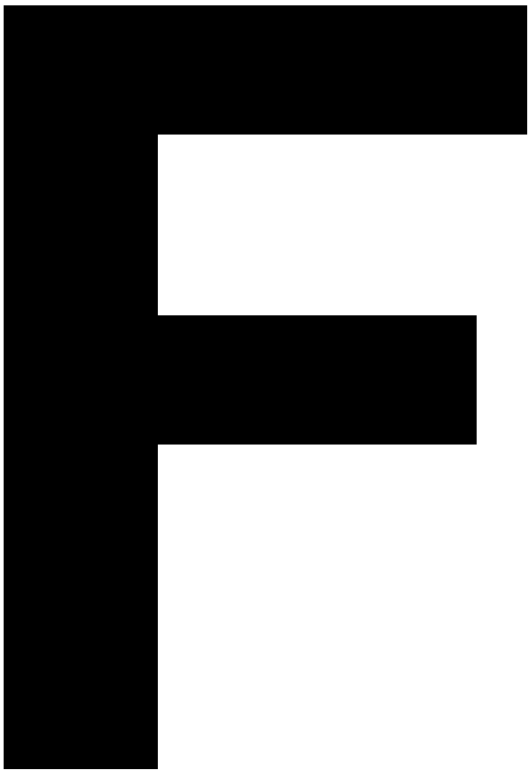
Capital Source of Funding	Initial Plan £'000	FOT £'000	FOT Variance £'000
Depreciation	34,991	34,794	-197
Grants, Donations & Disposals	500	652	152
Cash Reserves	4,198	4,384	186
Lease Liabilities	12,486	12,497	11
PDC - Central Programme (Pending Approval)	1,128	1,128	0
UHL Total	**53,303**	**53,455**	**152**
Depreciation	9,663	9,663	0
Agnes Unit PFI	100	100	0
Cash Reserves	6,002	6,002	0
Lease Liabilities	3,913	3,913	0
PDC - Central Programme (Pending Approval)	4,000	4,795	795
LPT Total	**23,678**	**24,473**	**795**
Total System Capital Funding	**76,981**	**77,928**	**947**

Both UHL and LPT are forecasting a slight overperformance against their capital plans.

UHLs sizeable YTD underspend is largely driven by costs in relation to the new build in theatres and critical care, equipment and IT hardware materialising at lower than planned levels.

LPTs YTD position is largely as a result of Virtual Pathway costs that were not included in the original plan.

The current position assumed spend against system reserves of £2.5m which will need to be released along with an additional £400k in order to live within the ICS capital allocation. The ICS capital group is considering options to ensure that this happens.



Name of meeting:	LLR Integrated Care Board Public		**Date:**	13 October 2022	**Paper:**	**F**
Report title:	**LLR ICS Finance Committee Highlight Report – 28 September 2022**					
Presented by:	Cathy Ellis Chair of ICS Finance Committee					
Report author:	Cathy Ellis Chair of ICS Finance Committee					
Executive lead:	Caroline Gregory Chief Finance Officer					
Action required:	**Receive for information only:**			**Progress update:**		
	For assurance:	✓		**For approval / decision:**		
Executive summary:	1. The LLR Integrated Care Board (ICB) is asked to: • **RECEIVE** for assurance the LLR ICS Finance Committee Highlight Report.					
Appendices:	• N/A					
Recommendations:	The LLR Integrated Care Board are asked to: • **RECEIVE** for assurance.					
Report history and prior review:	• N/A					

Implications	
a) Conflicts of interest:	These would be managed during the meeting and appropriate actions would be taken to mitigate conflicts should there be conflicts at any point during the meeting.
b) Alignment to Board Assurance Framework	Individual reports to the ICB are aligned to risks within the Board Assurance Framework
c) Resource and financial implications	The report highlights the risks associated with revenue and capital expenditure in 2022/ 23. There is a requirement for delivery of significant transformation in LLR.
d) Quality and patient safety implications	None.
e) Patient and public involvement	None.
f) Equality analysis and due regard	Not undertaken in respect of this report, however, would be undertaken in relation to the reports presented to the Transformation group.

LLR ICS FINANCE COMMITTEE –28 September 2022 meeting

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
Committee terms of reference	**High**	Minor amendments were made to the terms of reference	
System Revenue position at Month 5	**Low**	At month 5 the system reported a deficit of £7.4m (£4.3m deficit in UHL, £2.6m deficit in LPT and £0.5m deficit in the ICB). Year end forecast remains break-even for the system, but on a straight-line run-rate basis would be a deficit of £29m. The finance reports have been re-focused on key risk areas at month 5: • The net system risk after mitigations is estimated at £31m, further work is required to firm up the mitigations • Systemwide efficiencies are forecasting to deliver £65.7m which is £5m short of plan. 73% of the efficiencies are cash-releasing. • Elective Recovery Fund (ERF) activity is £2.5m below target at month 5 • Agency spend is £4.6m over target at month 5, mainly due to acuity in mental health. Action has been taken to reduce the run-rate in both UHL and LPT.	Both providers have phased the majority of the efficiency savings in Q3/Q4. Further risk of ERF and Winter monies clawback if targets not achieved. Risk of exceeding the system agency cap of £43.5m
Capital Report month 5	**Medium**	At month 5 the system capital is £5.3m underspent compared to plan. LLR have spent 27% of our capital limit versus 42% of time expired. As a control measure there will be a review of capital schemes at month 6 with an	Funding not confirmed for £10m of IFRS16 lease costs (change in accounting treatment)

Report	Assurance level	Matters for Committee escalation to Integrated Care Board	Risks to escalate
		opportunity to reprioritise unspent capital to other projects.	Risk that national digital capital may be reduced to fund staff pay award.
Managing the financial gap to deliver break even at the year end	**Low**	The System Executive have met to review the current system risk of £88m and potential mitigations identified to date of £57m. The £31m gap requires further mitigations, which are being worked up.	£31m risk to delivering break even.
Winter resilience funding	**Medium**	The system has secured £14m of winter resilience funding. £13m of revenue funding has been allocated to initiatives to grow the bed base and support discharge. £1m of capital is available.	The winter plan is in draft form at the time of reporting. Risks relate to delivery of the plan.
Delegation of specialised commissioning from NHSE in 2023/24	**Medium**	A paper was shared on the proposals relating to the delegation of commissioning to ICSs for pharmacy, optometry, dentistry and specialised services (high value /complex procedures).	Risks include the (as yet unknown) allocation of budget and workforce to LLR and risk will be managed across East Midlands ICBs.
Transformation	**Low**	There is an improvement in forecast year end efficiency savings, increasing by £6.7m from the previous month. The Committee have asked for assurance on cash releasing delivery in month 6 from the Transformation Group who have been conducting deep dives with the design groups and collaboratives.	Significant transformation needs to be delivered in LLR to offset demand growth and close the underlying financial gap.
UHL exit from Recovery Support Programme (RSP)	**Medium**	The Committee reviewed the UHL risk profile and action tracker to monitor progress on exit from the RSP. Many actions are complete with evidence submitted to the Regional NHSE team. The 2020/21 accounts were adopted at UHL board on 9th September, 2021/22 accounts are due at Board on 31st December.	Key risks for UHL RSP are the medium-term financial plan and the 2022/23 delivery.
Risk register Month 5	**Risks rated as indicated**	The ICS Finance Committee risk register is dynamic with updates every month to risk scores and mitigations. There are now 7 high financial risks: • Risk 3 Urgent Care Pressure **(rated 16)** • Risk 6 Workforce recruitment and retention **(rated 16)**	

Report	Assurance level	Matters for Committee escalation to Integrated Care Board	Risks to escalate
		• 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)**	
Deep dive into workforce risk	**Medium**	There was a review of the recruitment and retention risk and details of several initiatives to grow the workforce were outlined. People metrics are reporting workforce levels above the whole time equivalent (WTE) plan, however there is a need to report the actual vacancy levels and usage of temporary staff to highlight the staffing risk more fully in UHL and LPT.	

Authors:	**Cathy Ellis (Chair of Committee) and Caroline Gregory (LLR Chief Finance Officer)**

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**13 October 2022**	**Paper:**	**G**
Report title:	Assurance report from the Quality and Safety Committee		
Presented by:	Pauline Tagg, Non-Executive Director and Chair of the Quality and Safety Committee		
Report author:	ICB Corporate Governance Team		
Executive Sponsor:	Caroline Trevithick, Chief Nursing Officer Pauline Tagg, Non-Executive Director and Chair of the Committee		

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 and assurance following the meetings of the ICB's Quality and Safety Committee meetings held during September and October 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.	☒

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.*		Assurance relating to risk of compliance with performance standards.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Not specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		The focus of the Committee is on quality and safety risks and assurance.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		The focus of the Committee includes assurance on patient and public involvement.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report.

Assurance Report from the Quality and Safety Committee

1. The purpose of the report is to provide the Board with assurance that functions are being delivered in a way that secures continuous quality and safety of services across the organisation and also in conjunction with system partners.

2. The Committee receives regular system level reports from University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT) and East Midlands Ambulance Service (EMAS). These reports provide assurance that the Trusts are identifying and addressing quality and safety issues in their organisations and their respective Trust Boards are aware of the issues. The Committee ensures that key quality issues and challenges are reported through to the System Executive Committee for further consideration and action.

3. The key issues highlighted to the Committee included serious incidents relating to delayed responses reported by EMAS highlighting the pressures in the urgent care system and staffing pressures.

4. The Committee also received a patient safety report for quarter one, noting the publication of the Patient Safety Incident Response Framework (PSIRF) outlining a new approach to understanding incidents. An area of focus for future meetings will be to seek assurance on reducing reoccurrence of specific incident themes.

5. A specific area for noting is Looked After Children as detailed in the table below.

6. An update on quality and safety concerns and assurances relating to primary medical care services are also considered by the Committee, including assurance on areas for further improvement. This enables a positive interface with the Strategic Commissioning Group (sub-group of the System Executive Committee).

7. The Urgent and Emergency Care Patient Safety Quality Summit held on 13 September 2022 was reported as a successful event, with action plan, weekly winter meetings, approach to risk and clinical leadership noted as being positive.

8. The Committee approved the terms of reference for the following sub-groups: System Quality Group (SQG) and Public and Patient Involvement Assurance Group (PPIAG). The Committee also approved the ICB's Personal Health Budgets Policy.

Risk	Level of Assurance	
Alert		**Looked After Children** The Committee noted capacity issues within Social Care for Looked After Children and that this will impact on Health. There are also wider issues of capacity within Social Care including Frailty. It was suggested that the ICB should have system-wide conversations and for Health and Social Care to take a joint approach, this is being progressed through the Executives. The committee felt that there are no plans in place at present and responses are reactive.
Alert		**GP Practice with concerns** The CNO reported that a further quality summit has taken place relating to a GP practice in LLR with ongoing concerns. The revised Quality Improvement Plan did not address the issues indicated and root cause analysis into a specified incident was not sufficient. As a result, the ICB has resolved on further action which is to be communicated to the practice.

		The impact of any mitigations following this action is to be monitored. The potential impact of this action is not yet known.
Alert		**Primary Care Quality** The Committee was not assured that self-assessment processes are routinely undertaken within Primary Care. The self-assessment toolkit cannot therefore be relied on as a single means of assurance. However, there are other sources of assurance in place. Further work has been requested. The Committee has requested for a primary care highlight summary report to be developed for review in January 2023. The Committee requested further processes to demonstrate assurance around the primary care quality agenda. PPIAG have noted concerns regarding engagement between Primary Care and the public. A GP patient experience report and action plan will be presented to the October 2022 meeting to enable a discussion regarding the plans in place.
Assure		**Urgent & Emergency Care** The Committee was assured following the UEC patient safety quality summit that the LLR system is developing strong and effective governance, monitoring and reporting processes.
Assure		**Patient Insight** Committee was assured about the process for identifying patient insight data to inform service delivery developments.
Advise / Actions		No new risks were identified for inclusion on the risk register. It was noted that the risk for ambulance handovers reflects the current position and risk to patients in the community. The risk register also reflects the risks posed by workforce issues impacting nurses in Primary Care. Further work will be taking place to understand the relationship between the People Board and QSC.

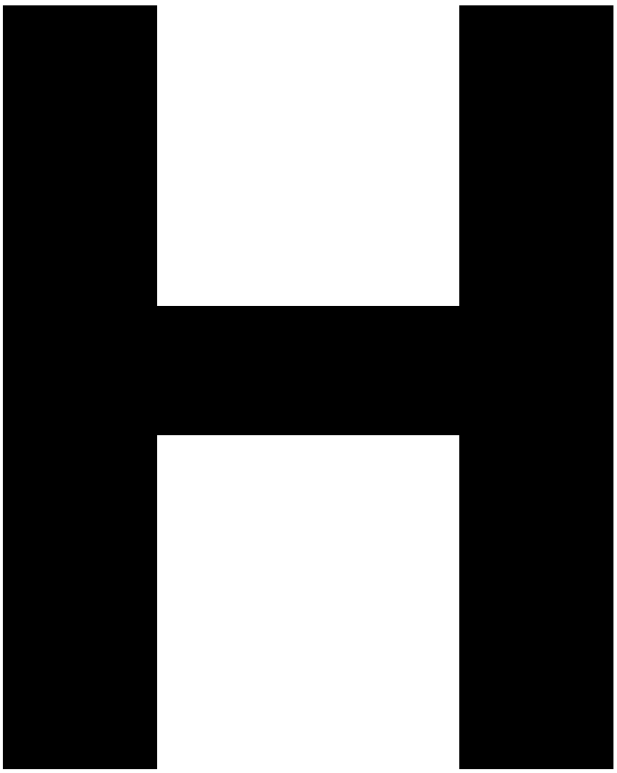
The key headlines/issues and levels of assurance are graded as follows:

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.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	13 October 2022	**Paper:**	**H**
Report title:	**Assurance report from the System Executive Committee in relation to system performance**		
Presented by:	Andy Williams, Chief Executive		
Report author:	Daljit Bains, Head of Corporate Governance		
Sponsor:	Andy Williams, Chief Executive		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. The System Executive Committee, as a committee of the Board, has responsibility for overseeing the development of strategic plans, financial plans and operational performance at system level. This includes finance, activity, digital, workforce, and performance against national and local standards.

2. The Committee undertakes a regular review of these areas to ensure appropriate actions are being taken and that there is adequate resilience in the system. The Committee also seeks assurance that action plans are developed to mitigate any risks to support improvements.

3. A report earlier on the Board agenda provides assurance on elective recovery and winter plans.

4. This report to the Board specifically focuses on system performance against national and local standards. Appendix 1 provides a high-level overview of some of the key challenges faced across Leicester, Leicestershire and Rutland.

5. Future reports from the System Executive Committee will provide more detailed assurance and analysis, including escalation of risks and actions that may require further consideration by the Board. In addition, assurance will be provided from the Committee in relation to decisions it has made aligned to its delegated authority.

Appendices:	• Appendix 1 – System Performance Report
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• System Executive Committee meetings.

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.*	Provides assurance in relation to strategic risks detailed in the Board Assurance Framework relating to NHS Constitutional standards and compliance with other performance standards.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report. However, there are financial implications considered through other Committees and meetings.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Performance against the relevant standards have an impact on quality and safety which is considered in more detail through the Quality and Safety Committee.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however consideration is given to our duty of equality.

NHS
Leicester, Leicestershire and Rutland

LLR ICS SYSTEM EXECUTIVE GROUP

Performance Overview

October 2022

Hannah Hutchinson

Assistant Director of Performance & Quality Improvement, LLR ICB

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

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, Mental health, 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.

Areas of Improvement

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

Long elective waiters (+104 weeks)

Cancer 2 week wait GP referral

Cancer 62 day wait

Areas of Deterioration

Ambulance Handovers 1hour +

Long elective waiters (+52 weeks) for all LLR patients

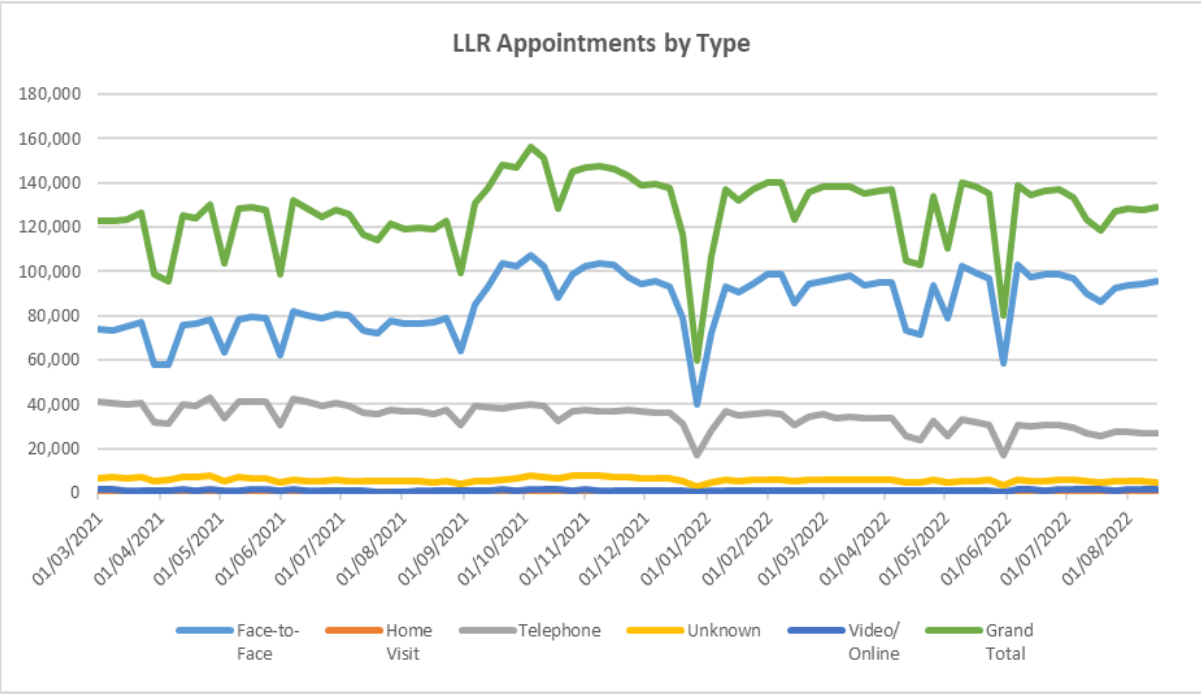
Priority 2 patient numbers

Breast Cancer 2WW

Primary Care – General Practice Appointments

Weekly LLR Appointments by Appointment Type

Mar 2021 – Aug 2022



Monthly data The table below shows the monthly number of all general practice appointments for July 2020, 21 and 22. Appointments in July 22, were higher than in July 2020 and 2021.

All Appointments	Total
Jul-20	456,706
Jul-21	526,792
Jul-22	527,692

LLR Appointments by Type

Measure	Latest Week Starting 15th August 2022	Previous Week Starting 8th August 2022	Variance	% Variance
Face-to-Face	95,364	94,208	1,156	1.2%
Home Visit	271	301	-30	-10.0%
Telephone	26,968	26,765	203	0.8%
Unknown	4,962	5,082	-120	-2.4%
Video/Online	1,391	1,508	-117	-7.8%
Grand Total	128,956	127,864	1,092	0.9%

The data is now received weekly as well as monthly. Weekly data shows the total appointment have increased by 0.9% from the previous week (total appointments w/c 8-Aug - 127,864 w/c 15-Aug - 128,956).

The number of face-to face appointments has also increased by 1.2% for the same time period.

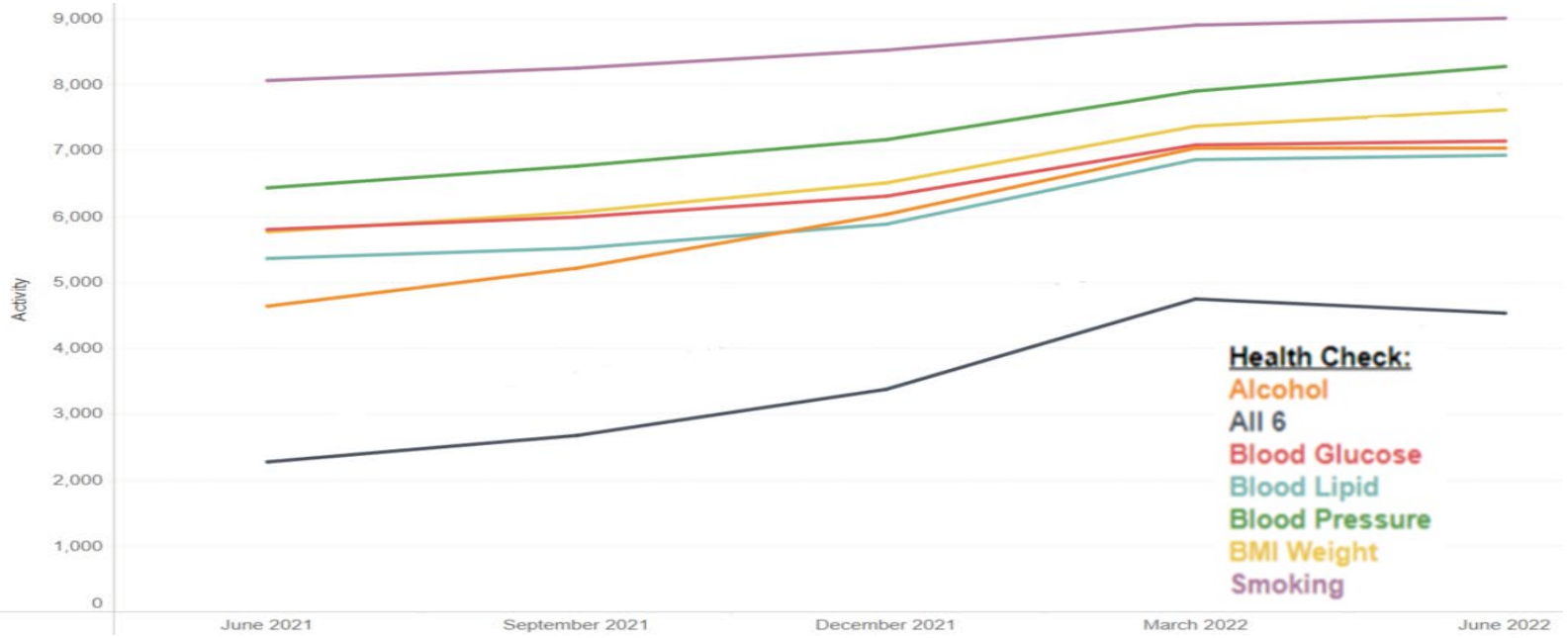
Mental Health: SMI- All six checks

All 6 checks (12 month rolling position)				LLR Target 60%	
	ELR	LC	WL	LLR	LLR%
30/06/2021	478	1229	564	2271	21.8%
30/09/2021	549	1497	626	2672	25.6%
31/12/2021	684	1814	875	3373	32.0%
31/03/2022	962	2435	1347	4744	44.5%
30/06/2022	923	2268	1338	4529	41.5%

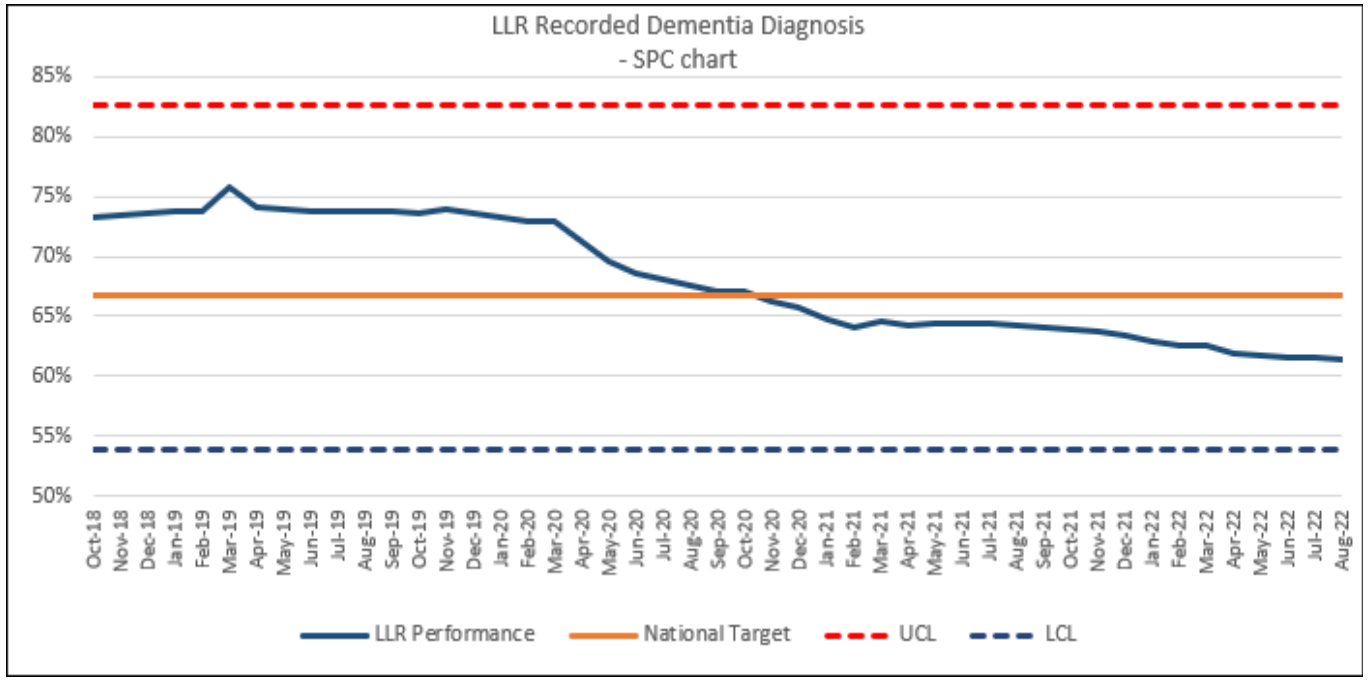
Number of people on the SMI register receiving each health check
Data source: https://future.nhs.uk/MHRH/view?objectId=101363237

	2021/22 Q4	2022/23 Q1	Direction of change
Full physical health check	4744	4529	↓
Alcohol	7034	7035	↑
Blood glucose	7083	7141	↑
Blood lipid	6859	6926	↑
Blood Pressure	7901	8273	↑
BMI Weight	7367	7614	↑
Smoking	8902	9006	↑

Health Check	June 2021	September 2021	December 2021	March 2022	June 2022
Alcohol	4,635	5,213	6,028	7,034	7,035
All 6	2,271	2,672	3,373	4,744	4,529
Blood Glucose	5,798	5,987	6,304	7,083	7,141
Blood Lipid	5,359	5,514	5,880	6,859	6,926
Blood Pressure	6,432	6,762	7,163	7,901	8,273
BMI Weight	5,761	6,061	6,506	7,367	7,614
Smoking	8,060	8,250	8,522	8,902	9,006
SMI Register	10,404.0	10,437.0	10,539.0	10,668.0	10,917.0



Dementia

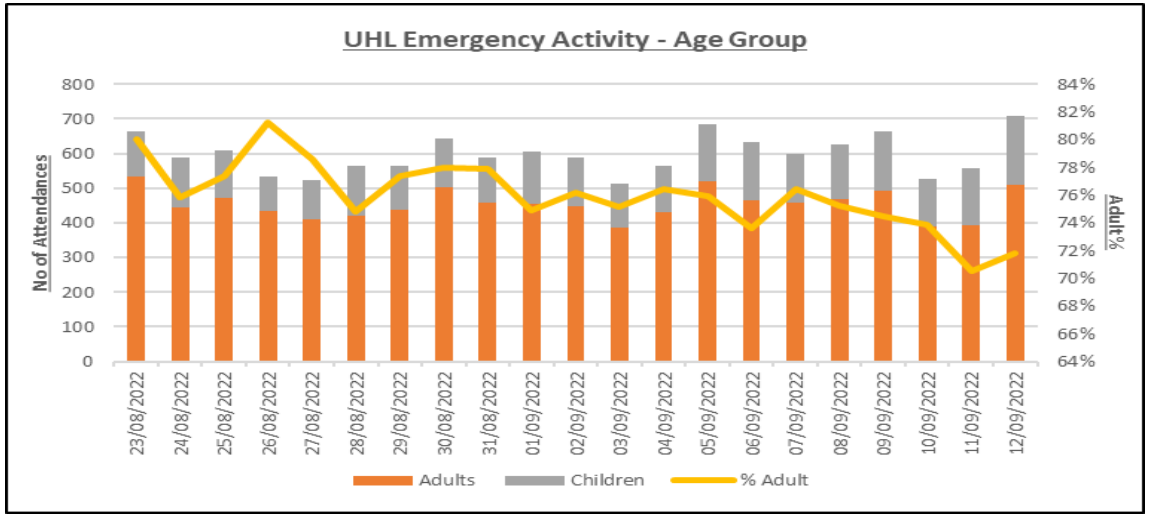


Benchmarking against LLR ICS Peers:	Aug-22
ENGLAND	**62.1%**
Nottingham and Nottinghamshire Health and Care ICS	68.8%
Staffordshire and Stoke on Trent ICS	67.7%
Bristol, North Somerset and South Gloucestershire ICS	65.6%
Bedfordshire, Luton and Milton Keynes ICS	63.4%
Derbyshire ICS	62.1%
Northamptonshire ICS	61.9%
Leicester, Leicestershire and Rutland ICS	**61.4%**
Mid and South Essex ICS	61.0%
Kent and Medway ICS	57.7%
Coventry and Warwickshire ICS	56.3%
Cambridgeshire and Peterborough ICS	54.2%

Dementia diagnosis rates have improved slightly in August 2022 with LLR performance standing at 61.4% which is under the national target of 66.7% and ranks 7/11 of ICS similar peers.

Performance for both County and Rutland has dropped marginally and remain under national target, whilst City has seen a slight improvement from previous month achieving 72.4%.

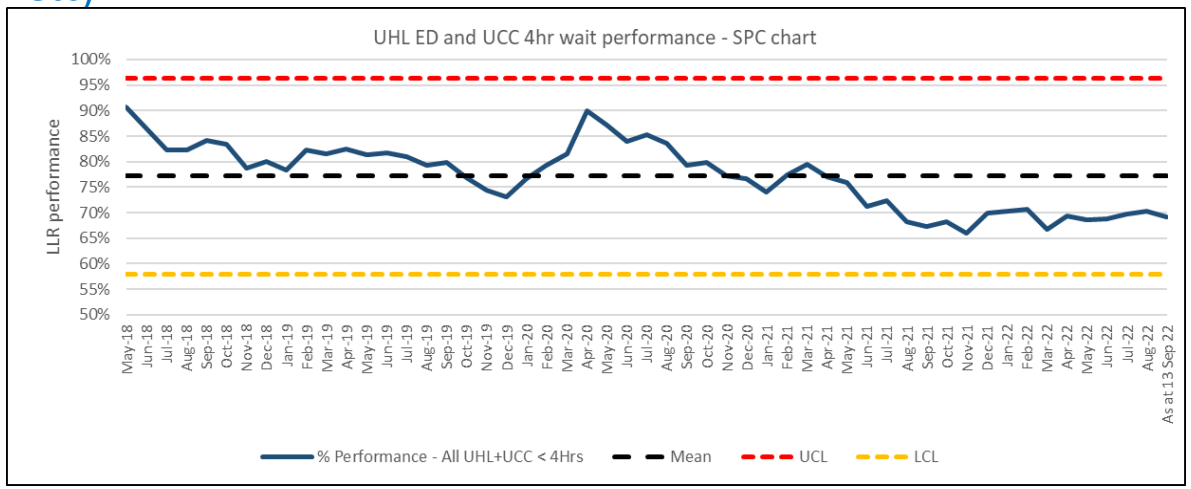
Urgent Care



There has been an increase in ED activity (3.0%) in the past week. Overall children's has seen an increase (14.7%) and adults have reduced slightly (0.6%) attending ED compared to the previous 7 days.

Emergency Department				
Measure	Latest 7 Days (6-12th Sep)	Previous 7 Days 30th Aug-5th Sep)	Var from Previous Week	% Var to Previous Week
UHL ED Activity: Total	4,314	4,189	125	3.0%
UHL ED Activity: Adults	3,180	3,200	-20	-0.6%
UHL ED Activity: Children	1,134	989	145	14.7%

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).



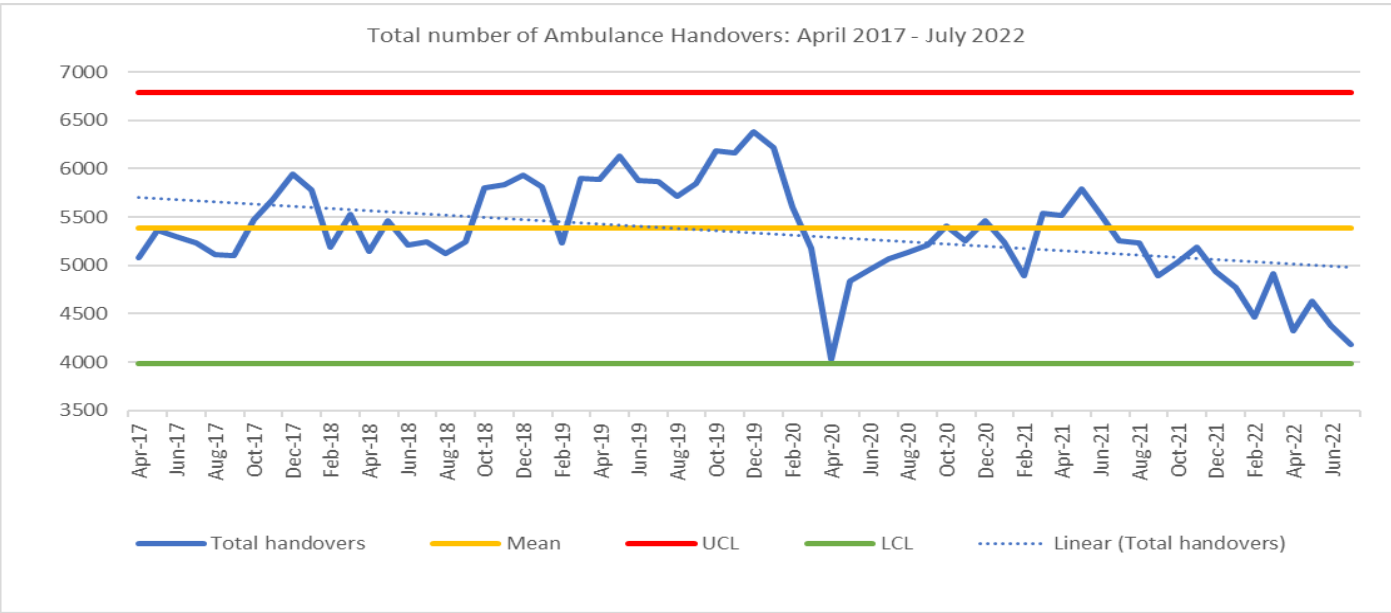
Out of County Provider A&E Performance							
Provider (All Patients)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22_23 YTD	
UH Derby & Burton FT	62.0%	64.2%	61.7%	62.4%	63.0%	62.7%	
Nottingham University Hospital	CRS Trial Site						
George Eliot Hospital	72.3%	76.5%	75.2%	76.2%	73.4%	74.8%	
UH Coventry & Warwick	67.0%	70.3%	69.7%	70.4%	64.4%	68.6%	
Kettering	CRS Trial Site						
Northampton	64.4%	66.0%	67.2%	65.8%	66.4%	66.0%	
NW Anglia FT	56.5%	53.2%	52.2%	48.9%	52.4%	52.6%	
UHL	56.0%	56.0%	56.3%	57.3%	56.9%	56.5%	

Ambulance Handovers

Urgent Care	21-Aug	28-Aug	04-Sep	11-Sep	Variation from prev wk (n)	% change from previous wk	% change from 4wks ago
EMAS UHL Handover: Cases	908	989	1,049	1,025	-24	-2.3%	12.9%
EMAS UHL Handover: Queueing >2hr	87	81	56	118	62	110.7%	35.6%
EMAS UHL Handover: Queueing >60mins	220	225	179	255	76	42.5%	15.9%
EMAS UHL Handover: Queueing 30-59mins	209	200	198	208	10	5.1%	-0.5%

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

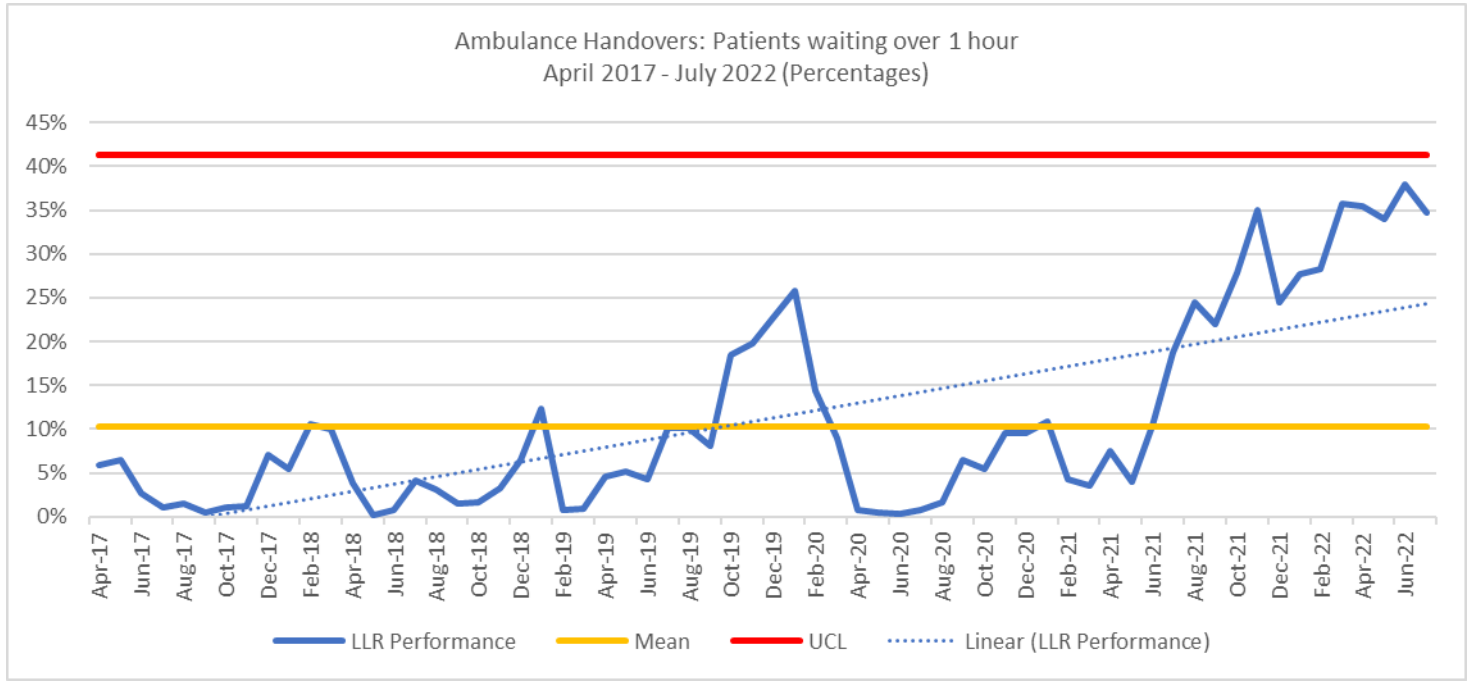
Monthly number of Ambulance Handovers The graph shows the monthly number of Handovers at UHL.



Ambulance waits continue to be a concern. Pressures within our local system are also replicated regionally.

Poor outflow across the emergency care pathway and a high inflow of patients walking in due to inability of getting an ambulance remain a concern.

Ambulance Handovers: Percentage of patients waiting over 1 hour (monthly)

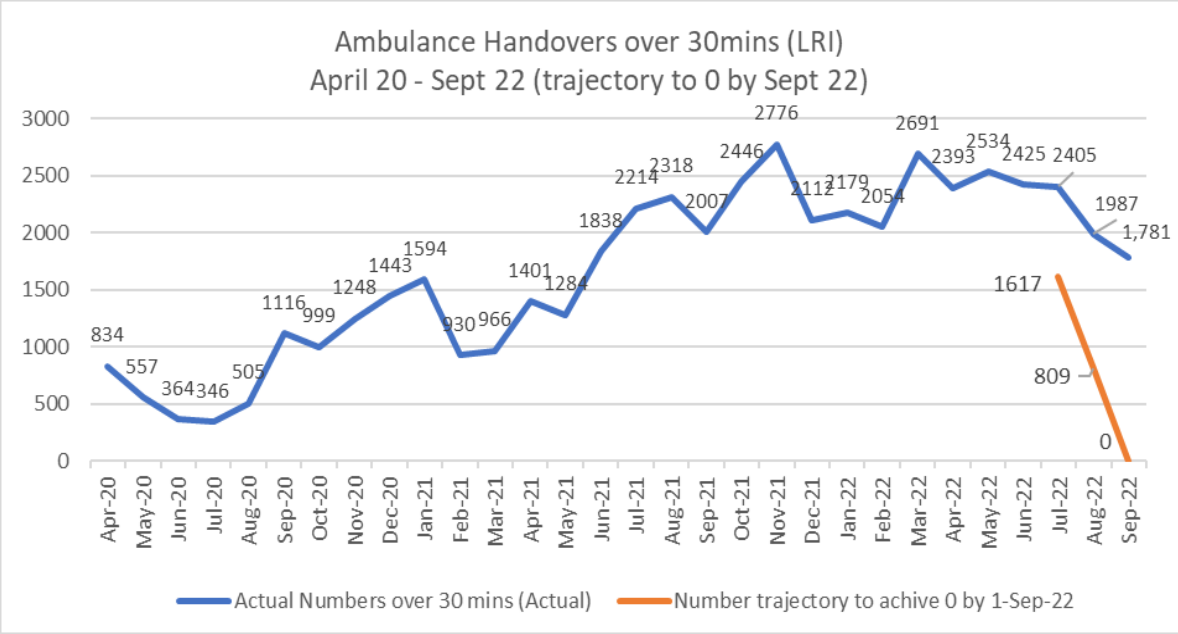


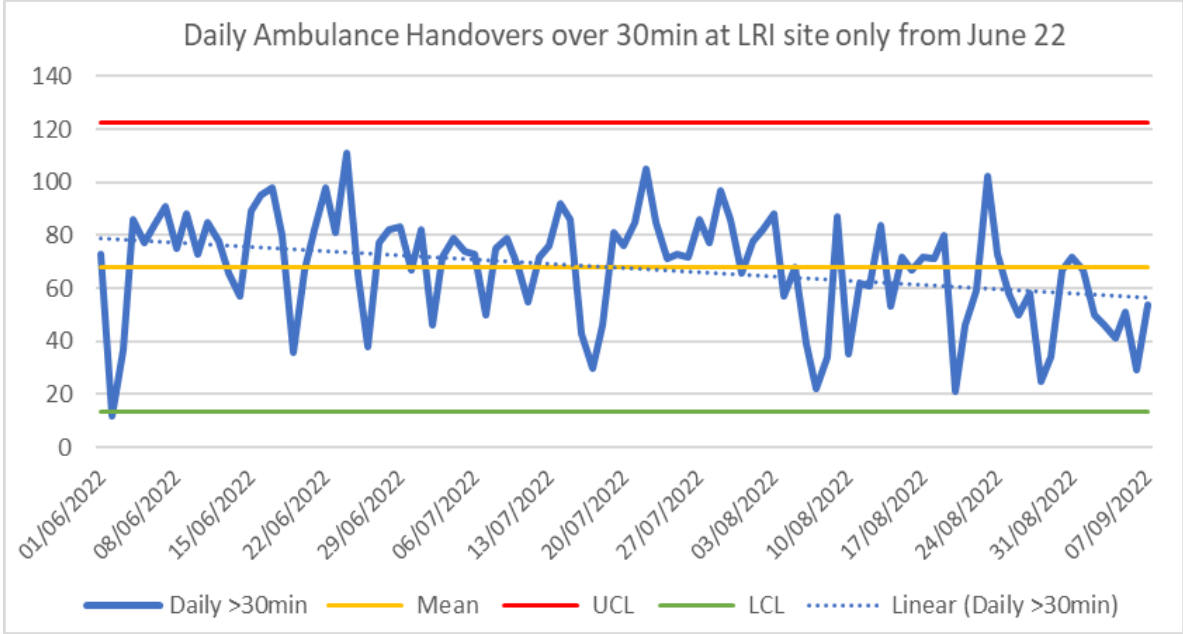
The graph shows the historical performance for the percentage of patients waiting over one hour.

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 to open a reablement ward
- Plan for additional UHL beds in Care Homes
- Cardiology in reach in place from September; 9-5 Mon to Fri and 9-12 Sat and Sun (pilot for 3 months)

Ambulance Handovers: Percentage of patients waiting 30mins



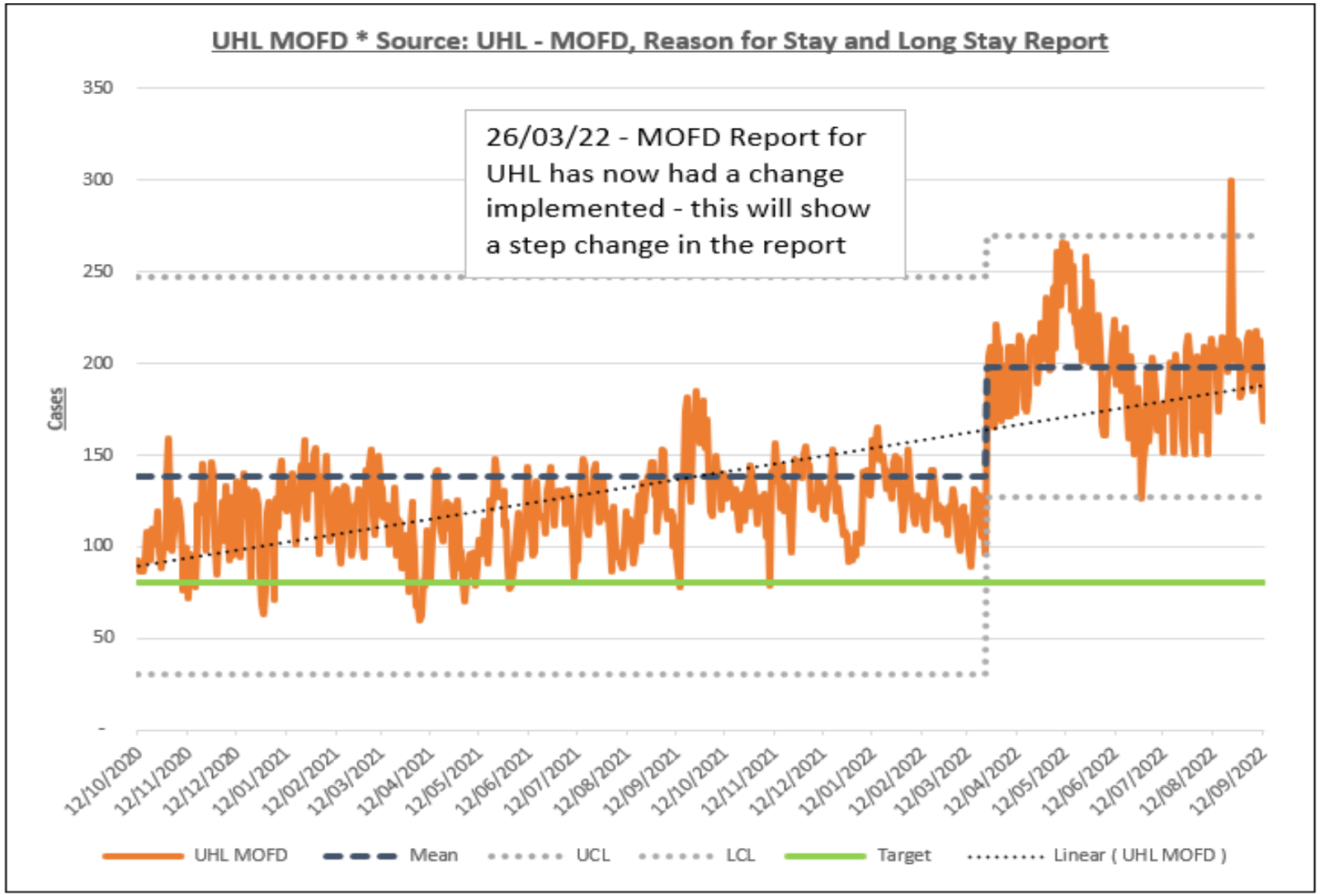


The graph above shows the monthly number of ambulance handovers waiting over 30mins at the LRI site only, against the trajectory of achieving 0 by 1-Sept-22

At the end of each reporting month, the number of >30min handovers is refreshed and therefore is likely to increase (by c.150 each month) compared with 'live' daily data.

The SPC graph above shows an overall reduction in the daily number of ambulance handovers waiting over 30mins at the LRI site, from June 22.

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 a reduction (1.7%) over the last 7 days.

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

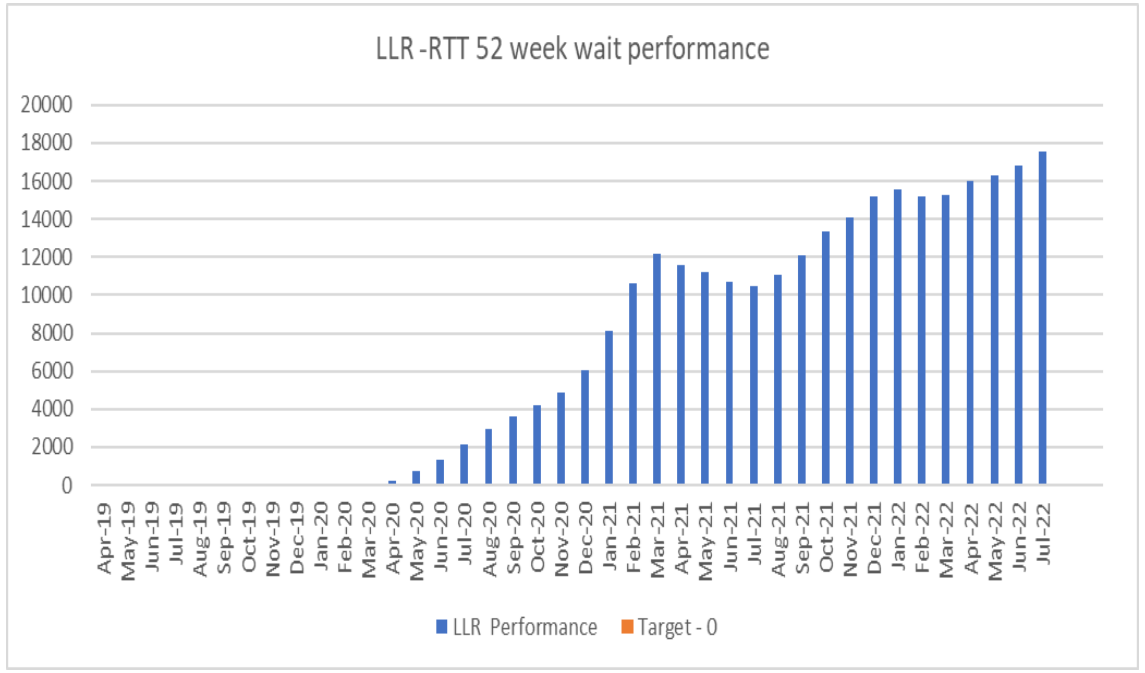
UHL Medically Optimised for Discharge - Reason to Reside	
Period	Medically Optimised for Discharge
Latest 7 Days (6th Sep-12th Sep)	1,372
Previous 7 Days (30th Aug- 5th Sep)	1,396
Variance	-24
% Variance	-1.7%

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

Actuals by Week -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
65,123	68,474	44,836	34,383	29,354	17,528	366

The total LLR waiting list size at the end of July was 133,597, an increase of just over 1100 LLR patients from June which stood at 132,452. 52-week waiters stands at **17,528** at the end of July 22, an increase of 748 patients from June 22. ***This is for LLR patients at all LLR providers.***

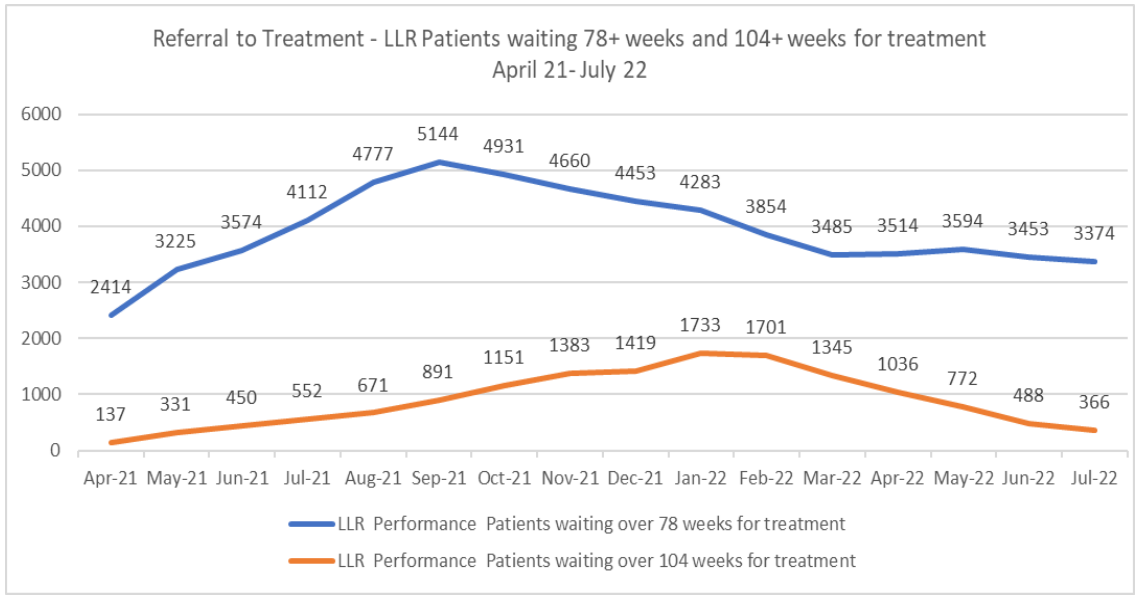


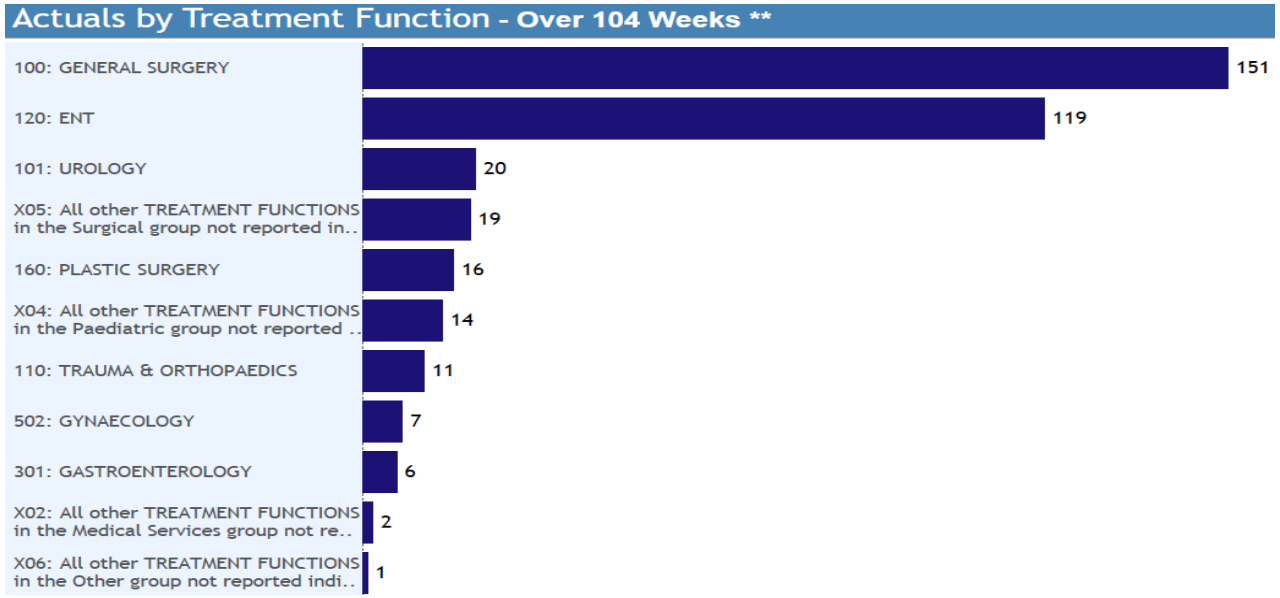
Waiters by Time Period and Provider - 2) Incomplete pathways for all patients (unadjusted)

	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)	52,447	58,639	38,949	30,263	26,014	15,958	308
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST : (RTG)	2,655	2,091	1,249	879	717	313	2
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST : (..	1,171	1,469	931	663	549	248	
WOODTHORPE HOSPITAL : (NVC40)	788	1,140	762	585	486	209	
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST : (RX1)	975	728	441	324	259	155	3
SPIRE LEICESTER HOSPITAL : (NT322)	351	567	434	332	283	119	2
NORTH WEST ANGLIA NHS FOUNDATION TRUST : (RGN)	1,111	710	371	241	196	93	
NUFFIELD HEALTH, LEICESTER HOSPITAL : (NT226)	59	167	139	122	119	92	5

Elective 78+ and 104+ week waits (LLR patients at all LLR providers)

In July 22 there were **3374** 78+ week breaches within LLR, out of which **366** were 104+ week breaches. There has been a decrease in the 104+ week waits since January 22. *This is for LLR patients at all LLR providers*





There has been an improvement in patients who have breached 104+ weeks, however elective capacity remains a challenge at UHL due to staff vacancies and sickness, particularly for anaesthetists and admin booking teams. The Trust is reliant on using insourcing to bridge gaps. GIRFT continues to support Mutual Aid and the system is liaising with IS providers to secure additional capacity as we head in the winter period. Local actions in place:

- 78+ trajectory meeting to take place with Specialities
- Service to validate October Cohort patients for suitability of Mutual aid.
- Pain list to start within Vanguard following C-arm move from General Hospital

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, over 78 weeks and over 104 weeks for elective treatment.

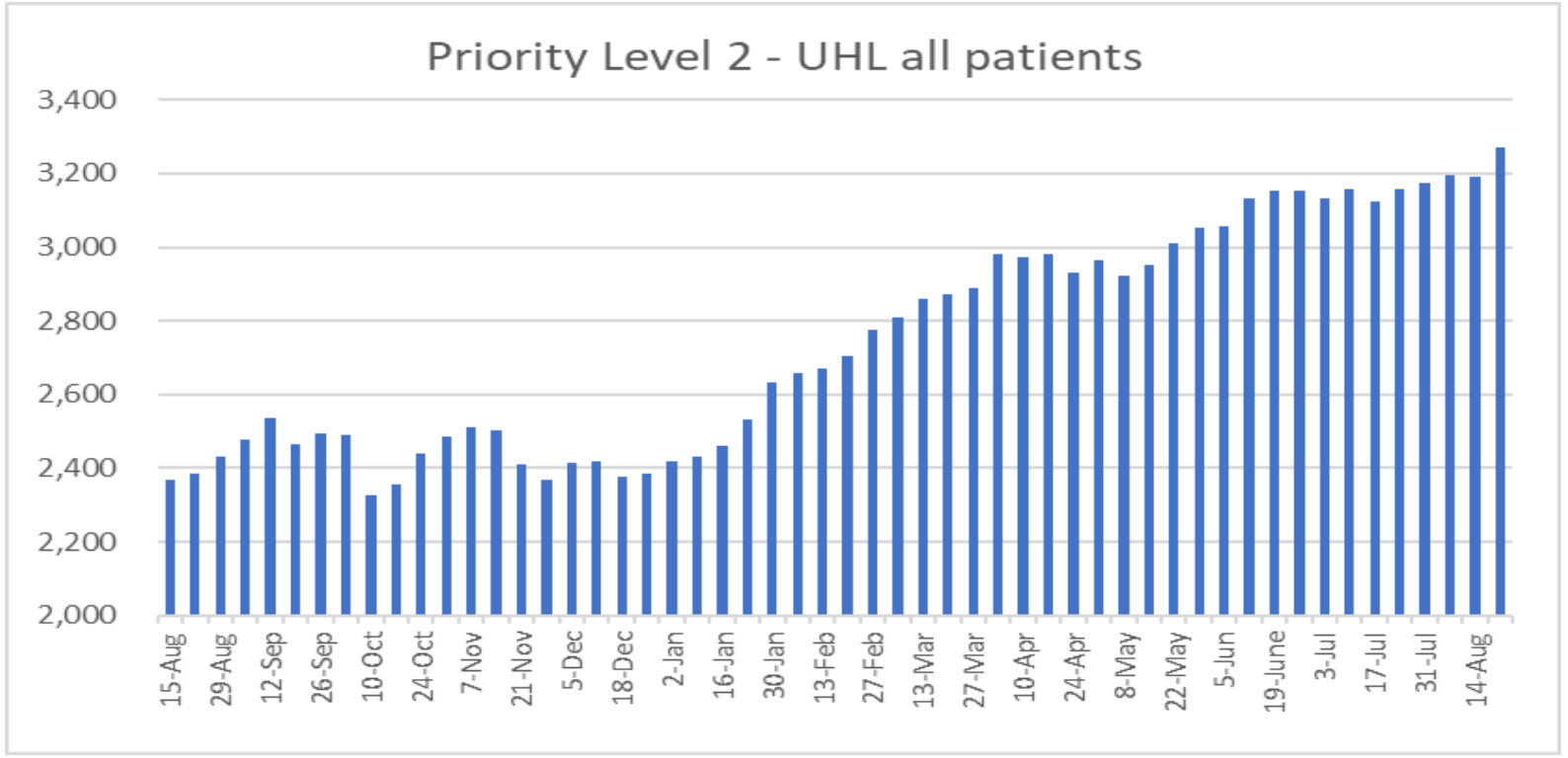
104+ wk waiters continue to reduce since a peak at the end of January 22. This is mainly due to ring fenced capacity for orthopaedics, additional ERF funded beds at the LRI, Vanguards on site from February 22 focussing on day case activity, mutual aid from regional NHS providers and new agreements with IS providers all contributing to the reduction.

	week ending (2022)						
UHL - Elective care	21-Aug	28-Aug	04-Sep	11-Sep	Variation from prev wk	% change from previous wk	% change from 4wks ago
18+ wks	66,612	66,704	67,398	67,167	-231	-0.3%	0.8%
52+ wks	18,272	18,455	18,382	18,345	-37	-0.2%	0.4%
78+ wks	3,391	3,400	3,506	3,407	-99	-2.8%	0.5%
104+ weeks	291	285	278	257	-21	-7.6%	-11.7%
Total Count (Incomplete Pathways)	124,797	125,587	125,916	125,628	-288	-0.2%	0.7%

Priority 2 Patients at UHL only

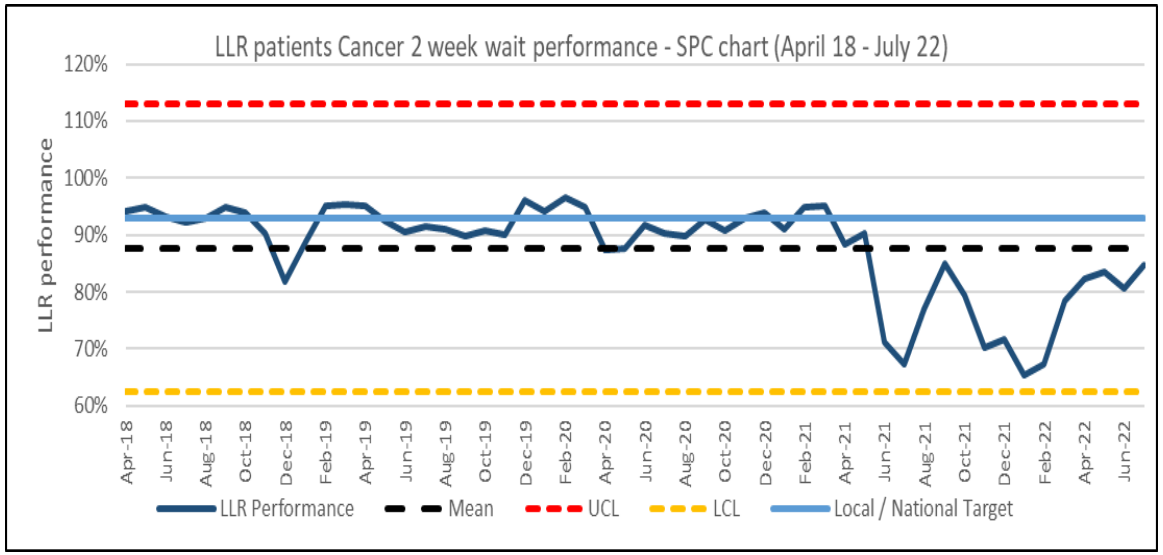
Definition of Priority Level 2: Surgery that can be deferred for up to 4 weeks.

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

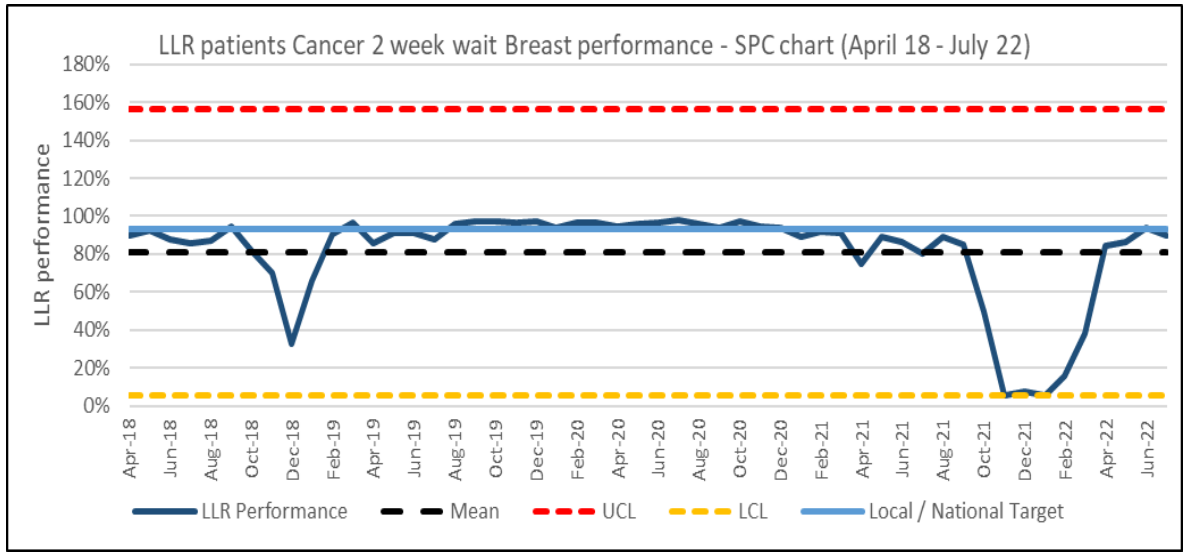


Cancer 2 week wait

2 week wait Cancer Performance for LLR patients at all providers



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



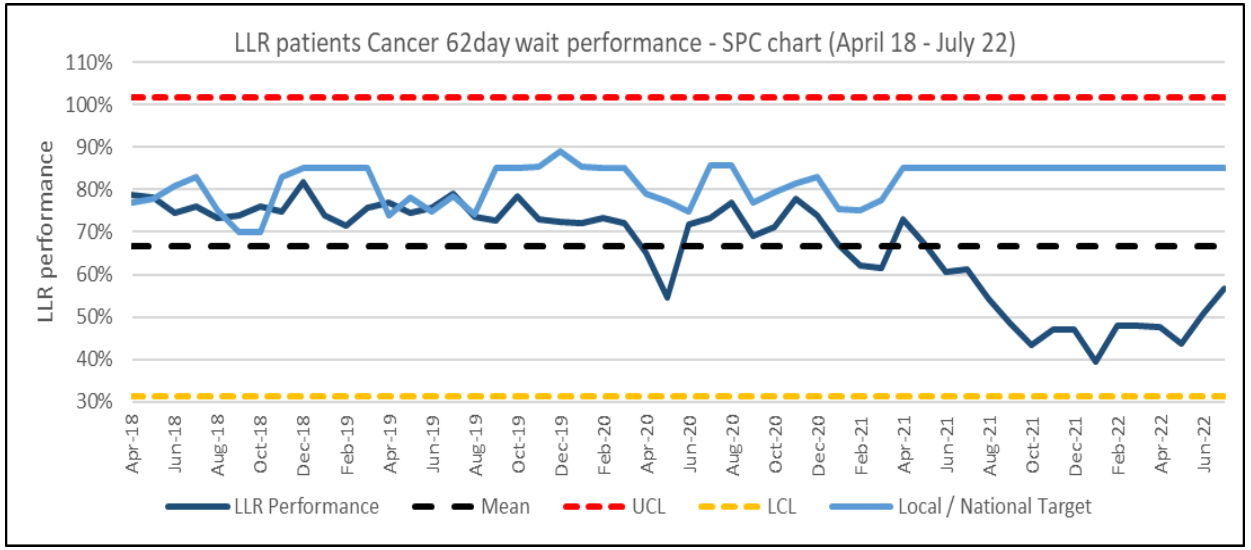
The 2ww demand and backlogs continue to directly impact on performance. Services have struggled to maintain 2ww capacity and despite pathway improvements the standard remains at risk due to the sustained increase in demand, outpatient and diagnostic capacity issues and workforce challenges. Local actions:

-Demand review meetings are being held with all tumour sites to define further required actions to support demand/capacity and improve performance. Additional outsourced capacity has been identified to support Urology diagnostics in August (funded by EMCA).

-Breast continuation of breast pain pathway and insourcing under 35’s.

-ENT backlog is improving due to the increase in clinic capacity.

Cancer 62 day wait



This standard remains challenged with performance standing at 56.82% for July. There are capacity constraints across all points of the pathways and workforce challenges including recruitment. Oncology and radiotherapy are a key area of concern with high wait times.

Local actions:

- Continue to clinically prioritise all cancer patients
- Mutual Aid and insource solutions sought for Urology
- NHSE investment to support Onc/Radth/Haem
- Recruitment for Onc/Radth investment in progress– anticipate impact from Nov.
- Demand and capacity review being shared with tumour sites.
- Develop a backlog report tool and next steps to support focused actions for recovery.
- Updated action plans by tumour site in progress anticipated to be completed by end of September

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%	Aug-22	56.9%	CRS Trial Site	CRS Trial Site	52.4%	63.0%	73.4%	64.4%			
Cancer 2 Week Wait from GP referral	>93%	Jul-22	86.28% 3251/3771	91.43% 64/70	74.29% 26/35	58.59% 58/99	70.11% 122/174	97.14% 34/35	71.67% 43/60			
Cancer 31 day first definitive treatment	>96%	Jul-22	86.26% 339/393	85.71% 6/7	83.33% 5/6	100% 7/7	93.75% 15/16	100% 5/5	100% 3/3			
Cancer 62 day GP referral to first definitive treatment	>85%	Jul-22	55.90% 109/195	100% 4/4	0.00% 0/3	42.86% 3/7	71.43% 5/7	100% 2/2	100% 1/1			
Cancer- 28 Day FDS two week referral	>75%	Jul-22	79.24% 2623/3310	93.75% 45/48	95.00% 19/20	66.67% 56/84	68.21% 103/151	62.50% 20/32	80.00% 32/40			
RTT-18 Weeks Incompletes	>92%	Jul-22	47.2%	66.1%	57.3%	61.0%	55.9%	70.4%	44.4%	38.2%	26.1%	68.9%
RTT-Overall size of the waiting list		Jul-22	111,086	986	1,703	1,821	4,746	1,373	2,640	918	226	928
RTT -Patients waiting over 52 weeks for treatment	0	Jul-22	15,958	14	155	93	313	15	248	119	92	1
RTT -Patients waiting over 104 weeks for treatment	0	Jul-22	308	10	3	0	2	0	0	2	5	0
Patients waiting six weeks or more for a diagnostic test	<=1%	Jul-22	51.39% 18,233/35,482	42.57% 252/592	38.25% 127/332	46.00% 213/463	32.86% 300/913	2.29% 5/218	10.61% 42/396	7.14% 3/42	0.00% 0/31	

Data source- Aristotle

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

Note:

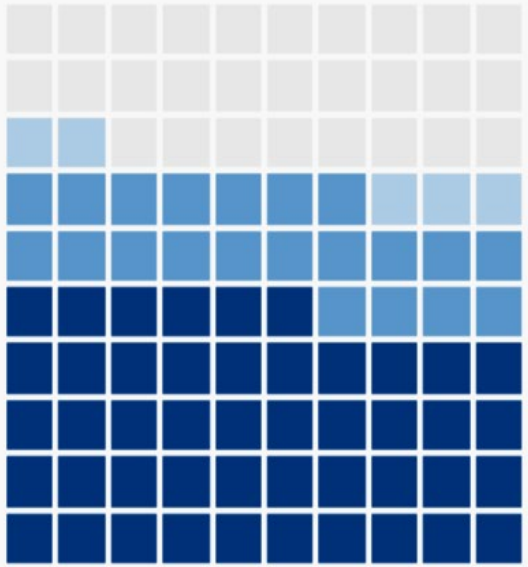
- A&E 4 hour wait remains at Provider level only
- For RTT, Diagnostic tests and Cancer metrics, data is shown for LLR patients only at these providers.
- Metrics have been RAG rated for LLR patients. In some circumstances a metric may be rated red for LLR patients but green as a whole provider position.

Covid Vaccinations – Published Data

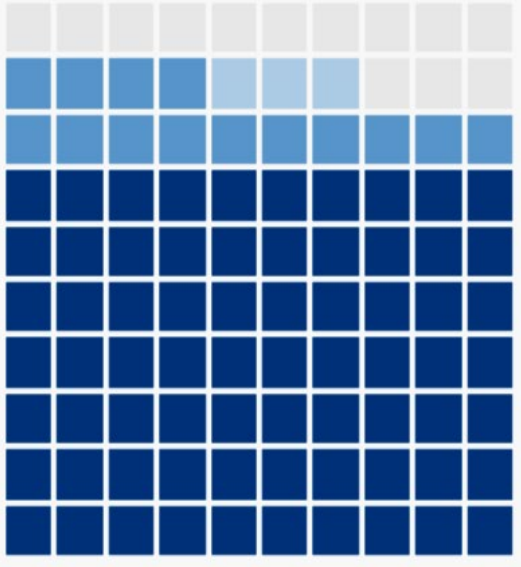
COVID Vaccinations Position, 8-Sep-22:

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

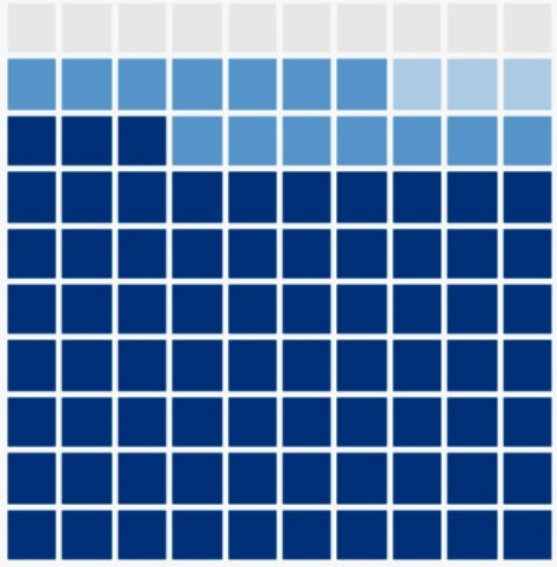
Vaccinations in Leicester



Vaccinations in Leicestershire



Vaccinations in Rutland



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	13 October 2022	**Paper:**	**I**
Report title:	**Assurance Report from the Audit Committee**		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the summary report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes from the inaugural meeting of the Audit Committee meeting held on 16 August 2022. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.
2. A summary of the level of assurance provided by the Committee is detailed in paragraph 18.

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

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

7. Integration	Deliver integrated health and social care.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	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.*	The focus is on the effectiveness of the risk management and internal control processes, which includes review of the Board Assurance Framework and associated processes.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and governance arrangements.

Summary Report from the Audit Committee

Introduction

1. This report provides a summary of the key areas of discussion and outcomes from the inaugural meeting of the Audit Committee held on 16 August 2022. The report also covers items for escalation and consideration by the Board ensuring that the Board members are alerted to emerging risks or issues. The following provides a short summary of the key areas of discussion.

Committee governance arrangements

2. **Review of the terms of reference and work programme –** the terms of reference were received and the work programme for the Committee was reviewed. It was agreed that the terms of reference remained fit for purpose with a minor tweak to include the term "functional standards" which is the current term for the counter fraud standards. The work programme for the Committee was approved.

External and Internal Auditors

3. The External Auditors (Grant Thornton) and the Internal Auditors (360 Assurance) introduced themselves at this inaugural meeting.

4. The **External Auditors** confirmed that the Value for Money (VFM) work 2021/22 for the three CCGs is currently ongoing and anticipated to conclude in the next few weeks. The Q1 external audit for 2022/23 for the three CCGs will be undertaken in January 2023 and the audit work for 2022/23 for the ICB will commence in May 2023.

5. The **Internal Auditors** presented the terms of reference for the Head of Internal Audit Opinion work underway in respect of the CCGs for the period 1 April – 30 June 2022. The Committee approved the Internal Audit Plan for 2022/23 for the ICB recognising the plan was extensive given the establishment of the new organisation, however remained comparable with other ICBs that the auditors worked with.

6. The Internal Auditors have been commissioned to assist with the audit of the **financial sustainability self-assessment.** This self-assessment is mandated by NHS England to determine whether ICBs are managing finances well enough to be sustainable. The self-assessment is to be completed and submitted by 30 September 2022 and the audit review will be undertaken during October – November 2022.

Counter Fraud

7. The Committee approved the Counter Fraud Plan for 2022/23. The key focus for 2022/23 will be to raise awareness amongst staff and work with risk owners to support in identifying potential fraud risks at all levels within the organisation.

Follow-up of Internal Audit actions

8. Committee members noted process in place to ensure internal audit actions are followed-up and implemented by lead officers following an internal audit review. A small number of actions (i.e. 10 actions) have been carried forward from the CCGs and the Committee was assured in respect of the plan in place to complete these outstanding actions by end October 2022.

Risk Management arrangements

9. An overview was provided of the current risk management arrangements in place across the ICB, and assurance provided that these arrangements continue to be embedded and are currently effective.

10. The Committee received an overview of the Board approved the Risk Management Strategy and Policy and the ICB Board Assurance Framework (BAF) 2022/23 containing the strategic risk profile as transferred from the LLR CCGs.

11. The Board has the responsibility to ensure appropriate risk management systems and processes are in place. The Executive Management Team is responsible for the effective implementation of risk management arrangements and ensuring adequate controls are in place to manage / mitigate risks. The Board will seek assurance from the Audit Committee in relation to the effectiveness of these arrangements.

12. It was recognised that risk management arrangements will evolve and also the interface with the risk management arrangements of partner organisations needs to be considered going forward. Consideration will need to be given to ICB specific strategic risks and risks that have an impact on the system, and whether the risk appetite and evaluation of these risks are the same or not.

13. Assurance reports in relation to wider areas of risk management (e.g. business continuity, information governance etc) will be provided to the Audit Committee in line with its work programme.

14. The Committee suggested that a risk in relation to workforce be considered for escalation to the BAF given the recent detailed discussion and concerns raised about workforce at the Board meeting.

Draft Annual Accounts 2022/23 (Q1 closure of CCGs)

15. Confirmation was received that the draft Annual Accounts for the CCGs have been produced. It was noted that there is no opportunity for audit adjustments as NHS England has not indicated a mechanism for this, therefore this is a possible risk should the Auditors identify an issue. The next step following Q1 will be for the external audit review to be carried out in December 2022 / January 2023.

Losses and special payments and waiver of Standing Orders

16. Two losses had been identified with a total value of £3,945.31. Committee members were assured by the rationale underpinning the loss.

17. The Standing Orders had not been waivered.

Summary of assurance from the Committee

18. The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance
1. Committee governance arrangements	**Green**	• Terms of reference approved by the Board. • Work programme in place as approved by the Committee.
2. Progress against External Audit Plan	**Green**	• Plan is progressing.
3. Progress against Internal Audit Plan	**Green**	• Plan is progressing.
4. Progress against Counter Fraud Plan	**Green**	• Plan is progressing.
5. Timely implementation of internal audit recommendations	**Amber**	• Process in place. • A small number of actions (i.e. 10 actions) carried forward from the CCGs and plan in place to complete actions by end October 2022.
6. Plan in place to undertake Financial sustainability audit review	**Amber**	• Plan in place however self-assessment is to be undertaken and submitted in line with national timescales.
7. Effectiveness of the ICB risk management arrangements	**Green**	• ICB Risk Management Policy and Strategy in place, ICB Board Assurance Framework 2022/23 in place, which continues to be reviewed by the Executive Management Team. • It is recognised that the Board will be considering system wide risk appetite, the development of this would be considered 'amber'.
8. Completion of Annual Accounts for Q1 CCGs	**Amber**	• Completion from ICB perspective, however External Auditors to complete their audit of Q1 accounts in December 2022 / January 2023.

Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the summary report for assurance.

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**13 October 2022**	**Paper:**	**J**
Report title:	**Summary report from the Health Equity Committee**		
Presented by:	Professor Azhar Farooqi, Health Equity Committee Chair		
Report author:	Clare Mair, Corporate Affairs Officer		
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:

- **RECEIVE** the summary report.

Purpose and summary of the report:

This report provides a summary of the key areas of discussion and outcomes from the LLR ICB Health Equity Committee held on 16 August 2022. This was the inaugural meeting of the committee which will meet on a bi-monthly basis. The report covers any items for escalation and consideration by the Integrated Care Board to ensure it is alerted to emerging risks or issues.

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

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.	Declarations of interest are declared and managed within the Health Equity Committee. There are no specific conflicts to raise in respect of this report as it is to receive for information.
☐	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.*		Aligned to risks detailed on respective Board Assurance Frameworks and operational level risk registers.
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.		Not reviewed in relation to this summary report as individual reports presented to the Health Equity Committee will have considered and taken due regards to the Public Sector Equality Duty as required.

Summary Report from the LLR ICB Health Equity Committee held on 16 August 2022

1. This report provides a summary of the key areas of discussion and outcomes from the LLR ICB Health Equity Committee held on 16 August 2022. This was the committee's inaugural meeting.

2. The report covers any items for escalation and consideration by the Integrated Care Board to ensure it is alerted to emerging risks or issues.

3. The following provides a short summary of the key areas of discussion, and minutes from the meeting are available upon request.

16 August 2022

3. **Terms of Reference and Work Programme** – following discussion further amendments or clarifications were requested to the Terms of Reference relating to vice-chairing arrangements, extending attendance to include an officer with a patient insight portfolio, making clearer reference to the workforce agenda and being more explicit in its remit of overseeing a reduction in health inequalities, ensuring equitable access and experience for all.

4. The terms of reference would be revised and considered at its next meeting, ahead of approval by the Integrated Care Board.

5. It was agreed the Committee would meet bi-monthly.

6. The Committee will receive assurance from different parts of the system. A dashboard was in the process of being compiled.

7. The work programme was considered. The Committee agreed it would firstly prioritise the national prevention programmes, implementation of the local strategy, local workforce metrics and health inequalities from the planning guidance.

8. **Health Inequalities Strategy overview** – the paper provided an overview of the strategic approach to reducing health inequalities. It had been written ahead of the Core20PLUS5 national expectations and would be revised, however feedback from NHSEI on an earlier iteration had been positive. Revised content would be received by the Committee in October. Delivery of the strategy would now commence.

9. **Funding Allocations for the Health Inequalities Fund** – the proposals for system and place allocations were supported by a simple, evidence-based funding formula. Place funding decisions would be taken through local authority integration structures. System schemes would be signed off by the health prevention and inequalities group. A small management function group would check the scheme proposals were utilising the Health Inequalities money as intended and assurance then provided by the Health Equity Committee.

10. A health inequalities unit was being established as soon as practical. However, the top sliced funds may not cover all intended posts/work.

11. **Digital Health Hub focussing on Health Equity** – The LLR ICB had been invited to participate in a bid for national research funding into digital health, in partnership with Lincolnshire ICB, Higher Education Institutes, Public Health, Private Sector industry leaders and Primary Care (Willows). The Committee gave retrospective support for this bid. The outcome was expected in February 2022.

12. **Tackling Fuel Poverty and Health Crisis in Leicester** – a Leicester City Council-produced briefing paper was received and elicited discussion. The far-reaching implications were acknowledged.

13. Working with the national charity NEA, the City Council was putting in place a 2-year support project (subject to ISOC and JISC approval) who would work to maximise opportunities for service users such as getting the best energy deal, being on the priority services register, access to more efficient boilers through grants, negotiating bills and debts. The work will be delivered in conjunction with and signposting to existing services. Awareness training will be provided to front line staff.

14. The work fits well with Core20PLUS5 deprivation and poverty themes.

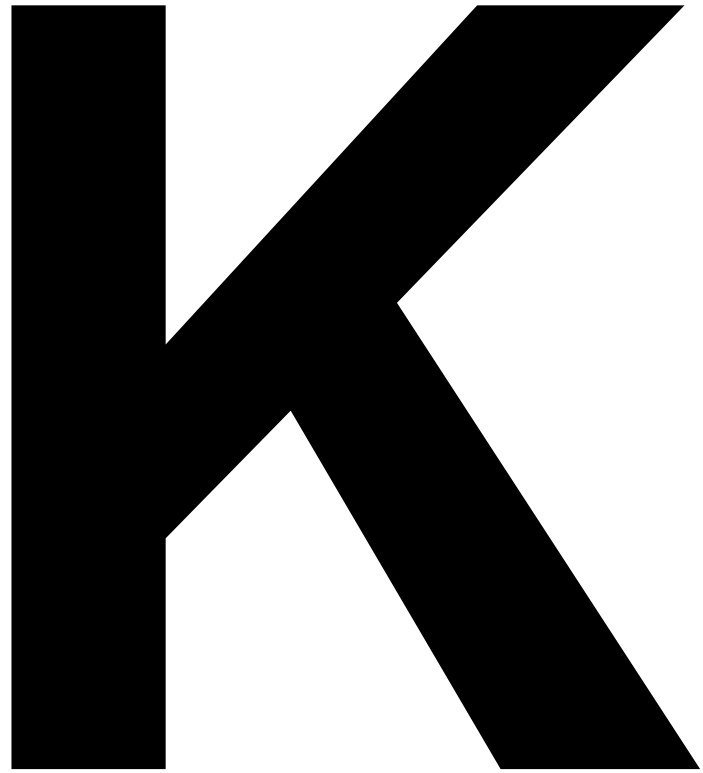
15. **Equality Delivery System** – already a statutory requirement to demonstrate compliance, from April 2023 this will become a legal requirement. The Committee will support this work by understanding how health equity is delivered through its commissioned services and demonstrated through its workforce, their wellbeing and inclusive leadership. Workshops will be arranged to support this programme of work.

16. **Primary Care Workforce** – in response to the comprehensive paper brought to the ICB in August by Dr Nil Sanganee, the Committee felt urgent action was needed to address the primary care workforce issues, particularly in the city. Professor Farooqi undertook to raise this directly with Mr Andy Williams.

Recommendations:

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

- **RECEIVE** the summary report.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	13 October 2022	**Paper:**	**K**
Report title:	**Mandated amendments to the LLR ICB Constitution**		
Presented by:	Sarah Prema, Chief Strategy and Planning Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Executive Sponsor:	Sarah Prema, Chief Strategy and Planning Officer 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 Integrate Care Board is asked to:

- **ENDORSE** and **ADOPT** the mandated changes to the NHS LLR ICB Constitution and Standing Orders as approved by NHS England.

Purpose and summary of the report:

1. The LLR Integrated Care Board (ICB) is asked to adopt and approve the mandated amendments to the ICB's Constitution as approved by NHS England.

2. NHS England's legal team have recently conducted a review of the model constitution that was published in May 2022 and identified several small amendments that need to be made. ICBs are required to amend their Constitutions to reflect these amendments.

3. A summary of the required amendments to the *ICB Model Constitution* document are detailed in the table below:

Section of the Model Constitution	Amendment
Section 1.4.7 (f)	Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z45'
Section 3.2.4	Reference to the 'sections 56A to 56K of the Scottish Bankruptcy Act 1985' replaced with 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
Section 3.2.7	'A health care professional (within the meaning of section 14N of the 2006 Act)….'. First line updated to remove reference to section 14N of the 2006 Act and capital letters for 'Health Care Professional'. Line to read as follows 'A Health Care Professional or other professional……..'.
Section 7.1.1	Reference to 'paragraph 11(2)' amended to 'paragraph 12(2)'.
Appendix 1	Add definition of 'Health Care Professional' to the table. Definition to be added: 'An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'

4. Once approved the updated Constitution will be published on the ICB's website.

5. Where changes are made to the ICB Constitution, usually there would be a requirement to submit an application to NHS England to approve these amendments. However, we have been advised by NHS England that on this occasion, as the above amendments have already been approved by NHS England, the Board is required to ratify this decision and confirmation of the decision made is to be submitted to NHS England.

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

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance arrangements could result in non-compliance with legal and statutory requirements.

b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and due regard is considered in the development of the strategies and policies of the organisation.

NHS LLR ICB meeting forward planner

LLR INTEGRATED CARE BOARD meeting work programme / forward planner (v6 September 2022)	Lead Officer(s) / Sponsor(s)	2022/23 (meetings to be held bi-monthly and development sessions in intervening months)									
AGENDA ITEMS		1st Jul	14 July	Aug	Sept (dev.)	Oct	Nov (dev.)	Dec	Jan (dev.)	Feb	Mar (dev.)
Welcome and introductions	David Sissling	✔	✔	✔		✔		✔		✔	
Apologies for absences	David Sissling	✔	✔	✔		✔		✔		✔	
Declarations of interest on agenda items	David Sissling	✔	✔	✔		✔		✔		✔	
Receive questions from the public relating to items on the agenda	David Sissling	✔	✔	✔		✔		✔		✔	
Minutes of the previous meeting - to approve	David Sissling	✔	✔	✔		✔		✔		✔	
Matters arising: update on actions from the meeting	David Sissling	✔	✔	✔		✔		✔		✔	
Notification of Any Other Business	David Sissling	✔	✔	✔		✔		✔		✔	
Chair's Overview	David Sissling	✔	✔	✔		✔		✔		✔	
Chief Executive's Overview	Andy Williams	✔	✔	✔		✔		✔		✔	
STRATEGY AND SYSTEM PLANNING											
Strategic Objectives, Principles and Priorities including 5 year Strategy Plan	Sarah Prema	✔									
5-year Forward Plan - updates	Sarah Prema					✔		✔			
5-year Forward Plan - to approve	Sarah Prema									✔	
Planning for second half of the year (H2) - review	EMT					✔					
System development Plan - to approve	Sarah Prema									✔	
Joint commissioning arrangements for 2022/23 (including joint committees with local authorities, trusts / foundation trusts, other ICBs and NHS England and Improvement) - to review and approve (tbc)	Sarah Prema / Rachna Vyas										
Provider partnership arrangements *(timescales to be confirmed)*	Sarah Prema					✔					
Sustainable Development Strategy / The Green Plan - to review (to go through System Exec)	Sarah Prema										
Sustainable Development Strategy / The Green Plan - to approve	Mike Simpson							✔			
People and Communities Strategy - to approve	Alice McGee	✔									
Quality Strategy - to approve	Caroline Trevithick	✔									
Quality Strategy - to receive report on impact of strategy	Caroline Trevithick							✔			
Professional Leadership Strategy - to approve	Dr Nil Sanganee	✔									
Professional Leadership Strategy - to receive report on impact of strategy	Dr Nil Sanganee							✔			
Digital Strategy - to approve	Alice McGee	✔									
Digital Strategy - to receive report on impact of strategy	Alice McGee									✔	
System level business cases (as required, above committee delegation)	EMT										
Delegation of NHS England & Improvement commissioning functions	Sarah Prema			✔							
Thematic reviews e.g. estates, system flow etc	EMT										
Equality Objectives - to approve	Alice McGee		✔								
Equality and Inclusion Strategy and Policy - *(timescales to be confirmed)*	Alice McGee									✔	
Health Inequalities Framework - to approve (tbc)	Sarah Prema										
Research and development - updates (via Clinical Executive through to System Executive now)				✔				✔			
OPERATIONAL											
System Flow update (elective and urgent and emergency care)	Rachna Vyas / Debra Mitchell	✔		✔		✔		✔		✔	
The 2023/24 Operational Plan - to review (tbc)	Sarah Prema										
The 2023/24 Operational Plan - to approve (tbc)	Sarah Prema										
Update on system leadership, People Plan and recruitment	Alice McGee					✔					
Ockenden Review into maternity services - briefing / assurance of implementation of recommendations	Caroline Trevithick										
Update on primary care	Dr Nil Sanganee			✔							
ASSURANCE											
Assurance Report from the Audit Committee	Caroline Gregory			✔		✔		✔		✔	
Assurance Report from the Remuneration Committee (as required)	Alice McGee										
Performance assurance report	Andy Williams (Caroline Trevithick)			✔		✔		✔		✔	
Assurance Report from the System Executive	Andy Williams			✔		✔		✔		✔	
Regular finance report	Caroline Gregory			✔		✔		✔		✔	
Assurance Report from the Finance Committee	Caroline Gregory			✔		✔		✔		✔	
Assurance Report from the Health Equity Committee	Sarah Prema										
Assurance Report from the Quality and Safety Committee	Caroline Trevithick			✔		✔		✔		✔	
GOVERNANCE ARRANGEMENTS											
ICB Constitution to review (including the Standing Orders) (as required)	Caroline Gregory	✔									
ICB Constitution to approve (as required)	Caroline Gregory	✔									
ICB Scheme of Reservation and Delegation (SoRD) - review	Caroline Gregory	✔									
ICB Scheme of Reservation and Delegation (SoRD) - approval	Caroline Gregory	✔									
Standing Financial Instructions - to approve	Caroline Gregory	✔									
ICB Governance Handbook - to approve	Caroline Gregory	✔									
Standards of Business Conduct Policy / Conflicts of Interest - to approve	Caroline Gregory	✔									
Functions and decision map - to review	Caroline Gregory	✔									
Functions and decision map - to approve	Caroline Gregory	✔									
Audit Committee Terms of Reference - to approve (statutory committee)	Caroline Gregory	✔									
Remuneration Committee terms of reference - to approve (statutory committee)	Alice McGee	✔									
System Executive Committee terms of reference - approve (locally established)	Andy Williams	✔									
Finance Committee terms of reference - to approve (locally agreed committee)	Caroline Gregory	✔									
Health Equity Committee terms of reference - to approve (locally agreed committee)	Sarah Prema	✔									
Quality and Safety Committee terms of reference - to approve (locally agreed committee)	Caroline Trevithick	✔									
Corporate Policies for approval	Caroline Gregory	✔									
ICB forward planner - for review	David Sissling			✔							
ICB forward planner - for approval	David Sissling					✔					
Undertake effectiveness review of the governance arrangements	Caroline Gregory									✔	
Development sessions / topics:											
Board Constitution and Governance	Caroline Gregory						✔				
Board/Team Development (Values, behaviours, criteria for success, Cohesion)	Alice McGee				✔		✔		✔		✔
Collaboratives (tbc)	Sarah Prema										
Place and Integration	Sarah Prema/Rachna Vyas								✔		
Addressing Health Equity	Sarah Prema								✔		
Transformation and service development	Rachna Vyas						✔				
Building Better Hospitals	Richard Mitchell (UHL)						✔				
People and Communities	Alice McGee										✔
Estates and the Green Plan	Mike Simpson (UHL)						✔				
People Plan	Alice McGee										✔
Board Assurance Framework - the Board's appraoch to Risk	Caroline Gregory				✔						
Quality improvement (tbc)	Caroline Trevithick										
Engagement with the public - open question and answer session	David Sissling				✔						
Digital Transformation (tbc)	Alice McGee										